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The applicability of the UK Public Health Skills and Knowledge Framework to the Practitioner workforce: Lessons for competency framework development

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Abstract

Background

Many countries have developed competency frameworks for public health practice. While the number of competencies vary, frameworks cover similar knowledge and skills although they are not explicitly based on competency theory.

Methods

15 qualitative group interviews (of up to 6 people), were conducted with 51 public health practitioners in 8 local authorities to assess the extent to which practitioners utilise competencies defined within the United Kingdom Public Health Skills and Knowledge Framework (PHSKF). Framework analysis was applied to the transcribed interviews.

Results

The overall framework was seen positively although no participants had previously read or utilised the PHSKF. Most could provide evidence, although some PHSKF competencies required creative thinking to fit expectations of practitioners and to reflect variation across the domains of practice which are impacted by job role and level of seniority. Evidence from previous NHS jobs or education may be needed as some competencies were not regularly utilised within their current local authority role.

Conclusions

Further development of the PHSKF is required to provide guidance on how it should be used for practitioners and other members of the public health workforce. Empirical research can help benchmark knowledge/skills for workforce levels so improving the utility of competency frameworks.

Keywords

education, employment and skills, public health

Word count

4290

A number of countries have specified competencies for knowledge, skills and attitudes for public health practice.[1-5] Frameworks cover similar competencies although in varying number. The United Kingdom Public Health Skills and Knowledge Framework (PHSKF)[1] has 70 competencies categorised within 13 functions. Some countries specify a minimum level of competency expected of all public health workers,[2] while others have different expectations for varying seniority.[3,4] An earlier PHSKF,[6] categorised nine workforce levels, however, a review[7] recommended simplification.

The various frameworks do not specify detailed methodology for their production other than reference to consultation with various organisations/individuals.[2-4] The best described was the updated PHSKF[1] which involved a desk–based review of other frameworks, eight consultation workshops, an online survey with 520 responses, and recruiting 100 public health workers to conduct a self-assessment against the previous version[6] of the framework.

One of the priorities of the United Kingdom Faculty of Public Health Workforce Strategy & Standards Document 2018-2021[8] was to define "standards for the necessary professional workforce required to enable transformations in health and wellbeing of the population to take place" including "the development of an effective public health practitioner workforce". The initial objective of this paper was to develop a public health practitioner apprentice training curriculum.[9] Given that the PHSKF[1] has been adopted for the UK, the PHSKF would be a sensible starting point. However, the PHSKF needs benchmarking to the level of the practitioner workforce. Hence, another objective of the study was to assess the extent to which practitioners utilise the competencies defined within the PHSKF. A further objective was to provide guidance on PHSKF competencies not adequately addressed by existing formal (degree course) and informal (on-the-job) training. The final objective was to evaluate the utility of the PHSKF itself. Whilst some of the frameworks have been refreshed, there seems to be no attempt to evaluate the extent to which they have been used and whether they are fit for purpose.

In the UK, practitioner is a mid-career post within the public health workforce[7] (level 5 and 6 on the previous PHSKF[6]) "who spend a major part or all of their time in public health

practice. They are likely to work in multi-professional teams and include people who work with groups and communities as well as with individuals. Some of this group may be involved in project delivery. At a more senior level, they will be providing management and leadership across different organisations".[10] This definition excludes public health specialists (and those training to be specialists); generic business support roles; healthcare and social care staff working directly with individual patients; laboratory-based scientists/technicians; members of the wider workforce where public health functions make up a minority of their role. The estimated 10,000[11] public health practitioners in the UK are mainly employed within local government, some within the NHS and public health agencies and a smaller number in voluntary or private sectors.

Methods

Email requests to interview public health practitioners were sent to all fourteen Directors of Public Health in Yorkshire and the Humber (population 5.7 million people). The email stated that a very broad definition of practitioner was being used. Although Directors of Public Health proposed interviewees, each participant provided written informed consent prior to interview.

Interviewees were sent the PHSKF prior to the interviews to familiarise themselves with its content.

Fifteen small group interviews (median size 3) involving 51 participants (36 females) (Table) were conducted in eight local authorities. Interviews were conducted by the lead author (DS) and held at participants' workplace. While saturation of ideas was achieved prior to completing all 15 interviews, all local authorities that had agreed to participate were visited.

Participants were asked to state their job title and role. The interviews also covered appropriateness of the PHSKF as a basis for degree curricula and apprenticeship schemes. PHSKF functions were discussed at random until all had been selected or the time for the interview completed. Randomisation was used to ensure an equal chance of a group discussing each PHSKF function.

Interviews were recorded and transcribed. A deductive approach was used within a framework analysis.[12] A deductive approach was used as the topic guide was developed to explore the skills and knowledge of interviewees in relation to an existing framework, in this case the functions listed in the PHSKF. Deductive approaches test whether a theory/framework is valid, whilst inductive approaches generate new themes and theory emerging from the data. The transcribed text was divided into sections of data relating to separate ideas. These could be part or all of a quotation from a single participant or an interchange between interviewees. Codes were manually applied to these data and combined into themes as appropriate. Interviewees commented on the completed analysis. Quotations supporting the analysis are provided in a supplementary data annex available on-line.

Ethics approval was obtained from University of Leeds Research Ethics Committee (MREC16-037).

Results

Participants had a wide range of roles and job titles, reflecting the broad definition of practitioner. Given the breadth and inconsistency in categorisation of job titles it was not possible to present a coherent analysis for the purposes of this paper. More senior participants were asked to comment on the knowledge and skills of practitioners within their team. One group contained two practitioners working in the voluntary sector.

None of the interviewees were registered as practitioners with the United Kingdom Public Health Register (UKPHR), which is one of the regulatory bodies for practitioners. The value of registration was discussed within interviews. A few had considered it but decided against it as there was no registration scheme covering the region and interviewees did not see the value if registration was voluntary and not an essential/desirable requirement within job descriptions. Two interviewees were registered with the Environmental Health registration Board.

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.

There was variation in the number of groups that discussed each function, the length of time discussing the various functions and hence the amount of data relating to each (Table). This partly reflects interest of participants discussing functions particularly related to their roles, but also that for others there was unanimity in view and hence less need for discussion.

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 of public health functions 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.

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.

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

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.

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

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.

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

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 the micro level, all practitioners have organisational obligations for fire safety and health and safety training which required staff to analyse/manage risks within their workplace

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

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

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.

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

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.

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

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.

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

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

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

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.

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

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.

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

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.

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

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.

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

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.

Discussion

Main findings of this study

Participants had not used the PHSKF and many had not seen the new version. Most participants were content that with sensitive interpretation and top-up training, they could provide some evidence for all competencies. It will be important to assess whether and how the updated PHSKF is being used, otherwise the utility of such frameworks is brought into question. Practitioners applying for registration with the UK Public Health Register[13] are assessed against the previous PHSKF, although the proportion of the practitioner workforce who have registered is very small.

Group participants were supportive of apprenticeships and a prospective training programme that allowed apprentices to rotate between training opportunities so that they could develop proficiency and document experience for all of the PHSKF competencies.

Some participants with less senior roles had more difficulty in providing evidence for all PHSKF functions, and hence there will be a threshold of seniority, below which competency in only defined areas of expertise might be expected. While the PHSKF may be applicable to the core workforce (practitioners, advanced practitioners, specialists etc.), it might not be applicable for the wider public health workforce. Separate research would be needed to identify the competency required of these parts of the workforce. Competency frameworks already exist, for example, for health promotion practitioners[14,15] or epidemiologists in communicable disease surveillance[16] (although details of the methodology used to develop these frameworks are also variable and do not appear to be underpinned by competency theory).

What is already known on this topic

Competency theory has been used to guide development and evaluation of competency frameworks in other clinical professions, e.g. pharmacy.[17]

Without theory to underpin public health framework development, there is a danger that they will not deliver some or all of the rationale for their development. Sandberg proposed three theoretical approaches to deriving competency frameworks.[18] In worker-orientated approaches, existing workers and managers identify knowledge, skills, abilities and personal traits required by workers for effective work performance. For example, numeracy and informatics skills would be required for health needs assessment. The approach has been criticised for producing descriptions of competence that are too general and abstract. Work-orientated approaches focus on personal attributes linked to activities central to the role of the worker. For example A1.5 of the PHSKF (which is in effect a health needs assessment competency) is defined in terms of ability to “collate and analyse data to produce intelligence that informs decision making, planning, implementation, performance and evaluation”. The weakness of this approach is that lists of work activities usually do not

adequately describe the attributes needed to accomplish tasks effectively. The multi-method-orientated approach combines both the worker- and work-orientated approaches and therefore tends to be more comprehensive.

The various public health frameworks all focus on the activities undertaken that are central to the role of the worker, and hence they seem to follow the work-orientated approach, although given that the frameworks were developed by existing workforce, it could be argued that a multi-method approach was used.

Norris[19] suggested three other way of categorising competency. The behaviourist construct is based on a description of behaviour (performance) and the situation(s) in which it is to take place in a form that is observable and measurable. Competence is something that a person is or should be able to do. In contrast the cognitive construct only defines competence as what a person knows and is able to do in ideal circumstances as opposed to performance under existing circumstances. The generic construct approach involves identifying the most effective performers in a job; studying what these people actually do that distinguishes them from individuals whose performance is less satisfactory; and identifying the specific skills, abilities and characteristics which are responsible for this difference. A study of patrol officers identified the following generic competences of good practice (which might equally apply to public health practitioners): "competence in 'assessing the total situation', 'self-monitoring one's own conduct', empathizing accurately with the concerns of others', and 'exercising power and authority in manner consistent with organisational goals and professional ethics'". We have previously used a generic construct approach within qualitative research[20] to identify leadership talents of 'Public Health Superheroes' which we mapped against other leadership competency frameworks to assess face validity.

Within competency literature there tend to be more concerns relating to the way frameworks are implemented:

> "As tacit understandings of the words have been overtaken by the need to define precisely and operationalise concepts, the practical has become shrouded in theoretical

> confusion and the apparently simple has become profoundly complicated… Notions of role, effectiveness standards and quality are combined into a model supposedly preserving the essential elements of competence and indicative of evidence of competent performance. Such models can be highly reductive, providing atomised lists of tasks and functions, or they can be highly generalised, offering descriptions of motivational dispositions or cognitive abilities such as problem-solving" (p331-4).[19]

Frameworks such as the PHSKF are developed with an objective to improve the delivery of public health functions. However, if they are not used, then it may be necessary to ensure strengthening of the workforce's competencies in reflective practice, self-evaluation and self-directed learning. An evaluation of the NHS Knowledge and Skills Framework[21] also identified problems with implementation.

It will also be important to strengthen the five disciplines of a learning organisation identified by Senge.[22] Public health practitioners learn together and from each other and perform together for common goals.[23] Thus personalised competency models may have limited utility, even though staff appraisal and personal development plans usually have a focus on the individual. In a review of the public health literature, Reid and Dold[24] found that although Senge was widely cited and clearly influential, there was limited substantive use and implementation of his key concepts (and those of Burns' Transformational Leadership[25]) within public health competency frameworks. Reid and Dold warned that unless public health organisations recognised the need for a common understanding of competencies, how to measure their attainment and act on that understanding, there may uncertainty as to whether certain individuals, public health agencies, or the entire public health workforce were competent.[24]

What this study adds

The research aim was to assess the applicability of the PHSKF to practitioners, and in particular whether it could be used as a curriculum for practitioner apprenticeship training. To this extent, frameworks such as PHSKF are suitable for this purpose. However, given that Public Health is a discipline that advocates the use of evidence, the methodologies used to

develop competency frameworks should be more robust and underpinned by competency theory.

Although the updated PHSKF abandoned competencies benchmarked to different levels within the public health workforce, this study has demonstrated that it is possible to use a 'single level' approach, provided each competency is interpreted for the specific section of the workforce. The practitioner definition used for recruiting interviewees was broad, and practitioner interviewees seemed to be operating at different levels. It may therefore be difficult to develop guidance for PHSKF interpretation suitable for all practitioners. The danger is that trying to tailor guidance to meet individual needs may lead to having a multitude of levels that was the problem with the old version of the PHSKF.[6]

Many interviewees said that they would use evidence from previous roles prior to reorganisation of Public health functions in England in 2013.[26] The PHSKF may need to be reviewed to reflect the changing working environment for public health practitioners and the skills and knowledge needed for evolving roles.

We contend that the solution to both of these conundrums is to use competency theory to derive the framework using a generic construct of competency that is less dependent on analysis of specific roles which vary between people or over time.

Limitations of this study

The vast majority of mid-level public health staff do not have 'practitioner' in their job title, and the lack of an agreed definition meant that it was left to recipients of the invitation letter to decide who was suitable to be interviewed. Therefore, there will be selection and volunteer bias within the sample. While the sample size is respectable in terms of qualitative research,[27] the number of people interviewed and bias means that care must be taken when extrapolating findings. Future research should apply a more explicit definition of practitioner in order to assess the skills and knowledge of specific sections of the public health workforce.

It would also have been desirable to analyse the data according to the seniority and public health discipline of interviewees. However, even though participants described their job titles and roles, the significant variation in job titles and the breadth and heterogeneity of roles meant that this was not possible.

The use of small focus group format permitted participants to interact with one another to test out understanding with colleagues as to whether elements of their work satisfied competencies. Whilst this is the main advantage of focus groups[28] there is a risk of participants not wishing to reveal significant competency gaps in front of colleagues.

It is also important to be reflective as to whether interviewees modified their responses to fit with perceived requirements of the interviewer, especially given that the interviewer was a senior local public health academic. While it is not possible to be certain if and how this might have introduced bias, the consistency between groups suggests that this impact was not significant.

It was also difficult to assess specific individual's competencies. Instead there was a tendency to assess the competency of the team. Whilst this is how the Public Health England intended the PHSKF to be used, future research should be conducted at an individual level.

The research was also mainly conducted with practitioners working within local authorities. The responses of practitioners from other types of public health organisations may have been different. The research was also only conducted within Yorkshire and the Humber, and it is feasible that practitioners working in local authorities elsewhere may have different experiences.

Conclusions

Most participants had not seen, let alone used, the PHSKF. Consideration should be given to publicise ways it could help the public health workforce.

It may be appropriate to use the PHSKF to develop a curriculum for a public health practitioner apprentice scheme, if the competency levels were benchmarked appropriately. Using the PHSKF for this purpose would also be appropriate as it has been adopted by countries within the United Kingdom. Apprentices could prospectively rotate between roles to gain the necessary experience, supported by an academic degree programme. There is also an argument that some, if not all, levels of the public health workforce do not need to be trained in all public health competencies. The PHSKF User Guide suggested that the aim of the framework is "to set out the functional areas in which individuals, teams and organisations operate, to deliver on public health outcomes… to provide a set of statement that describe what functions an individual might carry out in the course of their work. The combination of functions will vary from individual to individual, and from role to role". [27] Thus, while it does not benchmark competencies to levels (as in Canada[3] or USA[4]) it also does not claim that the competencies are required for all public health practice at the baseline level (as in New Zealand[2]). Instead, as the PHSKF User Guide[29] suggests, the key is that public health teams assess the group competencies required for delivering their functions and then ensure that individuals have specialist skills to contribute to the collective effort. However, in other research that we have conducted,[9] Directors of Public Health saw value in staff having a wider understanding of public health, in addition to the more specialist skills and knowledge required for specific roles.

Further work is required to permit individuals and organisations to interpret the breadth and depth of competencies for different levels of the public health workforce, especially for those in more junior roles, those in more specialist public health niches or who for the wider workforce. In particular, research is needed to understand competencies required for working in the voluntary and private sectors and how these can be achieved and maintained.

It was outside of the scope of this paper to review the curricula of current public health degree courses to assess whether they cover all PHSKF competencies. It is unlikely if many, align directly with the PHSKF functions. However, if at some point in the future practitioners are expected to provide evidence against PHSKF functions, universities may wish to review the content and structure of courses.

Frameworks will need regular updating to reflect evolving public health functions and organisations. There are trade-offs here between frameworks being in a constant state of review versus being out-of-date and hence not useful tools for some or all of the workforce. Frameworks should routinely provide details of methodology used for their construction, to assess methodological appropriateness and robustness. Having now tested the PHSKF against the self-reported knowledge and skills of practitioners in the field and previously developed our own leadership competency framework[9] we believe that competency theory should be used to guide these processes.

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Table: Number of participants and data items analysed within each group

Group code	Number of participants in group	Length of interview (minutes)	Data items* included in analysis relating to functions of Public Health Knowledge and Skills Framework												
			A1	A2	A3	A4	A5	B1	B2	B3	B4	C1	C2	C3	C4
B1	4	53	5	3	14	-	-	12	5	5	-	8	6	14	-
D1	3	58	-	-	-	9	-	-	3	-	-	-	3	-	7
D2	3	48	-	-	8	-	12	-	-	10	-	8	5	-	-
D3	4	51	-	4	6	7	-	8	-	5	-	-	12	3	-
D4	5	52	-	-	5	21	-	-	2	-	8	-	9	8	-
G1	6	57	9	-	6	-	4	7	-	-	7	-	12	11	-
G2	3	50	7	-	-	-	-	-	-	-	9	-	34	-	-
G3	6	48	3	5	5	4	2	4	4	5	4	1	2	2	2
H1	2	61	7	1	-	7	5	-	4	3	-	-	-	4	4
K1	4	46	-	-	13	-	-	-	6	-	8	9	-	-	-
K2	3	37	-	9	-	-	10	3	-	10	4	-	8	-	-
N1	3	54	-	9	22	16	9	5	-	7	-	-	14	13	-
N2	2	60	-	4	5	5	8	4	-	7	4	3	6	6	4
W1	2	57	1	1	5	2	8	6	3	1	5	4	7	7	11
Y1	1	50	2	1	3	2	4	3	2	2	3	2	2	4	5
Total	**51**	**782**	**34**	**37**	**92**	**73**	**62**	**52**	**29**	**55**	**52**	**35**	**120**	**72**	**33**

*A data item could be a quotation from a single participant or a short dialogue between participants that captures an idea/argument.

On-line Supplementary data annex

General comments

"My comment about this as a whole is this is more what a service manager does and they cascade those jobs down... And if you are [a practitioner] I think it could be quite demotivating because you're going to be looking at this framework and thinking well I don't do that I don't do that." [W1]

[This competency is at] "a very high level and asking a lot of people. I wouldn't expect practitioners to meet it other than in a very general way." [H1]

"It's harder to pin some of these down in the way you could with previous ones in terms of describing the level that one would expect someone to be using them because a lot of them are interpersonal skills that need a fair degree of mindfulness." [H1]

"An apprenticeship scheme really needs to make sure that they have an opportunity to work across the whole of public health. I have had that opportunity … I've been in different departments and done different pieces of work, and it does strengthen you and it stops you from panicking about having to pick up another piece of work" [D1]

"Before the person came in on the apprenticeship if you could put all those things in place and stipulate that's what happens then, that would be good." [B1]

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

A1.1 Identify data needs and obtain, verify and organise that data and information

A1.2 Interpret and present data and information

A1.3 Manage data and information in compliance with policy and protocol

A 1.4 Assess and manage risks associated with using and sharing data and information, data security and intellectual property

A 1.5 Collate and analyse data to produce intelligence that informs decision making, planning, implementation, performance monitoring and evaluation

A 1.6 Predict future data needs and develop data capture methods to obtain it

"We're all quite involved in analysing data and presenting data." [G1]

"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." [G1]

"For me, [predicting future data needs and developing data capture methods is] bread and butter in terms of substance misuse and the ongoing monitoring of what is being provided, it's heavily dataset orientated anyway. In looking at the trends … I need to have an eye in relation to what's coming up and what will we need to measure and if we haven't got anything in there to measure it how would we do that." [G1]

"We do it to a lesser degree with the GPs, if they want to know certain information we can drill down a little bit in to that, but in terms of the global data, just never been asked of us before." [G2]

"For me that links in to setting up service provision and interventions that have evaluation built in to them from the start, and that's one thing I don't think we're fantastic at doing." [Y1]

"This comes up with the contract management work that we do. Every quarter it's expected that they would provide a document outlining how the project is doing. You've got to bear in mind what you're able to report and what you're not. If the numbers are less than five then obviously it is identifiable data so you're not allowed to report on that. We also find that there's often a lot of anomalies or gaps, so that's something that we need to be mindful of. I've not come across it in any of my projects, but some of the other projects have issues around intellectual property rights, depending on which partners we're working with and who owns delivery manuals." [B1]

"I think the most that was ever asked of me was to present at a full team meeting the monthly statistics where you could compare like-on-like for the previous year, so you could probably think well what was going on in that month that made our footfall more, quit rates better, that sort of thing. But the wider data has tended to come from other people. We are able to look at a particular practice, see who referred, how many people, what age, what gender, what products they use, all that sort of thing, we can do that from the system that we use to record our stop smoking." [G2]

"At the moment we're doing a needs assessment in relation to do gap analysis to see how we go for commissioning. Because I am the only one in the team who has the experience in relation to substance misuse I'm working with the guys in analysis in order to write the tools having done that in the past. When we were in the NHS, part of my role was to actually do the analysis, whether that be clinical audits or so on. In relation to what we were doing for the needs assessment it was very much a collaborative approach in terms of using my experience, their knowledge and putting the thing together but at the same time it wouldn't be a generic thing that everybody would do." [G1]

"The sort of data that I use is with regard to housing inspections. The way that we assess conditions in a property now is statistical, looking at the hazards and risks and then we score them and that dictates what action we take. We use a lot of statistics for that that's quite complex. We don't collect the statistics, we just use the government statistic on risk to health. We quite often have to analyse where empty properties are, what size they are, how they compare nationally, whether the numbers are going up or down and that is related to the income that the council gets as well. So it's quite important that we get that data right and that we use it properly." [B1]

"We collect the data with our air quality monitoring equipment. We've got to be really aware of whether it's ratified data or raw data and what we release and what we don't, and being really careful about anything that we release having the proper quality checks. It makes such a difference to your end results, if the quality is not right. We also have to report our data to DEFRA, so there's a lot of double checking around the data that we've sent in and whether or not they're happy with it and the conclusions we've taken from it and what our next steps are going be, because the data that we take has go such implications for policy." [B1]

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

A2.1 Influence and strengthen community action by empowering communities through evidence based approaches

A2.2 Advocate public health principles and action to protect and improve health and wellbeing

A2.3 Initiate and/or support action to create environments that facilitate and enable health and wellbeing for individuals, groups and communities

A2.4 Design and/or implement universal programmes and interventions while responding proportionately to levels of need within the community

A2.5 Design and/or implement sustainable and multi-faceted programmes, interventions or services to address complex problems

A2.6 Facilitate change (behavioural and/or cultural) in organisations, communities and/or individuals

"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." [Y1]

"We're sort of designing local programmes that we commission someone else to deliver, or implementing, for instance PHE campaigns." [N2]

"What I do tends to support these things in the background, focussing on helping them with their intelligence needs… I'm quite new to public health so it's always good to get that wider perspective and it definitely informs what we do. You need to understand what people are looking for from us." [K2].

"This is something I do kind of every day. Some of the points I do more than others, definitely influencing and strengthening community action, although we don't do as much direct community involvement as we used to do, but we do still do more than other parts of the councils. Definitely advocating public health principles. A big part of my work is about influencing and working across organisations and across the council, rather than designing or implementing programmes or services. My role is more about influencing, but addressing the wider determinants of health and inequality is kind of the core of the work which I do. Facilitating change is major in my role." [K2]

"I used to do this all the time when I was in health promotion, so I've got that knowledge and probably still use it when commissioning, so I think definitely if there's an apprentice coming in then they do need to do some of this work." [N1]

"This is more of the area of work I was in in the voluntary sector as well, so that looks very familiar to me, but not necessarily because of my role here." [N1]

"I've got a clinical background in nursing and health visiting. I suppose this is what I was doing in that role, so I suppose I do have [these competencies], but I wouldn't say I use it a lot. I think it's useful to have it and it does inform what you're doing. I suppose us three do have that background whereas someone who maybe hasn't got that might do something differently" [N1]

"Sometimes there is that disconnect isn't there about what your theory or somebody who maybe hasn't got that experience wants or thinks would happen, and someone who's experienced this and sort of thinks that's not really going to work. And you need the two, you need somebody who's got that public health theory who thinks 'right well here's the evidence this is what we're going to do', and then also the person who has lived it and thought 'the population aren't going to take that or the client group you're trying to get here are not going to just go with that or the professionals just won't work in that way', so I think it needs to compliment it, definitely" [N1]

"We've got sort of a public awareness function because air pollution is not very visible. Part of what we're doing is trying to empower communities to have the information that they need to take action and look after their own health. I've been working with the Breath Easy Group discussing how we can sort of get information out to residents around managing their own conditions and avoiding air pollution and keeping an eye on air pollution forecast." [B1]

Some of this is stuff we directly do and some of it is about influencing others to do some of this. I think it's two levels. Colleagues on my team that will do this directly to communities but then we work with community teams or voluntary sector to do some of this work." [D3]

"I mean some of this is more senior management to be quite honest with you, design and implementation is more down from leadership, than we would actually be doing." [G3]

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

A3.1 Analyse and manage immediate and longer-term hazards and risks to health at an international, national and/or local level

A3.2 Assess and manage outbreaks, incidents and single cases of contamination and communicable disease, locally and across boundaries

A3.3 Target and implement nationwide interventions designed to offset ill health (eg screening, immunisation)

A3.4 Plan for emergencies and develop national or local resilience to a range of potential threats

A3.5 Mitigate risks to the public's health using different approaches such as legislation, licensing, policy, education, fiscal measures

"It's a focus within the local authority but because we have regional health protection units the bulk of the work is done within those. I think that's probably going to be a gap across the board for practitioners generally because I don't think we get that many opportunities to work directly in that. [Y1]

"We all have to put ourselves forward to be called in to support if something like [an emergency or infection outbreak] happens, and manage incidents. We've all had training around a control room sort of scenario, had mock runs of what would happen if we had to provide a coordinated response." [K1]

"If there was any bad drugs out there and … some deaths through contaminated drugs then we have to get the alert out to watch out and for pharmacists to make sure they have the discussions with service users and GPs." [K1]

"Yes there's air quality work which is under our remit so we look at that with the pollution control team around things that we can do to minimise the risks to health of air quality so that kind of thing does fit under all of our plans to a certain extent." [D3]

"So you've got your health and safety, but I'm thinking more in terms of, you immediately think health protection and we have leads on that and we have systems in place. So if somebody came to us with an emergency then we would have to enact the procedure which we'd been told to do, you know the number we have to ring. But what I'm saying is yeah, if you start unpicking it we all have to have health and safety training, we all have to do our risk assessments, so we are doing it, but I was immediately zooming in on health protection and communicable disease." [D2]

"I suppose we all mitigate risks to public health because we all use education to reduce people's risks around for example skin cancer, road safety, safer sex. That's all mitigating risks through education that we do." [D4]

"We do a fair bit at the moment on screening immunisation, but the flu vaccination rate here is quite bad and declining year on year so we've written a health protection report recently." [G1]

"We've got an emergency planning team here within the Council, I'm sure every authority does, but they are still fairly independent to us. It would be better I think if we were much more closely linked and to be aware of their response plans for things like this." [Y1]

"At our level we don't do any of this really… Screening and immunisation, so that's through the health visiting service and school nursing service but we, I've not been involved in this at all… And planning for emergencies I've not had any… I think it's more senior. Not that I think we couldn't be involved in it if there was a need." [N1]

"We've had an outbreak of cryptosporidium in one of our local farms, recently, which we weren't involved in. I did get involved a conversation but it was the consultant who led it. But then the work that's kind of come of that is for us to get messages out to the providers and the public through schools and things. So I think that would be the bit we do about that kind of infection management - proactive reducing the risk of happening rather than dealing with it once it's out there. But it's not that I'd be averse to learning any of this, it's not a bad skill to have, it's just it hasn't kind of come up in our team or role." [N1]

"Because we sit in sport and culture rather than public health actually some of our practitioners probably have a stronger understanding of this. Because if they've worked in leisure settings they understand about the spread of disease through not having legionella. They understand about blue green algae. They understand about pool plant and having to have the right chemicals and things. Our colleagues in Street Scene are probably strongest on hazards and risks because everything has to be risk assessed up to the eyeballs. We run a country park and water sport centres." [W1]

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

A4.1 Access and appraise evidence gained through systematic methods and through engagement with the wider research community

A4.2 Critique published and unpublished research, synthesise the evidence and draw appropriate conclusions

A4.3 Design and conduct public health research based on current best practice and involving practitioners and the public

A4.4 Report and advise on the implications of the evidence base for the most effective practice and the delivery of value for money

A4.5 Identify gaps in the current evidence base that may be addressed through research

A4.6 Apply research techniques and principles to the evaluation of local services and interventions to establish local evidence of effectiveness

"My team are very good at recognising evidence base, being able to analyse a database, understanding why it's important and so on. I think that [critical appraisal] can be quite a difficult skill … I don't think that's something you can just sort of pick up, that's something that takes practice. I think we get a little bit lazy … I think that's something that's important to keep up as a skill." [D1]

"We have to accept the limitations that we've got in the practical applications of research. We can't have a robust randomised control trial for everything. We work often in a responsive way to political demands." [Y1]

"I think a lot of what we do is using evidence and particularly NIHCE guidance, PHE guidance, all of the research as a starting point to inform what we should be doing against those guidelines … If we are setting up a new project we would start by reviewing the evidence base." [N1]

"I think this is probably one of the areas that local authorities struggle in actually, is using robust financial outcome based information, so economic analysis of cost benefits of things. We do at times tend to get drawn into discussions such as 'there's this service we need to maintain' or 'we've had a budget cut we need to make the best of it'. I think raising awareness of the things that are important such as key indicators would be great, and then giving people the ability to be able to talk to colleagues across the Council as to why those things are important." [Y1]

"I think what's also important, especially when we're out in the community with people who aren't used to an evidence base, to be able to explain to them why it's important and when they might pick up a newspaper article and say 'look at this' and 'we should do this', to be able to use the lay terms for people who are not used to critical analysis." [D1]

"In public health we're constantly looking at evidence base and using evidence in our practice. But we don't always think about exactly the ins and outs behind that and how they got there. I must admit sometimes I do like it when you get [evidence in a report] and it's all laid out nicely. But if you gave me a pile of papers, like academic papers to look through and say right what do you think about that, that would actually quite throw me. I think there's a lot to be said for learning how to interpret data and especially because I did my degree quite a long time ago and I haven't gone down a masters route, and I think sometimes you get out of the mind set of thinking behind papers and research and everything, and I think it would do quite a lot of us more good." [D1]

"I think the more comfortable and embedded we become within the Council, the more this will become a more important part of what we're doing. I think we're having to challenge a lot of pre-existing stuff that's gone on in the Council and say actually there's no evidence behind that or the evidence says we shouldn't be doing that. I make myself very unpopular regularly by challenging people like this and around things like this and having to present them with evidence and review things and so yeah I do more and more of that." [D3]

"I feel that I'm encouraged to do that and obviously with constraints around money, we've got a duty to make sure that whatever we're doing, we're spending public's money. So we've to be effective." [D4]

"Because we've got reduced capacity we focus a lot more now on core business. So a lot of my time at the minute is being taken up by commissioning things, greater health service and issues with contact management… I've just started looking at this obesity prevention research and that's the first time I've started to use any of my research skills in 2 years in this role. My line manager recognises I've got those skills so I'm being asked to do that work. So I think I would like to do it but I've got so much other stuff that needs doing, and is more important." [D4]

"We are also involved in commissioning external academic research as well, so there's a range of projects. For example, for the drugs and alcohol service, there was a commissioned external evaluation, and then we're just doing one for the young parents project as well. So that's been a learning curve for us sort of making sure that you're using the right academic language to encourage universities or potential bodies to apply for it."[N1]

"I don't have a public health background so I wasn't familiar with the CASP [literature review] tool. I've sat through a few journal clubs and this is quite hard for me, so I think there's support needed to get to that point, but I can see it's really important in our area of work to be very systematic and have a structure that we're working to say how we've come about getting this evidence together, cause at the end of the day we're spending a lot of money aren't we? So it's a biggie." [N1]

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

A5.1 Conduct economic analysis of services and interventions against health impacts, inequalities in health, and return on investment

A5.2 Appraise new technologies, therapies, procedures and interventions and the implications for developing cost-effective equitable services

A5.3 Engage stakeholders (including service users) in service design and development, to deliver accessible and equitable person-centred services

A5.4 Develop and implement standards, protocols and procedures, incorporating national 'best practice' guidance into local delivery systems

A5.5 Quality assure and audit services and interventions to control risks and improve their quality and effectiveness

"Sometimes at the end you think we've gone down this track and we haven't really thought about what we want to, we know what we want to achieve but we haven't really articulated it or thought how we are going to evaluate this really thoroughly." [N1]

"As I sit at the moment, I probably wouldn't have the time to do A5.1, but the rest of that is part and parcel of the process some of us are going through in terms of the needs assessment and the ongoing development of whatever's going to happen when we go out to recommission." [G1]

"There are people in our team I know who are more that way inclined, who would spend hours looking and researching, but that doesn't rock my boat anymore, but I'd do what I needed to do just for a piece of work." [D2]

"Because it's quite pressured and you need to get something done about this. After you've gone down a bit of a path you think 'oh hang let's just back track and how are we going to evaluate that'. Having the skill to do it is, can be tricky to figure how what is the best way and not going overboard so that you've wasted a lot of time doing something that's not really going to tell you anything, and not doing enough to really demonstrate the impact of that work. When you're scoping things you'll speak to other colleagues in other areas and you'll say 'how have you evaluated what you're doing?' and they don't really know either or they'll say 'we're thinking of doing an academic evaluation of it' or 'we think we'll do this but we're just running with the project at the minute because we have to spend the budget' or 'we thought this was the best thing with the evidence'. And I suppose it is a chicken and egg, you know you've got to do something because how are will you evaluate something if you never do something. But I think it's quite common that it's an afterthought, or not quite at the beginning. I think it's the fear of not having the skill, not knowing how to best do it or what the best tool is." [N1]

"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." [N2]

"I've not actually been involved in that much work that's really delved down in the kind of the economic analysis and the return on investment. I think that's maybe a stage beyond typically what we do." [K2]

"When I was managing the stop smoking service and that went out for tender. We made those decisions about the stop smoking service, looking at how much it was costing towards what we were actually getting… It was like as basic as that, but at the time it was all I had to kind of work out is this - is this value for money for the outcomes that we were getting?" [K2]

"I think my comment would be yes to all of those, I don't think there's an issue apart from the sort of caveat we put at A5.1. But again it's an assumption that you understand the aim and objective of the organisation you sit within, and therefore that defines how you evaluate things. I know how to do a standard evaluation framework, but applying it to that particular organisation you actually have to understand how to modify it and change it and make it fit for purpose for that organisation." [W1]

"The NHS purports to be an evidence led organisation. Local council is evidence informed, and the politicians get the evidence and they may ignore it completely, and that's the direction, and it's that thing of actually that you're working in an environment that's led by political decisions, rather than [National Institute of Health and Care Excellence]" [W1]

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

B1.1 Appraise and advise on global, national or local strategies in relation to the public's health and health inequalities

B1.2 Assess the impact and benefits of health and other policies and strategies on the public's health and health inequalities

B1.3 Develop and implement action plans, with, and for specific groups and communities, to deliver outcomes identified in strategies and policies

B1.4 Influence or lead on policy development and strategic planning, creating opportunities to address health needs and risks, promote health and build approaches to prevention

B1.5 Monitor and report on the progress and outcomes of strategy and policy implementation making recommendations for improvement

"A lot of our role is about implementing global or national strategies or initiatives. For example I led on the teenage pregnancy strategy, so that was a national strategy that we had to implement locally, so we had to … look at the data and then develop action plans to show how we were implementing the national strategy, and also monitoring and reporting on the progress through the action plans." [N1]

"We work a lot with the partners don't we to kind of identify the things that we need to be doing … we kind of lead on those type of things but in partnership I think, with other organisations, I think you can't do it in isolation." [N1]

"This feels quite strategic and I'm not sure that a practitioner would really have that much involvement in many of these areas, but an awareness of where policy comes from [is important]." [Y1]

"I think understanding the limitations of some of these global and national strategies in terms of our influence on those at a local level can be very minimal. So often we try and interpret those but we have to find local solutions that are not necessarily to the letter of the strategy and will be a bit more of a longer term developmental approach to work towards those. I think there's lots of factors that come in to play with that, in terms of is there a political will to support some of those? Are there local resources that are able to support some of those? Have we got commissioning cycles and arrangements in place that will allow us to implement some of those things? Have we got resources capacity? So understanding some of those limitations is really important. I'm struggling to see this as anything other than quite strategic thinking really. In terms of B1.5, monitoring and reporting on progress of outcomes of strategy, I think a lot of those things link back to some of the stuff we were talking about before about the focus on evaluation and let's understand what data is important to collect. We're going to have at times requirements to report against national data sets, so we have to do that, those don't always really tell us that

much in terms of local detail at ward level, so it's maybe about being aware of what the limitations of some of those things are and maybe trying to find some solutions that allow us to kind of get some more local meaning to it." [Y1]

"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." [K2]

"From working both organisations, if I'm honest, I prefer the Council. I prefer the accountability and the understanding of what's expected of you because it's consistent. In the NHS it isn't, it's inconsistent and it's just literally throw the cards in the air and you might or might not succeed. Although it can be inhibiting [in the Council] in a way it's infinitely more satisfying when you get to the end because it's actually done for a reason and it usually has a greater impact or benefit." [W1]

"I think for us [in a voluntary sector organisation] it's probably about looking at the healthy child programme, and looking at the integrated health in early years has been developed locally and looking at the action plans, looking at monitoring, where the gaps are, monitoring what services need to be developed, so I guess that comes in to the strategy." [B1]

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

B2.1 Influence and co-ordinate other organisations and agencies to increase their engagement with health and wellbeing, ill-health prevention and health inequalities

B2.2 Build alliances and partnerships to plan and implement programmes and services that share goals and priorities

B2.3 Evaluate partnerships and address barriers to successful collaboration

B2.4 Collaborate to create new solutions to complex problems by promoting innovation and the sharing of ideas, practices, resources, leadership, and learning

B2.5 Connect communities, groups and individuals to local resources and services that support their health and wellbeing

"Partnership working and collaboration with other agencies is key to what we're doing! We can't do things on our own. We need buy in from partners and it's a skill to get that buy in. You've got to be an effective communicator because all these other partner agencies have got their own remits, they've got their own targets, they've got their own agenda." [D4]

"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." [Y1]

"I'm fairly experienced in public health, I've got 15 years' service. Actually I think I achieve more there than I probably have done in any other area of work. But in terms of skills that was more to do with the fact that my strongest attribute is probably my ability to develop effective partnerships. What I find interesting, thinking of the public health workforce, is that not everyone has got those skills, and I'm not sure it's something that can be trained in, Some of it can, but it's essentially about how you are, what your personality is, and where there were absolute blockers in the system stopping things from happening it was always about individual personalities." [K1]

"Confidence to challenge I think that's the other thing. I think if you're expecting somebody to come in to a role, within the first five years and just dive in with everything that's required, you'd have to be a like Super Woman or Super Man. I think to develop the maturity and the experience to be able to handle difficult sometimes contentious relationships and produce results, I think that's something that you do have to learn. And having said, some people don't learn it. Some people are still afraid to challenge even after a long time in the role. I think that's one of the things that we do struggle with a little bit, this idea of public advocacy and how far and when to push things with people regarding the fact that some things are quite challenging and it's knowing when people are going to be receptive or whether you have to kind of force some ideas through." [K1]

"This underpins pretty much everything we do. We don't do anything in isolation. Having an awareness of where those kind of partnerships and stakeholders might be for different types of projects and the different types of level of involvement and engagement that people might have, the organisational priorities that might be considerably different between your own and another organisation are massively important to look at. I think when it comes to talking about partnerships and alliances and that sort of collaborative working I think an ability to take step back and look at who are the stakeholders and systematically identify who those might be, and including those who might feel quite challenging to engage with, is really key. We have to bear in mind that at the end of the day we're doing this to improve the health and wellbeing of the local population." [Y1]

"Yeah, all of the [B2 competencies]. Our role has changed since we've come over [to work in the Council]. Community development used to be within our roles and that's been removed now. It's due to capacity cause when we were here first, there was ten of us and we all had community roles. Obviously we've got less and less and less, although me and [a colleague] who were the original community development workers from like ten years ago, we still get rolled out every now and again, if there's an element of community development needed. We are definitely good at being the facilitator making sure that those connections happen. Between us all as in the whole of the team we've got a lot of connections, a hell of a lot of connections. An individual support well-being officer within the local authority might come to us and ask the team who's the best kind of referral etc., so we definitely facilitate. [D1]

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

B3.1 Set commissioning priorities balancing particular needs with the evidence base and the economic case for investment

B3.2 Specify and agree service requirements and measurable performance indicators to ensure quality provision and delivery of desired outcomes

B3.3 Commission and/or provide services and interventions in ways that involve end users and support community interests to achieve equitable person-centred delivery

B3.4 Facilitate positive contractual relationships managing disagreements and changes within legislative and operational frameworks

B3.5 Manage and monitor progress and deliverables against outcomes and processes agreed through a contract

B3.6 Identify and de-commission provision that is no longer effective or value for money

"I didn't used to do this until last few years. I'd no experience whatsoever in [the NHS] and then I was given commissioning to do so I now feel that I have done all of those things. I've decommissioned, I've commissioned, I contract manage." [D3]

"I think the way that things feel to me is that they're moving almost away from a clear focus on public health being a direct and sole commissioner of services. I think we're going to have to be moving more towards influencing commissioning arrangements within other departments and other stakeholders. An understanding of the commissioning process, the different options that you might have is really important." [Y1]

"When we're in the NHS we had the world class commissioning. I wasn't doing it then, and I was learning all this stuff, and it was like well I'm not using it, although we've always done the health needs side of it. Public health has always been seen as the first stage, the understanding the needs. But then we came in to the council and there was a big thing around commissioning and they were having all these workshops, and now the next minute we're decommissioning stuff, and it's a different ball game." [D2]

"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, so that you don't end up having to say 'oh well we're going to have to cut your budget, it's against the contract terms so we're going to have to terminate it'. There are different ways that you can approach that, and having an understanding of that is really key I think." [Y1]

"Fostering those relationships with the providers is a big thing because they need us and we need them. Obviously they want to maintain the relationship with us as commissioners

because it's their income, it's their job. I think we increasingly need to ask them to help us to do things, communication work or delivery of things, because we don't have that element to our role anymore, where we're not actually directly linking with the public a lot of the time, are we? So we do have to work with them well to say we need this or this is happening can you support it or can you work with us to deliver or design or whatever we're doing?" [N1]

"I think some of it also comes down to, if we're talking about an apprenticeship, is whether we'd maybe see that some kind of placement within a procurement team within the local authority would be a kind of key part of the programme, because I think that can vary quite significantly I think between authority to authority. But yeah definitely an awareness of how you approach a commissioning process and how you do it in a very structured and planned way so it doesn't become a situation where 'oh crap, the contract is running out in three months we've got to do something', you know, you've got a forward plan you've got a cycle, you've built in an awareness of what you're objectives what you're outcomes are, you've identified a budget, you've identified a key set of indicators you want to achieve as kind of must have's and then you've got a list of kind of almost wish list of things that we could build in if we had the opportunity. And I think as well for me it's probably about understanding that we probably need to move away from the more traditional model of we've put your contract in place for three years we'll meet once every quarter go through a list of key performance indicators give you pat on the back tell you you're doing really well and then not have any discussion about service development and service improvement." [Y1]

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

B4.1 Work to understand, and help others to understand, political and democratic processes that can be used to support health and wellbeing and reduce inequalities

B4.2 Operate within the decision making, administrative and reporting processes that support political and democratic systems

B4.3 Respond constructively to political and other tensions while encouraging a focus on the interests of the public's health

B4.4 Help individuals and communities to have more control over decisions that affect them and promote health equity, equality and justice

B4.5 Work within the legislative framework that underpins public service provision to maximise opportunities to protect and promote health and wellbeing

"It's become part of the day job now but you don't really realise that it's there! Like working to the policies and things like that." [D4]

[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." [G1]

"A piece of work we did fairly recently was the needs assessment for people with a learning disability and the feedback fairly consistently is 'I'm not heard'. Partly because I think that's true because it's difficult to achieve, and partly because the feedback that's being said doesn't feel like it goes anywhere. So there's not a two way communication process, and that's important because we need to understand where the frustrations lay for people who don't want to engage, and actually to give some feedback on 'okay you said this, we did this' or 'you said this, we can't do it because of this, this and this but we have heard'." [Y1]

"I think some of this is above our level, above our remit, but I would say that we do work in partnership with other organisations. For example we started to work with a clinic so we can deliver [smoking cessation services] from there, we've got a good knowledge of other organisations within the community that could help support our clients with other issues." [G2]

"I think in a local authority setting, an awareness of the processes and how the decision making process works is really important. You've got various different types of roles within local authorities that are focussed on that decision making process. We have officers who deal with that in this organisation. They will work on coordinating the public meetings, the executive decision making processes, the forward planning process, the requirements from

decision making from the council statute and Local Government Act, and all those sorts of things. I think understanding where the role of public health sits in trying to remain impartial in a political environment is really important." [Y1]

"Certainly my experience when I worked in the NHS was that you went, for example, to health and scrutiny to the overview committees and you did kind of work with council elected members but not in the same way as when you're actually in the local authority. I think this for me, certainly compared with public health ten years ago, there's a much higher level of competency required and this political astuteness in a local authority environment, than there is a health environment. [N2]

"I think for me, what's quite interesting about B4 is that it talks about promotion, health equity, equality and justice, and in different political contexts so they can have different political meanings. I guess in terms of public health how we position some of our work in a political environment is quite interesting because sometimes it may be perceived as being in conflict with sort of different political persuasions." [N2]

"I really enjoy working with politicians, I like the challenge. I like the fact that in many instances you're teaching them. I love watching that process where they go from there to there through your involvement. HIV is a good example, and we've recently had politicians that have said 'well it's their own fault if they're HIV positive it's their own fault'. I love having the opportunity to say to people have you ever had unprotected sex? There aren't many people that will say no." [K1]

"Obviously we have to be careful how we word these things, in terms of politicians and elected members. I think for me when we came across in to the local authority from the NHS we had two types of staff, two types of thinking. Because I'd worked in a local authority longer than I had the NHS, it felt right for me. It still feels right even though it's a horrible world at the moment in the public sector, it still feels right. If we are going to change the health of the population this is where we need to be, not the NHS. But then you've got some staff that because they spent their entire career in the NHS they just can't make that transition, and I understand that. So I probably understand the political process more than some, and understand the sensitivities around it, and how to manage it I suppose, most of the time." [K1]

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

C1.1 Act with integrity, consistency and purpose, and continue my own personal development

C1.2 Engage others, build relationships, manage conflict, encourage contribution and sustain commitment to deliver shared objectives

C1.3 Adapt to change, manage uncertainty, solve problems, and align clear goals with lines of accountability in complex and unpredictable environments

C1.4 Establish and coordinate a system of leaders and followers engaged in improving health outcomes, the wider health determinants and reducing inequalities

C1.5 Provide vision, shape thinking, inspire shared purpose, and influence the contributions of others throughout the system to improve health and address health inequalities

"We're all leaders aren't we?" [D2]

"I think a lot of these are probably more about what a public health role at maybe a more senior level will look like." [Y1]

"I think a lot of these are probably more about what a public health role at maybe a more senior level will look like, this is why it's important, I think at maybe at a more junior level [we must] instil a bit of a mind-set [that] you don't have to have a manager job title to be a leader." [Y1]

"I think C1.1 is absolutely vital, and I think there's no level to that cause I think everybody should be, at kind of the highest possible level. And particularly the personal development - again that's a debate that we're having at the moment around our responsibility for that as well." [N2}

"I guess this is something where I see a real distinction I suppose in terms of the levels that we're expected to do it, certainly working again within a local authority setting, so C1.5 for example I think we've got a role in that and certainly as a health improvement manager I would want to set provision for some of my programme areas I think working at a more senior level that's something the director would need to do, so I think it's the same competency and the same function, but working at totally different parts of the system." [N2]

"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. This is the bit of chicken and egg to me, it's not really talked about." [K1]

"I don't work in isolation, I have other people around me and it's a collective effort, it's what they talk about collective brilliance, but part of leadership seems to be about saying I do and I lead, and to me I don't understand why that developed." [K1]

"We had that very discussion yesterday around saying to junior members of staff 'it's not wrong to challenge or it's not wrong to tell us, ultimately I might make a different decision but there's absolutely no reason why you can't challenge it or say I think this might be better'. But the culture is, or was, you followed orders, and that is a really, really hard culture that we're trying to break, or reshape." [W1]

"This is one that is key to what we do. When we think about bringing people in to public health and that people have come from different places, not everyone has a solid understanding of the social determinants of health. Even people that have done training, courses, whatever, on social determinants of health, you still hear comments like 'but they're choosing to spend their money cigarettes and alcohol so why should we do that for them?' I hear that in public health, I hear it with GPs, and so yeah that for me is something that as a workforce we need to address." [K1]

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

C2.1 Manage public perception and convey key messages using a range of media processes

C2.2 Communicate sometimes complex information and concepts (including health outcomes, inequalities and life expectancy) to a diversity of audiences using different methods

C2.3 Facilitate dialogue with groups and communities to improve health literacy and reduce inequalities using a range of tools and technologies

C2.4 Apply the principles of social marketing, and/or behavioural science, to reach specific groups and communities with enabling information and ideas

C2.5 Consult, and listen to individuals, groups and communities likely to be affected by planned intervention or change

"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." [D4]

"We do all of them, from a meeting with a director to presenting to groups... We use different forms of social media, we use different forms of research, aides like e-surveys and so on." [D1]

"Probably we're not that fantastic at communicating things in non-traditional ways, we still rely on reports, we still rely on formal meetings… We're not fantastic at changing the way we give messages and using some of the technology we've got to hand [e.g.] video blogs, Twitter." [Y1]

"I'm quite in to social media, and I do a lot of the social media work for our team. I know it's a small part of what this is talking about, but obviously we look after a huge range of people from slightly under 18s to well in to the aged. Not all of them are into social media but we know a huge amount are. However, any stories that we do put on social media get the minimum possible engagement, and most of the stories are positive, I try not to put a negative image on at all, but even that seems to be a difficult way of engagement." [G2]

"It's a real skill to be able talk to people effectively from you know the mayor, the elected members, the director of public health, all the way down all the way down to general public. We have deprived areas out there and, and speaking to people in [well-being initiatives]. We doing some really great work out in [a deprived area] which is a really difficult area to engage. But they're doing it! It's all about getting the message across." [D4]

"You know we're all capable of sitting behind a computer and reading stuff and studying everything but also it's that you need to go out and talk to people and to get those skills to be able to talk to Joe Bloggs on street. Do you know what I mean and be able to engage with them?" [D4]

"I feel that we're using more of our dormant skills again, you know. We're being allowed to do that and explore other issues with them. I feel I've done a lot more signposting as well recently, for different things, and I think that's again because personally I'm not scared to do it and I'm not going to get my knuckles rapped for doing it, which is really good, cause A the client or patient gets the benefit of it, and B we build bridges with other agencies." [G2]

"It comes back to managing public perception and convey key messages, because public conception of us sometimes as a smoking service is 'oh give them a wide berth, here are the smoking police'. You can see people they physically, they walk away, you know, so we don't say that 'we're not the smoking police, we're here to help and support' and all that sort of thing. I think with the communities that we are expected to reach and trying to reach, there is that barrier, you know, because they struggle, they do what they do, they have what they have, and they don't like people coming in to tell them what they should and shouldn't do." [G2]

"I think we do a lot of duplication. I'm not really sure how much, but you know it's sort of like the NHS does something, we do something. When we talk to [central communication team in the Council] they're like well 'if the people get the message twice it's all for the good'. But I'm a bit unsure about what is our unique bit of this, how important are we in this process cause we're often using Public Health England's message to pass on? [N1]

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

C3.1 Scope programmes/projects stating the case for investment, the aims, objectives and milestones

C3.2 Identify stakeholders, agree requirements and programme/project schedule(s) and identify how outputs and outcomes will be measured and communicated

C3.3 Manage programme/project schedule(s), resources, budget and scope, accommodating changes within a robust change control process

C3.4 Track and evaluate programme/project progress against schedule(s) and regularly review quality assurance, risks, and opportunities, to realise benefits and outcomes

C3.5 Seek independent assurance throughout programme/project planning and processes within organisational governance frameworks

"Some of the focus on this is about understanding the difficulties of setting something up as a defined project when the parameters that we work in are often not as easy to define." [Y1]

"I think a lot of [C3 competencies] are dependent on how well they are managed to be able to do some of these roles. I think actually in principle most of those things a practitioner could do, but it's dependent on how well they're managed and trained and understand what's expected of them. What we find is if somebody is poorly managed you either get nothing or you get the mavericks who try and do absolutely everything. You're thinking that's not yours to do, so it's very much inherent on them having a good foundation and good developmental management. I suppose the only one that might be again a little bit ambitious is probably C3.3." [W1]

"I came from the voluntary sector and we were quite hot on this and had our own project management system. Everything had to go through it, all your staffing budgets and resources and absolutely everything to the nth degree, and everyone could see it. Obviously certain people could make amendments and things like that, and a lead person would be setting it up, but not onerous. I don't know what the Prince 2 is like but you know it sounds horrendous. You would complain a bit about it, got to go and do this, but at least it was all in one place and you could see it. What I've found, from my level, is my manager was off for maternity leave last year, and we had an interim manager in who wasn't allowed to have the access to the finances. So the consultant is asking me and I didn't have any access to it either, so I'm sort of working a bit blind on trying to give answers. [N1]

"Yeah, C3 all looks familiar. I have done some project management in the past but anything that I manage now, any projects is incredibly informal without any of the documentation, it's just me in my head knowing what needs to happen next, and then getting people involved. So I could draw on previous experience, we're going back about eight years." [B1]

"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. We've got local authority graduate trainee here, and I'm having to think about what can I get her to do, which is helping to focus me and say right well there's that bit of work that definitely needs doing and it can be achieved in this timeframe and it can be achieved by one person but linked in to these things and those things and I know what else she's got to do so is it achievable yes it is… [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? It's all well and good sometimes setting up a project to do a specific piece of work but then if that generates the need to do more work what happens then if we haven't thought through about what other resources and capacity we might need." [Y1]

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

C4.1 Identify, negotiate and secure sources of funding and/or other resources
C4.2 Prioritise, align and deploy resources towards clear strategic goals and objectives
C4.3 Manage finance and other resources within corporate and/or partnership governance systems, protocol and policy
C4.4 Develop workforce capacity, and mobilise the system-wide paid and volunteer workforce, to deliver public health priorities at scale
C4.5 Design, implement, deliver and/or quality assure education and training programmes, to build a skilled and competent workforce
C4.6 Adapt capability by maintaining flexible in-service learning and development systems for the workforce

"If it's a clearly defined piece of project work that maybe is grant funding based or has a particular amount of funding to set something up, then I think there's potentially some budget management there. I think we could probably find ways for a junior member of staff to manage elements of a budget as part of their development." [Y1]

"Budget holders will tend to be service managers or directly reports to a service manager, so [practitioners] might be identifying what spend would be, or proposing projects, but they won't be managing finance." [W1]

"I think this is also thinking about workforce as a resource isn't it, there's kind of the actual monetary type stuff and then there's, how can we develop our workforce, what assets do we have, what can we use, because there is no additional money, or very little." [D1]

"I think this is an interesting one, because I guess in terms of my own personal experience, I probably have less control over resources now than in previous roles. I don't know whether that's a reflection of the public health grant and some of the restrictions that are around that but 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 are or you do it as the team. In a previous role I was also health improvement manager, I was part of the senior management team, which is kind of the same job title but quite a different role. We used to work through what our priorities would be through a kind of complex matrix. Whereas now I don't feel like I probably have as much influence and it's not as large a part of my role as in the allocation of resources. I might shout about it a lot and I might think I make really reasoned evidence based sort of proposals as to why that is but I guess for me in this current role it's a lot less a part of my role the actual allocation of resources and allocating those priorities." [N2]

"I've got a team of three at the moment, and so that's very much about how I approach that management on a day to day basis, being available, being approachable, regular one-to-ones regular updates regular sort of communication about you know work programmes that are changing priorities, personal development reviews, those sorts of things. But I think a lot of that is also focussing on some of the softer side of things in terms of being available, being aware of how those individuals like to work, where they might be encountering pressure, where they're not, where their strengths are where their weaknesses are, where their development opportunities are, that sort of thing." [Y1]

"I think at a practitioner level I would be surprised if you did C4.3 or C4.4. I think they would be at a higher level, particularly around development of workforce capacity, I think you might contribute to it but I don't think you'd be actually in a developmental role particularly, and certainly within a local authority financial management and budget control is much tighter than it was in the NHS." [W1]

"I think that's training, I don't think they're actually developing workforce capacity. I think the sort of the ability to develop the workforce capacity is identified and then they're doing the delivery that enables that, so it's an enabling role rather than a developmental role, in my opinion. But I do believe that certainly C4.5 I think that's a strong one, because I think we've found where students [on placement with the Council] are good, they're quite good at being able to deliver and think about ways of doing sort of quite innovational training and that kind of thing." [W1]