Accepted version
Robinson, S. and Brownett, T. (2018) Educating public health champions. *Health Education Journal*, doi: 10.1177/0017896918786016

Educating public health champions

Abstract

Objective: This article describes a university course that aimed to create public health champions, and its evaluation. The course attracted 92 participants, over three cohorts. Participants included healthcare professionals, fitness instructors, a belly dancer, housing officers, community workers and those who worked in public health policy.

Design: The course evaluation aimed to provide a longitudinal understanding of the participants' learning and the impact of the course in terms of developing the attributes of public health champions.

Setting: A university setting in England

Methods: Evaluation methods included questionnaires, self-assessment against UK Public Health Skills and Knowledge Framework statements, 'check out' sentences post action learning set meetings, impact statements and unstructured interviews.

Results: The evaluation illuminated the participants' experience of their learning journey, which comprised cognitive, affective and conative learning, the development of public health competences and evidence of putting the learning into public health practice.

Conclusion: In total, 76 participants achieved a university award. There was evidence of participants identifying the underlying causes of ill health and using an evidence-based approach to planning, partnership and influencing others. Some reported actions that indicated they had become transformative leaders and public health champions. The article discusses limitations to the evaluation and some current challenges to public health workforce development in England.

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Educating public health champions

Introduction

The health costs associated with an ageing population, air pollution, mental illness, tobacco use, cardiovascular disease, cancer and health inequalities are outstripping resources across Europe. The World Health Organization (2014) argues that investing in prevention, in the form of cost-effective, sustainable, public health interventions, is an international priority. Public Health England (PHE)(2016a) and the National Health Service (NHS) (NHS/PHE, 2017) recognise the importance of developing public health within the health and care system, local authorities, workplaces and communities. The public health workforce comprises the core workforce of public health practitioners and specialists, for whom public health is their prime role. It also includes the wider workforce, an estimated fifteen million workers in England, whose work provides them with opportunities to make a contribution to preventing ill health and promoting the public's health (CfWI, 2015). Tapping into the potential of this wider workforce is a vital part of current strategic planning for protecting and promoting health in England (PHE, 2016b; NHS/PHE, 2017).

In 2008, the UK Public Health Skills and Career Framework (Skills for Health/Public Health Resource Unit (SfH/PHRU), 2008) was published to support public health workforce development. It comprised statements of knowledge and competences required for different groups and levels of the public health workforce. Some statements were updated in 2013 and the document was renamed the Public Health Skills and Knowledge Framework (PHKSF) (SfH/PHRU, 2013). This article describes a university course which sought to develop the public health workforce by providing participants with some of the knowledge and competences outlined in the PHKSF, and encouragement to become champions of public health.

Champions – origins of the concept

The concept of 'champions' was first identified within organisational analysis. Passionate individuals who promoted innovations and ideas via their social networks were identified as key drivers of opinion change and organisational transformation (Schon, 1963; Howell and Higgins, 1990; Markham, 1998). Central to the champions concept is the idea that such individuals must emerge spontaneously, driven by personal belief and enthusiasm for a subject, with the ability and desire to influence others to support their cause (Markham and Aiman-Smith, 2001; Thompson et al., 2006). The role of a champion is aligned with the social-influence theory of organisational change, in which 'opinion' or 'transformational' leaders utilise their social networks and communication skills to share ideas to enact behaviour change (Howell and Higgins, 1990; Flodgren et al., 2011). Thompson et al (2006) explain that champions have an overwhelming enthusiasm, they are visionary and have the ability to influence others to support projects. Not only do they identify themselves as champions, but so do their senior managers and peers.

Public health champions

The earliest references to champions within the field of public health literature seem to be Backer and Rogers (1998) and O'Loughlin et al. (1998). The authors identified the importance of having champions to introduce and sustain innovations in workplace HIV and community heart health programmes respectively. Recent public health champions, whose work has been recognised as good examples of promoting and advocating for public health causes include Robert Beaglehole and Ruth Bonita (Lane, 2013), Martin McKee (Shetty, 2013) and Fiona Loud (Davies, 2017). Some organisations have set up networks of public health champions to ensure that innovation spreads. These include the British Dietetic Association (BDA) (2017) which is aiming to have a public health champion within each NHS dietetic team across the UK. The BDA aims to train individuals within teams to champion public health to colleagues and service users. Other networks might comprise

those who contribute to a public health campaign such as cancer awareness (Curno, 2012; Bone and Johnson, 2011). Some provide support for communities, youth, early years or senior citizens from inside or outside health services (Altogether Better, 2017).

Greenhalgh et al. (2004) carried out a systematic review *How to Spread Good Ideas* about the diffusion, dissemination and sustainability of innovation in health services. They found moderate evidence to support the finding that individuals and organisations were more likely to adopt innovation if there were key individuals who had good personal relationships within their social networks and were willing to support the innovation. Greenhalgh et al. (2004) recognised the work of champions in developing, sharing and implementing public health innovations, and described them as major contributors, although not essential, for success. There are several types of champions and champions schemes within public health, and a variation and inconsistency in how the term 'champion' is used (Greenhalgh et al., 2004; Thompson et al., 2006). In some circumstances, the term champion is sometimes used synonymously with terms such as volunteer, peer advisor or lay health worker (South et al., 2010a; 2010b; NICE, 2016). This includes recruiting volunteers and calling them champions. The term 'community champion' can mean a volunteer or a highly skilled leader.

This article focuses on a course that aimed to develop public health champions as transformational leaders who can use their social networks and influence to improve the public's health. Their transferrable knowledge and skills can be applied across contexts. They understand that everyone can contribute to their own and others' disease prevention and health improvement by focussing 'upstream' to the underlying causes of ill health in everyday life and the environment. They work to bring about health promoting attitudes and behaviours in individuals, groups, organisations, and local, regional and national communities. Their enthusiasm and skills help to influence policy makers,

senior managers, colleagues, customers and people within their social networks. They raise awareness and provide education about how to improve health; know how to find, create, use and disseminate credible evidence; bring people and ideas together and encourage partnership working; and they help to develop and then transfer health promoting interventions to new audiences and across sectors.

The public health champion course

Education is often part of becoming a champion within public health. This can range from short training about a specific public health topic to education about wider, generic, transferable public health knowledge or competences. This article describes an example of the latter, a 12 month, university level short course, comprising a classroom taught and assessed 20 credit module at Higher Education (HE) level 4 (Module 1), a taught and assessed 20 credit module at HE level 5 including five action learning sets (Module 2), and a celebration event/awards in month 13. The course included 67.5 classroom-based teaching hours. The aim was to equip practitioners with the core knowledge and skills that would enable them to act as champions of public health within their areas of work and local communities.

The course was informed by an understanding that improving the health and wellbeing of a community often requires the development of strategies to address the social determinants of health alongside strategies to raise awareness, provide knowledge, provide skills, empower and/or change people's health-related behaviour. A number of concepts can help to explain health-related behaviour, such as motivation (Maslow, 1943), self-esteem and self-efficacy (Bandura, 1997). Models, such as the theory of planned behaviour (Ajzen, 1991) and social learning theory (Bandura, 1977), suggest that there are complex relationships between people's beliefs, knowledge, social attributions and behaviour. Health education and health literacy, an individual's ability to interpret

and use health information effectively, are also important facets of people's behaviour change (Nutbeam, 2000). It is for these reasons that Marmot (2013) argues that public health skills, such as communication, partnership and advocacy, as well as practice-specific ones, are essential for practitioners who tackle health inequalities in society. Skills, as well as knowledge, are the means by which public health champions can empower, educate and motivate individuals, colleagues and communities to improve health and wellbeing.

Insert Table 1

The course aimed to facilitate cognitive, affective and conative learning. Huitt (1999) defines cognition as knowing, processing, storing and retrieving information. The course content is summarised in Table 1. Module one was designed to provide core public health knowledge. Participants wrote an assessment about the health of a local neighbourhood, based on local data, which included a short reflection about a public health initiative in the area. Module two sought to encourage self-evaluation and to enable participants to practise specific public health skills in the context of championing public health. It aimed to encourage affective and conative learning. According to Huitt (1999) affective learning concerns positive or negative feelings towards the knowledge, and conative learning concerns the connection between knowledge and feelings to behaviour. Conative learning is about personal, intentional, proactive planning and striving towards a goal, and it is a critical component if an individual is to become self-directed. The Module two assessment required participants to write a reflection of their own development with reference to understanding themselves, working with others, championing skills, evaluation and moving forward in the context of a public health approach to improving population health and wellbeing. Classroom-based teaching for both modules included lectures and active methods such as group-work, simulation, reflection, games, brainstorming and case studies.

Illeris (2009) has argued for learning to be successful, knowledge and emotional incentives are insufficient. Learning needs to be personally integrated through interaction with communities. Interaction includes experience, participation, communication and co-operation and it is this interaction that provides the impulse for successful personal learning. The participants' written assessments included opportunities for interacting with their local communities. Local public health practitioners and specialists, as well as university public health academics, facilitated the classroom-based learning. Each participant visited a peer's workplace. Towards the end of and after the classroom-based learning, five action learning set (ALS) meetings were held. Each comprised approximately eleven participants, who met in various work places, with the aim to clarify, apply and embed the learning through peer support. Participants were encouraged to bring real issues and dilemmas relating to the course or their work to share. The facilitator's role was to model and encourage the practice of listening, questioning, challenging, supporting, reflection and giving feedback within a safe environment. The learning was formally assessed by the two written assessments, and this determined their award of University Certificate in Public Health Practice.

Participants

The local public health department and the university shared the marketing which comprised on-line advertising and invitations to two information events. The entry criteria were living and working in the region and having a passion for making a difference to community health and wellbeing. Applicants completed a simple application form which the public health department assessed. The public health department paid the course fee and employers committed to allow participants time to attend classes and ALS meetings. Ninety two participants started the course, with 30 or 31 in each of three cohorts. Eighty three per cent were women and seventeen per cent were men, with ages ranging from 25 to 63 years. They ranged from those who had no prior university experience to those who were graduates. Many worked in local authorities for example children's centres,

workplace health, human resources, parks and countryside, and public health policy. Some worked for charities such as drugs and alcohol, housing, sensory and autistic support, and community liaison work. Others had their own private businesses such as a belly dancer, fitness instructor and community arts maker. Some worked as midwives, health visitors or operating department practitioners within the English NHS.

Evaluation methods

Insert Table 2

Table 2 shows the evaluation tools and timescale. The course was evaluated at eleven points. The purpose of the evaluation was to gain a longitudinal understanding of the participants' learning and the impact of the course in terms of developing the attributes of public health champions. Each evaluation was completed anonymously, without the use of individual coding, and participants were informed that the data would be used for the purposes of feedback to the local public health department and in potential publications.

Modules 1 and 2

A standard university module evaluation questionnaire was used to evaluate participants' views of the modules' content, teaching/learning, resources and assessment. This comprised structured and open questions.

UK Public Health Skills and Knowledge Framework Statements

To evaluate self-perceived changes in public health knowledge and competence, the participants completed a questionnaire comprising a selection of knowledge and competence statements within

the Core and Defined Areas of the UK's PHSKF (SfH/PHRU, 2013). Those statements and their numeric level were selected because they reflected the intended learning outcomes of the course. The 31 knowledge and 25 competence statements comprised:

Core Area – Surveillance and assessment of the population's health and wellbeing: knowledge 4a, 4b, 4c, 4d,4e ,4f, 4i, 4j and competences 4.1, 4.2, 4.3.

Core Area – Assessing the evidence of the effectiveness of interventions, programmes and services to improve population health and wellbeing: knowledge 3b, 3d, 4b and competences 4.2, 4.4.

Core Area – Policy and strategy development and implementation to improve population health and wellbeing: knowledge 4a, 4b, 5a, 5c and competences 3.2, 3.3, 4.1, 4.2.

Core Area – Leadership and collaborative working to improve population health and wellbeing: knowledge 4e, 5a, 5b, 5d, 5h, 5i, 5j and competences 4.1,4.2, 4.4, 4.5, 5.1, 5.7.

Defined Area – Health improvement: knowledge 3a, 4b, 4d and competences 4.1, 4.3.

Defined Area – Health protection: knowledge 4a, 4b and competences 3.2, 4.1.

Defined Area – Public health intelligence: knowledge 4b and competences 4.1, 4.5.

Defined Area – Academic public health: knowledge 4b and competences 4.6, 5.10.

Defined Area – Health and social care quality: knowledge 4b, 4e and competences 3.4, 4.3.

Against these statements, participants rated themselves as; poor/no confidence at all, poor/not very confident, reasonable, confident/good or very confident/excellent. They rated their knowledge three times, at the start and end of the course, and six months after the course had finished. They rated their competences twice, at the start and six months after the course had finished.

Action Learning Sets (ALS)

To evaluate their experiences of the five action learning set (ALS) meetings, each group initially set out their own success criteria. For example one group wrote,

> Think about our own understanding and reflect on our own practice/Have shared good practice/Gain knowledge and share it/Learnt and had time to reflect on own practice/Feel more confident/Keep motivated and be encouraged/Be supported and feel enabled to work more effectively/Provoke thought and discussions.

At the end of each meeting, they agreed a 'check out' sentence which captured where the group thought they were in respect of their own success criteria.

Impact

To evaluate the impact of the course participants were asked to sum up how they had applied their learning to their work in the form of a picture and a brief phrase.They completed this at the end of the second module (Impact 1), at the end of the course (Impact 2) and six months after the course had finished (Impact 3).

Long-term impact

Long-term impact was evaluated through a simple, informal, unstructured, face-to-face, individual interview of approximately 10 to 15 minutes. It was based on the opening question, "What has been the impact of the course for you?" This was carried out with four former participants when they returned to attend the summer 2017 celebration/awards event, during breaks in the day. Written notes were taken and some quotes noted, but not full transcripts.

Data analysis

The quantitative data from the evaluations of Module 1 and 2, and the self-assessed PHSKF knowledge and competence statements were manually collated as descriptive statistics. The short comments from the evaluation of Module 1 and 2, the sentences from the Action Learning Sets (ALS 1 to ALS 5) and the phrases from Impact 1, 2 and 3 were analysed using content analysis (Tonkiss, 2004; Elo and Kyngäs, 2007). Initially, comments were coded into three categories based on the key characteristics of a champion (e.g. Markham and Aiman-Smith, 2001; Thompson et al., 2006; Greenhalgh et al., 2004). These were enthusiasm for public health/evidence of motivation and planning; influencing others using personal skills and networks; transformation of people and organisations/a public health intervention. During the reading of the comments, four additional categories emerged; increased public health knowledge, understanding my potential and role as a public health champion, transformation of self/personal change, and application of my learning to my role. Combining categories that are pre-set with those which emerge from reading is not uncommon, according to Tonkiss (2004). Four overarching, higher order categories emerged: cognitive, affective, conative and behaviour. Comments were coded to the seven categories by two researchers working independently. There was 94% inter-rater agreement about the coding of the 208 comments, and agreement about twelve comments was reached through discussion. The number of comments in each category were quantified to illuminate the stages at which categories

emerged during the course. The written notes from the long-term impact interviews, which included some direct quotes, were manually and inductively analysed to identify themes.

Findings

Over the three cohorts, 76 (83%) participants completed the course and gained a university certificate. All the participants who did not complete the course did so because of external work or personal pressures.

Insert Table 3

At the start of the course 91 participants completed the PHSKF questionnaire. This reduced to 58 at the end of the course and 34 six months post-course. As a percentage of these samples, across the 31 PHSKF knowledge statements, the participants rated themselves more frequently as confident/good or very confident/excellent at the end of the course. Perceived knowledge only increased a little in the six months after the course, at which time eleven statements were rated as very confident/excellent by all 34 participants (100%). The lowest frequency was 82% for one statement. The mean difference from the start to six months post course was 57%. Examples are shown in Table 3.

Insert Table 4

With respect to the 25 statements of competence, the percentage of those who rated themselves as confident/good or very confident/excellent was more frequent six months post course compared to the start. All 34 participants (100%) rated themselves as very confident/excellent for five of the

statements six months after the course. The lowest frequency for one statement, after the course, was 59%. The mean difference between the start and six months post course was 56%. Examples are shown in Table 4.

Insert Table 5

Table 5 shows that participants reported cognitive learning throughout the course, with the number of comments diminishing after the classroom-based learning. This reflects the quantitative self-assessment of knowledge in Table 3. At the end of Module 1, a typical comment was,

> Given a good understanding of public health, the wider picture. (Module 1)

By the end of classroom-based learning, the participants expressed greater confidence in their knowledge of public health and many named specific learning.

> I have a better understanding of funding and the commissioning of services. And where to focus our interventions based on quintiles of deprivation. (Impact 1)

By the end of the course, there was evidence of knowledge being synthesised and some participants thinking differently.

> Greater awareness and understanding on the significance of public health and how this can be applied to my daily work … I have now begun to think more widely through more of a public health 'lens' when deciding on actions for children and families in order to achieve

> best outcomes and improved public health for service users. I have greater awareness of joining my work alongside other agencies. (Impact 2)

> I have a much better understanding of local policy and strategy which underpins our activities and how to use public health intelligence and evidence to develop appropriate service provision. (Impact 2)

Participants' knowledge of the role of a public health champion was mentioned by a few participants at all points of the course.

> Confidence in our role and more understanding how to use this in our role … to have an impact. (ALS 1)

> I now have a better understanding of the public health picture in the UK, what is happening and why, to be able to advocate for change and try to influence agendas and programmes of work, to make a real difference, and try to ensure that public health promotion doesn't get lost during changes! (Impact 1)

Affective learning appeared to be developed after the first Action Learning Set,

> Confidence to challenge the status quo and public health agendas. (ALS 1)

Comments about self-reflection and increased confidence were prevalent by the end of the classroom-based learning.

> More confident of my research design when fulfilling information requests for other people. (Impact 1)

> Confident and empowered to make the case for public health to a range of audiences. (Impact 1)

> More reflective, using this work has led to more ideas for self-improvement (Module 2)

Later comments included evidence of personal transformation for some.

> I make fewer assumptions now about others' knowledge, but I have greater faith in their skills. (Impact 2)

> Eye opening and has lit a passionate fire within me. (Impact 2)

> … this course has improved my confidence and made me reflect upon my way of working and things I can do differently. (Impact 2)

> … this learning has made me a more critical advocate for challenging health inequalities. (Impact 3)

Conative learning was not revealed until the participants were asked to provide comments on the impact of the learning for their work, at the end of the classroom-based learning.

> I'm always talking about public health now – whenever I hear about anything relevant to the topic I say, "That's public health." (Impact 2)

> We are proud to be professional public health champions … and now feel motivated to continue our journey. (ALS 5)

> My learning has… made me think about how I can make a difference in tackling health inequalities … I want to be part of closing the gap. (Impact 2)

> It has spiked my enthusiasm and passion to improve population health. (Impact 2)

> I hope to further develop my public health skills to be able to help educate children and encourage them to take care of their own health. (Impact 2)

Participants' comments about acting on their learning were not present at the end of Module 1, but were much more prevalent by the end of the course and six months post course. These findings reflect those relating to participants' self-assessment of their PHSKF competences (Table 3). Most comments gave examples of how the participants' learning had been applied to their job role.

> I have applied my learning to my work role by using evidence and data to support reasons for doing or setting up a health intervention. (Impact 2)

> My role has changed to that of team lead and I feel that being a public health champion has encouraged me to take that step. (Impact 3)

> I actually got a job with Citizens Advice as a result of my increased knowledge and networks. (Impact 3)

> My learning has been applied broadly in taking an evidence-based approach to public health, I work with confidence in my ability as a practitioner to challenge the status quo and advocate good practice in public health in the services I commission. (Impact 3)

Forty individual comments provided evidence of influencing others by using their skills and social network.

> Presentation to public health commissioning led on to how my directive can continue to deepen joint working. (Impact 1)

> I am looking after the whole person and signposting them to other services based on their needs. I now do this on an individual, small group, local community and strategic level. (Impact 2)

> By using the language and arguments around wider determinants that public health colleagues use, to make my 'case' unmissable. (Impact 2)

> I have been able to help effect reform with … Council. We are in big talks with the authority to integrate public health into all areas of the council, with a greater understanding of how each service has its own effects on health. I have been sourcing out many different partners to work with that I had never previous thought of before. (Impact 3)

Behaviours to bring about public health improvements were revealed most frequently at the end of the course and six months later. These included evidence of using public health skills such as communication, partnership and advocacy skills and using evidence to inform business planning.

> I have begun a systematic review of my charity's early stages into advocacy and support, and created a new business plan based around public health principles (Impact 2)

> I have used my learning to develop and build public health leads across the county to develop upstream practices and thinking that will be more preventative (Impact 2)

> I now consider health in nearly everything I do. When we undertake community engagements we try to take literature on health so that we can give this to people alongside community safety advice and any events we undertake we invite colleagues from the public health team where possible. (Impact 2

Comments about specific public health interventions included promoting health within social care for older people, offering dance and fitness services to new audiences, planning a curriculum for working with male offenders and setting up a buggy health walk to encourage parents and children to be more active.

Interviews about the long-term impact of the course took place in summer 2017. Three, out of the four, participants had completed the course in 2016, and one in 2015. The common themes to emerge were that all cited changes that they had made to their work, their place of work and personal lives. All spoke of being better equipped to pass on public health knowledge to colleagues

and initiating practical public health interventions. The course had given them an in-depth insight into the wider context of public health (policies, agendas, structures) which enabled them to understand how their role fitted in, and how they could better work with external partners.

> The area in which I work is a deprived community, and I needed to get some health checklists completed. From learning about social equity on the course, I found out who the key figure was, which turned out to be the pub landlady, and I went to her and explained what I wanted to do. She managed to get the booking form filled up for me, which never happens. I wouldn't have thought to approach her had it not been for [the course].

Three participants reported positive impacts on their own wellbeing, including increased confidence, improved morale, positive changes to their home environment, and enhanced employability.

Discussion

The course elicited clear evidence of enthusiasm, and perceived public health-related cognitive, affective and conative learning and the development of public health competences. Seventy six participants (83%) achieved a university level award based on marked assessments which demonstrated the application of public health principles to an analysis of a neighbourhood and their own work-related practice. Evaluation showed that some participants described actions that suggested they had become transformative leaders who were using their social networks and communication skills to influence and improve the public's health. There was evidence, in both the evaluation and the written assessments, of course participants indentifying the underlying causes of ill health, an evidence based approach to planning, partnership and influencing others, and there was evidence of public health action. The long-term impact suggested that these attributes were

maintained after the course. These findings suggest that the course was successful in helping some participants to meet the course's description of public health champions.

The authors believe that the positive evaluation of the public health champion course lay in its inclusivity and partnership working. It was accessible to a very wide range of practitioners regardless of prior qualifications; teaching styles included lectures, small group work and peer learning; the first module was pitched at HE Level 4, the introductory level to university; and employers agreed to participants attending a relatively short course from which they could see potential benefit. University staff and local public health practitioners and specialists shared the marketing, recruitment and teaching; the learning took place in a university setting and local community workplaces; and the course linked public health principles and evidence to examples of local public health practice. Together, these elements appeared to create a vibrant learning community of those who were passionate about public health. The title 'public health champions' set a tone for success, and the short course culminated in an event which did not merely award certificates, but celebrated and disseminated their achievements to senior managers, key stakeholders, commissioners of services and existing public health champions. The champions received advice about further public health qualifications, and they joined a local public health champion network.

The evaluation provided an insight into the participants' learning journey. Their perceptions of cognitive and affective learning appeared to be greater during the classroom-based learning, moving from cognitive alone to both, which reflected the intended learning within the course design. By the end of the classroom-based learning, some comments revealed a transformation within the participant. This echoes the argument of Jarvis (2009), who says that human learning is existential. "Fundamentally, it is the person who learns and it is the changed person who is the outcome of the learning" (p. 24). The summative sentences agreed at the end of the Action Learning Set meetings

suggest that this collaborative work had helped to connect knowledge, feelings, motivation and planning for potential public health champion behaviour. Comments reflecting action became more prevalent at the end of the course, and six months later, alongside the PHSKF evidence that they thought they were more competent. The findings from the evaluation neatly present an impression of a learning journey comprising the accumulation of the knowledge required by a potential public health champion, an engagement of personal feelings and motivation towards this goal, followed by sustained public health action brought about by the enthusiastic application of knowledge, personal skills and social influence.

Limitations

There are some important limitations to the evaluation. Whereas 91 participants completed the evaluation at the start of the course, only 58 completed the end of course questionnaires and 34 the six months post-course evaluation. The evaluation data comprised personal views and self-assessment, with no objective measurements apart from the assessed knowledge and academic skills demonstrated in the two written assessments. The demographic data of the samples who completed evaluations was not collected. It was not practical to track the evaluation responses of each participant, especially as each was assured of anonymity. Consequently there is no way of knowing that the quantitative changes in knowledge and competence were statistically significant, nor that the trend of the journey of learning was similar for all, or none. The PHSKF statements may not have captured all learning. Although they were selected to reflect the intended learning outcomes of the course, there are always unintended learning outcomes, particularly from peer learning. The module evaluation questionnaires requested views about the module's content, teaching and resources and they elicited comments about knowledge and personal/affective change. The function of the Action Learning Sets was to help participants to apply and embed the learning, and this might explain why many of the summative sentences were affective and conative.

Only the impact task asked the direct question, "How have you applied your learning to your role?" which might explain the greater number of comments described as conative and behavioural. The long-term impact was assessed through four participants, who may have represented a more motivated sample. The evaluation did not measure the champions' effectiveness, for example neither the impact of the course on the public's health nor the impact of their reported interventions were assessed. According to Thompson et al. (2006), a champion is not only self-identified, but peers and senior managers recognise the champion too. The evaluation neither investigated, nor did any comments directly allude to, recognition by others beyond the peers and stakeholders of the course.

Conclusion

In 2016, Public Health England produced a new and simplified Public Health Skills and Knowledge Framework to replace the PHSKF and reflect the current strategic public health work force planning (PHE, 2016c). It does not contain knowledge and competence descriptors, but focuses on a concise set of high level functions that cover the range of public health practice. The public health context has also changed. Significant and urgent challenges within healthcare and social care appear to have pushed investment in public health down. Public health budgets, given to local authorities in England by the national government, have reduced significantly. Continued planned cuts will average 3.9% until the year 2020/21 (BMA, 2018); a 'death by a thousand cuts' (Buck, 2018). The local public health department was unable to re-commission the course after the third cohort. A major re-structure meant that many public health practitioners, including public health workforce development leads, left. Commissioners purchase services from external providers, project by project, and offer an on-line course about healthy lifestyles as a route to becoming a public health champion. It is a different view of a champion, and not one who focuses upstream and has the

confidence and skills to energise others to work in partnership. The current development of new public health practitioner apprenticeships (Skills for Health, 2018) might provide a new educational option which enables learners to integrate public health knowledge with experience. Provided there are workplaces to support apprenticeships, perhaps these will spawn the next generation of public health champions.

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Table 1 Course content

Module 1 Introducing Public Health 6 days in classroom	
Themes	*Examples of content*
Understanding the determinants of health Inequalities in health The public health landscape & workforce Identifying public health needs and assets Public health policies and practice	Ways to wellbeing Evaluation of self, workplace, local community Social and environmental determinants of health Local and national health inequalities Strategic needs assessment Health impact assessment Local public health observatory data Public health outcome framework
Action Learning Set 1 in the local community	
Module 2 Championing Public Health 4 days in classroom	
Themes	*Examples of content*
Understanding myself Working with others Developing my championing skills Am I a public health champion?	Self-reflection Knowledge, attitudes, behaviour Team, advocacy, leadership, partnership skills Building social capital Ethics and values Visit to peer's workplace Public Health Knowledge and Skills Framework Funding and writing a business case Evaluation
Action Learning Sets 2, 3, 4, 5 in the local community	

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Table 2 Evaluation timescale

Month		Evaluation research tool
1	Start of course	PHSKF knowledge and competences (questionnaire)
4	End of Module 1	Module 1 (questionnaire)
6	Action Learning Set 1	ALS 1 (summative sentence)
7	End of Module 2	Module 2 (questionnaire) Impact 1 (questionnaire)
	End of classroom-based learning	
8-12	Action Learning Sets 2-5	ALS 2, ALS 3, ALS 4 and ALS 5 (summative sentence)
12	End of course	PHSKF knowledge and competences (questionnaire) Impact 2 (questionnaire)
	End of course	
13	Celebration event/awards	
19	Six months post course	PHSKF knowledge and competences (questionnaire) Impact 3 (questionnaire)
24 -36	A year or more after course	Long-term impact (interviews)

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Table 3 Examples of participants' self-assessment of their public health knowledge rated as confident/good or very confident/excellent

PHSKF Knowledge Statements	Start of course (n=91)	End of course (n=58)	Six months post course (n=34)
Knowledge of health and its various aspects	38% (35)	97% (56)	100% (34)
Knowledge of inequalities in health and wellbeing and how they might be measured	20% (18)	88% (51)	100% (34)
Knowledge of the people and agencies involved in the surveillance and assessment of the population's health and wellbeing	16% (15)	72% (42)	100% (34)
Understanding of how to make an assessment of community conditions, social capital and community capacity	5% (5)	81% (47)	82% (28)
Awareness of how evidence should be used in decision-making	47% (43)	86% (50)	100% (34)
Knowledge of various sources of evidence and their use	27% (25)	84% (49)	100% (34)
Knowledge of policies relevant to own areas of work	44% (40)	86% (50)	97% (33)
Awareness of major government policies relevant to health and wellbeing and inequalities	19% (17)	90% (52)	97% (33)
Knowledge of methods of effective communication	66% (60)	93% (54)	100% (34)
Awareness of how different people can help to build capacity and capability in the system overall	32% (29)	84% (49)	97% (33)
Knowledge of the main health improvement messages and the key evidence supporting them	30% (27)	90% (52)	94% (32)
Knowledge of the sensitivities required and the various approaches needed when working with people	53% (48)	90% (52)	91% (31)
Awareness of health inequalities and the needs of vulnerable groups in protecting health and wellbeing	33% (30)	97% (56)	91% (31)
Knowledge of basic sources of data and how to access them	20% (18)	93% (54)	97% (33)
Knowledge of how own and team's area of work contributes to service quality	48% (44)	59% (54)	97% (33)

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Table 4 Examples of participants' self-assessment of their public health competences rated as confident/good or very confident/excellent

PHSKF Competence Statements	Start of course (n=91)	Six months post course (n=34)
Collect and collate basic data on health and wellbeing and the related needs of a defined population	1% (8)	85% (29)
Undertake a simple analysis of various types of data on health and wellbeing needs	8% (8)	91% (31)
Apply evidence to a specific area of work	33% (30)	94% (32)
Communicate evidence to a defined audience	41% (37)	97% (33)
Give constructive comment on the effect of policies and strategies on health and wellbeing	20% (18)	94% (34)
Be an effective member of various teams	66% (60)	100% (34)
Constructively reflect on my own work and area of practice	56% (51)	94% (32)
Collaborate with others effectively to improve population health and wellbeing	43% (39)	100% (34)
Communicate to relevant people the health concerns and interests of individuals and communities	41% (37)	97% (33)
Explain to individuals the reasons for monitoring risks and undertaking activities to protect health, wellbeing and safety	31% (28)	94% (32)
Collect data from a range of sources	20% (18)	65% (22)
Critically reflect on feedback and apply to own work	52% (47)	85% (29)
Disseminate research findings within area of work using methods appropriate to the audience	27% (25)	59% (20)
Develop relationships with the users of services in own area of work	44% (40)	97% (33)

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Table 5 Number of participants' comments at different points of the course according to categories

		Cognitive		Affec-tive	Conative	Behaviour		
Categories		Increased public health knowledge	Understanding my potential and role as a public health champion	Transformation of self/personal change	Enthusiasm for public health/ evidence of motivation and planning.	Application of my learning to my role	Influencing others using personal skills and social networks	Transformation of people and organisations/a public health intervention
Month								
4	Module 1	6						
6	End of ALS1	3	1	1		1		
7	Module 2	6	3	7				
	Impact 1	18	2	14	10	9	7	
	End of classroom-based learning							
8 - 12	End of ALS2		1		1			
	End of ALS3	1		3	1			
	End of ALS4		1	1	3			
	End of ALS5		2	3				
12	Impact 2	11	5	12	4	14	12	6
	End of course							
13	Celebration event/awards							
19	Impact 3	4	2	3		17	8	5