Department of Health

The Health and Care Professions (Public Health Specialists and Miscellaneous Amendments) Order 2015

Government response to the consultation

February 2015

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The Health and Care Professions (Public health Specialists and Miscellaneous Amendments) Order 2015

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Chapter 1: Introduction

The Department of Health ran a consultation on behalf of all four UK Health Departments, on the statutory regulation of public health specialists from backgrounds other than medicine and dentistry between 4 September and 14 November 2014. The proposal was to introduce an Order under Section 60 of, and Schedule 3 to, the Health Act 1999 to extend statutory regulation to this group of professionals through the Health and Care Professions Council (HCPC).

Following concerns raised shortly after the consultation was published, the consultation period was extended and an additional two questions were added to the consultation.
The consultation looked at a number of issues including:

- whether the HCPC is the right organisation to regulate public health specialists from backgrounds other than medicine or dentistry or whether this should be done by another body
- whether outstanding UKPHR fitness to practise cases at the time of transfer should be investigated and determined by the HCPC under the HCPC's rules
- a grandparenting period of two years to allow non-medical public health specialists who are not registered or eligible to be registered with the UKPHR to apply for registration.
- protection of the title "public health specialist" for those registered by the HCPC.
- whether the defined specialist category should be retained
- the impact of public health specialists from a non-medical or dental background being required to register with the HCPC and the consequences this might have for those registered with a professional body other than the HCPC
- changes to the governance arrangements of the HCPC to take account of recent court rulings

This document provides a summary of responses to the consultation and the Governments response.

Chapter 2: The consultation

The consultation exercise was in accordance with the Cabinet Office Consultation Principles published in July 2012 (Annex A). The consultation process ran from 4 September to 14th November 2014.

The consultation document was published on the Department of Health's website, with an option to respond on-line through Citizen Space. The consultation asked eight questions relating to the regulation of public health specialists from backgrounds other than medicine or dentistry and two about procedural matters for the Health and Care Professions Council (HCPC), including:

Number and range of responses

We received 168 responses to the consultation by e-mail and on-line of which 66 were on-line and 102 were by e-mail. Of the responses 50 were from organisations and 118 were from individuals. A full list of organisations responding is at Annex B.

Chapter 3: Consultation responses

In this section we have summarised the responses to each of the consultation questions. Not all respondents answered every question, whilst others commented more broadly on the proposal

In this response we deal firstly with the two supplementary questions that were added to the consultation on 9 October 2014. We then deal with the more detailed questions in the context of the responses to the supplementary questions.

Do you agree with the Department's decision that the HCPC should be the statutory regulator for public health specialists from backgrounds other than medicine or dentistry? If not, why not?

Do you think public health specialists should be regulated through another body? If so, who and why?

Responses to this question fell in to four broad categories:

- those that supported the proposal to regulate non-medical public health specialists through the HCPC (44)
- those that argued that the UKPHR should be either a voluntary or statutory regulator for this group (56)
- those that did not express a clear preference (20)
- those that argued against a requirement for dual registration (8)

I agree that the HCPC should be the statutory regulator for public health specialists from backgrounds other than medicine or dentistry. I do not consider it appropriate or desirable to create another statutory regulator specifically for public health specialists when an appropriate statutory regulator is already in existence. (individual)

No – not under the current system that the HCPC operates or under the terms of the draft Section 60 Order. As it stands, UKPHR should be the register for proper statutory registration of non-medical public health specialists. The HCPC has no experience in public health professionalism, has no revalidation procedures and only a generic CPD programme. (local authority)

Whichever body is chosen as the statutory regulator the most important consideration is that the body has the necessary resources and experience to effectively and efficiently regulate public health specialists. The regulator must ensure that: at the time of first registration, the specialist has demonstrated the competences in the most recent approved curriculum; that maintenance of this competence is demonstrated periodically; and that appropriate systems to ensure due process and sufficient resources are available to investigate and manage fitness to practice or other conduct issues. All this must be achieved at the minimum cost to registrants. HCPC are in a position to deliver this without any further delay" (national organisation)

We do not consider that the Scally review, or any of the other material cited in the consultation document, provides a clear evidence base to justify a requirement for dual registration on those individuals who are already regulated by another statutory healthcare regulator, where their scope of professional practice encompasses their practice as a public health specialist (regulator)

Of those respondents that thought public health specialists should be regulated through another body, the majority suggested UKPHR, with a small number suggesting the Nursing and Midwifery Council, the General Medical Council or the General Pharmaceutical Council.

A number of respondents, particularly those supportive of the UKPHR as the regulator, argued that regulation through the HCPC would further fragment the public health workforce.

> *Public health has already become fragmented within the new public health system with staff working in a variety of organisations on varying terms & conditions. Any further changes will only risk further fragmentation and cause further disruption amongst the specialist workforce. (individual)*

The Department acknowledges that the public health workforce is extremely diverse and indeed this is one of its strengths. Many health professional groups, particularly practitioners, are already subject to statutory regulation through different regulators for example, specialist community public health nurses and pharmacists. Whilst the UKPHR has ambitions to expand its practitioner registration scheme, which the Department supports, the numbers registered so far are small and we do not therefore accept that the proposal on which DH consulted would fragment the workforce.

Some respondents argued that the HCPC does not have any experience of public health and is not therefore an appropriate regulator for public health specialists.

> *It does not make sense to use a body that has no reference to public health and has 15 very different health professionals to regulate. We need an appropriate body that understands the career pathway to public health specialist level and takes into account the practitioner status. Something very similar to NMC and GMC but the product is multi-disciplinary public health at one of two entry levels on the register. (individual)*

The Department believes that the HCPC has is an experienced regulator and has a proven track record of taking on the regulation of new professional groups, most notably social workers in England in 2012. Given its history, the Department believes that the HCPC, working with key stakeholders, has the experience and capacity to be an effective regulator for public health specialists.

A number of respondents argued that the UKPHR should be made the statutory regulator for public health specialists.

> *I would favour turning UKPHR, already respected, proven and knowledgable, into a statutory register for all professional practice in Public Health enabling those wishing to retain prior registration with regulatory bodies such as GDC, NMC, GMC, IHM etc to do so as dually registered, if they wished, as both a nurse, for example, and a public health specialist (or practitioner). (individual)*

This Governments commitment is to introduce statutory regulation for public health specialists from a non-medical or dental background and whilst UKPHR's accreditation as a voluntary register is to be welcomed, a significant amount of work would need to be done over several years to establish it as a statutory regulator. There would have to be a consultation on that a new policy, and depending on the outcome of that consultation legislation in the form of a section 60 Order would be required to create a regulatory body. That process would take at least 2 years taking into account periods of consultation on the draft order itself.

Some respondents argued that statutory regulation of public health specialists through the HCPC will impact on practitioner registration.

The practitioner registration schemes are maturing and pilot 'advanced practitioner' schemes are being implemented. This is establishing a coherent career support pathway which would be fractured by the proposal. (individual)

The Department's view is that the proposal to extend statutory regulation to public health specialists from a background other than medicine or dentistry has been known about for some time during which many new practitioner registration schemes have been established across the UK and additional local schemes continue to be developed. We do not therefore accept this argument.

Some respondents argued that the proposal to regulate through the HCPC would not achieve the stated policy objective of equity between public health specialists from different backgrounds as there is no proposal to establish a revalidation scheme equivalent to that for public health specialists registered with the GMC. Respondents further argued that the UKPHR has an equivalent scheme and therefore would meet the stated policy objective.

> *The Scally review (2010) identified the importance of revalidation and highlighted that as UKPHR did not have an equivalent system to the GMC and GDC that was legally enforceable, that this created inconsistency. The GMC and GDC have robust systems in place and the NMC is in the process of implementing its model. The UKPHR now has in place a system that mirrors that of the GMC. The HCPC however, do not yet have a process for revalidation but are undertaking various research projects to determine whether they require any additional measures. (union)*

However, the GMC is unique amongst statutory regulators in that in addition to registration, it also conveys requires medical practitioners to have a license to practise to which revalidation is linked. It is therefore not possible for any of the existing statutory regulators to bring in an equivalent process without primary legislation, nor for the UKPHR system to be considered equivalent. If this policy objective were to be taken forward through the introduction of such a scheme for the HCPC, there would have to be a period of consultation on that policy. If a decision was made to implement that policy, then a section 60 would be required to amend the Health and Social Work Professions Order 2001.

The Department is supportive, in principle, of a revalidation scheme for public health specialists from a background other than medicine or dentistry and would encourage the Faculty of Public Health, Public Health England and the regulators to explore what non-statutory options there may be to introduce such a scheme.

In addition to the points above, we gave careful consideration to the arguments put forward by existing statutory regulators about the impact our proposal might have on public health specialists who also wanted to maintain registration with a regulator other than the HCPC. Detail of the Government's response to these arguments is set out in response to question three below.

Q1. Do you agree that outstanding UKPHR fitness to practise cases at the time of transfer should be investigated and determined by the Health and Care Professions Council in accordance with the Health and Social Work Order 2001 (S.I. 2002/254)? If not, why not?

Of those that responded a significant majority agreed with this proposal. Many of those who disagreed, did so because they believe the UKPHR should be the regulator and therefore saw no role for HCPC.

> *It is not clear that HCPC staff will have the competence or understanding of the profession at the point of transfer. It is obviously essential that the decisions are equivalent but it would be helpful to have a clear explanation of the way in which the staff and senior office bearers will acquire the expertise or appoint professional advisers from GMC/GDC/UKPHR to ensure the equivalence and robustness of decisions taken. (individual)*
>
> *Yes. However, PHE would like to see a clear handover process and, in particular for those whose investigations are drawing to a conclusion at the point of transfer, there will need to be a clear means of appeal via the new organisational structure. (national organisation)*
>
> *As long as the goal posts remain the same, as the boundaries for determining fitness, as they would have done under the UKPHR to practice then yes any outstanding cases should be investigated by the new regulatory body (individual)*

Based on the responses received, the Department will make no changes to the Section 60 Order.

Q2. Do you agree that the grandparenting period for registration as a public health specialist should be two years?

Of those that responded the majority agreed, while some respondents felt that grandparenting period should be shorter and a small number arguing that it should be longer. Some respondents felt that grandparenting should not be necessary as the portfolio route to UKLPHR registration has been available for many years.

> *Two years is a suitable time period (accepting the exemptions laid out in the consultation document) if a grandparent period is the only way to access the register. Thought should be given to providing a clear roadmap for future career pathways with flexible options for attaining accreditation as a specialist. (individual)*
>
> *I agree there should be grandparenting. The time will be dependent on the precise nature of what process will be in place to ensure competency etc. I think 2 years are likely to be a minimum, if this process is transparent and robust and also the professional assessors adjudicating on competence have had uniform training and a common understanding of what determines competence has been met. (individual)*
>
> *We do not agree that the grandparenting process should be two years. Within public health there has been a previous grandparenting process via the portfolio route and therefore all appropriately qualified and practising professionals should already been voluntarily registered or eligible to be on that register. It is therefore not necessary to have another grandparenting period when changing from voluntary to statutory regulation. Introducing another long grandparenting window that is not needed may allow people who have not been through a process to demonstrate competence to obtain equivalence with those who have. (public health registrars)*

Many respondents had interpreted the grandparenting period as time to allow people to complete a portfolio – one of several ways that someone who wants to use the protected title could demonstrate necessary competence to be accepted on to the register. The purpose of grandparenting is to provide someone who is currently using the protected title but not eligible for admittance on to a register, to produce evidence of competence and apply for admittance on the register. It will be for the HCPC to decide what eligibility criteria it will use for entry to the register and we would expect the HCPC to work with the FPH and other regulators to ensure there is consistency across the system.

> *This depends on the criteria for accepting people into the grandparenting period and who you are referring to – those on the training scheme – many will need longer that the 2 years to be registered if they have only just started their training. If you are referring to those that may be eligible through a portfolio route then again this depends on how eligibility for grandparenting will be assessed. It also depends on the options that will be available after the grandparenting period for people who still wish to become recognised as Public Health Specialists. If the portfolio route is to close then the grandparenting period will need to be extended. (individual)*

The Department has decided to leave the grandparenting period at two years.

Q3. Is the impact of these public health specialists being required to register with the HCPC of significant consequence?

This question was designed to test the impact on public health specialists who wanted to maintain registration with another regulator. The majority of respondents felt that a requirement for public health specialists who held registration with another statutory regulator would have no impact or would be beneficial. A small number felt the impact would be negative and some agreed it would be significant, but for a range of reasons.

> *The requirement to be registered with the HCPC will have a significant positive consequence, bringing equivalence to the profession and increased credibility for those public health specialists who have been under voluntary registration (Professional body)*

> *Yes but it is necessary. Having a voluntary register undermines the regulatory process as the general public may have a false assurance that public health specialists are regulated when they are not. Therefore mandatory regulated when they are not. (registrars)*

> *The regulators mentioned in the consultation document, including the Nursing and Midwifery Council (NMC), only maintain registers for the professions they regulate; they do not maintain specialist registers or lists which identify which of their registrants have subsequently gone on to qualify as public health specialists (regulator)*

Some of the existing regulators argued that this proposal would disadvantage public health specialists who wanted to maintain registration with a regulator other than the HCPC.

> *..we have significant concerns about the potential dual registration and regulation of pharmacists going forward. Therefore, we suggest that professional, who are already regulated by an existing health or social care regulator for their work in that profession, should be excluded from any new requirement to register with the HCPC (regulator)*

After careful consideration of these points, the Department has decided to amend the Section 60 Order so that the exemption that applies to public health specialists on the GMC specialist register and GDC specialist list will also apply to those public health specialists on the Nursing and Midwifery Council register and the General Pharmaceutical Council register, with an annotation recognising their specialist public health qualification. It will be for the NMC and GPhC to decide whether to introduce such an annotation and they will need to work with the HCPC, the other regulators and the FPH on the detail of these arrangements.

The Department also gave consideration to the issue raised of doctors who may be employed as a public health specialist but not on the GMC specialist public health register. Foundation Trusts have freedom to recruit consultants and may choose to recruit someone who has been through the training programme but for some reason has not obtained a CCT and is therefore not on the GMC public health register. As drafted, the effect of the Section 60 would mean those doctors would be committing an offence if they used the protected title of public health specialist. DH believes that providing doctors not on the GMC specialist public health register with an exemption could undermine the purpose of the protected title and has therefore decided not to make any changes to the Section 60 Order to ensure that there is consistency in its application across all regulators. Doctors who wish to use the title can to apply to register with either the GMC specialist register or in the part of the register that relates to public health specialists under HCPC.

Q4. Do you agree that "public health specialist" should become a protected title?

There was a mixed response to this question with the majority of respondents agreeing that "public health specialist" should be the protected title. However, a minority of respondents also called for "consultant in public health" and "Director of Public Health" to also be protected titles.

> *Recognising that protected titles are about demonstrating that an individual is qualified and registered, not about job roles, [we] agree with the protected title of 'public health specialist. [We] do acknowledge the arguments for the protected titles of 'Public Health Consultant' or 'Consultant in Public Health' as these are standard titles and do not emphasise a medical/nonmedical distinction. However, an individual is a consultant because they are appointed by an appointments advisory committee. Being a public health specialist is necessary but not sufficient to be a consultant, as competencies relating to the specific job description need to be demonstrated at interview (Professional body)*
>
> *A further consequence of the introduction of, in our view, the rather nebulous protected term, 'public health specialist' will be the inevitable 'rush' of many other public health practitioners in both the public and private sectors who are not currently statutorily regulated, and who Government have not identified as a risk. If the intention of this Order is to protect the public from harm from those who are practising as Directors of Public Health, rather than the wider public health workforce (which is of a significant size) could DH consider introducing statutory protection of title for 'Directors of Public Health?' (Representative organisation)*
>
> *Yes. We also agree with comments by other stakeholders that there is a real threat of diminishing the strength of specialist identity. We therefore believe that the job titles consultant in public health and director of public health should also be protected. (representative body)*

I think that the term Public Health specialist denotes expertise. Other terms such as Director of Public Health and Consultant in Public Health denote the level of seniority and responsibility that a PH specialist might be working at. A PH Director and a consultant should be a PH specialist but not all PH specialists would be consultants or directors. (individual)

The Department remains of the view that these are job titles that make up only a small number of job roles and functions performed by public health specialists and it would not be suitable or feasible to protect them. DH has decided that the protected title should be 'public health specialist'.

Q5: Which of these options for defined specialists, if either, do you think is appropriate?

There was a mixed response to this question with roughly equal numbers supporting option A, option B or not expressing a clear preference.

In general there was recognition of the skills and experience of people currently on the defined part of the UKPHR register but some respondents had concerns about the differentiation between generalist specialists and defined specialists. A significant number of respondents also argued that it is important that there is a single set of standards and a single protected title.

We are not convinced by the argument to separately distinguish generalist and specialist public health specialists. As with other professions HCPC should set the standards by which a 'public health specialist' is admitted to the Register and all practitioners who wish to enter the Register should meet these standards. Additional qualifications, specialisms or roles are a matter for the employer or professional body to determine. (professional body)

As the standard setter for specialist public health, [we] strongly argue that for the quality assurance of the profession, for the protection of the public, and the maintenance of high standards of public health competence that there must be only one standard and one set of competence areas for specialist public health. While the evidence required to demonstrate attainment of this standard can be flexible, the standard itself must be maintained. (professional body)

In terms of statutory regulation (whatever the regulator) there is no need to separate defined from generalist specialists as the portfolio requirements are judged to have equivalence. In terms of appointments to specific occupational roles, the particular expertise of certain defined specialists may play a part in appointment, but this is not an issue for the regulator. (individual)

Option B. There is a need for the continuation of the defined specialist registration route. There is already a national recognised gap for the development of the public health workforce between practitioner and specialist level and defined specialist registration offers some opportunity for aspiration and progression. There is also a need for defined specialists in the workforce particularly around the areas of infection control, public health analysts and academia. There is a concern that potentially relying on the generalist training route may result in insufficient numbers to meet the needs of the system. Closing the defined specialist route could potentially stunt the growth of the public health workforce. There is a need to protect this workforce and the statutory regulator must

guarantee there are robust mechanisms in place to assess and validate this route. (local authority)

"… defined specialists are very different individuals to generalists, with very specialist skills in focused areas of public health practice. However there is a need to ensure registration is kept simple and there should only be one register, possibly recording extra skills within the register. This issue around defined specialist registration probably needs further debate and communication to reach a clear conclusion (national organisation)

On balance, DH believes the benefits of option A outweigh those of option B and there will therefore be a single register for public health specialists within the HCPC.

Q6: Do you agree that the requirement for a Council member to chair Registration Appeal Panels should be removed?

The majority of respondents who replied to this question agreed with this proposal. Of those who disagreed some had misinterpreted the proposal as applying only to public health specialists rather than to the HCPC's overall operation.

Yes. A chair must have the necessary attributes, be properly trained, appropriately qualified, impartial, and have access to the necessary resource and support. The selection, training and monitoring of a chairs performance is key, not the requirement to be a member of council. (national organisation)

Yes, but there needs to be properly trained, appropriately qualified, impartial Chairs. (professional body)

No specific comment provided the process for appeals remains consistent across all regulators. (individual)

The process should mirror the GMC's as closely as possible. The registration appeal panel chair for the GMC is legally qualified and appointed from a pool maintained by the GMC. (representative organisation)

Based on the response, the Department will remove the requirement for a Council member to Chair the Registration Appeals Panel.

Q7: Do you agree that a HCPC panel should have the power to make a striking-off order in a health or lack of competence case provided the registrant has been the subject of a continuous substantive suspension or conditions of practice order for at least two years?

The majority of respondents who replied to this question agreed with this proposal. Of those who disagreed some had misinterpreted the proposal as applying only to public health specialists rather than to the HCPC's overall operation.

As with the previous two questions, the HCPC powers and processes in respect of public health registrants should be harmonised to those already used by the GMC, to ensure that the public can have confidence that the standards of regulation are the same for all public health specialists. (representative organisation)

If public health specialists are registered by HCPC, then their authorised fitness to practise panels should have the power to erase a specialist from the register. As noted above, however, in line with current good practice in professional regulation, the Panels should be at arms' length (or more) from the Register, rather than being viewed as 'a HCPC panel', as stated in this question. (national organisation)

Any regulatory body should be able to act in this way as long as it is within the law. Like the NMC the registrant needs to know what is at stake – worst-case scenario is being 'struck off' – this is what is seriously lacking with the current voluntary provision. Efforts to raise the standards of the individual in a safe way are important but strike off may be the only safe option (individual)

Based on these responses, the Department the Section 60 Order will provide the HCPC with this power.

Q8: Is our estimate of the numbers of non-medical public health specialists working in the independent or private sector reasonable?

This question was to support the development of our impact assessment, which assesses the impact our legislation might have on the private sector. The majority of public health specialists work in the public sector but we wanted to test the assumption we had made about numbers in the private sector that was based on the responses to the CfWI survey conducted in November 2013.

About a quarter of respondents felt our estimate was reasonable, about a quarter felt it was an underestimate and about half said they did not know or didn't answer.

Through my work with UKPHR I am aware that public health specialists are working in increasingly diverse environments but accept that the numbers will nevertheless represent a modest proportion of the whole. (individual)

We do feel this is an underestimate. There are quite a number of self-employed specialists and this has increased in the last few years. There are also quite a few people on interim contracts who may not be included in these figures. There are many others who work for other organisations such as PHAST, Matrix or organisations such as PWC etc. (professional body)

There may be a few more but we would agree that the economic impact would be negligible (local authority)

Yes based on what you have presented. (local authority)

The Department was grateful to those who commented on this question and has updated the impact assessment accordingly.

Annex A: The consultation process

Criteria for consultation

This consultation aims to:

- formally consult at a stage where there is scope to influence the outcome;
- consult for a proportionate period
- be clear about the process in the consultation documents, what is being proposed, the scope to influence, and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure effectiveness and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials are guided on how to run an effective consultation exercise and share what they learn from the experience.

Comments on the consultation process itself

If you have concerns or comments that you would like to make relating specifically to the consultation process itself please:

contact Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Annex B – List of organisations that responded

Association of Directors of Public Health
Association for Nutrition
Berkshire Public Health
Bristol City Council Public Health Team
British Dietetic Association
British Dietetic Association Public Health Network
British Medical Association
Camden and Islington Public Health Department
Chartered Institute of Environmental Health
Chartered Society of Physiotherapy
Cumbria and Lancashire Public Health Collaborative
Cumbria and Lancashire Public Health Leadership Group
Director of Public Health, Suffolk
Directors of Public Health Wales
Directors of Public Health Network, Yorkshire and Humber
Faculty of Public Health
Faculty of Public Health Specialty Registrars Committee
General Dental Council
General Medical Council
General Pharmaceutical Council
Health and Care Professions Council
Health Statistics Users Group
Kent County Council
Local Government Association
NHS Ayrshire & Arran Public Health Department
NHS Dumfries and Galloway Public Health Directorate
NHS Greater Glasgow & Clyde Health Board
NHS Health Scotland
Nursing and Midwifery Council
Pharmaceutical Public Health Network, Scotland
Professional Standards Authority
Public Health Agency Northern Ireland
Public Health Consultants and Heads of Service Network NE England
Public Health England
Public Health Network Scotland
Public Health Registrars Wales
Public Health Wales
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians
Royal Environmental Health Institute Scotland
Royal Pharmaceutical Society
Royal Society for Public Health
Scottish Health Promotion Managers
Scottish Public Health Specialists
Sefton Council
Sheffield City Council
Society and College of Radiographers
UK Public Health Registry
Unite
Welsh Dietetic Leadership and Advisory Group