The applicability of the UK Public Health Skills and Knowledge Framework to the Practitioner workforce

Professor Darren Shickle

Professor of Public Health

My presentation last year …

UNIVERSITY OF LEEDS

14 Interviews/ focus groups conducted with senior Public Health staff in 12 local authorities and in Public Health England in the Yorkshire & Humber

- Despite cuts in training budgets, junior staff were increasingly expected to deliver Public Health functions
- Absence of a career ladder for core Public Health workforce
- Concerns that financial constraints would lead to reductions in Public Health skills with fewer staff to provide critical analysis
- Formal qualifications were increasingly less valued
- Staff expected to have a broader skill set with emphasis on experience
- Entry points into Public Health careers need rethinking
- Public Health departments expected to 'grow their own'
- Apprenticeships very important to local authorities

Shickle D, Stroud L, Day M, Smith K. **Master or Apprentice: rethinking entry points and training in Public Health**. Journal of Public Health 2017, https://doi.org/10.1093/pubmed/fdx081

Public Health Practitioner Apprenticeships

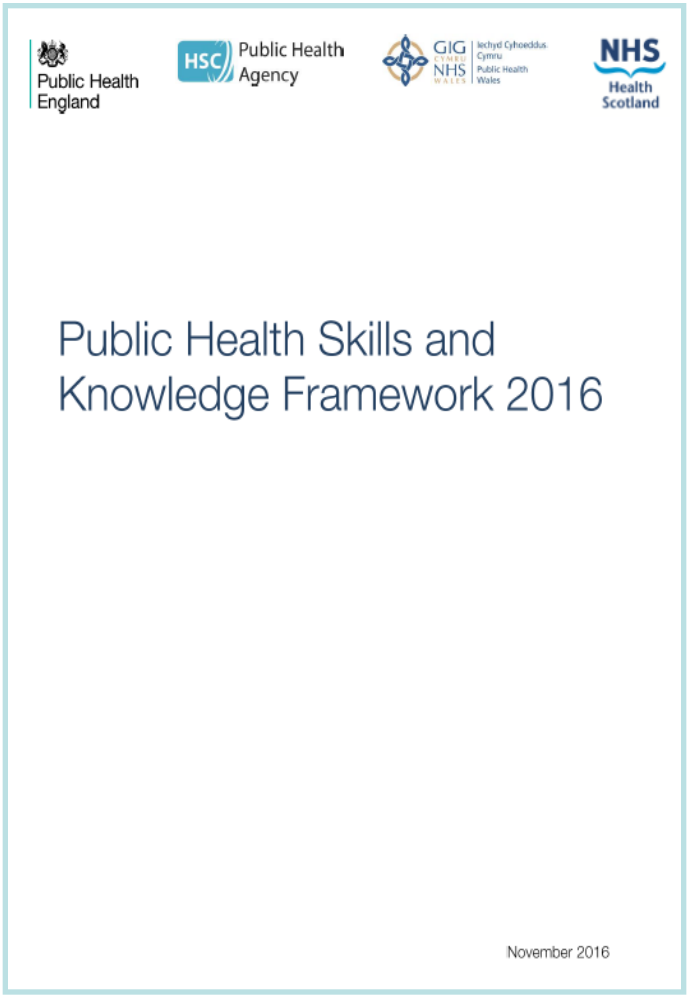
UNIVERSITY OF LEEDS

- Trailblazer group has been set up
- Expression of Interest approved by Institute of Apprenticeships
- Next task to develop the Apprenticeship Standard for a Level 6 Public Health Practitioner
    - Public Health Practitioner occupational profile
    - Responsibilities and duties of the role
    - Behaviours and values
    - Skills and knowledge

Defining the Practitioner Apprenticeship Standard

UNIVERSITY OF LEEDS

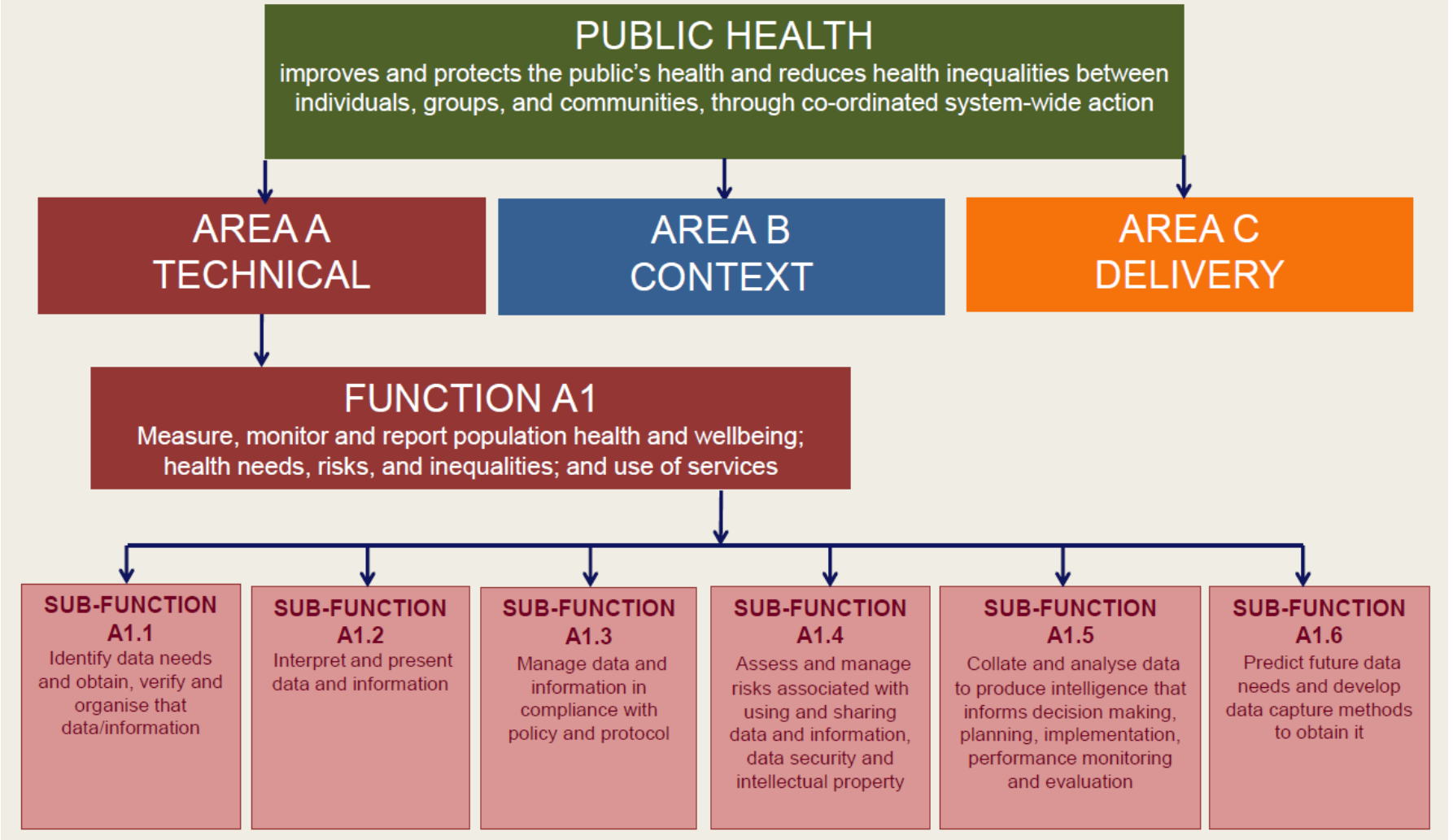
- Advantages
  - In theory, to be used in all parts of the UK for all PH staff
- Disadvantages
  - Not benchmarked to levels like the old PHSKF
  - UK Public Health Register yet to adopt the new PHSKF
  - Not clear to what extent PHE expect all PH staff to have all of the new PHSKF competencies



Public Health Skills and Knowledge Framework (70 competencies)

UNIVERSITY OF LEEDS

Functional mapping – areas, functions and sub-functions



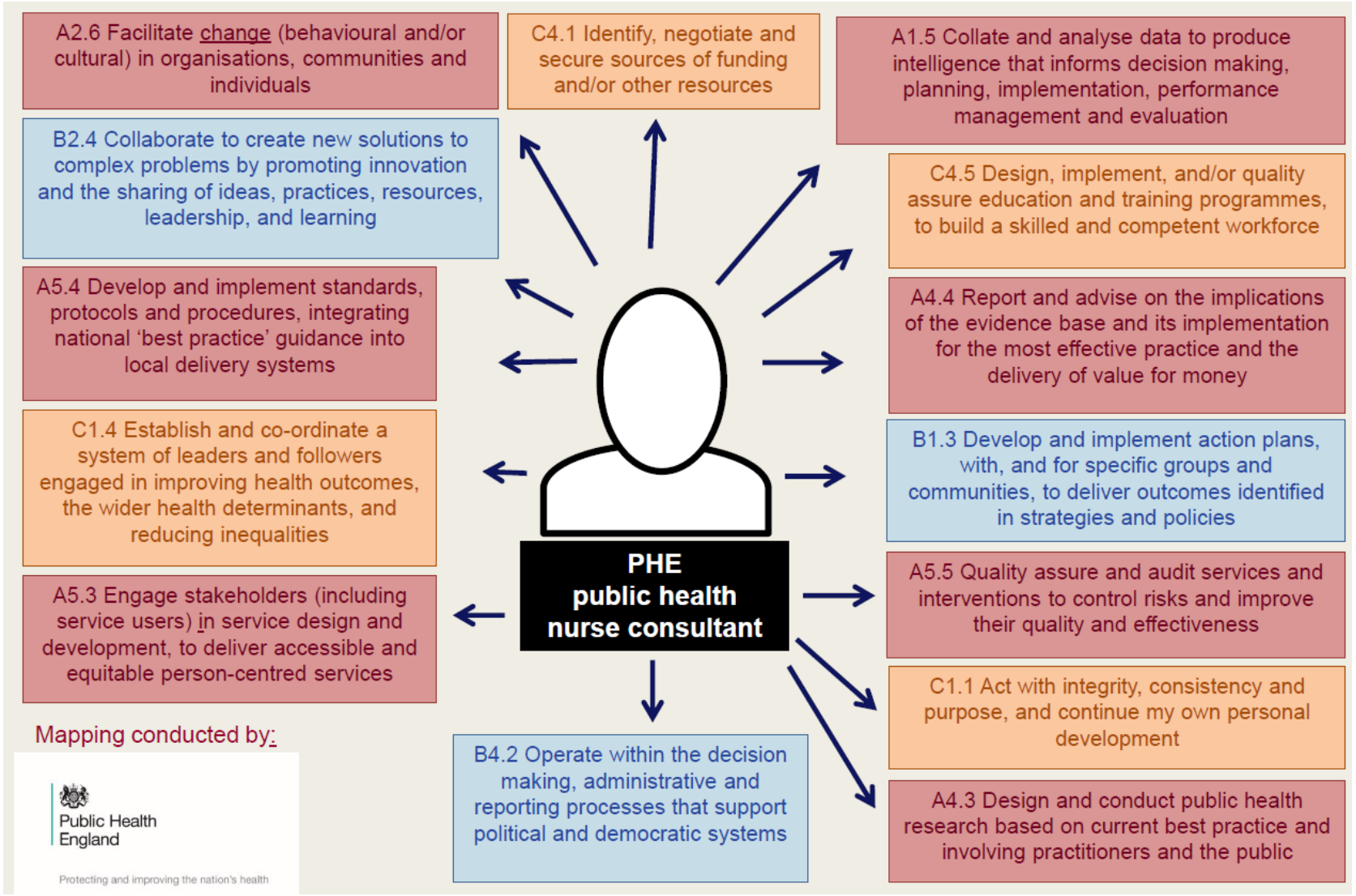
How the PHSKF could be used?

UNIVERSITY OF LEEDS

- Profile an individual worker through ‘self assessment’
- Provide a template for a role that frequently occurs in the public health family with established pre-registration curriculum eg: environmental health officer
- Create a job description for a new role that may need to be defined to meet a gap in a team or service
- Develop learning curricula linked to public health activity as it is being described in the workplace
- Describe areas of public health activity that need to be delivered through a service level agreement or specification
- Provide overarching context for the development of more detailed frameworks relating to very specific areas of expertise or focus, e.g. behavioural science, mental health, health protection

Mapping the PHSK Framework onto the wider public health workforce

UNIVERSITY OF LEEDS



Mapping conducted by:

Public Health England

Protecting and improving the nation's health

Methodology

UNIVERSITY OF LEEDS

- Interviews with Public Health practitioners to understand how the competencies needed for their existing role map onto Public Health Skills and Knowledge Framework
- 15 small group interviews
  - 9 local authorities in Yorkshire and the Humber
  - 1 - 6 people in each group (median=3)
  - 51 participants (36 females, 15 male)
  - 37-61 minutes
- Interviewees asked to state job title and role
- PHSKF functions were discussed in random order

Initial comments

UNIVERSITY OF LEEDS

- Participants had a wide range of roles and job titles, reflecting the broad definition of practitioner.
- Most participants had not seen the new or previous PHSKF.
- Those that had preferred the simpler, new layout.
- None had attempted to assess their competencies against the framework.

A1: Measure, monitor and report population health and wellbeing; health needs; risks; inequalities; and use of services

UNIVERSITY OF LEEDS

- On the whole participants were regularly involved in analysing and presenting data. Although this competency was more relevant to public health analysts.
- Those participants with less senior roles were least confident with the A1 competencies and were given data rather been expected to find/analyse it.
- The most problematic A1 competency related to predicting future data needs and developing data capture methods.

"It's more [of a public health analyst's role] but everybody within the team can still dip in and out, you know do it a little bit and if you need their support you can always go to the experts in this area."

A2 Promote population and community health and wellbeing, addressing the wider determinants of health and health inequalities

UNIVERSITY OF LEEDS

- Participants thought all public health workers would contribute to this function.
- However, many participants reported using these competencies less than they did previously.
- Some practitioners had limited contact with the public, but could still see why these competencies were needed.

“This is probably predominantly linked in to the needs assessment process in terms of understanding communities and contribute to strengthening community assets. It’s also embedded in a lot of the stuff we’re doing in terms of building community capacity as part of service development, and as well as linking in to peer support networks.”

A3: Protect the public from environmental hazards, communicable disease, and other health risks, while addressing inequalities in risk exposure and outcomes

UNIVERSITY OF LEEDS

- A3 competencies were perceived as areas of public health that required specialist (and typically clinical) expertise that most practitioners did not have.
- Although more senior participants recognised that they may need to provide support if there was an emergency incident or infection outbreak.
- Participants felt more comfortable when it came to competencies managing specific risks related to their role. For example, practitioners working with substance misuse needed to respond to deaths due to contaminated drugs.
- At micro level, all practitioners have organisational obligations for fire safety and health & safety training which required staff to analyse/manage risks within workplace

A4 Work to, and for, the evidence base, conduct research, and provide informed advice

UNIVERSITY OF LEEDS

- Utilising evidence and guidance, from a range of sources, was seen as very important for public health practice.
- There was a tendency to use guidelines and advice from respected organisations rather than searching for and interpreting the evidence themselves.
- Many participants discussed the challenges of using research techniques with limited time, expertise and resources, although some did commission/collaborate with Universities.
- An important skills was to be able to present evidence in a suitable format for a range of audiences.

A5: Audit, evaluate and re-design services and interventions to improve health outcomes and reduce health inequalities

UNIVERSITY OF LEEDS

- Participants were most concerned about competencies relating to economic analysis.
- Some participants would rely on other team members to lead on appraising new technologies and interventions.
- That said it was recognised that such skills were important.

"I think the economic one [A5.1] is one that we've probably dabbled in. We've made some attempts at doing it, but I think given the constraint in public health grant, this is something that we probably need to get better at. It's one of those competencies that probably wasn't as important in previous years as I think is now."

B1: Work with, and through, policies and strategies to improve health outcomes and reduce health inequalities

UNIVERSITY OF LEEDS

- Although they had less involvement in developing strategy, many practitioners implemented national or international strategies/initiatives.
- There was recognition that effective policies and strategies needed good partnership working.

"And I think as our remits get wider it's harder to keep on top of all the national policy and everything that's coming out. So as remits get wider, so I'm kind of working on children and young people, right from 0 to 19 but then I've also got the obesity stuff, I've got physical activity. So you've got lots of different policies to try and keep on top of which kind of gets harder as your remit get wider… and …yes you've got your day job to do haven't you as well."

B2: Work collaboratively across agencies and boundaries to improve health outcomes and reduce health inequalities

UNIVERSITY OF LEEDS

- There was unanimous agreement that partnership working and collaboration with other agencies was key to the work of a practitioner.
- Getting ‘buy in’ from partners was a skill.
- Practitioners needed to be effective communicators as partner agencies had their own remits, targets and agenda.
- Participants also spoke of the difficulty in engaging with some groups and communities.

“Some of those groups of communities that we really want to try and target are not easy to engage. The term of ‘hard to reach’ I think is a difficult one because they’re only hard to reach if you don’t put the effort in.”

B3: Work in a competitive contract culture to improve health outcomes and reduce health inequalities

UNIVERSITY OF LEEDS

- For many participants, commissioning was a very important aspect of their role, more than when they worked in NHS.
- There was a shift towards influencing commissioning arrangements within other departments and stakeholders.
- Thus, an understanding of the commissioning process was very important.

“I think finding solutions to allow services to continue in different ways, where funding cuts mean that actually you might have had to decommission before. I guess that comes back to some of the stuff around planning ahead, is how you build up these contracts so that they are more collaborative and you have shared risk between provider and public health team.”

B4: Work within political and democratic systems and with a range of organisational cultures to improve health outcomes and reduce health inequalities

UNIVERSITY OF LEEDS

- The need for these competencies was widely recognised as they had now become part of the ‘day job’.
- Although more junior participants thought they were less likely to get involved at their level.
- Many participants noted working within local government was different to working in the NHS as it was necessary to have the support of the elected politicians.

[In the NHS,] “the Director of Public Health could say what she thought, didn’t really have to worry about the politics. If she felt something she could say it quite happily and without any sort of fear. Whereas obviously if you were in the council it was a completely different thing because they couldn’t really say something that they knew [elected politicians] wouldn’t support.”

C1: Provide leadership to drive improvement in health outcomes and the reduction of health inequalities

UNIVERSITY OF LEEDS

- There was agreement on the importance of professional behaviours such as integrity, personal development, managing conflict and adapting to change.
- ‘Leadership’ and ‘providing vision’ were responsibilities at a more senior level, but participants recognised that they were all leaders in their own way.

“I find the leadership thing a big of a weird animal really because it’s not something that’s talked about or pushed until you get to a senior level. There isn’t at any point that somebody says right we want to develop you in to leading properly, that never actually happens. I think it’s just expected organically for people to pick up on that, and then you get to a point where you’re bombarded with things that are aimed at people working in a particular level that are about leadership, but they’re already working at that level so how did they get there without leadership training?”

C2: Communicate with others to improve health outcomes and reduce health inequalities

UNIVERSITY OF LEEDS

- There was widespread recognition of the importance of communication across the range of individuals and organisations.
- There was also a recognition of the need to coordinate communications to prevent duplication both within own and with other organisations.
- Some practitioners were using the range of communication skills, including new technologies and social media, better than others.

"There's communications and marketing and then there's communication on an interpersonal level. And we're all really good at both... because communication's absolutely key to collaboration. I think it's not something you can teach. It's something you get with practice."

C3: Design and manage programmes and projects to improve health and reduce health inequalities

UNIVERSITY OF LEEDS

- Many groups discussed the use of formal project management tools.
- Some practitioners had PRINCE2 project management training, but did not find it particularly useful.
- However, a structured approach to project management was important.

"I think there are benefits to almost being forced to looking at things in a 'projects way' because it does actually allow you to think about what your priorities are. … [Instead of Prince 2 training] maybe at a fairly general level of why it's important to make sure that you've got a remit, you've got buy in, you've got a clear objective, where there's any funding needed, what are we aiming to achieve by the end of this project, is it going to be sustainable if it needs to be sustainable?"

C4: Prioritise and manage resources at a population/ systems level to achieve equitable health outcomes and return on investment

UNIVERSITY OF LEEDS

- There had been more scope for managing budgets within the NHS.
- Managing budgets within local authority tended to be done centrally or by more senior staff.
- Although practitioners still had a role with opportunities for small projects.
- Whilst the financial management and the workforce development competencies appear separate, one participant recognised that they are inter-related as the workforce was still an important resource.

“I probably have less control over resources now than in previous roles ... I was always kind of used to being given a budget for your programme area and then you work through the systems to what your priorities”

Concluding comments

UNIVERSITY OF LEEDS

- On the whole, participants were able to demonstrate some evidence for all 70 PHSKF competencies.
- Although some evidence related to previous roles (e.g. prior to reorganisation in 2013), and hence would be more difficult to evidence in their present job.
- Some competencies required more ‘creative interpretation’ than others.
- Some of the more junior practitioners (who typically had less strategic roles e.g. smoking cessation advisors) had difficulty providing evidence of both breadth and depth.

Concluding comments

UNIVERSITY OF LEEDS

- Given that the PHSKF covers all levels of the public health workforce, all groups suggested that for some competencies there needed to be word changes to make them more appropriate for practitioners.
- For example, ‘ manage’ or ‘lead’, could be changed to ‘understand’, ‘develop’, ‘influence’, ‘contribute towards’.
- There was widespread acceptance of the need for a broad competency base for public health practice, within a prospective training programme (e.g. apprenticeship) for practitioners who hitherto had varying training opportunities and ambiguous career ladder.

Leeds Institute of Health Sciences

UNIVERSITY OF LEEDS

Professor Darren Shickle
Academic Unit of Public Health
d.shickle@leeds.ac.uk

Faculty of Medicine and Health
University of Leeds
Charles Thackrah Building
101 Clarendon Road
Leeds, LS2 9LJ

www.leeds.ac.uk/lihs