



# **Health Education West Midlands**

## **Evaluation of the Practitioner Development Scheme**

**June 2013**

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**scheme context**

# background to the UKPHR public health practitioner development scheme

## 1.1.1 Background to the scheme

The UK Public Health Register (UKPHR) promotes public confidence in specialist public health practice in the UK through independent regulation.

One of the key functions of the UKPHR is to publish a register of competent professionals, underpinned by standards that are set and promoted for admission to the register. To facilitate this process, in 2006 the UKPHR was commissioned through the English Department of Health, the Welsh Assembly Government, the Scottish Government and the Department of Health and Social Services and Public Safety, to take forward the development of public health practitioner registration.

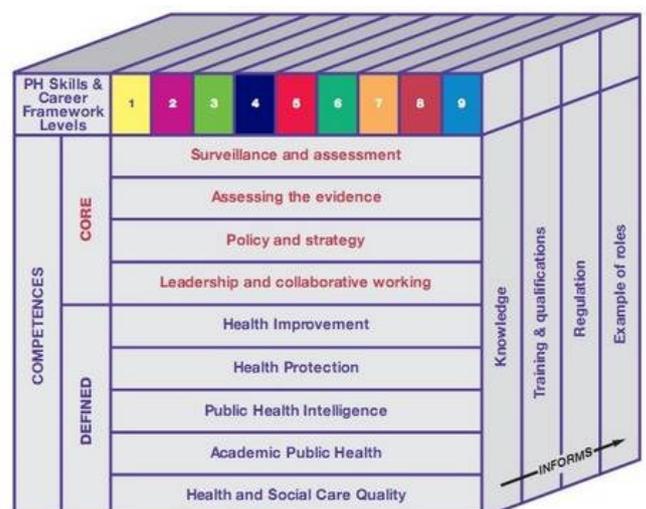
In England, 'Healthy Lives, Healthy People' was published in 2010, and was followed by a consultation on developing the healthcare workforce. To coincide with this drive for quality, the UKPHR supported pilot 'Local Assessment Schemes' to look at opening a regulatory pathway for public health practitioners by April 2011. The assessment schemes supported during the pilot phase were:

- NHS Kent and Medway
- Public Health Wales
- NHS South Central
- NHS West Midlands

Each scheme was developed in ways which were bespoke to the individual health communities, with the common thread that all candidates taking part were assessed against the Public Health Practitioner Standards, with a locally devolved assessment process with UKPHR trained verifiers and assessors.

These Standards are underpinned and informed by The Public Health Skills and Career Framework, which complements the national occupational standards (NOS) for public health, and the NHS Knowledge and Skills Framework (NHSKSF), as well as a number of other related frameworks. This cross-cutting framework approach ensures that the registration scheme will reflect the standard of work, skills and knowledge expected across all levels of the public health workforce, and across all sectors working in public health.

The learning and best practice from each of the pilot and continuation schemes will be reviewed by the UKPHR, in order to assess the implications for the function of the Register, particularly in light of the evolving role of Public Health in England. This will enable the UKPHR to develop a coherent framework for taking forward practitioner registration, to work alongside the new public health workforce development strategy.



## Changes in the public health environment across England: a brief context

### 1.2.1 What changes are happening in public health services?

Since the Health and Social Care Act gained royal assent in March 2012, public health services in England have undergone major restructure and changes, including a transition to local authority responsibility which came into effect on 1st April 2013.

A new service, 'Public Health England' has been created to oversee guiding frameworks in public health. This service will develop a new 'Public Health Responsibility Deal' to work with local authorities, businesses, the third and community sector, to deliver and commission public health services.

The reforms mean that local authorities are now taking the lead for improving health and coordinating local efforts to protect the public's health and wellbeing, and ensuring health services effectively promote population health.

Some of the changes that have occurred include:

- Clinical Commissioning Groups have replaced Primary Care Trusts;
- Strategic Health Authorities have been abolished and are replaced with new Health and Wellbeing Boards. They are required to develop 'Joint Strategic Needs Assessments' and 'Joint Health and Wellbeing Strategies' and are still finding their feet. They seem to offer one of the key elements of leadership in what is a system with little clear leadership;
- A new NHS Commissioning Board (NHS England) has been established;
- Local 'HealthWatch' organisations are meant to strengthen the voice of patients.

### 1.2.2 What impact are these changes having at a local level?

As of April 2013, England's public health reforms meant that the leadership for public health across the West Midlands is provided by local authorities. These local authorities are now responsible for taking on significant new public health functions in each of the three domains of public health: health improvement; health protection and healthcare (public health).

This leadership is underpinned by new statutory functions, dedicated resources and an expert public health team recruited from a range of disciplines and sectors.

Local political leadership will deliver a new focus on improving health and reducing health inequalities across the region. In the West Midlands, the Director of Public Health will lead on delivering these public health functions for their local authority, and support the political leadership.

Whilst the changes brought about by the recent Public Health reforms are still being put in place, it is likely the effect on teams, improvements in staff morale, changes to working practices and governance will take some time to 'bed-in'. In doing so, the potential role for the Practitioner Development Support Scheme is opportune. The reforms provide the chance for the scheme to cement the link between practitioner registration, quality assurance and professional currency in a new and emerging public health environment in which all those with a public health function are viewed as change agents to play their part in joint approaches to tackling health inequality.

## 1.3 scheme context

# how the practitioner registration support scheme operates in the West Midlands

### 1.3.1 Background to the scheme in the West Midlands

The West Midlands' Public Health Practitioner Development Scheme was launched in January 2011 by the NHS West Midlands Workforce Deanery. It is managed by the West Midlands' Public Health Workforce Specialist.

The scheme develops public health practitioners (those below the specialist level) and trains local assessors to provide a workforce that is assessed and certified as meeting the national UKPHR standards at an agreed level of competence (level 5 of the public health skills & career framework, PHSCF), equivalent to other practitioners in the NHS.

The scheme provides local and national recognition through a quality-assured process of assessment and verification to public health practitioners across the wide range of multi-sector organisations who contribute to the promotion, improvement and protection of health.

### 1.3.2 How does the scheme operate in the West Midlands?

Practitioners are recruited to the scheme in 'cohorts'. The scheme supports practitioners through facilitated learning sets and offers practitioners opportunities to attend a series of masterclasses in priority areas of CPD, to enable them to complete a developmental portfolio of evidence of competence against the UKPHR practitioner standards.

Each practitioner attends at least three facilitated learning sets, where they are supported to prepare their portfolio and get the opportunity to receive one-to-one feedback on progress.

The learning sets also give practitioners the opportunity to discuss their portfolios with their peers and gain support from them. Practitioners have the offer of a UKPHR trained mentor should they require one.

Assessors are appointed locally and work on a voluntary basis after completing training through the UKPHR. An assessor is allocated to a practitioner once they have started writing their first commentary. The practitioner submits evidence and commentaries against the UKPHR standards, to their allocated assessor for assessment. When all commentaries and evidence have been assessed as meeting requirements, completed portfolios are submitted for verification. If verification is successful, the practitioner is able to apply to the UKPHR for their registration, subject to an annual fee.

### 1.3.3 Numbers of practitioners and assessors recruited to the scheme

This evaluation report is primarily focused on cohorts 1 and 2 (database statistics up to February 2013) of the Practitioner Development Scheme in the West Midlands, with some references to cohort 3 which is ongoing at the time of this evaluation report. Evidence from the scheme database shows that since January 2011 the scheme has recruited and trained:

COHORT	Number of Practitioners Accepted on to the Scheme	Number of Assessors Trained
Cohort 1	100	30
Cohort 2	82	19
Cohort 3	33	10

# evaluation of the West Midlands public health practitioner development scheme

## 1.4.1 This evaluation report

Total Improvement Process Ltd were commissioned in late 2012 to undertake an evaluation of the West Midlands' Public Health Practitioner Development Scheme, with a principal focus on cohorts 1 and 2. The analysis is based on the scheme database figures up to February 2013, with occasional references to cohort 3 which is ongoing at the time of this evaluation report.

Evaluation interviews and questionnaires were used to gather information from practitioners, line managers, Directors of Public Health, the learning set facilitator, assessors and the scheme manager. The comprehensive scheme database was used to gather statistical information. Collectively, this data has been used to build an evaluation report around the following aim:

*To produce a formative evaluation of the West Midlands' Public Health Practitioner Development Scheme that will enable the West Midlands Deanery to assess and make informed decisions about sustainable progress in what is a dynamic public health landscape for the scheme going forwards.*

### EVALUATION SPECIFICATION

Provision of formative evaluation data through which the Practitioner Development Scheme can assess and make informed decisions about sustainable progress in what is a dynamic public health landscape, and then implement them.

Provision of impact data with which NHS West Midlands can identify the benefits to employers and practitioners from participation in the Practitioner Development Scheme.

Co-design of evaluation with the West Midlands Deanery lead for the Practitioner Development Scheme so that the interventions and timing are aligned with the timescales and needs of the scheme

## 1.4.2 The evaluation team

Total Improvement Process Ltd provides a wide range of evaluation services across the public, private and third sector. Three of our team of consultants were involved in the evaluation process:

### Tim Sims

#### Evaluation Director

Tim specialises in the evaluation of health programmes and coaching for leadership in health services. He has advised the World Bank, the Council of Europe and the EU Commission on evaluation of issues including water and sanitation, post-crisis reconstruction and equalising labour market opportunities for disadvantaged groups across the EU.

### Robyn Peel

#### Consultant

Background in operational and project management, and experience of working in a variety of public and third sector organisations. Robyn specialises in programme development, systems and processes. She has been involved in the evaluation of other regional practitioner development schemes for two years.

### Suryiah Evans

#### Consultant

Suryiah has a background in statutory and third sector senior management. She specialises in community development, third sector support, young people's services, educational programmes and accreditation, and integrated community strategy planning. Suryiah has been involved in evaluation of other regional practitioner development schemes for two years.

### 1.4.3 Evaluation methodology

The TIP evaluation team used formative evaluation principles, and a variety of methods to bring a fresh eye and new perspectives to the scheme's progress and challenges.

These methods comprised:

- Surveys administered electronically
- Telephone and face-to-face Interviews with practitioners
- Telephone interviews with the learning set facilitator, assessors, Directors of Public Health, line managers, and the scheme manager
- Analysis, interpretation of data and report writing

The number of respondents who took part and contributed to this report and how they are referenced are as follows:

No.	% of Total	DATA CONTRIBUTORS
9	-	Employers Interviewed
27	18.5%	Practitioners Surveyed (Cohorts 1 and 2 who are retained on the scheme)
16	-	Practitioners Surveyed (Cohort 3)
17	85%	Completed Practitioners Interviewed
12	33%	Practitioners interviewed who have withdrawn from the scheme
4	9%	Assessors interviewed
1	100%	Learning Set Facilitator interviewed

### 1.4.4 Emergent Learning

The West Midlands' Public Health Practitioner Development Scheme is still in its early stages. The purpose of this evaluation report is to highlight the learning and good practice that is emerging from the scheme, so that strengths can be built upon and any changes to the scheme can be considered for the next cohort.

### 1.4.5 Report structure

This report has been structured to reflect responses provided by all stakeholders who were interviewed or surveyed as part of the evaluation process, as well as the evaluation aim:

#### REPORT STRUCTURE

Scheme context

Evaluation headlines

Emergent learning

#### Acknowledgements

Total Improvement Process Ltd would like to thank all those who have co-operated during the evaluation process, and contributed to this report.

#### Disclaimer

This evaluation was performed in cooperation with the NHS West Midlands Workforce Deanery.

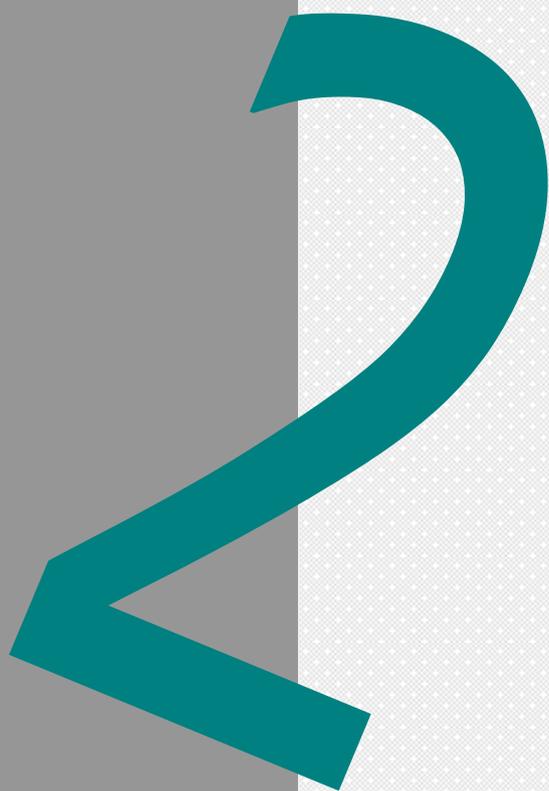
The contents of this report reflect the views of the author, who is responsible for the facts and accuracy of the data presented herein.

The contents do not necessarily reflect the official view or policies of the NHS West Midlands Workforce Deanery.

This report does not constitute a standard, specification, or regulation.

Trade names were used solely for information and not for service or product endorsement.

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**evaluation headlines**

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**1. The support available through the scheme:  
Managerial, learning sets and masterclasses**

The level of support available to practitioners on the scheme is valued. We think a shift of focus to a 'workshop model' format for learning sets will strengthen the support structure and enable a greater number of practitioners to complete their portfolios successfully.

**2. Practitioner and assessor experiences of the  
assessment process**

We think that a more standardised approach to assessment is needed. This could be addressed through better assessment training, clarification on the interpretation of the standards, template examples of commentaries, and group assessment approaches.

**3. Assessing impact of the scheme on employer  
and practitioner perceptions of 'currency' and  
career progression**

Employers are expressing interest in the potential of the Practitioner Development Scheme. Further promotion of the scheme as a national and local quality assurance process will strengthen the scheme's currency in the new and emerging public health landscape.

**4. Practitioner progress, outcomes and benefits  
from participation in the scheme**

The West Midlands Scheme has recruited the largest number of Practitioners of any UK pilot. This has enabled practitioners to access a significant number of CPD opportunities which have been highly valued, especially during a time of uncertainty in public health. A higher proportion need to achieve registration. Practitioners now need strong encouragement to make full use of the support available to complete their portfolios and gain registration.

3

**emergent learning**

3.1

# emerging learning and practice from the support available through the scheme: managerial, learning sets & masterclasses

## 3.1.1 What support was available for practitioners on the scheme?

The core of the support structure available to practitioners comprises Sally James, the Workforce Development Specialist; the Learning Set Facilitator; a number of voluntary assessors; and the higher speciality trainees who delivered the masterclasses.

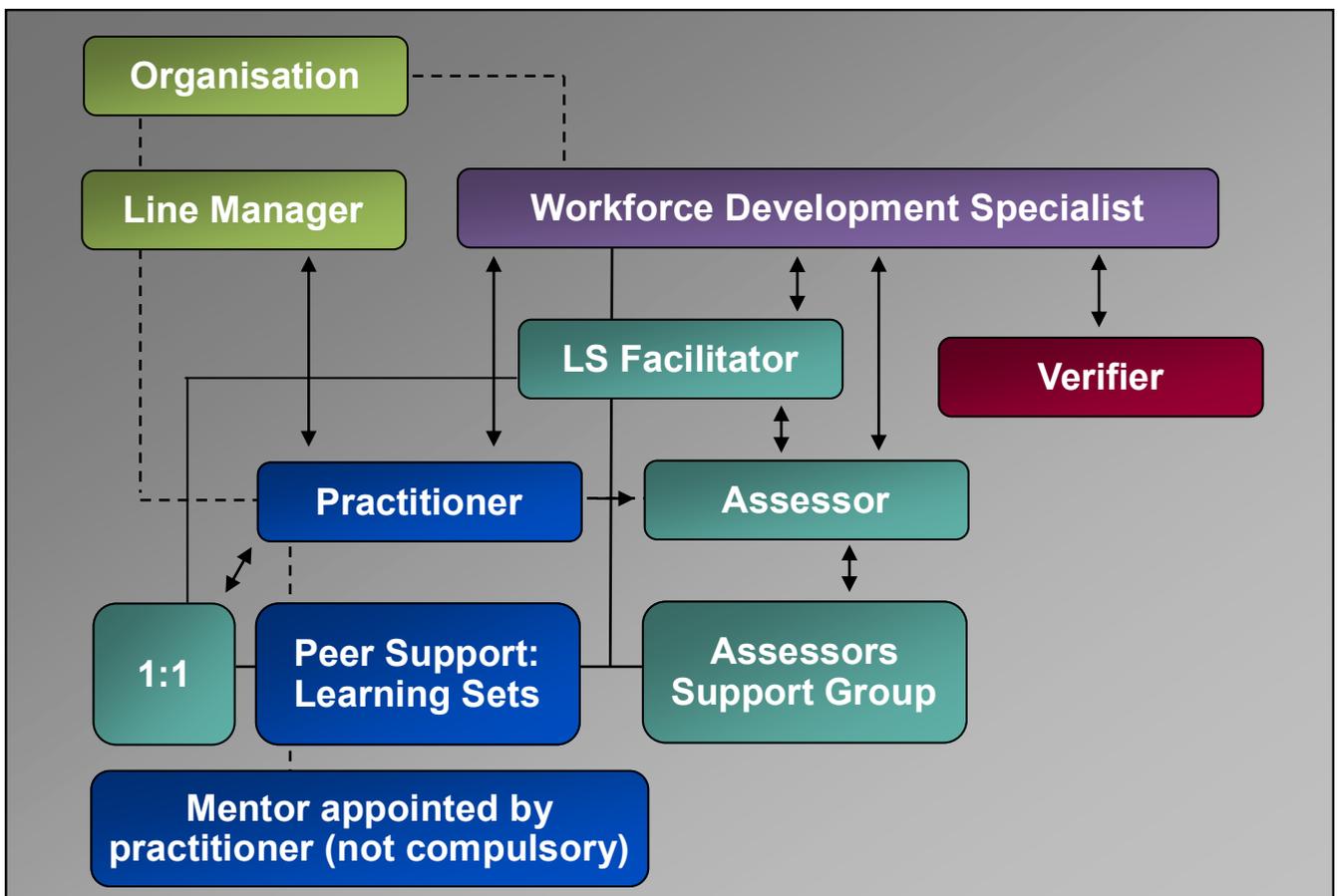
The employing organisation supports the scheme strategically, and peer groups, line managers and mentors if engaged by the practitioners, provide an important source of support.

The West Midlands support structure differs slightly from other regions due to an additional layer of support provided by Vicki Taylor, the Learning Set Facilitator.

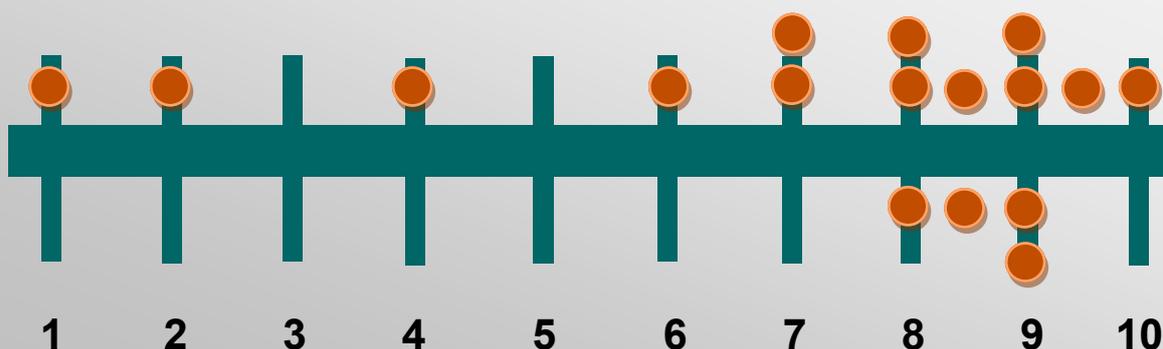
Her role on the scheme comprises facilitation, one-to-one support, and pre-assessment commentary review.

A series of three facilitated learning sets are made available to the scheme participants, alongside a suite of masterclasses. They aim to assist practitioners in building evidence against the competences, and to gain support and ideas from their peers. A comprehensive database of learning set attendance is managed by the West Midlands scheme Manager.

In this section of the evaluation report we look at the support provided through the managerial processes, and the support offered to practitioners through learning sets and masterclasses. Assessment and assessor support is analysed in section 2.2.



**Question: How happy were completed practitioners with the help and support they got to complete their portfolio? (score from 1-10). Score of 10 = highest**



### 3.1.2 How happy were practitioners with the support available for them?

17 practitioners who have successfully completed their portfolios were asked to indicate how happy they were with the support they received to complete their portfolio, on a scale from 1 to 10 (highest). 82% scored the support available to them at 6 or above; 65% scored 8 or above.

There was widespread affirmation for the supportive way the Workforce Development Specialist, the learning set facilitator and assessors spent time going through the commentaries and clarifying the requirements. A number of practitioners also welcomed the support shown by their peers and colleagues who helped them on an informal basis.

*“Sally was the best support...and to some extent my assessor...”*

The completed practitioners who scored the support they received as 7 or below, indicated that they would have scored more highly if:

- there was better interpretation of the standards and how they could be evidenced;
- they received a speedier response from assessors;
- the learning sets had a more structured approach and they could work in smaller groups.

*“The best source of help was being shown completed assessments and copies of assessment logs through the learning sets. Our facilitator of the learning set would encourage us to bring work to comment on which was good. But she also gave us individual feedback which was really helpful.”*

*“...a lot of it was down to the people attending - it was down to who talked the most got listened to. Groups were too big and many of the questions weren't relevant to me - smaller groups is better.”*

The 27 practitioners (cohorts 1 and 2) who participated in the evaluation survey also provided some feedback about support issues when they were asked about what would have helped them complete their portfolio more quickly. They felt that:

- Line managers need to improve their support of the process;
- They need more assistance to complete the commentaries;
- More one-to-one support or sessions to receive feedback would be helpful;
- A work-based mentor and/or assessor would offer another line of support.

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*“I was happy with the amount of sessions offered in the tutorial groups, but one-to-one tutorials may have helped move me through the process a little quicker.”*

### 3.1.3 Learning set attendance

The database evidence shows that learning sets are very well attended, particularly in comparison to figures from other regions running the scheme.

52% of cohort 1 practitioners and 62% of cohort 2 practitioners, attended two or more learning sets. Over 30% of both cohorts attended the full number of learning sets made available to them. In addition to learning set attendance, a number also sought one-to-one support from the learning set facilitator, and in some cases this is ongoing.

The database also reveals that many of the practitioners who did not attend any learning sets, opted to attend a series of masterclasses.

Feedback from 16 practitioners currently on cohort 3 of the scheme who responded to the evaluation survey, indicates that the high rate of learning set attendance is continuing. 94% have attended at least one learning set, and 63% have attended two or more learning sets.

### 3.1.4 Feedback on masterclasses

The database shows that 94 practitioners (from cohorts 1 and 2) have attended masterclasses over the life of the scheme in the West Midlands. 53% attended 3 or more masterclasses.

*“I did do masterclasses...I did about 4 and they were useful because there were certain gaps I had.”*

To date, 69% of the 16 cohort 3 survey respondents have attended at least 1 masterclass, and 25% have attended 3 or more masterclasses.



Feedback from practitioners who have completed their registration indicates that the masterclasses were particularly well received. The breadth of subjects covered and their relevance to the practitioner's practice and portfolio were valued by participants.

*“For example, critical evaluation, that was a fantastic masterclass. It helped with my interpretation and it really translated for me. It was brilliant because I could apply it...”*

Analysis of the database reveals that there is not necessarily a correlation between those who have successfully completed the registration scheme, and attendance at masterclasses and learning sets.

### 3.1.5 Organisation and purpose of the learning sets

There have been 9 sets in different geographical locations each meeting formally three times per cohort. They run between 9am and 3pm and the ideal membership is described as between 6-8 practitioners, though some cohort 2 learning sets had up to 14 participants.

The facilitator describes the broad purpose of the West Midlands Scheme Learning Sets as ‘providing a structure for a group of people to work together to share support and progress their portfolios’. Behind that are three key factors:

One is the ‘capacity-building’ impact of having practitioners meeting other members of the broad public health community of practice.

*“It’s often the first time they meet people in their patch outside their specific organisation...it’s putting people in touch with others in their (geographical) area...building awareness of the larger community of practice.”*

The second is a strong insight into the psychological demands of portfolio-building. This includes a perception that there seem to be two quite different approaches to the task depending on how people cognitively function. So practitioners need an informed choice about how best to work on their portfolios. It also includes the observation that:

*“People are not used to saying what they’ve done and celebrating what they’ve done as a personal claim; they are brought up to use the ‘we’ of a team...nor are many used to writing reflectively...”*

The third factor is a conviction that the formal learning sets can and should be instrumental in practitioners creating their own informal learning sub-sets, which can be a very powerful source of support and development.

The general structure of each session was described as starting with a draft agenda which is then refined in the light of:

- Individual updates;
- What participants want from the day.

What follows usually includes:

- Sharing what they have done on their evidence-mapping and commentaries;
- Critiquing what they have done;
- Questions about the standards and what they mean;
- Clarification about what counts as evidence and what they need to do with evidence.

The key professional skill is described as holding the tension between purposeful structure and individual needs:

*“I’ve done it differently every single time...every group is different...I just ascertain what the group needs - and what they say and what they want is often different.”*

The dominant approach seems to have been to treat the sets as cooperative self-supporting groups whose members come prepared and focused on their portfolio-building.

### 3.1.6 What were the main benefits of the learning sets?

Out of the 27 practitioners who responded to the evaluation survey (from cohorts 1 and 2), more than 50% indicated that they had attended the full series of learning sets provided through the scheme.

Cohorts 1 and 2 Learning Set Attendance Database Statistics Up to February 2013	Cohort 1 76 Participants (accepted on to the scheme as of Feb '13)		Cohort 2 70 Participants (accepted on to the scheme as of Feb '13)	
	No. of participants	%	No. of participants	%
	Attended 0 learning sets	14	18%	7
Attended 1 learning set	16	21%	18	26%
Attended 2 learning sets	18	24%	21	30%
Attended 3 learning sets	28	37%	24	34%

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These survey respondents suggested that the learning sets had a number of key benefits:

- Help to fill gaps in knowledge
- Space to reflect on practice
- Comparing commentaries to the competence evidence required
- Interpretation of the standards
- Networking and sharing ideas with colleagues
- Learning about practices in other public health organisations
- Support and professional guidance from the facilitator
- Gaining an understanding of what assessors are looking for
- Refreshing theoretical knowledge
- Peer support

*“For me, it was the input from Vicki who was excellent. I found that discussing ideas with other people helped me to write commentaries.”*

Feedback from the 16 cohort 3 survey respondents indicates that the benefits of the learning sets remain largely similar to those expressed by cohorts 1 and 2 survey respondents. However, there is a definite shift in emphasis from commentary completion and filling gaps in knowledge towards the value that can be gained from sharing learning and experiences. In fact, 81% of cohort 3 respondents referred to the benefits of peer support and learning from others.

*“To support and help the learner make sense of any concerns that they might have. It’s a good way for engaging with other learners and picking up ideas from them.”*

Learning sets are the main and most visible support. When we asked those who have completed, ‘on a scale of 1-10 how happy were you with the help and support you got on completing your

portfolio and writing commentaries’, the average score was 7.2 (with 10 scores at 8 or above). A deeper look at the comments suggests a complex picture.

### 3.1.7 What improvements could be made to the learning sets?

75% (18) of the respondents to our evaluation survey (cohorts 1 and 2) felt that improvements could be made to the learning sets to make them more successful. 50% of the 16 cohort 3 survey respondents also felt improvements could be made to learning sets.

Between the survey and the interviews (cohorts 1 and 2) there were 28 items of feedback about the learning sets. Six comments explained what they valued about the sets; 22 suggested ways in which they could be improved.

The valuing comments focused on the quality of guidance for completion of commentaries; they talked about critical discussion and peer feedback.

Half the suggestions for improvement focused on strengthening the leadership and structure of the sessions and the majority of those focused on more prescriptive facilitation.

Most of the others dealt with the size of the groups or the structuring of the groups - particularly around the progress level of the participants, eg a set for those submitting their first commentary.

The common denominator seems to have been the extent to which individuals could get their needs met, and effectively a return on their—and their employers’- investment of time. The biggest concern was the diversity of need.

*“So there weren’t enough of us at the same stage. The learning sets were done on a geographical basis which was good for travel but not so good for support as we were all at different stages.”*

Overall, the feedback from practitioners indicates that they feel the structure of the learning sets needs to be considerably strengthened in order to meet the needs of all participants. A number of survey respondents suggested that as part of this structured approach, the compulsory attendance at learning sets should be reinforced to reduce the risk of repetition and cement practitioner commitment.

*“Make them compulsory as part of the programme...these sessions only work if the participants do—ensuring you have something to bring to the table is key.”*

Contrasting to the issues highlighted by practitioners about the structure of the learning sets, they also commented that they found the one-to-one sessions they were able to have with the learning set facilitator highly valuable, and perhaps this is an addition to the learning set structure that scheme co-ordinators can further strengthen for the next stage.

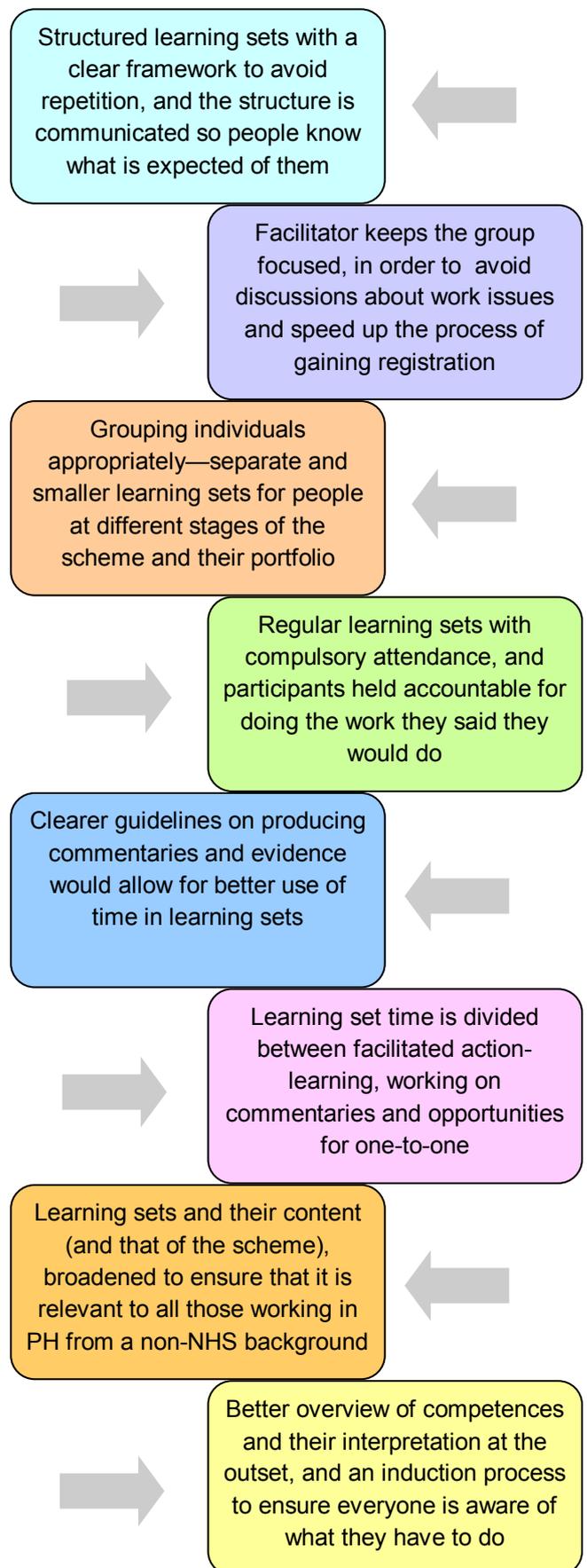
*“When I worked on a more individual basis with Vicki I found it immensely beneficial and it helped me to progress faster.”*

Participants have the opportunity to highlight what they would like to focus on during the learning sets and there appears to be a participatory focus. It may be this participatory focus with people wanting to discuss issues around the NHS restructuring and the effect it has had on morale (and perhaps their ability to complete the portfolio work they might have undertaken to bring), has led to a number of practitioners stating that the learning sets could improve with a more structured approach.

Practitioners suggestions for improving the learning sets have been gathered from the evaluation survey and interviews. They have been grouped as follows:

## Practitioner Suggestions for Improving Learning Sets

### Cohorts 1, 2 and 3



## CONCLUSION 1

*The support available through the scheme: managerial, learning sets and masterclasses*

**The level of support available to practitioners on the scheme is valued. We think a shift of focus to a ‘workshop model’ format for learning sets will strengthen the support structure and enable a greater number of practitioners to complete their portfolios successfully.**

Support is highly valued by practitioners coming through the scheme, whether this comes from the support offered by the learning set facilitator, peer support from others who are going through the process, organisational support including encouragement from line managers or support from the West Midlands Practitioner Development Scheme Manager.

Overall, practitioners rated the help and support they received through the process very highly. We therefore conclude that the processes on offer worked for those who completed the registration process, or they were sufficiently motivated to generate their own support processes. There was an almost universal valuing of the accessibility and quality of Scheme coordination. This valuing is a powerful affirmation of the work and effectiveness of the Workforce Development Manager in running such a pilot through such a turbulent period in the history of Public Health Practitioners.

*“Sally was amazing. She created the initial relationships and people wanted to engage with the programme so it worked. She went out of her way to help me after missing a session - very kind. She organised events and linked candidates with assessors - all the wheels to make things happen.”*

The learning sets have the potential to bring practitioners together from varying public health backgrounds, and provide a firm base for support and motivation to get people through to registration, and retain those that embark on the process. Indeed, one of the most important factors in the support process seems to have been the way that practitioners encountered others who were not of their specialism, and their consequent recognition of the breadth of the community of practice in which they worked and sought registration.

The learning sets in this scheme are probably the most numerous, well-attended and sophisticated amongst the UK pilot schemes. These day-long activities (we think about 27 days per cohort) are also probably the most expensive aspect of provision both financially and in terms of time away from work to attend. The fact that the overwhelming majority of users want improvement and the facilitator is an experienced adult learning professional makes this an ideal opportunity to undertake some enquiry-based improvement. Not only the West Midlands but UK-wide pilots could benefit.

75% of evaluation survey respondents (cohorts 1 and 2) felt that learning sets could improve, and put forward suggestions that mainly centre on a more structured approach. This feedback was echoed by 50% of the cohort 3 survey respondents. While the aspiration to create collaborative supportive groups of participants who come well-prepared is strong, we think it is not happening for participants.

The majority of participants seem not to be seriously embarked on portfolio-completion so not all come prepared with evidence and draft commentaries. They may not come from the launch day to the first set meeting fully aware of the responsibilities of participating. We also suspect that continuity of attendance is patchy but even were it consistent, building a strong collaborative group ethos out of just three meetings does not square with our experience of how quickly groups gel.

The learning sets represent a considerable investment of time and we think the return on investment will need to be higher in the eyes of participants than it is currently if the learning sets are to fully support participants to complete portfolios successfully. Consequently, we think they need to:

- As much as possible, group practitioners in the learning sets who are working at similar levels and pace. This might mean balancing considerations of geography against bringing together participants at similar levels of progress
- Shifting away from the probably over-ambitious 'support group' model to a 'workshop model' format for learning sets. This may help the facilitator divide time between plenary learning, optional opportunities for sub-groupings to compare commentaries, one-to-one facilitator support and protected time to work individually on portfolios.
- Introducing the use of a learning-set evaluation framework, to ensure that learning needs are being met, early detection of issues that can be addressed and to assist practitioners in monitoring their own progress.

However, whichever of these participant-led suggestions are considered, what we think may be most useful is systematic inquiry-based improvement of learning set facilitation. Of the various methods we would recommend triangulated action research led by the facilitator. By 'triangulated' we mean including:

- i) the active and structured involvement of set participants
- ii) a critical-friend observer
- iii) leadership of the research by the facilitator, investigating and evidencing small steps of change. The whole process would be governed by a clear methodology and ideally be supported within a further evaluation exercise. There is an international Action Research Network based in MMU, drawing its members from educational, health, social care, commercial and public services settings. It is a network committed to the values that underpin public health practice.

<http://www.esri.mmu.ac.uk/carnnew/index.php>

## RECOMMENDATION 1

*To strengthen this element of the scheme, you may want to consider:*

- A) Reshaping the launch day as a robust induction programme, to clarify expectations, and give participants opportunities to review the evidence mapping against competences in their applications (perhaps a mini learning set); and provide opportunities to explore feedback and learning from practitioners who have completed the scheme.
- B) Experimenting with facilitator-led small step improvements to the structure and management of learning sets, including:
  - Further opportunities for practitioners to access one-to-one support;
  - Grouping practitioners who are working at similar levels and pace;
  - Shifting away from the 'support group' model to a 'workshop model' for learning sets;
  - Introducing the use of a learning set evaluation framework.
- C) Taking some facilitator-led triangulated action-research cycles into any of the above or other improvements as part of a next evaluation.

## 3.2

# emerging learning and practice from practitioner & assessor experiences of the assessment process

### 3.2.1 How effectively does the assessment process seem to be working for practitioners?

In the main, feedback from practitioners about the relationship with their assessors and the assessment process was quite positive, with a number of practitioners particularly valuing the support they had received:

*“A great team in Sally and Vicki and I was assigned a really great assessor.”*

*“I have been impressed by the level of support from Sally James and my assessor.”*

*“My assessor was fantastic.”*

66% of practitioners participating in cohort 1 of the scheme were assigned an assessor, and 27% of practitioners participating in cohort 2 (based on database statistics up to Feb '13). The lack of firm commitment from practitioners and the continuing changes in public health likely contributed to less practitioners requesting assessors during cohort 2.

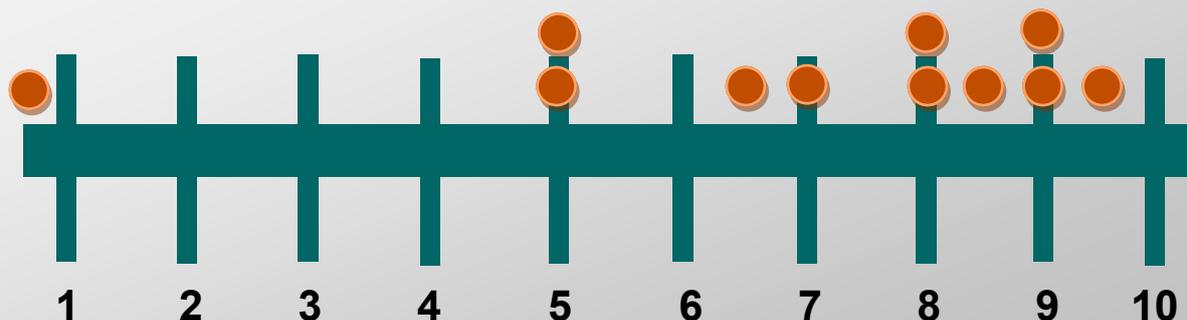
56% of the 27 evaluation survey respondents (cohorts 1 and 2) stated that they had been assigned an assessor; and 86% of those who had been assigned an assessor have had at least one commentary assessed.

During the evaluation interviews, 11 of the registered practitioners responded specifically about the assessment process. Of those, 6 (54%) were positive (mostly very positive), 2 were 'ok' about the process, and 3 were negative.

Of the three out of 10 who scored the robustness of the process at 50% or less, one cited excessive length of time to get feedback; one (from cohort 1) cited unacceptable quality of assessment and feedback; and one acknowledged a good personal experience but an awareness of a colleague whose experience was negative.

*“...it went fairly well for me but one of my colleagues is having trouble and has now been reallocated to someone much better.”*

**Question: How do you rate the robustness of the assessment process? (score from 1-10). Score of 10 = highest**



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This last example illustrates how someone's perception of the quality of assessment can be influenced by an impression of other people's experiences.

A review of information collected through the evaluation survey revealed that around 25% of respondents have some concerns about the consistency and response time of assessors, and cited these issues as the main barrier to completion of their portfolios.

The feedback also suggests that slow responses from assessors in their review of the commentaries can have a negative impact on practitioner motivation to continue with the scheme.

*"I lost motivation and momentum while waiting for feedback..there was a lack of any support or drive through work...I had to be totally self motivated..."*

The need for consistency in assessment and consistency in the guidance given by assessors in relation to the completion of commentaries were put forward as key scheme improvement areas by practitioners.

*"I completed one commentary and submitted to my assessor, who returned it for a couple of clarifications. When I was ready to re-submit my assessor was not available, so I was assigned another one. When I re-submitted my new assessor rejected most of the same piece of work. I then lost faith in the assessor process and felt my new assessor was asking for work way above the level required."*

Despite these difficulties, the evaluation information suggests that practitioners recognise that this scheme is still in its infancy, and that assessors are 'getting to grips' with the requirements of evidencing the competencies as much as the practitioners.

*"[My assessor] was thorough and had been through the process... accessible and responsive."*

### **3.2.2 How effectively does the assessment process seem to be working for assessors?**

4 assessors were interviewed as part of the evaluation of the scheme (out of 49 as of February 2013). Each assessor had over 12 months experience in the role, and most had assessed at least two candidates.

Analysis of the interview responses indicates that the scheme is highly valued among assessors. Most of them took on the voluntary assessment role in order to 'give something back' to the public health workforce at practitioner level, and play a key part in developing people's understanding of the public health role and benefits.

Assessors felt that the practitioner registration scheme will enable the public health workforce to be acknowledged as professionals, and will contribute to the development of a 'public health community' which is recognised and valued. They also suggested that the scheme helps practitioners identify a route for career progression.

Three out of the four assessors interviewed have assessed at least two portfolios, resulting in 5 practitioners whom they supported successfully completing their registration to date.

One assessor has not yet received any commentaries to assess, due to the work commitments of the practitioners the assessor is assigned to.

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Analysis of the scheme database reveals that this may be a relatively common issue, with a number of assessors who have not been assigned candidates; or assessors who have been assigned candidates that are taking considerable time to complete the programme or have become stagnant in their participation on the scheme.

It is worth speculating that assessors who are not having a regular flow of candidates to assess may be at risk of becoming disengaged from the process and are further at risk of not having the opportunity to hone their assessment skills.

*“I’ve been in touch with both [candidates] and discussed submission timescales, but they haven’t got around to completing a commentary yet.”*

The assessors interviewed seemed to be aware that the scheme is still at the ‘bedding in’ stage in the West Midlands. They indicated that they value the support processes that have been put in place, such as the online forum and the assessor network meetings which started in November 2012.

The creation of these six-weekly assessor network meetings were prompted by informal internal evaluation by the scheme Manager and the learning set facilitator, who herself is Vice Chair of the UKPHR Assessment Panel.



It recognises the inevitable variation between single assessors and seeks to introduce an element of continuous improvement into the assessment process. It follows informal monitoring/moderation during cohorts 1 and 2 through scanning assessor feedback where resubmission was necessary. There was also a recognised need to be able to feed back observations from the verification process to assessors.

Attendance is said to be between 10 and 15 assessors in which case there is clearly a felt need among assessors being met by this networking.

*“[The assessor network meetings] provide support which is needed for the assessor role, and sharing best practice with each other.”*

Two assessors told the scheme evaluators that they are involved with mentoring practitioners on the scheme, either as independent mentors or informally mentoring as part of the assessment process. They felt this was a necessary part of the process in order to get candidates to the stage where they can successfully complete their registration, but seemed to be aware that this can be conflicting. They suggested the introduction of mentors as part of the support package for practitioners joining the West Midlands scheme.

*“It would be nice to have more broader application of a mentoring scheme. It would be nice to do a bit of both - do a bit of mentoring and a bit of assessing.”*

Currently mentoring is an option offered to practitioners, who are invited to access UKPHR trained mentors or assessors and practitioners who have completed the registration process successfully.

When assessors were asked about any advice they would give to people thinking about becoming an assessor, they suggested a number of useful principles which may also be beneficial to consider at strategic levels:

- People need to know how hard it is for practitioners to do the process
- The support from individual assessors can be the key to whether practitioners will finish the process or not
- Consistency in assessment is crucial and can reduce practitioner frustration
- The bureaucracy of the process can affect practitioner motivation
- Opportunities to work together as assessors is important
- Practitioner expectations need to be managed - they need to know what they are embarking on and commit to the process by attending learning sets and masterclasses, and they need to put the work in
- Assessors have to put in the time to refresh their skills and respond to practitioners in a timely manner
- The potential benefits of the scheme needs to be better recognised
- Building a picture of the work of the person you are supporting
- Timescales and expectations need to be stricter to prevent the loss of momentum
- Assessors need to be open to the wide variety of evidence that may come from those practitioners outside the statutory sector
- Assessors need to understand their role and the importance of the practitioner scheme

The four assessors interviewed put forward a number of suggestions about how the assessment process and the structures that support it, could be improved. These suggestions have been condensed into key 10 points:

**ASSESSOR SUGGESTIONS ABOUT HOW THE SCHEME ASSESSMENT PROCESS AND SUPPORT COULD BE IMPROVED**

**Increase opportunities for group reviews of commentaries and emphasise the importance of assessors working together.**

**Monitor assessment consistency and timeliness of assessor feedback to practitioners.**

**Improved assessor training which puts less emphasis on awareness and does more to clarify the 'nuts and bolts' of the assessor role and enables assessors to discuss commentaries.**

**Reinforce the availability of access to UKPHR trained mentors as part of the scheme support process.**

**Clarify expectations of the scheme to practitioners through an induction or improved pre-entry briefing.**

**At the practitioner application stage, introduce a system where applicants map out the evidence they need to collect and identify gaps, to give them a pathway towards completion.**

**Stricter monitoring of practitioner deadlines and attendance of learning sets/masterclasses, with some compulsory measures.**

**Improve the 'sales message' about the scheme benefits strategically, to ensure practitioners are allotted time to complete portfolios and the scheme value is demonstrated.**

**Keep widening the diversity of recruitment to the scheme to all organisations that have a public health role.**

**UKPHR to improve communication with registered practitioners and simplify the wording/phrasing of the standards to make them more accessible.**

## CONCLUSION 2

### *Practitioner and assessor experiences of the assessment process*

**We think that the practitioner feedback underlines the importance of efforts to remove the variations in consistency between assessors around feedback, response times and expectations.**

For most practitioners, the support of their assessor, timely feedback and assessment of their commentaries, has helped the practitioner achieve registration or make good progress towards it.

A few practitioners have experienced difficulties with assessors. There are indications that these difficulties can contribute to a practitioner losing momentum or enthusiasm for the scheme, and can result in 'bad PR' for the registration process and the scheme benefits.

The issue of slow practitioner progress is explored in section 2.4. It can have a knock-on effect on the assessment process, where assessors too can become frustrated with the lack of commentaries they have to assess, the amount of time they need to invest in encouraging practitioners to produce timely work, and little opportunity to hone their assessment skills.

The scheme has set up an assessor network to help address these issues. This network activity is designed to reduce the chances of variations in assessment and assists continuous improvement.

This attention to assessment quality seems to be crucial to the credibility of the registration process. The 'currency' of practitioner registration almost certainly depends on the assessment process being seen to be robust; reliable, valid and above all consistent. 25% of a small sample from the initial cohorts are unconvinced of the robustness of assessment. Three people: one because of untimely feedback, one because of variations in assessment and a third because she had heard about the variations.

The issues involved have been responded to. The efficacy of the response will emerge as cohort 3 progresses through the scheme. (Please note—at the time of this report two of the cohort 3 evaluation survey respondents had been allocated an assessor, which did not constitute a sufficient sample to comment on changes made to the assessment process).

A new assessment process is bound to encounter variations in assessment. What is almost certainly of great importance is that these are addressed; and the indirect evidence we have suggests that this is the case.

The consistency in assessment was raised by a number of practitioners and assessors (cohorts 1 and 2). Some practitioners felt that the expectations of their assessors was too high for the level that the registration is aimed at, or that when a different assessor had been assigned to them for a particular reason, a standardised approach was not taken and work that had formerly passed assessment, was deemed to be no longer acceptable.

Both practitioners and assessors felt that a more standardised approach to assessment is needed, which may be addressed through better assessor training, clarification on the interpretation of the standards, template examples of commentaries, and group assessment approaches.

Feedback from the Workforce Development Specialist and Learning Set Facilitator indicates that an informal moderation process was in place for Cohorts 1 and 2, and assessment logs were scrutinised for attention to detail at the pre-verification stage. The online forum and assessor network meetings are responses to the difficulties detected through the early part of the pilot.



# emergent learning and practice from assessing impact of the scheme on employer and practitioner perceptions of ‘currency’, and career progression

## 3.3.1 What motivates practitioners to join the registration scheme?

Previous evaluations of the registration scheme in other regions have revealed a difference in practitioner motivations for joining the scheme. This difference is between the focus on quality assurance and personal development in Wales, and the interest in job security and recognised accreditation for career development in England. This almost certainly reflects the imminent transition of public health to local authorities, and the job insecurities associated.

The motivations of the West Midlands practitioner cohorts are consistent with this. Evaluation questionnaire respondents (cohorts 1, 2 and 3) focused their motivation for joining the scheme on professional recognition in the current climate, as well as enhancing career progression and positioning themselves professionally.

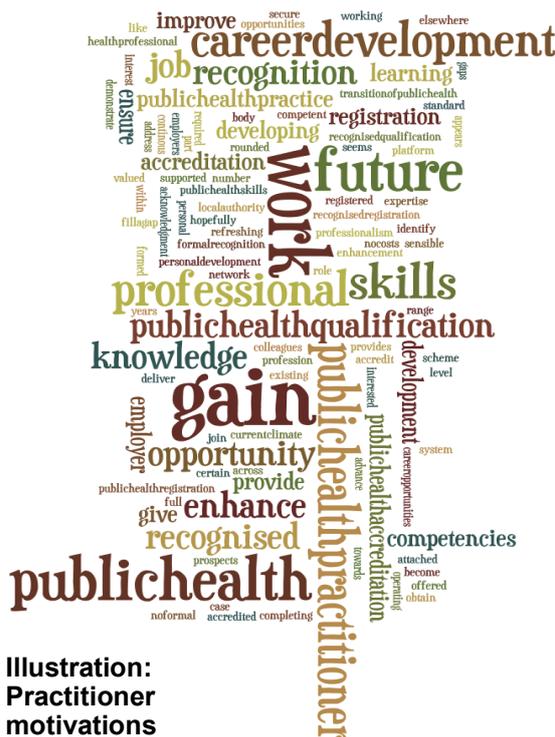
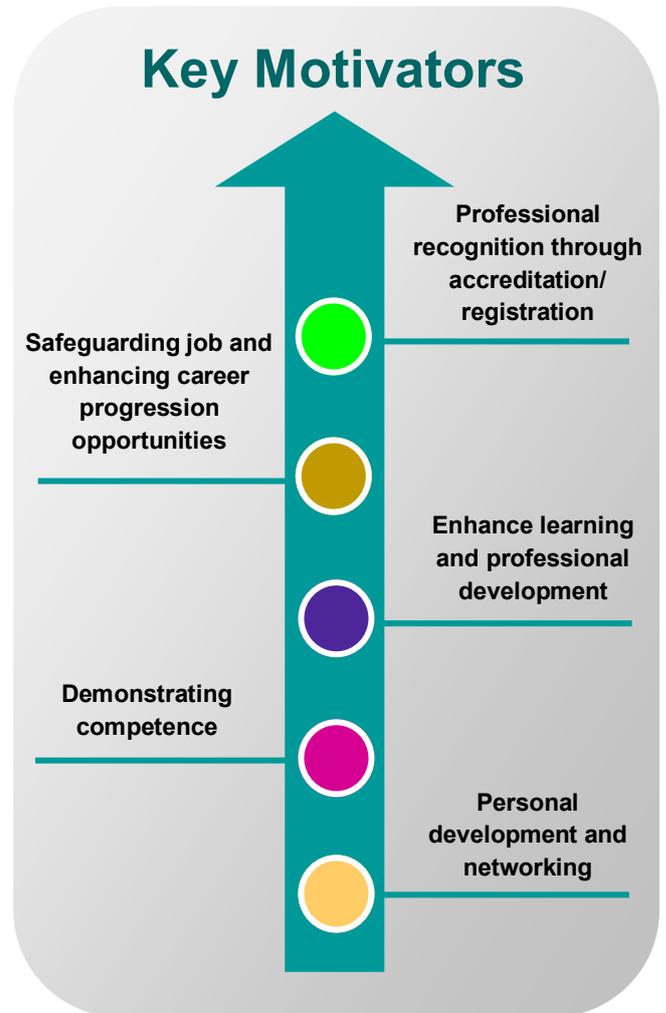


Illustration: Practitioner motivations

*“The scheme appears to fill a gap in the system, and provides recognition for a certain level of public health knowledge. It also seems sensible in the current climate.”*

*“To gain public health registration in advance of the transition of public health to local authority.”*

### 3.3.2 What motivated employers to support their practitioners to join the scheme?

Nine employers comprising line managers and Directors of Public Health, were interviewed as part of the evaluation process. Each had a distinct reason for supporting their employees to join the scheme, ranging from wanting to support professional development for career progression, to filling gaps in knowledge and expertise.

The employers also shared a common theme in their motivation for supporting practitioners to join the scheme. This centred around a strategic awareness of the changing nature of the current public health environment, and the need for professional recognition in a widening community of practice.

*“...we thought it would benefit our work overall. It fits the changes that are happening and makes it easier internally across departments.”*

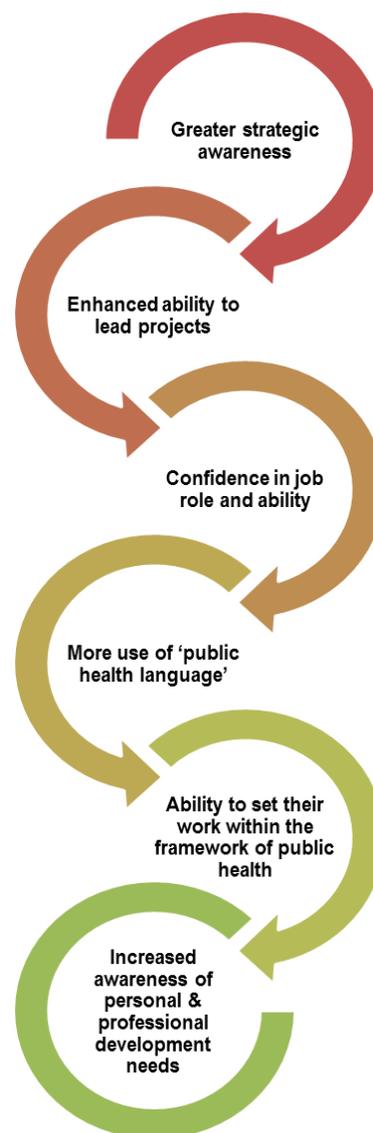
*“The public health net is being thrown far and wide....we are starting to get [other professions] doing public health work. There are lots of people who don't come from a public health background and it will be really useful for everyone to go through it.”*

### 3.3.3 What do employers say about the impact of the scheme on practitioners?

The response to this evaluation question from employers was interesting, and suggested practitioners who had undertaken the scheme had become more empowered and conscious members of a community of practice that shared values and standards.

Again, there were common themes: greater strategic awareness; enhanced ability to lead projects; a greater awareness of personal and professional development needs; more use of ‘public health language’; an ability to set their work within the framework of public health; and confidence in their role and ability.

*“[The practitioner] knows their job and what needs to be done. What has changed is the ability to contribute around public health issues. [The practitioner] is able to frame knowledge in a different way, using the language of public health and understanding the culture, and this takes time.”*



### 3.3.4 What does registration tell employers about the practitioner?

Employer responses to this evaluation question varied more widely. One employer suggested that registration demonstrates the practitioners' awareness of their own professional development, but may not necessarily impact their day-to-day practice. Other employers suggested that practitioner registration demonstrates the individual can apply themselves and the employer would be confident in their ability to 'see a piece of work through' - but made reference to the fact that this would apply to any qualification.

There was also some recognition of how the scheme can potentially have a positive impact on strategic service planning:

*"...it tells me that [the practitioner] is key to developing how we think about service issues. Traditionally we would look at causes, and that's changing to a more systematic approach. [The practitioner] is beginning to inform what we write in relation to advice and guidance to councillors."*



In slight contrast to responses from line managers, Public Health Directors focused their responses on more of an awareness of the changing public health environment and the need for practitioners to secure their place within it. They indicated that practitioners who go through the registration process may have the advantage of:



### 3.3.5 Are employers more likely to employ a registered practitioner?

Employers reflected on a number of advantages of employing registered public health practitioners, such as the transferability of applied skills 'in the field'; recognition of the accreditation and the work that has been put into achieving it; and that registration is 'current'.

*"...it gives you a bit of assurance that people have competence and senior people have signed up to say they have."*

Generally responses to this evaluation question were a little more reserved, perhaps indicating that recognition through practitioner registration is still in its infancy and there are questions over its currency potential in public health.

A number of line managers indicated some obvious reservations about what a portfolio does, and does not, demonstrate. However, registration does give the employer some assurance that the practitioner has 'covered the basics'.

*“Registration would help, but I’d need to know more about their portfolio...it’s the depth of work they have covered that matters, work that is of note, and that would be in an application form anyway.”*

*“Registration is what you get on merit...don’t know how much the employers would recognise what it is saying. I’m an advocate of accreditation of what you do in the field...I’ve always favoured experience.”*

Public Health Directors indicated that there were a number of advantages to employing a registered public health practitioner. They felt that the standardised approach that registration brings, together with the reflective thinking that practitioners need to do in order to achieve registration, would indicate both a safe foundation of skills and the ability of a practitioner to build on that foundation.

They also indicated that registration would strengthen practitioners’ professional autonomy and give an assurance to employers about quality practice.



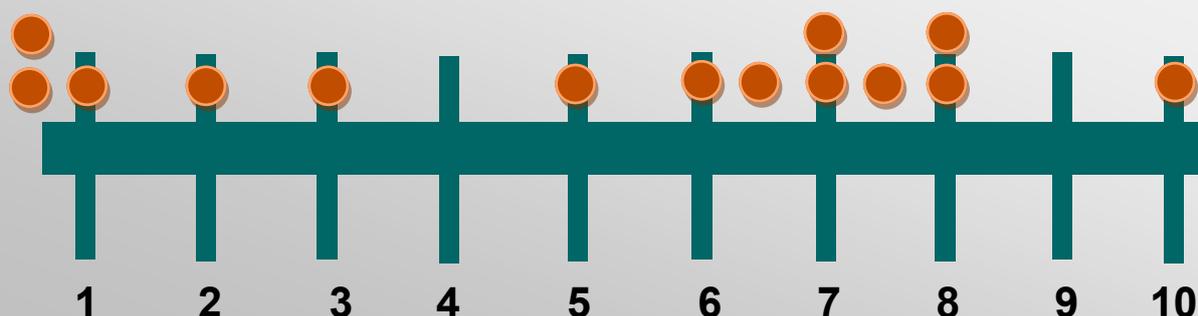
### 3.3.6 To what extent do registered practitioners feel that registration has helped progress their career?

Seventeen public health practitioners who have successfully completed the registration process, were interviewed as part of the West Midlands scheme evaluation. Their responses to evaluation questions show that their experiences of undertaking the scheme varied greatly, often depending on the relationship with their assessor and their experience of the assessment process.

Some practitioners felt that whilst the registration process had not/will not help them professionally, it has given them more confidence in making any future career choices and something 'recognised' to add to their CV. For others, there was still the question about whether the registration will be recognised and achieve 'buy-in' from public health organisations. Contrastingly, a number of practitioners reported that the registration had already helped with their career by giving them a defined progression route:

*“For me it has become the ladder, and again I know if I am out of the organisation, there will be a certain level that I can say I have achieved. It’s a shorthand way to say that I have achieved this level.”*

**Question: To what extent has the registration process helped career progression (score from 1-10). Score of 10 = highest**



Practitioners interviewed by evaluators were asked to score, on a scale of 1-10 (highest being 10), to what extent participating in the registration process may have helped progress their career. 14 out of the 17 interviewees responded, and around 57% scored towards the higher end of the scale (more than 5), indicating that they felt the registration process had helped career progression to differing extents.

Most practitioners scoring towards the lower end of the scale suggested that the registration process may not necessarily help their career progression, but it was a useful quality assurance and personal development exercise. Others felt that the timing had not been right for them undertaking the process, due to the pressures of organisational changes.

*“If I am trying to move to get to Consultant level, this isn’t required. But as a personal development process, with regards to knowledge, it helps me potentially get there. It helps with confidence and the feeling of authority to make that progression, but not professionally.”*

*“It may have the potential in the future but I don’t currently see any potential. I am hoping in the future employers will be asking for it. But until the register gets established and people are interested in it, it has been of no benefit.”*

### 3.3.7 To what extent do practitioners feel registration is valued by employers?

Feedback from the 27 practitioners who responded to the evaluation survey suggests that there is still some concern about ‘buy-in’ to registration at strategic public health levels.

Respondents suggested that public health consultants and directors could add weight and momentum to the registration process with occasional ‘check-ins’ at operational levels; they also suggested that more work-based support is required in order for the registration process to be perceived as valuable, and that the process needs to be embedded into the public health professional development commitment.

*“...there needs to be more work-based support for practitioners to complete it, more commitment from employers to make it a core part of an individual’s development.”*

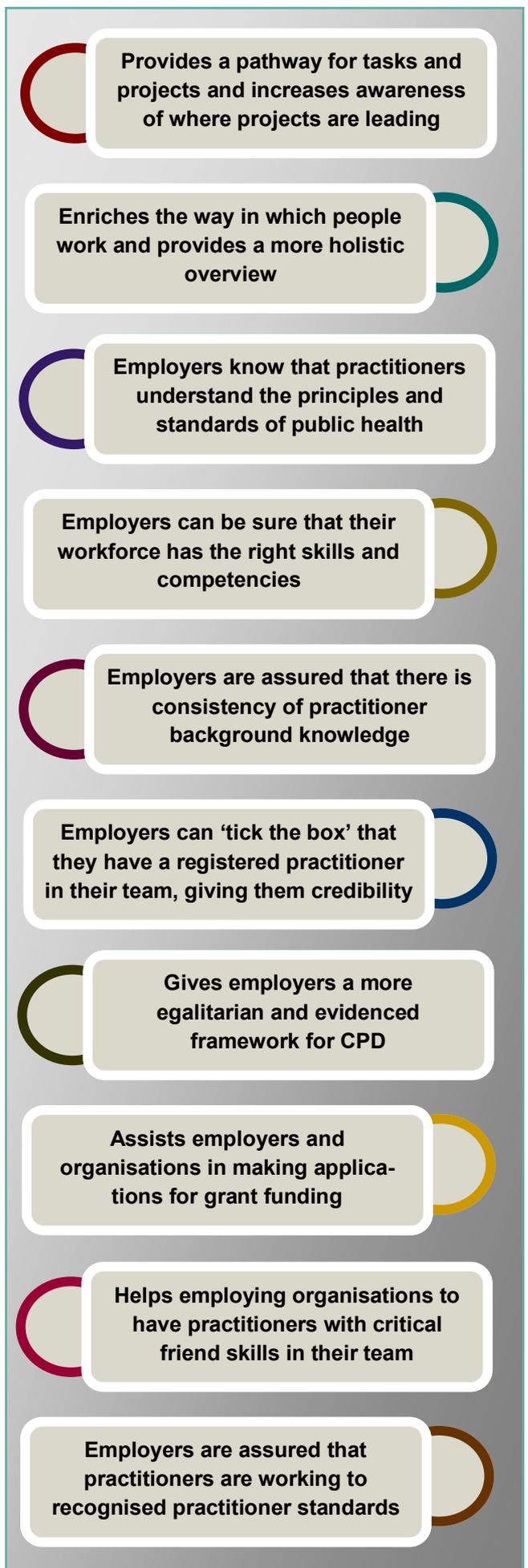
### 3.3.8 What advantages does having registered practitioners bring to the employer?

Feedback from the interviews with the 17 practitioners who have successfully completed the scheme reveals that some of them are unsure about what impact registration will have; particularly as practitioner registration is not yet embedded in employing organisations and employers will already have quality assurance systems in place and look to employ practitioners that have other qualifications that demonstrate their knowledge in the field.

*“I don’t think it does. It’s what your workforce would have in place....yes absolutely safeguards and standards, evidence competencies and how you do it, but no different from doing your degree and masters.”*

Most completed practitioners felt that although there is still a question over whether the registration would become recognised by employers, employing registered practitioners can provide some distinct advantages to the organisation. This includes an assurance that their staff are competent, have a knowledge of public health principles and the practitioner standards as a basis for their work. It also gives employers a ‘badge’ that they can use when applying for grants, highlighting their credibility in the field of public health, and that they recognise and value CPD for their staff.

*“As we are moving into a new world and bringing people from various walks of life, future employers will need to know no matter where you came from and what you have done, you can do the job. This will help.”*



### 3.3.9 To what extent do practitioners who have completed the process, feel that it has made a difference to how they do their job?

The scheme is promoted partly as a development process. We asked 14 practitioners who have completed the accreditation process, about any difference they think it has made to how they do their job.

54% of respondents felt that the process hadn't really made a difference (scoring under 5 on the scale), indicating that it had mainly confirmed that their practice was good and met nationally recognised standards. Some had not enjoyed the process, and felt that they couldn't translate the experience into their day-to-day practice. Others felt that it was too early in the development of the scheme to evaluate whether it will have an impact on their job, and they are waiting to see if the registration process gains currency in public health.

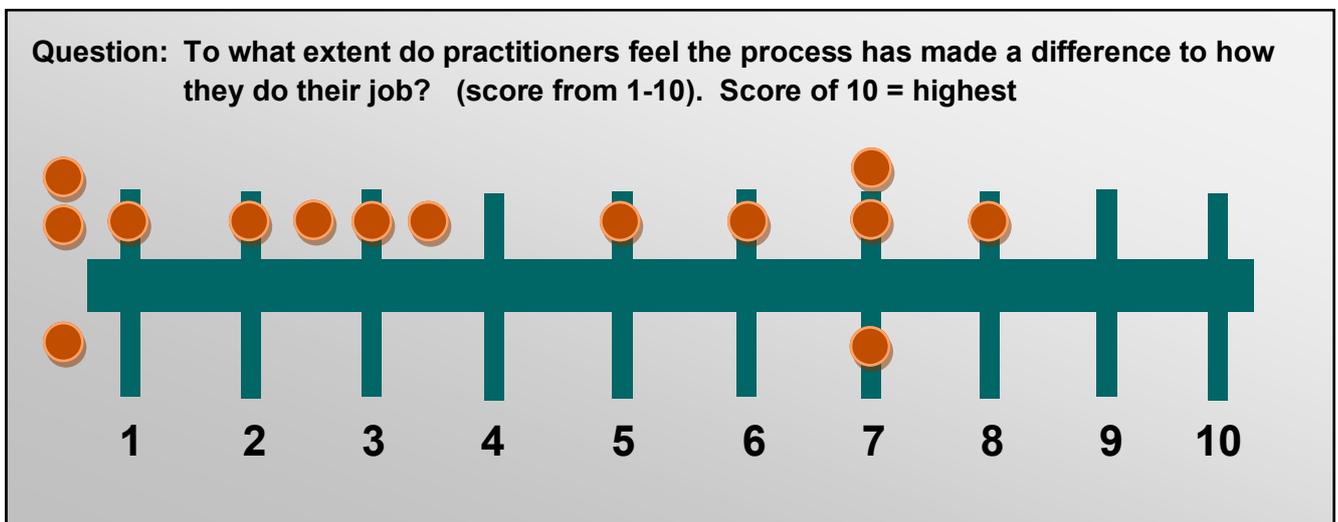
The 46% of respondents who scored 5 or more on the evaluation scale, and felt that the registration process had made a difference to how they do their job, mainly identified the difference as the way they think about approaches and solutions within a wider public health framework.



*“[Now] I ask myself questions: what are the ethics about doing this work?; will it impact on equality? Before I didn't ask those questions directly to myself. I am more conscious about those things and realise the impact of public health.”*

Respondents also identified how the process has helped them structure their personal and professional development. They indicated that it has made them think about the skills they need to do what they want to do; in turn this has given them confidence to update their CV.

Even those who gave high scores on the scale were reserved about the potential impact of registration on their work due to its infancy. However, they seemed willing to risk the time investment in the hope that registration for practitioners will become a future public health requirement.



## CONCLUSION 3

*Assessing impact of the scheme on employer and practitioner perceptions of ‘currency’ and career progression*

**Employers are expressing interest in the potential of the Practitioner Development Scheme. Further promotion of the scheme as a quality assurance process will strengthen the scheme’s currency in the new and emerging public health landscape.**

We think that the main motivation for practitioners signing up to the West Midlands Practitioner Development Scheme was to gain recognition as a member of a community of practice that might protect their identity and pay-grade in a local authority. This rests on the hope that this accreditation becomes “currency” in terms of recruitment and promotion.

At this stage, feedback from employers suggests that practitioner registration is viewed as having a growing value in terms of quality assurance, particularly for Local Authorities about their existing staff and in recruiting staff. Registration seems to offer these employers evidence of:

- External verification
- Competence and reflective practice
- Commitment to public health
- Commitment to training and professional development
- Expertise
- The ability to understand data and populations
- The ability to start and finish tasks

These elements help employers recruit to posts.

*“The advantage is quality assurance for local authorities in the future...”*



There is also an indication that there is not yet the level of senior public health support that would justify confidence among many practitioners that this substantial commitment to professional development and recognition is valued by those higher up the professional ladder.

The perception scores given by practitioners asked whether they see any improvement in the way they do their job as a result of the scheme, indicate a very weak association between the scheme and improving performance. We conclude from this three things:

- i) ‘Development’ in this scheme has been intended and experienced as improving awareness and understanding rather than performance. The very positive feedback about the masterclasses (section 3.1) supports this.
- ii) The impact on confidence has therefore not been on how confidently practitioners perform, but on their authority. We think people are describing a stronger authority with which to advocate core values of public health such as evidence-based decision making, and data-led improvement. We think that what we are evaluating is a process whereby practitioners explicitly start, and in some cases finish, a journey towards becoming members of a wider community of practice defined by shared standards and core values. We speculate that confidence to advocate particular ways of doing things seems to be enhanced by shifting from being just a member of a work team to joining a wider purposeful community committed to promoting the health of the public through specific types of recognised safe practice.

iii) The evidence does not suggest a sustainable case for saying that a retrospective portfolio-building exercise has much impact on competence or capability. While this was never claimed by the scheme, we were curious about any developmental impact and found no significant evidence that there was.

What we recommend as a consequence of this feedback from employers and especially Directors are two activities:

- i) the promulgation of views of senior managers in the light of experience of the pilots, and;
- ii) the continuing and stronger encouragement of employers to make Registration a desirable quality in advertised posts and to make working towards Registration an essential quality.

We see Registration as a great opportunity for Local Authorities who are now able to reclaim Public Health.

They have acquired staff who can convert the many statutory responsibilities Local Authorities undertake into healthy and life-enhancing activities, explicitly designed to strengthen the health of the public and extend our active life.

We think the clear message from practitioners, their managers and Directors of Public Health is that the Practitioner Development Scheme offers Local Authorities a ready-made low-cost process for telling central government and local electors that the responsibility for protecting the health of the public is not only safe in Local Authority hands, but rigorous.



Local Authorities can seize UKPHR Practitioner Registration as their quality assurance tool to demonstrate localism in public health will be taken forward by people qualified to do the job in a way that was never the case when they worked for the NHS.

They can ensure that public health practitioners who are often 'embedded' in other teams like planning teams - and thus separated day-to-day from public health colleagues – retain an umbilical connection to the public health community of practice.

They can extend the opportunity for Registration to all of their staff with public health responsibilities and encourage it with Third Sector partners on whom they increasingly rely for the delivery of services already. They can have a uniform set of expectations of those staff, including their safety to practice and their commitment to stay trained and up-to-date.

### RECOMMENDATION 3

*To strengthen this element of the scheme, you may want to consider:*

- A) Committing scheme time to communicating with West Midlands employers about what Directors of Public Health are saying about the value of practitioner registration to the Local Authority by having an externally validated assurance about the quality of the staff they now rely on to improve the health of the public.
- B) Investing time on encouraging Directors of Public Health to make practitioner registration a 'Desirable' element of any job description for posts advertised at practitioner level. This might best be seen as a local communication exercise with strong national UKPHR support.

## emerging learning and practice from practitioner progress, outcomes and benefits from participation in the scheme

### 3.4.1 To what extent are practitioners making good progress in achieving registration?

Since the start of the West Midlands Practitioner Registration Scheme in 2011, a total of 204 practitioners have opted to join the scheme (cohorts 1, 2 and 3). Cohorts 1 and 2 currently comprise 146 of these scheme participants (allowing for the 36 who have formally withdrawn).

At the time of the evaluation analysis, 22 practitioners had successfully completed the registration process (based on figures up to Feb 2013). Figures up to June 2013, and including cohort 3 which is ongoing, show that 32 have completed the scheme at the time of publishing this evaluation report.

The scheme experienced 24% formal practitioner withdrawals in cohort 1, and 15% in cohort 2. The main reasons given for withdrawal were a change of job or lack of time due to work commitments. On average, the percentage of 'formal withdrawals' correspond with feedback collected from the 27 evaluation survey responses, where 19% of respondents stated they did not plan to complete their

portfolio, due to lack of time, work commitments or disengagement.

Across both cohorts 1 and 2, practitioner progress has been slow. Evidence from the database records of practitioners from these cohorts and who are currently on the scheme shows that:

- They joined the scheme in 2011
- 47% have been assigned an assessor
- 42% of those assigned an assessor have not yet completed a commentary
- 73% have not submitted a commentary
- 7.5% have not attended a masterclass, learning set or submitted a commentary since 2011
- Around 12% have been involved in one activity (learning set, masterclass or one commentary).

During the evaluation interviews, assessors also expressed some concern over the progress rate of practitioners:

*“People weren’t doing learning sets or getting mentors...and they can’t be bothered to finish. This is a waste of time for assessors and practitioners...”*

Practitioner progress towards registration (database statistics up to February 2013)	Cohort 1	Cohort 2
Number of practitioners signed up to the scheme (not withdrawn)	76	70
Number of practitioners assigned an assessor	50	19
Number of practitioners submitted 0 commentaries	49	57
Number of practitioners submitted 1 commentary	6	5
Number of practitioners submitted 2 commentaries	1	3
Number of practitioners submitted 3 commentaries	19	3
Number of practitioners submitted 4 commentaries	1	1
Number of practitioners submitted 5 commentaries	0	1
Number of practitioners successfully completed registration	16	6



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Telephone interviews with 12 practitioners (cohorts 1 and 2) who did not complete the evaluation survey and had not successfully completed the registration process, revealed that only two of them intend on submitting their portfolios sometime in the future.

The reasons given include maternity leave, moving jobs or location, lack of time, redundancy, bureaucracy in the process or not seeing the worth of the registration scheme.

The issues around informal withdrawals from the scheme and peer discussions about its validity or potential currency in public health, have also been noted by other participants. For some, this has affected their motivation for continuing, but others persevered feeling that it would demonstrate their commitment to the changing public health agenda.

*“There were over 100 in the room initially. Then in the masterclass there were 30. Then over the time period if I think about how many of us went that I know of and now only me and [one other] have completed the course. So less than half are in the process now. I think those who haven’t completed probably won’t, because you need that [drive] from the employer, you need that back-up to build evidence as well.”*

Evidence from the database shows that 52% of practitioners who were not allocated an assessor, still pursued the CPD opportunities the scheme offered, and attended at least two learning sets of masterclasses. Some went as far as completing and submitting commentaries.

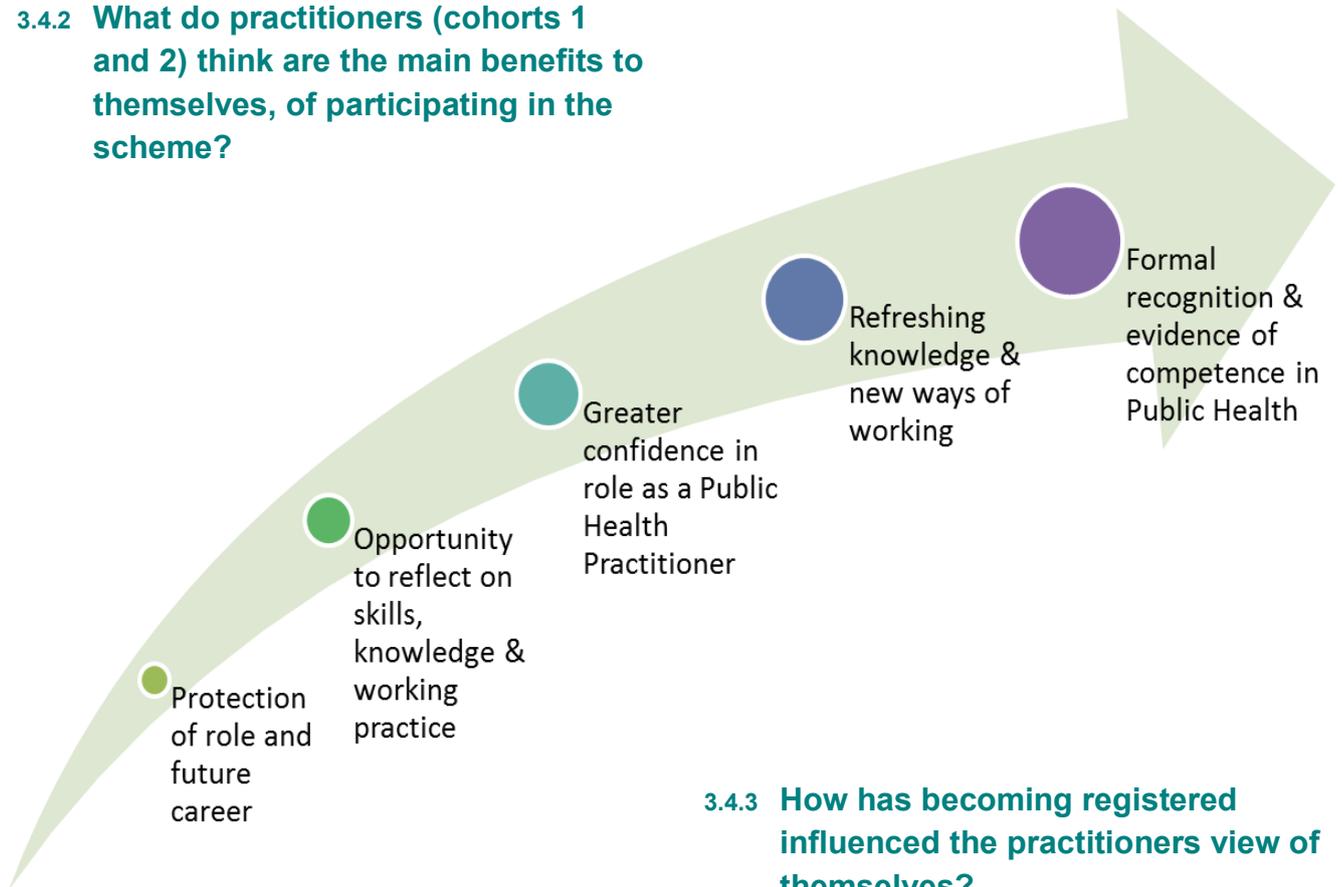
*“I would hope to complete within 3 years. The first six months I did two of my commentaries...”*

Feedback from the scheme manager, the learning set facilitator and assessors suggest that improvements to the scheme structure were put in place in preparation for cohort 3, including the introduction of an Assessors Forum to strengthen consistency, give assessors opportunities to discuss practice and approaches—these fora are very well attended by assessors; an increased focus on one-to-one support which have been highly valued, and considerable liaison at strategic levels. It is likely that these changes will contribute to practitioner progress and add significantly to the 22 candidates who have already succeeded through the scheme.

Evidence of the impact of the changes made may already be emerging, with 87.5% of the 16 cohort 3 survey respondents indicating they have begun work on their commentaries; two respondents stated they had completed all of their commentaries.



### 3.4.2 What do practitioners (cohorts 1 and 2) think are the main benefits to themselves, of participating in the scheme?



Echoing their motivations for joining the scheme, practitioners interviewed who had completed their registration indicated that they feel the main benefit of participating centres around professional positioning by proving competence and credibility by gaining recognition for their practice through registration. Refreshing knowledge and looking at new ways of working in a changing public health environment, and confidence in their role as a practitioner were also viewed as key benefits.

*“Confidence - in a number of ways. It’s confidence in competence; going back to pieces of work I’d forgotten about and seeing how they fitted gave me confidence in what I was doing. Also, confidence in yourself as a person, to have a go and sell myself, it gives me authority...”*

### 3.4.3 How has becoming registered influenced the practitioners view of themselves?

Some practitioners interviewed stated that the registration has not influenced the view of themselves; they felt it was simply a process that they had to go through in order to gain registration, and the worth of that process is yet to be proved.

Other interviewees felt that their view of themselves had been influenced in a number of ways;

- Increased confidence in their ability and knowledge
- Feeling of ‘proven competence’
- Increased motivation to ‘give it a go’
- More understanding of the basis of public health and addressing skill gaps
- Improved morale
- Reflective practitioner
- Appreciation of own accomplishments

*“It influences my view of my professional prowess.”*

*“...it has shown that yes, I am fit to practice.”*

## CONCLUSION 4

### *Practitioner progress, outcomes and benefits from participation in the scheme*

**The West Midlands scheme has recruited the largest number of practitioners of any UK pilot. This has enabled practitioners to access a significant number of CPD opportunities which have been highly valued, especially during a time of uncertainty in public health. A higher proportion need to achieve registration. Practitioners now need strong encouragement to make full use of the support available to complete their portfolios and gain registration.**

The 146 practitioners who took part in cohort 1 and cohort 2 (182 accepted minus 36 withdrawals) of the West Midlands Practitioner Development Support Scheme represent a healthy subset for a pilot study. 22 of those practitioners have already succeeded in gaining UKPHR Practitioner Registration through the scheme, and feedback from the evaluation survey suggests that a further 20 practitioners hope to achieve registration this year—an anticipated 22% completion rate. We also know that over half of the original 182 participants accepted on the scheme have participated in two or more learning sets and over half have participated in masterclasses. So we think that means:

- i) the process is demanding
- ii) most of those who signed up subsequently discovered a big gap between what they thought they could achieve and what they have achieved
- iii) around half the practitioners in the learning sets never completed and some never started
- iv) despite not completing, a large number of practitioners experienced continuing professional development in public health disciplines as part of a larger and more diverse community than that in which they worked daily.

We also know that this data is readily accessible in the scheme's exemplary administration records. This suggests the capacity exists to spot and respond to slow progress.

Whilst some practitioners have found the process rewarding and have managed to fit the registration scheme around their work and home schedules, around half to three quarters have found it difficult, and have lost momentum.

This has resulted in slow practitioner progress which can lead to them feeling frustrated and risks assessors becoming detached from the scheme due to a lack of portfolios to assess.

Based on our experience of pilot schemes with smaller numbers, less support, less expertise and without the exemplary system administration of this scheme, we conclude that this apparently high drop-out rate is primarily related to three key causes outside the power of this scheme to influence:

- 1) Portfolio-building is extremely hard work; it is also essentially retrospective and not an intrinsically developmental experience; it is very hard sustained work with benefits more apparent in retrospect than at the time.
- 2) There is only now emerging evidence that employers have begun to recognise the value of accreditation. We believe there are now, in Spring 2013, at least two public health job descriptions in the West Midlands referring to Registration as a 'desirable' quality. But if the main motivation for a practitioner signing-up has been a precautionary move to maintain marketability in public health then the absence up to recently of job descriptions containing any reference to Registration must be demotivating.
- 3) This is the most turbulent period in living memory for the employment of public health practitioners; the huge workload and disruption involved in migrating this workforce to new employers will have seriously eroded the discretionary time practitioners and their managers can allocate to portfolio building.

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In this evaluation we can focus on the learning that has developed from the piloting of systems and processes, and improvement that will have sustainable impact. But the benefits created by these improvements are likely to be marginal compared with the impacts of the process being hard work, little visible credibility with employers as yet, and massive system disruption. But we think these improvements can certainly make a degree of difference and prevent 'glitches' repeating themselves and adding avoidable barriers.

Some of the areas for improvement can be influenced by the way the scheme is set up by the UKPHR - for example the need for clearer guidance and templates; recommended assessment processes; lack of adequate communication for those who have gained registration; and the need to promote the 'currency' of the registration at strategic levels.

Some of the issues seem to be more localised, with feedback suggesting that the scheme would benefit from more structure with clearer guidance and expectations from the start, tighter deadlines, an improved format for learning sets, consistent assessment, and greater promotion of the value of the scheme at organisational and managerial levels.

But some of the issues also lie with the practitioners. A number of practitioners are not prioritising completion of the portfolio and suggest that they were unclear about the real demands of the commitment required to achieve registration. Perhaps in the current changing public health environment, it is difficult for some practitioners to risk time investment in a process which is as yet 'unknown' in terms of its professional validation and credence in public health.

This issue could potentially be addressed with a strengthened recruitment process and the introduction of a robust scheme induction programme. For instance, there may now be scope for an initial event to be less of an invitation and more of a strong education in the commitment as well as the support available,

with opportunities for those interested to group-interview practitioners who successfully gained registration through the process.

We think the principal challenge for the scheme, that is within its power to influence, is to have a voluntary scheme compete with more compelling demands on practitioners' time. Most people in our experience are deadline-driven. We think a key message from a lot of the feedback is the need to impose rigorous deadlines on participants which compete with the other deadlines they face. Providing this is made part of the commitment and is clearly 'contracted' initially with people who want to sign-up, then we believe this is both ethical and in the best interests of practitioners, assessors, verifiers and mentors. We suspect the rate of sign-up will reduce and the completion rate will increase as a consequence of introducing a clear structure with smaller amounts of 'wriggle-room'.

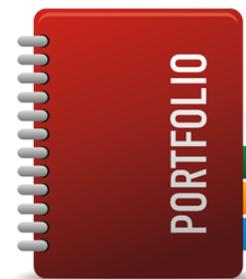
Even with those who have not completed nor are currently likely to; this scheme has provided activities—especially learning sets and masterclasses which are professionally developmental, focused on competence, and increase a sense of belonging to a wider community of practice for 146 people (accounting for withdrawals) at a time of confusion and uncertainty.

The key emerging benefit for practitioners is recognition of their competence to do their job; the confidence to know they are competent and the external validation of their work. In such a changing public health environment, with the number of people falling under the public health banner growing, practitioners who have achieved registration are now part of a group, or a defined community of practice. This allows them to 'wear a badge' to show they belong.

Being registered doesn't seem to make a difference to how a practitioner performs their job; and many practitioners felt that a tangible change in their day-to-day 'technical practice' was not evident.



# Key learning from external evaluation of Health Education West Midlands UKPHR Practitioner Development Scheme



## What is this UKPHR scheme?

This scheme is one of seven UK pilot schemes designed to enable Public Health practitioners to register with the UK Public Health Register by submitting for assessment and verification a portfolio of evidence of their consistent performance to UK-wide agreed standards, and committing to continuing professional development to maintain their registration.

## 1. High participation

The West Midlands Scheme between 2011 and 2013 has recruited the largest number of Practitioners of any UK pilot (215 of which 36 have formally withdrawn).

Although a scheme is ostensibly a process for supporting practitioners to complete portfolios, joining up to the West Midlands scheme has enabled practitioners to access a significant number of CPD opportunities. These have been highly valued, especially during a time of uncertainty in public health. Opportunities to come together with colleagues and feel part of a larger community of practice have been important for morale. Of 146 practitioners 83 (63%) attended at least two of the three learning sets and 94 (64%) attended at least one masterclass; over half attended three or more masterclasses.



## 2. “Tough love”

A higher proportion need to achieve registration. About one in five has done so. Partly this is because building portfolios to meet the stringent criteria is a tough process. Another reason has been a recognition by scheme organisers of the unprecedented turbulence and uncertainty for all practitioners across the West Midlands, which has created competing priorities. Practitioners now need strong encouragement and firm deadlines – what we call “tough love” - to make full use of the support available to complete their portfolios and gain registration in the face of competing pressures

## 3. Impact for employers

Employers are expressing strong interest in the potential of the Practitioner Development Scheme. Many see it as a key development which allows Local Authorities to recruit disciplined and experienced Public Health practitioners systematically and to be confident they keep their skills updated.

*“This is quality assurance for Local Authorities in the future.”*

Director of Public Health

## Feedback from Directors of Public Health

Interview extracts from three; in the biggest population centres and one rural area in the West Midlands.

### Demonstrating commitment

*“The standardisation tells me the level they are operating at, their commitment to training, their commitment to the professional approach, and it says something about their career aspirations. This is quality assurance for Local Authorities in the future. It testifies that across the breadth of work we do and the clear demarcation between different roles they all understand what the principles are; and that is so important”*

**Local Authorities**

Director of Public Health

### Ensuring we get the right people



*“It tells me people are on a first step; its evidence of baseline expertise. I want bright able people who are engaged. I'm keen on people being reflective and thinking about practice; actively engaged in looking at their practice, at what they can do differently. It indicates a greater range of skills, the ability to get involved in planning, to address public realm issues, to adopt a positive empowering population model. I will need people who understand data and populations. I will drive change through getting things delivered by other parts of the system; for example I've got a Practitioner embedded in the Planning department.”*

Director of Public Health

### Helping Local Authorities recruit to posts

*“The national guidance about the ability of staff to transfer across the Public Health system means that Local Authorities as employers now know who is formally accredited; it helps them recruit to posts. Practitioner registration has to be seen as something that gives people a foothold on the formal Public Health ladder.”*



Director of Public Health

### Benchmark and passport

*“This allows them to acquire almost a passport between the various Public Health organisations. For me as an employer it is a benchmark of someone's career; it enables me to recruit someone and tell the Local Authority that they are accredited members of the Public Health staff.”*



Director of Public Health

## Feedback from senior managers of participating practitioners

The views of those senior Public Health managers with practitioners in their teams who have participated in the scheme explain the impact they have seen – and what that means to them.

### Demonstrating commitment

*“It can be a really positive experience; they feel very good about the work they have done. People at junior level often lose sight of how their work fits into the bigger agenda. It tells me they are pretty well organised, pretty focused, able to think clearly about their role, that they have basic competence in applied PH. I would take it quite seriously...they've got someone with more than a paper qualification....the advantage for an employing organisation is that in recruitment it is a great risk mitigation...it reduces the risk by presenting evidence that they are appointable  
Consultant in Public Health”*

Consultant in Public Health



### Guaranteeing they are current and up-to-date

*“It shows that they are able to apply themselves – to start and finish and complete it. It's the same as any qualification.....The importance of this for an employing organisation is that it is current...I like the CPD approach as you keep up to date. It doesn't matter what you did 10 years ago, especially within Public Health which is always changing. Therefore it is important to keep up-to-date. What we know is changing literally by the day..”*

Regional Manager national  
Public Health agency

### Confidence and assurance

*In my line of work it tells me they have a basic level of competence. I could give them something to do and I could be confident they could do what I need. It gives you a bit of assurance that people have competence and senior people have signed up to say they have that competence.*

Team Leader Public Health Intelligence

### Externally verified experience in the field

*It pulls together a diverse skills base into one identity. People went for it to show they have something to show they are Public Health qualified. An externally verified piece of work for registration is what you get on merit. I'm an advocate for accreditation of what you do in the field with people on the receiving end; I've always favoured experience.*

Primary Prevention Service  
Programme Manager

## 4. Assessment and support

We think that a more standardised approach to assessment is needed. This could be addressed through better assessment training, clarification on the interpretation of the standards, template examples of commentaries, and group assessment approaches. The level of support available to practitioners on the scheme is valued. These are selection of practitioners' feedback.

### Scheme coordination

*"The Scheme Coordinator was amazing. She created the initial relationships and people wanted to engage with the programme so it worked. She went out of her way to help me after missing a session - very kind. She organised events and linked candidates with assessors - all the wheels to make things happen."*



### Examples and feedback

*"The best source of help was being shown completed assessments and copies of assessment logs through the learning sets. Our facilitator of the learning set would encourage us to bring work to comment on which was good. But she also gave us individual feedback which was really helpful."*

### Masterclasses were popular

*"For example, critical evaluation, that was a fantastic masterclass. It helped with my interpretation and it really translated for me. It was brilliant because I could apply it..."*

### Support that builds a community of practice

*"It's often the first time they meet people in their patch outside their specific organisation...it's putting people in touch with others in their (geographical) area...building awareness of the larger community of practice."*

We also think a shift of focus to a 'workshop model' format for learning sets will strengthen the support structure and enable a greater number of practitioners to complete their portfolios successfully.



Total Improvement Process Ltd has evaluated four of the seven UK pilots and works with Public Health teams across the UK