

**UK PUBLIC HEALTH REGISTER
DEVELOPMENT OF REGULATION FOR PUBLIC HEALTH PRACTITIONERS
CONSULTATION DOCUMENT**

WELCOME TO THE CONSULTATION ON THE REGULATION OF PUBLIC HEALTH PRACTITIONERS.

This document contains:

1. Information on the consultation
2. Information on the developments to date
3. The proposals:
 - a) The proposed process by which individuals will be assessed for admission to the Register
 - b) The proposed standards against which public health practitioners will be assessed for admission to the Register (which have been revised following the initial piloting stage)
 - c) The proposed Code of Practice.

We encourage everyone with an interest in public health to contribute to this consultation. We look forward to hearing your views on the proposals contained in this document.

1. INFORMATION ON THE CONSULTATION

1.1 What is the consultation about?

The UKPHR is developing regulation for public health practitioners. This is a consultation about:

- a. the proposed process by which individuals will be assessed for admission to the Register
- b. The proposed standards against which public health practitioners will be assessed for admission to the Register
- c. the proposed Code of Practice.

1.2 What form does the consultation take?

The consultation is taking a number of forms including:

- national / regional events with multi-disciplinary and multi-agency groups
- workshops with groups of public health practitioners who work in specific areas of practice (such as health protection, sexual health, health improvement, public health intelligence)
- workshops with different stakeholders (such as employers, other regulators)
- electronic consultation – for anyone who wishes to comment directly on the proposals.

In addition specific work is taking place to develop examples of practice against the draft standards that can be used to support implementation in the future.

1.3 What's the timescale?

The consultation document was piloted with two groups in October 2008 – sexual health advisers and the Practitioner Sub-Committee of the UKPHR. Following their feedback, the document has been amended and is now being made widely available.

The main consultation period is from 1 November 2008 – the end of February 2009.

1.4 If I take part, what will happen to my feedback?

All of the feedback we receive from whatever source and in whatever way will be collated and analysed. The independent consultant for the project will produce a report for the UKPHR with consultation findings, outcomes and recommendations. The Board of the UKPHR will make the final decisions on the way forward.

1.5 When is the Register likely to open to public health practitioners?

The UKPHR is committed to opening the register for public health practitioners in 2009. This means that the outcomes of the consultation will feed straight into the thinking of the UKPHR Board and decisions will be made on how best to proceed. Additional funding will be sought from the four UK Government Health Departments where necessary to bring this to fruition although, as with any form of regulation, the Register will need to be self-funding when it is fully operational.

1.6 How can I best be involved?

If you have already indicated your interest in this development to the UKPHR, you will be contacted direct and a form of involvement will be suggested for you. If this is not appropriate then please tell us.

If you are hearing about the consultation from a third party and want to become involved then please check on the UKPHR website - www.publichealthregister.org.uk - to find out about consultation events and how to sign up for them. Alternatively contact Zoe Clark, Practitioner Development Officer, at the UKPHR for further information - zoe_clark_po@hotmail.com

1.7 What if I have any questions?

If you have any questions that are not answered in this consultation document please contact Zoe on the email address above.

1.8 When does the consultation end?

The final date for receipt of electronic feedback is **Saturday 28 February 2009**.

Please send any electronic feedback to Zoe at the email address above and she will forward it to the independent consultant.

2 DEVELOPMENTS ON PUBLIC HEALTH PRACTITIONER REGULATION TO DATE

2.1 Background

The UKPHR has been commissioned by the four UK Government health departments to take forward the development of voluntary regulation for public health practitioners, particularly for those practitioners currently not registered elsewhere. This is one of the development strands that has arisen following the agreement and publication of the Public Health Skills and Career Framework (PHSCF)¹.

2.2 What is the Public Health Skills and Career Framework and how has it been used in this work?

The Public Health Skills and Career Framework is a tool for describing the competences and knowledge needed by all groups, domains and levels of the public health workforce. It was developed in response to the strong expressed need for a mechanism to facilitate collaboration and coherence across this diverse workforce to maximise its collective contribution. The Public Health Skills and Career Framework provides this by helping to ensure rigour and consistency in skills, competence and knowledge at all levels, regardless of professional background, and by enabling flexible public health career progression. The framework has been endorsed by the Department of Health in England, the devolved administrations in Wales, Scotland and Northern Ireland and a large number of other key stakeholders (see the PHSCF for details).

The PHSCF hence formed an excellent starting point for the development of standards for public health practitioner regulation. The UKPHR used the PHSCF as the source document for the development of the regulation standards. This meant that for public health practitioner regulation the knowledge and competence descriptions up to and including level 5 were used and for the development of the standards for advanced public health practitioner regulation the knowledge and competence descriptions up to and including level 7 were used. These statements were extensively tested with a range of practitioners during the initial pilot stage with a clear focus on the use of the Framework in regulation and have been modified following this initial work in the light of the feedback received. This is described more fully below.

2.3 What does voluntary regulation mean?

Regulation is primarily about public protection i.e. the UK Public Health Register allows the public and others to see who has met the standards to get onto the Register and to stay on the Register.

Essentially there are three main aspects to regulation:

- setting the standards and processes by which individuals gain entry to the Register

¹ See www.phru.org.uk

- setting the requirements for individuals staying on the register – this is primarily through individuals undertaking appropriate Continuing Professional Development (CPD) (although within statutory regulation there are discussions about introducing some form of revalidation²) and payment of a retention fee
- removal of individuals from the Register – either voluntarily (e.g. due to retirement) or due to mandatory removal when a complaint about an individual has been upheld and led to removal from the Register.

Underpinning all of these aspects is an ethical framework, set out in a Code of Practice, which should inform how individuals behave.

In essence for public health practitioners, the Register will be a public statement of those individuals who have met and agree to maintain standards of good practice appropriate to the level at which they work.

Voluntary regulation means that there is no form of statute or law on which the Register is based. In consequence the title ‘public health practitioner’ will not be a protected title. However if the Register for public health practitioners develops in the same way as that for public health specialists, then it is likely there will be increasing employment requirements for individuals working in public health to seek registration (eg by employers stating that registration as a public health practitioner is an essential / desirable requirement for the post in the Person Specification for relevant posts, or from commissioners of services requiring registered practitioners).

2.4 Who is the regulation for public health practitioners focused on?

This development is focused on public health practitioners. Public health practitioners are hands-on practitioners who spend the majority of their time furthering health by working with individuals, groups, communities and populations. The then Chief Medical Officer in England distinguished this group in an earlier report when he identified three main groups of staff who work in public health³:

- 1 the wider workforce - most professionals including managers in the NHS, local authorities and elsewhere (eg teachers) who would benefit from a better understanding of public health
- 2 public health practitioners - hands-on public health practitioners who spend the majority of their time furthering health by working with groups and communities (eg public health nurses, health promotion specialists, community health workers)
- 3 public health specialists from a variety of professional backgrounds

² This is one of the developments stemming out of the Regulation White Paper – see earlier.

³ Department of Health, 1998, *Chief Medical Officer's Project to Strengthen the Public Health Function in England: A Report of Emerging Findings*, London

and experience (such as medicine, dentistry, social science, statistics, environmental health) who need a core of knowledge, skills and expertise. It is this group which was the focus of the development of the Public health Specialist Register.

Public health practitioners are the second group in this categorisation and now form the focus of the UKPHR's development work.

2.5 Why is regulation for public health practitioners being considered?

Regulation of public health practitioners is being considered due to the nature of the roles that practitioners in public health undertake and the influence they can have on the health and wellbeing of populations, communities, groups and individuals.

It is recognised that some individuals have an interest in regulation for professional development and professional recognition purposes. However the UKPHR is mindful of the fact that these interests can be served by other means and this is not the primary purpose of regulation ie

“The driver for ... regulation is often complicated by the desire to raise the professional standing of a group and not always driven by the need to ensure public safety.”⁴

2.6 Will the regulation of public health practitioners be the same as that for public health specialists?

The UKPHR Board is committed to developing the same range of routes to registration for public health practitioners as for public health specialists i.e.

- retrospective routes – for those who have already been working in public health and believe they have developed the skills and knowledge for entry to the register
- prospective routes – for those who wish to develop their knowledge and skills to become a public health practitioner
- dual routes – for those who are already on another register and there is agreement on equivalent standards for entry to the public health register.

The UKPHR Board believes that it is unwise to assume that the approach for entry to the Register that has been taken with public health specialists in each of these three routes will be appropriate for registering public health practitioners. This is because there are significant differences between public health specialists and public health practitioners.

- The exact number of individuals currently working in public health practitioner roles and likely to seek registration is difficult to estimate.

⁴ Extending Professional Regulation Working Group – *Interim Report: Protecting the public by ensuring that workforce standards are met*, Department of Health, June 2008

However there are likely to be substantially more individuals seeking registration as public health practitioners using the retrospective route to the Register than has been the case for public health specialists where there has been just over 300 registrations to date.

- There is currently no nationally recognised education and training programme / scheme for public health practitioners and there are no known plans to develop such an approach. This means that there is no national system from which individuals can be asked to 'top-up' their knowledge and skills if they have gaps in their learning. Nor is there a nationally recognised education and training programme to enable individuals to develop their knowledge and skills prospectively.
- There are a number of other professional groups who are regulated in some form and who undertake public health roles (such as public health nursing, environmental health, nutrition). There is the likelihood that dual routes to registration might be appropriate for some or all of these groups but further detailed work will be needed to explore the exact relationship between the public health roles of these professions and those of public health practitioners.

The UKPHR uses the following approaches for the three different routes for registering public health specialists:

- for the retrospective route to the Register, individuals present evidence in portfolios against the public health specialist standards and the UKPHR assesses the evidence presented and determines if the individual has met the standards for entry to the Register - a regulator led model
- for the prospective route to the Register, individuals currently undertake training programmes run by the Faculty of Public Health who assesses their competence for entry to the Register at the completion of the programme - a devolved model of regulation
- for the dual route to the Register, joint agreements have been put in place with other regulators to give access to the Register for specific professional groups.

This consultation document sets out detailed proposals for how the retrospective route to registration might work for public health practitioners given the context set out above, and the need to develop a system that is both sustainable and cost-effective to implement.

As part of the collaborative effort to make best use of the PHSCF, the Faculty of Public Health has been commissioned by the four Government health departments to scope the current education, training and development, and assessment approaches that exist for public health practitioners. This project is due to report by the end of March 2009 and will be an essential stage in informing decisions on prospective routes to registration. It is not possible to

propose or offer a prospective route to registration for public health practitioners at the present time as no such programmes exist. The UKPHR is working closely with the Faculty to ensure that these two developments are taken forward together and inform each other so that a prospective route to registration can be put in place as soon as possible. Prospective routes to registration are not covered within this consultation document.

The UKPHR has been seeking to learn from the experience of other regulators as to effective approaches to addressing regulatory issues. Early discussions have taken place with some of the regulators who register practitioners who have public health roles. These discussions are being taken forward with individual regulators as to whether it might be appropriate to, and if so how, to develop dual registration processes. Dual routes to registration are not covered within this consultation document.

2.7 How much will registration cost?

It is not possible to state what the cost of registration as a public health practitioner will be at the present time. The UKPHR is committed to make the registration process as cost effective as possible as it recognises that public health practitioners do not generally command a high salary. The cost for registration will depend on the model of assessment used. The UKPHR is committed to make the assessment process as simple as possible to keep the cost to a minimum but it needs to do this in a way that maintains standards and protects the public from the risks that public health practitioners may pose.

2.8 What's happened so far?

The first step in voluntary regulation is the development of standards for registration i.e. what it is that individuals that are seeking to get on the register need to achieve. In the early months of 2008, two different models of draft standards for registration were produced at two levels – public health practitioners and advanced public health practitioners - drawing from the descriptions of competence and knowledge in the PHSCF.

These draft standards were tested in an initial pilot of the standards with a wide range of different groups of public health practitioners across the UK between April and June 2008. The purpose of this work was to check the 'understandability' and applicability of the standards to different individuals' work.

2.9 What were the outcomes of the initial pilot?

The initial pilot tested two draft sets of standards for each of the two levels of public health practitioner and advanced public health practitioner. The two models of standards tested were a generic model (broad standards which every individual seeking registration would need to meet by applying it to their area of practice) and an essential plus additional model of the standards where practitioners would have to meet all of the essential standards and would then have free choice from the other remaining standards.

Generally the statements within both sets of standards were well accepted and seen to reflect public health at the two levels, although the layout was found to be rather cumbersome. A number of detailed editing points were made to improve general understanding and clarity. In addition a number of key gaps were identified.

The initial pilot showed that the generic model of the standards was found to be generally manageable and easy to understand. It was felt that it was more likely to lead to an integrated public health function and less likely to lead to discrimination within public health. It was more suited to those individuals who did not work in a set discipline and who had come into public health from a varied background or through various routes. Specifically the generic standards were felt to better support the protection of the public as it would be clear as to the standards that individuals needed to achieve to get onto and stay on the register.

A number of individuals stated their preference for the essential plus additional model although the reasons given for this tended to relate to the benefits of this model for professional development. Whilst such development is valuable, it is not the purpose of a regulatory system.

Taking all of this feedback together it appeared that if the format of the standards could be improved and examples given on how generic standards might be met in different settings, this would ease the felt need for the essential plus additional model by some groups. It would also better meet the need for whatever is developed to be simple to apply, flexible in operation and sustainable over time. This is consistent with the principles of better regulation, which are that regulation should be: transparent, accountable, proportionate, consistent, and targeted⁵

Using the feedback from the initial pilot the standards have been redrafted in a way that is mindful of the concerns with wording that different groups noted and the need for the standards to be applicable to the wide range of diverse public health practitioners.

2.10 What has happened since the initial pilot?

Since the initial pilot the outcomes and progress to date has been reported to the UKPHR Board. The Board concluded that the initial pilot had proved to be much wider than anticipated involving a wide variety of practitioners from the NHS, local authorities and voluntary sectors and across all four countries in a substantial number of piloting events. It had produced a great deal of good quality information from across the range of public health practice.

The Board of the UKPHR decided at its meeting in early September 2008 that given the improvements that it has been possible to make to the standards following the initial pilot, it would be a better use of resources to move to a fuller consultation phase in which a number of different aspects are considered building on the enormous enthusiasm generated in the initial pilot.

⁵ Better Regulation Executive, The five principles of better regulation – see <http://www.berr.gov.uk/whatwedo/bre>
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This would also facilitate the opening of the Register to public health practitioners in 2009.

This decision has led to the development of this consultation document.

2.11 What about public health advanced practitioners?

The Board also agreed the importance of bringing together the work on developing the practitioner standards with the parallel strand of development work that has been undertaken to learn from other regulators. It also agreed that all of the development needed to be put in the context of developments stemming from the Regulation White Paper *Trust, Assurance and Safety*⁶.

This means that this next stage of development and consultation is focusing specifically on public health practitioners. The next section sets out the detailed proposals.

A parallel piece of work is being undertaken at the same time on public health advanced practitioners. This will be informed by a project which is being undertaken as part of the Regulation White Paper to define an Advanced Level of Practice across all health professions and which is due to report in December 2008.

2.12 What are the plans for taking forward the implementation of the Register for Public Health Practitioners?

The UKPHR is committed to opening the register for public health practitioners in 2009 once feedback has been received on the outcomes of this consultation and the Faculty of Public Health has completed its scoping work on current education and training programmes.

At the moment it is anticipated that, for the retrospective route, there will be a rollout programme with early implementation with selected groups who will do a live test of the system allowing it to be modified for other groups that follow.

The UKPHR anticipates that in the initial years of implementation the greatest demand will come from those individuals who are currently working in public health roles and will be seeking registration via the retrospective route. Over time it is anticipated that the numbers seeking recognition through the retrospective route will decrease and there will be increasing demands for prospective programmes to enable individuals to achieve the standards.

It is not yet possible to say when prospective or dual routes to registration will be put in place, or how these will be quality assured, as decisions cannot be made until the Faculty of Public Health has completed its work and there has been joint work with other regulators. The UKPHR will strive to develop these routes as soon as is practicable.

In order to ensure the approach taken to regulation is appropriate and

⁶ Department of Health, February 2007, *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*, CM 7013, DH London

effective for all groups, the UKPHR will review what is implemented after three years and make any necessary modifications. It will also consider the desirability of moving to statutory regulation.

3 THE PROPOSALS ON WHICH WE ARE SEEKING YOUR VIEWS

3.1 Introduction

As set out in section 2 of this document, this consultation focuses on the *proposed registration process for the retrospective route to registration* i.e. for individuals who have already developed their knowledge and competence as practitioners in public health.

In addition it sets out:

- *draft standards for public health practitioners* – these would form the basis for all routes to registration i.e. they are the standards that individuals would need to demonstrate they can meet to gain entry to the register (Appendix A)
- *the proposed Code of Practice for public health practitioners* (Appendix B).

Each section below has some consultation questions attached to it. The full list of consultation questions, together with the background information to your response, is also provided in Appendix C.

3.2 How does the UKPHR define public health practitioners?

The purpose of *public health* is to:

- improve health and wellbeing in the population
- prevent disease and minimise its consequences
- prolong valued life
- reduce inequalities in health.

This is achieved through:

- taking a population perspective
- mobilising the organised efforts of society and acting as an advocate for the public's health
- enabling people and communities to increase their control over their own health and wellbeing
- acting on the social, economic, environmental and biological determinants of health and wellbeing
- protecting from and minimising the impact of health risks to the population
- ensuring that preventive, treatment and care services are of high quality, evidence-based and of best value⁷.

Those likely to seek registration as public health practitioners will spend all or the majority of their time in public health activities. They may be working at different levels equating to level 5 and above in the Public Health Skills and Career Framework.

As described in the previous chapter, it is difficult to state exactly how many

⁷ This definition of public health is taken from the Public Health Skills and Career Framework (2008) – see www.phru.org.uk
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public health practitioners there are or who exactly should put themselves forward for registration. However public health practitioners are diverse in the work that they do. For example, some work one-to-one with individuals but do this from a population perspective, others mainly work with communities or groups, while others deal with information and intelligence about the population. In addition some practitioners specialise in one particular aspect of health and wellbeing (such as smoking cessation, physical activity, health protection) while others work more generally applying their skills to the work in hand. In this consultation we are keen to hear how well you think the developments so far are suitable for the public health practitioners with whom you are most familiar.

The UKPHR took the broad definition of public health practitioners set out in the PHSCF at level 5, tested this within individuals in the initial pilot and subsequently refined it. The current draft definition of public health practitioners is:

Public health practitioners have responsibility for specific areas of public health work, continually develop their area of work and support others to understand it. Practitioners are likely to contribute to multi-agency / multi-disciplinary programmes of work. Generally practitioners will work as part of a larger team led by someone working at a higher level.

Consultation question on the definition of public health practitioners

1. Is the definition of public health practitioners effective in *describing* this level of practice in public health? Yes / No
If not, please explain how it can be improved.

3.3 What is the purpose of regulating public health practitioners?

The primary purpose of regulation is to protect the public by putting in place a Register of those who have met set standards and having systems for calling registrants(i.e. individuals on the register) to account when there are complaints against them. Regulatory systems are increasingly based on risk i.e. the effect of an incompetent individual or unethical practice on individuals, groups, communities and populations. We are interested in hearing from you about the risks that incompetent individuals or unethical practice might pose in the area of public health with which you are familiar.

Consultation questions on the risks posed by public health practitioners

2. *What are the risks that incompetent individuals or unethical practice might pose to individuals, groups, communities or populations in the area of public health which you are familiar?*

3. *Are these risks addressed currently (i.e. without regulation)?
Yes / No
If yes, please explain how.*

3.4 What are the proposed standards for the regulation of public health practitioners?

As described in section 2 of this document, the initial standards for the regulation of public health practitioners were drawn from the PHSCF, specifically level 5 and including any other relevant standards in the levels below. These initial draft standards were piloted during the early part of 2008 and have been modified and restructured in response to the feedback received.

A set of draft standards for regulation has been produced and is set out in Appendix A. The standards have been structured to show the competences in the 1st column and the knowledge that supports the achievement of those competences in the 2nd column. The competences are designed to be applicable to whichever area of public health practice an individual works. The knowledge statements are designed to focus on the key aspects of knowledge and understanding that practitioners need to practise effectively in public health. To gain entry to the Register, individuals would need to be able to provide evidence that they could meet all of the competence statements within their own area of work and possess the knowledge set out in the standards.

As with any form of regulatory standards, the statements do not set out the very specific aspects that are needed for particular jobs. This is because the standards for regulation form benchmarks that individuals have to show they can meet to be fit for registration. Employers will need to ensure that any individual registrant has / develops the additional necessary competences and skills for the specific post in which that individual is employed ie being registered does not detract from the need for employers to develop and appraise their staff and hence ensure that they are fit for purpose in their particular post.

Please look at the draft standards in detail and answer the questions below.

Consultation questions on the proposed standards for public health practitioners

4. *Are the draft standards appropriate to the area(s) of public health with which you are familiar?
If not, please describe those statements that are problematic and why this is.*
5. *How would you expect the standards to be demonstrated in the area of practice with which you are familiar?*

6. *Are the standards sufficient to address the risks that incompetent practitioners / unethical practice pose (ie the risks that you identified above)? If not, please suggest how they can be improved.*

3.5 What ethical standards will public health practitioners be expected to uphold?

The UKPHR currently uses *Good Public Health Practice* as its Code of Practice for public health specialists. This was developed by the Faculty of Public Health through putting *Good Medical Practice* (GMC) into the context of public health. The standards of good behaviour and the ethical framework to inform behaviour should be the same no matter the level at which an individual works.

The UKPHR is consequently interested in hearing the views of those who are public health practitioners, or who have an interest in their regulation, as to the applicability and relevance of *Good Public Health Practice* to their practice (it is shown in Appendix B of this document). Once feedback has been received on this, the Board of the UKPHR will be in a better position to determine the best way forward for all its registrants.

Please look at *Good Public Health Practice* (Appendix B) in detail and answer the questions below.

Consultation questions on the proposed Code of Practice

7. *How well does the content of Good Public Health Practice relate to the work of public health practitioners? Please explain your answer.*
8. *Do you think that Good Public Health Practice is sufficient to reflect the type of work and the ethical dilemmas that public health practitioners face? Please explain your answer.*
9. *Are there any aspects of Good Public Health Practice that are not appropriate to public health practitioners? If yes, please explain what they are.*
10. *Are there any aspects that are important for public health practitioners that you cannot find in Good Public Health Practice? If yes, please explain what they are.*

3.6 What is the proposed registration process for the retrospective route to the Register for public health practitioners?

The UKPHR is proposing that registration of public health practitioners should be carried out using a devolved model of assessment. The UKPHR is keen to ensure that the process of assessment and regulation is kept as simple, flexible and inclusive as possible whilst assuring that standards of practice are properly assured. It is also keen to keep the cost of regulation as reasonable as possible to reflect the salaries of those employed as public health practitioners. This is explained in more detail below.

Assessment for registration will be against the standards for public health practitioners (once agreed and finalised) as set out in Appendix A.

Individuals who are seeking registration as public health practitioners will gather evidence against the standards. They will also confirm that they have met the standards set out – this would be done by signing specific statements against each of the different sections in the standards. Applicants will also be required to confirm that they understand the ethical framework set out in the Code of Practice, which includes that the individual agrees to act honourably and honestly.

The evidence presented by an individual who is seeking registration will be verified against the standards for public health practitioners by a Public Health Specialist i.e. an individual who holds registration with the UKPHR, and/or as a public health specialist with the General Medical Council (GMC) or General Dental Council (GDC). The Public Health Specialist will be known as the Verifier.

Public Health Specialists might be identified / found:

- in the practitioner's workplace (eg leading a public health team)
- through local, regional or national professional networks
- through specific collaborative arrangements with academic and/or professional bodies.

The UKPHR is keen to identify through this consultation whether it will be necessary to set up specific collaborative arrangements to ensure that every individual seeking to register as a public health practitioner is able to identify an appropriate public health specialist to act as their verifier, or whether current systems and networks would be sufficient for this to happen.

It is possible that the individuals who act as verifiers will change over time as the register for public health practitioners develops. However it is important that in the first instance, and to get the register started, the UKPHR uses individuals in whom trust can be placed as verifiers. The major benefits of using regulated Public Health Specialists as verifiers are their knowledge of public health practice, and the expectations that can be placed on them to act effectively and ethically in the process consistent with their regulatory body's

Code of Practice.

The verification will be undertaken using the standards as the benchmark and informed by guidelines/ examples (including the evidence that is required). Verifiers might also have to attend a training programme designed to ensure that they are competent in the process.

Currently the UKPHR is considering using one verifier. However it has been suggested that there should be a triangulated view of the evidence presented ie it would be appropriate to gain different views of the individual's competence and knowledge. This would mean that two individuals would independently verify the evidence provided and then this would be checked by the UKPHR. We would welcome your views on how to best balance the practical issues of accessing two verifiers, the additional quality assurance that would be offered, and the need to keep regulation proportionate, simple and sustainable.

Once Verifiers have signed to confirm that in their opinion, and having followed the set guidelines and examples, the individual has evidence to show they meet the standards, the completed application form will be sent to the UKPHR. The Register will undertake an administrative check to confirm that the relevant parts of the application form have been completed correctly and return any application that is incomplete.

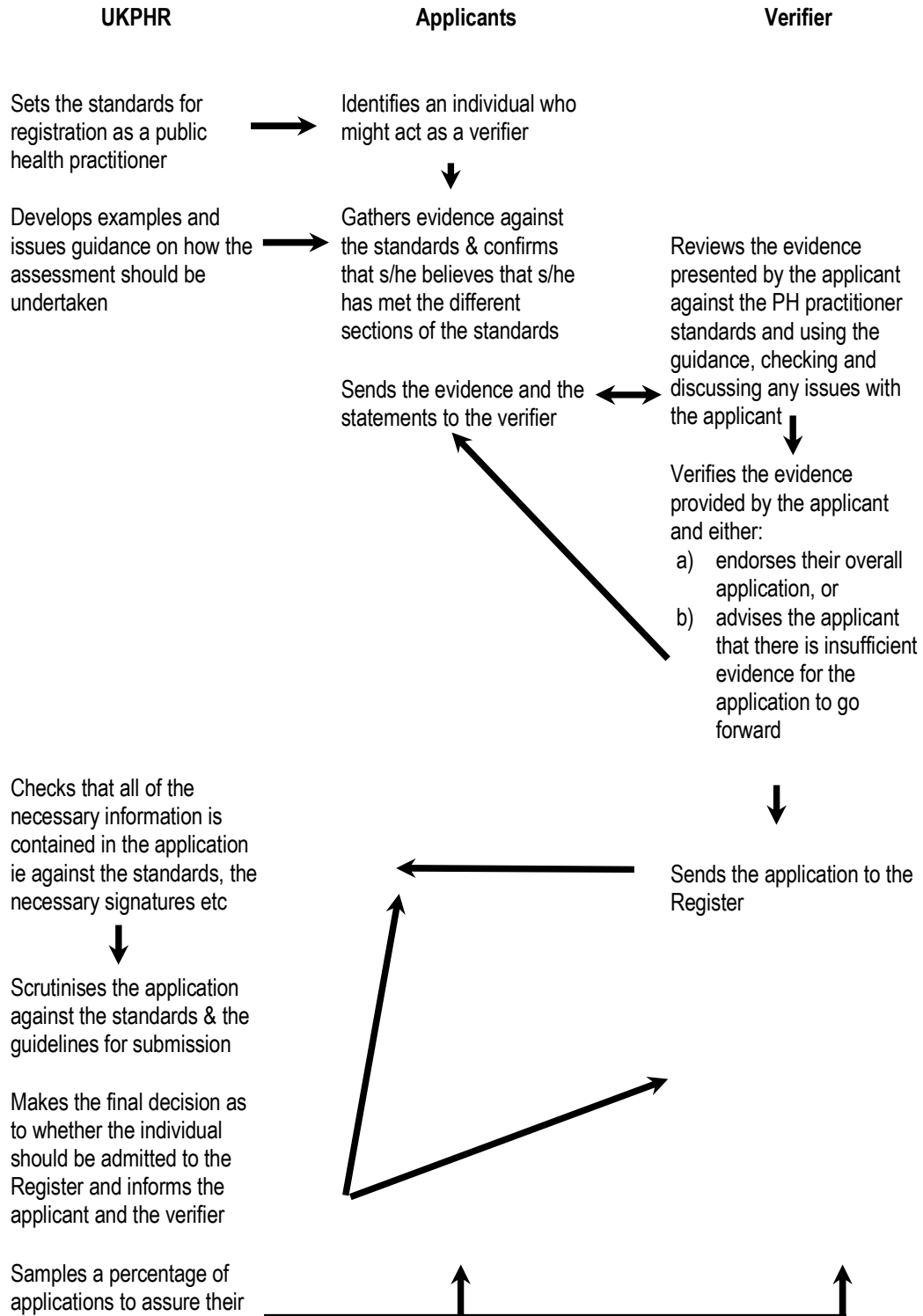
The Register will then undertake a more detailed scrutiny of the applications to ensure that the individual applicant and the Verifier have followed the guidelines for submission.

The Register will sample a percentage of applications each year. The sample will be of both the evidence used by the applicant to demonstrate competence to the Verifier(s) and the assessment of the evidence that the Verifier(s) has undertaken. The Register will retain the right to sample up to 100% in any one year.

This process is shown in the diagram that follows.

Overview of the proposed draft process for the retrospective route to registration

Note – this diagram will need to change in the light of the feedback received particularly in relation to the number of verifiers that should be used



Consultation questions on the proposed registration process for those seeking retrospective registration

11. Will this process work in the area of public health practice with which you are familiar? Please explain your answer.
12. What quality assurance processes would you want to see to have confidence in the assessment process for registration?
13. What in your view is the best way of addressing the practical issues of accessing verifiers, assuring the quality of the process and ensuring that the regulation process is proportionate, simple and sustainable?
14. If a triangulated approach to assessing evidence is adopted, do you think that:
 - a) both of the verifiers should be regulated public health specialists?
 - b) only one verifier would need to be a regulated public health specialist?If you think that only one of the verifiers needs to be a regulated public health specialist, where do you think the other person should be drawn from?
15. Do you think individuals will need support:
 - a) for learning and development to help achieve the standards?
 - b) in the process of preparing their application for the Register?If yes please explain where this support could / should come from.

If you are answering as a public health practitioner, please also answer this additional question

16. If the UKPHR required you to use someone who is registered as a Public Health Specialist to verify your work, how would you identify that person? Please explain your answer.

If you are answering as a public health specialist, please also answer this additional question

17. What support do you feel you would need to act as a verifier?

Finally we have some general questions about this work that we would be grateful if you would answer.

General consultation questions

18. Were you familiar with the Public Health Skills and Career Framework before you received this consultation? Yes / No
19. Are there any other comments you wish to make that are relevant to this consultation?

THANK YOU FOR YOUR INTEREST IN THIS WORK AND FOR PROVIDING FEEDBACK ON THESE PROPOSALS.

APPENDIX A: DRAFT STANDARDS FOR PUBLIC HEALTH PRACTITIONERS FOR REGISTRATION WITH THE UK PUBLIC HEALTH REGISTER– CONSULTATION VERSION

The initial standards for the regulation of public health practitioners were drawn from the PHSCF, specifically level 5 and including any other relevant standards in the levels below. These initial draft standards were piloted during the early part of 2008 and have been modified and restructured in response to the feedback received.

The standards have been structured to show the competences in the 1st column and the knowledge that supports the achievement of those competences in the 2nd column. The competences are designed to be applicable to whichever area of public health practice an individual works. The knowledge statements are designed to focus on the key aspects of knowledge and understanding that practitioners need to practise effectively in public health. To gain entry to the Register, individuals would need to be able to provide evidence that they could meet all of the competence statements within their own area of work and possess the knowledge set out in the standards.

COMPETENCES	RELATED KNOWLEDGE STATEMENTS	COMMENTS
Individuals will need to provide evidence for all of these competences (ie show how they meet the statements) in the area of work in which they practise.	Individuals will have to show that they possess the knowledge described in each of the statements.	This column has been left blank for you to insert any comments you wish to make in the consultation on the competence or knowledge statements.

In the knowledge statements, two different introductory terms have been used – ‘awareness of’ and ‘knowledge of’. The purpose of these terms is to indicate the broad level of knowledge that would be needed in relation to each of these statements. The table below indicates the type of things you might need to do in relation to these phrases:

Level of knowledge expected indicated in key word	Related learning outcome verbs
Awareness of	recall, define, state, list, repeat, name, recount, present, find, recognise, outline
Knowledge of	restate, identify, discuss, review, explain, clarify, distinguish, differentiate, calculate, debate, relate, compare, experiment, contrast, examine

So an example of expectations related to a statement in the draft standards would be:

Example statement from the standards	Example of the sort of evidence that might be used to demonstrate this
Awareness of how to constructively influence policies and strategies affecting own area of work.	<ul style="list-style-type: none"> Is able to outline the reasons why you may want / need to influence policies and strategies affecting your work Is able to state three different ways in which you might constructively influence policies and strategies affecting your work
Knowledge of the different determinants of health and wellbeing and their relative importance	<ul style="list-style-type: none"> Is able to describe the different determinants of health and wellbeing Is able to explain the way in which the determinants of health and wellbeing affect the health of individuals and populations

THE DRAFT STANDARDS FOR THE REGULATION OF PUBLIC HEALTH PRACTITIONERS

COMPETENCES	RELATED KNOWLEDGE STATEMENTS	COMMENTS
<p><i>There are no specific competences under this section as the knowledge underpins all of the other competences and also can be demonstrated in the competences.</i></p>	<p><i>Population health and wellbeing</i></p> <ol style="list-style-type: none"> 1. Knowledge of the difference between individual and population health and wellbeing. 2. Knowledge of the history, theory, philosophy and principles of public health in its current context. 3. Knowledge of health and wellbeing and its different aspects (i.e. physical, emotional, psychological, social) 4. Knowledge of how individuals' background, culture and experiences lead to different perceptions and expectations of health and wellbeing and of illness. 5. Knowledge of the different determinants of health and wellbeing and their relative importance. 6. Knowledge of the links between the determinants of health and wellbeing and how they impact on different populations. 7. Knowledge of the concept and nature of inequalities in health and wellbeing (including in relation to service provision and access to services) and how they are measured (e.g. index of multiple deprivation, Jarman scores). 8. Knowledge of the main terms and concepts that are used epidemiology and the basis of calculations related to these terms (e.g. morbidity, mortality, incidence, prevalence, and standardisation). 9. Awareness of how health and wellbeing can be linked to geographical location (e.g. postcodes, districts, counties). 10. Knowledge of the current priorities for improving health, the actions being taken to 	

COMPETENCES	RELATED KNOWLEDGE STATEMENTS	COMMENTS
<p><i>Surveillance and assessment</i></p> <ol style="list-style-type: none"> 1. Obtain, verify and use data to describe the health and wellbeing and/or health needs of a defined population 2. Interpret data on health and wellbeing and health needs and communicate the data to different audiences. 	<p>address them and the rationale behind them.</p> <ol style="list-style-type: none"> 11. Knowledge of the different models, principles and approaches that are used to improve the health of individuals, families, groups and communities. (Models and approaches - behaviour change, community development, health promotion, social marketing). 12. Knowledge of the causes, occurrences, risks and threats to population health and wellbeing. (Risks and threats - environmental, communicable and non-communicable disease, social (eg , terrorist attacks), major accidents). 13. Knowledge of the different models, principles and approaches to preventing risks and threats to population health and wellbeing - primary, secondary, tertiary. 14. Knowledge of the different models, principles and approaches to managing risks and threats to population health and wellbeing. 15. Knowledge of effective approaches and methods of communicating risks to different people and populations. 	
<p><i>Surveillance and assessment</i></p> <ol style="list-style-type: none"> 1. Obtain, verify and use data to describe the health and wellbeing and/or health needs of a defined population 2. Interpret data on health and wellbeing and health needs and communicate the data to different audiences. 	<p><i>Surveillance and assessment</i></p> <ol style="list-style-type: none"> 16. Knowledge of the nature, purpose, uses and techniques of surveillance and assessment of the population's health and wellbeing; and the people and agencies involved. 17. Knowledge of different methods for collecting qualitative and quantitative data relating to health and wellbeing needs and their strengths and limitations. (Quantitative – surveys, questionnaires, data returns (eg births, deaths, disease). Qualitative - focus groups, patient satisfaction surveys, questionnaires.) 18. Knowledge of different methods for analysing qualitative and quantitative data relating to health and wellbeing needs and their strengths and limitations. (Quantitative - mean, median, mode, graphs, variance, trend data, small-scale data collection, and the use of comparative analysis e.g. proportions, ratios, rates, confidence intervals. Qualitative – 	

COMPETENCES	RELATED KNOWLEDGE STATEMENTS	COMMENTS
<p><i>Evidence and quality</i></p> <ol style="list-style-type: none"> 3. Critically appraise publications for their strengths and weaknesses. (e.g. research, policies, legislation, guidelines) 4. Apply research findings to a practical issue related to population health and wellbeing. 5. Find, retrieve, validate and communicate evidence relating to own area of work 6. Contribute to reviewing the effectiveness of own area of 	<p>grounded theory, discourse analysis, qualitative coding systems)</p> <ol style="list-style-type: none"> 19. Awareness of software and database packages and their use in manipulating data (e.g. spreadsheets, databases, specialist software packages) 20. Knowledge of the different agencies that collect data relating to health and wellbeing, the different ways in which this is done and how the source affects the nature and quality of the data. 21. Knowledge of how to access different sources of data on health and wellbeing. 22. Knowledge of the type of anomalies that occur in data and how these affect the usefulness of the data. 	
<p><i>Evidence and quality</i></p> <ol style="list-style-type: none"> 23. Knowledge of different types and sources of evidence and their strengths and limitations. (Types of evidence - research evidence, benchmarking studies, outcome measures, information from evaluation and audits. Sources of evidence – NICE, Cochrane, research studies, grey literature). 24. Knowledge of how evidence is used in planning, providing, evaluating and improving services, programmes, projects and interventions. 25. Knowledge of principles and methods of quality improving the quality of services, programmes, projects and interventions (including the use of outcome data, user feedback). 26. Knowledge of how to use evidence in reviewing and improving own work. 27. Knowledge of the concept and principles of reflective practice in evaluating own work. 		

COMPETENCES	RELATED KNOWLEDGE STATEMENTS	COMMENTS
<p>work.</p> <p>7. Constructively reflect on own practice and improve own practice as a result.</p>	<p>28. Knowledge of the importance of accurate and appropriate recording of own work and its relationship to reviewing the effectiveness and performance managing services / programmes / interventions.</p> <p>29. Awareness of current research agendas relating to population health and wellbeing.</p> <p>30. Awareness of how services, programmes and interventions related to health and wellbeing are prioritised, planned, managed and evaluated (i.e. commissioned and provided) across different agencies and sectors.</p> <p>31. Awareness of how services, programmes and interventions can affect population health and wellbeing and reduce / increase inequalities.</p> <p>32. Awareness of how health economics affects the development of services, programmes and interventions.</p> <p>33. Awareness of the issues and tensions relating to equitable and fair provision of services, programmes, projects and interventions, as compared with addressing inequalities and providing for the needs of a diverse population.</p>	
<p><i>Policies and strategies</i></p> <p>8. Identify the effects of policies and strategies on health and wellbeing in own area of work.</p>	<p><i>Policies and strategies</i></p> <p>34. Knowledge of the different levels at which policies and strategies relating to population health and wellbeing are developed and the complexity of the policy context. (Levels – international, national, regional, local and organisational.)</p> <p>35. Knowledge of the policies and strategies relevant to own area of work, the interaction between them and how they should guide own work.</p> <p>36. Awareness of how policies and strategies are assessed for their impact on health and wellbeing and how they may contribute to reducing or increasing inequalities. (Impact</p>	

COMPETENCES	RELATED KNOWLEDGE STATEMENTS	COMMENTS
	<p>assessment – equality, health etc).</p> <p>37. Awareness of how to constructively influence policies and strategies affecting own area of work.</p>	
<p><i>Working in partnership and leadership</i></p> <p>9. Work effectively in partnership with different people to achieve outcomes.</p> <p>10. Contribute to the planning and evaluation of projects / programmes / services.</p> <p>11. Undertake and review specific aspects of projects / programmes / services.</p> <p>12. Develop relationships and communicate effectively with stakeholders in own area of work using appropriate methods.</p> <p>13. Contribute to the development of others.</p>	<p><i>Working in partnership and leadership</i></p> <p>38. Knowledge of the range of organisations, teams and individuals that contribute to developing and delivering policies and strategies related to population health and wellbeing.</p> <p>39. Awareness of the ways in which organisations, teams and individuals work in partnership to improve and protect population health and wellbeing.</p> <p>40. Knowledge of the principles of effective partnership working and how to apply these in own work.</p> <p>41. Knowledge of the different forms that teams might take, team dynamics and the principles of effective team working.</p> <p>42. Knowledge of how to involve effectively the public in improving and protecting population health and wellbeing and developing effective public services.</p> <p>43. Knowledge of how to develop effective relationships with the wide range of people who contribute to population health and wellbeing (i.e. the public, communities, individuals, organisations, teams and other practitioners).</p> <p>44. Knowledge of how to communicate effectively with different people (i.e. orally, in writing, electronically, diagrammatically / pictorially).</p> <p>45. Awareness of the effect that the media has on perceptions of the public about health and</p>	

COMPETENCES	RELATED KNOWLEDGE STATEMENTS	COMMENTS
<p><i>Legal and ethical practice</i></p> <p>14. Act in ways that:</p> <ol style="list-style-type: none"> acknowledge and recognise people's expressed beliefs, preferences and choices respect diversity value people as individuals. <p>15. Takes account of own behaviour and its effect on others.</p> <p>16. Act in ways that are consistent with legislation, policies, procedures and good practice.</p> <p>17. Recognise ethical dilemmas and issues in own area of work and proactively address them in an appropriate way.</p>	<p>wellbeing and the planning and provision of public services.</p> <p>46. Awareness of the difference between management and leadership.</p> <p>47. Knowledge of different leadership styles and how they might be used in own work. (Styles of leadership eg transactional, transformational.)</p> <p>48. Awareness of different learning styles and own preferred style of learning.</p>	
<p><i>Legal and ethical practice</i></p> <p>14. Act in ways that:</p> <ol style="list-style-type: none"> acknowledge and recognise people's expressed beliefs, preferences and choices respect diversity value people as individuals. <p>15. Takes account of own behaviour and its effect on others.</p> <p>16. Act in ways that are consistent with legislation, policies, procedures and good practice.</p> <p>17. Recognise ethical dilemmas and issues in own area of work and proactively address them in an appropriate way.</p>	<p><i>Legal and ethical practice</i></p> <p>49. Knowledge of legislation and related guidance and protocols applicable to own area of practice and how to apply them in own practice i.e.</p> <ul style="list-style-type: none"> data protection including: confidentiality, data sharing, personal information, the political sensitivities of data freedom of information equality and diversity health and safety protecting health and wellbeing <p>50. Knowledge of emerging legal and ethical debates in own area of practice.</p> <p>51. Knowledge of governance frameworks and systems relating to own work and the effect that they should have on own practice (including reporting of risks and concerns).</p> <p>52. Knowledge of the ethical issues in own area of work and the different strategies that are needed to address such issues.</p>	

APPENDIX B: PROPOSED CODE OF PRACTICE

The UKPHR currently uses *Good Public Health Practice* as its Code of Practice for Public Health Specialists. We would welcome feedback on the applicability of this document to public health practitioners.

GOOD PUBLIC HEALTH PRACTICE – GENERAL PROFESSIONAL EXPECTATIONS OF PUBLIC HEALTH PHYSICIANS AND SPECIALISTS IN PUBLIC HEALTH

Duties and responsibilities in public health

The principles of good public health practice and the standards of competence, care and conduct expected of you in all aspects of your professional work apply to all public health physicians (PHPs) / specialists in public health (SPHs) including those in training.

The standards against which you will be judged have been adapted from the GMC document *Good Medical Practice* and made appropriate for public health practice.

The seven core elements are:

1. Good public health practice

PHPs/SPHs must:

- practise good standards of public health, as described in the Faculty's work on GPHP, with particular reference to the ten key areas of activity and their necessary competencies;
- make sure that individuals and communities are not put at risk; and
- work within the limits of their professional competence.

2. Maintaining good public health practice

PHPs/SPHs must:

- keep their knowledge and skills up to date;
- regularly take part in educational activities that develop their skills; and
- try to act on what is said during appraisals.

3. Teaching and training

PHPs/SPHs with special teaching responsibilities must:

- develop the skills, attitudes and practices of a competent teacher; and
- be honest and objective when they are assessing the performance of someone they have trained.

4. Relations with individuals and communities

PHPs/SPHs must:

- make the health of their communities and individuals within them their first concern;
- treat all individuals politely and considerately;
- respect individuals/patients' dignity and privacy;
- listen to individuals and communities and respect their views;
- give information to individuals and the public in a way they can understand; and
- respect individuals/communities' right to be fully involved in decisions about their health and health care.

5. Working with colleagues

PHPs/SPHs must work effectively with their health care colleagues, local government colleagues and all other colleagues. Co-operation, trust and flexibility and team working are essential to good public health practice.

6. Probity

PHPs/SPHs must:

- be honest and trustworthy;
- respect and protect confidential information;
- make sure that personal beliefs do not interfere with their work at any level;
- act quickly to protect individuals and communities from any risk; and
- not abuse their position.

7. Health

If a PHP/SPH has a serious condition that could affect their performance, or could be passed on to patients or the public, they must seek and follow advice from an appropriate colleague.

1. Good public health practice

The core elements of public health practice have been agreed by the Faculty of Public Health. Work is currently going on to define standards of practice and levels of competence for specialist areas for whom some core elements are more relevant than others. However, it is expected that all public health practitioners will have basic competence within each core element.

1.1 All populations are entitled to good standards of public health practice, based on the Faculty's ten key areas of public health, from public health physicians and specialists.

10 KEY AREAS

1. Surveillance and assessment of the population's health and well-being (including managing, analysing and interpreting information, knowledge and statistics).
2. Promoting and protecting the population's health and well-being.
3. Developing quality and risk management within an evaluative culture.
4. Collaborative working for health.
5. Developing health programmes and services and reducing inequalities.
6. Policy and strategy development and implementation.
7. Working with and for communities.
8. Strategic leadership for health.
9. Research and development.
10. Ethically managing self, people and resources (including education and continuing professional development).

Essential elements of this are professional competence, described in the Faculty papers on training and continuing professional development, good relationships with the public and colleagues, and observance of professional ethical obligations. Standards for practice in the different professional specialisms within public health practice are currently being developed.

1.2 Good public health practice must include:

- high standards of competence in the ten key areas of public health practice;
- taking suitable and prompt action when necessary;
- seeking help from relevant partners.

1.3 In your work you must:

- recognise and work within the limits of your professional competence;
- be willing to consult colleagues;
- be competent when undertaking the tasks required of you;
- keep clear, accurate and contemporaneous records which report the relevant findings, the decisions made, the information given to colleagues/the public;
- keep colleagues well informed when working in partnership;
- pay due regard to efficacy and the use of resources;
- advise only the course of action which best serves the population's needs.

1.4 If you have good reason to think that your ability to practise safely is seriously compromised by inadequate premises, equipment or other resources, you should put the matter right, if that is possible. In all other cases you should draw the matter to the attention of your employing body. You should record your concerns and the steps you have taken to try to resolve them.

1.5 Decisions about access to health care

The investigations or treatment you provide or arrange must be based on your judgement of the population/individual needs and the likely effectiveness of the treatment/intervention. You must not allow your views about a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age or social or economic status, to prejudice the treatment you provide or arrange.

You must not refuse or delay because you believe that an individual's actions have contributed to their condition.

1.6 Treatment in emergencies

In an emergency, wherever it may arise, you must offer anyone at risk the assistance you could reasonably be expected to provide.

2. Maintaining good public health practice

Keeping up to date

2.1. You must keep your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities that develop your competence and performance.

2.2 Some parts of public health practice are governed by law or are regulated by other statutory bodies. You must observe and keep up to date with the laws and statutory codes of practice which affect your work.

2.3 You must work with colleagues to monitor and maintain your awareness of the quality of the practice you provide. In particular, you must:

- take part in regular and systematic audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practice, for example by undertaking further training;
- respond constructively to assessments and appraisals of your professional competence and performance;
- take part in confidential inquiries and critical incident reporting.

3. Teaching and training

3.1 You are encouraged to help the public to be aware of and understand health issues and to contribute to the education and training of other doctors, medical students and colleagues.

3.2 If you have special responsibilities for teaching you must develop the skills, attitudes and practices of a competent teacher. You must also make sure that students and junior colleagues are properly supervised. This applies to all practitioners.

3.3 You must be honest and objective when assessing the performance of those you have supervised or trained. Patients and the public may be put at risk if you confirm the competence of someone who has not reached or maintained a satisfactory standard of practice.

4. Relations with individuals and communities

The word community can be applied to professional communities, geographic communities or communities of interest with which a PHP/SPH has a working relationship.

Professional relationships

4.1 Successful relationships depend on trust. To establish and maintain that trust you must:

- listen to individuals and the public and respect their views;
- treat individuals and the public politely and considerately;
- respect individuals' privacy and dignity;
- treat information about patients as confidential. If in exceptional circumstances you feel you should pass on information without a patient or an individual's consent, or against their wishes, you should follow agreed guidance on confidentiality and be prepared to justify your decision;
- give individuals and the public the information they ask for or need;
- give information to the public in a way they can understand;
- be satisfied that, wherever possible, the public has understood what is proposed;
- respect the right of the public/individuals to be fully involved in decisions about their care;
- respect the right of the public/individuals to decline treatment or decline to take part in teaching or research;
- be readily accessible to the public and colleagues when you are on duty;
- be vigilant about issues concerning data confidentiality.

4.2 The research studies you provide or arrange must be based on your professional judgement of the patient/population's needs and the likely effectiveness of any intervention. You must not allow your views about an individual's lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social status, or perceived economic worth to prejudice your work or advice on the treatment you advise.

4.3 If you feel that your beliefs might affect your work, you must explain this to senior colleagues.

4.4 You must not delay because you believe that communities/patients' actions have contributed to their condition, or because you may be putting yourself at risk. If a patient poses a risk to your health or safety you may take reasonable steps to protect yourself before investigating their condition or providing treatment. This is particularly applicable to communicable disease control.

4.5 You must always treat individuals and the public fairly. In accordance with the law, you

must not discriminate on grounds of their gender, race, or disability. You must not allow your views of an individual's or member of the public's lifestyle, culture, beliefs, race, colour, sex, sexuality or age to prejudice your professional relationship with them.

If things go wrong

4.6 Individuals who complain about the care or treatment they have received have a right to expect a prompt and appropriate response. As a public health physician/specialist you have a professional responsibility to deal with complaints constructively and honestly. You should co-operate with any complaints procedure that applies to your work. You must not allow an individual's complaint to prejudice the care or treatment you provide or arrange for that patient.

4.7 Subject to your right not to provide evidence which may lead to criminal proceedings being taken against you, you must co-operate fully with any formal inquiry. You should not withhold relevant information. Similarly, you must assist the coroner or procurator fiscal with an inquest or inquiry.

4.8 If you are suspended from a post or have restrictions put on your practice because of concerns about your performance or conduct, you must inform any other organisations for whom you undertake work of a similar nature. You must also inform any patients you see independently of such organisations, if the treatment you provide is within the area of concern relating to the suspension or restriction.

4.9 In your own interests, you must obtain adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme.

Dealing with problems in professional practice

Conduct or performance of colleagues

4.10 You must protect individuals/the public from risk of harm posed by another doctor's or other health care professional's conduct, performance or health, including problems arising from alcohol or other substance abuse. The safety of individuals/the public must come first at all times. Where there are serious concerns about a colleague's performance, health or conduct, it is essential that steps are taken without delay to investigate the concerns to establish whether they are well-founded, and to protect individuals/the public.

4.11 If you have grounds to believe that a doctor or other healthcare professional may be putting individuals/the public at risk, you must give an honest explanation of your concerns to an appropriate person from the employing authority, such as the medical director, nursing director, chief executive, the director of public health or an officer of your local medical committee, following any procedures set by the employer. If there are no appropriate local systems, or local systems cannot resolve the problem, and you remain concerned about the safety of individuals/the public, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation or the GMC for advice. The safety of individuals/the public must come first at all times.

4.12 If you have management responsibilities you should ensure that mechanisms are in place through which colleagues can raise concerns about risks to individuals/the public. Further guidance is provided in the GMC booklet, *Management in Health Care: the Role of Doctors*.

5. Working with colleagues

5.1 You must always treat your colleagues fairly. In accordance with the law, you must not

discriminate against colleagues on grounds of their gender, race or disability. You must not allow your views of a colleague's lifestyle, culture, beliefs, race, colour, sex, sexuality or age to prejudice your professional relationship with them.

5.2 You must not undermine individuals/the public's trust in the care or treatment they receive, or in the judgement of those treating them, by making malicious or unfounded criticisms of colleagues.

Working in teams

5.3 Public health/health care is increasingly provided by multidisciplinary teams. Working in a team does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you must:

- respect the skills and contributions of your colleagues;
- maintain professional relationships with individuals/the public;
- communicate effectively with colleagues within and outside the team;
- make sure individuals/the public and colleagues understand your professional status and specialty, your role and responsibilities in the team, and who is responsible for each aspect of individual/the public's care;
- participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies.
- be willing to deal openly and supportively with problems in the performance, conduct or health of team members.

5.4 If you lead the team you must ensure that:

- medical team members meet the standards of care and conduct set in this guidance;
- any problems that might prevent colleagues from other professions from following guidance from their own regulatory bodies are brought to your attention and addressed;
- all team members understand their personal and collective responsibility for the safety of individuals/the public and for openly and honestly recording and discussing problems;
- each individual/the public's care is properly co-ordinated and managed, and that individuals/the public know who to contact if they have questions or concerns;
- arrangements are in place to provide cover at all times;
- regular reviews and audit of the standards and performance of the team are undertaken and any deficiencies addressed;
- systems are in place for dealing supportively with problems in the performance, conduct or health of team members.

5.5 Further advice on working in teams is provided in the GMC booklets *Maintaining Good Medical Practice* and *Management in Health Care, the role of Doctors*.

Arranging cover

5.6 You must be satisfied that, when you are off duty, suitable arrangements are in place. These arrangements should include effective handover procedures and clear communication between those responsible.

Accepting posts

5.7 If you have formally accepted any post, including a temporary post, you must not then withdraw unless the employer will have time to make other arrangements.

Delegation and referral

5.8 When you delegate you must be sure that the person to whom you delegate is competent

to carry out the work involved. You must always pass on enough information. You will still be responsible for the overall population.

Providing information about your services

5.9 If you publish or broadcast information, the information must be factual and verifiable. It must be published in a way that conforms with the law and with the guidance issued by the Advertising Standards Authority. If you publish information about specialist services, you must still follow the guidance.

5.10 Information you publish about your services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health.

Your duty to protect the population

5.11 You must protect the health of the population when you believe that a colleague's health, conduct or performance is a threat to their standard of practice.

References

5.12 When providing references for colleagues your comments must be honest and justifiable; you must include all relevant information that has a bearing on the colleague's competence, performance, reliability and conduct.

6. Probity - financial and commercial dealings Probity in professional practice

6.1 You must be honest in financial and commercial matters relating to your work. In particular:

- if you manage finances, you must make sure that the funds are used for the purpose they were intended for and are kept in a separate account from your personal finances;
- you must not defraud the organisation you work for;
- before taking part in discussions about buying goods or services, you must declare any relevant financial or commercial interest which you or your family might have in the purchase.

Conflicts of interest

6.2 You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgement. You should not offer such inducements to colleagues.

Financial interests in hospitals, nursing homes and other medical organisations

6.3 If you have financial or commercial interests in organisations providing health care or in pharmaceutical or other biomedical companies, these must not affect the way you work.

6.4 If you have a financial or commercial interest in an organisation to which you work, you must tell your employer about your interest.

Accepting gifts and other inducements

6.5 You should not ask for or accept any material gifts or loans, except those of insignificant value, from companies that sell or market drugs or appliances. You must not ask for or accept fees for agreeing to meet sales representatives.

Hospitality

6.6 You may accept personal travel grants and hospitality from companies for conferences or educational meetings, as long as the main purpose of the event is educational. The amount you receive must not be more than you would normally spend if you were paying for yourself.

Signing certificates and other documents

6.7 You must take reasonable steps to verify any statement before you sign a document. You must not sign documents which you believe to be false or misleading.

Research

6.8 If you take part in clinical drug trials or other research involving patients or volunteers you must make sure that the individual has given written consent to take part in the trial and that the research is not contrary to the individual's interests. You should always seek further advice where your research involves adults who are not able to make decisions for themselves. You may also benefit from additional advice where your research involves children. You must check that the research protocol has been approved by a properly constituted research ethics committee.

6.9 You have an absolute duty to conduct all research with honesty and integrity. In particular:

- you must follow all aspects of the research protocol; you may accept only those payments approved by a research ethics committee;
- your conduct must not be influenced by payments or gifts;
- you must always record your research results truthfully and maintain adequate records;
- when publishing results you must not make unjustified claims for authorship;
- you have a duty to report evidence of fraud or misconduct in research to an appropriate person or authority.

7. Health

If your health may put patients at risk

7.1 If you know that you have a serious condition which you could pass on to individuals/the public, or that your judgement or performance could be significantly affected by a condition or illness, or its treatment, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients.

7.2 If you think you have a serious condition which you could pass on to individuals/the public, you must have all the necessary tests and act on the advice given to you by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practice. This paper is not exhaustive. It should be seen as complementary to Good Medical Practice, which also applies to public health physicians, but it provides the basis of professional practice. It cannot cover all forms of professional practice or misconduct which may bring your registration into question if you are a doctor. You must therefore always be prepared to explain and justify your actions and decisions.

APPENDIX C CONSULTATION QUESTIONS

Please use the following questions to structure your response. These are the same questions as appear in the consultation document.

Please feel free to add any further information or other points of importance.

We are assuming that you will be responding electronically and will insert your response to the questions as you answer them ie use the amount of space that you need.

About you

Name and position	
Organisation	
Address	
Email address	
Please state whether you are responding to this consultation as an individual or on behalf of a group / organisation	Individual Group / organisation
Please state whether you are interested in a particular area of public health practice or have a general interest in public health	Specific area of practice ie General interest in public health
Please state whether you wish your response to remain confidential or whether it can be quoted from openly (eg quoted from in reports, named respondent).	I am happy for the response to be used openly Please keep my response confidential

CONSULTATION QUESTIONS

The definition of public health practitioners

1. Is the definition of public health practitioners effective in describing this level of practice in public health? Yes / No
If not, please explain how it can be improved.

The risks posed by public health practitioners

2. What are the risks that incompetent individuals or unethical practice might pose to individuals, groups, communities or

populations in the area of public health which you are familiar?

3. Are these risks addressed currently (i.e. without regulation)?
Yes / No

If yes, please explain how.

The proposed Code of Practice

4. How well does the content of Good Public Health Practice relate to the work of public health practitioners? Please explain your answer.
5. Do you think that Good Public Health Practice is sufficient to reflect the type of work and the ethical dilemmas that public health practitioners face? Please explain your answer.
6. Are there any aspects of Good Public Health Practice that are not appropriate to public health practitioners? If yes, please explain what they are.
7. Are there any aspects that are important for public health practitioners that you cannot find in Good Public Health Practice? If yes, please explain what they are.

The proposed registration process for those seeking retrospective registration

8. Will this process work in the area of public health practice with which you are familiar? Please explain your answer.
9. What quality assurance processes would you want to see to have confidence in the assessment process for registration?
10. What in your view is the best way of addressing the practical issues of accessing verifiers, assuring the quality of the process and ensuring that the regulation process is proportionate, simple and sustainable?
11. If a triangulated approach to assessing evidence is adopted, do you think that:
 - a) both of the verifiers should be regulated public health specialists?
 - b) only one verifier would need to be a regulated public

health specialist?

If you think that only one of the verifiers needs to be a regulated public health specialist, where do you think the other person should be drawn from?

12. Do you think individuals will need support:
- a) for learning and development to help achieve the standards?
 - b) in the process of preparing their application for the Register?
- If yes please explain where this support could / should come from.

If you are answering as a public health practitioner, please also answer this additional question

13. If the UKPHR required you to use someone who is registered as a Public Health Specialist to verify your work, how would you identify that person? Please explain your answer.

If you are answering as a public health specialist, please also answer this additional question

14. What support do you feel you would need to act as a verifier?

General consultation questions

15. Were you familiar with the Public Health Skills and Career Framework before you received this consultation? Yes / No
16. Are there any other comments you wish to make that are relevant to this consultation?