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UKPHR
Public Health Register
Protecting the public – improving practice

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Our report of responses to consultation: amended standards for practitioner registration

Introduction and methodology

The means of seeking views were by way of both a formal, published consultation document and an online survey (Survey Monkey).

The audiences were both invitees (registrants and a range of stakeholders including applicants for registration, members of UKPHR's Consultative Forum and partner organisations) and self-selecting respondents (the survey was published on UKPHR's website).

The survey was available for completion between 24 August 2018 and 19 October 2018.

This report summarises the responses we received, including statistics, illustrative statements from respondents and an interpretive commentary.

Where numbers of responses for or against a proposition are stated, respondents who responded "Don't know" or "Neither agree nor disagree" or did not give an answer have been excluded, hence total responses to any given question may not equal 100 per cent of those who responded to the consultation.

Who completed the survey?

We received a total of 35 responses. Of these, 31 responses were in the form of completion of the online survey, 29 completed by individuals on their own behalf and 2 completed on behalf of varying numbers of individuals. There were 4 formal written responses from representative organisations or groups.

Summary

UKPHR sought views between 24 August 2018 and 19 October 2018 from a wide range of stakeholders and other interested parties. This was a formal consultation over eight weeks setting out UKPHR's draft proposed amended standards for practitioner registration as settled by a practitioner registration review task & finish group, assisted by a standards sub-group and a commissioned contractor.

The draft proposed amended standards were accompanied by draft guidance. The draft guidance was provided for illustrative purposes to aid understanding of UKPHR's thinking. Guidance will be finalised and published later.

This report sets out the responses received, the issues raised for attention and how UKPHR has addressed points made by respondents.

Overall, there was strong support for UKPHR's intention to amend the practitioner registration standards and strong support for much of the detail which UKPHR set out for the proposed amended standards.

However, there were numerous comments and suggestions aimed at improving the amended standards. These comments and suggestions are helpful and UKPHR has made some changes to the draft amended standards consulted upon in response.

QUESTION 1 – Four section heads per PHSKF

We asked whether the four section headings (professional and ethical practice, technical, context and delivery) which matched those in PHSKF 2016, were appropriate and clear.

There was general agreement, but with one formal response from a representative group disagreeing.

However, when subsequent responses were considered it became clear that these four headings created confusion interpreting the standards and UKPHR decided to **remove the wording of the four headings.**

QUESTION 2 – Numbering system

We asked whether the numbering system (1.1, 1.2, 2.1, 2.2, 3.1 etc.) was appropriate and clear.

There was general agreement, with one formal response from a representative group disagreeing because of a concern that the numbering system might not work with an e-portfolio.

Reassurance was subsequently sought that the numbering system can be made compatible with the current e-portfolio, and any new e-portfolio procured in future.

"This is much clearer than previously as the number of sub sections was confusing in several of the areas."

QUESTION 3 – Area 1, 8 standards

We asked if the eight standards were appropriate and clear. There was general agreement, with one formal response from a representative group disagreeing because of a concern about "mandatory training" in 1.1 (see comment below).

"Why is mandatory training specifically referenced in standard 1.1? Would this be better to include as an example in the supporting information?"

Reference to "mandatory training" has been removed from the standard and will be emphasised in the Supporting Information.

QUESTON 4 – Reference to learning styles

We asked: Should there be specific reference to learning styles or is it enough to include this in Supporting Information related to the interpretation of 1.7 and 1.8?

By more than 2:1, respondents favoured referencing learning styles in the Supporting Information. It is therefore intended to make appropriate reference to learning styles in the Supporting Information.

"Learning styles are one aspect of the toolkit for reflective practice, so best placed in the supporting guidance."

"I think inclusion in the Supporting Information is fine. I'd be wary of making these standards too wordy."

QUESTION 5 – Remove any Area 1 standards?

We asked whether respondents wanted to suggest that any of the eight standards in Area 1 should be removed. There were 22 "No" responses and four "Yes" responses.

QUESTION 6 – Add any Area 1 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added to Area 1. There were four "Yes" responses and 23 "No" responses.

"Two people felt that there is no mention of the responsibility as a public official with regards to management of public monies. Either in terms of actual budgetary responsibility or the civil service codes for example."

"Should also explicitly mention health inequalities. I think this should be given a higher profile throughout the standards."

The standards address aspects of public health practice, rather than specific issues. Health inequalities are an important issue and their reduction is an integral part of the public health function; practitioners can address them through any of the standards, if this is appropriate to their area of work. Health inequalities are explicitly referred to in a standard where it is considered important to that specific aspect of practice.

QUESTION 7 – Area 2, 6 standards

We asked whether the six standards in Area 2 were appropriate and clear. Overall, the standards were supported (23 agreeing they were appropriate and clear and 3 disagreeing). Several comments were made suggesting attention to the wording of these standards.

"Much clearer than previous version."

"It feels like there is a lack of emphasis on understanding the nature of health inequalities and how to reduce health inequalities and the importance of the wider determinants of health (and also the tension between promoting population health and individual health - which comes in 4). As they are no longer included in the technical competencies, they now seem thinly spread through the standards. However, these are fundamentally important, and knowledge, understanding and application needs to be clearly demonstrated by public health practitioners."

The section headings will be removed; the significance of the term 'technical' in the current standards is no longer relevant.

Standard 4.2 addresses the difference between individual and population health and the tensions, which may arise.

Standard 5.2 refers explicitly to the wider determinants of health.

"I think that the standards identified are the right ones but have a concern about the descriptor given against Area 2 no 3, which could cause confusion. It states, 'using public health information to measure, monitor and manage population health and well-being'. Is 'manage' the right term here? on the six standards manage is only used in relation to managing data, whereas managing 'population health and well-being' is a far wider remit. I think more clarity is needed about what this phrase means in the guidance."

The description (title) of Area 2 will now read 'Using public health information to **influence** population health and wellbeing" to provide the context for the standards in this area.

QUESTION 8 – Remove any Area 2 standards?

We asked whether respondents wanted to suggest that any of the six standards in Area 2 should be removed. There were 25 "No" responses and three "Yes" responses.

QUESTION 9 – Add any Area 2 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added to Area 2. There were two "Yes" responses and 23 "No" responses.

QUESTION 10 – Area 3, 2 standards

We asked whether the two standards in Area 3 were appropriate and clear. Overall, the standards were supported (20 agreeing they were appropriate and clear and 5 disagreeing).

"3.1 I wonder if we need to clarify that we want the practitioner to access and appraise evidence relevant to the area of work they are writing about in their commentary."

The applicant will need to demonstrate knowledge of how to access and appraise evidence (which may be broader than his or her own area of work) and then show application in own area of work. This will be covered in the Supporting Information document (the principle that knowledge may be broader than application will be included in Guidance as well).

"This area should include knowledge of different sources and grading of evidence. 3.1. as it stands apart from not including the above, should read "...evidence of effectiveness (not as it is effective) public health interventions or services" ."

Standard 3.1 now reads ***"***Access and appraise appropriate evidence of **effectiveness for** public health interventions or services".

The heading description will be changed to '**Assessing the evidence for public health interventions and services'**

QUESTION 11- Reference evidence here or in Supporting Information?

We asked whether, in Area 3, there should be specific reference to different types, sources and levels of evidence in standard 3.1 or if it is sufficient to include this in Supporting Information. Respondents' views were evenly split between these two options.

"The supporting information guidance needs to be clear and give examples. the original supporting info documentation was not complete in its examples of suitable evidence. Perhaps add some examples of how others met the standards (helpful for assessors too as some assessors ask for too much / some accept less)."

The issue of consistency in assessment is important but needs to be addressed through training and quality assurance processes.

In the light of responses 11.6 and 4.6, and opinions being evenly divided, it is better to cover this issue in the Supporting Information.

QUESTION 12 – Remove any Area 3 standards?

We asked whether respondents wanted to suggest that either or both of the standards in Area 3 should be removed. There were 23 "No" responses and three "Yes" responses.

QUESTION 13 - Add any Area 3 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added in Area 3. There were 20 "No" responses and three "Yes" responses.

QUESTION 14 – Area 4, 2 standards

We asked whether the two standards in Area 4 were appropriate and clear. Overall, the standards were supported (18 agreeing they were appropriate and clear and 6 disagreeing).

"I feel that 4.2 is very broad and may need to be teased out more to enable a more specific answer."

The standard has been changed to 'Demonstrate how individual and population health differ and **describe** the possible tensions **which may arise between them when promoting health and wellbeing'.**

"Yes, but the descriptor against 4 is not, surely. the language of 4.1 and 4.2 is health and wellbeing (without the hyphen by the way!) but the language of 4 is 'while addressing inequalities in risk exposure and outcomes'. Inequalities implies avoidable differences but neither standard focuses on these. The wording is misleading and confusing for practitioners. "

"Differences" has been substituted for 'inequalities' in the area heading.

QUESTION 15 – Remove any Area 4 standards?

We asked whether respondents wanted to suggest that either or both of the standards in Area 4 should be removed. There were 22 "No" responses and three "Yes" responses.

QUESTION 16 – Add any Area 4 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added in Area 4. There were 16 "No" responses and six "Yes" responses.

"I suggest including PHSKF A3.5 instead."

Area 4 title reflects PHSKF function A3. A3.5 refers to using breadth of public health approaches such as legislation, licensing, policy etc to mitigate risk. It would duplicate standard 4.1, while also making the standard more complex. This issue can be addressed in the Supporting Information document.

QUESTION 17 – Area 5, 3 standards

We asked whether the three standards in Area 5 were appropriate and clear. Overall, the standards were supported (21 agreeing they were appropriate and clear and four disagreeing).

"There is confusion here between the language of the title 'Context', language of 5 'implementing' and the language of 5.1-5.3, which is variously 'support the implementation', 'demonstrate understanding' and 'critically reflect'. I think this area is about various types of action by practitioners, so the heading context is misleading. can it be removed?"

The heading 'Context' will be removed (see response 1.3).

"Very clear, in comparison to previous wording."

QUESTION 18 – Remove any Area 5 standards?

We asked whether respondents wanted to suggest that any of the three standards in Area 5 should be removed. There were 21 "No" responses and four "Yes" responses.

QUESTION 19 – Add any Area 5 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added in Area 5. There were 24 "No" responses and two "Yes" responses.

QUESTION 20 – Area 6, 3 standards

We asked whether the three standards in Area 6 were appropriate and clear. Overall, the standards were supported (18 agreeing they were appropriate and clear and four disagreeing).

"I think that standard 6.2 is asking too much of practitioners. The wording 'working in partnership in multi-agency collaborative' will confuse - do they have to demonstrate working with partners and in multi-agency situations and in collaborative ways? What is partnership if not collaboration, as your own descriptor indicates? "

Standard 6.1 is about how the principles of partnership working have been applied in their work and their contribution to that work; standard 6.2 is focused more on the specifics of the applicant's own behaviour when working across organisational boundaries; standard 6.3 addresses their personal impact on relationships when working with others from different teams or agencies. These three aspects of practice will be made clear in the Supporting Information.

Standard 6.2 will be redrafted to read: 'Demonstrate how you work **collaboratively with other organisations to improve public health'.**

QUESTION 21 – Remove any Area 6 standards?

We asked whether respondents wanted to suggest that any of the three standards in Area 6 should be removed. There were 21 "No" responses and four "Yes" responses.

QUESTION 22 – Add any Area 6 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added in Area 6. There were 25 "No" responses and one "Yes" response.

QUESTION 23 – Area 7, 7 standards

We asked whether the seven standards in Area 7 were appropriate and clear. Overall, the standards were supported (19 agreeing they were appropriate and clear and five disagreeing).

"See earlier comments about delivery title. Designing, managing and evaluating programmes will not necessarily be within the experience of all practitioners at this level. Some will not have 'planned' themselves but will be taking forward, or delivering planning done by others. The old standard 8 focused on planning and/or delivery whereas 7.1 requires all practitioners to have done the planning, which I would say is beyond level 5 for some types of practice in some contexts - unless you define this to include a very focused and local public health intervention - say planning sessions of smoking cessation, for example, when the whole intervention programme has been planned by someone else. The guidance here about what an intervention is would need to be very clear and it is not in the standards. If practitioners were not involved in the planning stage, then they would not necessarily know the target population were involved in the planning or delivery - indeed public health programmes may not 'involve' the population in planning or delivery though they may 'consult' them or use profiles to identify who to target. There is also a potential conflict between the descriptor, which states, 'programmes and projects' and the use of the term 'intervention' in 7.1 and 7.3-7.6. However, three standards (7.3, 7.5 and 7.6) do use the term 'planning or implementing' which is helpful."

The heading is intended to aid the interpretation of the standards. The term 'intervention' is deliberately broad to allow applicants to find evidence from their own area of work but would encompass programmes and projects. The scale of the intervention is not specified.
The area title will also be changed to read: '**Planning, implementing** and evaluating'

"7.4 - evaluation in PH terms/interventions is not always lend itself to assessing and reporting on the evidence of effectiveness of it. Donabedian's Process, structure, outcome evaluation framework comes to mind."

Standard 7.4 now reads '…reporting on **its effect** …"

Further information will be provided in the Supporting Information document.

QUESTION 24 – Remove any Area 7 standards?

We asked whether respondents wanted to suggest that any of the seven standards in Area 7 should be removed. There were 20 “No” responses and four “Yes” responses.

QUESTION 25 – Add any Area 7 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added in Area 7. There were 20 “No” responses and five “Yes” responses.

“Leadership to be included e.g. Demonstrate application of leadership skills when planning and implementing public health interventions. Also planning / delivering public health in the resources available – this is a key skill and recommended to be added. Also add audit skills in 7.6. Understanding of health economics, behavioural insights, digital interventions and innovation should all be included in the supporting information document.”

The ambition for the practitioner workforce in these comments is applauded but they go too far having regard to the level of autonomous practice for which practitioners must demonstrate competence.

QUESTION 26 – Area 8, 3 standards

We asked whether the three standards in Area 8 were appropriate and clear. Overall, the standards were supported (20 agreeing they were appropriate and clear and two disagreeing).

“Suggest 8.1 would be clearer as follows: Communicate public health information and concepts clearly to a variety of audiences using different methods.”

Standard 8.1 will now read; “Communicate public health information clearly to a variety of audiences”.

‘**Data’ has been omitted** as it is rare for data per se to be communicated without interpretation, so the term ‘information’ is sufficient.

‘Using different methods’ has not been included as the focus of this standard is that information is communicated effectively (implicit in ‘clearly’).

This may involve different methods, but not necessarily. For example, communicating identical information to different audiences using different methods would not meet the standard, while communicating an appropriately tailored message to different audiences using the same method would.

This will be addressed in the Supporting Information document.

QUESTION 27 – Remove any Area 8 standards?

We asked whether respondents wanted to suggest that any of the seven standards in Area 8 should be removed. There were 24 “No” responses and no “Yes” responses.

“But 8.2 might be more possible for those working at ground level to evidence rather than in more strategic posts. It also assumes that there is engagement with local people and this would be something the practitioner would be involved in.”

Practitioners can use work from throughout their careers to evidence the standards, so those in strategic posts should not be disadvantaged. Practitioners working autonomously should have opportunities to engage with local people and the term is intentionally broad to facilitate this.

QUESTION 28 – Add any Area 8 standards?

We asked whether respondents wanted to suggest that any other standard(s) should be added in Area 8. There were 21 “No” responses and three “Yes” responses.

QUESTION 29 – Any other comments about the draft amended standards

Asked if they wished to add any further comments, respondents provided us with 17 comments. Examples included:

“The plain language is very welcome and the separation of aspects such as communication is much better. The 8 named sections really help to understand the context in which the question is being asked and by doing this you've managed to remove the areas of replication in the standards.”

“Overall much clearer, especially with additional guidance around evidence of understanding.”

“I believe the practitioner standards are worded better and grouped more effectively. Although still rigorous they feel manageable and not too onerous One of the complaints I receive regularly is that the portfolio is a lot of work and practitioners often feel that the requirements are over and beyond acceptable at practitioner level. What would be helpful is for UKPHR to produce a 'so what' document outlining the benefits of becoming a registered practitioner as many feel it is a big ask for very little gain.”

“Generally clear and understandable.”

“They are more succinct and more clearly laid out than the current standards.”

“The streamlined approach from 40 to 34 competences is really welcome – layout and presentation much clearer.”

UKPHR is pleased to receive support.

“Timely to review the standards and reduce ambiguity of their interpretation. Moving in right direction but a little further work needed to get the standards phrased correctly.”

UKPHR has responded to respondents’ comments and suggestions and made changes where appropriate.

QUESTION 30 – No levels, same as PHSKF

Like PHSKF 2016, the draft Amended Standards contain statements of competencies without reference to levels of competence. The level of assessment will still be “autonomous practice”, which was level 5 in the 2008 Public Health Skills and Careers Framework. Asked if they agreed with this approach, there were 19 “Yes” responses and one “No”.

“A level 5 might not be fully autonomous - but could argue either way. not a useful statement.”

The term ‘Level 5’ will not be used. The practitioner must have acted autonomously in the work they use for evidence; this does not mean that practitioners will not be managed, but they mustn’t be supervised, at least not for the work they use to derive evidence for a standard.

“In reality, particularly in Wales, this is "pitched" way above a level 5 in fact it is predominantly band 7 who are encouraged and supported to undertake practitioner registration but not encouraged to work towards portfolio reg. I think things are out of kilter. I think there is a big gap between this "entry" level registration and portfolio route. The gap is still too big and having been an assessor in England and Wales there are marked differences in the expectation and level of practitioner this is "sold" to.”

UKPHR will register any practitioner who is able to demonstrate competence against the standards using evidence from work undertaken autonomously. The recruitment of practitioners is currently a matter for local schemes, who can set their own eligibility criteria for support from a local scheme. If a national registration is developed in the future, the eligibility criteria would need to be standardised.

QUESTION 31 – Cap on evidence

Asked if they would agree that a cap on numbers of pieces of evidence submitted in portfolios should be introduced, there were 20 “Yes” responses and 3 “No”.

“I think this is very difficult to require, partly because of the portfolio approach which puts the practitioner at the centre of the process in making choices about evidence but also because practitioner experience is so varied. What I think needs to be emphasised is using the relevant evidence is the section/page that actually demonstrates what is claimed rather than a whole chapter/report.”

There is a strong desire to reduce unnecessary evidence, but the comments indicate that merely introducing a cap is missing the point and that there are potential disadvantages.

A strong message needs to go out across the system (including for those using the current standards) that less is more, and that careful selection of evidence demonstrates understanding, while over-use of evidence, particularly when its relevance is unclear, demonstrates the opposite. This message can be strengthened in the Guidance and the Supporting Information document as well.

The pilot project and early adopters of the amended standards will provide information on how evidence is being used. The reduced number and increased clarity of the standards should reduce the volume of evidence submitted. Given that public health is an evidence-based discipline, we should be actively seeking evidence before introducing an arbitrary cap.

QUESTION 32 – Knowledge, Understanding & Application

Asked if they agreed that practitioners need to show "Understanding" as well as "Knowledge" and "Application" in portfolios, there were 18 "Yes" responses and three "No".

"This is fundamental for practitioners to demonstrate."

"Tricky to apply knowledge unless you understand it I would suggest, but on the other hand having that KUA message is very important in signalling that knowing something is not enough without reflecting on its meaning for the individual and applying it with understanding. So keep the three terms."

"A reflective account on the knowledge gained is adequate or a couple of sentences in the body of the commentary that demonstrate their understanding of the knowledge acquired is sufficient."

UKPHR is pleased to receive support.

Evidence is needed for how knowledge has been acquired as well as application. Understanding can be demonstrated by the choice of work to use for evidence against specific standards and the linking of the evidence to the standards in the commentary, plus commentary on how knowledge has been applied. The description of the work, the applicant's role and appropriate reflection add to the assurance of understanding.

QUESTION 33 – Set up an implementation group

The task & finish group recommended that UKPHR should set up an implementation group to take responsibility for implementing the Amended Standards and that this implementation group should carry out extensive awareness-raising and communications activity. Asked if they supported this approach, there were 21 "Yes" responses and one "No".

QUESTION 34 – Piloting the standards

Asked if they agreed that piloting and training will be required, there were 23 "yes" responses and no-one disagreed.

"I am not sure that a pilot will be the best way to test the new standards - or even necessary. Assessors should have the opportunity to talk and discuss each standard to see where they think any issues are. All people who are assessors, support providers are learned enough to adapt to these minor changes- without too much additional training. The concern is that we will lose assessors and verifiers by requiring them to attend further training sessions- it is hard enough to retain them already! Maybe some online webinars instead? "

The pilot has been designed so that the moderators can assess a small number of portfolios, which will inform the further development of Guidance and Supporting Information and provide training materials for assessors and verifiers.

Assessors, verifiers, scheme coordinators and support providers will also have an opportunity to contribute to these materials.

QUESTION 35 - Enough detail provided to date?

Once the amended standards have been agreed, UKPHR will publish new guidance, Supporting Information and training materials. An early draft of the guidance was published with the consultation to assist understanding of the draft amended standards.

Asked if UKPHR had provided enough information to ensure that the consultation was meaningful, there were 21 “Yes” responses and two “No”.

“Various comments to make on the rather disjointed guidance including the absolute need for clear examples of what exactly is being asked for y the UKPHR... Page 7 , 2.5 Presentation of evidence..."each standard should be evidenced from a single piece of work".....what is meant by a "piece of work"? Practitioners may confuse this with pieces of evidence. And also practically practitioners may need to draw on a couple of different projects for instance to fully satisfy a standard page 10, 2.8 The assessment log... "the log will show how each of the standards has been met and what evidence has been presented to demonstrate this.... needs to also include "and when this evidence was presented" Page 12, 3.1 Assessment of evidence... "assessment is a supportive process which can enable practitioner development". I completely disagree! It would be great if it was, but given the restrictions on assessor feedback etc, it is unfortunately not allowed to be Page 15, 3.6 Outcomes of assessment. Needs a better title to differentiate from 3.5 page 16, 4.1 Initial verification check...could be misconstrued...needs extra words... "do not undertake a second assessment BUT DO focus on standards where....etc" undertake a [sic].”

The distinction between a piece of work and the items of evidence derived from it is stated in the Guidance but will be considered further.

Each standard should be evidenced from one piece of work (or ‘project’ in the terminology of the comment). Unlike the current standards, the amended standards were designed to facilitate this.

The use of examples is difficult, because applicants need to demonstrate understanding and a key part of this is their choice of work and evidence for each standard. Examples may also foster a view that standards need to be demonstrated in a particular way, while portfolio assessment relies on applicants thinking this through in the context of their own area of work.

The comment about the supportive and developmental aspect of assessment is noted; the feedback during assessment is limited, but the staged process does allow practitioners to receive feedback, which can help with their future submissions. However, amendment to the Guidance to make the nature of the process clearer will be considered.

Further advice to verifiers will be considered as suggested.

“It has been difficult to answer the consultation questions without the supporting information as a reference, especially reference made to the supporting information in various questions. We would have benefitted from being able to consult on the supporting information or at least be able to use it while going through the standards in order to have the full picture of what practitioners, assessors and verifiers can expect.”

UKPHR has been helped by responses and comments in understanding what it will be helpful to include in the Supporting Information document. When this document is drafted, UKPHR will consult with appropriate stakeholders before the document is finalised and published.

QUESTION 36 – Two-year transition period for practitioners in the system

UKPHR is minded to set a transition period of two years for those practitioners who are already applying for registration under the Current Standards.

Asked if they agreed that a two-year transition period was reasonable, there were 20 “Yes” responses and two “No”.

QUESTION 37 – Agree UKPHR’s timeline for implementation?

We provided a preliminary timeline for completing the work needed to introduce the amended standards.

Asked if they agreed this timeline, there were 16 “Yes” responses and three “No”, noting that some respondents had suggested that a shorter transition period than UKPHR’s intended two-year transition period.

Having considered all responses, UKPHR has decided on a formal start date for the amended standards of 1st April 2019 but has given local schemes the option when during 2019 they commence recruitment to cohorts of practitioners who will be working to the amended standards.

The two-year transition period will apply from April for practitioners already working towards registration under the Current Standards.

QUESTION 38 – Any further comments

We asked for any final comments from respondents. There were several, including:

“You are doing a fab job - consultation very detailed. Thank you.”
“Practitioners are struggling. this should not be such a bureaucratic process if we want to encourage level 5 people to apply.”
“Well done to the group that have worked on this.”

UKPHR is pleased to receive support.

It is intended that practitioners will find the amended standards clearer and more straightforward (there are also fewer standards).

An e-portfolio with the new standards will be available for use by all schemes.

The UKPHR will continue to address the recommendations of the task & finish group in relation to registration processes.

And finally, our own thanks to all respondents for taking the time to respond to our consultation. We are grateful for all the constructive comments and suggestions received, which we hope you can see from this report we have considered and adopted where appropriate.

For queries or further information about this report and the consultation on which it was based please contact:

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