UKPHR
Public Health Register

This document contains the comments of the UK Public Health Register (UKPHR) on the proposals in the consultation document *Healthy Lives, Healthy People: Towards a workforce strategy for the public health system.*

UKPHR is an independent regulator. Its purpose is to protect the public through the voluntary regulation of public health professionals in the UK. It does this by:

- working with partners setting and promoting standards for admission to the register and for remaining on the register
- dealing with registered specialists who fail to meet the necessary standards
- publishing a register of competent professionals.

General comments

We are pleased that a strategy is being developed and are grateful for the opportunity to comment.

In general, we have to say we find the paper disappointing. The key aim of the public health workforce must be to improve the health of the population. The draft strategy appears to make little connection between the concerns of the public health community and those whose focus is on workforce planning. Though the draft recognises the diverse nature of the existing public health workforce, it nonetheless lacks clarity of direction for the future.

Further – and this is perhaps its most troubling feature – the paper offers little by way of detailed and robust thinking about the implications of the forthcoming significant change to the local government environment where, within only a few months, the greater part of the specialist and practitioner workforces will be located.

Overall, the general thrust seems backward looking: the increasing Marmot focus on the socio-economic and spatial dimensions of population-based public health takes us a long way from traditional social medicine recruitment pathways. Given the imminent shift to local government it will be interesting to see how the Local Government Association and similar bodies respond.

Turning to specific questions, we offer the following comments.

Question 1: Do you agree that a public health workforce strategy should be reviewed regularly? If so, should this be every three years or every five years?

Such a strategy should certainly be reviewed regularly. The need for sufficient attention to be given to public health in a local government context in any case demands this. At least for the first few years, the approach should be not one of periodic review but of continuous quality improvement.

Question 2: Are these four groups a useful way of describing the public health workforces?

We do not agree that the suggested grouping is well thought through. It is confused and makes sweeping assumptions which many would challenge. We have the following specific comments:

a. Specialists are not registered with the Faculty of Public Health: the Faculty is a professional membership body, not a regulatory body.
b. Specialists who are medical practitioners are registered with the General Medical Council, dentists with the General Dental Council and so on. Such practitioners may also be registered with the UKPHR, which also offers registration to public health specialists and practitioners from other backgrounds.
c. From a UKPHR perspective those who work in health intelligence, information and analytical support have, through 'defined specialist' accreditation, the possibility of achieving the same status as other public health consultants. The proposed scheme appears to assume that such practitioners cannot become consultants and have no specialist status. This is wholly wrong: the effectiveness of public health would be severely inhibited were it not for the high skills of its health intelligence staff, many of whom are now in very senior, strategically important roles.
d. In the same connection we note that the paper refers in several places (1.10; 1.13; 3.19) to the importance of a multi-disciplinary approach, attracting the best graduates regardless of their background and building a workforce with the wide range of skills needed: it is contradictory, therefore, to limit here the scope of the consultant to that of the generalist – currently, and confusingly, called a specialist merely to distinguish that consultant grade post from that of the less qualified practitioner.
e. Health promotion practitioners should not be grouped with nursing and health profession disciplines with which they are listed in the present box.
f. The third of the four groups assumes that some practitioners do not have a wholly public health role. But it is difficult to understand why, for example, smoking cessation and behaviour change practitioners have not been placed in the same category as health promotion specialists.
g. Some practitioners, grouped here as 'wider workforce', have a strong public health role. The fact that they work in the voluntary sector is irrelevant: their contribution is central to the public health agenda: public health is, by its nature, inter-sectoral.

We favour a simpler categorisation, probably along the lines laid out by the Chief Medical Officer in 2001:

- Specialist (including defined specialists including health promotion specialists)
- Practitioner (consisting of all practitioners dedicated to public health in its broadest sense)
- The wider workforce.

UKPHR would be more than happy to assist the Department in the development of a realistic and helpful categorisation.

Question 3: Do you agree that methods of enumeration of the public health consultant and practitioner workforces should be scoped and piloted at a national level? Or do you think that workforce planning can take place effectively at a more local level eg LETBs working with local partners?

There should certainly be enumeration. Inevitably a national approach, necessary in itself, is likely to focus this primarily on the specialist core of public health. So we support the addition of a more localised model which would capture better the breadth and resources available for the delivery of public health programmes. It will however be essential for a strong national steer to be given as local input is likely to be variable and the exercise will be worthless if not all areas enumerate their whole workforce fully, accurately, and according to common principles.

Question 4: Would these values, combined with the features of public health in Box 2, serve to bind together the dispersed public health workforces?

Common values and features must be helpful in unifying a workforce around common aims, but we are uncertain whether they would of themselves 'bind' the workforces; and the particular concepts set out appear to us more generic than the values of the public health workforces as such.

UKPHR, in common with all mainstream regulators, expects its registrants to adhere to a code of conduct. Any new statement of collective values would add value only if it did not cut across the existing Code of Conduct, *Good Public Health Practice*, to which public health specialists and practitioners must subscribe to retain registration with UKPHR.

Question 5: What further actions would enhance recruitment and retention of truly representative public health workforces?

We note that the Government is currently reviewing the efficacy of some of the 2010 legislation on equality. In the same context we endorse the comments of the Public Health Practitioner National Coordinating Group in relation to the inclusiveness which public health practice demands: the 'everybody's business' approach of PHORCAST is entirely right.

Question 6: Are there workforce challenges and opportunities we have not identified? What support could be put in place to meet those challenges?

We support the general spirit of the declaration in paragraph 3.25. The King's Fund seminars UKPHR sponsored on 19 October and 1 November 2011 are highly relevant to this theme; I attach our report on those two days of highly stimulating discussion.

Further attention must be paid to the social model of public health: this is where the opportunities are in the move to local government, and the implications for the

location, delivery and content of training are significant. There should be increasing recognition of the need for defined specialists as the role of public health develops in the new environment.

We would in fact urge a fundamental re-examination of career pathways for public health in all domains, with a view to developing more routes to qualification and registration at both practitioner and specialist levels. The King's Fund discussions identified a clear need to avoid a 'one size fits all' approach in the emerging public health environment: this has profound implications for the whole way we train and develop the workforce. Needs and skills will change and it must be recognised that multi-disciplinary training can come from more than one training scheme.

Question 7: How can local people be encouraged to develop their skills for public health in the new system?

Health champions programmes are an important vehicle for this: voluntary sector organisations, healthy living centres and community development practice (including the work of specialist public health) should all be commissioned to contribute to this. The opportunity is to look wider than existing training schemes, developing a network of existing training that develops defined specialists.

Question 8: How can the public health element of GP training and continued professional development be enhanced?

The Institute of Health Equity's Marmot Review has recently promoted this both through the BMA publication *The Social Determinants of Health: What Doctors Can Do* and its subsequent consultation on the role of health professionals in reducing health inequalities. This provides a good framework for developing appropriate skills and awareness.

The Health Inequalities Forum of the Medical Royal Colleges has written to the IHE proposing collaborative working to develop a programme of work to deliver such skills amongst the full range of health professionals. In addition, as commissioners CCG Boards, with their strong medical representation, will have legal duty, under the 2012 Act, to reduce health inequalities. So the focus on the development needs of GPs and other doctors who sit on CCG Boards could usefully include learning about effectively addressing health inequalities.

We would urge a stronger focus on behaviour change skills training such as motivational interviewing in both postgraduate and undergraduate training, together with greater focus on the social policy and social structure dimensions of public health practice. We would also point out that a small number of practising GPs are currently preparing for public health practitioner assessment and registration with UKPHR as a way of gaining increased recognition for their public health role.

Question 9: Would it be helpful to describe the potential career pathways open to public health practitioner workforces?

This question also bears on the issues raised by the proposed categorisation discussed under Question 2.

Paragraph 4.18 could be read as a little patronising. Most, if not all, Directors of Public Health are fully aware of how to develop career pathways for the public health practitioner workforce, despite the fact that much of this will be in provider organisations. What would be constructive would be a nationally agreed pathway for public health practitioners.

Many public health departments have resources to enhance the skills of practitioners on a continuing basis: this is something which many are choosing to safeguard because of the need to promote and maintain the skills of the practitioner workforce.

The strategy might be enhanced by placing upon Directors of Public Health a duty to maintain and champion the skills of the public health workforce. This is not an area that lends itself to centralised planning; but it could be supported from the centre, as for example PHORCAST should continue to be supported.

Of greatest importance for the future development of a coherent public health discipline and an integrated workforce is the need to create a career pathway which enables those who are able to progress seamlessly through all career grades.

Question 10: What benefits would new ways of cross-disciplinary training bring to the public health workforces?

It is essential that such training is multi-disciplinary both for the purpose of promoting awareness of public health concepts and for making full use of the contributions of different partners to the delivery of population health programmes. The benefit, therefore, will be apparent in effective, engaged, highly performing staff working to common agendas notwithstanding that they come from different career traditions and are employed by a diverse multiplicity of organisations.

We believe the review proposed under paragraph 5.8 needs to involve a wide range of stakeholders and should be led by Public Health England, as the body responsible for public health, in association with the Local Government Association, which is itself familiar with supporting a multi-disciplinary service. The identification of the Faculty of Public Health with an agenda which is, inevitably, primarily medical may send out a message that public health can be categorised in terms of a ‘medically’ and ‘non-medically’ qualified workforce. We do not believe it can be right to define the wide variety of public health disciplines, outside the medical discipline alone, in terms of what they are not rather than what they do contribute to public health practice.

Whatever the leadership of the review, its terms of reference should be unambiguous and it should draw on the experience and perspectives of a wide range of stakeholders so as to encompass training for the whole workforce, from practitioners to advanced practitioners to specialists.

We note that paragraph 5.11 refers to the lead taken by medical deaneries. If the approach is to become truly multi-disciplinary then this focus should change.

We are unsure how the approach proposed in paragraph 5.13 aligns with the move of public health to local government.

Question 11: How can LETBs best support flexible careers to build extended capacity in public health?

Where some Deaneries have been involved with developing both public health practitioner and specialist training, a seamless move into the LETB could provide a robust basis for development. This multi-disciplinary and multi-level approach could usefully be encouraged across all Deaneries.

Protected funding for training could make an enormous contribution to training the multi-professional wider public health workforce in the NHS and its partners. The potential role that LETBs could play is significant.

Question 12: Is the healthcare Education Outcomes Framework appropriate for public health education and training? If not, how could it be adapted?

The focus should not be so much on health services: the Framework could usefully be adapted to make it more applicable to the local authority workforce. Our references to social and spatial structure, social policy and social psychology and behavioural science indicate our view that the skill base for public health practice must inevitably widen within its new local government environment.

Question 13: How can flexible careers for public health specialists best be achieved?

The emphasis on medical models should be removed and the need for defined specialists, able to demonstrate specific as well as core public health competences, must now be recognised.

The paper appears not to recognise that revalidation must apply to all public health specialists and practitioners, with consistency across the board in its requirements.

Question 14: What actions would support the development of strong leadership for public health?

The move to local government makes it essential to re-think how public health specialist training prepares individuals for the leadership role in this context. The possible lack of leadership capability is a matter for real concern in public health – one which, as matters stand, is not properly addressed during training.

Question 15: What actions can be taken, and by whom, to attract high quality graduates in academic public health?

We are unconvinced that academic public health is a specialism into which proactive recruitment is possible, or even desirable. Those who work in this field must have the necessary attributes and demonstrate very high quality skills. This is not an open door for every public health specialist: the aim must always be to attract the best and to raise both the profile of academic public health and the respect in which it is held.

We would certainly urge that those recruiting should think more broadly than medical specialists. This is not uncommon in other areas of academic life. We note for example that the highly distinguished school of law at Warwick University was led successfully, for many years, by a 'non-lawyer'. The aim must always be to attract the best.

Question 16: Are these the right actions to develop and strengthen the public health information and intelligence function? Who should be responsible for delivering these actions?

Public health defined specialists in informatics are key to this; but the emphasis must be on consultant level appointments: the status of these staff must not be downgraded to practitioner level.

It is extremely important to recognise here the historic lack of effective careers pathways into, and training provision for, public health intelligence. Our consultation during the development of the public health practitioner standards for UKPHR registration involved several focussed events with public health intelligence staff. Although some participants would have liked to see a defined registration route for practitioners, the majority wished to see the same set of standards which apply to all public health practitioners as they begin their careers in the sector. It is important, therefore, that professional advancement is fully recognised; and that, ultimately, there is access to specialist registration as a defined specialist in public health intelligence.

Given the role of Public Health England in public health intelligence, it would make sense for them to take the lead in developing such a career pathway so as to enable public health intelligence staff to attain professional recognition and registration at the appropriate level.

Question 17: Do you have any evidence or information that would help analyse the impact of these proposals?

We have no such evidence but could, if asked, request UKPHR registrants to share their own backgrounds and career pathways.

The above represents our specific comments in response to the consultation questions. We look forward to taking part in the debate as it develops.

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