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Unite the Union Consultation Response to:

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

This response is submitted by Unite. Unite is the UK's largest trade union with 1.5 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport, local government, education, health and not for profit sectors.

Unite represents in excess of 100,000 health sector workers. This includes eight professional associations - British Veterinary Union (BVU), College of Health Care Chaplains (CHCC), Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Hospital Physicists Association (HPA), Medical Practitioners Union (MPU), Mental Health Nurses Association (MNHA), Society of Sexual Health Advisors (SSHA).

Unite also represents members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

Of particular relevance to this consultation is that;

(a) Through the agreement entered into by the MPU and the BMA on the 23rd December 1950 UNITE is party to the representative machinery of the medical profession and is the only trade union recognised by the NJC for Local Government.

(b) UNITE is the main trade union representing non-medical public health consultants and this is acknowledged by its seat on the Public Health Medicine Consultative Committee.

(c) The CPHVA Section of UNITE is the largest professional body for public health practitioners from a nursing background.

Introduction

Unite welcomes the opportunity to respond to the consultation on *the Health and Care Professions (Public Health Specialists and Miscellaneous Amendments) Order 2015.*

As part of this response, Unite has used its ongoing routes throughout the organisation to hear back the views of our members, particularly those who are Public Health Specialists, and these have informed our response.

Response to the consultation

Question 1: 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?

Unite members do not agree with the Departments decision for the reasons stated below;

- Unite agrees that statutory regulation is the most effective way of protecting the public, and that those that have responsibility for protecting the public's health should be regulated in this way to improve the quality and safety of public health practice. However, it considers that the transfer of public health specialists from the UK Public Health Register (UKPHR) to the Health and Care Professions Council (HCPC) will increase the inequity that currently exists among the public health profession.

- *Trust, Assurance and Safety*[1] stated that the intention was to '*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'*. Under these proposals Public Health practitioners, a developing group of public health professionals will remain registered with the UKPHR, doctors and dentists with the GMC and GDC and non-medical public health specialists (including nurses and midwives) will transfer to the HCPC. We would suggest therefore that this does little to 'narrow the gap'.

- 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 in place 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. Unite considers that this will reduce equivalence between public health leaders.

- The Law Commission draft Bill (April 2014) recommendation 22; states that '*Concurrent membership of the regulatory bodies should be prohibited*'. They take this stance because they consider '*concurrent membership undermines public confidence in professional regulation and raises potential conflict on interests'*. Unite considers that if this recommendation is accepted by government its nurse or midwife members working in public health roles requiring regulation by the HCPC would have to surrender their nursing or midwifery registration with the NMC or would be excluded from taking up senior public health roles. This would be to the detriment of public health since nurses and midwives have an important contribution to make to population health and well-being, bringing with them valuable knowledge, skills and experience and this therefore appears to be a backward step.

- The HCPC does not currently match GMC requirements for licensing nor does it have the same experience of issuing ethical guidance and codes of conduct. If it takes on this role it will need to match the GMC procedures in licensing and revalidation as previously stated. It would not need to develop additional ethical or conduct guidance, because if the same standard is to apply to all public health specialists, then to produce separate ethical guidance runs contrary to that.

- The HCPC also does not currently have the equivalent of the CESR route to registration. It is important that such a route exists and also that its standards need to be monitored so that they do not amount to a back door entry into the profession.

- HCPC has hitherto only regulated entry to paramedical professionals not a non-medical route of entry to a medical specialty (only the GDC and UKPHR have performed that function and only the former on a statutory basis).

- It is true that HCPC regulates biochemists, microbiologists, medical physicists and clinical psychologists, the most senior grades in which are consultant equivalent. However these are not entirely comparable situations. For these senior scientists there is no separate register for those entitled to the most senior grades so it is not HCPC which regulates that step. Doctors and non-doctors in these disciplines do not train in the same training schemes or apply for the same consultant posts. The disciplines in question are not listed as medical specialties in European legislation. In all these respects public health is different. Public health therefore has a formal status as a medical specialty with a non-medical route of entry alongside the medical and dental routes. This is different to just being a discipline whose most senior posts have a status broadly similar to those of a medical specialist.

- Enabling HCPC to meet the requirements would be a significant piece of work, and the suggested start date of end 2015 may not be possible if indeed HCPC is used.

Question 2: Do you think that public health specialists should be regulated by another body? If so, who and why?

Unite considers that there are two potential suitable alternative bodies.

- It has recently been mooted that the GMC could take on this role. It already regulates entry to medical specialties including public health for Registered Medical Practitioners. It is already responsible for regulating the ‘standard’ route of entry, by which 9 out of 10 individuals gain entry to the specialty, by, for example, regulating and approving the specialty curriculum, approving training locations and regulating specialty training overall. It has all the necessary processes in place and could carry out this task as a simple add on to them by way of a supplementary register. This would remove any doubt of the status of public health as a medical specialty or of the equal status of the different routes of entry. It is also more likely to be practical in the government’s expected time scale. It might also simplify the drafting of the Section 60 order. It would reduce the number of regulators.

- UKPHR could take on this role and could become a statutory body. It has experience of fulfilling it. It has played a role in establishing this route of entry to the specialty and regulating it to the point at which the medical profession acknowledges it as an equivalent route of entry. It already has processes in place for revalidation. It already has a Memorandum of Understanding with the GMC. It could meet the government’s timescale. Moreover, it is hard to see why UKPHR should be pushed aside in favour of a body without equivalent experience.

- We have not had sufficient time to fully debate the pros and cons of these two alternatives. We initially formed the view that it should be UKPHR. The idea of it being the GMC has only been mooted very recently and we have not had time to consider whether this changes our opinion. It would be helpful to know if this is a real option and if so to have time to debate it. We would support UKPHR in preference to HCPC.

Question 3: 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 Professions Order 2001 (S.I. 2002/254)? If not, why not?

In the event that the decision to move regulation to HCPC is upheld, Unite does not agree to the transfer of cases that are already in the process of being investigated by UKPHR as this would require a repeat investigation by HCPC under their processes thereby increasing time, costs and uncertainty both for the complainant and practitioner.

Question 4: Do you agree that the grand parenting period of registration as a public health specialist should be two years?

The criteria for grand parenting should be the same as those used when the GMC specialist register was established i.e. that the individual worked as or was qualified to be appointed as a consultant. We agree that the period for this should be two years.

On an on-going basis there should be a route of access to the register equivalent to the CESR route for the GMC specialist register.

Question 5: Is the impact of these public health specialists being required to register with the HCPC of significant consequence?

Unite considers that the impact is significant.

- Public health is a medical specialty with medical, dental and non-medical routes of entry. It is important for the equivalence of these different routes that all specialists should be entered on a register equivalent in standards and status to the GMC specialist register or the GDC specialist list. This is fundamental to the equal standing of the three routes of entry.

- However individuals who come to public health specialist practice from a background as public health practitioners (nurses for example) will wish to maintain their initial registration, just as doctors in public health remain registered as medical practitioners and dentists remain registered as dental practitioners.

- Whatever the registering body it should be feasible to devise a system in which it is possible to maintain both the specialist registration and the underlying practitioner registration through a single process.

- It should be noted that not all regulators are as clear as the GMC and GDC that specialist public health practice (treating populations) is a form of clinical practice and ambiguity about this can create problems for specialists wishing to maintain their practitioner registration in some professions.

Question 6: Do you agree that 'public health specialist' should become a protected title?

The proposal is that the title public health specialist should be protected for use only by doctors or dentists with appropriate entries on the GMC or GDC specialist register or individuals registered on the new non-medical register. We support that proposal.

UKPHR has pointed out that specialist status has been weakened by the fact that consultant appointment regulations do not bind local authorities. With that in mind we believe the job titles "consultant in public health" and "director of public health" should be protected titles used only for jobs filled by a public health specialist.

Question 7: Which of these options, if either, do you think appropriate?

Unite would support option B.

The Scally review indicates that defined specialists are required to show competency in *most* but not *all* other areas of public health.

Question 8: Do you agree that the requirement for a Council member to chair the Registration Appeal Panel should be removed?

Unite would agree to this proposal to ensure consistency across the regulators

Question 9: 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?

Unite would agree to this proposal to again ensure consistency across the regulators.

Question 10: Is our estimate of the numbers of non-medical public health specialists working in the independent or private sector reasonable?

We have no reason to doubt it but we have no informed opinion on this topic.

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[1] Department of Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, TSO.