Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Monday 9 December 2019**
Time **9.30 am**
Venue **Council Chamber, County Hall, Durham**

Business

Part A

Items during which the Press and Public are welcome to attend. Members of the Public can ask questions with the Chairman's agreement.

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 15 November 2019 (Pages 3 - 8)
4. Declarations of Interest, if any
5. Any Items from Co-opted Members or Interested Parties
6. NHS Quality Accounts 2018/19: Progress against 2019/20 priorities - Reports and presentations from (Pages 9 - 28)
   (i) Tees Esk and Wear Valleys NHS FT
   (ii) North East Ambulance Service NHS FT
   (iii) County Durham and Darlington NHS FT
7. Developing County Durham's Approach to Wellbeing: Report and presentation from the Director of Public Health (Pages 29 - 56)
8. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

Helen Lynch
Head of Legal and Democratic Services

County Hall
Durham
29 November 2019

To: **The Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee**

Councillor J Robinson (Chair)
Councillor J Chaplow (Vice-Chair)

Councillors A Batey, R Bell, L Brown, P Crathorne, R Crute, J Grant, T Henderson, E Huntington, P Jopling, C Kay, K Liddell, S Quinn, A Reed, A Savory, M Simmons, H Smith, J Stephenson, O Temple and C Wilson

Co-opted Members: Mrs R Hassoon

Co-opted Employees/Officers: Mr C Cunnington Shore

Contact: Jackie Graham Tel: 03000 269704

DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Friday 15 November 2019 at 9.30 am**

Present

Councillor J Robinson (Chair)

Members of the Committee
Councillors A Batey, R Bell, L Brown, P Crathorne, R Crute, J Grant, T Henderson, S Quinn, M Simmons, H Smith, J Stephenson and O Temple

Co-opted Members
Mrs R Hassoon

1 Apologies

Apologies for absence were received from Councillors J Chaplow, E Huntington, P Jopling, C Kay, K Liddell, A Reed, A Savory, C Wilson and Mr C Cunnington Shore

2 Substitute Members

There were no substitute members present.

3 Minutes of the meeting held on 3 October 2019

The minutes of the meeting held on 3 October 2019 were agreed as a correct record and signed by the Chair.

The Principal Overview and Scrutiny Officer gave an update on the following items:-

Item No. 7 – the Fishburn surgery closure had not been reported to the Primary Care Committee of the Clinical Commissioning Group (CCG) due to election purdah. This would now be reported late December/early January.

Item No. 10 – Children and Young People's Overview and Scrutiny Committee had a meeting scheduled on 27 November 2019 to discuss the best start in life. An invitation had been extended to this committee and would touch upon the breastfeeding and smoking at the time of delivery issues highlighted at the last meeting as areas to be looked at further.

Members were advised that a member training would be held at the conclusion of this meeting to discuss financial awareness and budget monitoring.

4 Declarations of Interest

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

There were no items to consider.

6 County Durham and Darlington Flu Prevention Board

The Committee received a joint report from the Director of Public Health that provided information and assurance on the progressing work of the County Durham and Darlington Flu Prevention Board to increase the uptake of the flu vaccination in the local area (for copy see file of Minutes).

The Consultant in Public Health advised that the evaluation carried out had shown that the take up was for low the eligible groups however the board would continue to meet throughout the year to oversee the key actions.

The Director of Public Health added that this area of work forms part of her statutory responsibility for health protection and that the service had a commitment to increasing the uptake.

Councillor Bell asked if all staff were eligible for the vaccine and was advised that it was aimed at a targeted group of people who provided direct up close and personal care. The Director of Public Health added that the uptake of this group of staff would need to increase before they looked at a wider group of staff.

Members were advised that staff were informed of the flu vaccinations by having conversations and publicising on the intranet.

Discussions took place about whether the vaccine should be mandatory and the Director of Public Health said that it would not be ethical to enforce this.

Councillor Temple welcomed the actions of the board but said that it was important to track progress and find out the cost benefit. He said that it would be helpful to be able to compare figures between the county average and each area. The Consultant in Public Health informed him that they were working with colleagues in the CCG and health practices to look at the variances between patient groups. He explained that the data received was at practice level but that there would be multiple counting across certain groups of people.

The Director of Public Health added that they were commissioned by NHS England and the data was received from them however she would look at how to report back to members in future so that the data was meaningful.

Councillor Crute agreed that it would be helpful to request further details on the data to enable monitoring.

Resolved:
That the report be noted and further work be undertaken by Public Health to enable meaningful data to be reported back to the Committee in future reports.

7 Director of Public Health County Durham Annual Report

The Committee received a report of the Director of Public Health for County Durham that presented the Annual Report for 2019 (for copy see file of Minutes).

The Director of Public Health gave a detailed presentation on the Annual Report that focused on the following:-

- Health and wellbeing across County Durham
- Where we live, our services and our communities
- Our priorities and progress towards them
- Mental health at scale
- Healthy workforce

The Director of Public Health reminded the Committee of the fictional family 'the Taylors' and how the priorities and progress had affected them and the benefits of this.

The Director of Public Health agreed to come back to a future meeting to update on progress and commented that next years report would focus on the 'Best Start in Life' and ensuring people had good jobs.

Councillor Bell asked if there were any underlying reasons regarding the increase in SEN numbers and the Director of Public Health advised that a piece of work was almost complete on this issue and would cover the reasons for the increase and the diagnosis. She would bring a report to a future meeting.

Councillor Grant welcomed the report however was concerned about the mental health figures especially the statistic that 1 in 10 children have a mental health disorder. She felt that everything needed a label and there was a danger that everyone with some form of mental health problem were being clubbed together. She accepted that there were periods in most people's lives that would trigger some sort of mental health problem but it could just be temporary. The Director of Public Health explained that it was a real challenge and that we tended to highlight

the bad rather than the good things that happen in life. She took on board these points for future reporting.

The Chair was pleased to see that people were now recognising mental health as a real problem and treating as a priority. He did appreciate that the figures covered everyone, from people suffering with anxiety and those who had autism and learning disabilities.

The Director of Public Health said that it was recognised that regardless of whether a symptom was long or short term that it was important to build in resilience and recognise triggers.

In response to a question from Mrs Hassoon, the Director of Public Health advised that each child has an individual plan to meet their needs.

Resolved:
That the report be received.

8 Health and Wellbeing Board Annual Report

The Committee considered a Joint Report of Corporate Director of Adult and Health Services, Corporate Director of Children and Young People's Services and Director of Transformation and Partnerships that presented the Annual Report 2018/19 (for copy see file of minutes).

The Strategic Manager Partnerships highlighted the initiatives that had taken place to achieve the strategic objectives in the Joint Health and Wellbeing Strategy and gave some examples across the following priorities:-

- Children and young people make healthy choices and have the best start in life
- Reduce health inequalities and early deaths
- Improve the quality of life, independence and care and support for people with long term conditions
- Improve the mental and physical wellbeing of the population
- Protect vulnerable people from harm
- Support people to die in the place of their choice with the care and support that they need

Future challenges were also highlighted and the continued threat of cuts to Public Health funding.

Further to a question from Councillor Henderson, the Director of Public Health explained that historically more men smoked than women however this has now balanced out. She went on to advise that the Local Tobacco Alliance would refresh their strategy in 2020 to help achieve the target of 5% by 2025.

Councillor Temple asked how a smoker was defined and if vapers were also classed as smokers. The Director of Public Health said that anyone who vaped were classed as non-smokers as the liquid did not contain tar. She added that people would not be encouraged to start vaping if they did not smoke but that it was used as an alternative to help people stop smoking.

Members were concerned about the safety aspects of vaping and the Director of Public Health confirmed that the products were highly regulated in this country and had to pass rigorous quality and safety standards.

Councillor Quinn commented that the price of soft drinks were really high and that when looking at reducing the intake of alcohol, this should be considered as did not deter people from opting for an alcoholic drink as these were often cheaper.

Resolved:

(i) That the Health and Wellbeing Board Annual Report 2018/19 be agreed.
(ii) That the timeline and next steps outlined in the report be noted.
(iii) That the intention to include more performance information in the Annual Report to demonstrate the impact, be noted.

9 County Durham Local Safeguarding Adults Board Annual Report 2018/19

The Committee considered a report of the Independent Chair of the Durham Local Safeguarding Adults Board (LSAB), which presented the Annual Report 2018/2019 (for copy see file of minutes).

The SAB Business Manager highlighted the work carried out with service users, Healthwatch and the Safeguarding Partnership. She informed the board that 30,000 members of staff had now accessed training in respect to safeguarding and 80 organisations had accessed information at shared events. She advised that there was now wider membership with the inclusion of the Probation and Prison Services and further links to Tees Valley Community Rehabilitation Company with a focus on the service user and looking at drivers around sexual exploitation.

The SAB Business Manager advised that they were keen to hear the voice of the practitioner, carry out audit activities and deep dives within the next year, together with strengthening arrangements with the advocacy provider.

Further to a question from the Chair the SAB Business Manager explained that Councillor Hovvels as Cabinet Portfolio holder was a board member, together with statutory partners including the Police, Probation and Prison Service, Fire Service, CCG, Community and Voluntary Sector and lay members.

The SAB Business Manager responded to a query from Councillor Temple about emerging issues and explained that the board were concentrating on areas such as financial abuse and self neglect for people living in their own homes to reduce those levels of risk. She added that physical abuse would always be the cause for the most concern.

Resolved:
That the annual report and achievements made in 2018/19 be noted.

10 Review of Stroke Rehabilitation service and Review of Inpatient Rehabilitation services at Bishop Auckland Hospital (Ward 6) - Proposed establishment of Joint Health OSC

The Committee considered a report of the Director of Transformation and Partnerships that provided information in respect of the draft terms of reference and protocol for a joint Health Overview and Scrutiny Committee to oversee the statutory consultation process of the review of Stroke Rehabilitation services in County Durham and Darlington and the review of Inpatient Rehabilitation services at Bishop Auckland Hospital (ward 6) (for copy see file of Minutes).

Resolved:
(i) That the report be received.
(ii) That the terms of reference and protocol for a joint committee be agreed.
(iii) That the appointment of representatives to the joint committee be agreed.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 2)

Headlines

Progress on the quality improvement actions has been good, with 49/56 (88%) either completed or on track. The most significant delays are around personalising care planning and the transitions priorities.

In terms of the Quality Metrics, **4** of **10** (**40**%) are reporting green and **6** of **10** metrics (**60**%) are red. However 3 of those red metrics saw significant improvement from Q1 to Q2 (% treated with respect, rates of physical restraint / intervention and MHSOP average length of stay). The other 3 metrics remain in a static position with small quarter to quarter fluctuations.

Key Issue: Quality Improvement Actions

The 7 actions that are behind schedule should be completed by Christmas (see Appendix 1). The delays are relatively minor, and progress is being made across the priorities of CYP-AMH transition, Personalising Care Plans; Dual Diagnosis; Urgent Care and Reducing Premature Deaths.

These minor delays include the opening of the new Durham and Darlington crisis team hub in Bishop Auckland, which should take place before Christmas now that estate issues have been resolved

Key Issue: Quality Improvement Metrics

There has been a significant improvement from Q1 to Q2 in the % of patients who report that they feel safe on our wards. It continues the trend noted during 18/19 of a decline over time in negative comments about this issue. This may reflect the focus put in this in recent months as operational services have reacted to the data, including an improvement in practice in dealing with dual diagnosis.

The physical intervention rate fell significantly from Q1 to Q2. All three geographic Localities saw significant reductions in intervention and restraint.

The average length of stay for older people has been worse than target since quarter 3 2013/14 In quarter 2 it was 64.69 days which was 5 days better than in quarter 1. In this quarter there were 11 patients discharged who had a length of stay greater than 200 days. Most had complex needs, including physical health problems (3) and finding suitable placements for patients subsequent to discharge (6). In all cases, services worked with patients and family to provide appropriate care and support.

The patient experience related metrics remain in a static position with small quarter to quarter fluctuations. There are developments within TEWV's business plan which might lead to sustained future improvements in these two issues for example the Right Staffing programme continues to focus on establishment reviews, increasing the numbers of people training to be mental health professionals, and reducing agency staff usage.

Key Issue: Priorities for 20/21

The Board of Directors have agreed the following improvement priorities for the next Quality Account:

- Personalising care planning (existing)
- Reducing preventable deaths (exisiting)
- Improving Child to Adult service transitions (existing)
- Increasing the proportion of inpatients who feel safe on our wards (new)

Detailed planning for these priorities has commenced. Governors will be able to take part in the Quality Account task and finish group in Spring 2020.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 2)

Appendix 1 – Review of Progress on Actions in the current Quality Account 30/09/2019

Green: Action is on track
Red: Action is not on track and has either been extended or wording amended
Grey: Action is not on track but is due to circumstances outside of the Trust's control

Priority	Green Actions	Red Actions	Grey Actions	Comment
Further improve the clinical effectiveness and patient experience at times of transition from CYP to AMH Services	10	2	0	• Due to competing priorities, the engagement event due to be held on 24th September 2019 has been postponed to Q3 19/20 • It has not been possible as yet to produce the report on the improvement trajectories that were agreed during Q1 19/20; however a meeting in relation to this was held on 9th October 2019, and the report will be produced during Q3 19/20
Make Care Plans more Personal	9	2	1	• As at 30th September 2019, 180 members of staff have received training on the CPA process. This training will continue throughout 2019, so it is anticipated that the target of 500 will be achieved during Quarter 3 19/20 • The work on DIALOG testing in a simulated live environment has been delayed due to Trust-wide issues with the implementation of DIALOG. It is anticipated that this will be completed during Quarter 3 2019/20 • There was a delay in the release of the new Trust-wide Change Implementation Workbooks and so this will be completed during Quarter 3 2019/20
Reduce the number of Preventable Deaths	7	0	0	• Actions on track
Develop a Trust-wide approach to Dual Diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services	15	1	0	• The review of Dual Diagnosis networks is in progress; however as there were changes to staffing this is not yet complete. It is anticipated that this work will be completed in Quarter 3 19/20
Review our urgent care services and identify a future model for delivery	8	1	0	• There have been delays to the implementation of a new operational model for the Durham & Darlington Crisis Teams due to issues relating to the team base and car parking. The new model will commence in Quarter 3 19/20

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 2)

Appendix 2: **Performance against Quality Metrics at Quarter 2**

	Quarter 1 19/20		Quarter 2 19/20		Quarter 3 19/20		18/19	17/18	16/17
Patient Safety Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	88.00%	65.59%	88.00%	79.17%	88.00%		61.50%	62.30%	N/A
Metric 2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	0.10	0.35	0.21	0.35		0.18	0.12	0.37
Metric 3: Number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	38.18	19.25	31.03	19.25		33.81	30.65	20.26
	Quarter 1 19/20		**Quarter 2 19/20**		**Quarter 3 19/20**		**18/19**	**17/18**	**16/17**
Clinical Effectiveness Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 4: Existing percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	>95%	95.5%	>95%	98.23%	>95%		96.49%	94.78%	98.35%
Metric 5: Percentage of clinical audits of NICE Guidance completed	100%	100%	100%	100%	100%		100%	100%	100%
Metric 6a: Average length of stay for patients in Adult Mental Health Assessment and Treat-ment Wards	<30.2	23.25	<30.2	25.47	<30.2		24.70	27.64	30.08
Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment wards	<52	69.89	<52	64.69	<52		66.53	67.00	78.08
	Quarter 1 19/20		**Quarter 2 19/20**		**Quarter 3 19/20**		**18/19**	**17/18**	**16/17**
Patient Experience Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 7: Percentage of patients who reported their overall experience as excellent or good	94.00%	92.12%	94.00%	90.76%	94.00%		91.41%	90.50%	90.53%
Metric 8:Percentage of patients that report that staff treated them with dignity and respect	94.00%	88.07%	94.00%	89.16%	94.00%		85.70%	85.90%	N/A
Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94.00%	86.60%	94.00%	86.56%	94.00%		86.9%	87.20%	86.58%

The Trust's Quality Account 2018/19 is available at:
https://www.tewv.nhs.uk/about-us/how-are-we-doing/quality-account/

Quality Account Update (Quarter 2)

Appendix 3: Performance against Quality Metrics at Quarter 2- Locality Breakdown

Quality Metric	Trust	Durham & Darlington	Teesside	North Yorkshire & York	Forensic Services
Patient Safety Measures					
Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	79.17%	85.59%	64.52%	77.27%	25.00%
Metric 2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) - for inpatients	0.21	0.12	0.12	0.64	0.06
Metric 3: Number of incidents of physical intervention/restraint per 1000 occupied bed days	31.03	11.15	79.87[1]	16.79	15.56
Clinical Effectiveness Measures					
Metric 4: Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care:	98.23%	N/A	N/A	N/A	N/A
Metric 5: Percentage of Clinical Audits of NICE Guidance completed:	100.00%	N/A	N/A	N/A	N/A
Metric 6a: Average length of stay for patients in Adult Mental Health Services Assessment and Treatment Wards: 30.2	25.47	N/A	N/A	N/A	N/A
Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment Wards:	64.69	N/A	N/A	N/A	N/A
Patient Experience Measures					
Metric 7: Percentage of patients who reported their overall experience as 'excellent' or 'good'	90.76%	89.96%	91.67%	91.32%	88.43%
Metric 8: Percentage of patients that report that staff treated them with dignity and respect	89.16%	91.21%	89.96%	89.02%	82.48%
Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	86.56%	88.11%	85.76%	86.49%	85.99%

[1] Please note that the Teesside figure includes the regional Children and Young People's wards at West Lane. These wards closed during Quarter 2.

The Trust's Quality Account 2018/19 is available at:
https://www.tewv.nhs.uk/about-us/how-are-we-doing/quality-account/

NHS
North East
Ambulance Service
NHS Foundation Trust

CATEGORY OF PAPER					
Specific action required:		**Provides Assurance:**	✓	**For Information:**	

Durham Overview & Scrutiny Committee – 9/12/2019	
Report title:	2019/20 Quality Priorities update
Purpose of report:	To provide the Overview and Scrutiny Committee with an update the delivery of the Quality Priorities 2019/20
Key issues: *(key points of the paper, how this supports the achievement of the Trust's corporate objectives, overview of risk implications, main risk details on page 2)*	North East Ambulance Service Quality Report 2018/19 outlined three specific quality priorities for 2019/20. These are: • Continue to develop a Just and Restorative Culture to improve patient safety • To develop our mental health implementation plan, working in partnership with others to improve the experience and care provided to patients with mental health needs accessing our services • To improve early intervention for patients in cardiac arrest The report provides assurance that progress to date has been made with each quality priority.
Issue previously considered by:	Durham Overview & Scrutiny Committee NEAS Quality Committee
Recommended actions:	The Committee is asked to note the progress made and will receive further feedback in 2020.
Sponsor / approving director:	Joanne Baxter, Director of Quality & Safety
Report author:	Debra Stephen, Deputy Director of Quality & Safety

Governance and assurance

Link to Trust Priorities: *(please tick)*	**Organisational Sustainability**	**Improving Quality & Safety**	**Workforce & Investors in People**	**Clinical Care & Transport**	**NHS 111 & Clinical Assessment Service**	**Comms & Engagement**
			✓	✓	✓	✓
Link to CQC / KLOE: *(please tick)*	**Caring**		**Responsive**	**Effective**	**Well Led**	**Safe**
					✓	
Link to Trust values: *(please tick)*	**Pride**	**Strive for excellence**	**Respect**	**Compassion**	**Take responsibility & be accountable**	**Make a difference – day in & day out**
	✓	✓	✓	✓	✓	✓
	This paper links to all Trust values in supporting staff to deliver high quality patient care					

(Please explain how this paper supports the application of the Trust's values in practice)	
Any relevant legal / statutory issues? *(Such as relevant acts, regulations, national guidelines or constitutional issues to consider)*	There is a requirement to report on Quality Priorities within the Trust Quality Report.
Equality analysis completed **If this is not relevant please explain why:**	**Yes** / **No** / **Not Relevant** ✓ An equality analysis is a review of a policy, function or significant service change which establishes whether there is a positive or negative impact on a particular social group

Key considerations	**Details**
Confirm whether any risks that have been identified have been recognized on a risk register and provide the reference number:	
Please specify any Financial Implications **Please explain whether there are any associated efficiency savings or increased productivity opportunities?**	There are no immediate financial implications.
Are any additional resources required e.g. staff capacity?	
Is there any current or expected impact on patient outcomes/experience/quality?	The corporate objectives will drive the strategic aims of the organisation to: Do what we do well Look after our employees Develop new ways of working.
Specify whether appropriate clinical and/or stakeholder engagement has been undertaken: *(stakeholders could include staff, other Trust departments, providers, CCGs, patients, carers or the general public)*	Quality Priorities have been widely shared internally and externally.
Are there any aspects of this paper which need to be communicated to our stakeholders (internal or external)? *(Please tick – if 'yes' then please complete all boxes. Please briefly specify the key points for communication and ensure the Comms team are informed via mailto:publicrelations@neas.nhs.uk)*	**Yes** / **No** / **Positive** / **Negative** ✓ / ✓ / ✓ / ✓ **Proactive** / **Reactive** / **Internal** / **External** ✓ / ✓ / ✓ / ✓ This paper is shared with the public, Governors and staff, demonstrating transparency on progress.

Durham Overview and Scrutiny Committee

NEAS Quality Priorities Update – November 2019

1. Introduction

This paper provides a progress update regarding the three quality priorities set out in the NEAS Quality Report 2018/19, which were agreed following internal and external consultation. There is a requirement to have a quality priority aligned to:

- Patient safety
- Patient experience
- Clinical Effectiveness

2. Quality priority: Continue to develop a Just and Restorative Culture to improve patient safety

The aim of this priority is to begin the work to ensure a just culture is developed within the organisation. A just culture will balance an open and honest reporting environment with a quality orientated learning culture, focused on ensuring safe systems are in place.

This will require a change in emphasis from focusing on errors and outcomes to system design and understanding how people behave at work (human factors). In order to do this we need to provide a supportive environment that enables openness and honesty and encourages responsibility and accountability with the clear aim of improving patient safety.

The initiatives we outlined are:

- Sign up to safety event – to encourage staff to share their experiences of patient safety

We have undertaken staff engagement sessions which have identified that there are some barriers to reporting incidents, such as access to the reporting system and time available to do this. This feedback has been used to influence how we develop our incident reporting system.

- To improve the ease of incident reporting for busy front line staff

We have gained feedback from frontline staff and managers to assist in making changes to our incident reporting system so that it is easier to navigate the system, easier to identify what information is required when reporting an incident and refreshed our approach to training to enable staff to use the system more effectively.

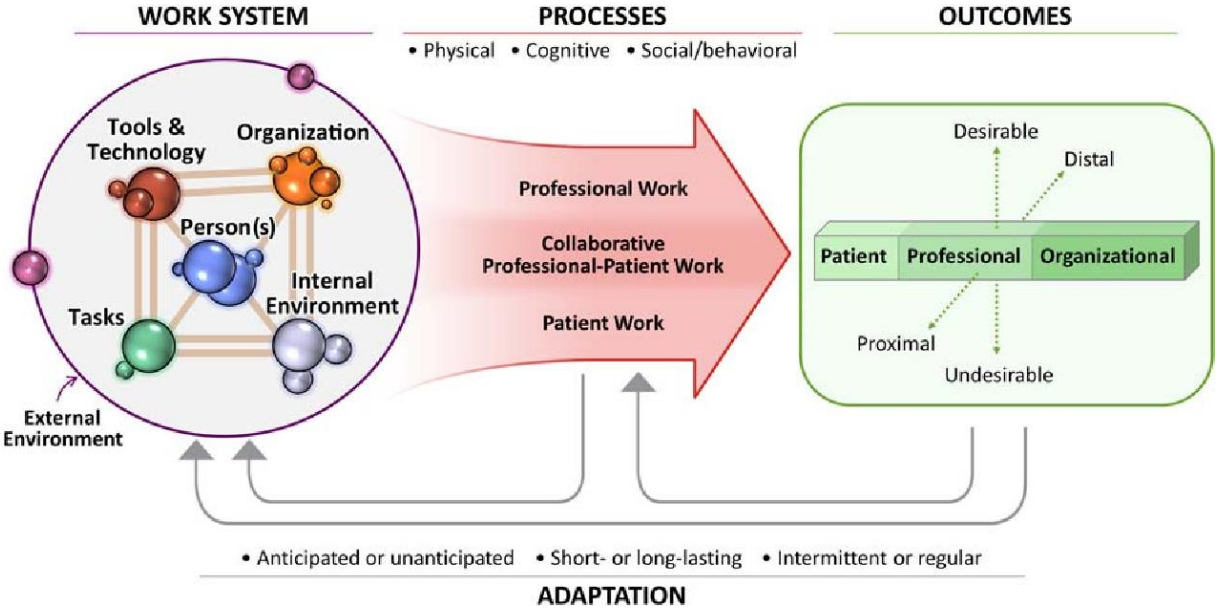
- To learn when things go well – embed excellence reporting

We have embedded excellence reporting in the organisation with reports demonstrating it is being used in all areas of the trust. We have also used the feedback through excellence reporting at our staff reward and recognition annual event.

- To change our investigation processes and policies so they are system focused

We have presented to a number of forums outlining how we will use the Systems Engineering Initiative in Patient Safety (SEIPS 2 model) to focus on systems learning rather than focus on the individual involved in the patient safety incident.

Figure1: SEIPS 2 model



As a result of this work we are now revising our incident management policy to reflect this work.

- To encourage front line staff to participate in the clinical review process

When a patient safety incident has been reported and identified as potentially causing moderate harm or above the incident is discussed at the weekly Clinical Review Group. This is a multi-disciplinary group, led by the Medical Director and Head of Patient Safety and Patient Experience.

We now use the SEIPs model to look at systems and processes, rather than focus on individual errors made; which has enabled those present to reflect on the systems, policies and processes within the Trust to see how these can be improved. This is where true organisational learning occurs to prevent similar incidents. As a result of this staff attendance at this meeting has increased, as has attendance by staff directly involved in the patient safety incident.

- To look at our HR functions and how we reduce the burden of investigations

The Deputy Head of HR has been working with HR, Operations and the Quality & Safety directorate to determine how best to respond to concerns, in line with our Just & Restorative Culture approach. There has been a revised disciplinary policy which is in draft with plans to consult on this widely.

- To understand more fully human factors and how they impact on patient safety

We have invested in training of 2 key people in the organisation to attend national Human Factors training events and their knowledge is informing our approach at Clinical Review Group to focus on system learning.

- To have 'Just culture champions' across all of our service lines

We have identified 15 'Just culture champions' across the organisation who will work with their teams to be ambassadors of this culture change. It is however recognised that to truly embed this change it requires an organisational development programme to underpin this. This is currently being considered by the executive leads for the programme.

- To invest in our Just culture staff engagement and educational events

We have invested in 15 of our staff attending a 4 day Just and Restorative Culture programme led by Mersey Care NHS Trust and Northumbria University, with the Executive Director of Quality & Safety and Director of People Development at NEAS providing board level commitment. This programme was also attended by 15 staff from Gateshead NHS Foundation Trust. We have agreed to work together to provide support for both organisations.

- To show staff we care when things go wrong – recognising the 'second victim' and providing support

We are now using the framework developed by Mersey Care NHS Trust to consider how we will look at incidents and this explicitly considers the 'second victim' and all those who may be affected by the incident. We have in place a system to provide staff with a welfare officer to ensure their needs are met and we are currently looking at that role and how it can be enhanced.

- To participate in local and national 'Just Culture' groups ensuring we have the resources & materials available to support our initiatives

We are linked into ongoing support from key staff in Mersey Care NHS Trust, Gateshead NHS Foundation Trust and we have a number of managers completing a Masters level qualification focusing on Just & Restorative Culture.

- To deliver human factors training to clinical managers

There have been sessions delivered to managers within HR, operations and the quality & safety directorate regarding human factors which influence how people work. Feedback from this will inform how we update the Trust's policy on developing policies and procedures to ensure any new or updated policies have true engagement with those staff who regularly have to implement them.

3. **Quality priority – To develop our mental health implementation plan, working in partnership with others to improve the experience and care provided to patients with mental health needs accessing our services**

The aim of this priority is to develop and implement year 1 of our Mental Health Strategy to improve the care of patients with mental health needs.

The initiatives we outlined are:

- Deliver year 2 of our three year Mental Health education programme to enhance the knowledge and skills of our frontline workforce to meet the care for patients with mental health needs

We are delivering year 2 of our education programme, as part of the Trust's statutory and mandatory training for operational staff. This is being delivered by external experts, alongside our Mental Health Lead and is well evaluated.

- Develop a three year implementation plan to support delivery of our Mental Health Strategy

The Trust had developed a draft strategy, which required further work following the publication of the NHS Long Term Plan. This has enabled NEAS to work with Mental Health Trust partners to review how best we can deliver frontline care and transport needs.

- Further refine the mental health screening tool for paramedics to support clinical decision making and referral on to appropriate services and pilot this

We have reviewed the mental health screening tool developed locally and have worked with North West Ambulance Service who developed a less complex tool. This tool is now being piloted in NEAS from November 2019 and will be formally evaluated following a 6 month pilot.

- To review the safeguarding referral process, where mental health is identified as a concern

We have worked with the two Mental Health Trust's in our region to better understand the services available for adults and children and delivered sessions to frontline staff to increase awareness of these.

- To work with NHS and third sector partners to look at how we care for patients where they are considering suicide

Work is ongoing with Crisis services in Tees, Esk and Wear Valley and Cumbria, Northumberland and Tyne & Wear NHS Trusts to look at how we can further improve working relationships.

It is hoped the mental health screening tool pilot will also improve the quality of the referrals we make to crisis services for those experiencing mental distress and contemplating or attempting suicide.

Working parties have been established with NHS providers and NHS England and raised as part of ICS Mental Health programme in our region. NEAS has representation at key meetings.

We have arranged professional development sessions for our staff on the role of Crisis teams and have arranged similar events of the role of the Local Authority Approved Mental Health Professional (AMHP) services in assessing patients under the Mental Health Act.

We participated in the Inside You campaign with a charitable organisation from Chester le Street called 'If you care, share'. This charity was set up by the bereaved family of a 19 year old man and aims to get people talking about their feelings and not bottling up their emotions.

4. Quality priority – To improve early intervention with patients in cardiac arrest

The aim of this quality priority is to improve the support provided to clinicians on resuscitation and therefore improve the quality and outcomes for patients.

The initiatives we outlined are:

- Purchasing Community Public Access Defibrillators (CPADs), through our NEAS Trust Fund to place in areas we feel would benefit most, based on our local intelligence

Our campaign to support the increase of CPAD's across our regional footprint continues through 2019/20. We will report the year end position in our Quality Report.

- Use smart technologies to notify the public to a nearby cardiac arrest

We have introduced the GoodSAM application to our Community First Responders, to enable them to be notified of a cardiac arrest nearby. We are looking at how we roll this out for NEAS staff too.

- Implement high performance CPR by running workshops and incorporating into the yearly training

We have implemented practical workshops to support high performance CPR and this includes resuscitation of the child too.

- Establish a cardiac arrest registry to identify further areas for improvement

We have established a cardiac arrest registry to gather data to support improvement work, alongside our Learning from Deaths process.

- Consolidate telephone CPR training and rapid dispatch for all cardiac arrests

We have reviewed telephone CPR training and will be implementing a specific dispatch desk with a specialist clinician to dispatch our Cardiac Arrest Response Unit (CARU) to those cases who are critically ill through trauma or serious medical emergency.

5. Conclusion

NEAS is committed to providing high quality care for patients and support staff in the delivery of care, often in pressured circumstances.

We have made progress in the delivery of the quality priorities for 2019/20 and this report provides assurance to the Overview and Scrutiny Committee that we are focused on the delivery of each priority.

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County Durham Adults Wellbeing and Health Overview & Scrutiny Committee
11th December 2019

NHS
County Durham and Darlington
NHS Foundation Trust

Quality Accounts 2019 – 2020

April – September 2019

Joanne Todd
Associate Director of Nursing (Patient Safety and Governance)

PURPOSE OF THE REPORT

To update the committee on progress of County Durham & Darlington NHS Foundation Trust with regards to the agreed priorities for improvements for the 2019/2020 period. This report provides and update from April 2019 to September 2019.

WHAT ARE QUALITY ACCOUNTS?

Quality Accounts are annual reports to the public from the providers of NHS healthcare about the quality of the services they deliver. The primary purpose is to encourage leaders of healthcare organisations to assess the quality of care they deliver. The Quality Accounts for County Durham & Darlington NHS Foundation Trusts includes indicators set by the Department of Health and those we have identified as local priorities.

PRIORITIES FOR 2019/2020

The table below sets out the priorities and position (where data is available). The priorities were agreed through consultation with staff, governors, local improvement networks, commissioners, health scrutiny committees and other key stakeholders.

Where progress can be reported at this point this has been colour coded as follows;

RED – not on track
AMBER – improvement seen but not to level expected
GREEN – on track

Priority	Goal	Position/Improvement
SAFETY		
Patient Falls[1] **(Continuation)**	Targeted work continued to reduce falls across the organisation and the introduction of the dedicated falls team To ensure continuation and consolidation of effective processes to reduce the incidence of injury. To continue sensory training to enhance staff perception of risk of falls. To continue a follow up service for patients admitted with fragility fractures.	- To continue the introduction of the Trust Falls Strategy, covering a 3 year period. - To agree a plan of year 2 actions. - To monitor implementation of year 2 actions against the Strategy. **Acute falls = 5.4 per 1000 bed days** **Community falls = 5.5 per 1000 bed days** **Multiagency action plan is underway and outcomes will be included in the Accounts** **Quality Improvement work continues and red zimmer frames have been introduced into key areas** **Lying/standing blood pressure has been built into the electronic observations tool to improve compliance**

Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia.	- The dementia screening tool has been incorporated into the electronic nerve centre, and removes the need for paper base assessment. - The next step is to migrate the data from nerve centre to formulate the national reporting criteria. This generates the statistics for measuring compliance with undertaking the dementia assessment. This will be migrated the end of the year. - Action plan developed from the NAD the intention is to utilise the finding from the 2018 NAD to see if there have been any changes in practice/improvements. - Carers survey has been completed. The recommendations are to be monitored alongside the national dementia audit recommendations. The action plans have been merged and form the Strategy Action Plan 2019/2020.This will be monitored. - Participate in a 5 year research project of dementia services within the Durham area to continue during 2019/2020. Participation to continue. - Continue the study in the development of a good practice audit tool for assessing patient care and services for those living with dementia. Participation to continue.
Healthcare Associated Infection **MRSA bacteraemia[1,2]** **Clostridium *difficile*[1,2]** ***(Continuation and mandatory)***	National and Board priority. Further improvement on current performance.	- Achieve reduction in MRSA bacteraemia against a threshold of zero. **One case reported since April 2019** - No more than 45 (see new reporting mechanism) cases of hospital acquired Clostridium *difficile.* **23 cases reported since April 2019** - Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.
Pressure ulcers[1] ***(Continuation)***	To have zero tolerance for grade 3 and 4 pressure ulcers	- Implement new national reporting metrics - Review of all identified grade 3 or 4 pressure ulcers - Continued education programme **Four identified between April and September where lapses in care were identified**

Discharge summaries[1] **(Continuation)**	To improve timeliness of discharge summary completion.	- Data collected via electronic discharge letter system and monitored via monthly performance reviews and Board reporting. - Care Groups undertake consultant level audits - Train 2019 intake of new junior doctors **Compliance has remained at around 94% during the period. Work programme continues**
Rate of patient safety incidents resulting in severe injury or death **1,2** **(Continuation and mandatory)**	To increase reporting to 75th percentile against reference group.	- Cascade lessons learned from serious incidents. - NRLS data. Enhance incident reporting to 75th percentile against reference group. **A 38% increase of incidents reported Oct to Mar 2019 compared to the same period 2018, however still remain in the middle 50th percentile of reporters.** - Continue to embed Trustwide work to embed and improve reporting of near miss and no harm incidents.
Improve management of patients identified with sepsis[3] **(Continuation)**	To maintain improvement in relation to management of sepsis	- Continue to implement sepsis care bundle across the Trust. - Continue to implement and embed post one hour pathway. - Continue to audit compliance and programme. - Hold professional study days. **On track**
EXPERIENCE		
Nutrition and Hydration in Hospital[1] **(Continuation)**	To promote optimal nutrition and hydration for all patients.	- Continue to work closely together on hospital menu development and nutritional analysis. - Continue to work closely with Speech and Language Therapy colleagues within the Trust towards achieving International Dysphagia Diet Standardisation Initiative (IDDSI) ward menus and nutritional products. - In terms of hydration we will consider how we maintain and monitor sufficient hydration status of patients requiring both artificial (intravenous or enteral) and non-artificial hydration support. - We will explore how CDDFT might require alternative ways of measuring oral fluid intake at ward level. - **In progress**
End of life and palliative care[1]	We now have an effective strategy and measures for palliative care. The	- We will work with CCG and NEAS to agree a comprehensive approach to personalised care planning.

(Continuation)	measures are derived from the strategy and will support each patient to be able to say: *"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)"*	- We will work with regional partners to develop electronic sharing of key palliative care information (ePaCCS). - We will support and monitor new out of hours advice service. - We will continue to deliver palliative care mandatory training for all staff. - We will implement actions from postal questionnaire of bereaved relatives (VOICES). - We will implement actions and learning from Care of Dying Audit. - **In progress**
Responsiveness to patients personal needs[1,2] **(Continuation and mandatory)**	To measure an element of patient views that indicates the experience they have had.	- Continue to ask the 5 key questions and aim for improvement in positive responses in comparison to last years results. - Quarterly Reports to Integrated Quality Assurance Committee and any emerging themes monitored for improvement through the Patient Experience Forum. - The Trust will continue to participate in the national inpatient survey. **Annual response from National Inpatient Survey – local survey continues quarterly (quarter 1 result shows standard on track to deliver)**
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)** **Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months**[2] **(Mandatory measure)** **Percentage of staff believing that the Trust**	To show improvement year on year bringing CDDFT in line with the national average.	- To bring result to within national average. - Results will be measured by the annual staff survey. Results will be reviewed by sub committees of the Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work. - In addition we will continue to report results for harassment & bullying and Race Equality Standard. **Annual response from Staff Survey**

provides equal opportunities for career progression or promotion[2] **(Mandatory measure)**		
Friends and Family Test[1] **(Continuation)**	To increase Friends and family response rates	- During 2019/2020 we will increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress and will be monitored by the Trust Board. **Improvement seen in response rates April to July**
EFFECTIVENESS		
Hospital Standardised Mortality Ratio (HSMR)[1] **Standardised Hospital Mortality Index (SHMI)[1,2]** **(Continuation and mandatory)**	To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary. To embed "Learning From Deaths" policy	- To monitor for improvement via Mortality Reduction Committee. - To maintain HSMR and SHMI within expected levels. - Results will be captured using nationally recognised methods and reported via Mortality Reduction Committee. We will continue to benchmark both locally and nationally with organisations of a similar size and type. Updates will be submitted to Trust Board via the performance scorecard. - Trust mortality review process, allocation of priority reviews to central review team for completion will continue to ensure any learning, positive and negative, is embedded in patient care. - Embed "Learning from Deaths" policy. - In line with national changes the post of Lead Medical Examiner has been advertised. The successful post holder will lead the introduction of the Medical Examiner System, during the coming months. **Mortality monitoring indicators within expected range. Mortality reviews continue**
Reduction in 28 day readmissions to hospital[1,2] **(Continuation and mandatory)**	To implement effective and safe care closer to home, improving patient experience post discharge.	- Further development of multi-disciplinary Teams Around Patients (TAPS). - Safe discharge is a key theme of the Transforming Emergency Care programme. - Monitoring through monthly performance reviews and Board

		reporting. - Agreement with Stakeholders to set this threshold at a higher level and aim for year on year improvement on this. Set at 12% for 2019/2020 **Current performance 12.3%. work continues to improve on this**
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] **Continuation and mandatory)**	To improve patient experience by providing safe and timely access to emergency care.	- Daily monitoring of performance indicators against NHSI and national 95% standards. - Monitoring through monthly performance reviews and Board reporting. - Transforming Emergency Care programme. - Review of escalation procedures. **4 hour wait indicator remains below 95%.**
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate.	- To aim to be within national average for improved health gain. - NHS England have removed groin hernia and varicose vein from mandatory data collection, hip and knee will continue. **Annual response**
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators.	- Continue to monitor for maintenance and improvement in relation to breastfeeding, smoking in pregnancy and 12 week booking. - Monitor actions taken from gap analysis regarding "Saving Babies Lives" report. **12 week booking 91.1%** **Breastfeeding 57.7%** **Smoking in pregnancy 15.2%**
Paediatric care (new indicator following stakeholder event)	Embed paediatric pathway work stream.	- Continue development of more direct and personal relationships with individuals within Primary and Secondary care by building on the work already undertaken. **Paediatric dedicated paediatric unit now opened adjacent to Emergency Department**
Excellence Reporting (new indicator following stakeholder event)	To ensure that CDDFT continues to embed learning from excellence into standard culture and practice through Excellence Reporting.	- A monthly report to the Executive and Clinical Leadership Committee (ECL) incorporating total Excellence Reports for the preceding month, a Care Group breakdown, highlights of departments with the most excellence reports and common themes. - A quarterly report to the Integrated

		Quality Assurance Committee (IQAC) summarising the ECL report and encompassing summary from learning from excellence group. **Embedded within Care Groups**

1 - continuation from previous year
2 - mandatory measure
3 - new indicator following stakeholder events

During 2019/2020 we will incorporate a section to include changes to services and their impact, with a particular emphasis on access to clinical services and whether their effectiveness has been diminished through service change.

Two Never Events have been reported since April 2019. Action plans are developed and monitoring is in place for completion.

Post setting this year's Accounts the Trust received correspondence from the Chief Nursing Officer to ask that the newly formed Learning Disability standards were included in the Quality Accounts. It was noted that Trusts are expected to publish their performance against these standards in their annual accounts: to demonstrate to the population they serve how they measure quality of services and whether quality is improving. We will ensure that this is included and progress monitored

Clostridium *difficile* (CDI) objectives for 2019/2020

Acute provider objectives for 2019/20 will be set using these two categories:

- **Hospital onset healthcare associated**: cases that are detected in the hospital three or more days after admission
- **Community onset healthcare associated**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

CDI Objectives for CDDFT have been set at **45** cases or rate of **16.4** per 1000 bed days

Recommendation

The Board receives the report as evidence of ongoing commitment to improve quality outcomes for patients under our care.

Joanne Todd
Associate Director of Nursing (Patient Safety & Governance)
September 2019

Adults, Wellbeing and Health Overview and Scrutiny Committee

9 December 2019

Developing County Durham's Approach to Wellbeing

Report of Jane Robinson, Corporate Director of Adult and Health Services, Durham County Council, and Amanda Healy, Director of Public Health County Durham, Durham County Council

Electoral division(s) affected:

Countywide.

Purpose of the Report

1 The purpose of this report is to:

- Provide an update on the development of the approach;
- Highlight examples of where and how the approach is being used; and
- Outline further areas to embed the approach.

Executive summary

2 There are many definitions of wellbeing, but in short it can be described as *'how well we are doing'* or *'how satisfied we are with our lives'*. As well as health, measures of wellbeing include our relationships; our work and finances; our levels of participation in sport, culture and community events, where we live and how safe we feel; and the services we can access. Wellbeing is starting to be seen as an equivalent measure to economic growth, ensuring that we consider these important factors in people's lives alongside factors influencing economic development.

3 Durham County Council has a statutory responsibility to improve and protect the health and wellbeing of local residents[1]. It also has a 'Wellbeing Power' that can be enacted in order to promote or improve the economic, social or environmental wellbeing of the area[2].

[1] Health and Social Care Act 2012
[2] The Local Government and Public Involvement in Health Act 2007

4 In recent years, we have seen many improvements in people's health and wellbeing, for example, as a result of targeted health improvement programmes and reductions in smoking rates. Consequently, our residents can expect to live longer lives than previously; however, they are not necessarily living happier and better quality lives and many still face a considerable number of challenges to their wellbeing.

5 For example, alcohol related deaths are increasing, and almost 17% of adults in Durham (14% in England) report levels of high anxiety. In addition, 12% of adults have a long term mental health problem, (only 9% across England), over 50,000 people in the county are diagnosed with depression and, it is estimated, that 1 in 10 children have a mental health disorder. Finally, healthy life expectancy (the years we can expect to live in good health) is only 58.7 years for women in Durham (60.4 in England), and 58.9 years for men (59.5 in England) and only 70% of people in Durham report a high level of wellbeing (or happiness), compared to 75% in England.

6 The CDP event in 2018 set us a challenge to move away from 'doing to' communities to 'working with'. This premise is now embedded in our County Durham Vision and is at the heart of the Wellbeing Approach. It builds on our long history of engaging with communities, through the work of our Area Action Partnerships and through initiatives such as the Voluntary and Community and Social Enterprise Sector Alliance and the co-production of services such as 'Joining the Dots'.

7 Many countries across the globe are recognising that the quest for economic growth can often result in widening inequalities where some groups of people being 'left behind'. Such groups then act as a "drag" on any further attempts at economic growth (OECD, 2015).[3] Consequently, the need for 'inclusive' growth and wellbeing is becoming increasingly important, with some suggesting that personal wellbeing rather than economic growth should be the primary aim of our Government's spending[4]. Certainly, this is now the approach being adopted in New Zealand.

8 Initiatives intended to encourage inclusive growth and improvements in wellbeing are founded on the engagement of communities and the devolution of power. County Durham has been at the vanguard in developing such approaches, engaging communities and sharing decision making through Area Action Partnerships. These have been originally designed to give people a voice in how local services are

[3] https://www.oecd.org/els/soc/OECD2015-In-It-Together-Chapter1-Overview-Inequality.pdf
[4] *A Spending Review to Increase Wellbeing: An open letter to the Chancellor (May 2019).* Report by the All-Party Parliamentary Group on Wellbeing Economics. www.wellbeingeconomics.co.uk

provided. We know that this can make a difference and can build on these to close the gap and not leave people behind.

9 Our Approach to Wellbeing has been developed by colleagues working across DCC and with partners on the Mental Health Partnership Board, and the Resilient Communities Group, reporting into the Prevention Steering Group.

10 The Wellbeing Approach brings a shift in emphasis and resources from the delivery of wellbeing services to an approach that introduces greater devolution of decision making to communities and stronger community engagement. This can lead to better health and wellbeing outcomes for local people. The challenge is to embed wellbeing in everything we do.

11 Colleagues across DCC have begun to use the Wellbeing Principles, exploring their benefits in their day to day work. This has included working in Adults and Health Commissioning, Regeneration and Local Services, Resources and TAPs (via Area Action Partnerships). Examples of this work are shared in the report and further discussions are also planned with senior NHS colleagues to discuss alignment with the County Durham Health and Wellbeing System Plan; the Fire & rescue Service for their Prevention Strategy, the Joint Health and Wellbeing Strategy, and with Children and Young People's Services to evolve their place-based working.

12 Adopting the Approach to Wellbeing will challenge us to deliver services and programmes in a different way. It will also challenge us to measure our performance in a different way. It will mean services and assets that are developed with people rather than consulting with them during or after the event. Doing so, is not easy, and in some cases may not feel comfortable. It means handing over control and sharing decision making. But doing so, will result in improved outcomes for our communities.

Recommendation(s)

13 Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to:

(a) Note the contents of this report and actively support the continuing development of the County Durham Approach to Wellbeing;

Background

14 Our Approach to Wellbeing builds on the County Durham Partnership Event last year which focused on mental health and the work of Cormac Russell on asset based community development; highlighting the importance of greater engagement with communities.

15 It also builds on the success of our Area Action Partnerships and their long established work with communities across County Durham. Our 14 Area Action Partnerships have been working within communities for over 10 years encouraging the identification of priorities and shared decision making on the funding of local services. The strong relationships they have built with community representatives and the voluntary, community and social enterprise sector (VCSE) across County Durham have been key to the engagement and support that has been offered in the development of this Approach to Wellbeing.

16 In 2010, the UK, through the work of the Office for National Statistics (ONS), became one of the first countries in the world to track the wellbeing of its citizens using, amongst other things, measures of health, relationships, education, finances and the environment. There followed a United Nations resolution and report in 2012 on the importance of wellbeing and happiness in forming a 'new economic paradigm' with a World Happiness report now being published annually by the UN.

17 More recently, in May 2019, New Zealand declared itself the first country in the world to measure its success by its people's wellbeing. Its entire Treasury budget is now built around a series of wellbeing priorities[5] (mental health, child wellbeing, supporting Maori populations, building a productive nation, transforming the economy, and a supporting capital investment programme).

18 Wellbeing is therefore becoming of increasing importance, with an All Party Parliamentary Group also suggesting that personal wellbeing rather than economic growth should be the primary aim of our own UK Government spending[6].

19 Wellbeing includes everything that is important to people and their lives. Wellbeing, rather than levels of employment of economic growth, even determines how people vote[7]. In purely economic terms, it is

[5] The Wellbeing Budget, May 2019: https://treasury.govt.nz/sites/default/files/2019-06/b19-wellbeing-budget.pdf

[6] *A Spending Review to Increase Wellbeing: An open letter to the Chancellor (May 2019).* Report by the All-Party Parliamentary Group on Wellbeing Economics. https://wellbeingeconomics.co.uk/wp-content/uploads/2019/05/Spending-review-to-ncrease-wellbeing-APPG-2019.pdf

[7] Ward, G. Happiness and Voting Behaviour in *World Happiness Report* (2019), New York, NY. UN Sustainable Development Solutions Network

responsible for levels of productivity, benefit dependence and absenteeism. In human terms, it can simply be described as *'how well we are doing'*, and *'how satisfied we are with our lives'*. This can then impact on a persons physical or mental health.

20 In recent years, County Durham has seen many improvements in people's health and wellbeing, for example, as a result of targeted health improvement programmes, the reduction in smoking rates or improved screening programmes. Consequently, our residents can expect to live longer lives than previously; however, they are not necessarily living happier and healthier lives and many still face a considerable number of challenges to their wellbeing.

21 For example, alcohol related deaths are increasing, and almost 17% of adults in Durham (14% in England) report levels of high anxiety. In addition, 12% of adults have a long term mental health problem, (only 9% across England), over 50,000 people in the county are diagnosed with depression and, it is estimated, that 1 in 10 children have a mental health disorder. Finally, healthy life expectancy (the years we can expect to live in good health) is only 58.7 years for women in Durham (60.4 in England), and 58.9 years for men (59.5 in England) and only 70% of people in Durham report a high level of wellbeing (or happiness), compared to 75% in England.

22 Taken together, these figures highlight the fact that there is more we can do to improve people's wellbeing across County Durham, and that doing so through interventions that engage communities, devolve power, develop social capital and build resilience will not only improve people's lives but lengthen their lives and improve our economic and inclusive growth. This will also support the County Durham Vision of More and Better Jobs, Long and Independent Lives and Connected Communities.

Advantages to using this approach

23 **Reducing Inequalities** - Performance management within the public sector is often focused on setting goals in plans and strategies and ensuring that targets are achieved through a planning and control cycle. However, this traditional approach in isolation can lead to criticisms of hitting the target but missing the point and the problem of relying too heavily on achieving indicators of economic growth with the danger that this can result in widening inequalities. For example, the employment rate across County Durham has increased from 69% to 74% in the past three years, there has been strong business growth, and GVA per head continues to grow. However, the gap in employment rate between those with a long-term health condition and the overall employment rate has increased from 16.5% in 2014, to 19.5% in 2018 and continues to

widen. Such widening inequalities can then result in some groups and communities requiring a disproportionate spend from a range of agencies in comparison with their peers.

24 **Low cost solutions to complex problems** - Focusing on greater community engagement and empowerment, whilst supporting communities to identify solutions and mobilise assets that may already be available, can lead, not only to people feeling they have more control over their lives, but can also result in lower cost solutions to complex problems. For example, the transfer of assets such as leisure centres to communities themselves can result in savings to the Council but result in greater ownership and control of assets by communities themselves.

25 **Lower dependence on healthcare and welfare benefits** - People who feel they have greater control in their lives and are able to build social capital and resilience by connecting and working with others in their community are likely to experience improved feelings of wellbeing and hence may be able to contribute further to their communities, to the local economy generally and may result in lower dependence upon healthcare and welfare benefits.

Developing the Approach to Wellbeing

26 This Approach has been developed through a series of workshops exploring the evidence base for community engagement and how this could be applied to a number of challenges to wellbeing. Scenarios built around the Taylor family, were used to identify key protective factors that could prevent ill health and developed a number of wellbeing principles. Key messages from those workshops included:

- the importance of connectedness;
- signposting to local assets;
- the danger of stigmatising and 'pathologising' what is 'normal'; and,
- the need to do things 'with' rather than 'to' people (ie no quick solutions).

27 The model is built around three components.

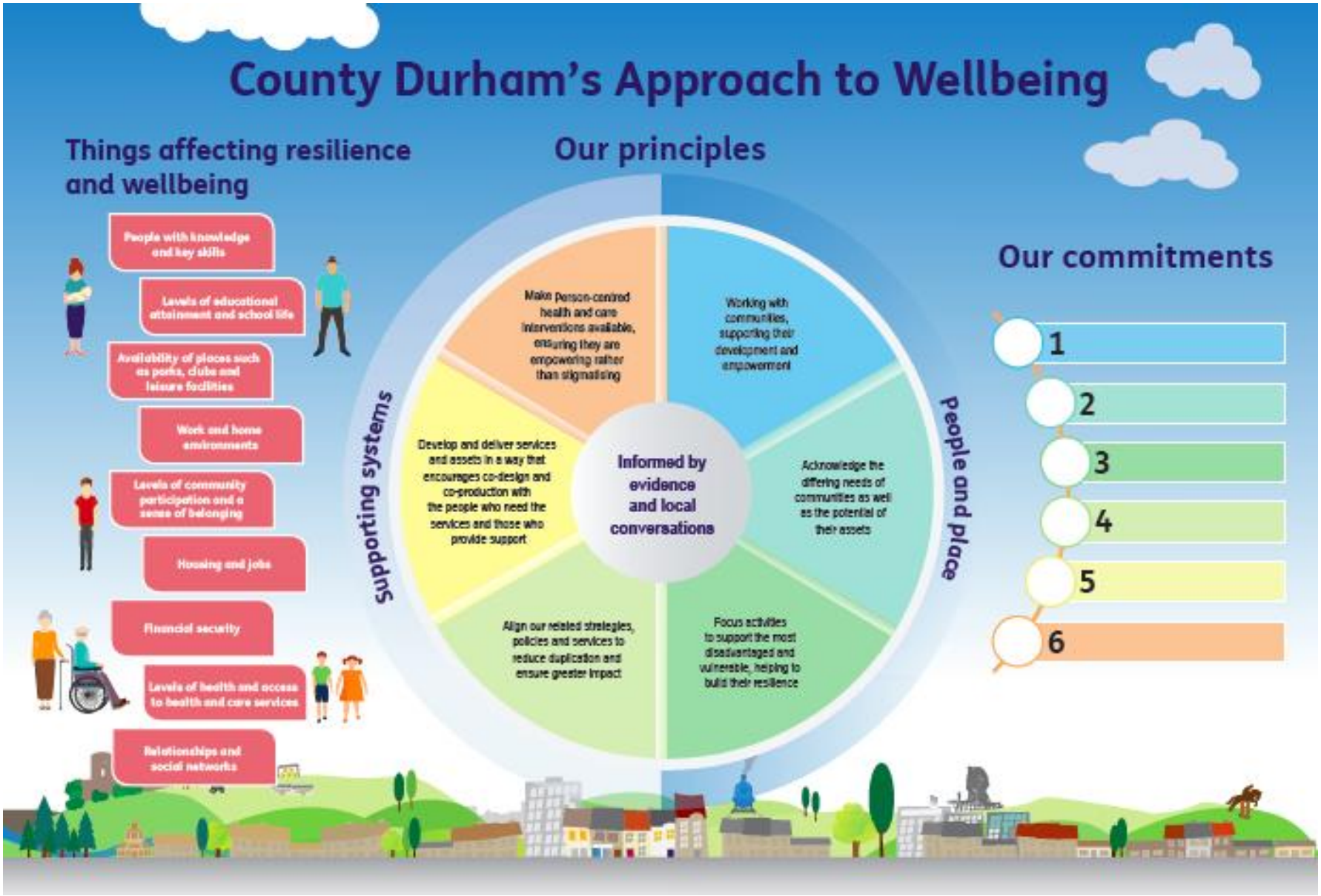
(i) It is ***Informed by Evidence and Local Conversations;*** highlighting the importance of ensuring a firm evidence base for our work, but at the same time, affirming the key role that communities play in supporting its own citizens, and the significant improvements in health and wellbeing outcomes that can result from involving communities more in decisions that affect them.

(ii) The approach has ***'people and place'*** at its heart. Working with communities, building on the assets of those communities, supporting the positive development of neighbourhoods that people live in, and fostering the resilience and empowerment of those communities through the support offered to everyone and, importantly, to those who are most vulnerable.

(iii) Finally, it highlights the importance of **'*supporting systems'***. Encouraging alignment of activities across agencies and sectors so that services are commissioned and delivered in a way that is collaborative and supportive; and that for those who require more formal interventions and perhaps NHS treatment, they are offered a person-centred approach with interventions that are empowering rather than stigmatising.

28 The three components of this Approach to Wellbeing are underpinned by a set of six principles, all included in the County Durham Vision.

29 These principles can be used in a number of ways. To support strategy and policy development, to review service provision and to support commissioning plans. They can also be used to gain feedback from communities themselves, testing out whether or not they feel they have been involved in making decisions that affect their lives. Finally they can be used to set out a commitment to change and do things in a different way.


County Durham's Approach to Wellbeing
Things affecting resilience and wellbeing
People with knowledge and key skills
Levels of educational attainment and school life
Availability of places such as parks, clubs and leisure facilities
Work and home environments
Levels of community participation and a sense of belonging
Housing and jobs
Financial security
Levels of health and access to health and care services
Relationships and social networks
Our principles
Supporting systems
People and place
Make person-centred health and care interventions available, ensuring they are empowering rather than stigmatising
Working with communities, supporting their development and empowerment
Develop and deliver services and assets in a way that encourages co-design and co-production with the people who need the services and those who provide support
Informed by evidence and local conversations
Acknowledge the differing needs of communities as well as the potential of their assets
Align our related strategies, policies and services to reduce duplication and ensure greater impact
Focus activities to support the most disadvantaged and vulnerable, helping to build their resilience
Our commitments
1
2
3
4
5
6

Using the Approach to Wellbeing

30 The Approach to Wellbeing model in intended to bring about change in the way we engage and work with communities. It is dynamic, adapting, changing and being shaped by local conversations with those who will both use it, and those who are intended to benefit from application of its Principles.

31 A tool has been developed for use as a 'self-assessment', with a number of colleagues and teams volunteering to review their practice and services against the Wellbeing Principles. These have helped to identify the scope of activities that can be supported by the wellbeing approach, as well as testing out the approach itself, subjecting it to changes that allow it to be understood and adopted more widely.

a) Adults and Health Commissioning and Corporate Procurement Teams

The team are looking at innovative ways to include the Wellbeing principles in contracts with mental health and wellbeing providers. Building on the Principle of co-production, they are working with colleagues in Corporate Procurement to:

- Explore a new approach to commissioning **(Alliance Contracting)**, building on agreed outcomes and a new model for community mental health services. This is intended to include collective ownership of opportunities, responsibilities and shared decision-making, rather than traditional forms of commissioning and contracting and has the potential to be applied to other services.

- Embed the Wellbeing Principles into all future contracts from service design stage through to contract monitoring.

- Agree outcome measures for Council-held community mental health services, based on the Wellbeing Principles and co-produced with health colleagues, providers, service users and carers.

b) Durham Health and Wellbeing System Plan

Senior NHS and DCC colleagues are looking to use the Wellbeing Principles to review the content of the Durham Health and Wellbeing System Plan. Whilst the System Plan is designed to align strategies and activities across agencies and to consult communities on major service change, there are further opportunities which can be explored to review and align the way in which assets are identified through Primary Care Network (PCN) link workers, the way health inequalities can be explicitly addressed through planned activities, and to consider greater alignment of the wellbeing principles with the personalisation agenda.

c) Area Action Partnerships

The lead AAP Co-ordinator for health and wellbeing volunteered to review the way in which AAPs approach their work against the principles of the wellbeing approach. This found close alignment between the wellbeing principles and the work of the AAPs as well as opportunities to:

- Use AAP funding processes to support greater identification and mobilisation of assets, as well as greater efforts to codesign and coproduce activities with communities.
- Develop a more systematic method of collating information about assets in order to inform the JSNA.
- More effectively address health inequalities through targeted call outs for projects.

As a result, changes are being considered to the wording of call outs and assessment forms for funding applications.

d) Regeneration and Local Services

The Wellbeing Principles have been used in two ways. Firstly, to review the high-level outcomes contained in the Housing Strategy, and secondly, to review the Housing Strategy's operational/ delivery based action plan. This enabled the team to identify:

- Which elements of their work were contributing to the improvement of wellbeing;
- Where language and terminology could be aligned to provide a clear link to the delivery of Wellbeing;
- Opportunities where the wellbeing principles could be used to inform and refine operational action plans, further detailed

action points and case studies, ensuring wellbeing principles are considered as part of partnership working and future delivery of the Housing Strategy.

e) Resilient Communities Group

Partners on the Resilient Communities Group are keen to explore the use of the Wellbeing Principles in the work of the Voluntary and Community sectors and a self-assessment is being undertaken with a commissioned service. Lessons can be learned from this which our commissioning teams can then apply to other commissioned services.

The RCG and AAPs are going to use the wellbeing principles as a means of testing out the degree to which communities actually feel involved in making decisions about things that affect their lives. This will be a vital element in enabling feedback to be given to those providing services to that community.

f) County Durham Fire and Rescue Services

Fire and Rescue Services – Discussions are taking place to determine how the Wellbeing Principles can be used in the development of the Fire and Rescue Services' Prevention Strategy. Consideration is being given to developing the Prevention Strategy with input from communities, as well as the revision of documentation and workforce training to ensure greater opportunity for person centred approaches and shared decision making for referrals.

32 Further actions include:

a) Transformation and Partnerships – The Wellbeing Principles are being used to help design the 'Holiday Activities with Food' programme. Funding is being disseminated by the 14 Area Action Partnerships to support parents and guardians in feeding young people during school holidays. The aim is to co-design the project using input from groups currently providing support to families, as well as engaging parents themselves.

b) The Civil Contingencies Unit – to consider assessing our current emergency planning against the wellbeing principles including the involvement of communities in designing those plans. The Cold Weather Plan and input to the development of the Humanitarian Assistance Centre Plan are two examples.

Next Steps

33 As the County Durham Vision is implemented, use of the Wellbeing Approach will become more systemic. We will continue to use the model across DCC and with partners in order to inform the steps that can be taken to improve the wellbeing of those living in County Durham. The approach is also congruent with other asset based approaches including “connecting people” and the development of the Durham Deal.

Knowing we have made a difference

34 It will be important to measure the impact of adopting this approach over time. This can be done in a number of ways including the use of data that is already collected nationally to measure wellbeing and is part of routine ‘performance monitoring’. However, it is important to also measure the impact of this approach on those communities and with those communities it is intended to support, gaining insight and feedback through local conversations and ensuring a dynamic approach to implementing this approach. It requires us to measure our success differently, for example in terms of building resilience within communities as well as social capital. Further consideration is required to embed existing and new ways of measuring wellbeing within our overall performance measurement framework.

What needs to change?

35 If this approach is to succeed, its implementation requires the support and commitment from partners working across all sectors and agencies. Each has a role to play in engaging and empowering communities, using the approach outlined in this document and aligning their activities with others, leading to greater gain. It is therefore important that the content of this document is shared widely, discussed and ‘owned’ by everyone across the County Durham Partnership. It will then be incumbent on each partner to support the Approach to Wellbeing, making organisational and personal commitments to help deliver supporting actions.

36 Ultimately, adopting these Wellbeing Principles will challenge us to deliver services and programmes in a different way. It will mean services and assets that are developed with people rather than consulting with them after the event. Doing so, is not easy, and in some cases may feel uncomfortable. It means handing over control and sharing decision making. But doing so, will result in improved outcomes for our communities.

Background papers

- Appendix 2: County Durham's approach to Wellbeing (Draft – 2 October)

Contact:	Amanda Healy	Tel: 03000 264323

Appendix 1: Implications

Legal Implications

This work supports the Council's statutory responsibility to improve and protect the health and wellbeing of local residents[8].

Adoption of this Approach to Wellbeing may have an impact on the way in which services are commissioned in the future. We will therefore need to ensure our work in this area complies with procurement legislation.

Finance

There are no financial implications arising from this approach at present.

Consultation

Formal consultation on this approach is not envisaged, however, proposals for wider engagement are highlighted in the main body of the report and will need to be considered further as part of a more detailed community engagement plan.

Equality and Diversity / Public Sector Equality Duty

Utilisation of this approach would support equality and diversity, emphasising the importance of citizens having equal opportunities regardless of where they belong, highlighting the need to address and reduce health inequalities, and valuing the diversity that people can bring to their communities as local assets.

Human Rights

This work would respect the human rights of citizens across County Durham, working with communities regardless of race, sex, nationality, ethnicity, language or any other status. In particular the work to engage communities would encourage freedom of opinion and expression.

Climate Change

None

Crime and Disorder

Improving community engagement and cohesion has the potential to reduce crime and disorder.

[8] Health and Social Care Act 2012

Staffing

There are no staffing implications arising from this approach at present.

Accommodation

There are no accommodation implications arising from this approach at present.

Risk

Partnership support will be required to take forward this Approach to Wellbeing and failure of this support may result in a risk to its adoption. The evidence base suggests that its introduction will result in improved health outcomes for communities, therefore the risk if it is not adopted is that improvement in health outcomes may be more limited.

Procurement

One of the key principles contained in this approach is the need to ensure collaborative commissioning and co-design of services. Adoption of this Approach to Wellbeing will therefore have an impact on the way in which services are commissioned in the future. These are considered in the paper.

Appendix 2: County Durham's approach to Wellbeing (draft 2 October)

Introduction

What is wellbeing?

There are many definitions of wellbeing but in short it can be described as *'how we are doing'*, and *'how satisfied we are with our lives'*. Surveys are regularly used to measure our levels of wellbeing, and in County Durham, our residents report being less anxious compared to other areas, but they also report lower levels of happiness, and of satisfaction with their lives. In contrast, our young people generally report higher levels of satisfaction with their lives than their peers across the region (and nationally), and their mental wellbeing is the same as that reported in other areas.

There are other ways in which we can measure wellbeing including our relationships with family members; our health; our work and finances; our levels of participation in sport, culture and community events; where we live and how safe we feel; and the services we can access. Together, this information can provide us with a picture of the levels of wellbeing in our communities that we can use to measure changes over time.

Things that affect wellbeing and resilience

We all face challenges to our wellbeing as part of everyday life. Coping with stress at school, home or at work, having to deal with poor health or disability, and dealing with transitions in life such as leaving school, facing retirement or experiencing bereavement.

Many things affect our resilience and ability to cope. They include our levels of educational attainment; the support available within our neighbourhoods and the places we grow up in, work and play; the strength and quality of our relationships; our sense of belonging; our health; and our feelings of being in control of our lives.

Such factors often operate on a continuum and can change over time. For example, at some points in our life, we may have a number of strong relationships which make us feel positive and from which we can garner support if needed. At other times, the quality of our relationships may not be so strong, leading to feelings of isolation and loneliness. Similarly, our financial security, our health, our homes and jobs will change over time each of which bringing with it either challenges to our wellbeing or building our resilience.

Sometimes, however, challenges can be such difficult, prolonged or isolating experiences that people are simply unable to cope. As a result, they may feel stressed, low in mood and experience feelings of hopelessness. They may also try to cope by turning to unhealthy behaviours such as drinking, overeating or smoking which may then compound their feelings with those of low self esteem. At such times, it is important that they know where they can get help; help which is supportive and non-stigmatising, and enables them to build their resilience for the future. Whilst such help may include services offered by statutory agencies, it can also be found where we live, and amongst supportive communities themselves; communities that have identified ways in which its members can be protected from such challenges to wellbeing and have put in place the right support that is available at the right time.

Developing our Approach to Wellbeing

Building our approach

This approach is based around a number of broad principles, which we hope can be agreed by policy makers, service providers and commissioners across County Durham. Over time, it may develop into a more formal Consensus or Accord, lending itself to the development of a supporting action plan that partners can contribute to, each understanding their respective roles in realising outcomes associated with the introduction of the principles in this model.

The intention for this approach is to be as inclusive as possible, and free from jargon wherever possible, enabling it to be used not just with partner organisations, but to begin conversations with communities themselves, supporting their development and empowerment.

Conscious, however, that this has not been developed with communities, but that a starting point was needed, the development of this approach began with a dialogue between Durham County Council public health team and partners on the Resilient Communities Group (RCG). The RCG comprises a range of agencies, predominantly, those working in the Voluntary, Community and Social Enterprise sectors (VCSE) who have close links with communities and the challenges facing people in those communities. It was established by the Mental Health Strategic Partnership Board in response to consultation feedback on the need to improve action to address the wider determinants of mental health.

This document and model is therefore reflective of those conversations, with the intention of developing an approach to wellbeing and furthering our steps to working with communities more closely, supporting their development and empowerment.

Learning from others

We have also examined the development of similar approaches elsewhere. Many, who had originally developed health and wellbeing services that employed staff to offer 1:1 and group advice, have been seeking new approaches that work harder to develop and engage communities, and working in a more co-productive way.

The VCSE sectors have been a critical part of their success, helping to reach the most disadvantaged groups and it will be important to build on the strong foundations set by VCSE organisations and community groups in Durham in developing our own approach as we move towards more person and community centred ways of working.

Based on evidence; built around people and places; supported by systems

Our model is built around three components.

Firstly, the model is ***Informed by Evidence and Local Conversations***. This highlights the importance of having a firm evidence base for our work, but at the same time, affirms the key role that communities play in supporting its own citizens, and the significant improvements in health and wellbeing outcomes that can result from involving communities more in decisions that affect them. The aim is to ensure that 'No decision about me, without me' is a central tenet of this work, and that the emphasis is shifted to one where people are asked, 'What matters to you?', rather than 'What is the matter with you?'.

Secondly, this approach has ***'people and place'*** at its heart. Working with communities, building on the assets of those communities, supporting the positive development of the neighbourhoods that people live in, and fostering the resilience and empowerment of those communities through the support offered to everyone, and importantly to those who are most vulnerable. Such communities include groups of people that are linked by geography and place, but also groups that may be linked by characteristics such as being Lesbian, Gay, Bisexual or Transgender.

The final component highlights the importance of ***'supporting systems'***. Ensuring that this Approach to Wellbeing is supported through alignment of activities across agencies and sectors; that services are commissioned and delivered in a way that is collaborative and supportive; and that for those who require more formal interventions and perhaps NHS treatment, are offered a person-centred approach with interventions that are empowering rather than stigmatising.

Our actions need to be informed by local conversations with people and communities, using their knowledge, and learning from their experience. It is important that conversations are held with communities about what is important to them and in doing so, recognising that this model must be a dynamic one, adapting, changing and being shaped over time by County Durham residents.

Our Principles

The three components of this Approach to Wellbeing are underpinned by a set of six principles. These have been derived from the evidence base and then further informed by conversations with partners on the Resilient Communities Group.

People and Places

Principle 1. Working with communities, supporting their development and empowerment

Communities have a vital contribution to make to health and wellbeing. Community life, social connections and having a voice in local decisions are all factors that underpin good health and there is a growing body of evidence that supports community engagement as a strategy for health improvement.[9]

The neighbourhoods where people live, work, play and have a sense of belonging to are also important. The design of a neighbourhood can contribute to the health and well-being of the people living there. Several aspects of neighbourhood design (walkability and mixed land use) can also maximise opportunities for social engagement and active travel. Neighbourhood design can impact on our day-to-day decisions and therefore have a significant role in shaping our behaviours. Other positive aspects of a neighbourhood are: feelings of safety, having places to meet people, a sense of belonging and a sense of control and thriving communities. These community/people aspects of a place are important health promoting components.

Working with communities and handing over power (also called **devolution of power**) and decisions from statutory agencies enables people to gain a sense of control over their lives. This can happen at an individual level through the development of personal skills and self-confidence, but also at a community level as people work collectively to shape the decisions that influence their lives and health. The approach can also lead to the development of **social capital**; the bonds that link people together (families, friends and neighbours), enabling a shared sense of identity which can then in turn provide help and support emotionally, socially and economically when needed.

The Due North report summed this up in the following way:

> *"…community empowerment initiatives can produce positive outcomes for the individuals directly involved including: improved health, self-efficacy, self-esteem, social networks, community cohesion and improved access to education leading to increased skills and paid employment. Evidence from the 65 most deprived local authorities in England shows that, as the proportion of the population reporting that they can influence decisions in their local area increases, the average level of premature mortality and prevalence of mental illness in the area declines."* [10]

In order to achieve this, our work with communities means identifying priorities by focusing on the things that truly matter to them. As well as sharing power, it involves sharing knowledge; ensuring a full understanding of local issues and the

[9] National Institute for Health and Clinical Excellence. Community engagement to improve health. London: NICE, 2008.
[10] https://www.gmcvo.org.uk/system/files/Due-North-Report-of-the-Inquiry-on-Health-Equity-in-the-North-final.pdf

barriers to change so that informed decisions can be made. In sharing decision-making, it means supporting the development of their leadership role. Throughout our work, it is also important that ways are developed to reach out and seek those voices that aren't ordinarily heard.

Next steps

- Continually build and develop this approach by identifying which communities to begin to work with and how. This could include place based communities or communities of interest.
- Share these ideas and this approach to wellbeing, and begin conversations with communities on whether or not this feels the right approach for them, including how they can be supported in the development of their leadership role and in determining priorities for the future.

Principle 2. Acknowledge the differing needs of communities as well as the potential of their assets

Every Local Authority is required to undertake what is called a **Joint Strategic Needs Assessment** (JSNA). This is a process through which a comprehensive picture of current and future health and wellbeing needs for the area is formed and then used to inform decisions for the planning and improvement of local services with the aim of improving health and wellbeing in our communities.

Traditionally, JSNAs have adopted what is described as a **'deficit model'** of health and wellbeing, focusing on problems, needs and deficiencies in communities such as deprivation, illness and death. Whilst it is important that we continue to understand population health and wellbeing needs and health inequalities, it is also important to understand the **assets** (or strengths) in a community and work has begun to ensure the JSNA does this.

Whilst many people think of assets as being about buildings and services, assets also include people and their skills, social groups and networks, activities and spaces. For those who are facing challenges to their wellbeing, it can be just as important for them to be able to find the right person to talk to and to make a connection across their community, than it is for them to be offered a 'service'.

Assets may also be **'place-based'** and relate to our sense of belonging within a community, our cultural heritage, and the environment we live in. This may include, for example, the opportunities we have for good employment and education, our access to rail networks and transport to enable us to get to work or visit our families and friends, our leisure facilities and green space, and whether or not we live in areas that are safe and free from fear of crime.

Assets will differ from community to community, and each community, having different needs and assets, will find different solutions to the issues facing them. Mapping of assets and working to mobilise them for the good of the community means also looking at what already exists and then establishing what are the

gaps where further development is needed. This also means statutory agencies moving away from the idea that one solution fits all.

Next steps

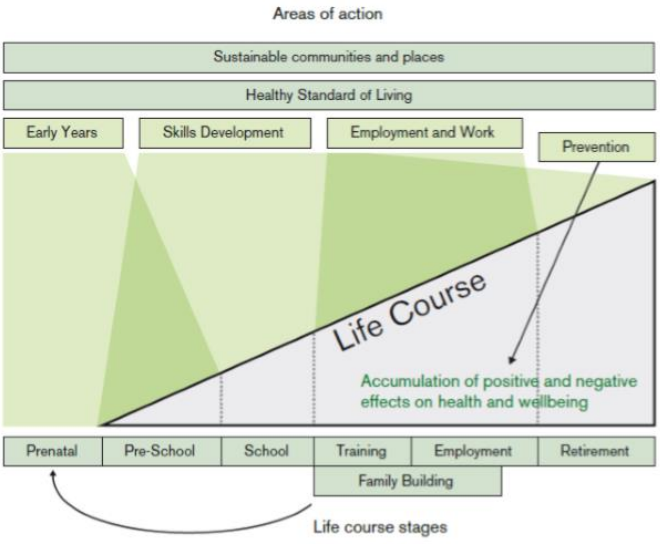
- Continue to develop the JSNA so it becomes more asset focused and place based.
- Share insights from the JSNA with communities to enable them to make informed decisions about the future.
- Pool information across partners on the assets and asset mapping that is currently known and then work with communities to enhance this.

Principle 3. Focus activities to support the most disadvantaged and vulnerable, helping to build their resilience

Some people living in our communities can face challenges and disadvantages, simply because of where they were born and raised. This may mean fewer opportunities being available to them as they grow and mature into adult life which can result in differences in their health and wellbeing compared to those born into more affluent families. Such differences are called **health inequalities**.

These inequalities and disadvantage can accumulate throughout life. For example, a child who suffers poor health and misses school, may leave school with fewer qualifications and therefore fewer job prospects. This accumulation of disadvantage emphasises the need to take action as early as possible in childhood and even before birth. This early intervention is key to breaking the cycle of health inequalities some of our communities face and is described as taking a **life course approach**[11]**.**

Marmot Review: Action across the life course model



[11] Fair Society, Healthy Lives. The Marmot review. Strategic Review of Health Inequalities in England post-2010.

Our approach to wellbeing will take these factors into consideration, focusing our activities where they can help support the most vulnerable and those at greatest risk of poor health, whilst helping to build both individual and community resilience. These activities will take place across a range of settings – in schools, workplaces, different types of communities, and at all stages of the life course.

Continued inequalities undermine resilience, however, reducing inequalities and the hardships people face can strengthen their ability to cope. Set alongside the building of social capital and the identification and use of local assets, these can work to build **resilience** to handle future challenges.

Next Steps

- Work with communities to identify those groups that are most vulnerable and consider actions that could support them.
- Review services and assets already available against those that it is felt are needed, and identify gaps where assets need to be mobilised, increased or commissioned.

Supporting Systems

Principle 4. Align our related strategies, policies and activities to reduce duplication and ensure greater impact

It is important that our wellbeing approach is aligned with, as well as supported by, other **strategies.** By doing so, we will ensure the support of key leaders who can influence and encourage its use, as well as a higher concentration and consistency of effort, resulting in a greater chance in achieving our goals and outcomes. The County Durham Vision, the Joint Health and Wellbeing Strategy, the Mental Health Strategy and Concordat and the Children and Young People Strategy are key strategies for the convergence of our principles and are also areas where this Approach can offer support.

Using strategy to influence **policy** is important too, so that we should be looking not just at health in all policies, but health and wellbeing in all policies.

Alignment and support for the most vulnerable should also extend beyond strategy and policy, but also in our actions, whether these are in the commissioning of services, the advice we give, the papers we write, and the influence we have on change.

Finally, aligning our **activities** can reduce duplication of effort, for example in reducing the number of strategies we have across partners, or in the number of asset mapping activities that are already done, the output and learning from which could be shared more widely and systematically. Alignment of activities also improves the 'offer' of services to communities. There are lots of services available across County Durham that can offer support for a range of needs. However, we need to ensure that they are responsive, visible, accessible and known to the communities they serve.

Next steps

- Use the outcomes from our discussions with communities to shape this wellbeing approach, as well as our related strategies, policies and activities.
- Consider how this approach to wellbeing can influence the way in which partners can work together with communities and improve the alignment of that work with one another.
- Ensure that the development of all new strategies that have an impact on community and individual wellbeing are aligned with our wellbeing approach.

Principle 5. Develop and deliver services and assets in a way that encourages co-design and co-production with the people who need services and those who provide support

This principle, whilst of relevance to people who commission services, has a far wider scope. Its adoption by those who deliver services too is vital, working with local communities to design those services together.

It should also be adopted by those responsible for the development of place-based assets such as the homes we live in, the parks that we walk and play in, the schools and libraries that our children study in and the transport links that maintain our social connections.

Our approach to this principle is underpinned by the concept of ***'Collaborative Commissioning'***. This term describes an approach where,

> *'Rather than being treated as the passive recipients of services designed elsewhere, the people of the community will be the active shapers of their own future, trusted to 'co-design' services, to direct commissioning decisions, and to play their part in making the service work.'*[12]

Collaborative commissioning requires **co-production**; a way of working that involves people, families, carers and communities being engaged and involved at the earliest stages of service design, development and evaluation. It acknowledges that people with 'lived experience' are often best placed to advise on what support and services will make a positive difference to their lives. It puts an end to 'them' and 'us' and instead, people pool different types of knowledge and skills, based on lived experience and professional learning. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.

The VCSE sectors, with their close community connections and position outside of the statutory sector, are important contributors to the co-production of health and care services.

[12] https://www.gov.uk/government/publications/civil-society-strategy-building-a-future-that-works-for-everyone/5-the-public-sector-ensuring-collaborative-commissioning

The concept of collaborative commissioning is in keeping with our ethos of engaging communities, empowering them and working with them to develop an approach to wellbeing. In terms of collaboration, commissioning will be done across organisational silos, engaging the VCSE sectors, as well as public and private sectors, and creating an environment of greater user-led, community–led and staff-led delivery.

Next steps

- Use this wellbeing approach to increase community engagement in the review and co-design of:
  - the services we provide.
  - the services that we commission from others.
  - the assets that we can develop and mobilise.

Principle 6. Make person-centred health and care interventions available, ensuring that they are empowering rather than stigmatising

On those occasions when people need more support than they can get within their communities, they need to feel confident that a referral into health and care services will be safe, of a high quality and person-centred.

Taking a *'whole-system'* approach to the wellbeing of our communities requires coordination and collaboration across a wide variety of sectors. It needs to be consistent and responsive to an individual's needs and to recognise that life circumstances are not static. The need for support can be complex and changing whether an individual experiences a single acute episode of ill health, or requires ongoing support for a longer term condition.

NHS policy is being refocused to enable people to have greater control over their own health and the care they receive[13]. It also recognises the role played by community staff to help people stay independent for longer; and the need for greater collaboration so that individuals, health and social care services, and national and local governments work together, alongside communities and employers, to remove barriers to healthy lives.

NHS organisations are also working with their local partners, as 'Integrated Care Systems', to plan and deliver services, and develop strategies to meet the needs of their communities. The principles in this Wellbeing approach can help to guide the development of such strategies including the introduction of social interventions and other programmes of work with the intention of preventing ill health. It will also encourage greater supported self-management and shared decision making. [14]

[13] https://www.england.nhs.uk/long-term-plan/

[14] https://www.gov.uk/government/publications/prevention-is-better-than-cure-our-vision-to-help-you-live-well-for-longer

Too often, people receiving health care can feel disempowered through the relationships they have with the professionals involved in their care and in some case stigmatised by the type of treatment they may receive. It is important that professionals working in the health and care system use person-centred interventions, ensuring that the language they use and the actions they take empower people, rather than disempower them. It is also important that we all work together to remove the stigma that is associated with some forms of health care intervention such as treatment for people who may be obese or experience mental health issues.

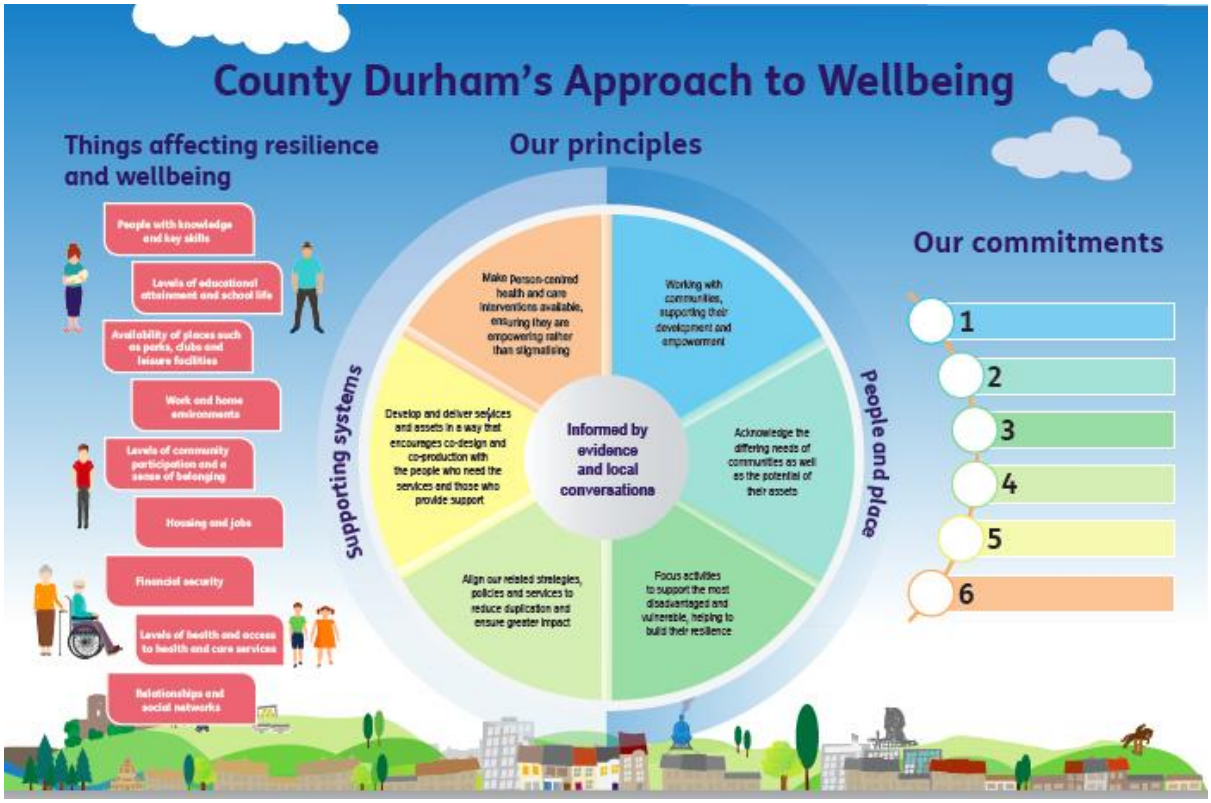
Next Steps

- Use this wellbeing approach to review and explore current and potential care and support pathways

The Wellbeing Model

The Wellbeing Model brings together all of elements into a single graphic highlighting the things that affect resilience and wellbeing, the evidence based that underpins this work and the six principles guiding our proposed actions.

The final section of the Wellbeing Model also refers to 'Your Commitments' and has been left blank. This section is intended to act as a starting point for discussions across partnerships, organisations and teams about the commitments they can make to support delivery of the model.



Implementing our Wellbeing Approach

A number of next steps are suggested throughout this document as a means of taking forward this Approach to Wellbeing. In summary they include:

- Continually building and developing this approach by identifying which communities to begin to work with and how. This could include place based communities or communities of interest.
- Sharing the ideas and approach to wellbeing contained in this document, to begin conversations with communities on whether or not this feels the right approach for them including how they can be supported in the development of their leadership role, and in determining priorities for the future.
- Continue to develop the JSNA so it becomes more asset focused and place based.
- Sharing insights from the County Durham JSNA with communities to enable them to make informed decisions about the future
- Pooling information across partners on the assets and asset mapping that is currently known and then working with communities to enhance this
- Working with communities to identify those groups that are most vulnerable and consider actions that could support them.
- Reviewing services and assets already available, against those that communities feel are needed, and identifying gaps where assets need to be mobilised, increased or commissioned.
- Use the outcomes from our discussions with communities to shape this wellbeing approach, as well as our related strategies, policies and activities.
- Considering how this approach to wellbeing can influence the way in which partners can work together with communities and improve the alignment of that work with one another.
- Ensuring that the development of all new strategies that have an impact on community and individual wellbeing are aligned with this approach to wellbeing.
- Use this wellbeing approach to increase community engagement in the review and co-design of:
    - the services we provide.
    - the services that we commission from others.
    - the assets that we can develop and mobilise.
- Using this wellbeing approach to review and explore current and potential care and support pathways.

It will also be important to measure the impact of adopting this approach over time. This can be done in a number of ways including the use of data that is already collected nationally to measure wellbeing and is part of routine ‘performance monitoring’. However, it is important to also measure the impact of this approach on those communities it is intended to support, gaining insight and feedback through local conversations and ensuring a dynamic approach to implementing this approach.

Making Commitments to Deliver Community Wellbeing

If this approach is to succeed, its implementation requires the support and commitment from partners working across all sectors and agencies. Each has a role to play in engaging and empowering communities, using the approach outlined in this document and aligning their activities with others, leading to greater gain. It is therefore important that the content of this document is shared widely, consulted upon and 'owned' by everyone across the County Durham Partnership. It will then be incumbent on each partner to support the *Principles for Wellbeing*, making organisational and personal commitments to help deliver the proposed actions.

These principles may also provide a starting point for conversations with communities themselves. Conversations that explore the value and appropriateness of this model itself, the needs and assets of each community, the identification of local priorities for action, and the support that can be offered by statutory and VCSE sectors. Working together to design solutions that are owned by communities themselves will create the environment for a lasting legacy of wellbeing in County Durham.