Building your Portfolio

for Public Health Practitioner Registration

Practical suggestions to help you to meet the requirements

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Introduction

This document is aimed at public health practitioners who have access to an assessment scheme and who are preparing their practitioner portfolio for initial assessment. The document can also support attendance to Portfolio Development Groups and be a useful 'aide memoire' for assessors and mentors.

While this document can support the portfolio building process, **All UKPHR documents provide the authoritative guidance on the process of practitioner registration and should be the FIRST point of reference for any queries.**

Every effort has been made not to duplicate information in the UKPHR documents, and so page references are given throughout so that the reader can readily access the source guidance in full.

Therefore, it is assumed that the reader refers to the:

UKPHR Framework and Guidance for applicants, assessors, verifiers (Dec 2013)
http://www.ukphr.org/wp-content/uploads/2014/08/UKPHR-Framework-and-Guidance-for-Applicants-Assessors-Verifiers.pdf

UKPHR Supporting Information: application forms and proformas (Jan 2012)
http://www.ukphr.org/wp-content/uploads/2014/12/Supporting-Information-Applicants-and-assessors-jan-2012-practitioners.pdf

Public Health Skills and Knowledge Framework 2008 (refreshed levels 1-4, 2013) – and in particular intermediate levels 5 – 7.
http://tinyurl.com/hjhdth3

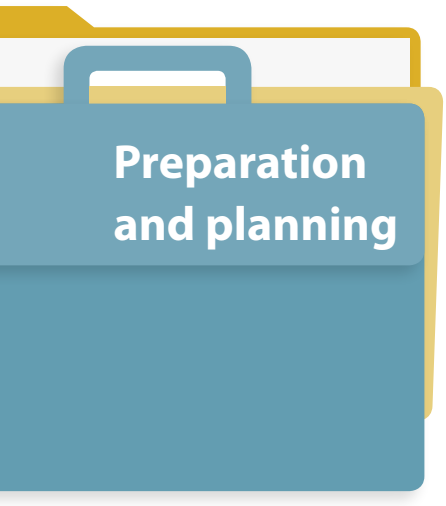
At certain points in the document the following table will summarise the key considerations that could be made by people with different roles in the portfolio building process – and these are just ideas offered by those with experience of the process. All individuals involved – practitioners, assessors, mentors and verifiers – should defer to the UKPHR guidance documents should there be any doubts or questions. If you are unsure about the interpretation of any of the guidance, or the local relevance of anything in this document, consult your local scheme coordinator.

Practitioners should be mindful of:
Assessors will be looking for:
Mentors could be thinking about:

Contents

In relation to the process of portfolio building, it is always worth keeping in mind the purpose of registration, as it will help you to interpret the standards.

Always ask yourself – why would the public health community be asking me to demonstrate expertise or competence in this way? Who or what is it to protect?



Standards, indicators, and sub-indicators

The 48 standards/indicators for public health practitioners are singular statements, similar to competencies. Practitioners have to present and explain their knowledge, understanding and application for each one. The standards have been put together in the interests of public protection and ethical practice. It is important that practitioners understand that they are not expected to provide a full illustration of their current job or duties on which a subjective judgement will be made. It's about what they know and understand, what they can do and how they can prove it through an objective and quality-assured assessment process.

An important feature of the practitioner portfolio is the currency of the capability being demonstrated. Hence, 50% of the items of evidence submitted should be from within 3 years of the date of application for registration to the UKPHR (ie: at the end of the portfolio assessment process) (see Framework and Guidance: pp. 14 and 20). Evidence of knowledge gained more than 3 years before registration will be deemed current if you can evidence how this knowledge has been kept up to date through CPD (Framework and Guidance, p. 14).

Level 5 – what does Level 5 look like?

'Level 5' refers to the levels of the Public Health Skills and Knowledge Framework 2008 (please see the UKPHR Framework and Guidance Dec 2013, p.11 and Annex 2). This level is similarly reflected in other competency frameworks developed by the skills council Skills for Health – and it compares to fully qualified and professionally registered nurses, dietitians, physiotherapists etc. http://tinyurl.com/he7jhx9

The knowledge base underpinning activity at this level is expected to be at graduate/ degree level or level 6 on the QAA qualifications framework (see Framework and Guidance, p. 22). http://www.qaa.ac.uk/en/Publications/Documents/qualifications-frameworks.pdf

The practitioner portfolio is aimed at public health workers who are operating at a minimum of level 5. It therefore does not preclude those who may be working at a higher level than this, and it does not reduce the value of the portfolio building process for those working at more advanced levels.

Practitioners working above level 5 may have more complex work experience on which to draw, or have examples of study at a Masters level. This may not always provide them with the full range of knowledge and skills to be demonstrated, so it does not necessarily follow that they will not have gaps and require further training or experience. Practitioners working above level 5 may find that they have several examples on which they can draw for evidence, and this can make the identification of the right pieces of work more difficult. **As a guide, practitioners should always strive for the best piece of evidence for each indicator.** Occasionally, practitioners provide over and above what is required, and a balance needs to be struck between building a portfolio that is representative of the practitioner, and one that is overly complicated to write and assess within realistic timeframes. It should not take longer than 12-18 months to build and assess a portfolio.

Public health practitioner registration will be a pre-requisite for advanced practitioner accreditation, proposals for which are currently being developed and piloted across the UK.

Understanding the AREAS of the practitioner standards

Before you start anything – make sure you understand how the standards and indicators have been organised, and what the focus is for each of the four AREAS.

AREA 1

Professional and ethical practice

STANDARD	INDICATOR
1. Recognise and address ethical dilemmas and issues, demonstrating:	a) knowledge of existing and emerging legal and ethical issues in own area of practice
	b) the proactive addressing of issues in an appropriate way
2. Recognise and act within the limits of own competence seeking advice when needed (links with 4a)	
3. Act in ways that:	a) acknowledge and recognise people's expressed beliefs and preferences
	b) promote the ability of others to make informed decisions
	c) promote equality and value diversity
	d) value people as individuals
	e) acknowledge the importance of data confidentiality and disclosure, and the use of data sharing protocols
	f) are consistent with legislation, policies, governance frameworks and systems.
4. Continually develop and improve own and others' practice in public health by:	a) reflecting on own behaviour and practice and identifying where improvements should be made
	b) recognising the need for, and making use of, opportunities for personal and others' development
	c) awareness of different approaches and preferences to learning
	d) the application of evidence in improving own area of work
	e) objectively and constructively contributing to reviewing the effectiveness of own area of work.

What this area is about: This area covers competencies that are not unique to public health. You would expect all public sector workers, indeed, all workers in all sectors to be able to demonstrate a lot of the standards and indicators in AREA 1 because they are embedded in legislation.

This area is focussed on your interaction with other people – your peers and your clients or service users – anyone you come into contact with, have a responsibility for, or are accountable to. Some employers are very clear about the behaviours they expect from their employees and require workers to sign up to these, and any transgression can result in disciplinary action.

What you need to do: It requires you to be self-aware and to be reflective about how you act, keeping yourself and others in check, and striving for continual improvement. You will be asked to demonstrate how you do this – awareness of the Good Public Health Practice Framework 2016 (Faculty Public Health) and the UKPHR Code of Conduct might help (see Further reading, p. 24).

Specific to this area will be the legislative framework within which you operate on a daily basis. List examples of the legislation that you think would be relevant to these standards:

Preparation and planning

AREA 2

Technical competence in public health

STANDARD	INDICATOR
5. Promote the value of health and wellbeing and the reduction of health inequalities, demonstrating:	a) how individual and population health and wellbeing differ and the possible tensions between promoting the health and wellbeing of individuals and the health and wellbeing of groups
	b) knowledge of the determinants of health and their effect on populations, communities, groups and individuals
	c) knowledge of the main terms and concepts used in promoting health and wellbeing
	d) knowledge of the nature of health inequalities and how they might be monitored
	e) awareness of how culture and experience may impact on perceptions and expectations of health and wellbeing
6. Obtain, verify, analyse and interpret data and/or information to improve the health and wellbeing outcomes of a population / community / group, demonstrating:	a) knowledge of the importance of accurate and reliable data / information and the anomalies that might occur
	b) knowledge of the main terms and concepts used in epidemiology and the routinely used methods for analysing quantitative and qualitative data
	c) ability to make valid interpretations of the data and/or information and communicate these clearly to a variety of audiences
7. Assess the evidence of effective interventions and and services to improve health and wellbeing, demonstrating:	a) knowledge of the different types, sources and levels of evidence in own area of practice and how to access and use them
	b) the appraisal of published evidence and the identification of implications for own area of work
8. Identify risks to health and wellbeing, providing advice on how to prevent, ameliorate or control them, demonstrating:	a) knowledge of the risks to health and wellbeing relevant to own area of work and of the varying scale of risk
	b) knowledge of the different approaches to preventing risks and how to communicate risk to different audiences

What this area is about: In contrast to AREA 1, these standards relate to the competencies that are very specific to public health. While the area is titled 'technical' competence, you will notice that a lot of the indicators are knowledge weighted. That is because there is an extensive body of knowledge /theory base underpinning public health and this is where you would be expected to demonstrate it - at Level 5 (PHSKF) or Level 6 of the QAA Qualifications Framework (graduate level).

These standards reflect the core business of public health - health improvement, health inequalities, health intelligence and appropriate use and application of data, health protection, research and evidence gathering/appraisal, and the management and prevention of risk.

What you need to do: Because these standards represent your particular expertise in public health, you must show the assessor that you are applying them across a breadth of your work, so you must use more than one piece of work in your portfolio to demostrate these standards. You only have to demonstrate them all once, but the most that you can demonstrate in a single commentary is 9 out of the 12 indicators.

Many practitioners find there are gaps in their knowledge, or they have not had opportunities to demonstrate application for AREA 2, so local learning and development opportunities may be available to support you. Make sure you conduct a gap analysis when planning your portoflio.

Preparation and planning

AREA 3

Application of technical competence to public health work

STANDARD	INDICATOR
9. Work collaboratively to plan and / or deliver programmes to improve health and wellbeing outcomes for populations / communities / groups / families / individuals, demonstrating:	a) how the programme has been influenced by: I. the health and wellbeing of a population II. the determinants of health and wellbeing III. inequalities in health and wellbeing IV. the availability of resources V. the use of an ethical framework in decision making / priority setting.
	b) how evidence has been applied in the programme and influenced own work
	c) the priorities within and the target population for the programme
	d) how the public / populations / communities / groups / families / individuals have been supported to make informed decisions about improving their health and wellbeing
	e) awareness of the effect the media has on public perception
	f) how the health concerns and interests of individuals groups and communities have been communicated
	g) how quality and risk management principles and policies are applied
	h) how the prevention, amelioration or control of risks has been communicated

What this area is about: This area looks similar to AREA 2 because it is about how those things in AREA 2 are applied in a certain context. There is one standard (9), 8 indicators and one of these has 5 sub-indicators. **These sub-indicators need to be addressed individually and to the same extent as the other indicators** (not necessarily from the same piece of work) and in the context of the stem, ie: the programme.

AREA 3 relates to the **planning and/or delivery of programmes** designed to improve health.

AREA 3 relates to **how** this is done while working **collaboratively** with others.

What you need to do: Be ever mindful of the collaborative context of Standard 9. Any examples in your portfolio that are not in the context of collaborative working for Standard 9 will not meet the standard.

The main enquiry as to your competence here is around the HOW? How did you **(and those you were collaborating with)** do it? How did you know who to target? How did you work out what resources were available? How did you apply the evidence base? How did you make sure that the end users voices and concerns were heard?

List those projects/pieces of work that you have been involved in that would enable you to demonstrate collaborative working for the indicators in AREA 3:

Preparation and planning

AREA 4

Underpinning skills and knowledge

STANDARDS	INDICATOR
10. Support the implementation of policies and strategies to improve health and wellbeing outcomes, demonstrating:	a) knowledge of the main public health policies and strategies relevant to own area of work and the organisations that are responsible for them
	b) how different policies, strategies or priorities affect own specific work and how to influence their development or implementation in own area of work
	c) critical reflection and constructive suggestions for how policies, strategies or priorities could be improved in terms of improving health and wellbeing and reducing health inequalities in own area of work
	d) the ability to prioritise and manage projects and/or services in own area of work
11. Work collaboratively with people from teams and agencies other than one's own to improve health and wellbeing outcomes, demonstrating:	a) awareness of personal impact on others
	b) constructive relationships with a range of people who contribute to population health and wellbeing
	c) awareness of: I. principles of effective partnership working II. the ways in which organisations, teams and individuals work together to improve health and wellbeing outcomes III. the different forms that teams might take
12. Communicate effectively with a range of different people using different methods	

What this area is about: AREA 4 is about the context in which you are operating as a public health professional. The national and local strategic and policy context – and the landscape, boundaries, cultures and agenda of the **external** organisations you interface with (standard 11). You will be using specific knowledge and skills to navigate, implement and influence these to best effect.

Draw a list of the knowledge and skills you will need to demonstrate for AREA 4

Knowledge	Skills

What you need to do: There is a theoretical basis to working sucessfully in partnership with others, and you will need to demonstrate where you have gained this knowledge and understanding for Standard 11, as well as the application. You will also need more than one example to fully meet Standard 12. Elements of both standards 11 and 12 can be evidenced and assessed **by observation** and pro formas are available in the **UKPHR Supporting Information document (Jan 2012)** that can be found on the UKPHR website under practitioner registration (see earlier weblinks).

Preparation and planning

REMEMBER: To refer back to the AREA and Standard when you come to demonstrate each indicator in your portfolio. It is easy to become preoccupied with the detail of the indicator, and to interpret it in isolation eg: b) the appraisal of published evidence and the identification of implications for own area of work

AREA	STANDARD	INDICATORS
Technical competence in Public Health	7. Assess the evidence of effective interventions and services to improve health and wellbeing, demonstrating:	a) knowledge of the different types, sources and levels of evidence in own area of practice and how to access and use them
		b) the appraisal of published evidence and the identification of implications for own area of work

The indicator relates to the stem or standard, so 7b specifically relates to the appraisal of evidence of **effective interventions.** If you talk about evidence of something else in your portfolio you will be asked to clarify how you are meeting the indicator. This standard is in the AREA of technical competence in public health, and the appraisal of evidence is one of the key public health technical skills.

Identifying at least 3 'pieces of work'

Your eligibility for practitioner registration will depend on whether you have enough depth and breadth in your work experience in order to provide sufficient evidence. The minimum requirement is that you can write about three different pieces of work, and these will need to be 'discrete' from one another, ie: not duplicating one another.
This does not mean that they cannot be in the same area of focus – for example, sexual health, tobacco control – but they should be geared around a different set of outcomes, and/or applying different methods/approaches. This is to ensure that you are able to demonstrate the full range of knowledge and skills.

Each commentary that you write will be based on a 'piece of work' that you have been involved with.

Poor portfolio planning in your choices of work examples will result in you being able to demonstrate some standards and indicators several times over and then struggling to demonstrate others at all.

If you go back to the four AREAS, you will need to make sure that between your chosen 'pieces of work' you are presenting activity that can demonstrate:

- a solid grounding in/and application of the **core knowledge base** for public health
- work that you have planned or implemented **collaboratively** with others (AREA 3)
- that you are working in a professional manner (**ethically**) and in compliance with the **legislation** by which we are all bound; for example, FPH good public health practice/ codes of conduct
- that you are mindful/inclusive of the **'end user(s)',** and others with whom you work
- adherance to, and delivery of national/regional/local **strategies, polices, protocols** – knowing the differences between each of these
- you are a **reflective**, self-assessing individual constantly **striving for improvement** through evaluation, feedback, and continual development of yourself and others
- that you understand the **principles of partnership** working and the dynamics of working with people from other organisational cultures with differing priorities
- that you can relate to different groups from a range of backgrounds, **communicating** sometimes complex information **appropriately**, tailoring the use of different methods of communication to suit the audience

This may build on the self-asessment that you will have completed for your scheme application. This is not an exhaustive list. It therefore pays to look for variety/differences in your 'pieces of work'. Identify your 3 or 4 pieces of work in the boxes below:

1. _____

2. _____

3. _____

4. _____

Key points about selecting your evidence– time and place

You may find that you have a suitable 'piece of work' but when you start the commentary writing, you find that you cannot source the evidence. This sometimes adds to the dilemmas faced by practitioners around which pieces of work to use. Again, it's all in the planning.

The most important thing about the evidence is that it **places YOU** in it:

- Did you write it?
- Did you organise it?
- Did you evaluate it?
- Are you present in the minutes?
- Are you acknowledged as a co-author?
- Is your role clear?

If you are talking about evidence of effective interventions, NICE guidance does not constitute your evidence (unless you were on the working group that wrote it). You may have referred to it, in which case find the evidence that shows the application of the NICE guidance in the project planning/execution, not the guidance itself.

The evidence – project plan, minutes of meeting, JSNA chapter - will also need to be dated so that the evidence shows **WHEN** you did it. If you are finding it difficult to find evidence to prove your involvement in something, or authorship, a testimonial from a senior colleague/ line manager can be provided in support of the claim for the standard or indicator: ie, the testimonial has to be indicator specific (not a general comment about overall capability).

Practitioners should be mindful of:

showing a range of knowledge and skills across their chosen pieces of work

Assessors will be looking for:

at least three discrete pieces of work and the currency of that work

Mentors could be thinking about:

whether the practitioner has sufficient experience and can cite the evidence

What is the purpose of the commentary document?

The commentary **document** is the instrument through which the practitioner presents each piece of work. There are several components to this document (see worksheets section at the back for a possible template, p. 32) including a piece of reflective writing. Check the Framework and Guidance document (pages 12-14) for what needs to be included. There is no set way or standard template for this so go with a format you are comfortable working with and then be consistent throughout your portfolio. The project/work does not have to have been fully completed - it could be work in progress – as long as your commentary is describing how the work presented demonstrates the indicators being claimed within.

All 48 indicators and sub-indicators have to be claimed, the indicators do not need to be claimed in order, and they only have to be claimed once. The commentaries don't have to be all the same size – but if you happened to use three pieces of work (the minimum) and produced equal sized commentaries – you'd be claiming 16 indicators in each one. Practitioners usually submit commentaries of varying sizes. **The key is to find the best piece of evidence** to demonstrate each indicator. If in doubt, consult your scheme coordinator for local guidance.

The 'narrative' part of the commentary

This is where the practitioner 'talks' the assessor through a piece of work that they have carried out.

At this point, it may be worth thinking about what the commentary is NOT. It isn't:

- A display of creative writing talent
- A dispassionate account of someone else's work
- A review of the evidence base and all of the key documents that the practitioner works to
- An essay to be reviewed and perfected for the final submission of a near-perfect product
- A dossier of endless email trails covering all of the practitioners 'virtual' interactions with others
- A place to criticise others

The commentary should contain only that work that generates evidence against the chosen indicators. Any other information is surplus to requirement – so there may be parts of the work that you choose to leave out (unless it provides context). The commentary is where, indicator by indicator:

the practitioner explains to the assessor why the work and each piece of evidence demonstrates the requirements of each indicator

The commentary is where, by the careful selection of evidence, and a clear grasp of the requirements of each indicator:

the practitioner demonstrates knowledge, understanding and application

Commentary writing

When writing the 'narrative' part of the commentary document, **write in the first person**... 'I know about health inequalities because...' Imagine you are 'talking' to someone who doesn't know much about public health. Your assessor will do of course, but importantly they won't know about you, or your work prior to reading your commentary. You will probably never meet them. The assessor cannot infer or guess, or give you the benefit of the doubt – you need to be explicit about your knowledge and experience, even if it feels, to you, like you're stating the obvious.

Getting started on the 'narrative' part of the commentary

When you first get started you may experience tensions between writing an **'indicator led'** commentary and a **'story led'** commentary. Some practitioners start with **bullet points** – to expand on at a later date - while others talk about the need to prepare a **full description** of the piece of work, with a view to editing where necessary later to improve the focus on the indicators, or remove passages that don't support any of the indicators.

It might depend on the area of public health that you work in, the nature of your work, or your own personal writing/learning style. Those involved in the implementation of programmes/projects may find it makes sense to go through the process **chronologically**, and even **logically** (should this be different!), or through a commissioning cycle.

Some PH workers can be more responsive in their work; for example, health analysts, health protection workers, or 'routine'; for example, environmental health officers and may provide information or support to wider programmes being managed by others, or coordinating a response to a request/event. There will be a methodology to this work – but these practitioners are often concerned that it might make for a 'bitty' commentary.

Sometimes it is worth identifying the best examples you have against individual indicators and then worrying about the title of the commentary later, looking for something that can embrace a group of indicators; for example, 'my support of the Cancer agenda' or 'supporting the management of a Mumps outbreak'.

Whichever way you start, the final narrative has to be **coherent**, and provide **ongoing context** relating to the 'piece of work' being used. If it is too minimalist in an attempt to be systematic about addressing the indicators, the flow/connectivity throughout the narrative can be lost and this becomes difficult to assess.

The text shown here is a practitioner's first attempt at trying to draft a commentary – recognising links with certain indicators, while trying to identify what they might use as evidence. This is a typical 'stream of conciousness' that starts the commentary writing process.

With thanks to Tim Hole, Public Health Advisor, London Scheme

There are other projects that I lead on, such as Happy Smiles project (a primary school based oral health promotion programme), which engage with large volumes of individuals, they are not necessarily the people in greatest need, or in the position to benefit most from the intervention. For example, pupils outside the normal state school system are not engaged. The reasons why they might be outside the normal schooling system may well reflect the poor status of any underlying determinant of health. As a result of this in 2013 I used National Smile Month (NSM) to target children who were enrolled in schools that catered for pupils with learning difficulties. If successful, over time Happy Smiles reduce the burden of poor oral health across the population. A targeted programme like NSM 2013 will do little across the whole population, but, if successful, should reduce the burden of disease on those individuals who are likely to suffer most. Complicated cases in oral health can involve a lot of treatment and so by targeting these individuals benefit (less pain, less negative impact on self-image, less inconvenience) as well as the state which doesn't have to provide extensive subsidised, or free, treatment. ***[5a, understanding and application? Evidence? Can I reduce this?] [3c, 3d – will report suffice for evidence?].*** *By targeting individuals at greater risk from disease this programme promotes health equality. Also by specifically targeting individuals who are less able to engage in well-established large-scale programmes, this demonstrates an appreciation of diversity* ***[4?]***

Commentary writing

What the 'narrative' has to deliver

The narrative, or text that you write, is where you explain to the assessor why the evidence you are submitting, and the work example that you are giving, illustrates the indicator you are talking about at that particular time. It has to be that focused. If you understand the indicator well, have a good work example, and have the right piece of admissible evidence this can be quite concise. You are looking for **FOCUS over VOLUME.** The narrative is also where you showcase your **UNDERSTANDING**. A possible layout is shown below.

Narrative/describing what you did	Indicator	Evidence
KNOWLEDGE *I know about the determinants of health (5b) because I attended …….. (see Ev C1.4/C1.5). What I learned from this session was that …….* ***UNDERSTANDING*** *The knowledge gained helped me to understand that the impact of the determinants on health are ……. for example ……and how this relates to health inequalities……..for example……..* ***APPLICATION*** *I applied this knowledge and understanding to this piece of work when I …… (see EvC1.6 slide 6/EvC1.7 page 5)*	**5b** 5. Promote the value of health and wellbeing and the reduction of health inequalities, demonstrating: b) knowledge of the determinants of health and their affect on populations, communities, groups and individuals	Ev C1.4 Certificate of attendance Ev C1.5 Training programme Ev C1.6 My presentation to the steering group Ev C1.7 Steering group action plan
How will you be demonstrating 5a? ***KNOWLEDGE*** ***UNDERSTANDING*** ***APPLICATION*** *(K, U and A do not have to be explained in any particular order – it will depend on the flow of the narrative, and which indicators have been discussed before or following – keep the 'story' running)*		

Narrative links the activity to the evidence and the indicator

Commentary writing

Things to remember:

- Address knowledge, understanding and application for **every** indicator **(K, U, A)**
- You don't have to write about aspects of the work that won't help to demonstrate an indicator – think 'if you can't demonstrate an indicator with it, why is it there?'
- Understanding can be demonstrated in the narrative – **the narrative is where you explain to the assessor how the relevant pieces of evidence demonstrate each aspect of the indicator**
- It will help to present each indicator in a separate box in a table (especially when you come to amend the commentary following a clarification and everything goes out of alignment!). See the 'fruit machine' apples above – **'narrative - indicator – evidence'** – aligned (again, it doesn't have to be in that order).

In the example below, the practitioner has moved on from the initial scoping stage on page 13 to setting up the commentary template and settling on the key pieces of evidence. Below you can see that in this draft the practitioner has emboldened the text that picks up the phrasing in the indicator, and used red text to highlight the evidence that will be used (prior to coding once all of the evidence has been identified). The practitioner has led the assessor into a discussion related to the indicator using a *'for example'* to illustrate their understanding.

With thanks to Nicola Blake, Health Improvement Specialist, KSS Scheme

Std	Narrative	Evidence
9e 9. Work collaboratively to plan and / or deliver programmes to improve health and wellbeing outcomes for populations / communities / groups / families / individuals, demonstrating: e) awareness of the effect the media has on public perception	*One of the survey findings had been that 40% of respondents had strongly disagreed with the statement "most child accidents are preventable". As I was aware of t**he effect the media can have on public perception,** I was not particularly surprised. From the secondary research I conducted as part of the evidence review I previously undertook (evidence = additional evidence section of accident prevention Project Initiation Document - PID) I gained knowledge of the ways in which the media has been found to affect public opinion on childhood injuries.* *For example, it is argued that numerically rare accidents tend to be those that are most heavily reported in the media (eg: flat screen TV falling onto child); this possibly therefore draws attention away from more common, but less newsworthy types of accidents (such as falls in the home) which cause a significant number of hospital admissions and A&E attendances each year (Making the Link 2010). Secondly, the media has been found to often frame childhood injuries as 'freak accidents'; potentially shaping the public's view of accidental injuries as non-preventable. Furthermore, media stories of unintentional injuries often do not contain injury prevention messages, which could further lead to a lack of concern of true conceptualisation of the problem (Smith et al. 2012)*	PID? Tbc

Read through this passage and ask yourself – *'has the practitioner addressed KNOWLEDGE, UNDERSTANDING and APPLICATION?'. 'Have they satisfied all aspects of the standard/indicator?'*

☐ Yes	☐ No

Commentary writing

In this draft the practitioner did go further to explain how they then adapted materials and information used with local early years staff to amplify national child safely campaigns, increasing awareness of the most common unintentional injuries that occur and countering what is portrayed in the media.

How have you become aware of the effect the media has on PUBLIC PERCEPTION?

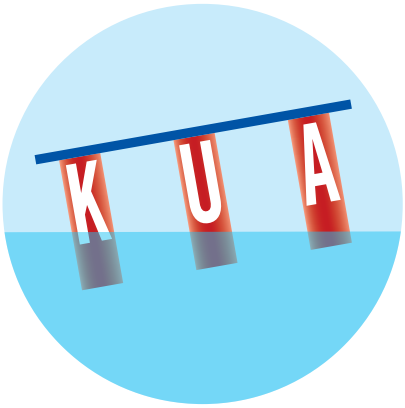
Getting the balance right with the indicators

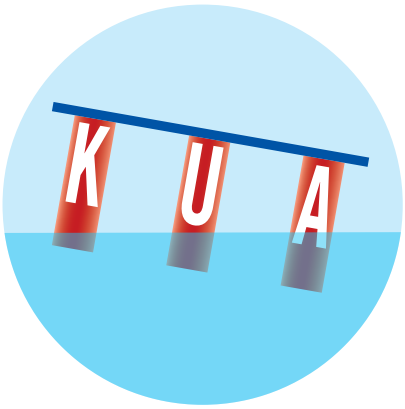
Imagine K, U and A as a floating cork triangle. Each corner represents Knowledge, Understanding and Application.

K=KNOWLEDGE
I know about.....

U=UNDERSTANDING
The knowledge gained helped me to understand.....

A=APPLICATION
I applied this knowledge and understanding to my practice when.....





There is some variation in the 'weighting' of some of the indicators. Some ask you to demonstrate 'knowledge of the……'You will notice that quite a lot of these are in AREA 2, technical competencies in public health (though not exclusively). That is because there is a significant theory base that underpins public health practice. These indicators will require evidence of the level of knowledge you would expect of a competent autonomous practitioner, at graduate level. You would still have to demonstrate understanding and application, but the LEVEL of knowledge here is really important. Hence the 'K' corner of the cork would be laying lower in the water in terms of weight of evidence, with accompanying demonstration of understanding.

Some indicators are more application weighted, demonstrating how you 'Act in ways that...' Other indicators may refer to how you personally impact on others. The knowledge base may be demonstrated through corporate mandatory training; for example, e-learning to keep you abreast of equality and diversity legislation and corporate policy/protocol. Clearly, there are principles at play here that you will need to acknowledge in your understanding, but the emphasis is on the evidence demonstrating the application. Hence the 'A' corner lies lower in the water. Again, think about the purpose of registration, and the risks posed to the public by practitioners being ill-informed or ill-prepared for their role when providing evidence in relation to your competence.

Strategies to work out what the indicators require

If you are struggling to work out what an indicator means, or what is required of you, ask yourself the following questions:

Why is it in the standards in the first place? Going back to page 3, what risks to the public might be at stake here? Turn the indicator on its head – what would happen if you didn't act in the way described in the indicator? Or didn't have the relevant knowledge and understanding?

What Area (context) is it in? Are we looking at professional behaviour and corporate policy and protocol? Are you being asked to demonstrate the core knowledge, theory base, and technical competence for public health practice? Is this in the context of working collaboratively with others and jointly targeting your combined resources? Is this about how you apply your transferable skills to your public health practice – implementing, reflecting, influencing, communicating, prioritising, engaging with cultures from external agencies etc?

What are the key words? What are the important words in the indicator? Does it say 'and' or 'or' ('and' means 'and', and 'or' means 'or'); 'communicating risk' (what risk?), different approaches to preventing risks (what are the approaches?), is it referring to risks to health or risks to project delivery? 'different audiences' (what is meant by different – on different days or pitching the communication to meet different needs?), is it about methods of analysing both qualitative AND quantitative data?

What is the 'aspect/emphasis' of the indicator eg: 'knowledge' oriented or 'action' oriented? Eg: 'demonstrating knowledge of….'' acting in ways that …..' (bearing in mind you still have to demonstrate knowledge/understanding/application to some extent for every indicator).

What are the 'points to prove' ? Picking up on the previous points, it may help to break down the indicator into a series of questions; for example, indicator 8b:

AREA	STANDARD	INDICATORS
Technical competence in Public Health	8. Identify risks to health and wellbeing, providing advice on how to prevent, ameliorate or control them – demonstrating:	a) knowledge of the risks to health and wellbeing relevant to own area of work and of the varying scale of risk b) knowledge of the different approaches to preventing risks and how to communicate risks to different audiences.

NB: to ameliorate: to make (something bad or unsatisfactory) better: eg: 'the reform did much to ameliorate living standards'.

Points to prove:

1. What are the different approaches to preventing risks? How do I know this (what is the source of my knowledge?) bearing in mind this is Area 2 where you are expected to have a sound grasp of underpinning public health theory/knowledge
2. Which particular approach am I using in my work example/this piece of work?
3. How can I show that I have communicated 'risks' to different audiences?
4. How will I evidence the different audiences?
5. How did that communication contribute to the risks being prevented, ameliorated or controlled?

Writing Reflectively

Each commentary document should include a section at the end where you reflect on the piece of work. This is a good way to provide further assurance about your understanding. Some of the indicators also require you to be reflective; indicator 4a for personal reflection, and 10c for critical reflection, which are not the same thing, so you will need to check your understanding through reliable and identified sources. You may want to write a reflective piece to demonstrate other indicators – this is acceptable, and you could discuss this with your supervisor/mentor/group facilitator. Reflection is personal, and involves your take on an experience and how you feel about it. Two key things tend to happen through a reflective process:

- You will **LEARN** something (either about yourself, or something else or probably both)
- You will **CHANGE** something - ie: you will have an idea about how you might do something differently next time

The Faculty of Public Health have useful notes on reflective thinking (see p.25) which show how reflection is part of a learning cycle. The FPH notes are a good place to start to know more. http://tinyurl.com/kq4ppmo
Faculty of Public Health Tips on Writing Effective Reflective Notes, September 2012

Practitioners should be mindful of:

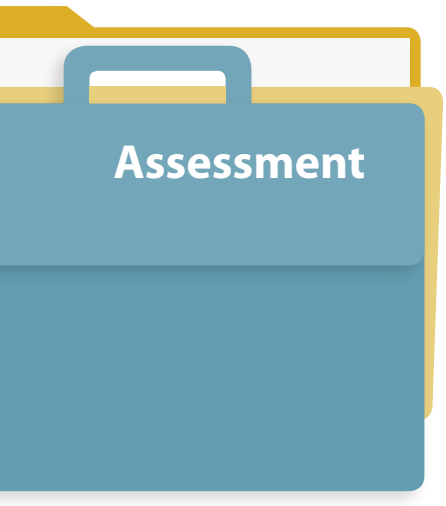
ensuring that they understand the indicator and what is required

Assessors will be looking for:

clear and appropriate demonstration of all aspects of each indicator

Mentors could be thinking about:

how they can support the practitioner in understanding the requirements of each indicator, and getting the balance right



As is the case throughout the portfolio building process, the definitive guidance is in the **UKPHR Framework and Guidance** document (Dec 2013). Read all sections – including the guidance for the assessors and verifiers.

The purpose of the assessment log

An important thing to understand from the beginning is that the assessment process is fully recorded, and the assessment log provides a full **AUDIT TRAIL** of this process. The practitioner, if submitting a paper portfolio, must complete the assessment log, list the evidence against each indicator, and date their submissions. The assessor will record their assessment outcomes and date each entry. This will happen every time the practitioner submits subsequent commentaries. The **SAME LOG** is used throughout the process – each version being an update of the previous, but recording all previous actions. Nothing is deleted from this document.

If you are using an e-portfolio the UKPHR assessment log will still be in full use, but depending on which e-portfolio system you are using, the assessment log will be automatically populated from the assessor comments, and the dates that you submit sections for assessment. The e-assessment log can be accessed any time through the e-portfolio. If unsure, check with your scheme coordinator.

The assessment log is a key document for the **VERIFIER**, whose role is to oversee the assessment process once completed, looking in detail into the portfolio and evidence where there appear to be irregularities in the assessment process, with a particular focus on clarifications, resubmissions or partial acceptances, or where the verifier seeks assurances regarding the process and/or outcome.

Completing the assessment log

If you are using a paper-based portfolio you will need to insert all of the evidence you are submitting against each indicator (see below), so that the assessor and verifier can see at a glance what evidence is for which indicator.

Practitioner standards	Applicant evidence	Assessment outcome	Assessor's comments	Verifier check
10. Support the implementation of policies and strategies to improve health and wellbeing outcomes, demonstrating:				
a) knowledge of the main public health policies and strategies relevant to own area of work and the organisations that are responsible for them	Submission date C1: 04/06/2015 EvC1.6 Masterclass programme (2011) EvC1.7 Masterclass certificate (2011) EvC1.8 Project Initiation Document (2012)			

EvC1.6 Masterclass programme (2011)

Code:
Ev: evidence
C1: commentary 1

Code:
.6 – sixth piece of evidence submitted for C1

Title of the evidence

Date/yr:
Date of the evidence (so that currency is clear)

Understanding assessment outcomes

Actions against the assessment outcomes are summarised below. A resubmission (R) should generally follow a clarification (C), (see Framework and Guidance page 22). A partial acceptance (PA) is only used in exceptional circumstances (Pg23). As a general rule, practitioners are not expected to clarify or resubmit evidence more than twice for any one standard (see Framework and Guidance, p. 24).

ACCEPT	Indicator successfully demonstrated, no further action needed
CLARIFICATION	Shortfalls against the indicator can be addressed in the **same commentary**
PARTIAL ACCEPTANCE	Some aspects of the indicator have been accepted in the commentary being assessed BUT the shortfalls against the indicator need to be addressed in a **new commentary,** ie: a different 'piece of work'
RESUBMISSION	This occurs when the practitioner has been unable to satisfactorily demonstrate the indicator within the piece of work. The whole indicator will need to be addressed in a **new commentary,** ie: a different 'piece of work'

Understanding assessment timescales

The Framework and Guidance document provides guidelines on the timeframes for assessment (see table below). Your scheme may work to varying timescales – check with your scheme coordinator.

Framework and Guidance page	**Stage**	**Suggested** time frame
Page 20/21	Turn around time for assessing one commentary	Within 3 weeks
Page 23	Clarification evidence to be received by the assessor	Within 2 months
Page 23	Resubmit new evidence relating to a new piece of work for a resubmission	Within 6 months (your scheme may set its own limit)
Page 23	If first resubmission is inadequate – second resubmission required	Within a second 6 month period
Page 14/15	Completion of the whole assessment process	12-18 months (may vary between schemes)

How the assessor can and cannot help you

- The assessor is trained to give you feedback on every indicator whatever the outcome, ie: including why they have awarded an ACCEPT. The Verifier, in particular, needs to know this.
- They must tell you which aspects of the indicator need clarification – whether it is the **knowledge part, the understanding or the application,** or possibly two, or all three – or they may seek clarification on the practitioner's **role** in the work being described
- They must tell you which part/segment of the indicator needs clarifying eg: the first bit is fine but clarification needed on the second part
- They CANNOT tell you **how** to clarify; for example, suggest which piece of evidence to provide instead, suggest that you explain better in the commentary or tell you how another piece of evidence they've already seen would work here

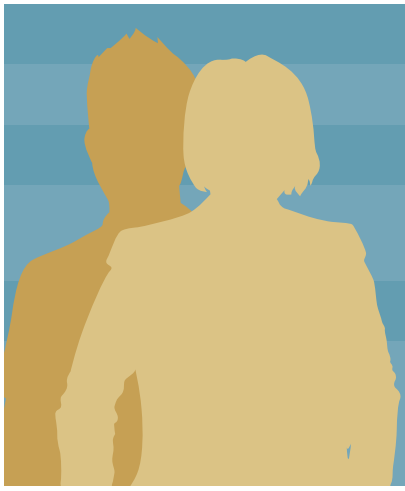
In summary – the assessor can tell you **WHAT** is wrong/missing but can't tell you **HOW** to fix it.

How to make things easier for your assessor

(and reduce the likelihood of clarification)

- Set out your **time plan** and inform your assessor of intended commentary submission dates and completion target date (see spreadsheet in appendices)
- **Communicate** regularly – especially if you have become diverted and your timeplan is slipping – assessors don't like months of silence but understand that 'life' can often stall progress. Everyone – practitioners and assessors alike – will be engaged in this process **in addition to** their regular jobs and personal commitments so a bit of give and take is expected. At the same time, if you or your assessor hold up the process for too long, the assessor is not free to take on another practitioner who may be ready for assessment.
- **Date** all of your evidence eg: Ev3.5 Steering Group minutes (**2012**) when listing it in the commentary document, and/or when listing it in your evidence folder on the e-portfolio
- You could use some of the **language from the indicator** in the narrative to keep your mind on track, and your writing indicator specific. However, some do this less effectively than others, and it should not be done in place of explaining your understanding of the indicator.
- Try to achieve **FOCUS OVER VOLUME** – try and make everything you say relevant to the indicator under discussion at any one time
- **Make the connections** between the evidence and the work in your commentary, and which indicator you are adddressing at any one time. Don't expect the assessor to work it out for themselves – they won't – so you risk clarification even if it is clear in the assessment log.
- **Signpost to specific parts of the evidence** in the narrative eg (see EvC2.13, page 4, paragraph 3), so that it is obvious which piece of evidence relates to which indicator. This is particularly important if you are demonstrating two indicators through the same piece of work, in the same paragraph in the narrative – perhaps using a different part of the same piece of evidence

- Keep to a **consistent coding system** for your evidence throughout the portfolio and make sure the portfolio is easy for others to navigate. **One piece of evidence** should only have **one code number** eg: EVC1.23, even if you use it several times against different indicators
- **Spell check** (little things can niggle and the portfolio should be a quality document)
- similarly set your Word programme to the English language to avoid US spellings (for example, center, color, program, organization)
- **Protect** the original integrity of email evidence; for example, print and scan/convert to pdf/rtf (do not copy and paste into a word document which can be altered)
- **Protect** the identity of personal and/or sensitive data in line with information governance protocol/data protection legislation, or delete/block out commercially sensitive data (see **UKPHR Framework and Guidance** document, p. 21)



Practitioners should be mindful of:

providing the assessor with everything they need to make a decision

Assessors will be looking for:

the ways in which the practitioner has made the assessor's job as straightforward as possible

Mentors could be thinking about:

how the practitioner plans to make sure their completed commentary will be checked prior to submission (for example, against a checklist, by another person)

Interpreting assessor comments and making changes

Even in some of the briefest comments from assessors, they will have given you a steer with regard to what is missing. Take some time to read the comments several times before launching into your response, because it may not be as 'bad' as you think, and you may not need to find new evidence, but provide a fuller explanation to support the evidence you have provided. Sometimes it is the explanation of your understanding in your commentary that provides the greatest assurance to the assesssor. Think about the things discussed in this document so far and what is missing – is it:

- the knowledge part, understanding or application;
- that not all of the indicator has been addressed;
- lack of clarity on the practitioner's role, or where they are apparent in the evidence;
- something administrative/organisational – evidence missing, commentary doesn't tally with the assessment log etc – or
- the indicator has not been understood or has been demonstrated in the wrong context

Assessment

What do you think the assessor means in the 'real' comments below, and how would you address the shortfall (you should be able to work out which indicators they refer to):

***Clarification**: Applicant has provided samples of published evidence showing recognition of relevant areas, but further evidence needed to show applicant's **appraisal** of this evidence and the **implications** for their area of work*

***Clarification**: Evidence X provides a discussion on costing and the use of resources, however it doesn't state how the programme has been **influenced** by this consideration*

You will need to decide how you are going to address the clarification. Will you be providing additional evidence; providing testimonial support to verify your part in the work; will you be extending the narrative to provide a fuller explanation; will you be organising your paperwork better; will you be providing better sign-posting to the assessor, etc.

If you provide additional evidence: give it a code that does not disrupt the existing coding system you have used eg: EvC1.23**b** for a new piece of evidence added. **DO NOT** change the coding on any of the evidence already submitted and **DO NOT** swap evidence, ie: taking evidence out and putting in different evidence but giving it the code from the previous evidence. If submitting a 'paper' based portfolio, don't forget to update the assessment log – adding information but not taking anything away (it is an audit trail).

If you extend your commentary: add any new text in a different colour or **font**. If you want to discount/remove any of the narrative put a strike-through through the text – DO NOT delete it. This is because the assessor (and the verifier) need to be able to see what information is new, ie: how you have responded to the assessment outcome. Make sure that your commentary document still clearly aligns the evidence – indicator – narrative (see 'fruit-machine,' p. 14) as the format may have been disrupted.

If you ask your line manager/senior colleague to provide a testimonial: make sure their contribution is relevant to the requirements of the indicator being demonstrated. You may have to explain to them what particular actions need to be testified.

Practitioners should be mindful of:

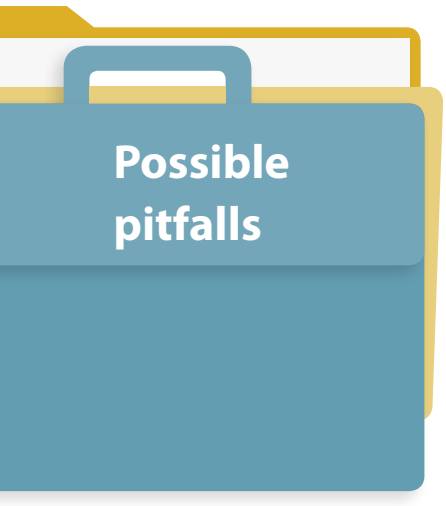
reading the assessor comment carefully and getting the right message

Assessors will be looking for:

the practitioner to interpret the assessor comment correctly, or if unclear the practitioner to contact the assessor (being proactive)

Mentors could be thinking about:

their own understanding of the assessment outcomes and how these are commonly communicated by assessors



Here are some examples of how practitioners might trip up:

- They are **not clear about their role** in the work they are describing – this is particularly a risk if they have been working closely with others, sharing responsibilities, or did not lead the work. It is also a risk if the practitioner is a little bashful and is reluctant to blow their own trumpet.
- They have been clear about their role, but the **evidence doesn't back this up** because the practitioner is not clearly placed in the evidence provided – so it is either the wrong piece of evidence, or the practitioner needs to substantiate their claims; for example, obtain a testimonial, **specific to the indicator**, from a senior colleague to verify their contribution.
- They have used a large piece of evidence against several indicators (eg: a service specification, literature review/assignment or dissertation, committee report, PID (Project Initiation Document), JSNA or PH Annual Report document), but have **not given the assessor clear reference** to the specific chapter/page/paragraph that is relevant to each indicator - and explained the relevance in the context of the indicator.
- They have **addressed only part of an indicator** eg: 6b – they have provided the evidence and narrative in relation to quantitative data but not addressed qualitative data.
- They have **forgotten to list all of the evidence** being submitted against an indicator either on the assessment log or forgotten to cross-reference it on the e-portfolio if they have one.
- They have **under-estimated the level of focus** required for each indicator, and tried to meet 2 or 3 indicators with the same paragraph of explanation, without making separate reference to each indicator, and separate reference to the evidence/parts of the evidence for each indicator. The assessor will not make these links for you and you will be light on showing your understanding.
- They have **misplaced the context** of the indicator. Don't forget which area each indicator is in and the context.
- Sometimes practitioners don't understand the requirements of the indicator because there are **gaps in their public health knowledge** and understanding. This may reveal the need for further study, or further work experience on the behalf of the practitioner.
- **Basic disorganisation;** for example, the same piece of evidence given a number of different codes (one piece of evidence, one code within a commentary); failure to link the evidence to the indicator in the narrative; misalignment of indicator-narrative-evidence in the commentary so it is not clear to the assessor which piece of evidence relates to which paragraph; evidence missing altogether; etc.
- They've been a **bit 'lazy'** in explaining their understanding of the knowledge base, and how it applies to the indicator under discussion, perhaps thinking that it is 'obvious' This can lead to a clarification on the understanding, particularly if the application could be stronger.

Further reading

These are either available on line, or you may have a public health library in your area. Alternatively, some of your colleagues may have relevant texts that you could borrow. Use the portfolio as an opportunity to revist and consolidate your knowledge base, and/or to extend it.

UKPHR Framework and Guidance document (Dec 2013)
http://www.ukphr.org/wp-content/uploads/2014/08/UKPHR-Framework-and-Guidance-for-Applicants-Assessors-Verifiers.pdf

FPH Tips on writing effective reflective notes
http://tinyurl.com/kq4ppmo

Working in Collaboration: learning from theory and practice (2007)
http://tinyurl.com/qfw3o42

Health Knowledge website – Partnerships (2007)
http://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2h-principles-health-promotion/partnerships

Shaping the Future Ethical Framework: RSPH (Royal Society of Public Health) (2006)
http://tinyurl.com/jubqwuv

Public Health: Ethical issues, Nuffield Council on Bioethics, (Nov 2007)
http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf

Best Practice Guide – team working – management standards centre
(brief outline to assist with further exploration of the theory base)
http://tinyurl.com/jny9qar

Good Public Health Practice (2nd edition, 2016)
Faculty of Public Health
http://tinyurl.com/h42wd78

UKPHR Code of Conduct for Registrants
UK Public Health Register
http://www.ukphr.org/registration/code-of-conduct/

Risk Communication and Public Health
Ed: Peter Bennett, Kenneth Calman, Sarah Curtis, Denise Fischbacher-Smith
(10 Dec 2009, 2nd edition) Oxford Press

Basic Epidemiology (2nd edition)
Bonita, R; Beaglehole, R; Kjellstrom, T.
World Health Organisation 2006

E-portfolio resources for practitioners and assessors, Kent Public Health Observatory
http://tinyurl.com/zgqp75z

WORKSHEETS

Understanding the AREAS

Characteristics of AREA 1

Characteristics of AREA 4

Characteristics of AREA 2

Characteristics of AREA 3

Linking indicators to pieces of work

Look at these work examples. Assuming that the required evidence will be readily available, think about which indicators each of the workers might be able to demonstrate through the piece of work being described. Work through the questions below, choosing one indicator to look at in detail.

Jamie is a health improvement practitioner with a remit for mental health promotion. Jamie worked closely with a LGB&T group of service users to look at ongoing service improvement and data capture for the service. This required Jamie to identify venues for group meetings; contact the group by email; support minute taking; and empower the group so that it became self-directed and sustainable.

Dave is a public health information analyst. He has been leading on the JSNA Chapter on dementia. Working closely with his mental health colleagues and the local CCG, he has been collecting all of the necessary intelligence for the report, and attending meetings to discuss all elements of the chapter.

Sanjay is a health improvement practitioner with a remit for young people. Sanjay led the development of a website specifically designed for young people, signposting them the to relevant services to support sexual health; mental health; alcohol and smoking advice/services; and services that support physical activity and healthy eating. Aspects of the site included 'social networking'. The Council member for Children and Young Peoples' Services required assurances around the safety and appropriateness of aspects of the site. Sanjay had to work closely with his manager to ensure the correct protocols were followed.

Caroline is a public health assistant commissioner. She is involved in the commissioning and delivery of services using the government's annually funded strategy to reduce winter deaths in older people. This requires her to ensure she has early notification of the financial envelope each year, and to engage with the right departments and agencies to ensure the timely delivery of interventions, ensuring the resources get to those in greatest need, in the most cost-effective way. Outcomes then have to be reported to Council members, and central government.

Lucy is a public health strategist with a remit for obesity prevention. Lucy supported her manager in the development of a multi-agency strategy for obesity prevention. This required the relevant research to make the case for funding and to identify criteria for prioritisation of interventions; the networking to secure buy-in from a range of agencies and the communication of the strategy to those who could contribute to the desired outcomes and to those who would act as advocates for the strategy.

Anastasia is a health protection nurse. She has been involved in the management of an outbreak of food poisoning in an old people's home. She received the call reporting the outbreak and was required to take action. This required her to involve her environmental health colleagues in the local authority. As well as ensuring cases received the right care and treatment, the outbreak needed to be controlled, identifying the cause and ensuring the right preventative actions were taken to avoid reoccurance.

1. Which practitioner standards/indicators might be demonstrated by this piece of work?
2. Choose one of the indicators that you have identified and complete the following:
   - What the PH worker did/what actions were they taking
     ……
   - Where they could have gained the knowledge relevant to this indicator and when
     ……
   - What their understanding of the indicator is, based on that knoweldge
     ……
   - How they applied that knowledge to the actions they took
     ……
   - What would make a good piece of evidence for this indicator?
     ……

Mapping your own 'pieces of work' against the standards

PIECES OF WORK

1	2
3	4

	Standard	Indicator	1	2	3	4
AREA 1 Professional and Ethical Practice	1. Recognise and address ethical dilemmas and issues, demonstrating:	a) knowledge of existing and emerging legal and ethical issues in own area of practice				
		b) the proactive addressing of issues in an appropriate way				
	2. Recognise and act within the limits of own competence seeking advice when needed					
	3. Act in ways that: (links with standard and ethical frameworks)	a) acknowledge and recognise people's expressed beliefs and preferences				
		b) promote the ability of others to make informed decisions				
		c) promote equality and value diversity				
		d) value people as individuals				
		e) acknowledge the importance of data confidentiality and disclosure, and the use of data sharing protocols				
		f) are consistent with legislation, policies, governance frameworks and systems.				
	4. Continually develop and improve own and others' practice in public health by:	a) reflecting on own behaviour and practice and identifying where improvements should be made				
		b) recognising the need for, and making use of, opportunities for personal and others' development				
		c) awareness of different approaches and preferences to learning				
		d) the application of evidence in improving own area of work				
		e) objectively and constructively contributing to reviewing the effectiveness of own area of work.				

Mapping your own 'pieces of work' against the standards

AREA 2 Technical competence in Public Health	Standard	Indicator	1	2	3	4
	5. Promote the value of health and wellbeing and the reduction of health inequalities, demonstrating:	a) how individual and population health and wellbeing differ and the possible tensions between promoting the health and wellbeing of individuals and the health and wellbeing of groups				
		b) knowledge of the determinants of health and their affect on populations, communities, groups and individuals				
		c) knowledge of the main terms and concepts used in promoting health and wellbeing				
		d) knowledge of the nature of health inequalities and how they might be monitored				
		e) awareness of how culture and experience may impact on perceptions and expectations of health and wellbeing				
	6. Obtain, verify, analyse and interpret data and/ or information to improve the health and wellbeing outcomes of a population / community / group, demonstrating:	a) knowledge of the importance of accurate and reliable data / information and the anomalies that might occur				
		b) knowledge of the main terms and concepts used in epidemiology and the routinely used methods for analysing quantitative and qualitative data				
		c) ability to make valid interpretations of the data and/or information and communicate these clearly to a variety of audiences				
	7. Assess the evidence of effective interventions and services to improve health and wellbeing, demonstrating:	a) knowledge of the different types, sources and levels of evidence in own area of practice and how to access and use them				
		b) the appraisal of published evidence and the identification of implications for own area of work				
	8. Identify risks to health and wellbeing, providing advice on how to prevent, ameliorate or control them, demonstrating:	a) knowledge of the risks to health and wellbeing relevant to own area of work and of the varying scale of risk				
		b) knowledge of the different approaches to preventing risks and how to communicate risk to different audiences.				

Mapping your own 'pieces of work' against the standards

AREA 3 Application of technical competence to public health work	Standard	Indicator	1	2	3	4
	9. Work collaboratively to plan and / or deliver programmes to improve health and wellbeing outcomes for populations / communities / groups / families / individuals, demonstrating:	a) how the programme has been influenced by: I. the health and wellbeing of a population II. the determinants of health and wellbeing III. inequalities in health and wellbeing IV. the availability of resources V. the use of an ethical framework in decision making/ priority setting				
		b) how evidence has been applied in the programme and influenced own work				
		c) the priorities within, and the target population for, the programme				
		d) how the public / populations / communities / groups / families / individuals have been supported to make informed decisions about improving their health and wellbeing				
		e) awareness of the effect the media has on public perception				
		f) how the health concerns and interests of individuals groups and communities have been communicated				
		g) how quality and risk management principles and policies are applied.				
		h) how the prevention, amelioration or control of risks has been communicated				

Mapping your own 'pieces of work' against the standards

AREA 4 Underpinning skills and knowledge	Standard	Indicator	1	2	3	4
	10. Support the implementation of policies and strategies to improve health and wellbeing outcomes , demonstrating:	a) knowledge of the main public health policies and strategies relevant to own area of work and the organisations that are responsible for them				
		b) how different policies, strategies or priorities affect own specific work and how to influence their development or implementation in own area of work				
		c) critical reflection and constructive suggestions for how policies, strategies or priorities could be improved in terms of improving health and wellbeing and reducing health inequalities in own area of work				
		d) the ability to prioritise and manage projects and/or services in own area of work				
	11. Work collaboratively with people from teams and agencies other than one's own to improve health and wellbeing outcomes , demonstrating:	a) awareness of personal impact on others				
		b) constructive relationships with a range of people who contribute to population health and wellbeing				
		c) awareness of: I. principles of effective partnership working II. the ways in which organisations, teams and individuals work together to improve health and wellbeing outcomes III. the different forms that teams might take				
	12. Communicate effectively with a range of different people using different methods					

A possible commentary template

Section	Content	Claim?
Title of piece of work	Make sure the title sums up the essence of the work and the focus *eg: your work remit may be around substance misuse, but for the purposes of the commentary you may be talking about a specific programme or intervention targeting injecting drug users, so capture that in the title.*	✗
Time frame of the work	Eg: April 2011 – December 2012. *Remember that half of your portfolio's evidence has to be drawn from the last 3 years.*	✗
List of indicators demonstrated	This could be at the start or the end of your commentary documentation.	✗
Context (this section can be succinct)	Remember that your assessor might not know who you are, or possibly even where you are. Let the assessor know your job title and employing organisation *eg: I am a health protection officer based in the local (Sussex) Public Health England office.* Briefly contextualise the work that you do in relation to national public health outcomes/ priorities *eg: my work contributes to the government target to achieve 95% MMR uptake by 30th Sept 2013 as part of the 'catch-up' campaign. Then you can clarify the local mechanisms for this, eg: working closely with local traveller communities as part of the work to deliver on local priorities xx and xx around tackling health inequalities.* If you are going to refer to national/salient strategies and policies here, and make links to related pieces of evidence, ensure that you provide discussion around how these have been applied to your practice, to satisfy the requirements for the relevant indicators (10a/b). These can be covered in the main body of the commentary if you prefer.	JD CV Submitted with portfolio ✓
Own role	Here you can provide clarity on the level you might be working at, eg: leading or supporting programme development/delivery; in a commissioning or a provider capacity; who your immediate working partners are internally and externally; who you report to, and the outcomes expected of you *eg: my personal objectives as cited in my appraisal at the time, for this piece of work were/are*…… so that the assessor can see what you set out to achieve.	JD CV Submitted with portfolio
Acquisition of knowledge*	**Evidence for all indicators needs to include relevant knowledge, understanding of that knowledge and how you have applied it.** Therefore, this doesn't have to be a separate section, but some practitioners find it easier to talk about courses, training and CPD all at once (bearing in mind that it may mean some standards or indicators are only demonstrated in part). *Note: Knowledge gained beyond 3 years ago will still count if backed up by more recent CPD or refresher courses.*	✓
The narrative: what I did in this piece of work	This is where your narrative or 'story' really starts – where you can explain the sequence of your actions in relation to the design and/or delivery of the service/programme/ intervention. Your commentary must show your knowledge*, understanding, and link your actions to the indicators and to the specific parts of the evidence you are presenting. This will be the largest single section of the commentary.	✓
Reflecting on outcomes	This is where you can reflect on the work, and your own personal contributions, in relation to the desired programme outcomes and your personal objectives (whether the programme is still in progress or has been fully implemented). Some of the standards/ indicators might relate to this section.	✗
Identifying sources	The most important things when making reference to books, articles, guidance documents in the portfolio is that you are clear about the **source and application.** The assessor will want to know where you gained your **knowledge*** or guidance from – authors, publication, date, chapter, page, paragraph and also how that knowledge informed your actions – reflecting on what you've learned, showing your **understanding** and **application** of the information. *(The preferred referencing format for UKPHR is Harvard, but it is optional – there is no penalty for not using a formal referencing system).*	✗

Focusing in on an indicator

AREA 1	Standard	Indicator
Professional and ethical practice	1. Recognise and address ethical dilemmas and issues, demonstrating:	a) knowledge of existing and emerging legal and ethical issues in own area of practice b) the proactive addressing of issues in an appropriate way

What is your own area of work in the context of this commentary/portfolio? Eg: sexual health

What do you think is meant in 1a by:

Legal issues?

Ethical issues?

Can you think of any examples from other areas of work in public health where there may be ethical tensions/dilemmas? What **existing** and **emerging** issues might there be?

What do you think is meant by the '**pro-active addressing'** of issues in 1b?

What are the ethical and legal dilemmas that you face in your area of work, how do you know this, and what do you do to make sure these issues are addressed?

What are the sources of your knowledge with regard to public health ethics and legislation?

Mock Assessment for Standard 5a

Look at the submission below and try and look at it through the assessors eyes. How would you assess this entry for this indicator?

Title: **Implementing the National Child Measurement Programme in Someplace County**

Dates: **January – April 2013**

My role:

As a 'Healthy Schools' specialist, my role was to coordinate the delivery of the National Child Measurement Programme from within our social enterprise organisation 'Someplace Community Health', working with the SCH school nurse team and school PHSE coordinators, ensuring that we delivered to all of the key performance indicators set by the commissioning authority, Someplace County Council.

Indicator to be demonstrated:

5 – Promote the value of health and wellbeing and the reduction of health inequalities – demonstrating:

a) how individual and population health and wellbeing differ and the possible tensions between promoting the health and wellbeing of individuals and the health and wellbeing of groups

Indicator 5a

Narrative

When discussing data with schools I often have to discuss the difference between individual health issues and those of the wider community and how these can cause a tension. For example, one of the main issues that comes up is that of observed underweight children.
In these cases I explain how the data informs the services provided, and how, although a worry, pupils who are underweight are luckily a small minority of our population. This means that the data shows there is a need for services for those who are overweight but there is little provision for those children and young people who are underweight.
I discussed with the school that their data for obesity shows local rates in Year 6 as 24% (Someplace average is 18.5%), but there is no data for the number of pupils underweight as numbers are so low that they are suppressed to protect confidentiality, and because they show no significant concern at a community level.
The tension between the school's perceived needs of the pupils and the assessed needs of the community may be solved by focusing work within the school around being a 'healthy' weight rather than avoiding obesity or reducing weight.

Evidence

Ev XY

School Visit Audit Form (2013)

How would you assess this submission for 5a?

Check pages 14 – 17 of the Framework and Guidance for 'working with your assessor'.
Check pages 19 – 24 of the Framework and Guidance for the guidance for assessors.

Questions:

Is it an appropriate example/piece of work for the indicator?
Does it provide everything that is required for the indicator to be fully demonstrated?
Will the evidence be at the right level?

Further Reading:

Foundations for Health Promotion (Naidoo and Wills) published by Elsevier (3rd edition, 2009)
Search : 'prevention paradox'

Is my commentary ready for assessment? CHECKLIST

CHECKLIST for applicants before submitting Commentary 1	Tick
1 Have you ensured how all 48 indicators will be demonstrated across all of your commentaries/your portfolio? (ie: completed your mapping before submitting anything)	
2 Have you checked over Commentary 1 to ensure that all of the indicators have at least 1 piece of evidence against them?	
3 Have you checked that all evidence has been cross-referenced against the assessment log or on the e-portfolio system (if you have one) to the indicators it is being used to demonstrate?	
4 Have you checked on the assessment log or the e-portfolio system that the commentary has been cross-referenced against each indicator being demonstrated by that commentary?	
5 Does your commentary explain to the assessor why/how the evidence chosen, and which part of the evidence in particular, demonstrates the indicator – or which part of the evidence demonstrates which part of the indicator?	
6 Does your commentary 'talk' about knowledge, understanding and application in relation to every indicator being demonstrated?	
7 Is it going to be clear to the assessor which indicator you are talking about at any given time in the commentary, and which pieces of evidence you are referring to?	
8 Have you dated the evidence listed in your commentary so that it is clear to the assessor and verifier that 50% of it is within 3 years of registration?	
9 Have you included a reflective piece at the end of C1/each commentary?	
10 Have you included your CV, and current JD in your paper portfolio, or uploaded them onto the e-portfolio system in the supporting documents section?	

UKPHR
Public Health Register
Protecting the public – improving practice

UKPHR Twelve Essentials Of Practitioner Registration (Provided By The UKPHR)

Knowledge, understanding and application: For every single indicator, regardless of its wording, there must be evidence of learning, understanding of that learning (in the commentary) and an example of how the learning has been applied in practice

Evidence of knowledge: The glossary in the UKPHR's Supporting Information document may help to indicate the coverage of public health knowledge required, which should be at the equivalent of first degree level

Level of practice: The "shows" evidence should demonstrate that the practitioner works independently and makes their own judgements in a managed context. But the evidence need not be complex and the practitioner need not lead service delivery

Commentaries: The commentary should make clear what evidence (knowledge, understanding and application of knowledge) relates to each indicator of effective practice for each standard, describe the applicant's own role, and include a reflective learning piece. Observation proformas must be accompanied by a commentary

Three or more commentaries and applicant completion of assessment log: The completed portfolio must include at least 3 discrete pieces of work, each described by a commentary. Applicants should list and reference evidence in the assessment log column "applicant evidence"

Standards 5-8: These are the technical competencies in public health and must be evidenced across two commentaries. At least 3 of the 12 indicators of effective practice in these standards should be from a second commentary and evidence

Currency of evidence: At least half numerically of the items of evidence submitted, i.e. the items linked to each commentary, should be from within 3 years of the date of application for registration to the UKPHR

Currency of knowledge evidence: Evidence of knowledge from learning undertaken more than 3 years before registration will be deemed to be current if there is associated evidence of keeping up-to-date through Continuing Professional Development (CPD)

Clarification: This means that the assessor believes that the practitioner does have the evidence to meet the indicator, but requires more detail; for example, on course content or the role of the practitioner

Resubmission: This means that the assessor considers the evidence is inadequate to meet the indicator and new evidence is required from a different piece of work

Verification: The verifier box on the assessment log should be initialled for all indicators, to verify that evidence has been assessed for each indicator and that the assessor has given clear reasons in the comments box for every indicator why the evidence is acceptable or not

Registration process: After the Verification Panel has recommended a portfolio for registration, applicants have 3 months in which to apply to the UKPHR

Glossary of terms used in the standards

The terms and descriptions are illustrative only.

Term	Description
Health and wellbeing	A state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity.
Health inequalities	Variation between groups in physical and mental health, health risks and health-related behaviour. Groups may be based on socio-economic conditions, ethnicity, gender or sexual orientation or geography.
Determinants of health	Personal, social, economic and environmental factors – including health behaviour and lifestyle, income, education, employment, access to health services, housing and the natural environment – which determine the health status of a person or community.
Promoting health and wellbeing - main terms and concepts:	
Behaviour change	Using a range of theoretically-based tools and techniques to help people to make healthier lifestyle and personal health choices.
Community engagement	Utilising the assets of communities; helping communities to have control over their health, through working in partnership with them or delegating power to them, in order to improve health outcomes.
Empowerment	Promoting the participation of individuals, organisations and communities in processes that enable them to have more control over their health.
Health promotion/ improvement	Helping people and communities to gain control over the influences on their health, making the healthier choices the easier choices.
Hierarchy of prevention	Primary, secondary and tertiary prevention
Social capital	Investment in the social fabric of society; effective community networks, relationships and structures which help to promote health.
Social marketing	The systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals for a social good.
Basic sources of public health data	Includes data from ONS and the census, Hospital episode statistics, locally collected survey data.
Data analysis and interpretation	Systematic approach to data allowing reliable inferences to be made.

Glossary of terms used in the standards

The terms and descriptions are illustrative only.

Term	Description
Basic statistical terms	for example median, mean, mode, range, variance, graphical presentation, simple tests of differences between groups or populations.
Data anomalies	where data does not fit the known picture – how to detect, describe and rectify.
Routine data analysis	calculation of population rates (viz: mortality/ morbidity rates), confidence intervals.
Quantitative data analysis	the process of presenting and interpreting numerical data, using basic statistics.
Qualitative data analysis	the process of analysing data collected in a non-numeric form, such as documentary, visual, observational or interactive (focus groups, interviews) information.
Data presentation	using tabular and graphical presentation, understanding of the use of mapped data and basic geographical information systems (GIS).
Epidemiology	use of routine vital and health statistics to describe and study the distribution of disease and determinants of health in time and place and by person or group and the application of this study to control health problems.
Epidemiology - main terms and concepts:	
Incidence	the number of new cases of a disease or condition in the population at risk in a specified period of time (e.g. a year).
Prevalence	the proportion of the population at risk who are cases of a disease or condition.
Health status	Numerator, denominator, population at risk. Concepts of measures of risk (odds ratio). Calculation of mortality/ morbidity rates.
Sources of evidence	Research evidence, evidence of effectiveness, outcome measures, evaluation and audit.
Evaluation	A process that attempts to determine systematically and objectively the relevance, effectiveness and impact of activities in the light of their objectives.
Risks to health, wellbeing Involves:	Including threats from communicable disease and and safety. environmental determinants.
Assessment of risk	identification of risk and evaluation of impact of adverse events to a given group or population.
Management of risk	evaluation of risk management options, implementation, monitoring and review.
Communicating risk	informing other professionals, or the public, about actual or potential risk, openly and appropriately.

WORKPLAN for building my portfolio

Activity	Mth1	Mth2	Mth3	Mth4	Mth5	Mth6	Mth7	Mth8	Mth9	Mth10	Mth11	Mth12
Insert month for your own use												
Attend introductory day												
Identify which pieces of work I will be using (these will be my commentaries)												
Map these pieces of work against all 48 indicators so that I know which indicators I will be demonstrating in which commentary												
Attend portfolio development group (PDG) and start to build Commentary 1 (C1)												
Select and store evidence for C1 while writing a paragraph or so against each indicator I am demonstrating												
Attend PDG workshop for trouble-shooting and checking I'm on track with technique and interpretation of the indicators												
Apply for an assessor for C1 submitting evidence with the application (once submitted this cannot be changed) eg: via e-portfolio												
Receive clarifications (if any!) from the assessor and start working on amendments												
Attend PDG for assistance in interpreting assessors comments and to support further portfolio development												
Work on C2/C3 in the light of assessors comment from C1												
Submit further commentaries to the assessor												
Await further assessment outcomes												
Sign-off by assessor and assessor sumbits to verifier												
Forwarding of portfolio to verification panel												
Submission of portfolio to UKPHR registration panel												

Planning pieces of work for your portfolio. Each piece of work is presented as a COMMENTARY:

Pieces of work (short description or title):

What you did/what you will 'talk' about:	Indicators you will claim:	What evidence you will use: