Summary Evaluation report for the Public Health Practitioner Training Scheme (Year 2).

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**Abbreviations**

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<thead>
<tr>
<th>Abbreviation</th>
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</tr>
</thead>
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<tr>
<td>AfC</td>
<td>Agenda for Change</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>FD</td>
<td>Foundation Degrees</td>
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<td>FG</td>
<td>Focus Group</td>
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<td>HCA</td>
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<td>MPH</td>
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<td>MSc</td>
<td>Master of Science</td>
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<td>NHS</td>
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<td>NVQ</td>
<td>National Vocational Qualification</td>
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<td>PCT</td>
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<td>PH</td>
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<td>Public Health Practitioners Training Scheme</td>
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<td>PHS&amp;CF</td>
<td>Public Health Skills and Career Framework</td>
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<td>PO</td>
<td>Programme Organiser</td>
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<td>SC</td>
<td>South Central</td>
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<td>Skills for Health</td>
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<td>Strategic Health Authority</td>
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<td>UKPHR</td>
<td>UK Public Health Register</td>
</tr>
<tr>
<td>WRT</td>
<td>Workforce Review Team</td>
</tr>
</tbody>
</table>
## Content

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Executive summary</td>
<td>4</td>
</tr>
<tr>
<td>2.0 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2.1 PH workforce development and national policy</td>
<td>5</td>
</tr>
<tr>
<td>2.2 The PH practitioner workforce education and training requirements</td>
<td>7</td>
</tr>
<tr>
<td>2.3 The PH practitioner training scheme</td>
<td>8</td>
</tr>
<tr>
<td>3.0 Methodology</td>
<td>10</td>
</tr>
<tr>
<td>4.0 Summary of results</td>
<td>11</td>
</tr>
<tr>
<td>4.1 The scheme and perceived PH practitioner workforce development in NHS provider and commissioning organisations and LAs</td>
<td>11</td>
</tr>
<tr>
<td>4.1.1 Definition of the PH practitioner role</td>
<td></td>
</tr>
<tr>
<td>4.1.2 Views on developing the PH practitioner workforce</td>
<td></td>
</tr>
<tr>
<td>4.2. The scheme and PH practitioner registration</td>
<td>12</td>
</tr>
<tr>
<td>4.3 Developing trainees as PH practitioners</td>
<td></td>
</tr>
<tr>
<td>4.4 Overall perceived benefit of the scheme by organisations</td>
<td>13</td>
</tr>
<tr>
<td>4.4.1 NHS provider organisations</td>
<td></td>
</tr>
<tr>
<td>4.4.2 NHS commissioning organisations</td>
<td></td>
</tr>
<tr>
<td>4.4.3 Local Authority</td>
<td></td>
</tr>
<tr>
<td>4.5 The scheme</td>
<td>14</td>
</tr>
<tr>
<td>4.5.1 Reasons for joining the scheme</td>
<td></td>
</tr>
<tr>
<td>4.5.2 Numbers of ‘shows how’ and ‘knows how’ competences achieved by trainees on the scheme</td>
<td>15</td>
</tr>
<tr>
<td>4.5.3 Placements</td>
<td></td>
</tr>
<tr>
<td>4.5.4 The Masters</td>
<td></td>
</tr>
<tr>
<td>4.5.4.1 The academic course at London South Bank University</td>
<td>16</td>
</tr>
<tr>
<td>4.5.4.2 The academic course at King’s College</td>
<td></td>
</tr>
<tr>
<td>4.5.5 Learning sets</td>
<td>17</td>
</tr>
<tr>
<td>4.5.6 Protected study time</td>
<td></td>
</tr>
<tr>
<td>4.5.7 Influence of the scheme in the workplace</td>
<td>18</td>
</tr>
<tr>
<td>4.5.8 Impact of backfill on team development</td>
<td></td>
</tr>
<tr>
<td>4.5.9 Line Manager support</td>
<td></td>
</tr>
<tr>
<td>4.5.10 Supervisor (mentor) support</td>
<td></td>
</tr>
<tr>
<td>4.5.11 Impact of the scheme on careers</td>
<td></td>
</tr>
<tr>
<td>4.5.12 Progression from PH practitioner to specialist level</td>
<td>19</td>
</tr>
<tr>
<td>4.5.13 Perceptions on funding for the scheme</td>
<td></td>
</tr>
<tr>
<td>5.0 Discussion</td>
<td>20</td>
</tr>
<tr>
<td>6.0 Conclusion</td>
<td>22</td>
</tr>
<tr>
<td>7.0 Recommendations</td>
<td>23</td>
</tr>
<tr>
<td>8.0 References</td>
<td>26</td>
</tr>
<tr>
<td>Appendix</td>
<td>27</td>
</tr>
</tbody>
</table>
1.0 Executive summary

The Public Health (PH) Practitioner Training Scheme was developed within the South Central Strategic Health Authority’s (SC SHA) vision to increase the capability of the PH workforce. The strategy for PH 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 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.

This interim report on the evaluation of the scheme between October 2008 and October 2009 offers a detailed explorative breakdown of the qualitative data received from the participants – trainees from cohorts 1 and 2, line managers, mentors and scheme organisers. It also includes quantitative analysis of the number of ‘shows how’ and ‘knows how’ competences achieved by trainees. It provides:

- Detailed evidence (quotes from participants) as a base to inform decision makers about the progress of the scheme in its second year (first and second cohorts) and its growing significance in the PH community. It explores how the different organisations involved – NHS providers, commissioners and Local Authorities (LAs) – have benefitted from having a trainee on the scheme and the scheme’s potential impact on cross-organisational PH workforce development.

- Interim recommendations for developing the scheme that may inform the commissioning of similar training initiatives. They will be reviewed in the following year.

- An account of how the scheme’s different elements, including backfill funding, learning sets, placements, MSc and links to the Skills for Health PH competency framework, have influenced the trainees and their workplace and the progress of trainees who have not yet completed full training.

- An analysis of the PH competences achieved.
2.0 Introduction

2.1 PH workforce development and national policy

Public Health (PH) policy in the UK has taken a new direction since 1997 (Mackenzie, 1997). In the DH report ‘Project to strengthen the PH workforce’ (2001), PH practitioners were identified as being critical for the delivery and success of PH policy priorities. This report outlined three PH workforce groups and specified roles for each group:

- PH specialists
- PH practitioners
- Wider workforce

It also recommended putting in place a workforce strategy to increase both capability and capacity.

In ‘Shifting the Balance of Power’ (DH, 2001) the DH outlined the need to develop and maintain a well-educated and trained multidisciplinary PH workforce performing to a consistent standard in the UK. Sim et al. (2002) calculated that PH practitioners and wider workforce groups accounted for about 99.63% of the total PH workforce. The Wanless reports (2002 and 2004) recommended a shift from secondary care to primary and community-based care with improved patient involvement – thereby providing a PH focus. The NHS Improvement Plan (2004) also signalled the need for further cultural change and imposed an increased emphasis on health promotion and wellbeing within primary care. In the delivery plans published in the DH's White Paper ‘Choosing Health’ (2005) the need to build the PH capacity and capability was re-emphasised across this workforce.

Much of the focus for increasing both capacity and capability has fallen on the development of PH specialists. Their training was based on the medical model and included work rotations and assessment through RITAs (Faculty of PH, 2005).

Brookehurst et al. (2005) suggested that the reason for the apparent neglect in developing the other two PH workforce groups was the more effective and cohesive leadership for specialist development. The authors identified a role for the DH, Government Offices, SHAs, and the then Healthcare Commission (now Care Quality Commission), in taking on the strategic leadership necessary for PH workforce development. Their vision included developing:

- A career framework for PH practitioners
- Voluntary national register for PH practitioners
- Knowledge skills framework and Agenda for Change
- New and expanded roles.

They recommended that the Directors of PH should lead, at local level, the development of the PH workforce, providing organisational training needs analysis and capacity mapping with targets linked to annual appraisal. There was no clearly defined role for workforce planning, although this would be linked with capacity mapping and developing new and expanded roles for PH practitioners.

The Cumbria and Lancashire SHA identified a number of needs regarding the development of their PH practitioner workforce to be resolved before establishing a strategy for practitioner workforce development (Cumbria and Lancashire SHA, 2005). These included:
• PCT unable to see the relevance of PH
• Complex Local Authority and PCT arrangements
• Short term funding of projects for developing the workforce
• Local Authorities not engaged at a regional level in developing the local agenda, and LAs not recognised as a major employer in ‘Choosing Health’ (2005)
• Shortage of certain PH skills in Local Authorities
• Lack of a PH practitioner workforce with adequate skills and knowledge
• Professional isolation of PH practitioners.

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

More recently, Lord Darzi’s report ‘High Quality Workforce: NHS Next Stage Review’ (2008) focused on the shift to primary care within his nine clinical pathways. It stressed the intention to increase capacity and capability of the PH wider workforce.

Work in partnership was also a requirement where a PCT’s commission of wellbeing and prevention services should emphasise quality of care, health improvement, tackling inequalities and personalised care. In its document ‘Workforce Summary – Public Health Consultants and Specialists’ (2008), the Workforce Review Team appeared to concentrate its efforts on increasing the capacity of the specialist PH workforce. This was done by expanding ‘top up’ training schemes. There was no specific indication as to how the rest of the PH workforce might be developed. One of the reasons for this was:

‘At present, public health practitioners are difficult to clearly identify in the workplace. Data gathering efforts on the wider public health workforce should continue to produce a clearer picture of demand for public health practice and enable more effective planning.’ (Page 1, Workforce Summary, 2008)

Nevertheless, the Faculty of PH advised that:

‘The demand for the PH specialist workforce and practitioners with relevant knowledge and skills looks set to outstrip supply. Expansion of training alone is not sufficient to meet demand and creative skill mix in teams and support and personal development for individuals will continue to be crucial.’ (Curson et al., in the Faculty of PH newsletter, ‘Workforce planning for PH’, December 2008).

The need to invest in the development of PH practitioners and training was also stressed in a report by the UK PH Register Board (2009).

‘There are a large number of public health workers who feel somewhat adrift in that they have no professional allegiance, no professional recognition, no career structure, nothing to aim for professionally – but we expect them to do a very professional job.’ (from ADsPH response to consultation on PH practitioner regulation, 2009).

The proposed framework for regulating practitioners was to provide recognition and value for their work, assurance for delivering competent PH programmes, facilitate mobility and help in providing clearer CPD, PDP and HEI educational initiatives. Workforce planning was again closely linked to workforce development.
Developing the PH workforce was also the focus of an international initiative. The European Commission outlined the prospects for developing the European PH workforce in its White Paper ‘Together for Health’ (2008) with emphasis on reducing health inequalities. The message was to be reinforced through the implementation of the Green Paper ‘On the European Workforce for Health’ (2009). The challenges addressed in both papers include the ageing population (both in terms of workforce and general demographics), health workforce shortages and lack of appropriate training opportunities. The Green Paper states:

‘To reduce the burden of curative medicine and health systems at large, efforts should be made to increase the public health capacity of Member States to enable more preventative medicine and health promotion’ (section 4.2, page 7).

The adequate development of the PH workforce has been at the forefront of a number of national and regional policies both in the UK and abroad. National and international policy reports have proposed a homogeneous multi-organisational approach to PH workforce development linked to workforce planning. The UK PH Register maintains a register of PH competent and validated professionals

2.2 The PH practitioner workforce education and training requirements

The report ‘Skills for Health’ (2004) identified significant knowledge and gaps in PH practitioners competence related to:

- Health needs assessment
- Partnership working
- Programme management
- Evidence based PH practice
- Community development.

Furthermore, a successful PH practitioner training programme has been defined as incorporating these essential features (Beaglehole et al., 2004):

- Leadership and strategic functioning
- Collaborative actions
- Multidisciplinary approach
- Political engagement (local, national and/or global) in PH policy
- Community partnership

There is therefore some overlap between the two reports on the perceived needs of the workforce. Ideally, the education and training programmes for the workforce should incorporate the above elements for developing competences in PH. As different programmes emerged there was a growing need to evaluate their efficiency in:

- Developing the PH practitioner workforce
- Providing adequate training for them.

The literature suggests that although PH course providers evaluate the training offered this tends to be with a focus on curriculum development and not necessarily on the impact of training in the workplace. It has been reported that programmes should ideally be evaluated in the context of their potential wider impact on workforce development and needs (Bolthole et al., 2004). The need for evidence-based development strategies for educating and training
PH practitioners and developing training opportunities have 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).

There have been a limited number of training programmes offered by university providers aimed to develop the PH practitioner workforce. The North West London PH practitioner training programme is an example of one such programme (Brocklehurst et al., 2005). This programme offered trainees:

- A taught course to diploma level
- PH project (on a small multidisciplinary topic)
- Six half-day learning sets
- Assessment through a portfolio of work
- Use of a Virtual Learning Environment

Some programmes tended to lack a more ‘hands on’ practical component that would allow the learning to be embedded in practice.

In their review of the literature, Latter et al (2003) stressed the importance of placements for exposing PH trainees and students to PH practice, and learn about engaging practitioners in PH work under supervision. The authors expressed the availability of theoretical knowledge through Continuing Professional Development (CPD) and Higher Education (HE) courses that seemed unlikely to be consolidated, applied or developed in practice. Flexible, practice-based, problem solving and work-based strategies were the preferred methods of addressing the lack of knowledge identified by trainee PH nurse practitioners. It was therefore suggested that SHAs, PCTs and other organisations should provide a supportive network of mentors and adequate placements that would enhance the practical experience of trainees, as well as preparing mentors for the task (Latter et al., 2003). This approach to training would enhance the multidisciplinary facet of PH work and maximise exposure to PH.

Qualified practitioners have been able to access training opportunities such as MSc and Master in Public Health (MPH) courses delivered by HE providers that lack the practical component identified as being important for consolidating knowledge (Latter et al., 2003).

The UK requires a competent workforce with a broad view of PH that can work collaboratively across disciplines and organisations and have the ability to influence policy-making at local, national and global levels. Taking this experience into account, the SHA commissioned NHS Education South Central to establish this pilot PH Practitioner Training Scheme

2.3 The South Central PH practitioner training scheme

The PH practitioner training scheme is a two-year programme. It includes an MSc in PH or equivalent, placements, and learning sets that would be likely to meet the proposed UK Public Health Register requirements for practitioner registration by portfolio submission. Individual learning needs are assessed according to the competences outlined on the PH Skills and Careers framework (Skills for Health, 2008) and developed as part of the scheme to NHS Agenda for Change band 7 competency levels. The additional third year is spent completing the MSc dissertation.
The scheme includes the following:

- PH Masters level qualification (two year diploma and final year dissertation)
- Learning sets devised based on the PH Skills and Careers Framework and UKPHR requirements for practitioner registration
- Placements
- Portfolio of evidence around the competences for registration
- Workplace training (to some extent and where applicable)
- Backfill funding
- Mentoring (or supervision).

The PH practitioner training scheme fulfils the SC SHA strategy (2007) and meets national policy by:

- Offering a novel local programme for developing knowledge, skills and competences in adequate PH learning environments that contribute to increased capability and equity across levels (to band 7).

- Providing a robust evaluation of the training programme to fulfil the SHA’s ‘urgent need to improve the data collection and understanding of the workforce’ to link workforce planning with development and training (SC SHA strategy; 2007).

- Meeting the national policy requirement to work collaboratively across organisations such as PCTs and Local Authorities.
3.0 Methodology

The evaluation is for the second year of the scheme and explores the perceptions of the trainees, mentors and line managers from the two cohorts. It is explorative and does not include the final recommendations that will be developed at the end of the third cohort in 2010. This evaluation follows the PH proposal that was agreed by the Advisory Group in January 2008. This service evaluation was with participants who were involved on the scheme and includes; all trainees (cohort 1 and 2), their line managers and supervisors, and scheme organisers from NESC. There were a total of five trainees for each of the two cohorts (total of 10) and respective mentors and line managers. Some mentors had a dual line management role and the text clearly states when a quote has been mentioned by a mentor, supervisor or an individual with both roles. The researcher offers an interpretation of the data that is not tinted by any previous experience of public health.

The participants volunteered to offer their views and experiences on the scheme. They all received a written and oral explanation of the purpose of the evaluation. All participants were informed of their rights to withdraw at any point during and after the evaluation, without offering a reason under 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. The data from interviews was collected in note form and included quotes wherever possible. Anonymity in this report has been maintained throughout, as far as possible, with trainees identified by coded numbers that vary throughout the text to maintain anonymity. It is not possible to follow the trajectory of any one trainee by code in the text.

The qualitative data was collected via focus groups, questionnaires and interviews with participants. All the data was analysed together to triangulate information received from all the participants in the study. Strategies from a grounded theory approach (Strauss and Corbin, 1998) were employed along with discursive analysis in analysing the data. All transcripts and notes made from interviews were carefully written and read (and in some cases transcribed by the researcher) for familiarisation purposes. Analysis of the first focus group with trainees meant a coding framework could be developed to follow the trainee’s progress. The framework was used to encapsulate other data emerging from interviews with mentors and line managers. One by one, all the data was compared and contrasted with each other, causing the addition or modification of codes on the framework.

The quantitative data on the competences was collected from trainees. Trainees were asked to present their competence assessments against the PH Skills and Career Framework (2008) that is used as part of the scheme. Trainees provided a baseline at the beginning of the academic year and final year assessments at the end of their placements. Trainees provided this information in various formats. It was possible to carry out a quantitative analysis on the competences achieved by a group of four trainees (one from the second cohort of trainees) as the other formats varied too much to be included. The data was then analysed using Excel.
4.0 Summary of results

This section only offers a breakdown of the main results from the evaluation. Please refer to the full report for more in-depth information and examples of quotes (Zolle, Evaluation report for the PH practitioners training scheme (year 2): interim detailed evaluation (Oct 2008 – Oct 2009).

4.1 The scheme and perceived PH practitioner workforce development in NHS provider and commissioning organisations and Local Authorities

4.1.1 Definition of the PH practitioner role

The PH practitioner role was considered as an influencing factor in developing training initiatives for practitioners. The role varied, as the original definition for PH practitioners was broad, including practitioners from a number of different types of organisations - the NHS, other government organisations and the third sector. It also varied depending on perceptions about the medical or social model of working in PH.

Participants found the definitions between practitioners and non practitioners relatively clear. Non-practitioners (e.g. GPs) working on PH topics were seen to require a specific level of knowledge that was provided by the numerous academic type courses on offer. Non-practitioners did not need experience in developing PH initiatives or PH community programmes.

In contrast, participants reported that PH practitioners require formal PH practitioner training. Differences in PH practitioner needs were perceived for roles in PCT commissioning and PCT provider organisations.

4.1.2 Views on developing the PH practitioner workforce

4.1.2.1 The PH practitioner workforce was described by participants as being ‘complex requiring careful planning’. PH practitioners working at Agenda for Change bands 5 to 7 were seen to belong to the ‘wider workforce’. The actual PH workforce consisted of PH consultants and specialists (band 8 and above). NOTE: The wider workforce includes 99.6% of the PH workforce in the UK (Sim et al., 2002).

4.1.2.2 Developing the workforce required ‘a homogeneous approach with a specific direction’. Participants felt that the SHA should provide the direction required for a homogeneous and equitable workforce development and training.

4.1.2.3 Participants reported that there was less experienced PH staff in PCT providers than commissioning organisations. It was also felt that in PCT provider organisations PH experts and practitioners were required to implement and deliver strategic PH initiatives that may also be delivered in partnership with others.

4.1.2.4 LAs developed their workforce according to local needs and involved mainly in-house training, CPD and external Master courses, NVQs and Foundation Degrees. LAs have been trying to correlate pay structures from Agenda for Change. The PH Skills and Career Framework (2008) for PH practitioners is not used in LAs as these are not NHS organisations.
Nevertheless, registration with the UK Public Health Register would still apply for individuals working in LAs with roles in PH, and PH practitioners in the near future.

It was felt by some participants that this proposed registration does not currently consider some wider aspects of working in PH that involve a social model for community working. LAs were able to access NHS training available for their health promotion workforce and this was important in attaining a PH impact in the community and work in partnership. However, some LA staff working in PH (such as environmental health and public protection) felt excluded from training provided by the NHS because the practitioner training scheme was not seen as appropriate to their PH roles.

4.1.2.5. Data showed the scheme offered comprehensive training with theoretical and practical development of ‘shows how’ and ‘knows how’ competences as per the PH Skills and Career Framework. It was appropriate for health promotion and PH practitioners at LAs and NHS organisations as the training was linked to proposed registration with the UKPHR.

The training organised through SHA/NESC offered equitable training for staff in LAs and NHS.

4.1.2.6. Participants felt that the scheme increased both capacity and capability of the PH practitioner workforce.

4.2 The scheme and PH practitioner registration

4.2.1. The scheme was seen to allow the individual development of competence to an Agenda for Change band 7 level aligned to the PH Skills and Career Framework. Trainees from the two cohorts thought the links to registration were important. There were mixed views about the ‘portfolio of evidence’ as the exact requirements for practitioner registration were still unclear at the time of writing. It was, however, seen as an exercise that would help trainees with further consultant/specialist registration if they wished to pursue careers in PH any further.

4.2.2. Trainees from cohort 2 felt that being part of a formal register (UKPHR) increased their credibility and perceived standard of work.

4.3 Developing trainees as PH practitioners

4.3.1. All trainees felt that the scheme widened perspectives and provided important insights into what it meant to be a PH practitioner. All trainees commented on having gained a wider scope about PH to the extent that it had changed their practice in PH.

4.3.2. Cohort 1 trainees described their knowledge of PH before joining the scheme as ‘tabloid knowledge’.

4.3.3. Trainees felt the scheme had shaped their understanding of PH and PH policy, as well as increasing their understanding of PH, which was ‘more than target based’. Trainees commented on having had a holistic patient model that was too narrow minded as it excluded aspects of population health. There was an increased
awareness of the two different PH models – social and medical. Trainees said the scheme provided the tools to be able to **transfer from one model** to another depending on what was required for any particular initiative or strategic plan.

4.3.4 Trainees felt they had gained **critical thinking skills** through the scheme. Trainees also claimed to have ‘**gained professionalism**’ in PH and the **ability to support others** in the team at work.

4.4 Overall perceived benefit of the scheme by organisations

4.4.1 **NHS provider organisations**

4.4.1.1 Line managers felt the scheme had provided more ‘grounded individuals’ in PH with increased understanding about their roles. **Trainees could prioritise tasks, write project plans, and look for the evidence base, which meant they could support the writing of bids and a project in a more strategic manner.**

Some line managers reported increased **confidence** in trainees to the point of **increasing responsibility and leadership on PH initiatives.**

The scheme was also seen to increase the local capacity of PH expertise.

Line managers and trainees reported that other PH practitioner colleagues had felt motivated to embark on further PH study by following the example provided by trainees on the scheme. Colleagues in the workforce had felt that doing academic work whilst on the job was an impossible task without support from such a scheme.

4.4.2 **NHS commissioning organisations**

4.4.2.1 Commissioner organisations mirrored the line managers’ comments from provider organisations on the increased confidence and application of PH knowledge and skills to the job. Line managers and supervisors felt that some aspects of commissioning (such as World Class Commissioning) had not been addressed as part of the PH Skills and Career Framework and had therefore been omitted from the scheme.

Trainees felt **they required specific commissioning skills that had not been addressed by the scheme (or the PH Skills and Career Framework).** Previous roles in PH were seen as having been more practical and ‘hands on’ in nature. There had been discussions in the workplace about removing the ‘PH practitioner’ title for one trainee from a commissioning organisation.

It was felt that the scheme and training **should reflect proposed PH practitioner registration.**

4.4.3 **Local Authority**

Similar comments to the above were received from line managers regarding the increased trainees’ confidence and application of PH knowledge and skills to the job. It was felt that the trainee was able to ‘operate at a more senior level’ and had an increased ability to ‘develop partnership arrangements’.
The scheme was said to offer a clear route into a framework of well defined careers in PH careers and was having a positive effect on other practitioners who had been enquiring about the scheme.

4.5 The scheme

4.5.1 Reasons for joining the scheme

Several reasons were provided by trainees to include;

1. To evolve as practitioners in the workplace
2. Fulfil career expectations
3. Study and find out more about PH
4. Gain ‘hands on’ experience to a more strategic level
5. Learn about other organisational environments and culture and improve partnership working
6. Earn a recognised qualification that would allow them to take forward what they’d learned
7. Gain skills recognised by the NHS and governmental institutions.

4.5.2 Number of ‘shows how’ and ‘knows how’ competences achieved by trainees on the scheme (according to the PH Skills & Career Framework for band 7 PH practitioners; 2008) A full breakdown of the quantitative data may be found in the Appendix.

Percentage of core ‘shows how’ competences achieved during one year of training = 70% (n=94 competences out of a total of 134) (calculated from a mean sample of five trainees)

Percentage of core ‘knows how’ competences achieved during one year of training = 74% (n=84 competences out of a total of 113) (calculated from a mean sample of five trainees)

Progress on achieving ‘defined shows how’ and ‘defined knows how’ competences was slower than in core areas. Trainees appeared to be concentrating their effort on gaining competence in one specialist area of PH e.g. PH intelligence. It was more difficult for trainees to achieve the ‘shows how’ competences in other defined areas.

Trainees, line managers and mentors felt there was a need to link the achievement of ‘shows how’ competences acquired at work to those acquired through placements. It was felt important to try to align the learning needs to the competences in the job to use all the opportunities available at work for developing the competences throughout the scheme.

The competences to be acquired provided a professional direction for each individual trainee and a way forward. It was felt that the academic course did not deliver some of the ‘knows how’ which were then provided by the learning sets and workshops. The lack of criteria and tools for completing competences made it difficult to assess what was adequate evidence of their attainment. There were no guidelines by the UKPHR on what might be considered as an adequate assessment of competences.
It was felt this was subjective and open to interpretation. Some mentors and line managers believed the competence framework was too generic to cater for all trainees’ individual needs. Completing placements was paramount for acquiring ‘shows how’ competences by trainees who had limited exposure to PH in their current roles.

4.5.3 Placements

These should **strike the right balance** between:
- filling gaps on the competency framework,
- providing an appropriate learning environment for trainees,
- producing a level of work adequate for the trainees’ aspirations and learning needs,
- providing a service to the host organisation,
- working independently under adequate supervision and understanding the novel organisational culture.

Trainees were taken away from their ‘comfort zones’ in PH to experience ‘new PH horizons’. Placements provided an opportunity for putting what was learnt into practice. This was particularly important for trainees with limited experience of PH in the workplace. Placements offered a variety of learning experiences adequate for each trainee (examples of descriptions on placements are provided in the full report).

Trainees also reported having gained a **boost in morale** by working in more ‘stable’ organisations. The scheme enabled the **building of networks and partnerships** and encouraged a **broader perspective** of the work carried out in partnership between LAs and PCT providers. It allowed trainees to experience PH environments where they might **prefer** to work in the future (and vice versa). Placements were seen to synchronise with the other elements of the scheme and trainees felt able to take the learning to a more strategic level. Placements promoted independent learning. Trainees valued the experience of autonomy.

Placement organisations felt they had benefited from taking on a trainee as it **helped them ‘to move things forward in key areas’**.

Trainees felt that it was difficult to organise their own placements. One trainee worked in the same organisational environment as their daily job. The trainee did not recommend the experience. It was felt the work undertaken during placements should be manageable within the period of time allocated (five weeks). It should have a clear structure and aims, together with clear competence objectives to be achieved. One trainee suggested taking appropriate chunks from the time allocated for placements e.g. two weeks preparation in one block and three weeks taken after their completion.

Placements should be part of the planning for the scheme to accommodate to the different learning needs of trainees. Trainees wanted (and were encouraged) to meet the placement supervisor before agreeing on the placement.

4.5.4 The Masters

4.5.4.1 The academic course at London South Bank University (MSc – follows a social model for PH)
4.5.4.1.1 Trainees were allowed to choose a Master course that was convenient to them. All participants (including trainees) agreed that the course provided the ‘knows how’. Trainees said they developed these rapidly. Some trainees found the academic work difficult due to self imposed expectations. They said submitting written academic work was a relief as well as a rewarding experience. The experience allowed trainees to think more broadly about CPD options in the work environment. They felt the modules were relevant to their daily jobs. Trainees thought some of the assignments were ‘very useful’ as they were able to plan an intervention and then put it to practice in the workplace. By attending the academic course together as a cohort of trainees (cohort 1) were able to establish a closer peer relationship and support network with each other. Some trainees claimed having a high level of familiarity with some of the concepts taught but not all. The learning sets were structured so that they wouldn’t clash with deadlines for assignments and other academic work. This was very useful.

4.5.4.1.2 It was difficult for line managers and mentors to ‘get a feel’ for what was being taught as part of the MSc. It was clear that not all the ‘knows how’ competence levels had been hit by the MSc.

4.5.4.1.3 Support received by the university and information about the course was felt as unclear. Some trainees reported some concern regarding the structure and teaching methods used by some of the lecturers, describing them as too ‘didactic’ in some cases. Also, accommodation was felt to be too small for the number of learners. The lack of learning outcomes from some of the lectures also posed some problems in relating the topic taught with the writing of some assignments. NOTE: Trainees have also provided feedback about the above to the course organisers at the university. Every session is carefully evaluated by lecturers for the purpose of curriculum development.

4.5.4.2 The academic course at King’s College (Master in Public Health and not an MSc – this course follows a medical model for PH)

4.5.4.2.1 This course differed in both content and structure to the MSc at London South Banks University. The trainee had to take exams at the end of each module, requiring extra time for revision. The trainee said that the extra demands imposed by the course made the experience more stressful. Learning sets were also scheduled with respect to the academic course at London South Banks University.

4.5.4.2.2 The trainee’s line manager reported providing a flexible approach to try and help with the extra stress as it had an important influence on the trainee’s workload and work-life balance.

4.5.4.2.3 The relationship with peers on the scheme was not seen to be affected by having a trainee on a different academic course. Providing different points of view (from a medical model perspective of PH taught at King’s College versus a social model taught at London South Banks University) enriched the discussions.

4.5.4.2.4 The trainee reported having received excellent support from peers on the Masters outside the scheme and also from tutors and lecturers.
4.5.5 Learning sets

These were ‘tailor-made’ to a certain extent. They provided the extra ‘knows how’ competences that are not covered by the Master courses. Aimed to provide a safe environment for trainees to discuss the applied learning and different experiences. Further learning occurred through reflection. Trainees shared work and placement experiences quite readily with each other. When cohort 1 (now finished formal participation in the scheme) was asked about the most memorable part of the scheme, the unanimous answer was the peer learning, together with the competency grids that were designed by one of the trainees and shared by all. Cohort 1 had felt under extra pressure trying to structure the learning sets to their own learning needs. There were mixed feelings about learning sets.

4.5.6 Protected study time

Organisations allowed for different study times. Backfill funding was provided to ensure equity. Protected study time was seen as indispensable for completing the scheme. There was some anxiety expressed by cohort 1 trainees regarding the lack of protected study time for their final year on the Masters. Some organisations were able to bank the days that had not been used by the trainee to a later less work-demanding time. The scheme provided guidance to employers about a recommendation of study time for the final, third year, to complete the dissertation once the 50% backfill had ceased.

4.5.7 Influence of the scheme in the workplace

Trainees were seen by participants as being accountable and responsible for their roles while training. So PH practitioners felt more under pressure to perform both on the scheme and at work than PH specialist trainees who are not accountable or held responsible for their roles during training. Trainees with limited exposure to PH in their roles had gained indirectly from the scheme by applying the knowledge to other people’s practice. It was difficult for trainees to adapt from full-time to part-time working. Many reported feeling ‘out of the loop’. Trainees resorted to working extra hours and this increased the pressure felt by some. Line managers felt that it was difficult to engage some trainees at work because of the shift to part-time working.

Trainees commented on feeling isolated at work and some felt they were not being challenged enough by their line managers. Other team members were able to see that there were achievable training opportunities for PH practitioners and some line managers reported an increase of interest in the scheme.

Trainees commented on being able to reflect on past mistakes and were applying a more focused outlook to their PH work. Trainees from different cohorts reported having the credibility they required to engage others that have a different outlook on PH matters. They felt it was important to link their dissertation to the workplace.
4.5.8 Impact of backfill on team development

Backfill was used flexibly – examples may be found in this section. In some cases it helped develop other team members. Some trainees found that their backfill was one of the scheme’s highlights. Organisations claimed they would not have joined the scheme without backfill being provided, as organisations do not have the capacity or the money to support this type of training. Backfill had a roll out effect on team members when the backfill replacement was found from within the team. This meant that other team members also benefited from further experiences in PH. The wider workforce was also being trained. Trainees were responsible for training their backfill replacement and had to take time to do this too.

4.5.9 Line manager support

Trainees needed support to get the right balance between work, the scheme and life. Support was also required to complete the learning needs assessment at the beginning of the academic year. Assistance was requested to complete the competences, projects, and work-related assignments. Trainees would ask their line managers more readily for advice than their mentors. There were mixed feelings regarding individuals with dual supervisory and line management roles. Some trainees commented on this as being particularly useful whereas others reported that time spent supervising was usually taken on by work commitments. Some line managers felt they were supervising when this was perceived as line management by the trainee. Supervisor/line managers also reported being confused as to when one role started and the other finished. Participants suggested that some guidelines should be developed explaining line management/supervisory roles.

4.5.10 Supervisor (mentor) support

Meetings varied from weekly to every couple of months. Support included looking at dissertation proposals, providing help to find adequate placements and projects for placements and advice on assignments. There were also discussions about the different academic modules and competences. One supervisor felt the role allowed him/her to develop as a mentor. Supervisors were generally used for networking opportunities. Some trainee mentors only met sporadically, which might account for some supervisors believing that practitioner training demands less of them than specialist training.

4.5.11 Impact of the scheme on careers

The experiences of placements in other organisations equipped trainees with a broader understanding of the types and variety of roles available to practitioners in PH. Trainees were able to see opportunities that were available to them perhaps as an expansion of their roles at their own organisations. They felt prepared to work at a higher level after the two years of training. Trainees with roles that were not directly linked to PH felt that it was difficult to get involved in PH areas as the organisation would need to have someone carrying out their current roles. Some cohort 1 trainees wanted to focus on applying to their roles and were looking forward to going back to working full time. It was generally felt that the impact of the scheme on careers had been important at different levels. In one way trainees felt they had given up part of their roles by working part time...
and being on the scheme, which influenced their work. On the other hand they were aware that their career prospects would be increased by the end of the course.

Line managers commented on the value of finally having a pool of already ‘trained PH practitioners’. Trainees were seen as having great potential in the job market.

4.5.12 Progression from PH practitioner to specialist level

One supervisor felt that the scheme ‘set people up admiringly’ for the PH specialist scheme. It was hoped that trainees would become more senior and apply for the specialist programme or perhaps become defined specialists in a PH area if they wished.

4.5.13 Perceptions on funding for the scheme

Participants hoped the scheme would offer training for a greater number of trainees (currently 10 from cohorts 1 and 2, and six from cohort 3). Since the training is for band 5 to 7, the backfill is expensive. Organisations felt it would be an unrealistic expectation to ask them to fund the training.
5.0 Discussion

We are currently facing a climate of rapid changes and challenges in our attempts to improve health indicators and the wellbeing of the world (WHO, 2002; The Lancet, 2002). The capacity of the PH workforce does not appear to be able to respond effectively to the changes and the causes for this have been determined as lack of education and training opportunities available for a capable PH workforce (Beaglehole et al., 2004; Mackie and Sim, 2005). It seems that the development of the PH workforce which should deliver a number of these changes has been widely neglected as leading authors declare the unpreparedness of the PH workforce to face the changes and challenges in the UK and the world (Beaglehole et al., 2004).

The PH workforce has been described by participants in this evaluation as being ‘complex requiring careful planning’. The WRT’s objective from 2008-2009 was to increase the recruitment and retention of PH specialists and consultants by encouraging individuals to apply for training. According to Sim et al (2002) this PH workforce consists of a total of 0.4% of the total PH workforce in the UK.

It is proposed that individuals are able to apply for UKPHR registration and submit a portfolio of evidence that would provide national recognition of the training received. Although there are clear training routes for bands 8 and above there is very little training on offer for what the WRT considers the wider PH workforce.

One of the problems in achieving the objective set by the WRT is the lack of an adequately trained workforce at a practitioner level that could lead to the specialist and consultant training routes. The challenge faced is therefore in motivating individuals to embark on high level training at specialist or consultant level without any former formal training in PH.

PH practitioners have been identified in the literature as being at the core for delivering and implementing PH programmes (Beaglehole et al., 2004; Mackie and Sim, 2005). Authors reported the importance of providing training opportunities that would enhance and improve the current understanding and skills of this workforce. Participants felt that understanding the role of the PH practitioner was paramount to developing adequate training opportunities for this workforce.

The use of the PH Skills & Career Framework’ (2008) as a guide to develop ‘knows how’ and ‘shows how’ competences in PH has meant aligning the scheme to a standard for training that is adequate for PH practitioners. The competences are broad and allow the development of practitioners from a number of different disciplines and organisations, providing the homogeneity in the training reflected by participants. The scheme provides practitioner level insight into the social and medical models for planning and delivering PH initiatives through academic work and sharing of experiences. There is evidence in this report to suggest that trainees are not only gaining core ‘shows how’ and ‘knows how’ competences, they are also producing pieces of work that are strategic as expected from a band 7 PH practitioner that would allow a progression route into specialist or consultant training.

Some comments received from PCT commissioning organisations, however, suggest the need to revise the competency framework to incorporate other strategic band 7 competences that are directly related to commissioning roles for practitioners. The recent split between NHS providers and commissioners has been reported to have caused an imbalance in the PH workforce where PH experts in provider teams appear to be scarce. This appears to have caused problems with delivering PH programmes in the community.
that have now been described as being very target-led, lacking an understanding about the social detriment of health. This therefore suggests that PCT provider organisations would benefit from training their PH practitioners to help address the imbalance and raise the PH quality of the interventions.

The SC SHA strategy for education and training of the PH workforce indicated the need to integrate PH practitioners in commissioning teams. This would support leadership in the general development of health improvement programmes in the community. It also identified that PH practitioners were ‘less well integrated into the health service agenda’ and that commissioning teams did not quite know ‘how to use PH skills when this is available’ (SC SHA, Education, Training and Development Strategy, 2007-2012). This report provides evidence that both commissioning and provider organisations require PH practitioners to adequately deliver professional PH target outcomes.

NHS provider, commissioning and LAs have benefited from having a trainee on the scheme in various ways. These organisations have been able to offer a comprehensive practitioner training package. It encompasses theoretical and practical training tailored to suit the needs of the individual trainees with respect to the PHSCF competency framework (2008) and future requirement for registration with the Faculty for PH. The scheme has been shown to offer an adequate progression route into consultant and specialist training.

One of the main reasons why practitioners joined the scheme was to evolve as PH practitioners in the workplace. Trainees commented on having gained a ‘wider scope’ about PH to the extent that it had changed their practice. They felt that the scheme had helped shape their understanding of PH (described as being ‘more than target based’) and PH policy.

Line managers have reported that trainees have been able to take on new responsibilities, have improved report writing skills, partnership working skills and have been able to apply the theoretical learning to the workplace even after just one year of being on the scheme.

Trainees from both cohorts have reported an increase in confidence, knowledge, understanding and skills of what it is to be a PH practitioner. It is evident that trainees have gained PH competences and we have shown these to be about 74% of ‘knows how’ and 70% of ‘shows how’ in the core areas of the competency framework. This result may seem surprising since trainees perceive that their ‘knows how’ have been more easily attained. One explanation for this could be that the competency framework does appear to have more ‘knows how’ than ‘shows how’ to be achieved for an Agenda for Change band 7 role in PH. There is therefore more of a knowledge and theoretical than practical requirement although both knowledge and skills for the role are still quite substantial.

Some trainees have gained a number of competences also in the defined areas of PH, particularly in health improvement. The competences have been achieved through a combination of learning sets, Masters, placements and opportunities at work. The scheme was perceived as ‘fitting nicely’ with the Local Authority and NHS organisational PH workforce development. Further work would need to be carried out in the future to explore to what extent the current competences from Skills for Health match those required by the different PH roles.

The scheme has influenced PH teams across organisations and has provided a lever for PH practitioners who are reticent to embark on similar type training due to workload demands. The scheme is achievable, although it may require some readjustments to accommodate attendance at different Master courses.
6.0 Conclusion

This report presents a summary update for the evaluation of the PH practitioner training scheme that has developed practitioners’ competences to a band 7. It has provided practitioners with the knowledge and skills required for their PH roles through sufficient exposure and experience in PH.

This scheme is unique in the way that it addresses proposed PH practitioner registration, competences and training.

Overall this report emphasises that increasing PH capability by developing the practitioner workforce at the SHA level is perceived to:

- Reduce professional isolation by setting up a peer group and embedding the practitioner in a number of different PH placements
- Develop in practitioners a more robust knowledge base, framework and tools
- Provide a high quality training opportunity (deemed to be limited)
- Provide sufficient exposure and experience in PH through placements
- Promote homogeneity of training standards
- Provide a vital element of development within a PH career pathway towards specialist level
- Identify a group of PH practitioners to become registered on the UKPHR when this is available
- Provide practitioners without existing professional registration (such as nurses on the NMC or environmental health practitioners on the CIEH) a foundation to become registered themselves
7.0 Recommendations

The following recommendations are offered to the providers of the PH Practitioner Training Scheme and its professional advisory group to be taken into account alongside other developments regarding practitioner training and registration processes.

7.1 Maintain links with the UK Public Health Register regarding the future of practitioner registration

Trainees are maintaining a portfolio of evidence of competence as preparation for registration. PH registration requirements have not, as yet, been finalised for PH practitioners. It is therefore important to maintain links and work with the UKPHR to inform practitioners and update the scheme as required.

7.2 Provide evidence to Skills for Health to evaluate the extent to which the competences in the PHSCF accurately reflect the current role of the PH practitioner.

There is evidence in this report to suggest that the competences on the PHSCF may need revision to accommodate recent changes in the role of the PH practitioner as a result of the NHS commissioner/provider split. It may be necessary to evaluate to what extent the competences for commissioning and other aspects of PH are reflected in the PH competences developed by Skills for Health.

7.3 Evaluate the impact of the role of the PH practitioner in the PH workforce – also to attain an understanding of the breadth of the role as related the competences for developing training initiatives

This report suggests that the definition of a PH practitioner role may vary from one organisation to the next (e.g. PCT and LA). Understanding of roles is also perceived as being paramount to developing adequate training initiatives. The scheme provides a form of comprehensive and a homogeneous standard of training for practitioners.

It would be useful to evaluate the impact that the broad role of the PH practitioner in NHS and other organisations has on the PH workforce in an attempt to obtain a clear definition and understanding of the competences of this workforce. This is particularly important if there is to be a standard of services to be provided by PH practitioners and also to inform future training developments.

7.4 Increase awareness of the scheme to engage more practitioners and organisations.

The scheme provides comprehensive training for practitioners from various organisations. The lack of adequately trained PH practitioners means that the PH practitioner training scheme trainees that have completed the scheme are highly employable. There is therefore a demand in the job market for adequately trained PH practitioners.

7.5. Link PH workforce planning to workforce development and training

There is evidence in this report to suggest the need to link PH workforce planning to development, with a clear understanding of progression routes. An understanding of service needs through workforce planning would allow identify work areas in need of practitioner
development. This would provide organisations with demand-led training and enhance the retention of trainees within their organisations once the training is completed.

7.6. Provide an initial workshop on the scheme for line managers

Most trainees appear to rely mainly on the advice provided by their line managers. This will ensure that all line managers are aware of the UKPHR requirements for registration and the PH competences that are to be achieved by trainees. It would allow trainees to receive the maximum support from their line managers.

7.7 Continue backfill funding

Line managers and trainees have reported that they would not have ventured into the scheme without this support.

The data presented in this report suggests that trainees would be unable to cope with the stress exerted by all the different elements of the scheme without the support provided by backfill funding. If backfill funding were to be removed from the scheme, the whole training programme would have to be revised thereby substantially decreasing the number of competences to be achieved (perhaps to a level that would question the change). Some comments were made regarding travel expenses for attending Master courses that are currently being paid as part of the backfill funding. Travel to London for lectures can, in some cases be costly.

7.8 Continue to encourage applicants from various organisations and backgrounds to join the scheme

Trainees learnt from each others' experiences and expertise in PH. This helped them develop a number of new competences. It allowed trainees with no specific role in PH to become PH practitioners. It would be interesting to explore in the future how other individuals with no previous experience of PH might benefit from the scheme.

7.9 Continue training links with LAs and NHS organisations through placements

Trainees from both NHS and LAs exchanged experiences and gained a broader understanding of PH as a result this might lead to a more equitable and homogeneous practitioner workforce. Organisations should also be encouraged to provide placement opportunities. It has been suggested that it might be useful to provide support for placement supervisors so that the aims of the scheme and of the placements are clear from the onset. There is a guidance paper on this for managers/supervisors. Clear competence objectives should be set from the start of the placement. It has been suggested this could be done in line with the learning needs assessment carried out at the beginning of the academic course.

7.10 Provide guidance for mentors and line managers on the scheme

At the moment trainees are not maximising the benefit of having a supervisor on the scheme. Trainees have reported not really knowing what might be the right level of engagement with their mentors. Although the role for "educational supervisors" on the national deaneries' specialist training scheme is well defined, this is not the same for this local, practitioners training scheme. Line managers also felt they required updating on the current PH practitioner competences to support trainees and avoid being ‘thrown in the deep end.’
7.11 Revise learning sets

Evidence in this report suggests that it was necessary to put in place learning sets that would provide the ‘knows how’ gaps of the competences that were not developed through the Masters courses. Revising the learning sets would increase the opportunity to gain ‘knows how’ competences above the current 74%. The use of the learning sets could be modified to encourage further learning. Trainees have commented on the need to make the learning sets specific to each cohort’s needs rather than provide a repetition of the same.

7.12 Continue the provision of the PH Practitioner training scheme by SHA/NESC

The scheme was seen to provide a comprehensive form of training that is homogeneous and equitable to all practitioners from different organisations. PCTs and LA organisations felt it appropriate and necessary for PH practitioner development in the region that SHA/NESC provided a central drive for this. The scheme would not have succeeded without this drive.
8.0 References


European Commission, Green Paper: On the European Workforce for Health (2009), EU, Belgium


Mackenzie M (2008) Doing public health and making public health practitioners: putting policy into practice in Starting Well, Social Science and Medicine, 67(6), 1028-37


UK Voluntary register for public health specialists, www.publichealthregister.org.uk


Quantitative data on the PH practitioner training scheme

Quantitative data on the average number of ‘shows how’ and ‘knows how’ achieved by trainees. The average was calculated from the total possible number of competences that are to be achieved at a band 7 level for PH practitioners (Skills for Health PH careers and Skills competency framework, 2008).

Table 1. Core PH areas of ‘shows how’

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<tr>
<th>Core PH areas of ‘shows how’</th>
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<tbody>
<tr>
<td>Total possible number of competences to be achieved for a band 7</td>
<td>134</td>
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<tr>
<td>Total number of competences achieved by trainees</td>
<td>94</td>
</tr>
<tr>
<td>Percentage of competences achieved during one year of the scheme</td>
<td>70%</td>
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Table 2. Core PH areas of ‘knows how’

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<th>Core PH areas of ‘knows how’</th>
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<tbody>
<tr>
<td>Total possible number of competences to be achieved for a band 7</td>
<td>113</td>
</tr>
<tr>
<td>Total number of competences achieved by trainees</td>
<td>84</td>
</tr>
<tr>
<td>Percentage of competences achieved during one year of the scheme</td>
<td>74%</td>
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</table>
Graph 1. Average breakdown figures for each ‘Shows How’ PH competences attained for 2008 (blue rhomboids) and 2009 (red squares) also showing the maximum number of total individual competences for a band 7 on the framework (green triangles). The y axis shows arbitrary competence units for each area.

Graph 2. Average breakdown figures for each ‘Knows How’ PH competences attained for 2008 (blue rhomboids) and 2009 (red squares), also showing the maximum number of total individual competences on the framework (green triangles). The y axis shows arbitrary competence units for each area.