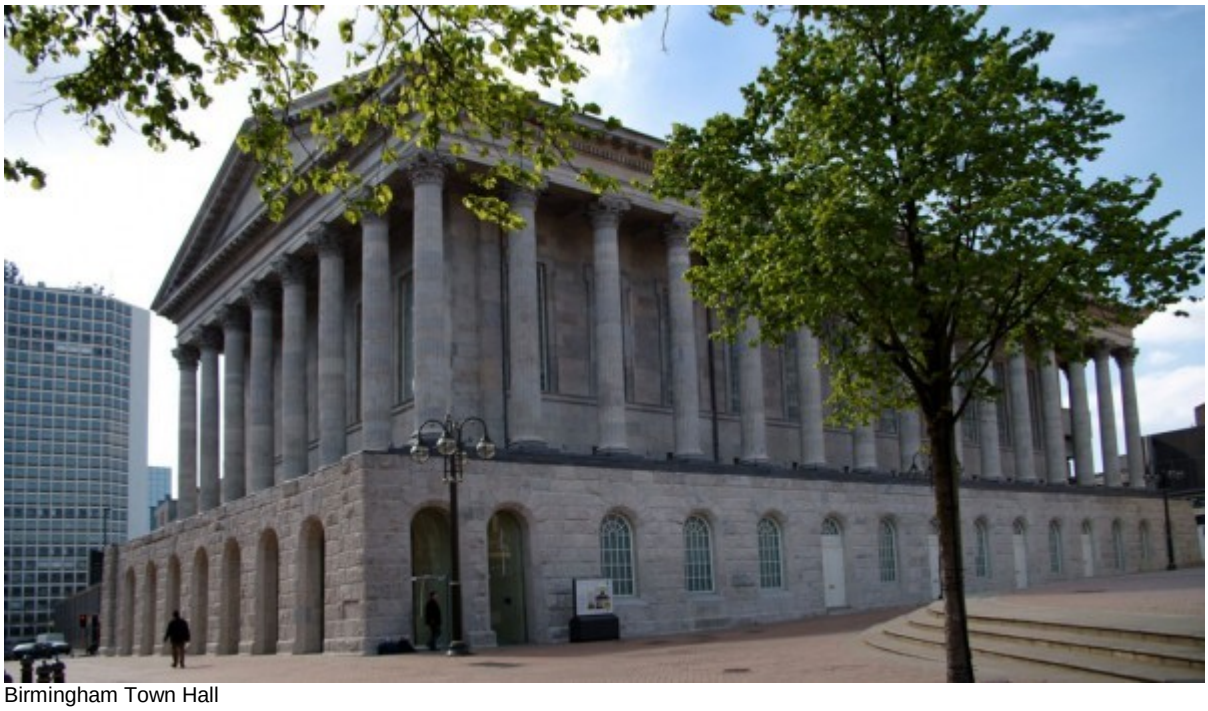
UKPHR's ANNUAL REPORT 2014-15

UKPHR

Public Health Register

Protecting the public – improving practice

Public Health: a democratic mandate



Birmingham Town Hall

Foreword

Professor Bryan Stoten, Chair

This has been a good year for UKPHR, yet when I wrote my introduction to last year's Annual Report we were very uncertain about our future.

The long announced but still to be determined transfer of Specialist Registrants was a major threat to our very existence while our Executive Director, David Kidney, was all but single-handedly managing our move to Birmingham, some drastic staff changes and all within a very tight budget.

Today we still have no resolution to the threat of Specialist transfer but following the Department's consultation with our Public Health stakeholders, there are few observers who continue to support such a move.

We report in this document our newly acquired charitable status, that the Professional Standards Authority have renewed our accreditation, that HMRC now accept our registration fee as an essential employment expense (how could it ever have been otherwise?) and, most recently, PSA's important policy paper on Rethinking Regulation which simply provides more support for the form of "right touch" regulation for which we have always argued.

In addition to a "field army" of assessors and moderators so ably supported by Cerilan Rogers we have an extraordinarily talented full-time team in the Birmingham office. I've been delighted to welcome Dr Viv Speller to the Board and very sorry indeed to say farewell to Claire Barley who added both HR and invaluable Welsh insights to our thinking.

This Annual Report marks some major developments in Practitioner regulation, it reviews our assessment methodology and assesses the current local authority context within which many of our Registrants practice. I think it reflects an organisation fit for purpose and "match-fit" for the Public Health challenge set by the Five Year Forward View.

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Chair's Report

Professor Bryan Stoten, BA Hons; M Soc.Sc; D Univ Hon; FRSPH; CIHM

My first observation on the year that is past is to reflect on UKPHR's good fortune. Our move from London to Birmingham has proved to have been beneficial in so many ways: our expenditure has fallen by 36 per cent compared with our running costs in previous years, our recruitment of Pav Sull both fortuitous and successful, our much improved accommodation allowed for rationalisation of our portfolio collection and our access to the whole of the UK has been enhanced.

The Public Health agenda was given a major boost by the publication of NHS England's "Five Year Forward View" in which Simon Stevens reflected on the necessity to address the health improvement and sickness avoidance measures which lie at the heart of Public Health. Disappointing though the General Election discussion of health issues was, again reverting to a preoccupation with clinical staff numbers and acute hospital issues (with the honourable exception of Norman Lamb's Mental Health concerns), we were encouraged by the way in which the Public Health community came together to adopt a shared approach to the Government.

Early days, but in seeking engagement with the Prime Minister the new UK Public Health Network, of which UKPHR is part, looks likely to raise the profile of all our priorities in a far more effective way given our commitment to joint working rather than competition between us. To see the RSPH, Faculty of Public Health, UK Health Forum and the Association of Directors of Public Health working together must place the case for workforce development central to policymaking. We are encouraged by the support given to our work in this area by Public Health England and, specifically, Duncan Selbie.

Consequently we are committing substantial resources to Practitioner standard setting, accreditation and regulation. As a result UKPHR's work in standard setting and registration, the practitioner workforce has gone from strength to strength.

Within the Register I must report the huge loss resulting from Professor Nairn Wilson's retirement following on his election as President of the British Dental Association. Nairn has worked alongside me since my appointment as Chair in 2012. I could not have asked for a better "comrade in arms". Always steady, calm, insightful and constructive, he balanced my impatience and enthusiasm in an entirely beneficial way. But by encouraging Anne McMillan to offer herself as Registrar in succession to himself, Nairn performed a final act of generosity. Anne, now half a year in post, has proved a worthy successor: forensic and logical she has enabled us to keep a clear head and avoid short-term pragmatism with thought-through applied principle. We are already deeply in her debt.

When I first accepted the Chair of UKPHR, the Secretary of State – Andrew Lansley – had announced that he intended to introduce statutory regulation of Public Health Specialists by transferring our Registrants to the Health and Care Professions Council. The reasons for our opposition to this proposal have been rehearsed enough times already without doing so again here. Suffice it to say we believed it would damagingly cut off Specialists from Practitioners and indeed possibly close down UKPHR as an independent specialist public health regulator.

That threat has hung over UKPHR for the last three years and it is testament to the conviction and commitment of our assessors and moderators, co-ordinators and, indeed

Board, that there has never been a moment that I felt our pace slacken in building a regulated workforce of both Specialists and Practitioners. Nonetheless the uncertainty has been hugely dysfunctional. Not only has it introduced anxiety for our paid staff, it has also left Registrants and would-be applicants uncertain about their future status – especially those who are Defined Specialists or considering applying to become Defined Specialists – while making our financial planning and even our accommodation arrangement precarious. Having been assured that legislation resulting in a transfer of Registrants would be secured before the General Election the actual Statutory Instrument needed to give effect to the transfer was not voted on during the last weeks of the last Parliament.

Nothing has emerged prior to the first summer recess of the current Parliament and so we are once again in limbo. For an Administration unequivocally committed to enhancing Public Health this situation is at least destabilising. We would, of course, like to see a rethink in which bringing the whole Public Health workforce together within a single regulatory regime would now follow. One can but hope.

Finally I must praise my Board and my Executive Director. David Kidney joined us at a key point in our development. He has built on our relationships with the rest of the public health community. He plays an active national role and has created the kind of systems within UKPHR which have made our – initially reduced and now re-established office workforce – far more productive than we could ever have hoped. His regular news bulletins are clearly, from the feedback I receive, valued. Board members have been generous with time, advice and stalwart support especially in some of our more difficult moments. The decision to move to the Midlands was brave and inevitably disruptive, and for some highly inconvenient. It has turned out to be an enormous success but without their confidence and belief in the importance of what we are doing I fear we might have settled into a gentle running down of the Register and resignation that our fate was best left in the hands of others. Not a view they took, not one I do either.

The scale of the Public Health Workforce now identified by the Centre for Workforce Intelligence makes the development and regulation of a Multi-Disciplinary Public Health Workforce crucially important if we are to satisfy NHS England's aspiration for a sustainable healthcare system by 2020. The Review of Public Health in Scotland is also concerned with sustainability and both Public Health Wales and the Public Health Agency in Northern Ireland are wrestling with the same challenge.

Together with RSPH's experience and capacity working with this workforce, I know we – the public health sector of which UKPHR is a part and the workforce of public health professionals we register - can deliver on improving the health and wellbeing of the public and contributing to more sustainable models of health and social care. I know UKPHR is in the kind of state to do just that.

Registrar's Report for 2014-15

Professor Anne McMillan, PhD, FDSRCPS, FDSRCS

There was a change at the helm with Professor Nairn Wilson stepping down to become President of the British Dental Association. I have been in post since March 2015.

The process of registration and the maintenance of the Register have been subject to continuous quality improvement throughout the year. A new category of registration, *Specialty Registrar,* was introduced to offer registration to trainees who were not eligible for registration with the GMC or GDC.

The Registration Panel chaired by Sue Lloyd, co-chaired by Vicki Taylor, and Cerilan Rogers as lead Moderator along with the many individuals who have served as assessors have provided sterling service in processing the growing number of applications for specialty registration in part prompted by the potential change in the regulatory home of specialist registrants and related transitional arrangements. In addition, the Registration Panel has received an increased number of recommendations for practitioner registration and of applications for re-registration of specialist registrants.

The local practitioner scheme continues to grow apace with a new scheme, East of England, added during the year resulting in a greater opportunity for Public Health practitioners to register with UKPHR. The growth in practitioner registration is in no small part due to the teams of highly-skilled people responsible for the smooth and effective running of the local schemes. These people have provided enormous and invaluable service to UKPHR. The achievement of the local support necessary to establish practitioner schemes is still challenging. Nonetheless, such support clearly yields significant benefit in terms of practitioner registration.

The introduction of the Register's Code of Conduct, the revision of the annual declaration, refinement of the re-registration process during 2013-14, and the continuing professional development scheme continue to underpin initial and continuing UKPHR registration.

All this work is over seen by the Registration Approvals Committee (RAC), which I chair. A recent comment was made by Elisabeth Shendge, a lay member of the RAC: *"I continue to be impressed by the quality, detail, accuracy and sheer quantity of work undertaken by all those who are, in a pro bono capacity, involved in the registration process".*

UKPHR's Accredited Voluntary Status was recently renewed and is testament to the Register's key role in the maintenance of standards and the regulation of multidisciplinary public health.

The 2014-2015 registration statistics for UKPHR are as follows:

	31st March 2014	31st March 2015
Total No of Registrants	**684**	**776**
Of which		
Specialists	**562**	**625**
Practitioners	**122**	**151**

Fig 1*. The table above illustrates the total number of registrants on 31st March 2014 and 31st March 2015 near a breakdown of total number of Specialists and Practitioners on those dates. Practitioner numbers by scheme on the register as at 31st March 2015 are also shown.*

Fig 2*. The table below displays the total number of new registrants between the dates 1st April 2014 – 31st March 2015 alongside a breakdown of total number of newly registered Specialists and Practitioners.*

By Scheme	
Kent, Surrey & Sussex	**47**
Thames Valley	**15**[1]
Wales	**14**
Wessex	**29**[1]
West Midlands	**35**
West of England	**8**
West of Scotland	**11**

Total No of new registrants in 2014-2015	**92**
Of which	
Specialists	**63**
Practitioners	**29**

In 2014-2015 no matters were referred to the Register's Professional Conduct Panel.

I would wish to express my thanks to all those who have so generously given their time to support UKPHR registration and related processes. In particular, I would like to thank Nairn Wilson for providing such a smooth handover of Registrar duties. I would also wish to thank the staff of the UKPHR for their administrative support throughout the year.

[1] Both schemes involved in 8 registrations

Moderators Report for 2014 – 15

Cerilan Rogers

This is the 6th annual report on moderation of assessment, an important element of the UKPHR's quality assurance processes. This report covers the period January 2014 to end of March 2015. During this period, the moderation team consisted of Cerilan Rogers (lead moderator, specialist and practitioner registration), Ros Dunkley and Alyson Learmonth (practitioner registration) and Krishna Ramkhelawon (specialist registration). Krishna Ramkhelawon stood down at the beginning of 2015 and an additional moderator for specialist registration will be recruited.

The role of the moderators is to ensure fairness and consistency throughout the assessment process. Only the Registration Panel and Verification Panels (for practitioner registration) can overturn assessment decisions; the moderation role is advisory to the panels. However, the moderators have the right to be heard and their views must be provided to the panels.

The lead moderator attended, either in person or by telephone, all UKPHR Registration Panel meetings in the period covered by this report; other members of the moderation team also attended occasional meetings. Their views were sought and carefully considered at and between meetings. Overall, there were no major concerns with the quality of assessments undertaken for specialist and practitioner registration.

Evaluation of the support provided by moderators, particularly for practitioner registration, was undertaken routinely; the support appeared to be well received and valued.

The lead moderator was interviewed as part of the public health review in Scotland.

Moderation of assessment for specialist registration

Methods of moderation include:

- Review of specific portfolio referrals from the Registration Panel
- Provision of advice and support to individual assessors on request
- Random concurrent sampling of the assessment of portfolios
- Retrospective audit of pro forma completion by assessors.

7 specialist portfolios were moderated (all defined specialists), 4 at the request of the Registration Panel, 2 moderations at the request of assessors and one as part of routine quality assurance. The lead moderator also scrutinised the reasons for the acceptance of all higher level claims and for clarifications and resubmissions, as part of the Registration Panel process. The assessment process was found overall to be rigorous, fair and consistent.

Queries from assessors, not requiring portfolio moderation, about interpretation of the guidance were also answered, as were queries from UKPHR officers, often generated by queries from applicants about eligibility for registration or feedback during assessment.

Support for assessment for specialist registration

The lead moderator provided training for specialist assessors, which resulted in 7 applicants successfully completing specialist assessor training, a valuable addition to our current pool of assessors.

Despite the hard work of assessors, waiting times for assessment remained longer than desired, although there has been an improvement during the last six months of this period. The Register's contact with assessors has improved and staff monitored the throughput of portfolios closely, which has contributed to the improvement noted above, despite the continuing constraints on assessors' time.

Attendance at an assessor development session (and at least one Registration Panel meeting) every 18 months is a requirement for remaining a specialist assessor with the UKPHR. Two development sessions have been provided during this period and good assessment practice was discussed at panels.

Practitioner assessment and registration schemes

Local scheme coordinators are pivotal in the quality assurance of practitioner registration; the moderation team provided telephone and email support to them on request throughout the year. Moderators participated, when available, in the regular national teleconferences of scheme coordinators.

Other support to schemes during the year included:

- Practitioner introductory days (15)
- Assessor training (9)
- Verifier training (5)
- Assessor/verifier development (13)
- Verification panels (21)
- Moderation of assessments (14)
- Scheme launches (2)
- Update for training providers (1)

One new scheme was launched, East of England in December 2014. Along with the launch in London at the end of 2013, these have provided a welcome increase in accessibility of practitioner registration. There are now 10 schemes in operation across the UK.

The above represents an increase in the workload of the moderation team, which has been manageable and has not resulted in delays in the provision of support to the schemes. The expertise now residing in the schemes themselves has helped to achieve this. Further recruitment to the moderation team would be pursued if needed.

Acknowledgements

The moderation team would like to thank all UKPHR assessors, the Chair and Vice-Chair of the Registration Panel, the Chair of the Board, the Registrar, all practitioner registration local scheme coordinators and the UKPHR Chief Executive and staff for their support of our work.

Coordinators report for local practitioner registration schemes during 2014 -15

In December last year we welcomed the launch of the East of England local practitioner registration scheme and scheme coordinator, Alix Sheppard. The new scheme joins the existing collective and brings UKPHR that one step close to achieving nationwide coverage.

Table 1 shows all current schemes and their respective coordinators. London, Thames Valley, Wales and West of England schemes have new contacts since our previous report; Anisha Wadhwani, Branwen Thomas, Lesley Maitland, Kelly McFadyen and Bronwen Koolik.

Table 1 – *Registration scheme coverage and their corresponding coordinators*

Scheme	Geographical area covered	Coordinator
East of England	Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk, Suffolk	Alix Sheppard alix@healthtalks.org.uk
Kent Surrey & Sussex	Kent, Surrey & Sussex – on the PHE map this is region 11.	Louise Holden louise.holden@kent.gov.uk
London	North Central and East London (NCEL HEE area) with a view to moving capital wide shortly	Anisha Wadhwani anisha.wadhwani@phe.gov.uk
Thames Valley	Thames Valley	Branwen Thomas Branwen.Thomas@phe.gov.uk Lesley Maitland lesley.maitland@ouh.nhs.uk
Public Health Wales	Wales. The scheme is open to requests for support from practitioners in Northern Ireland	Kelly McFadyen Kelly.McFadyen@wales.nhs.uk
Wessex	Hampshire, Isle of Wight & Dorset	Em Rahman Em.Rahman@wessex.hee.nhs.uk
North East	Redcar and Cleveland, Stockton-On-Tees, Middlesbrough, Hartlepool, Darlington, Durham, Sunderland, Newcastle, Gateshead, South Tyneside, North Tyneside and Northumberland Local Authorities	Annie Wallace annie.wallace@sunderland.ac.uk
West Midlands	Hereford & Worcester, Birmingham & Solihull, Black Country, Coventry & Warwickshire, Shropshire & Staffordshire	Sally James Sally.james@wm.hee.nhs.uk
West of England	South Gloucestershire, Bristol & Bath and North East Somerset	Bronwen Koolik bronwen.koolik@bristol.gov.uk
West of Scotland	Ayrshire and Arran, Greater Glasgow & Clyde, Highland & Lanarkshire	Karen McGuigan Karen.McGuigan@lanarkshire.scot.nhs.uk Clare Black Clare.Black@aapct.scot.nhs.uk Jane Groves jane.groves2@nhs.net

We would like to thank all coordinators and their support networks for their support and co-operation in all aspects of our work to ensure a robust and devolved practitioner registration process. We congratulate them too on the continuing effectiveness of their and their local schemes' operations.

Total number of registered practitioners is on the rise, not only within each scheme but also as a whole. We have this year registered our first practitioners from the North East scheme that was set up in early 2014 and our schemes are recruiting strongly.

Table 2 – *Total number of registered public health practitioners by scheme*

Scheme	Current
East of England	**0**
Kent, Surrey & Sussex	**43**
London	**0**
Thames Valley	**13**[2]
Public Health Wales	**14**
Wessex	**37**[2]
North East	**2**
West Midlands	**36**
West of England	**10**
West of Scotland	**16**
TOTALS	**163**

2014's Annual Practitioner Event took place in Glasgow on 3rd November. We are grateful to NHS Health Scotland and our West of Scotland practitioner registration scheme for organising, hosting and paying for the event. As a result of this generosity, the 100 free places on offer were all taken. The proceedings on the day were characterised by learning and celebration with presentations by Shirley Cramer CBE, Gill McVicar and Andrew Fraser to name but a few.

Hilton London Stansted Airport will be the venue for this year's annual event on the 26th November, which looks to consolidate and increase the value of registration for key national stakeholders.

Coordinators continue to come together (with UKPHR) and share best practice and in particular recognise, celebrate and strengthen the role of assessors in registration.

'Assessors play a vital role in supporting the PH Practitioner Registration programme for local schemes. In Wessex, we see the role of an Assessor being key in developing the PH workforce and ensure that each time an Assessor completes the assessment of a portfolio, that this is recognised in Wessex. Our Assessors also highlight how looking through practitioner's portfolio provides them with an insight into the breadth and diversity of the PH work that takes place in Wessex'

Em Rahman, Scheme Coordinator at Wessex

This year also saw UKPHR approved as the National Accreditation Organisation (NAO) of the United Kingdom for the International Union of Health Promotion and Education (IUHPE). Since receiving NAO status a task and finish group was formed to advise UKPHR's Board on the appropriate structure and process for registering health promotion practitioners who meet the competency standard set by IUHPE's competence framework, CompHP.

[2] Both schemes were involved in 8 registrations

PH Excellence
Edgbaston March 2015

Development of advanced practice for public health is being led by Public Health Wales in collaboration with existing established schemes. Work currently is at a pilot stage with a supplementary evaluation planned. The Wessex scheme alongside fellow coordinators is scoping employer and practitioner interest in advance practitioner development and accreditation. Directors of Public Health, registrants and practitioners were interviewed and there was a strong sense that advanced practice needs to be employer-led.

Wessex and West Midland's pilot Pre-ST3 practitioner tutorial programme (available to registered practitioners) received applications and following initial aptitude tests, individuals participated in various support programmes in preparation for Part A exams.

Kent, Surrey & Sussex and the Wessex scheme have taken an innovative approach to encourage the use of e-portfolios. A short video (https://youtu.be/q9Xm055i1hA) has been produced and there promises to be more video guides on how to navigate the system. Both schemes have also adopted a fast-track approach to preparing for registration.

The West of Scotland scheme presently covers four NHS Boards and has recruited 2 cohorts. Progress is good with 16 registered practitioners to date. Whether the scheme will continue and recruit further cohorts, or even perhaps grow to cover all of Scotland, is dependent on the outcome of the current public health review in Scotland.

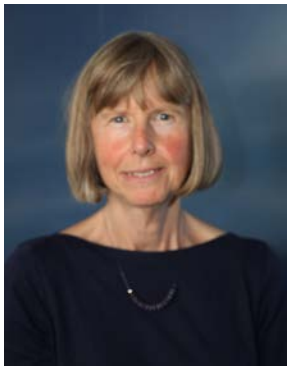
Practitioners from Northern Ireland who express interest in registration at this time are able to "piggy-back" on the existing all-Wales scheme. UKPHR is holding its next consultative forum in Belfast in November to hear of progress towards launching a stand-alone scheme.

There is a notable increase in demand for registration from areas not covered by present schemes and from a wide range of organisations. We hope that during the coming year opportunities will arise that will lead to all members of the core public health workforce being able to achieve registration so enabling them to demonstrate their competence and their commitment to protecting the public and improving practice.

Annual Practitioner Event,
Glasgow November 2014

England's new public health settlement: the democratic mandate

Professor Linda Jones, Vice Chair of UKPHR
BA (Hons) M.A., PhD, PGCE



There was no part of the Health & Social Care Act 2012 reorganisation that was uncontroversial, but the proposal to transfer the lead for public health in England from the NHS to upper tier local authorities did have support.

Some in local government saw this as public health coming home but in reality both public health practice and local authorities' approaches are very different from anytime pre-1974 when they may previously have shared a home.

It is true that throughout history local authorities have made stunning contributions to improvements in the public's health and wellbeing. Here in Birmingham, where UKPHR is now based, Joseph Chamberlain used his three years as Mayor of Birmingham 1873-6 to transform the City. His three main ventures were to purchase the local Gas & Light Companies, acquire public control of the Birmingham Waterworks Company and his town improvement scheme.

The 1875 Artisans Dwelling Act allowed corporations to purchase slum property for the purpose of clearance. Chamberlain saw in this not only an opportunity to clear away the slums in the overcrowded town centre, but a chance to carry out a radical new town improvement. Birmingham's Improvement scheme covered an area of 93 acres.

Many slum properties were demolished. However, no provision was made in the Act or the Birmingham scheme for rehousing those made homeless. Not surprisingly this attracted criticism. 'The Dart ' had this to say:

New Birmingham recipe for lowering the death rate of an insanitary area. Pull down nearly all the houses and make the inhabitants move somewhere else.
'Tis an excellent plan and I'll tell you for why.
Where there's no person living, no person can die.[3]

Ah yes, democracy can be a tricky business. Our approach to public health in the UK is influenced by political decisions made in the EU, the Westminster Parliament, the national parliaments and local authorities. Decisions made at the higher end of this spectrum can constrain, liberate or pass the buck to those lower down.

The huge cuts to the grant funding of local authorities have left in place the freedom to make local decisions suited to local conditions but denied councils the resources to act as holistically as a sound public health strategy might require.

Under the coalition government, we learned more about a political approach less attracted to direct intervention by way of regulation. We got our heads round concepts of a "ladder of intervention", "responsibility deals" and "nudge". We hear less of these concepts today – and less still of "Big Society" and "all in it together".

[3] http://www.birmingham.gov.uk/cs/Satellite?c=Page&childpagename=Lib-Central-Archives-and-Heritage%2FPageLayout&cid=1223092751966&pagename=BCC%2FCommon%2FWrapper%2FWrapper

In public health terms we need politicians to be bold. Simon Stevens' *NHS Five Year Forward View* [4] was an impressive pitch to our Government and Opposition parties. All signed up, during the General Election campaign, to the case for an increase in health spending of £8bn a year by 2020.

It is yet to be demonstrated that parties are equally signed up to the radical upgrade in prevention and public health that was the Forward View's first and most urgent call. This is particularly so when one of the first acts of the new Westminster Government was to cut England's public health budget by £200m in-year.

The politicians in the national Parliaments of Northern Ireland, Scotland and Wales have all shown a commitment to improving the health and wellbeing of the public to whom they are accountable:

- Northern Ireland's *Making Life Better*,[5] a whole system strategic framework for public health across Northern Ireland's NHS, local authorities and wider civic society;

- Scotland's Minimum Unit Pricing of alcohol, a Public Health Act (2008) and the Public Bodies (Joint Working) (Scotland) Act (2014), the latter a major initiative to integrate health and social care and bring NHS and councils closer together in Scotland;

- The new Public Health (Wales) Bill,[6] which brings together a range of practical actions for improving and protecting health in Wales.

In local authorities, what of public health's homecoming in England? For all those public health professionals pursuing the Marmot vision[7] of a healthier society, reduced health inequalities and population based interventions designed – applying relevant evidence – to address the wider determinants of health and wellbeing, is local government the appropriate setting for their work?

All local councils, not just the "upper tier" local authorities in England designated by the 2012 Act, are well placed to deliver a health and wellbeing strategy set locally but informed by the nationally constructed Public Health Outcomes Framework. Councils have levers to pull in terms of their statutory powers (regulation, inspection and enforcement) as well as their representative powers (spending, listening and persuading).

These levers are so extensive that Councillors should insist on an over-arching public health strategy that can join up the powers and actions and convert them into a holistic approach to improving people's health and wellbeing and reducing health inequalities.

We should not ignore the power and responsibility that the democratic mandate brings with it either. Councillors engage with their communities in seeking election and work with their local communities once elected in order to earn the eventual re-election. As a result, they tend to know more about people and places than any amount of surveying can turn up. It makes the democratic mandate a vital tool in the implementation of a public health strategy – reaching out, engaging, cajoling and yes, leading.

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[4] http://www.england.nhs.uk/ourwork/futurenhs/5yfv-exec-sum/
[5] http://www.dhsspsni.gov.uk/making-life-better
[6] http://gov.wales/legislation/programme/assemblybills/public-health/?lang=en
[7] https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

So at its best, local government should be a key asset. Councillors and officers who are interested and involved in the commissioning and delivery of a wide range of services ought to be pivotal in setting, implementing and evaluating a strong health and wellbeing strategy.

To date, however, it has not all been plain sailing. There are now many examples of local authorities taking up their new public health responsibilities and running with them to the betterment of health and wellbeing in their areas. This year, the Local Government Association updated its publication of case studies demonstrating much of this great work.

Unfortunately, there are also examples of poor practise within local authorities. It may be spending ring-fenced public health funding on projects only loosely linked to public health priorities or lacking evidence of their efficacy. It may be a council which fails to maximise the talent, experience, skills and knowledge of its public health specialists and core workforce.

For one or both of these reasons, there are councils which are missing opportunities to join up interventions to best effect, missing opportunities to partner with organisations locally capable of making a difference for the better and failing to empower individuals and communities and to work with partners to improve the health and wellbeing of those individuals and communities.

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

An urgent task ahead for all of us who are committed to improving the health and wellbeing of the public and reducing health inequalities must be to help raise the performance of the poor performers to the level of the best. Communication, joined-up effort across the public health system and a concerted focus on quality education and training (as well after qualifying as prior to qualifying) will be our means. Here at UKPHR we very much wish to be part of this system-wide push.

There have been inevitable distractions during the transition from a service that was NHS-led to one that is now firmly established in local authorities. Pay, pension, terms and conditions are not inconsiderable matters to resolve during a period of transition. Sadly, the divide created by a difference in pay scales between NHS and local authorities has in part translated into a divide between medically qualified specialists (who have mostly found employment with Public Health England) and specialists in many other disciplines who have mostly found employment in local government.

This specific issue will have to be addressed going forward.

It is far too soon to judge whether conferring the public health lead on some local authorities in England is a successful and effective model. Yet intuitively it ought to be a good move. At UKPHR we want to be active in making the best of the transfer and evaluating its effects. There is no shortage of work to be done in public health in localities as well as nationally and internationally. We wish all public health professionals, wherever they practise, every success and you have our support for the tough but rewarding work you undertake.

[8] https://www.rsph.org.uk/en/about-us/latest-news/press-releases/press-release1.cfm/pid/26C2063A-ADE4-4DD1-AD2B29626D32B7E9

August 2015

Confidence in the wider workforce: Professional Standards Authority's Accredited Registers

by Christine Braithwaite
Director of Standards and Policy, Professional Standards Authority.

The Professional Standards Authority for Health and Social Care[9] promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. This includes the General Medical Council, Nursing and Midwifery Council, General Pharmaceutical Council and the Health and Care Professions Council.

In 2012, our role was extended by the *Health and Social Care Act (2012)* to include raising standards of registration of people working in occupations that are not regulated by law. We set *Standards for Accredited Registers*, assess their performance annually and award our quality mark to those who meet them. Over 63,000 practitioners in 25 health and care occupations are now on Accredited Registers. Our recent report *Accredited Registers: Ensuring that health and care practitioners are competent and safe* (2015) sets out the significant scale of improvements made.

Accredited Registers are a new approach to regulation – a solution designed to meet today's needs, not yesterdays. It is proportionate to risk, less costly than statutory regulation and able to adapt quickly as needed to meet changing care demands. A full list of the registers we have accredited is available on our website. They include the UK Public Health Register.

Protecting the public and supporting choice

Both Regulators and Accredited Registers protect the public by setting and upholding standards, registering only those who are competent and removing those who are subsequently found not to meet their standards. Regulators and Accredited Registers protect the public by ensuring that they can access health and care from practitioners who are competent and safe. We help to ensure that they do so effectively. The UK population's health and care needs, both now and in the future, require a different approach to delivery that draws upon a wider workforce.

Improving the health of the population

It also opens up significant opportunities to help improve public health. Between them practitioners on Accredited Registers see millions of patients annually, providing new opportunities for improving the health of the population, particularly in settings outside the NHS. For example, almost 3000 acupuncturists in private practice see an average of 48,000 clients a week. Taking that as a theoretical average for the 63,000 practitioners on Accredited Registers provides over a million contacts per week, 52 million a year.

[9] The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

If the Accredited Register workforce were connected to the regulated workforce, for example, to GPs who see over 90% of patients, 88,000 social workers, to schools, care homes and domiciliary agencies they could help to make a real difference to public health.

Our work in overseeing professional regulators and accrediting registers provides assurance to those designing, delivering or commissioning health and care services so that they can innovate with confidence.

Further information is available at: http://www.professionalstandards.org.uk/home

UKPHR

Public Health Register

Protecting the public – improving practice

PUBLIC HEALTH REGISTER

(A COMPANY LIMITED BY GUARANTEE)

ANNUAL REPORT AND UNAUDITED FINANCIAL STATEMENTS

FOR THE YEAR ENDED

31 MARCH 2015

PUBLIC HEALTH REGISTER
CONTENTS

PUBLIC HEALTH REGISTER

COMPANY INFORMATION

Directors	Andrew Corbett-Nolan Linda Jones Bryan Stoten Amanda Fletcher Richard Parish Patrick Saunders Claire Barley Selena Gray Fiona Harris Claire Cotter Jeremy Hawker Viv Speller
Company secretary	David Kidney
Registered office	18C McLaren Building 46 Priory Queensway Birmingham West Midlands B4 7LR
Accountants	mca leamington 16D The Mclaren Building 46 The Priory Queensway Birmingham B4 7LR

PUBLIC HEALTH REGISTER

DIRECTORS' REPORT FOR THE YEAR ENDED 31 MARCH 2015

The directors present their report and the unaudited financial statements for the year ended 31 March 2015.

Directors of the company
The directors who held office during the year were as follows:

Andrew Corbett-Nolan

Linda Jones

Bryan Stoten

Amanda Fletcher

Richard Parish

Patrick Saunders

Claire Barley

Selena Gray

Amy Nicholas (Resigned 25 September 2014)

Fiona Harris

Claire Cotter

Jeremy Hawker

Viv Speller (appointed 25 September 2014)

Small company provisions
This report has been prepared in accordance with the small companies regime under the Companies Act 2006.

Approved by the Board on 27/07/15 and signed on its behalf by:

.....
Bryan Stoten
Director

CHARTERED ACCOUNTANTS' REPORT TO THE BOARD OF DIRECTORS ON THE PREPARATION OF THE UNAUDITED STATUTORY ACCOUNTS OF PUBLIC HEALTH REGISTER FOR THE YEAR ENDED 31 MARCH 2015

As described on the balance sheet you are responsible for the preparation of the financial statements for the year ended 31 March 2015 set out on pages 4 to 7 and you consider that the company is exempt from an audit. In accorance with your instructions, we have compiled these unaudited financial statements in order to assist you to fulfil your statutory responsibilites, from the accounting records and information and explanations supplied to us.

mca leamington

mca leamington
16D The Mclaren Building
46 The Priory Queensway
Birmingham
B4 7LR
Date: 30th July 2015

PUBLIC HEALTH REGISTER

PROFIT AND LOSS ACCOUNT FOR THE YEAR ENDED 31 MARCH 2015

	Note	2015 £	2014 £
Turnover		225,010	179,279
Administrative expenses		(357,880)	(317,872)
Operating loss		(132,870)	(138,593)
Other interest receivable and similar income		1,079	1,132
Loss on ordinary activities before taxation		(131,791)	(137,461)
Tax on loss on ordinary activities	2	238	(213)
Loss for the financial year	7	(131,553)	(137,674)

The notes on pages 6 to 7 form an integral part of these financial statements.

PUBLIC HEALTH REGISTER
(REGISTRATION NUMBER: 04776439)
BALANCE SHEET AT 31 MARCH 2015

	Note	2015 £	2014 £
Fixed assets			
Tangible fixed assets	3	4,913	-
Current assets			
Debtors	4	-	9,000
Cash at bank and in hand		89,692	257,594
		89,692	266,594
Creditors: Amounts falling due within one year	5	(15,820)	(56,256)
Net current assets		73,872	210,338
Net assets		78,785	210,338
Capital and reserves			
Profit and loss account	7	78,785	210,338
Shareholders' funds		78,785	210,338

These accounts have been prepared in accordance with the provisions applicable to companies subject to the small companies regime and in accordance with the Financial Reporting Standard for Smaller Entities (effective 2008).

For the year ending 31 March 2015 the company was entitled to exemption under section 477 of the Companies Act 2006 relating to small companies.

The members have not required the company to obtain an audit in accordance with section 476 of the Companies Act 2006.

The directors acknowledge their responsibilities for complying with the requirements of the Act with respect to accounting records and the preparation of accounts.

Approved and authorised for issue by the Board on 27/07/15 and signed on its behalf by:

.....
Bryan Stoten
Director

The notes on pages 6 to 7 form an integral part of these financial statements.

PUBLIC HEALTH REGISTER

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2015

1 Accounting policies

Basis of preparation
The financial statements have been prepared under the historical cost convention and in accordance with the Financial Reporting Standard for Smaller Entities (effective April 2008).

Turnover
Turnover represents registration fees for the register

Depreciation
Depreciation is provided on tangible fixed assets so as to write off the cost or valuation, less any estimated residual value, over their expected useful economic life as follows:

Asset class	Depreciation method and rate
Fixtures and Fittings	25% straight line

Hire purchase and leasing
Rentals payable under operating leases are charged in the profit and loss account on a straight line basis over the lease term.

2 Taxation

Tax on loss on ordinary activities

	2015 £	2014 £
Current tax		
Corporation tax charge	-	213
Adjustments in respect of previous years	(238)	-
UK Corporation tax	(238)	213

3 Tangible fixed assets

	Fixtures and fittings £	Total £
Cost or valuation		
Additions	6,185	6,185
Depreciation		
Charge for the year	1,272	1,272
Net book value		
At 31 March 2015	4,913	4,913

4 Debtors

	2015 £	2014 £
Other debtors	-	9,000

5 Creditors: Amounts falling due within one year

	2015 £	2014 £
Trade creditors	10,067	10,067
Corporation tax	-	238
Other taxes and social security	2,753	-
Other creditors	3,000	45,951
	15,820	56,256

6 Company status

The company is a private company limited by guarantee and consequently does not have share capital. Each of the members is liable to contribute an amount not exceeding £1 towards the assets of the company in the event of liquidation.

7 Reserves

	Profit and loss account £	Total £
At 1 April 2014	210,338	210,338
Loss for the year	(131,553)	(131,553)
At 31 March 2015	78,785	78,785

8 Pension schemes

Defined contribution pension scheme

The company operates a defined contribution pension scheme. The pension cost charge for the year represents contributions payable by the company to the scheme and amounted to £nil (2014 - £15,300).

professional standards authority
accredited register

UKPHR
Public Health Register
Protecting the public – improving practice

ANNUAL MEETING 2015

24th September, 2-6pm

Professor Bryan Stoten, Chair of UKPHR invites you to attend UKPHR'S Annual meeting 2015 at Thinktank, Birmingham Science Museum.

Speakers:

"Local Governance is what it's all about!"

***Professor Bryan Stoten**, Chair, UKPHR*

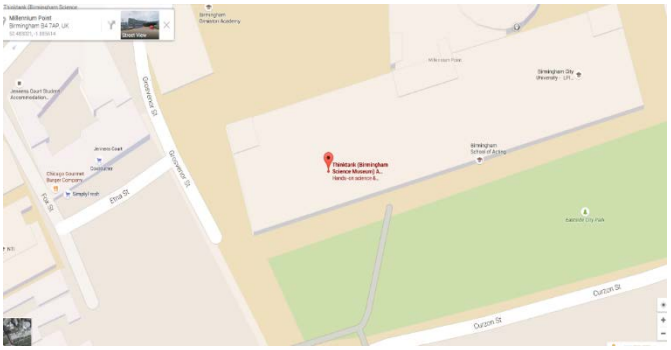
"Moving out of precarious housing"

***Dr Jane Kennedy**, Head of Public Policy and Research, London Borough of Newham*

The meeting host will be Professor Linda Jones, Vice-chair, UKPHR

RSVP: register@ukphr.org

thinktank
Birmingham science museum



Suite 18c, McLaren Building,
46, Priory Queensway,
Birmingham B4 7LR

☎ : 0121 296 4370

✉ : d.kidney@ukphr.org

: http://www.ukphr.org

: @UKPHR1

Venue: Thinktank Birmingham Science Museum, Millennium Point, Birmingham B4 7AP

Time: 2pm for 2.30pm start.

Refreshments & Finger Food Buffet from 4.30

End by 6pm

There is also a fantastic chance for you to explore the rest of Thinktank Museum during your visit here. To take advantage of this amazing opportunity, you will need to arrive earlier than the scheduled time of the Annual Meeting. We look forward to seeing you there!

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