Lessons Learnt from the Public Health Practitioner Training Scheme (Year 3)

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Towards a healthier future...
1.0 Executive Summary

The development of a robust national public health service and health and well being boards as part of the White Paper ‘Liberating the NHS’ (DH, 2010) proposals should be supported by the development of training and development opportunities for the workforce. This is to ensure the successful and high quality delivery of the public health service in a challenging financial climate. In the UK, the training and development for bands 4 to 7 for individuals with key roles and responsibilities in public health has been nonexistent. This is in spite of the carefully developed public health skills and careers competence framework that encompasses the skills and competences required for public health progression at each level of the workforce (Skills for Health, 2008).

In 2007, the Head of Public Health Development from the Workforce and Education division at South Central SHA (former NHS Education South Central) developed the public health practitioner training scheme with the aim to develop public health individuals from a variety of backgrounds and organisations at bands 5 to 7 (and local authority equivalent). This scheme is the only one of its kind in the whole of the UK. The scheme includes the following components; Masters level qualification (two year Diploma and final year Dissertation), Learning Sets devised around the Public Health Skills and Careers Framework (2008), UK Public Health Register standards for practitioner registration, placements, portfolio of evidence and public health mentoring.

This report provides evidence for the success of the public health practitioner training scheme in developing individuals from governmental, NHS commissioning, provider organisations and local authorities to an appropriate standard of skills and understanding of public health. In particular, it provides evidence for the need to assess portfolios if the scheme is to help progress and develop competent practitioners into public health specialists and defined specialists.

Key Evidence:

1. Trainees and their line managers and mentors were able to describe how the scheme changed the trainees’ practice and had provided them with a clearer understanding of the wider implications of their work to the field of public health.

2. Trainees gained public health skills as suggested by their initial learning needs assessment against the achieved ‘knows how’ and ‘shows how’ competences. The academic Masters provides the ‘knows how’ competences and the placements provide the ‘shows how’ competences. Both are seen to complement each other.

3. The success of the scheme lies in adopting the Skills for Health public health skills and careers framework (2008) as the driver for development. Since the Skills for Health competences drive the development of trainees, trainees should be assessed to ensure that these are being achieved to a known standard. The assessment of competences and portfolio of evidence against standards based on the competences provides the recognition of skills that practitioners require. Recommendations from previous evaluation reports on the public
health practitioner training scheme included regulation/assessment of competences for the practitioner workforce.

4. The impact of the scheme in the workplace has been very varied. This depended on whether the organisation has undergone any changes and on whether the trainees feel vulnerable on the scheme during such changes.

5. Placements are geared to fill in ‘shows how’ gaps in competences that are not catered for at work. The placements allow trainees to perform strategic pieces of work outside their comfort zones that they would not have been able to undertake in their workplace.

6. All trainees understood the career progression pathway in public health during the training.

Lessons Learnt:

1. A training scheme set to develop public health practitioners must follow homogeneous competences that will allow all public health practitioners to transfer their skills from one organisation to another.

2. Such a scheme must also provide an adequate progression route into specialist training.

3. Making homogeneous competences the driver for practitioner development supports the need for the assessment of gained standards and competences in a quality assured manner. The assessment must be undertaken by qualified assessors.

4. The learning sets must provide a focus on submitting evidence for examination against the standards. The learning sets should be designed to help practitioners understand their options and requirements for submission. Practitioners must understand how the competences apply and can be translated into standards for assessment.

5. Placements must be scheduled as soon as possible if they are to complement the ‘shows how’ competences without affecting the theoretical knowledge or the workplace. There is a need to procure a network of placement choices and this may be difficult to do in the current climate of organisational changes.

6. There is a need to support trainees that feel at risk as a result of the current changes in public health. This will ensure retention of the workforce.

7. There is a need to raise awareness of the public health workforce and issues related to its training and development so that public health professionals are able to support each other’s development.
2.0 Background

The recent White Paper ‘Liberating the NHS’ (2010) announces the creation of a new public health service with a strong emphasis on community health. Past efforts to increase the capability and capacity of the public health workforce have provided training and development opportunities for the higher levels of the workforce (bands 7 and above) and the lower ends of the workforce (band 3) (and local authority equivalents). There is therefore a lack of public health development and training opportunities for the middle range bands.

The public health practitioner training scheme was developed in 2007 by South Central SHA to provide training for bands 5, 6 and 7 (and local authority equivalent banding). The scheme follows a number of recommendations set out in the literature for training and development of the public health practitioner workforce. The Cumbria and Lancashire SHA identified a number of needs regarding the development of their public health practitioner workforce (Cumbria and Lancashire SHA, 2005). These included;

- PCT unable to see the relevance of public health
- Complex Local Authority and PCT arrangements
- Short term funding of educational projects for the development of the workforce
- Local Authorities were not engaged at a regional level in developing the local agenda also Local Authorities were not recognised as a major employer in Choosing Health (2005)
- Lack of certain public health skills in Local Authorities
- Lack of a public health practitioner workforce with the adequate skills and knowledge
- Professional isolation of public health practitioners

The workforce development needs assessment carried out by this SHA revealed a number of factors that are not exclusive to this region. It was therefore important to ensure that public health workforce planning encompassed both local authorities and NHS in a homogeneous approach to procure appropriate practitioner workforce development and training.

In their report, Skills for Health (2004) identified significant knowledge and gaps in public health practitioners related in particular to;

- health needs assessment
- partnership working,
- programme management
- evidence based public health practice
- community development
The education and training programmes for the workforce should therefore incorporate the above elements for the development of competences in public health. There was also a growing need to evaluate the efficiency of educational programmes for:

- Developing the public health practitioner workforce
- Providing adequate training for the workforce

There have been a limited number of training programmes offered by University providers aimed to develop the theoretical public health knowledge of the practitioner workforce. The North West London public health practitioner training programme is an example of one such programme (Brockleshurst et al., 2005). Some programmes tended to lack a more ‘hands on’ practical component that would allow the learning to be embedded in practice. The need for evidence-base development strategies for educating and training public health practitioners has been identified in a number of studies and reports (SC SHA, Education, Training and Development Strategy, 2007-2012; Latter et al., 2003; Conceicao et al., 2009).

In their review of the literature, Latter et al (2003) identified the importance of placements for the exposure of public health trainees and students to public health practice. It was deemed important to learn about the engagement of practitioners in public health work under supervision. The authors expressed the availability of the theoretical knowledge through Continuing Professional Development (CPD) and Higher Education courses that seemed unlikely to be consolidated, applied or developed in practice. For example, the preferred method for addressing the lack of knowledge identified by trainee public health nurses was flexible, practice-based, problem solving and work based strategies. It was therefore suggested that SHAs, PCTs, deaneries and other organisations should provide a supportive network of mentors and adequate placements that would enhance the practical experience of trainees also with a view of preparing mentors for the task (Latter et al., 2003). This practical approach to training would enhance the multidisciplinary facet of public health work as well as maximise exposure to public health. It would therefore seem that the best method for training public health practitioners is through a scheme that provides a mixture of methods; academic, placements and workplace learning.

Qualified practitioners have therefore been able to access ad hoc development opportunities such as MSc and Master in Public Health (MPH) courses delivered by Higher Education providers that lack the practical component that is important for the consolidation of knowledge (Latter et al., 2003).

The public health practitioner skills and careers framework (Skills for Health, 2008) carefully designed a framework of public health competences for the development of this level of the workforce. This framework allows the transference of practitioner skills from one workplace and organisation to another. The framework separates practitioner competences into knowledge (‘knows how’) and experience (‘shows how’). It also includes competences such as Leadership and Management that
need to be demonstrated through evidence. A regulatory framework for practitioners would therefore provide an infrastructure for the assessment of evidence against each competence on the Skills for Health framework.

A framework for the regulation of practitioners or some form of practitioner assessment of competences (Public Health Skills and Careers Framework) would offer recognition of and value the work of the workforce, its development, assurance for the delivery of competent public health programmes, facilitate mobility and help in the provision of clearer educational initiatives.

The public health practitioner training scheme by South Central SHA orchestrates all of the training approaches identified in the literature for the efficient and effective development and training of the practitioner workforce.

2.1 The Public Health Practitioner Training Scheme

The Public Health Practitioner Training Scheme was developed within the South Central Strategic Health Authority's vision to increase the capability of the PH workforce in 2007. The strategy for public health workforce development was to have; ‘A skilled and competent workforce that prevents disease, protects and promotes health and prolongs healthy life for the population of South Central.’ (SC SHA, Education, Training and Development Strategy, 2007-2012). Developing the PH workforce was therefore seen as pivotal to improving the health and wellbeing of the population. The aims of the strategy were to develop the workforce in an integrated manner that would maximise its effectiveness.

The public health practitioner training scheme offers a novel regional scheme for the development of knowledge, expertise, skills and competences in based on the Skills for Health competency framework that contribute to increased capability and equity across levels (from band 5 to a band 7; and local authority equivalent).

This scheme comprised of the following education and training elements (as recommended by the literature):

- Masters level qualification (two year Diploma and final year Dissertation)
- Learning Sets devised around the Public Health Skills and Careers Framework (Skills for Health 2008) and UK Public Health Register standards for practitioner registration
- Placements
- Portfolio of evidence
- Workplace training (to some extent and where applicable)
- Backfill funding
- Public health mentoring
3.0 Data collection and analysis

This service evaluation involved people working in public health and included line managers of trainees, voluntary mentors and practitioner trainees on the three cohorts of the practitioner training scheme. The qualitative data was collected via focus groups with trainees and interviews with line managers and mentors. Interviews were also conducted with two trainees on different Master programmes. All participants received a written and oral explanation of the purpose of the evaluation. Tape recorded focus groups were carried out and all participants were informed of their rights to withdraw at any point during and after the evaluation without offering a reason according to the Human Rights Act 1998. Participants were also informed that all transcripts would be anonymised and held in accordance with the Data Protection Act 1998. Informed consent was sought for participation in interviews.

Anonymity in this report has been maintained throughout as far as possible and trainees have been identified by coded numbers that have varied throughout the text to maintain the anonymity. It is therefore not possible to follow the trajectory of any one trainee by code in the text.

All the qualitative data was analysed by themes to triangulate information received from all the participants in the study.

The quantitative data on competences was collected using a table format and analysed on Excel spreadsheets.
4.0 Findings

4.1 Practitioner trainees and the public health practitioner training scheme

The public health practitioner training scheme was designed to train the public health practitioner workforce in the skills and knowledge required at practitioner level (NHS bands 5 to 7 and local authority equivalent) in line with the public health practitioner skills and careers framework (Skills for Health, 2008). There were two cohorts (with five and six individuals) completing the scheme during the academic year 2009 to 2010. Trainees came to the scheme from a variety of public health backgrounds. This included public health analysts, public health managers (from commissioning organisations, government organisations and health promotion division at local authorities), public health community nurses and other public health and social care practitioners. At the time of writing, there were no clear progression pathways from health trainers (at band 3) to practitioner level (bands 5 to 7). Some trainees had just been appointed to their posts and had no previous knowledge or expertise in public health. All trainees were carrying out full time roles in different departments and organisations where public health was their sole responsibility. Trainees switched to working part time in order to fulfil the two and a half days a week of protected study requirement for the scheme.

4.2 The Public Health Practitioner Skills and Careers Framework as a driver for competence training

At the heart of the training scheme lied the Skills for Health public health practitioner skills and careers framework of competences (Skills for Health; 2008). Each trainee completed a learning needs assessment against the competences at the start of the scheme. The framework separates competences into knowledge (‘knows how’ competences) and skills (‘shows how’ competences). The trainees were to collect evidence against the competences in a portfolio. The aim for each practitioner would be to try and fulfil as many gaps in competences appearing on their learning needs assessment. The learning needs assessment therefore acted as a baseline of competences from where to build skills and knowledge.

Once completed most trainees would share their learning needs assessment based on the competency framework with their line managers and mentors. Mentors could assist in the design of appropriate placements and help in the negotiations. Line managers could assist in the development of new competences in the workplace. The degree of sharing varied from one trainee to the next. It depended on the trainees’ confidence to approach the different individuals and also on the trainees’ perception about the different types of support required from line managers and mentors. Some trainees would therefore resort to sharing their learning needs assessment with their line managers and not with their mentors. This was due to the perception that their line managers were in a better position to suggest opportunities at work for addressing gaps in competences. One trainee, for example, reported that her understanding and knowledge of statistics had gradually increased since she began the scheme. The need for competence in statistics had been identified by the practitioner
trainee through the learning needs assessment. The trainee was therefore looking at using as many opportunities as possible in the workplace to carry out data collection and analysis on excel spreadsheets. Two years after the competence had been identified the trainee felt that her skills and knowledge of statistics had improved;

‘I use statistics now every day and I am learning more about how I do things. I am more robust in my practice because I relate more to the evidence base. It is also about understanding the wider picture about the different approaches to public health’ (NHS commissioning, practitioner trainee)

The above quote illustrates how setting competences to be achieved from the onset of the scheme provided the drive to attain further public health competences and skills. Trainees sought opportunities from the workplace (as in the quote above), from their academic studies, from placements and learning sets to attain as many competences as possible within the duration of the scheme. In this sense, trainees as a whole were unable to decide what vehicle (academic study, workplace training, placements, workshops, etc) was the most adequate for the development of new competences. An analysis of the competences achieved by practitioners in the year also shows that a particular vehicle for learning such as the Masters course does not fulfil all the ‘knows how’ competences required. These must therefore be complemented with ‘knows how’ competences from workshops and learning sets. Although practitioner trainees acclaimed the learning from the Masters as providing a fundamental basis to their development, the analysis of the competences achieved by trainees as a whole shows that ‘shows how’ competences are more difficult to achieve by trainees (Graph 1, ‘Shows how’ and ‘Knows how’ competences achieved by trainees in the academic year 2009 to 2010).

4.3 Learning Sets, public health practitioner competences and practitioner regulation

The purpose of learning sets was seen as being two-fold. On the one hand it allowed trainees to learn from each other’s experiences of public health and share the ‘knows how’ of the experience. On the other it allowed trainees to learn how to read and assess their competences against the public health practitioner skills and careers framework (Skills for Health 2008). Learning sets were also developed to assist trainees in providing a portfolio of evidence against standards related to the achieved competences. This would have been in line with the requirements and standards derived from the competences for practitioner regulation by the UK public health register.

Learning sets were used for sharing good practice. Trainees reported that they were also used to ensure that everything was ‘going on track’ for management purposes. Trainees would be asked to provide a summary of what they had been up to as a way of ensuring that the academic side of the programme was being met. Trainees felt that learning sets were useful to them when they shared experiences from their public health roles. Peer learning in this way was greatly valued by all participants. Learning sets therefore provided a safe environment in which to share the learning;
The people you meet are the best part of the programme. We have made good friends and colleagues. You can draw on people’s skills like statistics or community skills and looking at the more strategic commissioning side of public health. We learn a lot from each other and we can say the most ridiculous things and admit that you own what you have said. [Laughter] I wouldn’t have liked to do this without them [other practitioner trainees on the scheme].’ (Local authority, practitioner trainee)

This strong connection felt with each other was as a result of getting together through learning sets. Practitioner trainees felt that the informal peer learning offered through the learning sets was an invaluable source of information about the way different organisations work and about establishing organisational partnerships. Trainees that completed Masters in other Universities (also interviewed in isolation away from the focus groups with peers) reported feeling that they were very much part of the group and didn’t feel isolated about studying in different institutions.

Trainees became very frustrated when the content of the learning sets would not include information about maintaining a portfolio of evidence based on the competences gained throughout the scheme;

‘I thought that we would discuss topics at University when we are all together and talk about competencies and things like that but we don’t talk about them. This is what the learning sets are for. We have not done anything on portfolios. We feel that this is what the scheme is all about.’ (Provider organisation, practitioner trainee)

‘I like to be taken on a one to one on what I need. My portfolio is personal to me. This is very much an individual thing and should be within the programme and learning sets.’ (Commissioning organisation, practitioner trainee)

The objective was to collect appropriate and enough evidence to prove that competences had been gained. Once translated into the appropriate standards, there was a possibility of submitting these for registration purposes;

‘There has been some discussion about putting a portfolio of evidence together but we have had no details of how to actually do this and take us through the stages. That worries me a lot. I have spoken to my line manager to see if she can help me with the portfolio. She said she is also struggling with her own portfolio. Now if my line manager is struggling with hers and she is more senior than me, how am I going to be able to do this on my own?’ (Provider organisation, practitioner trainee)

The quote above alludes to the portfolio on the standards for specialist training that was being completed by the trainees’ line manager. The UK Public Health Register provides clear standards and options for specialist registration and submission of portfolios for public health specialist registration. Trainees felt confused about the requirements for practitioner registration. Some, for example, were failing to understand the difference between practitioner and specialist registration. Many practitioners felt that they could simply apply for the specialist registration on completion of their Masters degree. Practitioner registration and the portfolio of collected evidence could help recognise their current public health skills and knowledge without undertaking the five year specialist training and public
health specialist examinations required by the Faculty of Public Health. Some trainees were unable to see the links between training and registration at the different levels of the public health workforce. This was due, in part, to a lack of understanding about the public health workforce and what determines the different levels of the workforce. The definition of ‘practitioner’ for this level of the workforce was also somewhat confusing as trainees would associate the term with public health individuals that work in direct contact with the general public. For example, a public health practitioner trainee (band 6) that had been transferred during the scheme from an NHS provider to a commissioning organisation felt detached in her new role from the general public to the point of denying being a public health ‘practitioner’. Nevertheless in terms of public health workforce terminology, the trainee is defined as a practitioner in line with her banding (Skills for Health, 2008). Practitioner regulation was seen by all participants as a way of recognising individual skills and knowledge in public health, appropriate for practitioner employees from different organisations, and a step into a public health career; ‘We need to ask ourselves, were we people that would have been put forward for any portfolio before joining the scheme? No. I think if you are talking about equity and quality of opportunity with other levels of the workforce, this programme should go forward on that alone.’ (Provider NHS organisation, practitioner trainee)

Unfortunately, plans for practitioner regulation were thwarted at a national level. Practitioner trainees therefore felt ‘suspended in thin air’ with respect to gaining a level of professional recognition about the achievement of competences. In spite of the accumulated evidence against the competences by practitioners in training, they were unable to demonstrate that these had been achieved. The lack of a system for assessment/regulation of the competences at a practitioner level placed doubts in trainees’ minds as to there being a public health infrastructure to support them. It was important for them to feel professionally recognised; ‘Other people need assurance of what I can do in public health.’ (NHS provider, practitioner trainee)

Trainees seemed to place more importance to their regulation in discussions than on the achievement of the Masters qualification. In spite of having gained an important number of ‘knows how’ and ‘shows how’ competences, the only ‘demonstrable outcome’ stemming from the scheme for these practitioners was the Masters qualification;

‘I have been doing my job for three years now and I just feel that I don’t have the evidence to go and say; ‘here this is what I can do.’ (Provider NHS organisation, practitioner trainee)

A system for assessing competences would require qualified trained assessors and verifiers to support it. There was therefore increased frustration amongst practitioners who felt that regulation would determine their professional level of performance. This was particularly important for public health practitioners as there was no other form of professional recognition available to them.

4.4 Workshops
Workshops were linked to learning sets providing the provision of additional ‘knows how’ competences in areas that were not covered by Masters Courses such as Leadership and Management. The workshops were open to members outside the scheme and were attended by a number of different public health colleagues (some individuals were at higher Agenda for Change banding than practitioners). Practitioner trainees commented on having learnt from these public health colleagues and having expanded their public health networks by attending workshops. Some workshops were organised by organisations outside the scheme. All workshops were intended to provide Continuing Professional Development (CPD) to public health individuals outside the scheme.

4.5 ‘knows how’ competences and learning through the Masters

Trainees were able to choose the Masters course of their liking as part of the scheme. There were therefore separate individuals from the two cohorts undertaking a Masters course at King’s College (cohort 2), and Masters at the University of Southampton (cohort 3). The rest of the trainees chose to do their Masters course at London South Banks University. This meant that trainees would be completing public health modules at different times in the academic year. Having trainees doing courses at different Universities coloured the learning and provided further depth to peer learning through learning sets.

The Masters course was identified as providing an important set of ‘knows how’ competences. Trainees on the scheme linked academic assignments with their practice in the workplace. This was done with the intention of demonstrating new knowledge in public health;

‘Working on Chlamydia screening we look at how risk is attenuated by young people. I did an assignment for my sociology module looking at risk communication. This was useful with respect to the population I work with because they are risk takers.’ (NHS provider, practitioner trainee)

Trainees felt that the Masters course had been very useful in providing the theoretical knowledge and ‘knows how’ competences behind the delivery and implementation of public health initiatives. This has allowed trainees to take a more systematic approach to their work;

‘...before it was a bit more ad hoc. I was taking snippets of information from here and snippets from there... now I am more rigorous and systematic in my approach. As a practitioner I feel I have developed the confidence with the knowing about what I am doing whereas before I’d be constantly wondering, am I doing this the right way?’ (Local authority, practitioner trainee)

Trainees also reported that some of the learning from the academic programme had been taken place in a ‘passive form’. Apart from attendance to lectures, this may have been gained through developing academic reasoning and a new appreciation of the need to look at good quality evidence before taking decisions. The academic learning was associated with developing an ability to critically analyse public health information. Trainees felt that critically appraising data and information was gained
through a ‘passive form’ of learning. The critical thinking gained as a result was having repercussions in all areas of the trainees’ life;

‘...I look at data in a much more critical way and am able to interpret what it is telling me and what it isn’t... and be able to look at the wider perspective... I might be watching News Life and I am looking at it in a different way than I did before I did the training. I am learning how policies are put together. I look at the way it is being presented but there is always a different perspective. I ask what is the middle ground and why is it being presented the way it is. I am now more of a critical thinker, not just with my academic peers or at work but in life in general.’(Commissioning NHS organisation, practitioner trainee)

Trainees with no previous experience or knowledge of public health felt that the academic learning had been an ‘eye opener’ providing the ‘ins and outs’ of the wider theoretical and experiential aspects of public health. This increased the trainees’ confidence as illustrated by the two following quotes;

‘It is about understanding the public health context and using it to make decisions work.’ (Provider organisation, practitioner trainee)

The quote above suggests that the understanding of public health gained through the academic learning has allowed practitioners to be more effective at work. The wider perspective of public health gained through the academic learning is also illustrated below;

‘I’ve always loved my job and once I did my little bit it then disappears... I knew there were commissioning and provider sides to public health but in the little job I did I did not see how that fed in or how it affected the public in general. Now I can see things from different angles and see the effect that my work can have in the future...I can see the wider impact of what I do.’ (Provider organisation, practitioner trainee)

The guttural learning of the theory behind public health opened up trainees’ perspectives on the different approaches to public health. Trainees with previous experience and knowledge of public health felt the differences between the social versus the medical model for public health services;

‘Before I started the Masters course I thought I knew that public health used a population approach and a preventative model. Although the Masters was more of a medical model it has been interesting take on public health as all my previous studies had been based on the social model. It has given me a more rounded approach to data analysis and data prevalence which do provide a narrow view of public health. It has made me more focused on achieving the health outcome desired...My learning has been more grounded.’ (Provider organisation, practitioner trainee)

Trainees with previous experience and knowledge of public health therefore gained a deeper insight into public health. The academic learning therefore allowed all practitioner trainees on the scheme to gain a similar level of ‘knows how’ competences towards the end of the scheme regardless of the different backgrounds and previous knowledge of public health.
4.6 Placements

Practitioners carried out five week placements in public health organisations of their own choosing. It was important that they chose a placement to fulfil any gaps in their public health competences (as set through the initial learning needs assessment against the Skills for health public health skills and careers framework, 2008). Trainees were asked to use their negotiation and communication skills to find their own placements. Trainees carried out well defined placement projects in a number of different organisations such as NHS provider, NHS commissioning, local authority, and government agencies. This usually meant that placements offered to expand each individual’s horizons on two fronts. On one front, placements allowed individuals to learn and experience a different organisational culture and on the other they allowed individuals to come out of their comfort zone by undertaking a different type of public health work to the usual. This allowed practitioners to address a variety of skills and competences that they would not have developed without the opportunity of working outside their usual jobs as illustrated by the following comment;

‘I was looking at partnership working and went to a regional set-up at a local authority... That was a cultural change. They use a different language and different ways of doing things. Local authorities look at things in a much wider way. I could go in and out of all these different organisations... You tend to think most naively that most places function more or less like your own, and they don’t. Everywhere I went was so different. That was really beneficial. I was able to bring some of that into my workplace.’ (Commissioning NHS organisation, practitioner trainee)

The quote above shows that the practitioner trainee benefitted from the experience by gaining an understanding of the differences between public health work in local authorities and the NHS. The experience equipped the trainee with some tools for potential employment in a local authority.

Similarly, a local authority trainee claimed that placements were useful to ‘expand horizons’ in public health as some city councils do not operate health promotion teams;

‘I am a public health practitioner working within a city council where there is no health promotion and they do not do anything in the community. They are weak. So the placement means that I can move totally into the provider arms and do some work in the community.’ (Local authority practitioner trainee)

Not all trainees enjoyed the new environments where they completed their placements. This was partly due to a lack of understanding about the aims of the scheme by some host organisations;

‘The placement was interesting, I learnt a lot but I felt uncomfortable there. They have trainees on the specialist scheme, they know what this is about, but they do not know what we are doing. My experience is that they think we are in some random scheme’. (Provider practitioner trainee)

There was also some perceived unease amongst trainees regarding completing placements at host organisations that had been abolished by the coalition government. There were moral reasons for
feeling uncomfortable about undertaking project work for training purposes at organisations where everyone was being made redundant.

For some trainees, undertaking a placement at a different organisation helped them determine whether they would be happy undertaking a similar type role in the future, and also whether they would feel comfortable working for a particular type public health organisation. The extent by which placements were of benefit to each practitioner varies from one individual to another. The success of placements lies in achieving the right balance between the following:

- Appropriate choice of host organisation (location, type and new organisational culture)
- Feasibility and impact of project to demonstrate new skills and competence (5 weeks for completion)
- Accommodation and support of the trainee by the host organisation
- The trainee’s confidence in developing new skills outside their comfort zone and in a new organisation
- Understanding of the scheme’s aims and public health workforce by host organisations

There are therefore many variables that help orchestrate a successful placement. Unfortunately the placements provided for practitioner trainees lacked the quality assurance offered for specialist placements through the deanery. There was great variation in the types of completed projects and personal sense of achievement.

One trainee Practitioner reported carrying out work that aimed to achieve band 7 competence in leadership and management. Some of the completed projects were based around the leadership and policy competence domain as practitioners are not always able to meet this set of competences through their jobs. Many practitioner trainees, including analysts and community nurses, therefore resorted to fulfilling this competence by learning to complete strategic policy work and strategic health need assessments in host organisations.

Practitioners that had completed two separate placements reported that the learning experience was enhanced only where placements were well understood, co-ordinated and planned, with distinct and well supported projects that were achievable within the given time;

‘I went from a provider environment to a commissioner environment... in a different topic, surveillance and assessment and was analysing data. That was quite good because it took me out of my comfort zone. It linked to my competences and to my field of work. The placement support received was excellent. I was ‘buddied’ with a colleague that provided me the ongoing supervision and the manager dipped in to provide overall support. My mentor [from the scheme] guided me throughout.’ (Provider practitioner trainee)
Many practitioner trainees became ‘experts’ in the area of work and reported being contacted by placement teams for further information and advice, well after the placement had been completed. In the beginning of the academic year there was great enthusiasm amongst cohort 2 practitioners for the completion of a second placement;

‘I would like to carry out a health needs assessment on my next placement and shadow someone who has done one so that I can pick up some skills in terms of what level they are working at and so forth. So I am now little by little actually building up a skill set.’ (Cohort 2 trainee FG1)

Trainees often reported that they felt more confident and capable of taking on larger pieces of work (either encompassing wider populations, or requiring new public health skills) after completing some placements and in combination with the academic learning. This suggested that the choice of project by some trainees might sometimes be associated with skills that one might be able to bring to the workplace rather than using the opportunity to build on totally new competences. Placements were therefore sometimes chosen with a view to enhance current careers in public health.

Some trainees that were able to take their theoretical ‘knows how’ learning to practise in the workplace did so through the completion of assignments related to areas of work that helped consolidate the learning. Unfortunately not all practitioners were able to apply their academic learning to the workplace. This was mainly due to work constraints and limitations imposed on achieving targets and work schedules. Placements provided the opportunity to consolidate the learning in the absence of work limitations.

‘The whole experience put together works because you are learning about the theory and the practice... there is more to learning than academic knowledge.’ (NHS provider, practitioner trainee)

They reported that developing their skills and knowledge through placements and the Master course allowed them to gain a wider understanding of public health and therefore felt more effective at work. Analyst public health practitioner trainees, for example, claimed to have gained a deeper and less insular understanding of the work they were completing in public health. The broader perspective allowed them to provide a more in depth analysis with an improved understanding of both the upstream and downstream effects that their work could have on populations and development of public health programmes. Community nurse practitioner trainees from provider organisations claimed to have gained a more strategic view and ideas about tackling health inequalities. Some gained an insight into strategic planning by undertaking strategic health need assessments during their placements.
4.7 Impact of the scheme in the workplace

The scheme is seen to offer a structured training approach to building public health skills and competences whilst on the job. The scheme was seen to impact the workplace in the following ways;

- Development of enhanced public health roles and responsibilities at work
- Greater understanding of trainees’ strengths and weaknesses based on the public health skills and careers framework (Skills for Health, 2008)
- Use of the learning needs assessment against the competences as part of appraisals at work
- Increased learning opportunities for team members through the use of backfill from within the organisation
- Increased the public health quality of outputs by practitioner trainees
- Increased interest from public health colleagues (and line managers) about training on the scheme

Line managers were able to provide clear examples of progress in the work of a trainee throughout the scheme;

‘Previously before she went on the training scheme I would have to facilitate her more closely in a lot of activities and she now has more confidence. She has a greater awareness of public health issues.’ (Provider, line manager)

The deeper understanding of public health gained by trainees on the scheme sometimes acted as a catapult from where more public health roles and responsibilities could be developed. This is illustrated by the following comment;

‘We work with children with special needs as part of the school nursing community team. The community team provide the clinical role such as gastrostomy care plans, epilepsy care plans, effects on training, down syndrome... we were providing the clinical input on clinical conditions allowing the child to be in school. The health promotion element or public health element was not there. My role developed as I went from doing social health and sex education when I did a health promotion course. Following from that I started doing healthy eating, obesity, oral health... I have raised the public health awareness in the team. My role has evolved and changed... since I started the scheme I have a full health programme. My colleagues struggle to see bring the public health element into it because they see themselves as clinical staff.’ (NHS provider, practitioner trainee)

The development of responsibilities and roles more in line with the field of public health was important to maintain the expertise and skills gained through the scheme and the trainee. The ability of trainees to apply the scheme at work often meant that trainees would be considered as experts in public health and within their line of work. Many trainees saw their influence increased in public health matters and
decisions taken by their organisation. A local authority trainee claimed that this was particularly important where training opportunities were scarce in an organisation;

‘Within our service in the local authority there isn’t much emphasis on qualifications and learning. None in the management team have done a Masters in public health. I have been challenging the way we do things. I think that my colleagues recognise the competences and skills that I have now and they are coming to me to sign up with more work. They think I have the skills to do it. Certainly managers have recognised the value of the scheme.’ (Local authority, practitioner trainee)

The use of the public health skills and careers competence framework (Skills for Health, 2008) as a support for individual progress and achievement helped identify individual strengths and weaknesses in the work context. Practitioners have therefore been able to ascertain from a new knowledge base those public health areas of work where support is required. This has been important, for example, in the completion of public health audits at work and has been used by some line managers to inform appraisals.

Training on the scheme increased the confidence of trainees to tackle public health issues. Trainees often reported feeling ‘more respected’ by their organisation and having gained ‘credibility’ for what they do. Trainees felt more engaged in discussions with individuals about public health. They claimed to provide more advice in support of important decisions related to public health. The newly gained confidence, knowledge and skills in public health were noted by trainees, line managers and mentors. Practitioner trainees also commented on the ability of using their skills to their ‘full potential’,

‘The scheme has made me realise I had skills I wasn’t using to their full potential. I can use these skills now.’ (Commissioning NHS organisation, practitioner trainee)

The current financial climate and perceived uncertain future for public health practitioners linked to the abolition of PCTs and government organisations had left trainees feeling particularly vulnerable in their jobs;

‘I’ve had six managers in the past two years...your managers don’t know what is going on... they can’t genuinely tell you what they don’t know themselves. The question is what is the world of public health going to look like... and what are practitioners going to do in the public health workforce? because yes, there is the health promotion aspect and you can see the role of the public health consultant and the directorate, but getting below that level, the waters are getting muddier.’ (Commissioning NHS organisation, practitioner trainee)

There was some apprehension about the time spent outside work whilst organisations were being restructured for a period of political ‘transition’:

‘I feel that at any time they can say, ‘we don’t need you anymore... we’ve managed without you for the last two years and you haven’t really been around’, and there are not many jobs out there at the moment... you have to work twice as hard... you have to increase the amount of work you are putting in to show them that you are still there!’ (Provider NHS organisation, practitioner trainee)
The current financial climate and abolition of NHS and government organisations have increased uncertainty in the public health workplace. There is a perceived danger that under the current climate of uncertainty individuals working in public health may feel under pressure to find employment elsewhere and outside the public health field. The general gap in training and development opportunities for the public health practitioner workforce between bands 4 and 7 means that the workforce attracts individuals from a diversity of backgrounds. This level of the workforce sees itself as ‘fluid’ with the ability to ‘jump’ from one field of work to another.

All practitioner trainees trained through the public health practitioner training scheme by South Central SHA reported the desire to remain working in public health regardless of the future. The scheme therefore helped retain practitioners to the public health field.

4.7.1 Backfill funding

In previous years backfill was reported as being a fundamental aspect to the scheme. The drop in working hours from full time to part time placed line managers with the dilemma of what to do with the remaining trainees’ workload. The provision of funding for backfill allowed for this workload to be carried on by a new member of staff. In some cases, line managers were able to distribute the workload amongst colleagues and used the funding to employ an additional administrator required by the team. In one particular case, the new allocation of a trainees’ workload opened up possibilities for further learning by the whole team. Trainees felt at ease with workplace arrangements that would ensure the carrying over of their work. At the beginning of the scheme trainees would usually have to spare some time ‘training’ the person doing the backfill. Trainees and line managers felt that it would have been impossible for the trainee to commit to the demands of the scheme without the backfill funding. Other trainees were on training posts where the re-allocation of the trainees’ workload was not an issue. In this case the backfill funding was used to support the team.

Line managers felt that backfill funding was indispensable, particularly in the current financial climate;

‘...with the backfill funding and ability to extend the learning across the team we have been evolving all roles within the team that tended to be fairly dynamic. We used the funding to backfill the administrative side of that role so the trainee could be part time project worker. There has been a lot of juggling with the placements and the MSc. It means that we don’t end up training people at our expense and then lose them to moving on. We have gained from this too. It is about tapping into the scheme and make the most out of it to benefit us. If this is not funded by the scheme we cannot afford to give people backfill so that they can go on courses.’ (NHS provider, line manager)
4.8 Support from mentors and line managers

4.8.1 Support from line managers

Line manager support was required to increase the flexibility in workloads and try to set targets in line with the demands of the scheme. In general and where possible, line managers were actively engaged in helping the trainee achieve new competences and other opportunities for development such as carrying out job interviews;

‘It is about striking that balance between what we must deliver to meet service specifications and providing opportunities for development.’ (NHS provider, line manager)

Where there was a need to augment the public health skills in the workplace, they had identified suitable staff members for the public health practitioner training scheme;

‘This person was three years into her role and needed to expand her knowledge of health promotion and public health. We were hoping to start developing that in depth knowledge of health promotion.’ (Provider NHS, line manager)

The learning needs assessment and requirement for fulfilling competences was shared by trainees with their line managers. This allowed to maximise the opportunities for developing skills and competences in the workplace. Updating competences also helped maintain interest about the progress of the trainee on the scheme.

One of the challenges faced in some organisations was calculating the exact annual leave for the trainee. Line managers reported feeling slightly removed from the scheme and suggested receiving information regarding the trainees’ progress on the scheme. Some suggested the need for a feedback mechanism that would inform them on the trainees’ strengths and weaknesses. This was also suggested by some trainees who felt that it was important to keep their line managers informed about their achievements;

‘... by providing more feedback we would probably have a bit of a more open relationship about how we are feeling in terms of impact at work, or how they are feeling... we are currently left to our own devices... I think it is that we are away for a long amount of time. It is difficult for managers. He doesn’t really seem to know when to expect me back. He was expecting me around for one full week in the summer holidays...’ (Provider NHS organisation, practitioner trainee)

Overall line managers felt that trainees had accomplished and progressed greatly in public health. They felt confident to provide the trainee with more public health responsibilities where necessary and/or appropriate;

‘It is of value to know that we have given someone to gain things from this training. We wouldn’t have given them tasks otherwise or we would have found other ways to do it.’ (Provider NHS, line manager)
One line manager reported that one of the benefits of training practitioners in public health is that they could be redeployed more easily within the organisation in the future.

4.8.2 Support from Mentors

The initial learning needs assessment against the competences was shared with mentors as well as line managers. Mentors would generally meet their trainees as and when the trainee requested it. There was some confusion amongst mentors and trainees about the role of the mentor on the scheme. Some trainees would only occasionally meet with their mentor. Other trainees would avidly discuss assignments, gaps in competences, workplace opportunities for development, and use the mentor’s network of contacts to find suitable placements. In some cases there was a close relationship built up between trainee and mentor. The mentor would look closely into the trainees’ progress and act as a dynamic source of public health information helping to bring the trainee up to speed on a one to one monthly basis;

‘The mentoring I received was one of the stronger points of the scheme. I have a really good mentor; supportive, directive, encouraging... It has been one of the surprises on the scheme.’ (Provider NHS, practitioner trainee)

Mentors reported that trainees benefitted from reflecting on their competences;

‘So they can learn from mistakes and learn as they go along.’ (NHS commissioning, mentor)

In this respect, the mentor could be seen as acting somewhat as a competences co-ordinator, looking at gaps in competences and providing advice on the type of evidence that would be appropriate for each one. Trainees that had a more ad hoc relationship with their mentors felt they were at a disadvantage. All trainees felt that it would be useful to have mentors outside placements and Masters that could act as co-ordinators of the whole experience. They would be the only individuals to have a clear perspective on the competences achieved mapped to the progress of each trainee on the different elements of the scheme. It was therefore important to establish the exact role of the mentor in helping sustain the trainees’ progress on the scheme.

4.9 Career progression and preparation for the future at a time of uncertainty

Throughout the academic year, from September 2009 to September 2010, the workplace kept changing for many trainees. The abolition of PCTs by 2013 amplified the uncertainty felt about the future. The future also seemed unclear to health promotion public health practitioners working in local authorities. At least three trainees had their job roles reviewed between September 2009 and September 2010. One trainee had waited a long time to be employed in health promotion, only to see her role in jeopardy;

‘The scheme has made the difference where I am asking myself the question of whether I’d still be in my job if it weren’t for the scheme.’ (Provider NHS, practitioner trainee)
Practitioner trainees felt they were well prepared for specialty training.

One trainee’s job description changed title from ‘public health practitioner’ to ‘public health programme manager’. This trainee had experienced six different line managers within the year. Many trainees therefore felt at a disadvantage in comparison to their work colleagues. This was related to only working part time as opposed to full time whilst on the scheme. Both cohorts claimed that their colleagues had made remarks about them not being around the office. At the time it was felt that this added pressure might have been resolved with improved communication in some cases between line managers and staff. Trainees felt they had to outperform themselves at work as well as maintain their participation and learning on the scheme.

Being half way through the scheme, cohort 3 trainees felt particularly disadvantaged. The uncertainty about their future and about their career in public health was apparent;

‘My job is being reviewed at the moment. Nobody knows what is going on at PCTs. It is difficult to plan for the future when nobody knows what that future will look like. The thing is I am being trained to be a public health practitioner and I do not know if I will have a job in the future or not.’ (Provider organisation, practitioner trainee)

The uncertain future made cohort 3 trainees feel they would have benefitted from having a more structured approach to practitioner registration or assessment of their competences. This would encapsulate and provide evidence for their learning and newly gained standards in public health. In spite of feeling vulnerable, trainees felt more equipped than before for undertaking a variety of public health roles.

Cohort 2 trainees felt grateful for the training opportunity brought by the public health practitioner training scheme. They felt they were in an enviable position to apply for jobs in the future.

‘I feel more secure career-wise. By the end of the scheme we will be more qualified and more skilled. The scheme has given me a lot of choices for the future. I’m really grateful for the opportunity.’ (Commissioning NHS organisation, practitioner trainee)

Line managers and mentors also perceived the scheme as providing perfect training for practitioners. Practitioners that had completed the scheme had found new band 7 public health jobs with relative ease after the training;

‘The scheme stands people in a good step for public health roles. If you have two candidates, and one has completed the training and one hasn’t, the one that had would be in a much stronger position for the post.’ (NHS commissioning, mentor)

Those trainees that had completed the scheme would therefore be in an excellent position to move forward in their public health careers. Only seven of the eleven trainees in cohorts 2 and 3 were hoping to apply for specialist training (with two public health practitioners hoping to apply for the defined specialist route). The other trainees were hoping to apply the learning to their current roles. It
was difficult for trainees to feel they had accomplished the aims of the scheme without an appropriate
assessment of the competences gained through the scheme.

At the beginning of the scheme, practitioner trainees were confused about public health, about the
public health workforce, and about public health training. The scheme therefore served as an ‘eye
opener’ not only for gaining an appreciation, skills and knowledge of public health but also formed the
basis to inform practitioners of career pathways and career progression in public health.

The public health practitioner training scheme therefore serves the purpose of developing public
health professionals at bands 5 and 6 (and local authority equivalent) from a diversity of backgrounds
for their core public health roles.
5.0 Conclusion

Together, all the elements of the scheme contributed to the development of trainees in a variety of ways. The accumulation of new competences and skills by trainees gave individuals a strong sense of achievement in new public health areas. Practitioners reported that learning occurred on many fronts;

- The scheme reinforced the trainees’ understanding of public health, thereby influencing their practice. It increased the trainees’ confidence to question public health information. This was useful to ensure that initiatives were to an adequate standard. They felt they had gained public health ‘credibility’ amongst work colleagues

- The scheme increased their knowledge and skills in public health

- The scheme increased their understanding of public health and dismissed any original misconceptions or ideas about public health

- Trainees on the scheme developed critical thinking, research and leadership skills in public health

- Trainees were more aware about public health policy and its effect on public health programmes and the public

Trainees felt very strongly that it was the combination of the different elements of the scheme that contributed to their substantial progress in both their training and at work.

The public health practitioner training scheme is seen to offer ‘a very good opportunity for individual development.’ All the separate elements of the scheme taken together are seen to be responsible for the trainees’ achievements.

The scheme therefore fits into the provision of current public health training as depicted in the following diagram (Figure 1.)
Figure 1. The public health practitioner training scheme and public health career progression
6.0 Lessons Learnt

The following are recommendations for the future running of public health practitioner training;

1. **Assessment of competences in the absence of practitioner regulation**

   The driver behind the practitioner training scheme is the achievement of ‘shows how’ and ‘knows how’ competences on the public health practitioner skills and careers framework (Skills for Health, 2008). It therefore follows that there must be a system that assesses competences to an adequate standard, with trained assessors and verifiers. The achievement of the competences determines the extent of each individual’s success on the scheme and its assessment provides professional recognition and validation of public health practitioner attainment. In the absence of regulation/assessment it is difficult to ascertain whether competences are being achieved to the right standard. Participants in the evaluation felt that a Masters qualification was not appropriate for the validation of skills and ‘shows how’ competences. Regulation/assessment would therefore ensure the high quality of public health services offered by practitioners.

2. **Raising awareness of the public health practitioner training scheme**

   The trainees also found that there was little or no knowledge of the public health practitioner skills and careers framework (Skills for Health, 2008) in some organisations. This meant that there was a need to negotiate the terms and conditions of the five week project in order to meet the requirement of the scheme to fill gaps in competences. The position of the scheme had been to allow practitioners use their leadership and negotiation skills for the development and implementation of an appropriate project. Practitioners felt that this might be ‘pushing them a little too far’ since it is difficult to negotiate a placement with the aim of gaining new skills and knowledge that lie outside one’s own comfort zone. This was one of the issues surrounding the completion of projects within the allocated time as practitioners claimed not knowing how long a project might take, particularly if they had never used the skills before. Some practitioners therefore relied on the use of their mentors and their mentor’s networks to find suitable placements and help design some of the projects to meet the scheme’s criteria. In some cases, trainees resorted to completing placements at their mentor’s organisation.

   Trainees suggested linking the current placement options for the public health practitioner training scheme with the currently established network of six month specialist placements offered by the deanery. Practitioner placements could become a short version of existing specialist placements.

3. **Quality Assurance of Placements**

   Unlike the 6 month placements provided for specialist trainees through the deanery infrastructure, the 5 week placements for practitioner trainees lacked quality assurance. This
meant that there was a great variation in the experiences of trainees, with some gaining more than others from their placement experiences. It would therefore be useful to provide some form of quality assurance for placements as part of the scheme.

4. Provision of all ‘knows how’ competences.

Masters do not provide ‘knows how’ competences for all the different aspects of the competency framework. There is a need to provide additional resources such as workshops, to ensure that there is an adequate delivery of training that is in line with the requirements on the Skills for Health competency framework (2008).

5. Engagement of mentors and line managers on the scheme

Trainees felt that the feedback from both mentors and line managers was inspiring and helped them focus on the attainment of competences either in the workplace or through placements. The participation of mentors and line managers in the achievement of competences should therefore be encouraged with clear engagement opportunities from the onset.

Trainees often reported that there was a lack of clarity about the roles of mentors and line managers and about how they could be more engaged with the scheme. Access to mentors, for example, was unclear to the extent of understanding what, how, when and how often they should be approached by trainees. Trainees suggested that a document depicting the exact roles of each individual involved in the scheme would help with mentor and line manager engagement in the formulation of learning needs assessments and the identification of competences that may be achieved in placements and/or the workplace.

6. Opportunities for peer learning

The variety of public health practitioner trainee roles offers a cauldron of bubbling knowledge and experiences that are eagerly shared with each other. Practitioners are therefore given the opportunity to maximise their learning experience and share their learning in a safe environment. Practitioners felt that they might not have gained as much knowledge from each other without some initial specific time set aside to meet with the purpose of sharing their learning. In some cases, this sharing of experiences helped achieve ‘knows how’ competences for some trainees that were then able to consolidate the learning in practice (though placement or in the workplace).

The peer learning was particularly important for those practitioner trainees attending different Master courses. Trainees studying for different Master courses to the rest of the cohort were able to join the learning sets without feeling secluded. Everyone was able to participate and gain from the experience.
7. **Focus of learning sets**

Trainees reported that learning sets should have a clear focus with clear learning outcomes assigned to each session. Trainees suggested taking more ownership of the learning sets so that the shared learning and the competence and portfolio training would be clearly delineated into equal sections of time.

8. **Protected time for Dissertation**

The practitioner training scheme supports trainees up to their second year of a part time Master course. This is the time when the academic lectures and learning sets are completed. After this time, practitioners return to working full time for their organisations. The scheme provides five extra protected study days to help with the completion of the dissertation. Trainees felt however that this could be extended. They also reported requiring assistance with completing a portfolio for registration during this period of time.

9. **Assignments applied to the workplace where appropriate**

Practitioners commented on the need to ensure that the aims of the scheme were well understood by host organisations. There was some flexibility around the five weeks for the completion of the placement. Some practitioners resorted to project planning within the first week and then carrying out the bulk of the project in a four week block with some space between planning and delivering.

10. **Scale of project and timescale for placements.**

Practitioners commented on the need to ensure that the aims of the scheme were well understood by host organisations. There was some flexibility around the five weeks for the completion of the placement. Some practitioners resorted to project planning within the first week and then carrying out the bulk of the project in a four week block with some space between planning and delivering.

11. **Finding host organisations for placements**

Practitioners found it difficult to find suitable organisations in which to carry out their placements. In the absence of specific guidance for organisations or choices for appropriate placements, one practitioner trainee from a governmental organisation was asked to provide a *curriculum vitae* and references as well as attend an interview before being able to undertake the five week project at the host organisation.
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