**Public Health Practitioner Commentary Template**

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| **Title of commentary** | Community Centred and asset-based approaches in relation to a cross site evaluation of the integrated wellbeing and wellness services (IHWBS) across the North East | **Standard being claimed** | **Evidence *(ref)*** |
| **Reference Number** | Commentary 1 |  |  |
| **Standards Claimed** | 1a, 1b, 3a, 3b, 3e, 4b, 4c, 5c, 5d, 5e, 6a, 6b, 9f, 11a, 11b, 11c, 12 |  |  |
| **Context** | “The transfer of public health to local government, has created opportunities for public health and healthcare to become more person and community centred, enabling individuals to realise their potential and to contribute to building healthier, more resilient communities”. (South, 2015).  How we understand health and well-being determines the way re respond to it. Typically, a community is seen from the perspective of its largest deficit however assessing and building the strengths of individuals and the assets of a community, opens the door to new ways of thinking about improving health and of responding to poor health. Many of the key assets required for creating the conditions for health lie within the social context of people’s lives and therefore have the potential to contribute to reducing inequalities.(South, 2015).  PHE’s role is to promote these approaches, share learning and examples of practice, support the embedding of these approaches within public health interventions and support the principles of these approaches within every day public health practice.  Community centred and asset-based approaches (CABA) have gained increasing popularity since The Marmot Review and the increase in evidence that addressing the social determinants of health is needed to reduce persistent health inequalities, however, much of the philosophy behind these approaches has been practised for many years, through fields such as community development.  A growing number of Local Authorities (LAs) have established integrated health and wellbeing services (IHWBS) in an attempt to deliver cost effective, preventative services using CABA. These services adopt an individual lifestyle, holistic approach and aim to support people to live well and maintain optimum levels of health and wellbeing for themselves and other in their community. Outcomes are focused on reducing demands on health and social care services, and tackling inequalities in health.  There are 4 IHWBS operating in the North East, all providing different combinations of 1:1 support, group activities, volunteer support, training and workforce development, and community centred approaches campaigns.  It was agreed that Teesside University (with funding and support from Public Health England) would undertake a cross site evaluation of the 4 services to map the nature of the 4 programmes and understand what is working, where, for whom, and under what conditions.  The study incorporated a mixed method approach, using routinely collected quantitative data to identify patterns of use, and qualitative semi-structured and in-depth interviews to further explore some of the key themes emerging from the quantitative data. |  |  |
| **Own Role** | *Give a brief description of your role related to this work, e.g. commissioner, coordinator, chair of a steering group, key partner involved in area of work being presented*  I am currently a Health and Wellbeing Support Manager in the Health and Wellbeing Team at Public Health England (PHE) North East. I provide support and leadership to several public health topics, including CABA.  The IHWBS evaluation project was a co-produced piece of work between academics, the public health system (including commissions and providers), and PHE. My role was pivotal in this project and as a member of the Research Team and the Advisory Group, I was involved from the very beginning to discuss the need for the evaluation and the desired outcomes, right through to data collection, data analysis, and dissemination of the findings.  I provided a leadership role in relation to the management of the Research Team and the Advisory Group. This involved: drafting an MOU between Teesside University and PHE; establishing and maintaining a Research Team and Advisory Group and providing public health input into discussions; developing and maintaining a Gantt chart to keep the project to time; liaising with external stakeholders on behalf of the lead researcher as part of the in-depth interview recruitment process; co-facilitating focus groups; undertaking a thematic analysis of the 4 service key performance indicators; and organising a CABA event to inform wider stakeholders on the findings from the evaluation and discuss how they link to the CABA programme.  I co-facilitated community focus groups, contributed to the discussion and refinement of the qualitative coding process for the thematic analysis, supported the development of the thematic analysis, co-produced the evaluation report, delivered, presentations and contributed to the development of posters and other material to disseminate and promote the findings. |  |  |
| **Acquisition of knowledge** | *Where did you get your knowledge from to understand the requirements of this area of work (you do not claim standards here, just list how you acquired your knowledge, putting dates next to learning events etc*  I acquired my learning via a variety of methods including self-directed learning such as: reading; on the job activities; attending meetings, conferences, workshops and masterclasses; and undertaking specific academic courses. These included:  I attended a public health practitioner masterclass in January 2016 on CABA. This provided me with foundation knowledge around what the approaches are and how they can be applied to public health interventions to address the health and wellbeing needs of the targeted communities. (Ev. 1.2).  I attended a ‘Think Piece’ event at Leeds Beckett University in May 2016 where we shared insights and learning on community centred and assed based approaches with a range of academics and practitioners from across the country. (Ev. 1.3).  I attended the PHE Annual Conference in September 2016 and took part in a workshop to discuss the role CABA can play in addressing inequalities.  I undertook a Public Health Interventions MPH module at Newcastle University in January 2016 which developed my learning around implementing effective interventions which target the health and wellbeing needs of specific populations. It also helped me to understand the theories and models which underpin the evidence base around these interventions. (Ev. 1.4)  I organised a regional event in March 2016 to showcase and promote CABA, and attended a workshop dedicated to discussing progress 1 year on for the 4 IHWBS.  I undertook a ‘Qualitative Research Methods’ MPH module in September 2017 to ascertain the knowledge and skills to effectively and ethically carry out primary qualitative research. I consolidated and built on this knowledge in October 2018 where I undertook a ‘Fundamentals of Research’ MPH module at Newcastle University.  I read various documents including: The Marmot Review: Fair Society Health Lives, 2010; A Guide to Community Centred Approaches for Health and Wellbeing, 2015; Promoting Asset Based Approaches for Health and Wellbeing, 2017; NICE Guidance: Community Engagement, Improving Health and Wellbeing and Reducing Health Inequalities, 2016; |  | 1.2 PH Practitioner Masterclass – CABA Jan 2016  1.3 Leeds Beckett Think Piece Event on Asset Based Approaches May 2016  1.4 MPH certificate public health interventions Jan 2016  1.6 MPH Qualitative Research Methods Sept 2017  1.5 MPH Fundamentals of Research Oct 2018 |
| **Evidence to support meeting the competencies** | *This is the main area where you explain how you meet the knowledge, understanding and application (KUA) of each standard you are claiming in this commentary. This section will expand over multiple pages as you inform your assessor about the area of work you are presenting.*  *Please remember to tell your assessor where you gained your knowledge (with submitting evidence), inform your assessor of your understanding from the knowledge gained and finally show how you have applied this knowledge to the work being described (with evidence).*  To gain my knowledge around the importance of ethical practice, I attended a PHE workshop on ‘Ethics and Risk’ (Ev. 1.7). This workshop was an opportunity to recognise and address ethical dilemmas and issues, gain knowledge of existing and emerging legal and ethical issues in my own area of practice, understand how an ethical framework is used in decision making and priority setting and understand how quality and risk management principles and policies are applied to public health programmes.  I attended a lecture on ethics as part of my ‘Leadership and Management’ degree at Northumbria University (Ev. 1.8, and also undertook a public health master’s module at Newcastle University on ‘Qualitative Research Methods’ which included a presentation on the importance of ethics. (Ev. 1.9).  I also read various documents and guidance. As part of my self-directed learning, I found out that according to the Centre for Innovation in Research and Teaching (2018), ethical considerations and conduct are a critical and essential part of research as they distinguish between right and wrong and acceptable and unacceptable behaviours. In essence, the researcher should ensure that the research in no way harms a participant, or could be used to harm a participant. (<https://www.dawsonera.com/readonline/9780273723455>).  My **legal** knowledge was gained by attending the Ethics and Risk masterclass (Ev. 1.7) which provided an opportunity to glean further insight into legal issues that affect public health work, and I was able to reflect on how this could impact my work area. For example, the Equality Act (2010) outlines 9 protected characteristics which are important to consider in the IHWBS project as the focus of this work was to address inequalities. As part of the quantitative research, we explored access to services by sex, age, and ethnic background to identify any inequalities. It also gave me an opportunity to discuss the Data Protection Act (2018) and how this could now impact on how we collect and store personal data. The quantitative data collection did not collect patient identifiable information, however I understand the implications of the new GDPR and the use of and storing of personal data.  I also gained my knowledge via on the job training. My previous role as a Business Support Manager included a finance and business element. I was responsible for a Government Procurement Card (GPC) which meant I had to be aware of and adhere to PHE’s GPC policy. (see attached guidance).  I met with the Operations Manager / Finance lead to discuss standard MOU’s and what should be included in them. (Ev. 1.11). I also looked at other government MOUs to give me some guidance such as Ofsted and the Food Standard Agency, and an internal PHE MOU between the Genomic Services and Development Unit and PHE Lab.  The above knowledge has helped me understand the importance of ensuring all aspects of a legal agreement are explicit and agreed by both parties to ensure both parties are clear about their roles and responsibilities. When funding is granted, it is important that the project delivers on what it said it would do in the funding application.  Ethical - The knowledge acquired from the above courses and modules has helped me to understand the importance of considering ethics in my practice. In relation to the IHWBS evaluation, this was particularly important as I was handling and storing sensitive data and therefore needed to understand the importance of anonymising data before sharing with members of the advisory group. It also helped me to understand the importance of obtaining informed consent from service users before undertaking focus group work. Obtaining informed consent involved ensuring participants adequately understood the purpose of the focus group, how it would be run, what we expected from them and what they should expect from us, how their discussions would be recorded, stored, presented and acted upon, and to reassure them that they did not need to take part if they didn’t want to.  **APPLICATION**  Legal - When the IHWBS evaluation project was first established, a MOU was needed to establish the roles and responsibilities of the leading organisation (Teesside University) and PHE. I liaised with the Principal Investigator and took the lead in developing a MOU which was agreed by both parties. (Ev. 1.12).  PHE also secured some Pump Prime (research) funding for the project and I managed the process for drawing this down and having the funds transferred to Teesside University. (Ev. 1.13). This involved: liaising with PHE’s and Teesside University’s procurement and legal team to ensure we followed appropriate processes; agreeing staff time and resources; agreeing intellectual property rights; and outlining contractual implications.  Ethical – As a member of the research team, I contributed to the ethical approval application process through Teesside University (Ev. 1.14).  The group recognised a possible ethical dilemma in relation to confidentiality and anonymity during the proposed qualitative data collection process. This involved the lead researcher intending to interview lead commissioners in each of the 4 sites. However, if the lead researcher was to contact the commissioners directly, this would raise ethical issues as they would not be able to accept or decline anonymously. **1b** explains how this issue was resolved.  I took part in a discussion around whether to anonymise the quantitative data when discussing it with the research team. As a member of the research team I agreed that there would be benefits in commissioners being able to see and discuss each other’s data as I felt this would allow for a more practical and informed discussion. (Ev 1.15 - see paragraph in red on page 2).  When undertaking focus group work with community groups and services users, I provided a briefing at the beginning of the group to ensure participants fully understood the aims of the project, the purpose of the focus group and what we planned to do with the data. I gave service users an opportunity to discuss any concerns or ask any questions before asking them to sign a consent form. (Ev 1.16). | 1a | 1.7 PH Practitioner masterclass – ethics and risk  1.8 Northumbria Uni Research Ethics lecture  1.9 Newcastle Uni Ethics and Qualitative Research Lecture  1.7 PH Practitioner masterclass ethics and risk  1.10 PHE Policy on Government Procurement  Card  Evidence 1.11 Advice on development of MOU’s  1.12 IHWBS Final MOU  1.13 PPF Application Oct 2015  1.14 Request for ethical approval April 2017  1.15 IHWBS Research Team Action Notes Sept 2017  1.16 SU and community groups consent form |
|  | My knowledge and understanding on existing and emerging legal and ethical issues are described and evidenced in **1a**. To proactively address issues in an appropriate way, when the ethical issue was raised around anonymity of commissioners when deciding to take part in the research, to overcome this, I agreed to contact the commissioner’s on behalf of the lead Research (Ev 1.15 - see paragraph in red on page 3, and Ev 1.17 - example email from me to one of the commissioners).  When I contacted the commissioners to check if they would be happy for their site to be identifiable in the quantitative data presentation at the Advisory Group meeting in order to stimulate and enrich discussion, some commissioners raised concerns. As providers would be in the room, they felt there could be a conflict of interest in relation to future procurement opportunities. (Ev. 1.18). I discussed this verbally with the research team and took a decision to remove site names and used generic labels instead – Service A, B, C, and D. (Ev 1.19). | 1b | 1.15 IHWBS Research Team Action Notes Sept 2017  1.17 IHWBS example email correspondence to commissioners and providers  1.18 Email to Advisory Group re identifying services  1.19 Quants presentation with services anonymised Sept 2017 |
|  | To update my knowledge around acknowledging and recognising people’s expressed beliefs and preferences I completed a Civil Service e-learning module on active listening. (Ev. 1.20). This deepened my appreciation of the way active listening can positively influence relationships with colleagues and helped me to learn the techniques needed in order to effectively listen to people to fully understand their expressed beliefs and preferences.  I also have a vast amount of on the job training. I have worked in project management roles for over 15 years and within these roles, I have learnt the importance of being able to ‘actively’ listen in order to capture individual views and concerns and act appropriately. This ensured that people felt their views were important and would be considered so they felt valued as a participant or member of the meeting.  When applying this knowledge and understanding I would acknowledge, understand and record people’s views and beliefs and ensure they were fed into any future meetings to shape discussions and steer decisions. In the IHWBS project, this was particularly important when attending the community focus groups. My role was to co facilitate the discussion and record salient messages and concerns which were then fed into the qualitative research which helped shape the findings (Ev 1.1 - see pages 28-32). | 3a | 1.20 Active listening elearning Sept 2018  Evidence 1.1 IHWBS Final Report May 2018 |
|  | To gain my knowledge around the principles of informed decision making, I read about the NHS ‘Shared Decision-Making Programme’. Although this is in a different context to my work, as this is from a treatment perspective rather than a prevention perspective, I found it interesting to learn about their personalised care programme as there are strong links to the CABA work in relation to empowering people to have greater choice and control over the way their health and care is delivered. This resonates with the CABA programme as this focuses on empowering people to have greater control over their health and wellbeing in their own communities. The NHS see shared decision making as the patient and clinician working together to look at various options and then deciding on the best treatment or support package for the patient. It allows the patient to share their expertise about their own health and what is important to them with the clinician, and the clinician to share their knowledge around risks and benefits of available options so that a fully informed joint decision can be made. This reading helped me to understand the important of promoting the ability of others to make informed decisions and I was able to translate this into the context of my work in relation to understanding how it can maximise the positive impact to individual and community health and wellbeing.  To apply this knowledge and understanding to my practice, I have attended several meetings and events to promote CABA and provide a learning session on the key theory, models and principles to support public health practitioners to feel more enabled and confident to make informed decisions when commissioning and supporting CABA led services within their localities. I facilitated a group discussion about how these approaches can be embedded within their practice, offering practical suggestions and explaining how they have worked in other areas. This enabled participants to gain an insight into the benefits of these approaches and make informed decisions about how to implement them. It also provided them with the vital knowledge and understanding to be able to take back to their localities to share with key partners such as provider services so that they can work more effectively with their communities to empower them – thus supporting the mobilisation of knowledge across the public health system.  Most recently, I have presented on the theory and principles of CABA and how these approaches can be implemented and embedded into public health ways of working at a Sexual Health Commissioner’s network (Ev. 1.21), a Public Health Intelligence North East event (Ev 1.22), the North East Association of Directors of Public Health (Ev 1.23), and an Obesity and Physical Activity Network (Ev. 1.24). | 3b | 1.21 Sexual Health Commissioner’s network Sept 2018  1.22 CABA presentation for PHINE event Oct 2018  1.23 DsPH CABA workshop agenda Sept 2018  Evidence 1.24 OPAN Agenda Oct 2018 |
|  | To obtain my knowledge of the importance of data confidentiality and disclosure, and the use of data sharing protocols, I read the NICE guidance on data sharing protocols. <https://www.nice.org.uk/Media/Default/About/Who-we-are/Policies-and-procedures/Data-sharing-protocols.pdf> and the Wellcome ‘sharing research data to improve public health’ guidance - <https://wellcome.ac.uk/what-we-do/our-work/sharing-research-data-improve-public-health-full-joint-statement-funders-health>  This helped me to understand what information can and cannot be shared and under what circumstances. I also refreshed my knowledge of data protection laws by reading the updated 2018 Data Protection Act <http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted> This refreshed my knowledge around the law, data confidentiality, and key data protection principles in relation to lawful and fair processing of personal information.  I also undertook mandatory training to ensure I understood my role in relation to handling information. This e-module included topics such as government security classifications, protecting and sharing information, staying safe online, fraud and managing information as an asset. (Ev 1.25)  My understanding of data confidentiality and data sharing protocols was gained by attending several of the Research Team and Advisory Group meetings to discuss the rationale for why data sharing protocols needed to be established with each of the 4 sites in order to access their data to undertake a cross site analysis. In this instance, although the data was not patient identifiable or potentially disclosive in any way, I learnt that initiating a data sharing protocol was still good practice as the data specifically related to commissioned services and could be considered commercially sensitive. The agreement also provided a record of the exact data requested, the data capture period and confirmed to external auditors that no patient identifiable data was being used. It also set out how the data would be securely transmitted to maintain appropriate data confidentiality. I agreed to work with the lead quantitative researcher to produce a data sharing protocol template. (Ev.1.27).  During the IHWBS evaluation, to gain access to the quantitative data from the 4 sites, I liaised with the 4 commissioning leads to establish data sharing protocols I worked with the lead quantitative researcher to develop a data sharing protocol which was then signed by the 4 commissioners. | 3e | 1.25 Responsible for Information training March 2018  Evidence 1.26 IHWBS Data Sharing Protocol discussion Feb 2017  1.27 IHWBS Data Sharing Protocol Feb 2017 |
|  | My knowledge in relation to improving my own and others’ practice was gained by attending PHE Management Seminars (Ev. 1.28) which provided an introduction to the skills and behaviours needed to enable managers to: get the best out of their staff; know the importance of and how to increase empowerment and engagement of their staff; identify their own and their team’s development priorities and identify support and resources to address them. The seminars included some theory around leadership models including John Adair’s the Function Theory. There was also an opportunity for self-reflection as leaders via a variety of self-assessment tools and models including:   * Maslow hierarchy of needs (Abraham Maslow, 1943) – explored what motivates staff to achieve their personal objectives. * The Johari window (Joseph Luft and Harry Ingham, 1955) - highlighted the important role leaders play in promoting a culture of openness and honestly when giving and receiving feedback in order to create an environment to support people to fulfil their potential and positively contribute to the organisation’s success * Group work and exercises - explored people’s perceptions of good leaders and the traits of good leaders, as well as their own traits leadership styles   I also attended a ‘constructive’ conversation workshop which gave me the confidence to have constructive conversations (including performance conversations) in difficult situations. I also learnt about tools and practicing techniques which can be of help. (Ev. 1.29).  I recently undertook a ‘Leadership’ module (Ev. 1.31) as part of my degree in ‘Leadership and Management’ (Ev. 1.30). This included taught classes on: organisational culture and employee engagement – exploring the link between leadership and organisational culture and how this may impact on employee motivation and engagement, examining models of leadership in relation to employee engagement empowerment, and considering leadership behaviours that promote employee commitment, motivation and engagement; leadership development - to consider the various forms of leadership development used in organisations and the effectiveness of different methods of development, and to assess my own leadership competence and identify areas for future leadership development.  I attended appraisal training and read PHE performance development guidance to ensure I was aware of and understood how to align individual performance to organisational objectives and ensure I was competent at identifying and addressing my own areas for improvement and development, as well as those I line manage.  All of these training opportunities have provided me with the relevant knowledge to be able to understand what tools, techniques and processes can help to facilitate a reflective approach to identifying my own and others’ development needs, and the how these needs can be translated into practical learning opportunities.  When exploring my own areas for development, I identified public speaking as an area for development. To address this, I proactively sought opportunities to present the CABA work at a variety of different meetings and events to a variety of audiences, including Directors of Public Health (see evidence in 3e). I also acknowledged that I needed to expand my knowledge around the theory of public health interventions, so I attended a master’s module (see evidence for 5d).  In 2017/2018 I have really challenged myself to continue to develop and improve my own practice in public health by strengthening my academic skill. I completed a Degree (with 1st Hons) in Leadership and Management to strengthen my leadership skills, and also completed a Postgraduate Certificate in Public Health and Health Services Research to strengthen my academic theory and knowledge.  Within my line management responsibilities, I have utilised regular formal supervision meetings and annual appraisal processes to identify and address staff development needs. I have held conversations with staff about any gaps in skills or areas they felt they needed to strengthen and develop, and then worked with them to identify appropriate training and development opportunities via a variety of formats including Civil Service Learning, on the job training and shadowing, and external educational courses. (Ev. 1.77) (Ev 1.78). | 4b | Evidence 1.28 PHE Management Seminar Feb 2016  1.29 Constructive Conversations workshop Sept 2016  1.30 BA Leadership and Management Certificate Dec 2018  1.31 Northumbria Uni BA Leadership Module Sept 2017  1.32 PHE Appraisal Briefing April 2016  1.77 Performance & Development Review Oct 16  1.78 Staff super vision log May 2016 |
|  | Some of my knowledge and awareness of different approaches and preferences to learning was gained during my degree ‘leadership’ module. I undertook the Honey and Mumford Learning Style Questionnaire which essentially splits learning styles into 4 categories – Activist, Reflector, Theorist and Pragmatist. This helped me to understand, interpret and reflect on my own learning style. The questionnaire indicated a propensity towards a ‘theorist’. According to Honey and Mummford (1986), a theorist thinks rationally and methodically, and adapts a systematic, logical approach to their work. They prefer to work with theories and principles rather than ambiguous or subjective concepts. They learn best from structured approaches with well argued, evidenced concepts and tend not to respond well to situations that are unexpected, and have no logical purpose or structure.  I agree this is a true reflection of my learning style and feel that this style has served me well as it enabled me to take a rational, disciplined approach in my role in managing the IHWBS evaluation project. I developed a GANTT chart to illustrate key actions and timescales and ensured these were met. (Ev. 1.33) However, it highlighted that this approach is not always appropriate in my wider CABA work and sometimes I need to be broader minded and feel confident to explore alternative ways of doing things, particularly around some of the evidence and evaluation of these approaches as they are much more difficult to measure than traditional methods which have lots of KPIs and measurable outcomes.  I am also aware of the many ways in which people can learn such as reading/writing; auditory learners (prefer to listen such as a presentation or seminar); visual learners (prefer to see things on infographics and picture format); hands on learners (prefer interactive, tasks/activities); and social learners (prefer group discussions). To ensure I supported different styles of learning as part of the CABA learning and embedding of the CABA approaches, I produced learning materials in different formats, including a poster (Ev. 1.34) , a slide deck (Ev 1.22) , and a written report (Ev. 1.35), I have also organised 4 annual events to share learning and at these events, I have ensured a good mix of presentations, table discussions, poster showcasing/viewing, and mini interactive workshops. (Ev. 1.36). I also ask delegates to complete an evaluation form at the end of the event to identify areas for improvement which I will learn from to help with my planning of future events. (Ev 1.37). | 4c | 1.33 IHWBS Gantt Chart Sept 2016.doc  1.34 Implementing CABA poster July 2016  1.22 CABA presentation for PHINE event Oct 2018  1.35 CABA principles and narrative August 2018  1.36 CABA Annual Event March 2016  1.37 CABA Annual Event Evaluation Form March 2018 |
|  | As part of the IHWBS project, we recognised and acknowledged CABA as catalysts and enablers to delivering community services. My role involved promoting and embedding CABA approaches across the local authorities. It was essential that I understood how these approaches could be implemented to improve health and wellbeing and reduce health inequalities. To do this, I needed to understand the terms and concepts used in promoting health and wellbeing. I read PHE’s public health matters <https://publichealthmatters.blog.gov.uk/2015/12/30/promoting-health-and-wellbeing-nationally-a-year-in-review/> . I also read the WHO Health Promotion glossary <http://www.who.int/healthpromotion/about/HP%20Glossay%20in%20HPI.pdf>  I also completed a public health master’s module on public health interventions. (Ev. 1.4). This taught me the theory, models and evidence that underpin public health promotion and how to implement effective interventions.  This reading and learning helped me to understand some of the common terms and concepts used in promoting health and wellbeing. These include: the burden of disease – the gap between a population’s current health and healthy life expectancy; global health - the impact of globalisation on health determinants which are beyond the control of individual nations; capacity building – effectively developing knowledge, skills, commitment, structures, and leadership to enable effective health promotion; evidence based health promotion – the use of information derived from formal research and systematic reviews to identify cause and contributing factors to health needs; health impact assessments – a combination of procedures, methods and tools by which a policy, programme or product may be judged based on its effects on the health of the population; needs assessment – a systematic process for determining the health needs in a population; social marketing – the application of commercial marketing technologies to the analysis, planning and evaluation of programmes and campaigns designed to influence the behaviour of target audiences to improve the welfare of individuals and society such as “One You” and “Stoptober”.  Essentially my reading enabled me to understand they key public health issues and how PHE and local authority Public Health teams can tackle these. Effective health promotion is about empowering individuals to make healthy choices so that we can reduce long term chronic diseases, preventable deaths and disabilities. So ultimately people live healthier for longer. Many of the conditions are preventable and caused by unhealthy behaviour such as smoking, drinking, and unhealthy eating habits. To tackle these, PHE and public health teams implement a range of preventative interventions from stop smoking services, sugar reduction programmes, physical activity campaigns such as ‘Everybody Active Every Day’ and ’10-minute shake-up’. Tackling health inequalities is also a critical role of public health teams. Health inequalities are exacerbated by some of the wider determinants of health such as unemployment, education, and housing and so it is imperative that public health services also tackle these issues in order to reduce the health gap between the poorest and most affluent.  This learning was applied in the IHWBS work as the report itself (Ev. 1.1) aimed to promote the value of health and wellbeing by demonstrating the value of integrated services and the impact they have on the health and wellbeing of individuals and communities. I needed to understand and describe each service model and be able to draw out from the findings the key ingredients in relation to what worked well, for who and under what conditions. I could then understand whether the services targeted those most at need and therefore addressed inequalities, so I could then contribute to the writing of the conclusions. | 5c | 1.4 MPH Certificate public health interventions  1.1 IHWBS Final Report May 2018 |
|  | My knowledge of health inequalities was gained by attended a lecture on ‘Health, inequality and Socio-economic outcome gradients’ as part of my public health master’s module on ‘Public Health Interventions’. (Ev. 1.38). I was able to define and describe health inequalities, learn how intervention generated health inequalities can occur, and understand how to evaluate interventions to reduce health inequalities. I also strengthened my knowledge of monitoring health inequalities by reading a BMJ journal entitled ‘Importance of monitoring health inequalities’ <https://www.bmj.com/content/347/bmj.f6576>  I also gained much of my knowledge via on the job training as part of my CABA role was to understand how inequalities impacted on communities. As part of my business support role to the Health and Wellbeing Team, I used a Health Equity Audit Tool (HEAT) to review the objectives within our team delivery plan to ensure they addressed health inequalities. This gave me a much deeper insight into how our team works to reduce health inequalities.  One of the key outcomes of the IHWBS evaluation was to identify whether the current service models targeted the most vulnerable and socioeconomic disadvantaged communities. In order to understand how individual and population health and wellbeing differ and the possible tensions between promoting health and wellbeing of individuals and groups, I read the Marmot Review: Fair Society Healthy Lives, 2010.  <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf>  I applied my knowledge of how inequalities may be monitored by contributing to discussions within the IHWBS research team and advisory group meetings (Ev.1.15 – highlighted in red on page 3). We agreed to use the Buck and Frosini report on ‘Inequalities in Life Expectancy’ and adjusting this to North East recent data to highlight those in the target group who exhibit 3 or more unhealthy lifestyle behaviours. We could then use the population profile uptake and translate this into a need adjusted profile. I suggested that as the Health Equity Audit states that where there is more need, there should be more service, we should therefore focus on per thousand in need of a service rather than per thousand population. Members agreed, and we agreed tol use the estimate of those exhibiting 3 or more unhealthy behaviours alongside the Buck and Frosini report. This looked at socioeconomic group by education nationally, so we were then able to look at it for North East for a more recent 3 years pooled period. This was what we were then able to use to explain our measure of need. Once adjusted for need, we were then able to show an equal rate of access. This also allowed us to demonstrate where services had targeted different types of population, and whether they targeted them enough to take into account level of need  I was able to apply my knowledge and understanding of inequalities within the CABA element of my role. As part of a wider ‘North region’ pilot project team to develop and collate community centred public health practice examples, I liaised with service and project leads from across the North East to identify innovative examples of promoting health and wellbeing and reducing health inequalities. I identified 8 examples which I then developed into case studies to showcase the project and highlight their achievements, challenges and outcomes. (Ev 1.39). To promote and share learning, I contributed to an evaluation report (Ev. 1.40) and slide deck which was presented at the 10th European Public Health Association conference in Stockholm. Examples are also now accessible to support the mobilisation of knowledge and share learning around using CABA to reduce health inequalities. Available at <https://phelibrary.koha-ptfs.co.uk/practice-examples/caba/>  An example which particularly reflects an intervention that addresses health inequalities is the Gypsy Roma Traveller (GRT) programme in Durham. This programme aimed to reduce health inequalities for this marginalised group by providing accessible information on various issues, providing support to access health services, and working with services to make them more accessible for the GRT population. (Ev 1.41). | 5d | 1.38 Newcastle Uni HI and socioeconomic outcome gradients  1.76 H&WB Team Business Planning Session May 2016  1.39 CABA practice examples Nov 2017  1.40 CABA practice examples report May 2017  1.41 CABA practice example GRT January 2017 |
|  | My knowledge in relation to culture and experience and how this may impact on perception and expectations of health and wellbeing was gained mainly from on the job experience. This included co facilitating and attending a CABA masterclass for school nurses and health visitors. The masterclass was designed as part of a workforce training package specifically for these workforce groups to update their knowledge and understanding around the theory and principles of CABA and how they relate to health and wellbeing. I liaised with some local organisations who were delivering innovative CABA based work within community nursing and health visiting, targeting specific cultures, such as the GRT community. I arranged for these organisations to share their learning at the CABA Masterclass to help the school nurses and health visitors reflect on how they could incorporate CABA into their professional practice and their local plans.  My understanding was gained by listening to the local presentations and understanding the perceptions of the GRT community in relation to their health and wellbeing. This helped me to understand that universal public health interventions may not be appropriate in different cultures. For example, members from the GRT community talked about their attitudes towards sexual health and how in their culture, it is socially acceptable to have children at a young age, therefore teenage pregnancy prevention interventions, may not be as affective as in other communities. They also discussed their attitude towards general health and their reluctance to access GP surgeries and other community services, however they were open to health care services being available on site. This is relevant when thinking about access to services – particularly those that are set up to tackle inequalities and target particularly deprived communities, including the GRT communities. This understanding was consolidated during my MPH PH Interventions module where we discussed the health and wellbeing perceptions of different cultures, aswell as social norms and socioeconomic backgrounds and how these need to be properly assessed and accounted for when planning public health interventions. For example, in the IHWBS, it was interesting to see that whilst alcohol is a significant problem in the North East, no one would site this as their reason for accessing the service, but often once they had built up a level of trust with the staff, they would open up and talk about their alcohol use, which could then lead to a further conversation or referral to an alcohol service.  I have also gained an understanding of the health and wellbeing needs of other cultures and communities such as the MSM community, where we have some significant sexual health issues in relation to the rise in syphilis and other sexually transmitted diseases, exacerbated by changes in social behaviours such as engaging in chemsex. Effective, targets interventions in relation to safe sexual practice are paramount in these groups however it is often difficult to engage them in traditional services. Social media apps and websites can be an effective way of improving access to public health messages and engaging these communities.  I have demonstrated that I have applied my knowledge and learning by ensuring that the behaviours, views and perceptions of different cultures are shared with public health practitioners, decision makers, and commissioners across the public health system via CPD training sessions, masterclasses, and regional events to ensure they are fed into the design and development of health and wellbeing interventions. This includes promoting the findings of the IHWBS evaluation (Ev. 1.72); organising the CABA masterclass mentioned above for school nurses and health visitors (Ev 1.73); and I worked with the PHE sexual health and drugs and alcohol lead to plan a workshop aimed at commissioners and providers to raise their awareness of chemsex and how this had become a growing trend, particularly amongst the MSM community (Ev. 1.74). | 5e | 1.72 CABA Annual Event March 2018  1.73 CABA Masterclass for SN and HVs March 2017  1.74 Chemsex, Drugs & Alcohol Workshop April 2017 |
|  | It is important to be able to understand and interpret data and information in a public health role as we need to be able to identify and reveal trends in disease and inequalities and then promote and respond to these by advising and supporting our local public health teams. We are also often required to disseminate, present and discuss quarterly data on PHE fingertips, ONS and other data sources. To gain my knowledge I attended a statistics session delivered by Peter Kelly, Centre Director, PHE North East Centre. (Ev. 1.42). I also completed a ‘Fundamentals of Research’ MPH module at Newcastle University (Ev. 1.5). These sessions gave me an in-depth understanding of how data is collected, i.e. quantitively via RCT’s systematic reviews or qualitatively via focus groups, ethnographic studies and interviews). I also learnt how data can be presented and interpreted, and how to critically analyse research methods. I learnt how to perform calculations such as relative ratios and odds ratios and work out confidence intervals to determine the validity and reliability of data in relation to whether small studies can be representative of wider community groups or populations. (Ev. 1.44). I also gained an insight into how anomalies can occur when data is misrepresented or misleading, for example by not considering confounding factors in a study (i.e. a study shows alcohol use causes cancer, but the study does not consider confounding factors such as smoking).  I was able to apply this knowledge and understanding effectively within the IHWBS evaluation as this involved quantitative and qualitative data. As part of the research team, I assisted with the collection of the qualitative data by attending the focus groups and co facilitating the sessions. To ensure data was collected accurately, the focus group was recorded and transcribed. I also took notes of any salient points to support the thematic data analysis process (Ev. 1.45). The main findings from the data was then interpreted and summarised on page 33 of the report. (Ev. 1.1)  The quantitative research involved collecting and analysing routinely collected data from each of the sites to identify patterns of 1:1 service use, including the extent to which IHWBS services reduce health inequalities. The data collected was able to show who was accessing each service, for what, and with what outcomes. To account for confounding factors, the data was adjusted for need using a health equity audit to ascertain the level of health need within each population subgroup (gender, age, ethnic group, socioeconomic group) using responses to the 2008 Health Survey for England in relation to proportion of the population undertaking 3 or more of 4 unhealthy behaviours (smoking, alcohol, physical inactivity, poor diet). This is described on pages 12 and 13 of the report.  To strengthen the validity of the data (ensuring inferences could be made about the health issues affecting the population), population data sets such as the ‘Buck and Frosini’ report – ‘Clustering of Healthy Behaviours Over Time’) were considered. As part of my role within the research team, I worked with the quantitative researcher to identify these data sources. However, real estimates were used where possible, e.g. the Healthy Lifestyles survey in Sunderland. (Ev. 1.46 – highlighted on page 2).  During the data collection process, my role was to sense check the data before disseminating to the wider Advisory Group. I highlighted an anomaly in relation to the numbers of men accessing a particular service as it looked unusually high and out of sync with what we would expect. This was then explored, and it was identified that there had been some targeted work with males in that particular service. (Ev. 1.47 – highlighted on page 2).  To contribute to the quantitative research and to add context to the discussion around the commissioning of IHWBS services, I carried out a qualitative thematic analysis of the Key Performance Indicators (KPIs) across the 4 services to ascertain the amount of KPIs within their contracts, and draw out what the common themes were around outcomes and targets in order to compare this with what people were accessing the service for. This led to suggestions within the recommendations around there being less focus on compliance, contract adherence and performance monitoring. (Ev 1.1 - page 59). | 6a | 1.42 Health statistics revision certificate Aug 2018  Ev.1.5 MPH Fundamentals of Research Oct 2018  1.44 Newcastle Uni MPH Frequency association and risk lecture Oct 2018  1.45 IHWBS Community focus group Jan 2018  1.1 IHWBS Final Report May 2018  1.46 IHWBS Advisory Group Meeting June 2017  1.47 IHWBS Research Team Mtg Dec 2017  1.1 IWBS Final report May 2018 |
|  | I obtained my knowledge of the main terms and concepts used in epidemiology and the routinely used methods for analysing quantitative and qualitative data by attending the Fundamentals of Research Masters module’ and the statistics masterclass described in 6a. This introduced me to the main qualitative and quantitative methods which include:  Quantitative – testing a hypothesis or theory and generating statistical and numeral data. Most common methods include Randomised Control Trials (RCTs), systematic reviews and cohort studies (Saunders, 2016). Data analysis is either done manually using Excel or Access database, or by using a Statistical Package for Social Sciences (SPSS) which performs the data analysis and produces reports and diagrams.  Qualitative – collects in-depth non-numerical data to explore the why, what and how elements. Most common methods include focus groups and 1:1 interview. (Blaxter et al, 2010). Methods of data analysis include: thematic analysis which searches for emerging themes or patterns in the data (Dawson, 2009); template – initial data is coded straight away before searching for themes (Saunders, 2016); comparative – data for individuals is compared and contrasted until no new data arises (Esser, 2017); content - An analytical technique that allows qualitative data to include a quantitative element (Saunders, 2016); and discourse (Fisher, 2010).  It is important to understand the advantages and limitations of each approach in order to make an informed decision about which method to use when conducting public health research. RCT’s are often used in clinical trials and are very effective in being able to ascertain a causal link between the medical condition and the exposure. (Saunders, 2016). Qualitative research is becoming increasingly popular in applied public health research as it allows the research to explore underlying, inherent and general behaviours to better address health inequalities when planning public health interventions. (Barbour, 2014). In the IHWBS evaluation, the qualitative research was conducted after the quantitative data to allow the emerging findings to shape the questions within the qualitative data collection. (see attached minutes from meeting)  I also learnt about the main concepts used in epidemiology by attending an Epidemiology lecture as part of my ‘Public Health Protection’ module on my MPH. (Ev. 1.49) This taught me the meaning of epidemiology in relation to public health – it is the study of the distribution of health relates states and how this knowledge is then applied to the control of diseases and other health problems and the design of public health interventions. I also learnt about the differences between incidence (the number of new cases in each population and a given time period), and prevalence (all cases in a given population and given time period) and how to correctly interpret incidence and prevalence in relation to public health data, i.e. the incidence rate of HIV is reducing however prevalence is rising. This is because there are less people developing HIV due to sexual health promotion and interventions and there are more people living longer with HIV due to more effective treatment.  I read 2 articles to help me understand how indicators are chosen in applied public health research which enabled me to then take an active part in discussions at the Research Team Meeting about what quantitative data to collect and what indicators we needed to use. These articles were:  Donabedian A. Evaluating the quality of medical care. Millbank Memorial Fund Quarterly 1996; 44: 166. available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690293/> especially the section “Approaches to Assessment: What to Assess”  Pencheon D (2008) *The Good Indicator Guide*, Association of Public Health Observatories and NHS Institute for Innovation and Improvement available at <https://fingertips.phe.org.uk/documents/The%20Good%20Indicators%20Guide.pdf>  especially p23 criteria for good indicators  Donabedian discusses the use of process, outcome and structure indicators, all of which were used in the IHWBS evaluation. Structure indicators were used to look at the utilisation of staff and process and intermediate outcomes were used to analyse routine data from each service to see who was using the service, for what, and with what outcomes (by gender, age, ethnicity, and socioeconomic disadvantage).  I applied my knowledge and understanding of these concepts within the IHWBS evaluation as I was able to contribute to the discussion around the rationale behind why we decided to conduct the qualitative analysis first. (Ev. 1.48 – highlighted on page 3). It also gave me an understanding of how focus groups and 1:1 interviews were conducted to ensure I was competent in my role as co facilitator. We analysed this data by using a digital recorder to maximise accuracy. I also took notes of key points and noted any non-verbal communication so this could be fed into the thematic analysis. Thematic codes were derived from initial findings from the interviews with commissioners and focus groups being discussed at the research and advisory team meetings (Ev 1.47 – highlighted on page 2). I took an active part in these discussions and was able to draw upon my experience of attending the focus groups as I was able to highlight what I felt were the most salient discussions and issues. Based on discussions of findings, I produced an initial coding framework which was applied across all the transcripts. (Ev. 1.50). Page 11 of the report sets out how the data was collected and analysed (Ev. 1.1) I felt this process worked well as the themes were developed iteratively over time as themes and patterns emerged in the transcripts. These themes were then broadly reflected in the subheadings in the evaluation report.  I also needed to understand the data collection process for the quantitative data to contribute to discussions around what indicators to use to collect data from the 4 services. We needed to collect data that would allow us to assess the profile of the service user and determine whether this reflected the profile of need therefore we decided to use a Health Equity Audit (HEA) approach. We referred to Buck and Frosini “Clustering of Unhealthy Behaviours Over Time” (2012) report which identified 4 lifestyle risk factors (smoking, excess alcohol use, poor diet, and low levels of physical activity). The report identified that people from lower socioeconomic backgrounds were more than five times as likely to engage in all 4 poor behaviours than those of higher socioeconomic backgrounds. Essentially, the report indicates a widening over time in the inequalities gap between rich and poor. We agreed that the analysis of the data would need to be adjusted to the level of need in these four communities to strengthen its validity. To do this, we would look at those who exhibited 3 or more of these unhealthy behaviours. I took an active part in these discussions.  To analyse the data, we requested aggregated level data based on record level data held by each service. Numbers less than 6 were supressed and the lead researcher calculated and applied population rates to give us an estimate of need. Data was analysed using an Excel statistical analysis package (STATA).  I suggested that this data by collected over a 1 year period which would allow for ample data and would avoid any seasonality anomalies, i.e. xmas could be a quieter time. I also suggested that this time period should be a time when all services were mature to avoid any set up issues that could skew the data. We requested that the data be split by disadvantage to advantage and broken down by age, gender and then level of disability.  We had hoped to explore whether all clients experienced equal outcomes so that we could determine whether the service addressed inequalities, however due to data quality issues we were unable to do this. Instead, we were able to analyse the type of goal they set and how many people were successful at achieving their goal. We then looked at whether the numbers achieving their goals differed between goals and then whether these goals reflected the need in the community. An interesting finding was that whilst alcohol is a known problem and we have Health Survey for England and ONS data to show this, very few people chose reducing their alcohol use as a goal. | 6b | 1.49 Newcastle Uni MPH health protection module Sept 2018  1.48 IHWBS Advisory Group Meeting Feb 2017  1.50 IHWBS Coding for thematic analysis Jan 2018  1.1 IHWBS Final Report May 2018 |
|  | I gained my knowledge of working collaboratively to deliver health and wellbeing programmes by gaining on the job experience. As part of the H&WB team in PHE, my role is to develop, maintain and update the team delivery plan (Ev. 1.52). The plan details all our public health work programmes and our priorities for the year. We often collaborate on areas of work as there is so much overlap and interdependencies within our work, for example, obesity links strongly to physical activity in relation to promoting health eating and physical activity campaigns. I have worked in this team since 2013 (and we were all part of the National Treatment Agency before than from 2002) and have developed strong working relationship with individuals which has helped me to understand the value and importance of working collaboratively to share knowledge, expertise and learning in order to develop the most effective product, package of support, training or guidance to local authority public health teams.  My knowledge and understanding of how the health concerns and interests of individuals groups and communities were gained by attending my MPH Public Health Interventions (Ev 1.4) and Public Health Protection modules (Ev. 1.75). The Public Health Interventions gave me an insight and an understanding into the value and importance of gaining service user and community engagement and involvement in the design and planning of public health interventions to ensure their health needs are communicated to commissioners and policy makers. This can be done as part of a wider needs assessment whereby health behaviour data and statistics can also be taken into account, however it is important to not be completely guided by the data in relation to what services are developed as they may not be what the community want. For example, there may be a geographical area that has high smoking rates and so a public health intervention such as a stop smoking service is developed. However, if the health concerns and interests of that community were properly sought and communicated, it may have been that they were more interested in peer support or a weight management programme. The weight management programme may have then been successful in drawing the community in, where they staff may have then been able to deliver public health messages around smoking, and make further referrals.  As part of my public health protection module, I attended a lecture on communications (Ev. 1.66). We learnt about the relationship between media interest and actual public health risk and perceived public health risk and how these are communicated. We learnt about the impact of social media and how it is an accessible platform for individual groups and communities to communicate their health concerns and interests, for example via blogs, twitter, facebook and You Tube. In some instances, this can generate misconceptions and promote unnecessary or inaccurate risks, and facilitate a public health perception around a risk that might be blown out of proportion. However, it can also ask as a useful mechanism for public health agencies to work together to promote public health messages and campaigns and can actually in itself, be an effective public health interventions, for example sexual health apps such as the C Card condom finder developed by Newcastle university aimed at young people.  I have applied this knowledge and understanding within my role in the IHWBS evaluation. I co facilitated the service user focus groups and, as well as recording and transcribing these, I made a note of any salient points to ensure these got fed into the evaluation report. As an author of the evaluation report, I played a pivotal role in pulling out key quotes for inclusion in the report to ensure the health and wellbeing concerns and interests of the individuals and community groups in each of the 4 areas were communicated clearly and accurately. (Ev 1.1 page 27-33). | 9e | Ev 1.52 H&WB Team Delivery Plan 2018/19  1.4 MPH Certificate PH Interventions January 2017  1.66 Newcastle Uni MPH Comms lecture Oct 2018  1.1 IHWBS Final Report May 2018 |
|  |  |  |  |
|  | I gained my knowledge of working collaboratively as part of a team initially from working as part of my own internal team. I have organised several Health and Wellbeing team building meetings which focus on working as a team to deliver a programme of work to improve health and wellbeing outcomes for populations. (Ev. 1.51). Being involved in the organising of the day and development of the agenda, allowed me valuable insight and understanding into everyone’s different skills sets and topic areas and the interdependencies within these. I was able to then format the day to allow team members to contribute their individual work area objectives to a wider team workplan which I then aligned to the national PHE business plan and the North East centre business plan. I then continued to maintain and update the plan by working collaboratively with the team. (Ev. 1.52).  To work effectively with people from other teams, it is important to know your own working styles to ensure you contribute effectively as a team member. As part of my degree in Leadership and Management, I learnt about different leadership styles. I studied the Goleman model which describes 6 leadership styles: affiliative; democratic; coaching; pace setting; commanding; and visionary. My leadership style can be described as ‘Affiliative’. This style worked well within the IHWBS team and had a positive impact on the morale of the team, leading to a more productive performance. I am acutely aware of the impact negative attitudes and discord can have in a small team environment, and I strive to ensure unity is maintained. I understand the importance of acknowledging each other’s strengths and weaknesses and identifying areas to help and support each other. As a result, the IHWBS was a close, cohesive team with a good synthesis of skills and personalities which enabled it to successfully deliver on its objectives and produce a report which highlighted tangible recommendations to improve health and wellbeing outcomes.  I also studied Bass et al’s 5 styles of leadership: Directive, Consultative, Participative, Negotiative and Delegative. My style leans more towards Directive. However, depending on the situation, I can demonstrate a participative/delegative style. For example, when making decisions within the research team about timescales and actions, I used a directive approach to communicate clearly to the team what their actions and timescales were. I explained the task, outlined clear actions and timescales, and monitored progress via a GANTT chart throughout the project. However, when discussing ways in which to present the data to the Advisory Group (anonymised v’s not anonymised) and agree methods and routes for disseminating and promoting the findings, I used a participative approach to ensure the team were able to contribute effectively and take ownership of certain elements of the promotion campaign. I discussed different approaches and routes with them, taking on board their comments and suggestions, before making a decision as to how the report would be promoted. I consulted with them at regular intervals throughout this period.  To have awareness of my personal impact on others, as part of my leadership module, I undertook some self-analysis tools. These included the Big Five Inventory (developed by John & Srivastava, 1999), (Ev. 1.52) and an emotional intelligence self-analysis test. The findings from the Big Five inventory indicated an ‘agreeableness’ approach. This is a fairly accurate reflection of the behaviours I apply in my role. I have a calm, composed demeanour; I aim to please; and avoid conflict by tailoring tasks to people’s strengths, rather than placing them in a situation that challenges them, however this could then limit their potential for development.  The emotional intelligence self-assessment (Ev. 1.54) indicated an intrinsic level of self-awareness and understanding of how my behaviour can affect others. I am a good listener and can be empathetic and supportive, dependable and approachable. For example, in the focus groups, there were times when individuals became upset when talking about their personal difficulties and health problems. One particular individual seemed nervous and anxious before the group discussion began so I sat with her and through listening to her, I observed that talking about her son made her happy and positive so I asked more questions and showed genuine concern and interest. This seemed to settle her nerves, made her feel more relaxed and helped her develop a rapport with me. It established a level of trust so she felt more positive about taking part in the discussion and was relaxed enough to contribute openly and honestly.  I applied these collaborative working skills within my role in the IHWBS work. This involved working as part of a team of people from across the sector including academics from Teesside University, commissioners from the 4 local authorities and service managers from the providers of the IHWBS services. I was aware that aswell as providing valuable public health input, the team looked to me to manage the project and were aware of my behaviour so I ensured I always came across positive and calm and provided solution focused suggestions if timescales were pressured.  I provided leadership to the group and developed a GANT chart to keep the project to time. (Ev. 1.33). I worked collaboratively with members of the team to ensure the research was carried out and that the evaluation and learning was promoted and disseminated within the agreed timescales set out in the MOU. I took the lead for ensuring action notes were captured and followed up by the appropriate team members and as a co-writer of the evaluation report, I ensured learning, outcomes and recommendations were explicitly set out to enable commissioners and providers to implement changes to improve the health and wellbeing of their populations. For example, the findings supported the need for decision makers to work more collaboratively with providers and service users to co-design and co-produce services and interventions to enhance the reach and relevance of IHWBS services (Ev. 1.1 - page 42).  To ensure the health needs and interests of individual groups and communities were effectively communicated, I was aware of my impact on individuals in the community focus group so ensured I presented a friendly, approachable manner and expressed empathy and genuine concern to facilitate a more open conversation. This helped strengthen the richness and quality of the research which then enabled the outcomes to be more accurate and meaningful to the service users aswell as strengthening the reliability of the results to make them more applicable to the wider population.  I worked with the qualitative researcher to pull out key quotes from the service user focus groups and included these in the main report to minimise misinterpretation and add strength and validity to the findings. Examples of these are illustrated on pages 29-32 where service users give powerful insight into the impact issues such as social isolation, loneliness, long term health conditions, austerity, welfare reform, funding cuts, lack of employment opportunities have on their health and wellbeing, and the importance community interaction and connectivity can have on improving their overall health and wellbeing. (Ev. 1.1) | 11a | 1.51 H&WB Team Away Day April 2018  1.52 H&WB Team Delivery Plan 2018-19  1.53 Northumbria Uni Leadership module The Big Five Inventory Nov 2018  1.54 Northumbria Uni Leadership module EI self assessment Nov 2018  1.33 IHWBS Gantt Chart Sept 2016  1.1 IHWBS Final Report May 2018  1.1 IHWBS Final Report May 2018 |
|  | My knowledge and understanding of developing constructive relationships was gained from my leadership and management degree. In particular, my leadership module where we learnt about organisational culture and employee engagement and how good, authentic employee engagement leads to more motivated, empowered employees who have positive, constructive relationships with their line managers and colleagues.  We also learnt about team leadership and the positive or negative impacts this can have on team relationships, and how effective fellowship, coaching and mentoring schemes in the workplace can also contribute to positive, constructive relationships in teams and with wider colleagues.  I understand the different forms that teams might take in order to strengthen their relationships with others and how important it is to embed some key principles within these relationships to facilitate this. Some of these key principles include: having openness, trust and honestly, agreeing shared values and objectives, and communicating regularly. Ways in which we develop constructive relationships with a range of people who contribute to public health and wellbeing is to establish public health networks and facilitate opportunities to come together as a regional public health system. I have direct experience of establishing and reviewing networks, as well as organising regional public health conferences to bring together key partners from the public health system to explore and identify opportunities to collaborate on shared public health priorities and initiatives.  Topic based public health networks operate across the North East and include membership from PHE and the topic leads from each of the 12 local authorities. These networks are essential for sharing practice, accessing technical expertise from each other, for example developing service specifications or managing re-procurement processes; accessing CPD opportunities, and keeping up to date on national guidance and products. As part of my CABA role, I was asked to undertake a review of the effectiveness of these networks and explore opportunities to embed CABA as a way of working. I invited NHS Improvement to attend a session to share their network tools with the public health network chairs so that they could utilise these in their networks and improve their overall effectiveness, including their working relationship with each other as a network. I developed a poster to share the learning from this piece of work which was accepted and presented at the PHE Annual Conference in 2018. (Ev. 1.55) The outcome of the review meant that the networks are now operating more effectively and working more cohesively as a team to address specific public health priorities to improve population health.  I have also organised annual CABA events to bring together key partners, share learning and knowledge nationally and locally, celebrate successes and identify challenges, and explore opportunities for collaboration at a regional or sub regional level. (Ev. 1.56).The events attract key partners from local authority public health teams, the voluntary and community sector, and academia.  I applied this knowledge and understanding to my role in the IHWBS research as I ensured I developed positive working relationships with all members of the team so that we could work together as an effective, cohesive team to contribute to population health and wellbeing. I have included testimonials from the lead researcher as well as other colleagues who have commented on my leadership skills and ability to develop constructive relationships.(See evidence 1.57 – 1.60). | 11b | Evidence 1.30 BA Leadership & Management Dec 2018  1.55 A review of public health networks in the North East Sept 2018  1.56 CABA Annual Event March 2016  Evidence 1.57 – Evidence 1.60 Appraisal feedback 1-4 |
|  | My knowledge and awareness of the principles of effective partnership working was gained from different aspects of my leadership module where we learnt about managing change effectively and the importance of effective partnership working in order to effectively enact change – creating the right culture and environment to embrace change, and creating opportunities for employees to be part of the change and evolve with it at an organisational or partnership level.  I also undertook some self-directed reading on the key principles via online learning portals such as ‘mindtools’. This describes the key principles as trust, mutual respect, mindfulness, welcome diversity, and open communication. I can identify quite strongly with these principles as they essentially mirror PHE’s People Charter which all employees are required to embed into their ways of working.  My understanding of the key principles of effective partnership working is evident in how I demonstrate the behaviours of the PHE people charter:  Communicate - delivering presentations on CABA to different audiences with different levels of knowledge(Ev. 1.22). It was important to communicate clearly, avoiding use of jargon and acronyms and ensuring the language and examples were relatable to the audience. Actively communicate in a friendly, open and positive manner using a variety of methods including: face to face (attending meetings to provide progress updates) (ev. 1.21); written (writing reports, summaries, briefings) (Ev. 1.62); email; skype (videoconference and telecons to participate in national meetings and learning seminars/webinars  Achieve Together - worked collaboratively with the IHWBS research team to produce the evaluation report (Ev. 1.1), highlighting strengths and limitations of the study and making recommendations for population wide health improvement.  Treat people fairly with kindness and respect – during the qualitative research of the IHWBS evaluation, I ensured I was approachable to the service users, making them feel at ease and comfortable to talk to me. I expressed empathy, compassion and concern to encourage them to open up and feel they were being genuinely listened to.  I have applied this knowledge and learning to my role within the IHWBS project as I have demonstrated these skills throughout the project and by doing so, have set an example to others and as project manager, have facilitated effective partnership working.  Organisations, teams and individuals work together by bringing together their range of knowledge, expertise and skills sets to achieve the project outcomes. This was particularly evident in the IHWBS work as the research team was made up of skilled quantitative and qualitative researchers with exceptional academic writing skills to ensure effective translation of the study and its findings into a credible, strong report.(Ev. 1.1 and Ev. 1.63). It also utilised the skills and expertise of myself as the project manager and research support to manage capacity and workload and ensure the project remained on schedule and everyone contributed fairly (Ev. 1.33). The wider Advisory Team utilised valuable insight, knowledge and expertise of the individual IHWBS service providers and the local authority commissioners of those services to ensure we understood the history, background and context to each service and were able to target the relevant and appropriate service users. This increased the validity and reliability of the study as it enabled us to recruit the right individuals and groups to the qualitative study and analyse the most accurate and detailed quantitative data by working with data leads from within the local authorities. By getting the right people involved in the project, it meant everyone was able to make a valuable contribution to ensure the utmost success.  My knowledge of the different forms that teams might take was gained from becoming a member of the NHS England Source4Networks website <http://www.source4networks.org.uk/diagnostics> where I was able to access learning materials and resources to help new and mature networks identify the type of network there are or want to be, and review their effectiveness. To fully understand how to best utilise these tools (to support my work around reviewing public health networks as mentioned in 11b), I undertook some self directed online reading about the different forms teams can take. I learnt about the differences between groups (usually formed around common interests with no formal accountability or governance), and teams (work towards a common goal with individual and team responsibilities). I then learnt about the effectiveness of teams and some of the enablers and barriers in relation to members, leadership, motivation and communication.  The most common forms of teams are project teams (all members share a common goal and everyone has clear roles and responsibilities. These include functional teams which are usually permanent and made up of members of the same department, cross functional where members are from different departments to draw on different expertise, matrix teams where there is more than one leader/boss, and contract teams whereby members are outsourced and contracted); self managed teams (usually have a wider remit with no clear leader or hierarchy); virtual teams (members are based in different locations and need to communicate and collaborate effectively to achieve shared goals); operational teams (created to support other teams); task and finish teams (time limited to solve/implement a specific issue or piece of work).  Teams are often defined by the nature of their purpose, for example a ‘working group’ is established to undertake a project or piece of work; and an ‘advisory group’ is established to glean opinion, advice and guidance.  I applied this knowledge and learning to my project management role within the IHWB project in the early developmental phase by contributing to discussions about the types of teams we would need to form to manage the evaluation. We needed to establish a ‘working group’ to actually undertake the evaluation so it was important that this was made up of all the key people carrying out the research. We therefore convened the Research Team which acted as a working project team. We also needed to establish a wider group of advisors to gain insight and guidance. We therefore set up the Advisory group which was made up of the providers themselves and national advisors. I was responsible for articulating these governance processes into our service level agreement.(Ev 1.12 – see item 5 page 10, and Ev. 1.79 page 3 highlighted in red) | 11c  i  ii  iii | 1.22 CABA presentation to PHINE network  1.21 SH Commissioners Network Sept 2018  1.62 Final A Review of Public Health Networks in the North East DPH Briefing Sept 2018  Ev 1.1 IHWBS Final Report May 2018  1.1 IHWBS Final Report May 2018  1.66 IHWBS Interim Report Nov 2017  1.33 IHWBS Gantt Chart Sept 2016  1.12 IHWBS Final MOU July 2016  1.79 IHWBS Meeting Notes 21.3.16 |
|  | My knowledge of effective communication with a range of different people using different methods was gained from on the job learning and self-directed learning. (Ev. 1.64). This included:  I completed a Civil Service e-learning module on ‘Effective Communication’. This helped me to learn and improve my understanding of the communication process (the importance of each element of the communication cycle : **source** – who is sending the communication; **encode** – constructing a clear, concise message; **channel** – in what format/method the message will be communicated; **receive** – how the message will be received and by who; **decode** – the receiver being able to understand the message and **feedback** – receiving and acting upon constructive feedback).  I also learnt how to be more effective in verbal (face to face, telephone, video conferencing) and written (email, letters, memos, reports) communication, and understand how to apply the 7 c’s to my communication. These are: Clear, Concise, Concrete, Correct, Coherent, Complete, Courteous.  As a result of this module I am now able to apply the six elements of the 'communication process' and avoid the associated barriers to face-to-face communication, apply the '7Cs' model of written communication, apply effective listening techniques, ask effective questions, create rapport and manage non-verbal behaviour, and write more effective general correspondence and emails.  I also read PHE’s tips for managers on active listening and reading non-verbal communication. (Ev. 1.65). This helped me to understand the techniques involved in actively listening to people by concentrating on what they are saying and showing that you are listening by engaging with them, making eye contact, asking appropriate questions throughout, summarising the discussion afterwards and not showing judgement.  I read a book entitled ‘Communication Skills’ which was published by Ferguson Career Skills Library in 2009. This gave me an indpeth knowledge of the key skills and behaviours needed to demonstrate effective communication techniques including: writing with purpose speaking with confidence and communicating effectively. This helped consolidate my e-learning as it provided a more detailed, academic perspective and reinforced what I had already learnt.  I also attended a Communications lecture as part of my Public Health Protection MPH module (ev. 1.66). This outlined the principles of how to handle media in relation to communicating public health messages and risks to public health. It helped me to understand the risks and challenges in the new world of digital communication (blogs, social media such as Facebook, Twitter and You Tube) and how messages can be misinterpreted and how risk perception determines people’s actions therefore communicating clear, accurate public health messages via these platforms is vital. The lecture also explained how to interpret ‘perceived’ and ‘actual’ public health risks and how these should be effectively communicated via targeted marketing campaigns which, if done properly, can be effective interventions as they can lead people to take appropriate action to protect themselves and their families.  The above knowledge and learning has helped me apply my communication skills effectively in my role as CABA lead for the H&WB team. It has involved being able to present to a variety of different audiences using a variety of formats. I presented a poster to the PHE All staff event (Ev. 1.67 and 1.68) and delivered a 10minute presentation highlighting key messages from the poster and answering any questions. (Ev 1.69) This audience was made up of a variety of colleagues including health protection nurses, the Centre Director, the Deputy Director for H&WB, knowledge and intelligence specialists, researchers, epidemiologists, H&WB programme leads and managers and corporate and business staff. I have also delivered a presentation to the Association of Directors of Public Health network on embedding CABA approaches (Ev. 1.23), aswell as the Obesity and Physical Activity Network (Ev. 1.24) and Sexual Health Network (Ev. 1.21) These networks are made up of local authority public health leads for those topic areas.  I have used other methods of communication effectively within the IHWBS evaluation. These include: communicating clear and effective action notes to the research and advisory teams – these teams are made up of academics, researchers, commissioners and providers.    I was also required to communicate effectively during focus groups with service users. I used what I had learnt about actively listening in relation to using non-verbal communication, body language, tone of voice and style of language to create an informal friendly environment to make participants feel comfortable and at ease. I would use my verbal communication skills to build rapport with participants by chatting to them in a friendly, open, non-intimidating or confronting manner, actively listening to them by using their language, adopting their tone or adjusting my tone and behaviour to make them feel I was on their wavelength. I would show empathy and understanding and try and offer reassurances to anyone feeling anxious or nervous.  As part of my role in the IHWBS research, I used the 7c’s to guide my written communication to ensure action notes and email correspondence was clear, concise, concrete, correct, coherent, complete and courteous. (Ev. 1.70 and 1.71) | 12 | 1.64 CS Effective communication module Dec 2018  1.65 PHE Tips for Managers  1.66 Newcastle Uni MPH Comms Lecture Dec 2018  1.67 Implementation of CABA poster Nov 2018  1.68 Thank you email for presenting at PHE All Staff event Nov 2018  1.69 CABA presentation for PHE All Staff event Nov 2018  1.23 DsPH CABA workshop agenda Sept 2018  1.24 OPAN Agenda Oct 2018  1.21 SH Commissioners Network Sept 2018  1.70 IHWBS Email correspondence Nov 2017  1.71 IHWBS Email correspondence Sept 2017 |
| **Key outcomes/**  **Results** | CABA – the key outcomes related to this workstream are around knowledge mobilisation and include: sharing and learning from others in relation to successes and challenges; providing much needed evidence around the success of these approaches to support commissioners to commission more flexibly and work in a co-productive way with their communities; and utilising their community assets to improve the health and wellbeing of the residents of those communities. The presentations delivered to various public health networks, the collation of case studies and opportunities I facilitated to share local practice and build relationships across the system built a greater awareness of these approaches and enable confidence in implementing these approaches and imbedding CABA principles as a way of working.  IHWBS project – the evaluation highlighted some stark, tangible learning, areas for improvement, recommendations and opportunities for more integrated working between commissioners, providers and communities. These included: the need for clear leadership and commitment with a strong understanding of the value and benefits of integrated services and the role of CABA as creative and innovative ways to make real meaningful differences to the health and wellbeing of individuals and communities; opportunities to work collectively and collaboratively to share expertise and maximise available budgets; taking a whole system holistic approach to address wider determinants of health such as housing, welfare/benefits, employability and education and training; challenging traditional commissioning models with stringent KPI’s and outcome targets and focus more on what is really important to the service user, encouraging more co-productive, constructive working relationships between commissioners and providers, a better focus on workforce development and training to enable staff to feel more confident to build trusting relationships with service users to facilitate more open discussions in order to address complex concerns affecting the service user’s health; challenges in relation to the impact of austerity, welfare reform and universal credit call for a long term collaborative model of delivery in partnership with a strong and vibrant VCS sector to meet the needs of target populations and be more responsible to those most vulnerable and facing the greatest inequalities.  The findings demonstrate the vital role IHWBS play in facilitating social connectedness and community empowerment so individuals have a say in how they address their health and wellbeing.  The findings indicated that men are underrepresented, suggesting that more targeted work is needed to engage them and improve access for them. They also highlighted that access was higher in areas of socioeconomic disadvantage, suggesting that targeted efforts to reduce inequalities had worked. The qualitative findings suggested that bringing people together and improving social connectedness via CABA significantly contributed to reducing social isolation and loneliness. Evidence from the findings indicated that IHWBS improved community cohesion, volunteering, and access to peer support, particularly amongst people with mental health and long term conditions. |  |  |
| **Reflection**  *(you will be invited to a reflective practice workshop)* | I feel I have learnt and grown as a practitioner as a result of being involved in this work as it was a really positive experience which provided me with a sound insight into health inequalities and how public health interventions try to address these, and a much more indepth understanding of how IHWBS work, under what circumstances, and for who. By writing and developing learning materials in relation to CABA, I have gained a deep understanding of how to embed these approaches, and what the benefits are to individuals, communities, providers and commissioners.  I feel the evaluation of the 4 IHWBS was a great success as we were able to really unpick some of the challenges and issues faced by services, and really understand the needs of the communities these services were set up to engage. We were able to establish that the services were reaching the most deprived individuals and therefore did address inequalities. We were also able to provide some tangible, practical learning and recommendations for commissioners and decision makers to take forward into their procurement and service development conversations.  I feel proud of my contribution to the IHWS project and was delighted that our findings were embraced and welcomed by our key stakeholders.  I feel I have achieved significant progress in my role as CABA lead for the PHE centre and it has been rewarding to hear some of the feedback from my colleagues and peers in relation to my presentations and learning sessions that I delivered.  I have also addressed some of my learning and development needs in relation to public speaking, delivering presentations and taking more of an active role in meetings.  My CABA role is still evolving and growing and I have adapted my practice along the way as I have learnt more. For example, I have more recently started to learn more about what is happening in other regions around areas we are struggling with in the North East such as evaluation of CABA and I have started to look at other areas across the country and establish links with them so that we can share their learning. I have invited some speakers from an embedded research project in London to speak at our upcoming Social Prescribing event in March. |  |  |
| **Evidence included** | * 1. IHWBS Final Report May 2018   2. PH Practitioner Masterclass CABA Jan 2016   3. Leeds Beckett Think Piece Asset Based Approaches May 2016   4. MPH Public Health Interventions Jan 2017   5. MPH Fundamentals of Research Oct 2018   6. MPH Qualitative Research Methods Sept 2017   7. PH Practitioner Masterclass Ethics and Risk Sept 2018   8. Northumbria Uni Research Ethics Lecture Feb 2018   9. Newcastle Uni Ethics and Qualitative Research Oct 2017   10. PHE Policy Government Procurement Card Jan 2013   11. Advice on development of MOU’s Jan 2019   12. IHWBS final MOU July 2016   13. PPF application Oct 2015   14. Request for ethical approval April 2017   15. IHWBS Research Team action notes Sept 2012   16. SU and community groups consent form Sept 2017   17. IHWBS example email correspondence to commissioners and providers Nov 2017   18. Email to Advisory Group re identifying services Nov 17   19. Quals presentation with anonymised sites Sept 2017   20. Active Listening e-learning   21. SH Commissioner’s Network Sept 2018   22. CABA presentation for PHINE event Oct 2018   23. DsPH CABA workshop Sept 2018   24. OPAN Agenda Oct 2018   25. Responsible for Information Training March 2018   26. IHWBS data sharing protocol discussion Feb 2017   27. IHWBS data sharing protocol Feb 2017   28. PHE Management seminar Feb 2016   29. Constructive conversation workshop Sept 2016   30. BA Leadership and Management Dec 2018   31. Northumbria Uni Leadership Module Sept 2017   32. PHE Appraisal briefing April 2016   33. IHWBS Gantt Chart Sept 2016   34. Implementing CABA poster July 2016   35. CABA principles and narrative Sept 2017   36. CABA Annual Event March 2017   37. CABA Annual Event evaluation form March 2018   38. Newcastle uni HI and Socioeconomic outcome gradient March 2016   39. CABA practice examples Nov 2017   40. CABA practice examples report May 2017   41. CABA practice example GRT Jan 2017   42. Health statistics revision certificate Aug 2018   43. Newcastle uni MPH Fundamentals of Research Oct 2018   44. Newcastle uni MPH Frequency Association and Risk lecture Oct 2018   45. IHWBS Community focus group notes Jan 2018   46. IHWBS Advisory Meeting June 2017   47. IHWBS Research Team Meeting Dec 2017   48. IHWBS Advisory Group Meeting Feb 2017   49. Newcastle Uni MPH Health Protection module Sept 2018   50. IHWBS Coding for thematic analysis Jan 2018   51. H&WB Team Away Day April 2018   52. H&WB Team Delivery Plan 2018/19   53. Northumbria Uni Leadership module the Big Five Inventory Nov 2017   54. Northumbria Uni Leadership module EI self assessment Nov 2018   55. A review of PH networks in the North East Sept 2018   56. CABA Annual event March 2016   57. Appraisal feedback 1 April 2017   58. Appraisal feedback 2 April 2017   59. Appraisal feedback 3 April 2017   60. Appraisal feedback 4 April 2017   61. PHE People Charter Sept 2013   62. A review of PH networks in the North East briefing for DPH Sept 2018   63. IHWBS Interim report Nov 2017   64. CS Effective Communication module Dec 2018   65. PHE Tips for managers Sept 2013   66. Newcastle MPH Comms lecture Oct 2018   67. Implementation of CABA poster Nov 2018   68. Thank you email for presenting at All Staff event Nov 2018   69. CABA presentation for PHE All Staff event Nov 2018   70. IHWBS email correspondence Nov 2017   71. IHWBS email correspondence Sept 2018   72. CABA Annual Event March 2018   73. CABA Masterclass for SN and HVs March 2017   74. Chemsex, Drugs and Alcohol Workshop April 2017   75. MPH PH Protection February 2018   76. H&WB Team Business Planning Session May 2016   77. Performance and Development Review Oct 2016   78. Staff supervision log May 2016   79. IHWBS Meeting Action Notes 21.3.16 |  |  |