An Evaluation of the County Durham Approach to Wellbeing

Introduction

Wellbeing is a broad concept, with often no clear definition of what it is. It has been defined by a UK government project as 'a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community' (Foresight Mental Capital and Wellbeing Project, 2008, p.10). Wellbeing is thought to have an objective component, involving the material and social factors that impact on quality of life, and a subjective component, relating to how people feel and function (Western and Tomaszewski, 2016). Circumstances that are believed to improve wellbeing include: good physical, mental and social health; financial and personal security; rewarding employment; inclusive communities; and attractive environments (DEFRA, 2011, Michaelson et al., 2012). Wellbeing helps to promote health by helping multiple biological systems run effectively (Ryff et al., 2004). A high level of wellbeing can increase resistance to illness, speed up physiological recovery, increase survival rates, with low wellbeing associated with slower wound healing (Cohen et al., 2003, J-E De Neve et al., 2013, Kiecolt-Glaser et al., 1995, Lamers et al., 2012).

Internationally, there has been an increasing recognition of the need to develop a broad and inclusive set of wellbeing indicators, and that a nation's welfare should not be measured simply by their economic growth (ONS, 2014, Miles et al., 2008, Stiglitz et al., 2009). More recently, in May 2019, New Zealand declared itself the first country in the world to measure its success by its people's wellbeing. Their entire Treasury budget is now built around a series of wellbeing priorities: mental health, child wellbeing, supporting Maori populations, building a productive nation, transforming the economy, and a supporting capital investment programme (Anderson and Mossialos, 2019).

National Context

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. The National Wellbeing Programme was launched in the UK in 2010, driven, in part, by the demand for subjective wellbeing measures to be used in policy-making processes (Hicks et al., 2013). According to the Office for National Statistics (ONS), 'Wider and systematic consideration of well-being has the potential to lead to better decisions by government, markets and the public and, as such, better outcomes' (ONS,

2013). 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. 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 (The All Party Parliamentary Group on Wellbeing Economics, 2019).

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 (Ward, 2019). In purely economic terms, it is responsible for levels of productivity, benefit dependence and absenteeism. The World Health Organization defines positive mental health as *'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'* (World Health Organization, 2001). Or simply, described as *how satisfied we are with our lives*. This can then impact on a person's physical or mental health.

Wellbeing in Durham

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, Durham 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.

For example, alcohol related deaths are increasing, with 23.3% of adults in Durham (21.9% in England) reporting levels of high anxiety (Durham Insight, 2022). Nearly 80,000 people in the county have a common mental health disorder and it is estimated, that 1 in 10 children have a mental health disorder (Durham Insight Mental Health Infographic, 2022). Finally, healthy life expectancy (the years we can expect to live in good health) is only 58.3 years for women in Durham (63.5 in England), and 59.6 years for men (63.2 in England) (Public Health England Fingertips Profile, 2022).

Taken together, these figures highlight the fact that there is more to 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 economic and inclusive growth. This will also support the County Durham Vision of More and Better Jobs, Long and Independent Lives and Connected Communities.

Background and evolution of the Approach to Wellbeing (A2WB) model

In 2019, County Durham developed an Approach to Wellbeing (A2WB) that was an asset-based model intended to engage communities and encourage devolution of power to them, alongside increasing shared decision making. The Approach built on the success of Area Action Partnerships (AAPs) and their long-established work with communities across County Durham.

The principles of the A2WB model were developed as part of an iterative process engaging members of the Resilient Communities Group, the Mental Health Strategic Partnership Board, the Public Health Team, the Mental Health Stakeholder Forum and teams within Durham County Council and the NHS.

The original model was perceived by some partners as being 'difficult' to understand and was viewed as 'quite high level'. It was seen as being theoretical and conceptual rather than being of practical use. This resulted in two further strand of work. Firstly the development a new, simpler, one page 'Soundbites' model; and secondly an 'audit' tool that would enable people to put the principles into practice. This resulted in the development of the Self-Assessment Framework which began to be utilised by Council teams and other external partners.

Such changes addressed the identified gap between academic theory and practice.

Aims and Objectives of the Evaluation

The primary aim of this study was to evaluate the implementation of the County Durham A2WB. The evaluation was intended to take place in three phases with associated objectives as follows:

Phase 1: A retrospective review of early adopters in order to:

- Explore the reasons why some teams adopted the use of the Wellbeing principles at an early stage to influence their work.
- Consider what barriers there may be to others adopting the Wellbeing approach and how those barriers could be lifted.
- Determine whether the use of the wellbeing principles has been helpful in framing future and more long term intentions of use.

Phase 2: A contemporaneous chronicle of activities pertaining to community engagement, including testing, further development and refinement of the wellbeing principles, alongside the co-production of the evaluation objectives themselves. Including:

- Identifying specific communities of interest.
- Reviewing the method of community engagement used.
- Exploring the extent to which solutions to issues affecting communities have been co-produced.
- Identifying examples of power being devolved to communities.

Phase 3: To examine essential factors pertaining to future internal evaluation of the adoption, impact of the adoption, and implementation of the wellbeing approach across relevant County Durham organisations, as well as development of a recommendation of a feasible model for how this may be achieved. This stage includes:

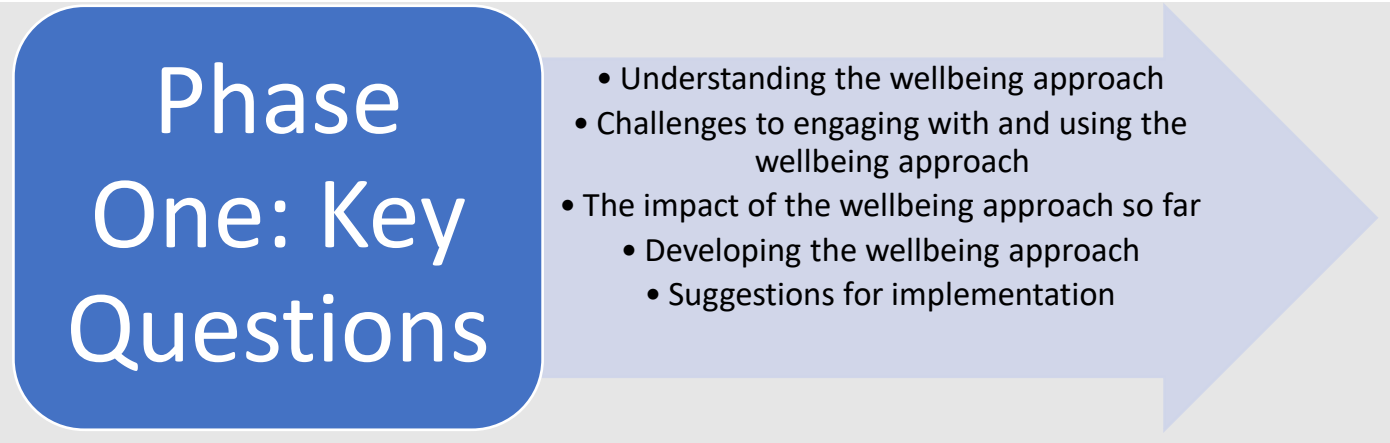
- Which measures of wellbeing will be taken as constitutive of success when gauging outcomes from the approach to wellbeing?
- Where will responsibility for future evaluation lie, and how will continuation of evaluative measures be ensured in future?
- How can the wellbeing approach itself be at the heart of future evaluation?

Each phase comprised key questions and areas for investigation as well as findings and recommendations.

The report is structured to provide summaries of each of the phases, with full reports of each phase captured in the appendices.

Phase One - Early Adopter Focus Groups and Interviews

"It's very difficult sometimes to get colleagues to understand that their bit of the business impacts on the wellbeing of the population when actually all of our business impacts on the wellbeing of the population".



The full report for Phase 1 is captured as Appendix 1. Two focus groups and two interviews with early adopters of the approach took place remotely via Microsoft Teams. Thematic analysis revealed the following as significant themes pertaining to the approach to wellbeing.

Understanding the approach

It was clear that the participants had an understanding of the A2WB, and an understanding of why it was developed. It was felt that departments within DCC were already trying to deliver on a similar agenda, and so it made sense to try and develop a framework which would capture what was already taking place. However, it was evident that it had taken time for some participants to fully understand the approach, and also understand the tool used to measure the approach (the self-assessment framework). Part of that was delving into the question, 'What is wellbeing?'

One of the changes that participants hoped that the approach would bring, was the opportunity for the local authority, and wider organisations across County Durham to deliver things differently by giving power back to the people. It was agreed that there would need to be a concerted effort to support managers and clinicians to feel comfortable in letting go of some elements of their work, as well as community members taking more responsibility for their wellbeing. The overall goal being to introduce, develop and finally embed the A2WB so that the approach becomes automatic.

Challenges to engaging with and using the wellbeing approach

There was a belief that some people might think the approach was simply another public health initiative, and that they wouldn't view the approach as

applicable to their area. It was felt that a way to overcome this challenge was to make sure the work was put in now.

At first, the concept of 'community' was difficult for some participants to understand, with regards to thinking of a geographical community rather than a community of interest. There were some participants who didn't struggle with the A2WB and believed that it worked very well for their organisation. The downside was that for larger organisations, the model was seen as trickier to adapt.

It was felt that partners from the commissioning sector might struggle to engage with implementing the A2WB as it represents a move away from measurements and performance based on numbers only. Additionally, the next steps of embedding the A2WB were difficult due to the COVID-19 pandemic. The approach needs time invested in it to understand it, therefore wasn't a priority during 2020. However, for the participants who had provided early feedback, but not had the opportunity to test the principles during COVID-19, there was still a willingness to utilise it moving forward.

Developing the A2WB

As picked up previously in the report, the difficulties in understanding the model were met by public health staff who were keen to listen, learn, and make changes to the model. Changes that have since been made have been well received by those participants who have seen the revision from the original model to the soundbites model. More importantly, it was felt that the changes that the model had undergone were done using a coproduction approach.

It was felt that some of the questions in the principles still might be difficult to understand when engaging at a community level. Re-wording the principles might be necessary. In addition to this, the language used needed to be updated, as there were words that pigeon-holed the A2WB to one sector, rather than cutting across various.

Lastly, future development of the A2WB included adding in an expected timeframe into the self-assessment framework. It was agreed that the framework should be monitored annually, but that this needed to be made clearer. Adding in '*possible next steps and agreed timescales'* at the end of the framework would help to add some accountability, but not be so strict as a Key Performance Indicator.

Suggestions for implementation

Participants felt strongly that for the A2WB to be embedded successfully in their respective departments and organisations, it needed to be driven down from a strategic level.

The timing needed to be right to start introducing the A2WB at the community level. People are working so hard to support their community at the moment, that the approach might not be received positively. An example of engaging at the right time could be to make use of the AAP roadshows, where there could be further work around re-wording the principles. It was felt that the model 'still feels a little too academic'.

With regards to consultation, geography- wise, it was seen as crucial to cover the North, Central, and South of County Durham. This will ensure that rural, urban and semi-rural areas are captured, as they may have differing views. This will also ensure that the consultation is inclusive, giving an opportunity for all to engage.

Finally, it was agreed that a key aspect in rolling the A2WB out was for partners, stakeholders, organisations and services to see what was in it for them. How could the A2WB add value to the work that they carry out; their ambition, aims and objectives.

The themes from the first phase of data collection have been used to help inform phase two of the evaluation with the COVID-19 Champions and will help to triangulate findings in the final report.

Phase One Conclusions

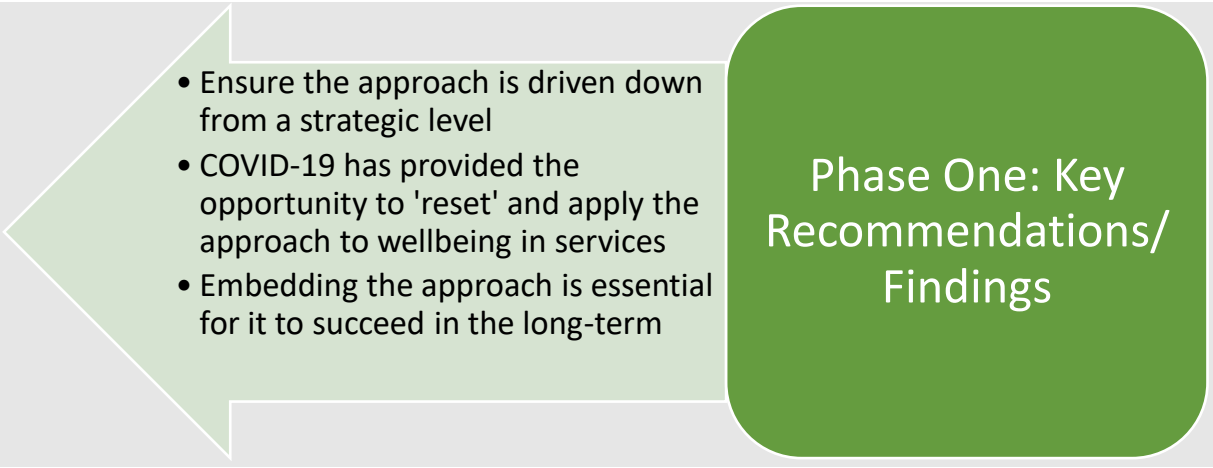
The findings from phase one indicated that the A2WB that was being offered across County Durham was understood by members of the steering group as well as partners who were early adopters of the approach. There was an understanding of why it had been developed, although this took time for some participants to fully understand the approach. However, it was agreed that there were still changes to make. Participants in the focus groups and interviews felt that there were a number of challenges to the implementation and embedment of the approach. These included the A2WB being viewed as only a public health initiative, rather than cutting across different sectors; the model potentially still appearing too academic; communities being viewed in a geographical sense, rather than communities of interest; COVID-19 impacting on the speed of roll-out, due to staff pressures and furloughed staff; and the commissioning process becoming more comfortable with outcomes rather than just numbers.

Examples of the positive impact of the A2WB included: partners thinking about what their service was providing in terms of empowering communities to improve their wellbeing; improved accountability; providing a framework to demonstrate added value and providing an opportunity to showcase their work. The development of the model was respected, due to the nature of public health staff listening to feedback and coproducing any changes. To help improve and develop the approach further, it was suggested that revisions might be required

to then introduce the model at a community level, as well as ensuring the language used didn't exclude a particular sector, i.e. the A2WB can be used in multiple sectors.

Finally, suggestions for the future implementation of the A2WB included: ensuring that the approach was driven down from a strategic level; working to introduce the approach to communities at the right time, due to COVID-19 fatigue; ensuring that engagement and consultation was inclusive; providing plenty of practical examples of how to use the A2WB principles and framework; and emphasising the added value that the A2WB can bring to an organisation.

These initial findings were utilised to drive the next stage of data collection and analysis and informed a number of recommendations for the next stage. It was suggested that the soundbites model be developed with a community of interest, using a good geographical spread of County Durham, for roll out at a community level; the language of both the soundbites and the model needs to be considered so that terminology is understand by all; the framework and model needs to be driven from the top, so that staff have the necessary directive within their workload; the framework and model need to be presented for various perspectives, not just a public health angle; there is the potential to add a section at the end of the self-assessment framework, which measures outcomes; and finally, worked, practical examples are needed, which show how other sectors and organisations have applied principles and framework to their service area.



Changes to the Evaluation during 2020

The first version of the A2WB evaluation protocol only had three phases: 1) early adopter interviews, 2) exploration of community engagement, and 3) looking at the longer-term impact of the introduction of the A2WB on the health and wellbeing of local communities. The A2W steering group were involved in developing phase one, with phase two and three being further defined and shaped by the Steering Group after the analysis of phase one.

As a result of the COVID-19 pandemic, the evaluation protocol was revised to capture the experiences of those responding to COVID-19, whilst at the same time exploring the use of the A2W principles. This resulted in the inclusion of an additional phase within the evaluation in the form of a case study, which was intended to capture learning that had taken place with regard to the assimilation of the A2W principles as part of the COVID response. The evaluation phases were therefore revised to the following:

Phase 1: A retrospective review of early adopters

Case Study: Using the A2WB within the COVID-19 Community Hubs

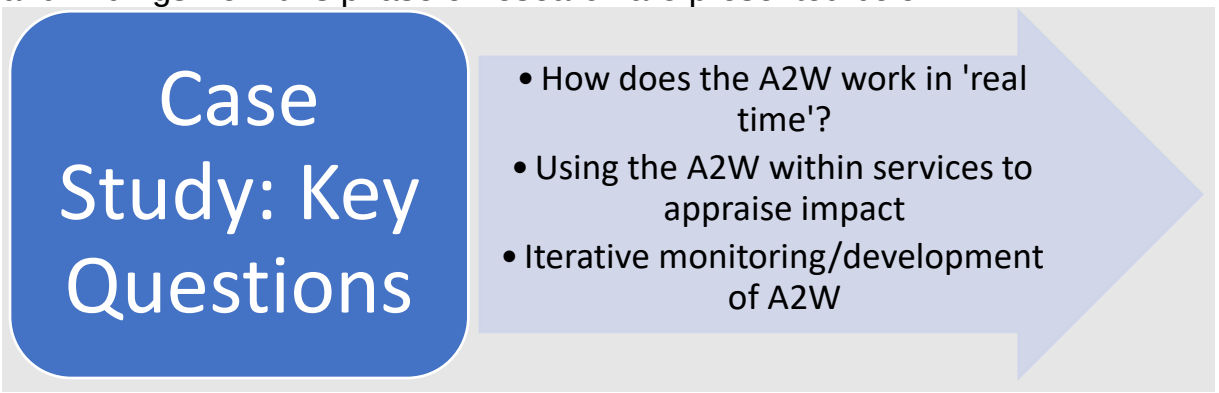
Phase 2: A contemporaneous chronicle of activities pertaining to community engagement, including testing, further development and refinement of the wellbeing principles, alongside the co-production of the evaluation objectives themselves. Including:

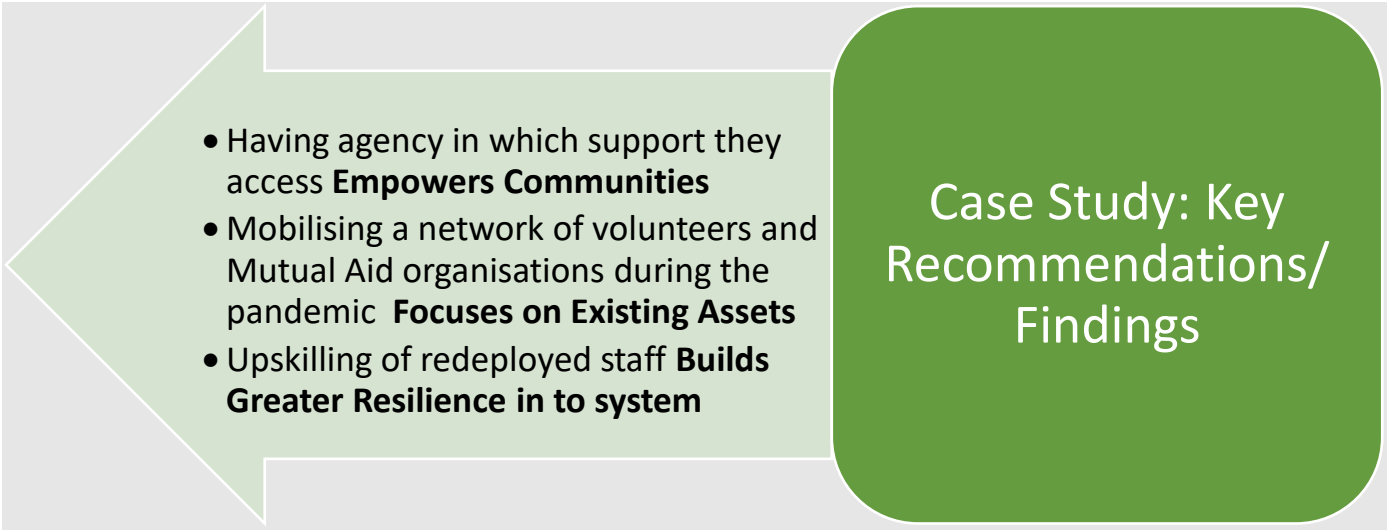
Phase 3: To examine essential factors pertaining to future internal evaluation of the adoption, impact of the adoption, and implementation of the wellbeing approach across relevant County Durham organisations, as well as development of a recommendation of a feasible model for how this may be achieved.

Case Study on the use of the approach in the development of the Community Hubs in response to the Covid-19 pandemic.

The community hub concept (which later became known as the County Durham Together Hub) was introduced in March 2019 as a suggested response to the Covid-19 pandemic to support residents to be able to access information around Covid-19 and initially to support around food poverty and hardship. This case study was designed to appraise the impact of the approach to wellbeing and its application to provide a real-time evaluation of the approach to wellbeing in a fast-moving service.

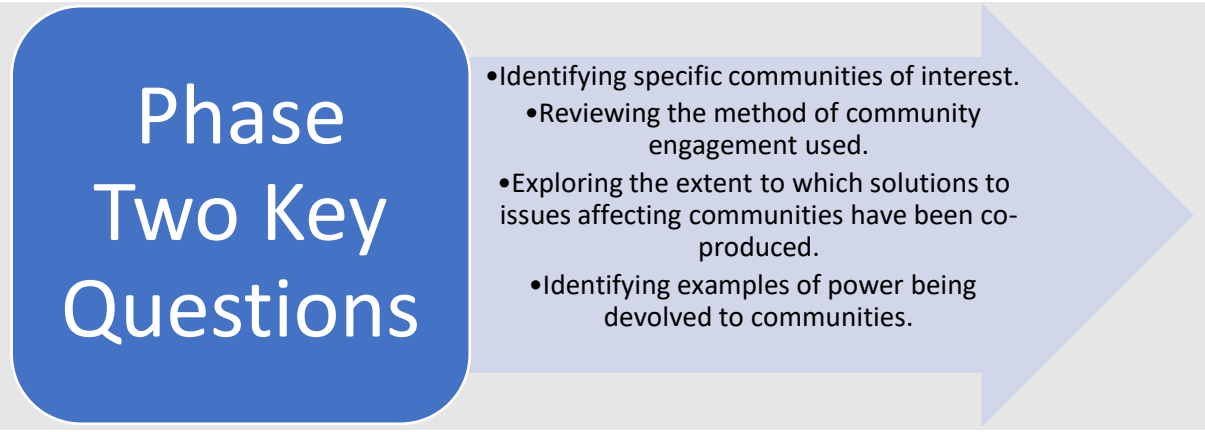
Full details of the case study can be found in *Appendix b.* The key questions and findings from this phase of research are presented below:





Phase Two Methods – A contemporaneous chronicle of activities pertaining to community engagement, working with a community of interest COVID-19 'Champions'

"It just brings us closer to actually building on the thoughts of the community and how they feel things should go…It's using that to make real decision-making changes. That's where I'm coming from, I think."



The full report for Phase 2 is captured as Appendix 3. One focus group with COVID Champions and 2 1:1 interviews took place remotely via Microsoft Teams in addition to 5 completed questionnaires being returned to the research team. Combining these and subjecting both written responses and transcripts to thematic analysis revealed the following as significant themes pertaining to the approach to wellbeing.

Purpose and scope:

One notion to which each respondent returned over the course of interviews, focus groups and questionnaires was that of the purpose of the wellbeing approach (and by extension so too its scope). What is the wellbeing approach there *for? Who* is it there for?

For many, the response to these two questions was simple: the approach to wellbeing was a way to ensure that the voice of the community was at the forefront of their role. There was also the feeling that the principle of consultation and empowerment was something that should apply to them (and other staff within DCC) as much as it did with communities themselves.

This would, it was suggested, not only improve the wellbeing of staff and volunteers but would also allow greater efficiency within the authority as it would eradicate the duplication of work or the need for central 'fact-finding' about needs within certain areas, as those working and living within communities would already have this knowledge at their disposal.

One participant suggested that they felt that their primary function as a COVID-19 champion was to act as a conduit for both the local community *and* the local authority putting one in touch with the other, and signposting communities to services.

For others, their role as COVID-19 Champions allowed them to directly contribute in ways that were not so tangible, but were no less important to community engagement and the wellbeing of people within those communities through simply listening to what people had to say.

Adherence:

A key feature of questionnaires, focus groups and interviews was finding out to what extent COVID-19 champions (and the network in general) were following the wellbeing principles and how much their everyday activities were guided by the principles. Perhaps unsurprisingly, the wellbeing principles, and their use, were not something of which the COVID-19 Champions were explicitly aware.

The conscious effort to keep the principles in mind was much more apparent for those who interacted with the approach to wellbeing in a strategic manner, in line with the other aspects of their roles. Again, perhaps unsurprisingly, the way in which they interacted with the wellbeing approach was directly linked to the way in which they interacted with their role overall and reflected those things which were important within that role. As someone for whom one of the primary concerns of their role was evaluating and providing evidence, the participant below understood the approach to wellbeing and its constitutive principles in these terms.

Although the principles as such may not have been at the forefront of the COVID-19 Champions' minds, that was not to say that they were not being upheld in the way(s) in which they interacted with the communities they worked with, and both the focus group and questionnaires showed this. Some examples from both are included below to give a greater idea of this phenomenon, as well as those areas that the COVID-19 champs felt greater improvements could be made, mapped against each of the wellbeing principles.

Embedding the Approach:

Although many of the principles of the wellbeing approach were being fulfilled by their actions, this was not something that they were explicitly aware of. Furthermore, there were areas in which they highlighted certain areas in which they felt the programme, and DCC as a whole, needed to do more. One particular challenge that was highlighted throughout both focus groups and questionnaires, was the inconsistent nature of just how invested people were

in delivering the services that were representative of the approach (and thus the approach itself).

One of the greatest challenges that was identified at all levels was trying to ensure that the principles made sense to those that were expected to use them to guide their everyday working.

The key message being shared was that embedding the approach to wellbeing at all levels was the thing which needed greatest investment from all levels of the local authority, but particularly those at executive or strategic level, in order to ensure that the approach to wellbeing and its principles permeated every aspect of DCC. How this embedding was to take place, and how best to ensure its success was largely dependent on the nature of the role to which the principles were being applied. For those in largely strategic roles, treating the approach to wellbeing in terms of engaging directly with the high-level principles that underpinned it yielded positive results.

However, in discussions with all participants (and as can be seen in the previous section) it emerged that the Self-Assessment Framework may not be the best way of evaluating the performance of COVID-19 Champions (and thus by extension other delivery-focused roles) against the approach to wellbeing, because, quite simply, the feeling was that the way in which they were currently presented (soundbites model) was too abstract, and too 'high level' to be of practical use to them in their roles:

Fundamentally, the successful integration of the wellbeing approach to the COVID-19 Champions role was seen to rely upon being able to embed it within the role itself which in turn relied on communicating the approach in a way that made sense. In this regard, particular training around the principles as a standalone concept (albeit one in which it's importance to their role was stressed) may not have been the best way to ensure this was something that stayed with those who participated. During discussions with the research team, participants from the Champions network did not remember a great deal about the training they had undergone, nor did they have a particular recollection of the wellbeing principles themselves. But, as we have also seen, these facts did not in large part hinder their adherence to those principles, even if they were not necessarily aware of it. One participant put it thus:

As well as making sure the approach to wellbeing was put at the heart of everything the COVID-19 Champions did from the outset, the way in which this was done, and the language used was seen as being of paramount importance:

Phase Two Conclusion:

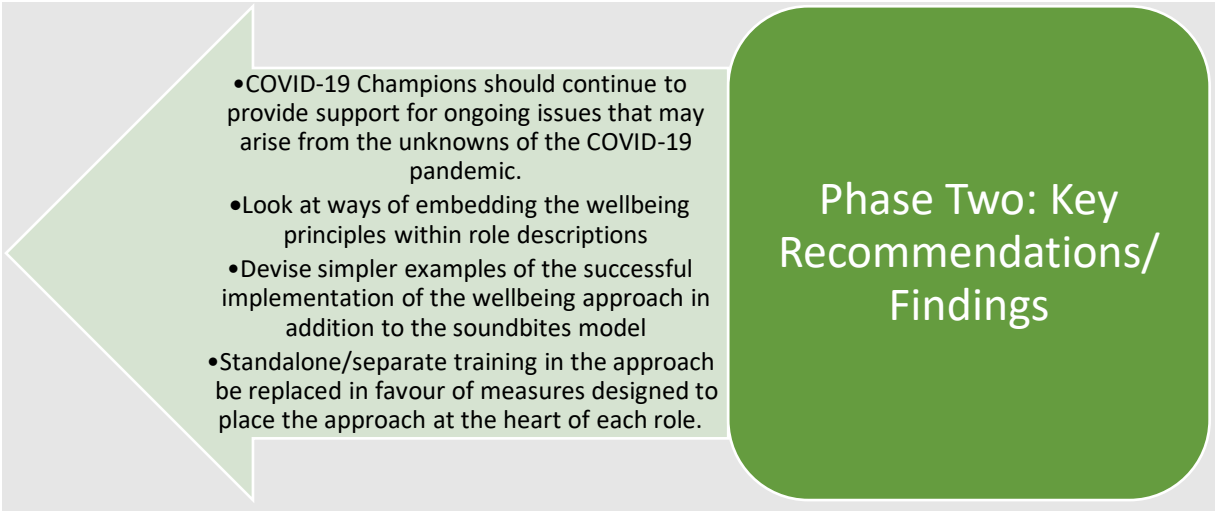
After engaging with all participants throughout phase two of the evaluation, it is clear that there is a general commitment to see the aims of the wellbeing approach realised within the interactions that COVID-19 Champions have with the communities they serve. What is also clear however is that if this is to be set up and meaningfully continued in the future, then there is a need to translate the approach and its principles from their current state into a more practical form.

Part of making the approach less unwieldy may also lie in some of the specific issues that COVID-19 Champions encountered in their role. One of the greatest challenges relayed by the COVID-19 Champions was in engaging some marginalised communities A particular difficulty in this regard revolved around the trust that members of such communities were prepared to place in individuals that were seen as from communities very much separate from their own.

As well as utilising existing groups and channels of communication and community-based assets, another suggestion for how to engage marginalised groups was to attempt to recruit individuals who would be regarded as part of a community rather an outsider to it.

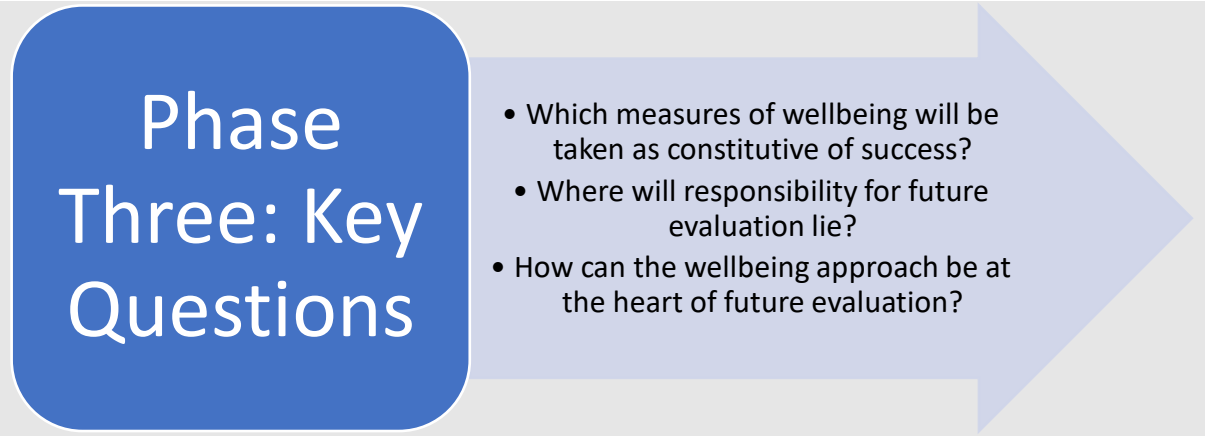
The potential of the COVID-19 Champions to diversify and potentially even repurpose their role into more generalised areas of community support must be tempered by stressing the importance of communicating the approach to wellbeing properly to its success. This communication potentially needs to be better across the county because gaps have been identified.

One of the challenges of expanding the COVID-19 Champions network (raised by the COVID-19 Champions themselves) lay in ensuring that access to the programme and its benefits was open to all, and not just in areas where enthusiasm was high. Rural or geographically isolated areas were identified as a specific setting in which this needed to be addressed.


•COVID-19 Champions should continue to provide support for ongoing issues that may arise from the unknowns of the COVID-19 pandemic.
•Look at ways of embedding the wellbeing principles within role descriptions
•Devise simpler examples of the successful implementation of the wellbeing approach in addition to the soundbites model
•Standalone/separate training in the approach be replaced in favour of measures designed to place the approach at the heart of each role.
Phase Two: Key Recommendations/ Findings

Phase Three – To examine essential factors pertaining to future internal evaluation of the adoption and implementation of the wellbeing approach across relevant County Durham organisations

The primary aim of the third and final phase of the evaluation (Appendix 4) was to examine essential factors pertaining to future internal evaluation of the adoption, impact of the adoption, and implementation of the wellbeing approach across relevant County Durham organisations, as well as to develop some recommendations of a feasible model for how this may be achieved.



It was envisaged that answers to the above would culminate in the formulation of a suggested outline or toolkit of how evaluation may be continued in future, the measures that will give the best insight to this, as well as how these can both reflect the values inherent in the approach to wellbeing and enhance their incorporation across DCC.

The value of the Self-Assessment Framework (SAF):

A recurrent theme throughout each stage of the evaluation into the approach to wellbeing has been the positive reaction to the use of the self-assessment framework in appraising the internal adherence to the constitutive principles of the approach. The SAF has allowed individuals to take stock of their practice and evaluate its adherence to the overarching principles which make up the approach to wellbeing.

However, although this proved a valuable tool for those who may have been more familiar with the approach to wellbeing itself, in interviews with COVID champions it emerged that using the SAF (and its corresponding reliance on explicit reference to the principles at the heart of the approach to wellbeing)

was not necessarily something that would be either intuitive or practical, given their focus on delivery and community interaction, rather than planning, management and strategy. As such, a sensible way to tailor the advantages of the SAF – both its reflexive practice in general and the specifics of engaging directly with the principles of the approach to wellbeing – is important in ensuring a whole system approach in future.

In devising a way in which this could be done, consultation was undertaken with a number of key members of staff that would be integral in implementing the approach to wellbeing in future in order to ensure that any recommendations issuing from this phase of the evaluation were practicable (at least in theory) within existing DCC structures.

A need to combine the SAF with other measures to 'situate' the value of the approach to wellbeing within teams and roles is evident. Throughout the different stages of evaluation, and across different iterations of how the core values of the approach could be adopted into practice and delivery, a common issue has been how to bridge the gap from theory to practice. Furthermore, in many cases, even where formalised, 'standalone' training has been well received, the tendency is towards the awareness of this waning over time – which is of course the same with many forms of knowledge (Murre and Dros 2015).

The solution to this issue is to fully embed the approach to wellbeing across the entirety of the DCC system, something which has already been identified and to some extent achieved within certain areas of DCC. Suggestions for how this may be done will be explored below, but the salient thing to note is that it is a combination of the SAF with other measures that are likely to ensure greater assimilation into the wider DCC system and increase the benefits of using the approach. In order to drive this, a culture informed by the wellbeing approach needs to be facilitated and fostered within DCC services.

To increase the extent to which the approach to wellbeing is adopted and used throughout DCC, the suggestion here is that individual services and teams be encouraged both to build the Approach to Wellbeing into routine team meetings and make the Approach to Wellbeing an integral part of development sessions with respective teams.

Embedding the approach to wellbeing via regular team engagement, rather than 'one-off' or formalised training is not the only way to affect the change of culture needed to ensure greater buy-in. Another potential way in which the approach can be at the heart of services is to represent the principles of the approach to wellbeing with within role descriptions and key foci for individual roles. Not only would this firmly state a commitment to the approach at a senior level, it would also give an internal basis upon which to judge how

much the approach is part of an individual's, a team's, or even an entire service's 'everyday business'.

A vital component needed to compliment the self-assessment framework – particularly if the wellbeing approach is to be more widely shared outside of DCC - is to identify a suitable way to gauge the *impact* of the adoption of the approach to wellbeing on the people that interact with DCC across a range of settings. In order to be able to cite the impact of the approach to wellbeing on the population, there is a need to have a corresponding, objective barometer of wellbeing that can be used to verify any changes in overall self-reported wellbeing for anyone interacting with DCC. Any measure used should enable comparison of the general population with those interacting with any services provided by, or on behalf of, DCC. Ideally, such a barometer should also be able to gauge wellbeing at entry to, and exit from, a given service if this is appropriate to the service in question. Using such a measure alongside the existing self-assessment framework will arrive not only at at both internally and externally verified evaluative processes to monitor the impact of the approach to wellbeing but will also allow more outward-looking (and forward-looking) evaluation to allow some measure of intelligence around any tangible impact to using the approach within the community over time.

Following discussions with the Approach to Wellbeing steering group, it was suggested that for any evaluative tool or process to be of practical use in doing so, it must be *FAST: Feasible, Accessible, Standardised,* and *Transferable.*

Feasible:

In order for any measure of wellbeing to be applied as a way of monitoring wellbeing it must first be established that it is something that people, both from a DCC operational perspective and from those who may potentially be surveyed will find it feasible to undertake. As such, any proposed measure should not be overly onerous to either administer/monitor or to fill out in the first place. Specific questions pertaining to feasibility are:

- *Is this measure already used on a significant scale within DCC?*
- *If not, how easy would it be to introduce it?*
- *How likely is it that people will respond?*

Accessible:

Perhaps the most important aspect of any measure of wellbeing, and one that is inextricably bound to the notion of *empowerment* at the heart of the approach to wellbeing itself, is accessibility. Such accessibility primarily rests on how easy it is to actually understand and respond to a questionnaire based on any particular scale. For this reason, the questionnaire itself that is issued as part of any attempt to gauge wellbeing should be worded as simply as possible, and should also avoid any

abstract or high-level concepts within any deliberative process that is asked of respondents.

Specifically, any prospective measure should provide satisfactory answers to the following:

- *Is the language contained in any questionnaire easy to read?*
- *Are the concepts that form the scale simple to understand?*
- *Is it accessible to a range of individuals?*

Standardised:

Having standard measures of wellbeing improves the quality, reliability and validity of any conclusions that are derived from data collected. Subsequently this allows for a greater confidence when using such measures and data in any decision-making process.

Questions pertaining specifically in relation to the standardised nature of any proposed wellbeing measure must be subjected to the following questions

- *Can the measure be used to evaluate the impact of services over time?*
- *Is data generated by the measure reliable and robust?*
- *Is there enough data at present to create a reliable baseline for County Durham?*

Transferable:

- *Can the measure be applied across DCC services, while maintaining suitability to services?*
- *Are the target measures general enough to be used system-wide?*

Appraising current measures:

With help from colleagues from public health, a picture of the types of measure that were currently employed by various services within DCC was gained.

As can be seen in the appendices to this document, there is a vast array of different measures and metrics currently collected across public health in County Durham. Due to the sheer range of these, some of the most prominent measures currently in use were appraised in order to ascertain the relative merits of each. These included:

- WEMWBS/SWEMWBS – a 7/14-point scale to assess mental wellbeing.
- EQ-5D-3L – a 5-item measure of health-related quality of life covering *Mobility, Self-Care, Usual Activities, Pain/discomfort* and *Anxiety/Depression*

- The Outcomes Star – an evaluation tool with the points of the star being ascribed to any intended outcome or measure identified by the user.
- ONS-4 – 4 subjective questions on wellbeing used as part of the ONS Annual Population Survey.

A small internal working group within the Council was established to consider the value of each of these highlighting the advantages and disadvantages associated with each tool. The findings are set out in detail in the Appendix to this document.

As can be seen from the above, the *ONS-4* stands out as being the most suitable option to measure wellbeing across the whole of DCC services. Because of this, suggestions of how this may be introduced are examined below, as are suggestions for how to navigate the issue with the *ONS-4's* readability.

Readability Issues.

The primary issue affecting the introduction of the *ONS-4* wellbeing measure within DCC is its relative difficulty in readability. It is, in its original form (appendix 4) the most complex to read:

While this may not be an issue for some potential participants in any survey, there may be others for who this complexity could be a barrier. In such instances, the *Personal Wellbeing Score* could be an alternative. "The Personal Wellbeing Score (PWS) is based on the Office of National Statistics (ONS) four subjective wellbeing questions (ONS4) and thresholds. PWS is short, easy to use and has the same look and feel as other measures in the same family of measures." (Benson, Sladen et al. 2019).

Perhaps most salient is that the *PWS* can be used in conjunction with the *ONS-4* (thus meaning either can be used) as it uses thresholds that correspond with the *ONS-4.* As can be seen below, the *PWS* is comparable to *SWEMWBS* in terms of readability but has clear advantages in terms of brevity over other standard measures of wellbeing. It also benefits from the widespread robust data of the *ONS-4* discussed above.

For ONS4 life satisfaction, worthwhile and happiness scores, responses 9–10 are grouped as *Very high*, 7–8 as *High*, 5–6 as *Medium* and 0–4 as *Low*. For anxiety scores, responses 6–10 are grouped as *High*, 4–5 as *Medium,* 2–3 as *Low* and 0–1 as *Very low* and correspond to each of the 'emojis' used on the *PWS*.

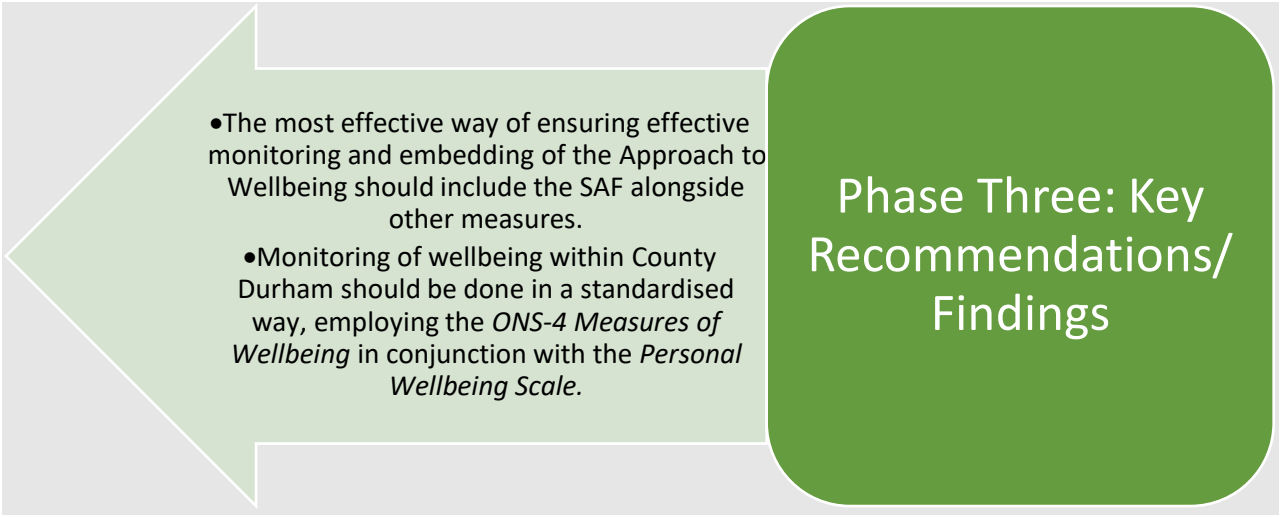
Creating a strong baseline

As previously stated, because the ONS-4 is so widely used, there is a wealth of data already available that can be used to create baselines. This data is taken at a local, regional and national level and has been for over a decade. This data is presented below and gives an insight into the value of the data to produce robust baseline data (appendix 4). A brief look at this data allows for the following conclusions relating to wellbeing in County Durham to be made (since 2011):

- *Life satisfaction in Durham is consistently 'High' and a little higher than national and regional averages.*
- *The feeling that life is worthwhile (Eudaemonic wellbeing) in Durham again is consistently 'High' and a higher than national and regional averages.*
- *Happiness' scores across the county have been considerably less consistent, and in 2012/13 almost dropped from 'High' to 'Medium'.*
- *Regarding anxiety, the picture is changeable. While a significant drop in reported anxiety levels from in 2016/17 may be a surprise, the rise in 2019/20 across all areas is perhaps less so. What is important here however, is that the ONS-4 data has captured this increase in anxiety over this time.*

Using pre-existing data to draw such (quick) conclusions also helps to point to how the *ONS-4/PWS* can be used specifically by DCC to measure the impact of the wellbeing approach. *The first being tracking general changes over time across the whole population via publicly available ONS-4 data, much in the same (albeit more detailed) way to what has been done here.*

Secondly, the *ONS-4/PWS* allows for the monitoring of interim measures which could be undertaken either through DCC commissioned services or by ad-hoc surveys. These could potentially be set against the background of the ONS-4 measurements. This would allow DCC to ascertain whether or not the interventions they are making result in a positive contribution to people's lives. Data collected by DCC in general could be compared to background data, to see if individuals who interact with DCC services experience greater wellbeing and could further be employed to measure and demonstrate the impact of specific services on wellbeing, by asking individuals to report their wellbeing (alongside any other data requested by any such service) at the beginning and then the end of their journey with the service, if applicable.


•The most effective way of ensuring effective monitoring and embedding of the Approach to Wellbeing should include the SAF alongside other measures.
•Monitoring of wellbeing within County Durham should be done in a standardised way, employing the *ONS-4 Measures of Wellbeing* in conjunction with the *Personal Wellbeing Scale.*
Phase Three: Key Recommendations/ Findings

Internal Stocktake – 2 year review

An additional piece of work that is of note, is a 2-year review of the A2W that was undertaken internally by the Public Health Team (appendix 5).

It included an audit of the A2W against guidance published by Public Health England In January 2020, entitled 'Community-centred public health: Taking a whole system approach' (PHE, 2020). The paper was intended to 'summarise the key elements, core values and principles needed to develop whole system approaches to community-centred public health', and also to 'improve the effectiveness and sustainability of action to build healthy communities, whilst embedding community-centred ways of working within whole systems'.

Taken as national guidance on the best approaches to community engagement, it was decided to look at how that guidance could then inform further changes to the Wellbeing Approach.

Whilst the audit found a number of strengths in the Wellbeing Approach, (namely the ease of its practical application due to the development of the soundbites model, and the self-assessment framework), there were some areas where changes could be made to improve the impact of the Wellbeing Approach. This included strengthening the focus around a number of key strategic enablers to support successful implementation. For example, the PHE model emphasised:

1 leadership,

2 building skills across the workforce,

3 the mainstreaming and scaling up of interventions,

4 structured approaches for engaging communities,

5 building capacity within communities and the VCS,

6 setting out long term ambitions with outcome frameworks;

7 and efforts to identify and lay the ground-work for successful whole system working.

Taken alongside the University evaluation at the time, three areas for action stood out, including the need to

a) ensure leadership buy-in,

b) the importance of developing a systematic approach to community engagement, and

c) the importance of mainstreaming the approach.

The Approach to Wellbeing Steering Group therefore reflected on the following questions.

- Has enough been done to secure support for the Wellbeing Approach at senior level within the organisation(s)? Could more be done?
- Have we determined a structured and consistent approach for the way in which we engage communities?
- Do we have a system in place to mainstream and scale up those interventions we know work?
- Could more be done to build skills in community-centred working across the workforce?
- What are we doing to build capacity in communities and ensure our VCS is thriving? Can we do more?
- Have we set out a long-term vision for the Wellbeing Approach? What should that be?
- What outcomes are we working towards? How are we measuring our success?

An action plan containing some practical actions in response to these questions was discussed and approved at the Approach to Wellbeing Steering Group and is included in Appendix 6.

Overarching Conclusions and Recommendations

Having considered each phase of evaluation, including recommendations from the Community Hub (Appendix *(b)*) and Internal Stocktake paper (Appendix 5) the following conclusions have been reached, and recommendations made:

- Feedback from COVID-19 Champions is that they already provide a wealth of information and support across their areas, but there is also the recognition that some areas are less well supported. Rural and geographically isolated areas in particular were identified as those which may need further engagement.
- Trust is key to engaging any community, and we often find it easier to trust individuals that we share common experiences with. Because of this, **it is necessary to recruit as representative a populous of Community Champions as possible. Where there is particularly low engagement from a community, particular effort should be made to reach out and attempt to recruit Champions to aid engagement.** One particular community with whom this may be helpful is amongst those individuals sceptical or unwilling to be vaccinated against COVID-19.
- Although there is a clear commitment at all levels to follow the approach to wellbeing and apply its principles, in practice this can be difficult due to their, sometimes abstract, nature.
- While the Self-Assessment framework and wellbeing principles 'as is' are suitable at strategic level and provide a valuable instrument to guide and review decision-making and performance, these are often too time-consuming or too far removed from everyday practice in delivery settings.
- For this reason, **it is also recommended that dedicated training in the approach to wellbeing be replaced in favour of measures designed to place the approach at the heart of each role. Including these elements in role specifications and key areas of focus will also aid in affecting whole system 'culture shift' towards the wellbeing approach. Appraising key role competencies in a manner that is wellbeing-driven can also be a valuable approach to affecting such culture shift.**
- When dedicated training is delivered, it can sometimes be difficult to transport any learning from this environment to the 'real world'.
- Furthermore, the more time that passes following this training, the more difficult it becomes to recall its content and purpose. Because of this, **a further recommendation is to look at ways of embedding the wellbeing principles within role descriptions and at the heart of team meetings and development sessions.**
- It has been suggested that the communication of the approach to wellbeing may still be too abstract for use in community settings. These examples should illustrate the benefits of the wellbeing approach in relatable ways

but should refrain from doing so in an abstract fashion. Ultimately, any explanation of the approach should make sense to the target audience.

- **A recommendation in this regard** therefore **is to devise a variety of simpler and more instructive examples/case studies of the successful implementation of the wellbeing approach in addition to the soundbites model already developed.**
- It is vital to be able to objectively measure and monitor wellbeing within County Durham over time in order to support the continued application of the approach to wellbeing. **It is recommended that this monitoring of wellbeing within County Durham is done in a standardised, consistent and universal way in order to ensure the greatest benefit.**
- **It is further recommended that this measurement/monitoring use an externally validated, quantifiable measure to maximise how robust any data collected is, strengthening any conclusions drawn from such data.**
- Key factors that should be taken into account with any system employed to collect data for wellbeing purposes (though potentially also applicable to any data collection) is that it is F.A.S.T. (Feasible, Accessible, Standardised and Transferable).
- **It is recommended that the *ONS-4 Measures of Wellbeing* are used (in conjunction with the *Personal Wellbeing Scale*) as these offer the best combination of ease of introduction, brevity, readability and richness of existing data.**
- While it is anticipated that introducing the *ONS-4/PWS* hybrid measure will result in the creation of a robust and instructive dataset in a manageable fashion, this is currently hypothetical. Therefore, **it is recommended that a small-scale pilot be run in which suitable services begin to introduce routine collection of *ONS-4* data to gauge its suitability in real terms.** Because it already uses such data, **including the Social Prescribing Link Worker Service in this pilot is suggested.**

Appendix

Appendix (1):
Phase 1: A retrospective review of early adopters

Introduction to the evidence base

In 2019, County Durham developed an A2WB that was an asset-based model intended to engage communities and encourage devolution of power to them, alongside increasing shared decision making. The Approach built on the success of Area Action Partnerships (AAPs) and their long established work with communities across County Durham.

National Context

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.

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 (1) (mental health, child wellbeing, supporting Maori populations, building a productive nation, transforming the economy, and a supporting capital investment programme).

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 (2).

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 (3). In purely economic terms, it is 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.

Wellbeing in Durham

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, Durham 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.

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.

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

Background and evolution of the A2WB model

The 6 principles of the A2WB model were developed as part of an iterative process engaging members of the Resilient Communities Group, the Mental Health Strategic Partnership Board, the Public Health Team, the Mental Health Stakeholder Forum and teams within Durham County Council and the NHS. Implementation of the model

resulted in two strands of work; the design of a theoretical model (Figure 1), and an ‘audit’ tool that would enable people to put the principles into practice, which resulted in the development of the Self-Assessment Framework (Figure 2).

Figure 1: The original A2WB model, showcasing six principles

Figure 2: The Self-Assessment Framework

People and Place	Supporting Systems
1. Do you work with communities to support their development and empowerment?	4. Are your strategies, policies and services aligned with those of other sectors to ensure waste and duplication are reduced, and ensuring greater impact?
2. How have you acknowledged the differing needs and assets of communities in your day to day work?	5. Are your services co-designed and co-produced with the people who need them, as well as their carers?
3. Do you focus your activities to support the most disadvantaged and vulnerable, helping to build their future resilience?	6. Are your interventions person-centred and do they empower rather than stigmatise?

Through feedback from partners, the theoretical model was developed into a 'Soundbites' model (Figure 3).

Figure 3: Revised A2WB Soundbites model

Methods

Study Design

This evaluation is an implementation evaluation, focussing on participants engaged with the A2WB, using qualitative methods. In the phase one focus groups and

interviews, participants were asked about their experiences of working with the A2WB principles and framework. This has allowed the research team to suggest revisions and potential developments to the approach, based on feedback.

Ethical Approval

Ethical approval from the School of Social Sciences and Law Ethics Committee at Teesside University was given for phase one. Following on from this, approval was received from Durham County Council through their Research and Guidance process (RAG).

Phase One – Early Adopter Focus Groups and Interviews

Interviewees were recruited from the staff that have been involved in developing and using the wellbeing approach and its self-assessment framework. Participants were approached by the public health team and consent sought for their participation. 12 members of DCC staff and external partners were invited to attend a focus group or interview. Those who wished to take part were asked to confirm with the member of the public health team, and a mutually convenient time for the focus group or interview was agreed. Two focus groups and two interviews took place remotely via Microsoft Teams. A topic guide was prepared in advance and covered a range of topics.

The interviews with DCC staff and partners were audio recorded to aid in transcription. Once the transcripts had been completed the data was analysed using applied thematic analysis. Research staff from Teesside University worked in collaboration with public health staff from DCC in the identification and coding of themes. For the purpose of this research an inductive approach to coding was adopted as we were looking for feedback on a service and were not coding the transcripts in line with existing theories.

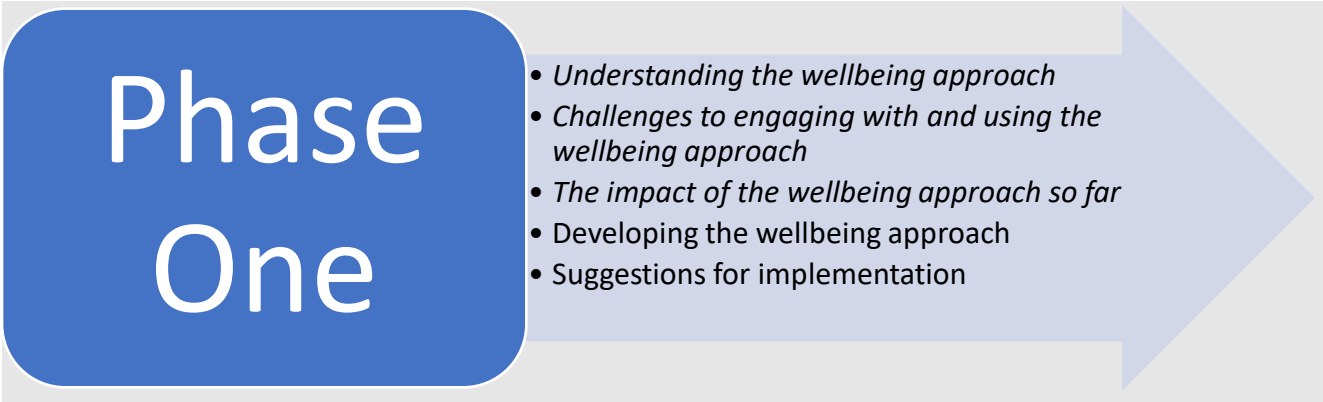
Evaluation progress to date

- Phase one ethics application submitted and approved from Teesside University, and a Research and Guidance (RAG) application submitted and approved from DCC

- Between March and June 2020, discussions with the research team and steering group to adapt the evaluation to incorporate the complexities of COVID-19
- Qualitative data collection for phase one, which involved two focus groups and two interviews with members of the A2WB steering group, and partners who were involved as early adopters of the A2WB (n = 7).
- Brief presented to the steering group to include an additional phase to the evaluation; the case studies
- Initial analysis of phase one data to develop an options appraisal for the steering group for phase three (Appendix 1)
- Phase three ethics application submitted to Teesside University, and conditional approval granted
- RAG application completed, ready to submit to DCC
- Preparatory work for phase three data collection

Qualitative results

Two focus groups and two interviews were held within County Durham. Participants included members of the steering group who have been involved in developing the wellbeing approach, and leads from services within DCC and external partners in the voluntary and community sector who have engaged with the wellbeing approach to date (n = 7). Five major themes have developed from the analysis of the focus groups and interviews relating to:



Understanding the approach

Members from the steering group took part in a focus group. It was clear that the participants had an understanding of the A2WB, and an understanding of why it was developed. It was felt that departments within DCC were already trying to deliver on a similar agenda, and so it made sense to try and develop a framework which would capture what was already taking place:

> *"….it was being done sort of disparately but bringing it together in one approach that we could then apply to other things, I think that's how I would explain it. I think we were all having the same thought processes doing it in our own little places and being brought together as an approach for the whole systems if that makes sense". Participant 2*

There was agreement that there was still a lot of work to do, and that the changes that needed to take place would allow the approach to be delivered system-wide, not just service-wide. One of the changes that participants hoped that the approach would bring, was the opportunity for the local authority, and wider organisations across County Durham to deliver things differently by giving power back to the people; empowering local people:

> *"We have a patriarchal approach where we want to care for everybody we want to do for everybody and we've taken some of that power away from our population and this is this is a way of trying to give a bit of that back like not just to individuals and to the community organisations that work with them". Participant 2*

> *"…..this wellbeing approach could work and would make a difference now….. is very much about giving the power back, or moving the power back out into the community". Participant 1*

In order for this to be achieved, it was agreed that there would need to be a concerted effort to support managers and clinicians to feel comfortable in letting go of some elements of their work. As well as community members taking more responsibility for their wellbeing:

> *"……rather than thinking 'patients' we need to think about 'partners'…. we need people to start to take responsibility for their wellbeing and not be patients themselves but actually be citizens, residents and not just service users but actual genuine partners in their wellbeing". Participant 3*

The overall goal of introducing, developing and then embedding the A2WB is to enable the approach to become automatic. That people don't even realise they are using the approach; that it just happens:

> *"I suppose that's the kind of overall goal isn't it that people don't ever need to see the model people just work in that way because that's the right thing to do and there is that culture and system wide change that means that you don't have to sit down with a set of six principals and say to people this is how you need to be working or this is how you should be working in order to improve the wellbeing, that people just do it". Participant 7*

Early adopters of the approach who took part in interviews and a focus group also had an understanding of the A2WB, but discussed how it had taken time to fully understand the approach, and also understand the tool used to measure the approach (the self-assessment framework). Part of that was delving into the question, '*What is wellbeing?':*

> *"You've got to be got to be careful because this tool is quite vague which is great and it's very freeing and flexible. But it has the potential to get very confusing and messy very quickly……I think that was quite a tricky thing as everybody you know everybody wants people's wellbeing to be good but what do you mean by wellbeing?" Participant 4*

That challenge of understanding the approach is discussed further in the next theme, *'Challenges to engaging with and using the wellbeing approach'.*

Challenges to engaging with and using the wellbeing approach

Participants discussed some of the barriers that might stop partners and organisations getting on board with the A2WB. There was a belief that some people might think the approach was simply another public health initiative, and that they wouldn't view the approach as applicable to their area:

> *"No disrespect to public health colleagues but what happens is people think public health, airy fairy, conceptual and you know all this theoretical stuff and colleagues within particularly within the local authority I can see*

them now standing in front of me saying 'But what does it actually mean (name)?" Participant 2

"….in the early days I don't think a lot of people got it and I think a lot of people thought it was just another public health initiative….. The initial model was the one with the pie chart and then you know, the outcomes, and it was really complex and I don't think a lot of people could see how it applied, particularly in the VCs, that some of the smaller sort of grassroots organisations, I think, really struggled to see how it applied to them". Participant 7

It was felt that a way to overcome this challenge was to make sure the work was put in now. This was so that the approach had been developed to the point where the value of using it was obvious to organisations outside of public health, rather than just being seen as a tick-box exercise:

"…..that preparatory work (is done)…….so that when I then take it into a much more rigid NHS environment there is already evidence within County Durham that this adds value rather than going to our providers and saying we want to incorporate this and they then thinking that it is a public health slant on the world and okay we'll stick it in and tick that box." Participant 3

In addition to this, there is also the challenge of responsibility and accountability:

"It's very difficult sometimes to get colleagues to understand that their bit of the business impacts on the wellbeing of the population when actually all of our business impacts on the wellbeing of the population". Participant 2

At first, the concept of 'community' was difficult for some participants to understand, with regards to thinking of a geographical community rather than a community of interest. Therefore, there is a danger in being unable to translate this to other sectors, such as NHS services, and services generally when people don't think they work with communities, they work with patients:

"I was like oh I think because our service is so specific it's people living with dementia and their carers' and it was talking about communities and I hadn't quite made that link but I suppose now I look at the community as

it's a community of people living with dementia or carers rather than the physical community or the geographical community". Participant 6

The original model was perceived by some participants as *'difficult'* and was viewed as *'quite high level'*. It was seen as a theoretical model rather than a practical model. The positive view is that participants believe that they have been listened to. Their feedback has been taken on board and now the model has been adapted. This has resulted in a new, one page model, which participants felt addressed the gap between academic theory to practice.

There were some participants who didn't struggle with the A2WB, and believed that it worked very well for their organisation. The downside was that for national organisations, larger organisations, the model was seen as maybe trickier to adapt. There is a less room for a local branch of an organisation to make decisions and change the service delivery model, based on the outcome of completing the self-assessment framework:

"….is a little difficult as well, if I'm honest, and things have kind of brought up locally, sometimes if you're a national model, I suppose how does that fit?" Participant 6

The next steps with embedding the A2WB have been difficult due to the COVID-19 pandemic. Some organisations have furloughed staff, so they are not at work to be able to embed the approach. Also, organisations have been responding to situations that are urgent and need an immediate response. The approach needs time invested in it to understand it, therefore hasn't been a priority during 2020:

"We haven't used the wellbeing the new wellbeing tool…..I would say it's because of the lockdown so everything's just stopped". Participant 4

"Lots of people have been furloughed, a lot of organisations looking at redundancy, all that kind of stuff, and when you're then presented with something like this, as we've said that maybe does look a little academic and time consuming, have people just gone… I can't that can't be my focus right now everybody's focus has had to go into emergency mode". Participant 6

It was agreed that although some organisations had not been able to underpin their work with the A2WB over the past few months, one positive was seeing how some of the community responses were able to use it:

> *"From an NHS perspective this has gone by the wayside it has been all hands to the pump and it hasn't underpinned any of the response from a hospital type environment I have heard that it has supported much more in the communities/community hubs that kind of thing but in terms of acute service provision we are not there". Participant 3*

For some participants who had provided early feedback, but not had the opportunity to test the principles during COVID-19, there was still a willingness to utilise it moving forward.

A barrier that participants felt was impacting on how partners from the commissioning sector engaged with the A2WB, was due to the nature of trying to move away from measurements and performance based on numbers only. With regard to people delivering contracts, the challenge was '*how are you going to hold them to account?':*

> *"….always a bit of a battle with commissioning to try to get them to understand the impact your service has on people's lives as opposed to, I know in the past (name) and I would sit and look at things and I'd say to (name), what does it matter whether we have seen 250 people this quarter have we actually made a difference to any of those 250 peoples lives?" Participant 7*

In addition to this, not all commissioning services know about embedding the upcoming A2WB, although awareness of it is starting to trickle through the system:

> *"….the commissioner officers and managers…..some of them are still not fully aware of what the approach is. But they are being made aware quite rapidly". Participant 7*

The impact of the A2WB so far

A positive view from participants was that the A2WB framework was providing an opportunity for organisations to think about what they were doing:

"When we talking about involving the community and the design and development of service.....it gave us a framework to work from that absolutely challenge what we think we're doing but actually may not really be doing and actually having to articulate and think about it. I think it was really helpful". Participant 1

"You need to make sure that there's a lot of scrutiny while you when you're going through this process because it would be very easy just to go oh yeah we do that, we do that". Participant 4

The space to think about what they were doing also helped participants to think about and add accountability:

"So while that next steps may not be actively doing things, what I do think that next step is for an organisation who works in this way is that accountability and thinking about I am accountable for everything I said". Participant 7

Participants felt that the model allows them to add value; it provides a framework to evidence work that is already being carried out, for commissioners. It also highlights the self-assessment framework as a positive tool for providers in enabling them to gather evidence about the effectiveness of their work:

"…we gathered case studies every month from the advisers who used to look at getting that impact work and then as we have gone on and developed that relationship with the commissioners we actually really decided they did quite like that and being able to quote things and know the difference it made to people's lives" Participant 7

The self-assessment framework has helped participants to demonstrate the fantastic work that is already taking place. The framework helps to make a service become outcome focussed, rather than just be about numbers, and show the greater impact on people's lives. An opportunity to influence commissioners from the 'bottom up':

"What we struggled to do was to really shine and show commissioners what we were doing well….the contract report and didn't give us the opportunity to do that. Because it was very much focused on quantitative data of numbers….so what it did give us the opportunity to do was really sing about the things that we were doing well, but it also helps us focus and realise that we were doing all of this". Participant 7

Finally, for some participants, the model was used easily, as it fitted the approach of the organisation, rather than the organisation trying to fit the wellbeing approach:

> *"I looked at what the model was…and I thought, well, we do that anyway….it was a way of evidencing because we were coming up about having to write a massive report for commissioning… there was lots of evaluations data they wanted, that was more about the qualitative and the wellbeing and the difference it made people's lives, so we were able to use it to really evidence that we were doing that". Participant 7*

Developing the A2WB

Data emerged from the focus groups and interviews which explored the key elements of developing the A2WB to date, and what participants felt was needed moving forward with any revisions. Multiple methods were used to communicate the A2WB, which meant participants had heard about it from various committees, groups and boards. However, the original model was difficult to understand for some:

> *"Yeah – I think the original diagram and use of the …. I can't even remember the name of the family! The Taylors, I'm being frank now right….a lot of people didn't associate with the Taylor family graphic and then having that pie chart was a little bit complicated so taking that out has made it a little bit more acceptable I think". Participant 2*

As picked up previously in the report, the difficulties in understanding the model were met by public health staff who were keen to listen, learn, and make changes to the model:

> *"I think the most helpful thing developing this approach is (name) been very genuine with wanting to develop the …. the amount of times I've done it myself or other people have said well you have a look at this and then you've made some suggestions and they don't want to hear that……(name) genuinely been that she wants to make this work……so that's helped to be able to give feedback". Participant 4*

So far, the changes that have been made have been well received by those participants who have seen the revision from the original model to the soundbites model:

> ***Participant 4:*** *One thing that (name) and I know discussed is it wasn't a circle wasn't it?*

Researcher: *Yeah*

Participant 4: *And for me I thought that's actually quite helpful because you can start at whatever point it makes the most sense for you to start at*

"…..gone from this, like, big theoretical document that was probably about 50 pages long to now a one page sound bite document". Participant 7

More importantly, it was felt that the changes that the model had undergone were done using a coproduction approach:

"So I think one of the positives I would say about the development of the model is that hasn't been done to organisations, it's been done with them…..It's not just another public health initiative that's been chucked at people and gone do this, It's actually been done with people". Participant 7

"I think the fact that I can see from that initial stage from where we are now it certainly has changed and you can only assume that is going to happen because they have listened….. it has been developed with people". Participant 6

Although there has been a lot of development work carried out, participants feel that there are further revisions to go. It was felt that some of the questions in the principles still might be difficult to understand when engaging at a community level. For example, principle 5 uses the word 'co-designed'. What does that mean? Some community members would needs explanations to understand the terminology used, as it *'might frighten some people'.* Re-wording the principles might be necessary. In addition to this, the language used needs to be updated, as there are words that pigeon-hole the A2WB to one sector, rather than cutting across various:

"So under Principal 6 which is doing with not to, it talks about making our health and care intervention to empowering and centred around you as an individual but what we want to do is embed this into all service delivery whether it be housing strategy whether its bin collection. So we need to remove the health and care aspect as this needs to be applicable across all sectors and not just health and care. Because actually everybody's wellbeing is everybody's responsibility not just the health and care sector and I think that has been a barrier up until now because some organisations have looked at it and gone well we are not health and care organisation so it has nothing to do with us". Participant 7

"It's just it's sort of the terminology….principle five…are your services co-design and coproduced with the people who need them as well as their carers? Yeah. Some people will get that, but some people will probably think, what does that mean?…..I just think some community members might need a little bit of an explanation as to what the terminology is". Participant 5

Moving forward, COVID-19 has provided the opportunity were a lot of organisations are hitting the re-set button. It's an opportune time to help these services embed the A2WB now:

"Covid could be an opportunity because you know families and communities actually have had to look after themselves and had to provide sort of support so you're knocking on an open door in many respects". Participant 1

"I mean in some regards it's a bit like Winston Churchill said "never waste a crisis" the covid has enabled us to try and move some of this a little more quickly through the community hub work through the relationships that are building within the voluntary sector themselves and out there in the communities". Participant 2

There is going to be a period of recovery, but also an opportunity for services to be re-designed. Some participants were taking this time to ensure that the A2WB was influencing how some services would be delivered in the future:

"We have put wording in all of our contracts around the wellbeing approach so we are bringing it in as part of the reset and redesign going forward". Participant 2

Lastly, future development of the A2WB included adding in an expected timeframe into the self-assessment framework. It was agreed that the framework should be monitored annually, but this needs to be made clearer. Adding in *'possible next steps and agreed timescales'* at the end of the framework would help to add some accountability, but not be so strict as a Key Performance Indicator.

"It is probably worth having some kind of expected timescale on there (the framework) because you can say possible next steps I'm going to do an evaluation and not do that for 3 years there is no…..expectation on timescale". Participant 6

Suggestions for implementation

Participants felt strongly that for the A2WB to be embedded successfully in their respective departments and organisations, it needed to be driven down from a strategic level:

> *"…provided our head of services said to do it, we're quite happy to do what we can……I think it's probably been at a higher level to decide what the next step was, and like I said, everybody's that preoccupied with COVID at the minute it's maybe not been on people's agendas at the minute, maybe that's just my opinion. So yeah, if its going to be picked back up again I think that needs to be somebody higher than me who says, yeah, we can start". Participant 5*

The timing needs to be right to start introducing the A2WB at the community level. Communities are working so hard to support their community at the moment. Participants asked the question, *'Do they have the capacity?'* It was also felt that any conversations with communities needed to be framed in a way that's not 'you should be doing it like this'. It needs to be framed positively:

> *"I think I'd be very careful at the minute as to what I was sort of putting out there…..it's a sensitive time and I just think everybody's ran ragged and everybody's tried to do their bit in the community and we're into second lockdown now. And if you started putting something out like this, that no disrespect, they might think, is this really necessary? Is this really helping at the minute?" Participant 5*

An example of engaging with the community could be to make use of the AAP roadshows, where there could be further work around re-wording the principles. It was felt that the model *'still feels a little too academic'*. A suggestion from a participant was to ask community members the question '*What do these principles mean to you?'* By doing this, the A2WB will be attempting to work across different levels, to engage with a particular audience:

> *"…it needs to work at a strategic level, an operational level, an individual level and then at a community level in order to achieve its aims". Participant 3*

With regards to consultation, geography- wise, it was seen as crucial to cover the North, Central, and South of County Durham. This will ensure that rural, urban and semi-rural areas are captured, as they may have differing views. This will also ensure that the consultation is inclusive, giving an opportunity for all to engage. Engagement will vary across the AAPs, but the opportunity needs to be there.

> *"But within my area…..we either try to do pilots in the North, Central or South…..you're going to be better off trying to invite a lot of them and they might not all engage, but you've given them the opportunity". Participant 5*

Although there were no examples of how to use the model and self-assessment framework to begin with, earlier feedback from partners meant that case studies were developed. Participants thought it was good to have examples of how other services and organisations have applied the model; working examples and case studies that can be looked at:

> *"When you were trying to look at the principles, and there wasn't any, like, nobody could give you any examples of how it was done, because it hasn't been done. But now, we've got so much opportunity to be able to do that. So I think it was just that for me in the early days". Participant 7*

> *"…..actually doing the exercise and doing a bit of work around it and putting into really plain language and translating into actual practical things and sharing that into somewhere else that you want to do this work so they can see a bit of an example of where it has been practically applied…. has really helped". Participant 1*

> *"But I learn always kinda by getting something in my hands….I can say in my head that is actually our service anyway is outcomes focused and that is what we have always done and it was how to kind of match them up and it was seeing on paper it was probably just me and how I learn". Participant 6*

Finally, it was agreed that a key aspect in rolling the A2WB out was for partners, stakeholders, organisations and services to see what was in it for them. How could the A2WB add value to the work that they carry out; their ambition, aims and objectives:

“People have to understand how it applies to them. everybody's busy, everybody's got a role, everybody's, you know, doing what they do and for something new to come along, it has to be applicable, doesn't it?” Participant

The themes from the first phase of data collection have been used to help inform phase three of the evaluation with the COVID-19 Champions, and will help to triangulate findings in the final report.

Conclusion

The findings from phase one indicate that the A2WB that is being offered across County Durham is understood by members of the steering group as well as partners who were early adopters of the approach. There is an understanding of why it has been developed, although this took time for some participants to fully understand the approach. However, it was agreed that there are still changes to make. Participants in the focus groups and interviews felt that there were a number of challenges to the implementation and embedment of the approach. These included the A2WB being viewed as only a public health initiative, rather than cutting across different sectors; the model potentially still appearing too academic; communities being viewed in a geographical sense, rather than communities of interest; COVID-19 impacting on the speed of roll-out, due to staff pressures and furloughed staff; and the commissioning process becoming more comfortable with outcomes rather than just numbers.

Examples of the positive impact of the A2WB so far include: partners thinking about what their service is providing in terms of empowering communities to improve their wellbeing; improved accountability; providing a framework to demonstrate added value and providing an opportunity to showcase their work. The development of the model so far was respected, due to the nature of public health staff listening to feedback and coproducing any changes. To help improve and develop the approach further, it was suggested that revisions might be required to then introduce the model at a community level, as well as ensuring the language used didn’t exclude a particular sector, i.e. the A2WB can be used in multiple sectors.

Finally, suggestions for the future implementation of the A2WB included: ensuring that the approach was driven down from a strategic level; working with introducing the approach to communities at the right time, due to COVID-19 fatigue; ensuring that engagement and consultation is inclusive; providing plenty of practical examples of how to use the A2WB principles and framework; and emphasising the added value that the A2WB can bring to an organisation.

These initial findings can be utilised to drive the next stage of data collection and analysis, and also inform a number of recommendations for the next stage:

Recommendation 1: The soundbites model needs to be developed so that it can be understood at a community level. The first development was theoretical, and the second stage of revisions was to help with practical implementation. Further work is now needed to be able to communicate at the community level.

Recommendation 2: There is fatigue in the community after the first phase of lockdown. It is perhaps not the right time to approach and involve the community in the next stage of model development. Therefore, it is suggested that the team start with a community of interest to develop the soundbites model. Asking '*What do these six principles mean to you? How will your community respond?'*

Recommendation 3: Make sure there is a good geographical spread when working with the selected community of interest (and beyond). Go to the north, central and south of County Durham, to cover rural, semi-rural and urban areas.

Recommendation 4: The framework and model needs to be driven from the top, to ensure buy-in to trickle down, and that staff have the necessary directive within their workload.

Recommendation 5: Both the framework and model need to be presented for various perspectives, not just a public health angle. The framework/model introduced needs to cut across departments and sectors. How can it translate to other services, such as the NHS?

Recommendation 6: When refining the soundbites, thought needs to be given to how communities will understand the language. For example, Principle 5 uses the phrase ‘co-designed’- what does that mean? There potentially needs to be an explanation of terminology.

Recommendation 7: Consideration also needs to be given to the language used in the model, as it needs to be appropriate across multiple sectors and organisations (e.g. using the word communities v patients). Principle 6 says ‘health and social care’, but the A2WB is for use across more than just this sector.

Recommendation 8: There is the potential to add a section at the end of the self-assessment framework, which measures outcomes. An example given was about ‘accountability’, with a question on ‘*Possible next steps and agreed timescales’.*

Recommendation 9: Worked, practical examples are needed, which shows how other sectors and organisations have applied principles and framework to their service area.

Appendix (2):
Case Study on the use of the approach in the development of the Community Hubs in response to the Covid-19 pandemic.

Background
The community hub concept (which later became known as the County Durham Together Hub) was introduced in March 2019 as a suggested response to the Covid-19 pandemic to support residents to be able to access information around Covid-19 and initially to support around food poverty and hardship. The idea was to provide a central point of contact for residents to gain support and information.

What was clear from the beginning was that to have the greatest possible reach any response needed to promote building resilience both on a community and individual level and the mobilisation of existing community assets/resources.

Development
This was a top down approach which had to happen at a very fast pace and had to evolve and change as it delivered due to the nature of its inception. It was not a planned and researched response but came about as an imposed health protection measure. However, there was a consistent commitment from all involved to improving and developing, based on what residents were saying they needed and on what the sectors had to give.

It was identified that residents needed a single point of contact – SPOC. Despite time constraints, some elements of an evidence base were able to be used around the initial set up by using local knowledge to decide on how the hub areas would be split to ensure the best possible service for residents and to take into account known socioeconomic issues in some areas e.g. those with higher levels of deprivation or known areas of less community resilience. Initially the telephone process was quite complex: customer services gathered information, which was then passed to hub supervisors, who then triaged and passed this to an officer for action, where appropriate. It became clear that this was not the best approach as people in crisis were having to tell their stories more than once to different people. This initial script was also very focused on identifying the immediate problem rather than taking a more holistic approach and understanding what was going on around the individual that had led them to a crisis point. By changing the conversations to become more person centred, it resulted in people presenting on less occasions with the same issues as they had the correct support around them. MECC

(Making Every Contact Count) training was also successfully used to train staff. This training supports staff to have conversations with people in a more person-centred way and to look at situations holistically as opposed to seeing them in isolation.

Initially the main focus of the hubs was around food and providing emergency food packages or doing shopping for people who were shielding and self-isolating, however over time the Hubs were able to withdraw from providing this service by supporting our community led assets to build capacity and deliver this for example AAP's giving funding to local groups to do this. This led to a much better use of resource and less confusion for people.
The hub was initially staffed by redeployed staff from areas of the council where service delivery had ceased, which initially led to some problems as staff did not have the skills or experience to deal with people in crisis, and emotionally they initially found this quite challenging. However, extensive staff training was developed and support services including regular catch ups and supervision were put in place with staff to help them in their roles. This has had a positive effect and staff will be able to take these new skills back into their own areas of work and think differently about the conversations they have with residents? and the impact their interventions could potentially have.

The Self Assessment Framework (SAF) was a particularly useful tool for constantly evaluating the service delivery model to ensure that all the principles were being reflected. It was a useful tool for development meetings in terms of giving discussion topics to focus on, and a structured way of not only evaluating what was already in place but also what the gaps were and next steps to be taken. This approach ensured that the principles were just embedded in what was being delivered.

The pandemic also led to the expansion of Locate as a platform to empower people to build their own resilience which helped to foster a County wide approach met by local knowledge. Durham Locate is an online directory which allows residents to connect with local services in their community.
This approach has led to the strengthening of working relationships across the county and the development of more robust and easier to access referral pathways. It has also reduced duplication of working, and has fostered new pathways for the future, and has helped to highlight the importance of the VCS in service delivery. It could be said that without the partnership working and recognition of the valuable contribution that communities play in their own development such a successful response could not have been delivered.
This approach also helped in the identification of areas of high resilience and those areas where resilience is not so high – this evidence has also been further confirmed with the distribution of Covid Community Champions where

we have been able to see the geographical spread of champions as aligned to areas of higher resilience.

Key Recommendations/Findings

- Multi agency approach/whole county approach works well – increased reach and more efficient use of resources.
- SPOC is imperative – people need one place to go to avoid confusion or knowing which avenue is the right one.
- Residents only want to tell their story once as sometimes it takes a lot for somebody to be able to pick up the phone, and often the people coming through the hubs are in crisis. Resolutions need to be met by the person on the phone if possible (this was key in development from the initial response of contact centres collating the information which was then passed to hub supervisors to triage to the current system of the information, namely assessment and conclusion trying to be reached in one call)
- Area based – meaning staff got to know what was available in their areas, and this also fed into the expansion of Durham Locate. AAP's, being the people on the ground, were able to collate local service information and ensure this was added. This also helped to identify any gaps in services in areas showing to be less resilient.
- Targeted funding in areas identified as not being as resilient to provide services – working better together – hubs feeding this info to AAP – this also helps to reduce the likelihood of a postcode lottery
- Upskilling of redeployed staff - this is also a benefit going into the future for the way they approach conversations in their usual roles (mainly culture and sport staff). It has also provided a platform for staff to gain experience to move into other roles within DCC and the sector.
- Responsive to need where possible and we haven't always been able to do this efficiently or in a timely manner.

Discussion

Considering the 6 principles it can be demonstrated below how the community hub has integrated these principles into its way of working. It is not about delivering the Approach to Wellbeing, it is about delivering a service that is aligned to these principles where they are so engrained in the way of working that there is no separation between the Approach and service delivery (not explicitly using the principles but being able to evidence that they have been used and considered).

1. Empowering Communities - When clients contacted the Community Hub, their needs were identified and ranged from access to food through to mental health support. There were many people presenting with mental health issues who had never experienced these before therefore felt disempowered and their resilience was low as they did not know where to turn. Depending on need, the Hub Officer talked through the options with people to best meet their needs and the individual will then make decisions about their support themselves. Where possible, the residents were encouraged to make contact with local groups/support themselves to build personal resilience, however, many needed the intervention of the Community Hub to take this step and establish the referral/link. Sometimes, however, people do not act on the information given to them meaning they re-enter the Hub. Quite often these people had complex needs and needed additional specialist support to overcome their issues. With consent of the client, referrals were made to the appropriate organisations to obtain the assistance they required.

2. Being Asset Focused - The Covid-19 pandemic caused unprecedented and new challenges to individuals, communities, regions and at a national level, across all sectors of society. The Hub was established in response to this to meet the essential, new and unmet needs of residents across the county and to link those accessing the services to local support or meet the needs of those not met elsewhere. The Community Hub utilises the assets within communities to signpost and refer people for support where it is available. Through the Covid-19 pandemic, a number of VCS organisations adapted to include food collection and delivery as well as issuing free food parcels to those considered vulnerable in their communities.

The Community Hub used local voluntary and community sector organisations as the main assets within communities. The development of the Hub has led to the rapid expansion and updating of the Council's Locate website to facilitate this. The pandemic has identified areas of the county where VCS may not be as strong and has enabled funding to be directed to organisations to strengthen this as well as a sustainable funding offer to the VCS infrastructure organisation, Durham Community Action.

A number of new organisations also emerged in response to the pandemic such as the Mutual Aid groups now operating across County Durham. These groups were offered support through Durham Community Action around governance and training and the opportunity to bid for funding. These groups have also been added to Locate as a referral 'destination'. These could be used as a proxy indicator of the strength and resource within communities to provide support of and within themselves.

3. Building Resilience - The Community Hub (responsive /inbound calls and online forms) was established to respond to and meet the needs of those most acutely affected by the pandemic.

Proactive calls were made to those in the county identified on the NHS lists and more in depth 'layering' of need using population health management data to identify those at risk and needing targeted support.

The utilisation of the Wellbeing for Life service also enabled the cross referencing of clients already on their caseloads to ensure continuity of care and reducing duplication and facilitating access to GPs where needed.

Those identified were also the first to receive 'mail drop' communications about the Community Hub's offer. The Community Hub was also widely publicised via all the council channels to ensure wide reach and access.

At the outset of this service referral pathways to key services were established and shared with all Community Hub staff to ensure direct and timely referrals of clients e.g. Early Help, One Point, Domestic Abuse, Learning Disabilities. As escalation process was also put in place to ensure safeguarding, challenging and complex needs were addressed appropriately.

Upskilling of staff working on the hub is a real positive going forward as it has helped create a more person centred/focused approach and staff will take this back to their day jobs in the future which it is anticipated will have a positive impact on future service delivery.

4. Working Better Together - The pandemic has positively contributed to joint working to address the unprecedented circumstances experienced by all in society and most acutely by those with least resilience and personal resource.

A volunteer unit was established following the creation of the CDT hub as it was found that many volunteer requests were coming through from both individuals and organisations. The unit built on the work of the CDT hub. It aimed to provide a central location where organisations needing additional help or practical resources could go to register that need as well as managing the offers from businesses and individuals who volunteered their services and resources in County Durham. Staff are then able to match them to groups across the county's VCS sector with things such as extra staff, equipment, IT support and premises.

The aligning of services to support this innovation has been complimented by the system.
Amidst the speed of implementation of the Community Hub key principles of the County Durham Vision, Health and Wellbeing Strategy and the Approach

to Wellbeing underpinned the Hub development including engagement and coproduction with some partners.

5. Sharing Decision Making - The adoption of this principle was limited due to the timescale dictated by the pandemic, however, some key elements to ensure the resident experience was captured were included in the Community Hubs design- customer satisfaction survey and feedback functions monitored daily by the Case Management system. The Hub has also evolved over time by listening to what customers have been telling us and what they want and need which also led to the creation of the Check and Chat service and has helped inform gaps and areas for development of services where we have been unable to signpost people to this support. The Community Champions have been key in feeding back residents' experiences to the Hub, sense checking what the

6. Doing With Not To - The design of the initial access and the script for call handlers was underpinned by a person-centred approach, addressing the holistic needs of the clients and seeking to empower them via signposting to resilience and independence, and if those accessing could not attain to this level of autonomy they were supported to ensure needs were met in the most sustainable way available. This further developed by trialling the Hub Supervisors taking the calls at which point they are able to use MECC and effective communication skills to holistically assess the client's needs meaning people are less likely to have their needs missed and also have to tell their story to less people which can be much more empowering to people who can become fatigued by having to tell multiple people what they need before they receive the support.

Appendix (3):

Phase Two Methods – A contemporaneous chronicle of activities pertaining to community engagement, working with a community of interest COVID-19 'Champions'

Study Design

This element of the evaluation was initially conceived to contain three elements, namely: observations of the COVID-19 champions during their Approach to Wellbeing training (March 2021); two focus groups with COVID-19 champions (June 2021); and finally, the completion of a questionnaire by COVID-19 champions. This phase of the evaluation was fundamentally designed to include:

- *Identifying specific communities of interest.*
- *Reviewing the method of community engagement used.*
- *Exploring the extent to which solutions to issues affecting communities have been co-produced.*
- *Identifying examples of power being devolved to communities.*

Due to changeable COVID-19 restrictions during this period, internal capacity within DCC to support the evaluation, and the availability of the COVID champions themselves during this time, changes were made to this initial plan. It was not possible for the research team to observe training undertaken by the

COVID-19 champions and as such the decision was made to consult the COVID-19 champions on their views of the Approach to Wellbeing and its perceived value in supporting their delivery of wellbeing support and engagement with the community. In this way, feedback on the practical application of the Approach to Wellbeing and its principles when working to empower communities would be gained.

Ethical Approval

Ethical approval from the School of Social Sciences and Law Ethics Committee at Teesside University was given for phase three. Following on from this, approval was received from Durham County Council through their Research and Guidance process (RAG). It was decided to incorporate any permissions or elements of the final phase of research within ethical approval for phase 3, due to desk-based nature of research to be employed in phase 4.

Recruitment

Inclusion Criteria:

- *Currently volunteering as a COVID-19 Champion in County Durham*
- *Aged 18 or over.*

Recruitment commenced in June 2021 with the expectation that focus groups would take place virtually throughout June and July 2021. Participants were recruited via email, using the COVID-19 Champions email network, with Durham County Council acting as an intermediary and gatekeeper for participants' data, so no direct contact was made between participants and researcher prior to the focus groups taking place. The only exception to this would be if participants had any questions about the evaluation prior to taking part, in which case potential participants were invited to contact the researcher directly with any queries.

Those wishing to take part were asked to confirm this by completing a consent form which was sent to their programme lead and forwarded to the research team at Teesside University.

In addition to focus groups, questionnaires relating to the approach to wellbeing training and the Self-Assessment Framework were distributed amongst the COVID-19 Champions network for return to the research team.

Data Collection

As alluded to above, due to issues with the pandemic, the recruitment of COVID-19 Champions proved challenging. In total, responses to both the questionnaire (*n=5*) and focus group (*n=4*) were low. Because of this, in addition to a focus group it was decided to conduct 1:1 interviews (*n=2*) with individuals in programme lead and Public Health roles that fed into the strategy and management of the COVID-19 Champions to ascertain the impact of the approach to wellbeing and any associated issues from a strategic through to a delivery level.

All interactions with participants took place via Microsoft Teams, with the exception of questionnaires. The purpose of interviews, focus groups and questionnaires was to explore the experiences of the approach to wellbeing training programme delivered to COVID-19 champions and to answer the following questions:

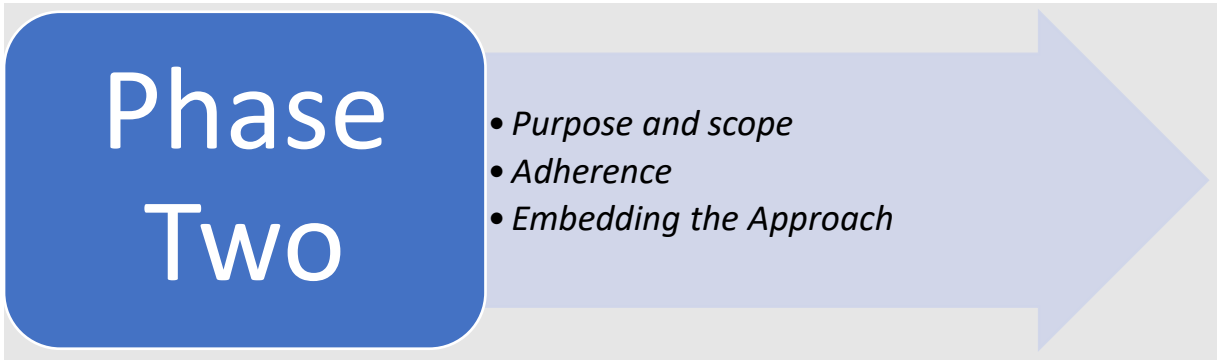
- What are the barriers and facilitators to COVID-19 champions using the approach to wellbeing principles?
- How well have the approach to wellbeing principles been adopted by COVID-19 champions?
- What are the barriers and facilitators to COVID-19 champions using the approach to wellbeing self-assessment framework?

Data Analysis

In line with previous phases of the evaluation, the interviews with DCC staff and with COVID-19 Champions were audio recorded to aid in transcription. Once the transcripts had been completed the data was analysed using applied thematic analysis. Research staff from Teesside University worked collaboratively to identify and code of themes. For the purposes of this research an inductive approach to coding was again adopted to capture feedback and thoughts on aspects of the wellbeing approach rather than applying pre-existing theory to this area.

Results

As outlined above, one focus group with COVID Champions and 2 1:1 interviews took place remotely via Microsoft Teams in addition to 5 completed questionnaires being returned to the research team. Combining these and subjecting both written responses and transcripts to thematic analysis revealed the following as significant themes pertaining to the approach to wellbeing:



Each of these primary themes contained several sub-themes, each of which will be considered in turn below:

Purpose and scope:

One notion to which each respondent returned over the course of interviews, focus groups and questionnaires was that of the purpose of the wellbeing approach (and by extension so too its scope). What is the wellbeing approach there *for? Who* is it there for?

For many, the response to these two questions was simple: the approach to wellbeing was a way to ensure that the voice of the community was at the forefront of their role. As one COVID-19 Champion observed:

> *"And I say whatever the task is, our main role is community engagement. And whatever the issue is, it's my job to take that back to the council, because I know who to report to." (Participant 6)*

This feeling was shared at all levels, and there was a clear commitment amongst those consulted to use the approach to wellbeing as a vehicle to affect greater involvement for the community as a partner in the services delivered by DCC, rather than passive recipients. This was the case whether they were in a primarily delivery or strategic role:

> *"It just brings us closer to actually building on the thoughts of the community and how they feel things should go…It's using that to make real decision-making changes. That's where I'm coming from, I think." (Participant 10)*

> *"I mean for me, it [the most important part of the approach to wellbeing] is the working with communities' element…As a local authority, we are traditionally paternalistic. And I think that's the area [the approach] has helped most…It's that bottom-up approach." (Participant 11).*

Amongst those who were COVID-19 Champions, there was also the feeling that the principle of consultation and empowerment was something that should apply to them (and other staff within DCC) as much as it did with communities themselves:

> *"I feel that the [COVID-19] champions need to have more autonomy within the scheme, such as to be able to manage events within their area." (Participant 1)*

This would, it was suggested not only improve the wellbeing of staff and volunteers but would also allow greater efficiency within the authority as it would eradicate the duplication of work or the need for central 'fact-finding' about needs within certain areas, as those working and living within communities would already have this knowledge at their disposal:

> *"That's when I find it most helpful already being there. It's like that's when people will tell you something: like, whether it's about waste disposal in the area, or whatever it is." (Participant 8)*

> *"One thing that came back from our community quite early on was that people were struggling to get to vaccination centres. The expectation was to go to the other side of Durham...and a lot of people were unwilling to do that. One group were vaccinating at one of their other surgeries rather than the surgery that's closest. And basically one of the things I found back was that people said it would be useful to have a drop in session [for vaccines] in our area. I found that a couple of times, and it took quite a while but eventually we did get a vaccine event in the carpark of our local supermarket. That sort of message was quite useful to get to not necessarily just the council but to public health and the CCG as well." (Participant 9).*

One participant suggested that they felt that their primary function as a COVID-19 champion was to act as a conduit for both the local community *and* the local authority putting one in touch with the other, and signposting communities to services:

> *"I sort of feel like I'm acting as a hub between groups that I was already aware of in my area and the COVID champions programme. There's a lot of that." (Participant 8).*

For others, their role as COVID-19 Champions allowed them to directly contribute in ways that were not so tangible, but were no less important to

community engagement and the wellbeing of people within those communities through simply listening to what people had to say:

> *"I think there's a lot of a lot of those interactions that you have that aren't…they're not kind of tangible in the way that you could kind of count them or you know, but I mean, it's one of the things I think that with the idea of being community focused, you know, this kind of thing has to be at the heart of that" (Participant 7).*

> *"Sometimes people will just want to tell their stories…You know: 'Me [sic.] Grandma's just died of COVID'. And it's like people just want to offload their experience…Another, she said her husband had died last Christmas and I said: 'Well, my mum died two days before Christmas'. So that's when we started, I gave her a hug and we sat down and talked and that." (Participant 8).*

Adherence:

A key feature of questionnaires, focus groups and interviews was finding out to what extent COVID-19 champions (and the network in general) were following the wellbeing principles and how much their everyday activities were guided by the principles. Perhaps unsurprisingly, the wellbeing principles, and their use, were not something of which the COVID-19 Champions were explicitly aware:

> *"So while we may have those [principles] underlying the information we send out to people, it's the information that's most important. You know, people are worried about getting sick. You're telling people 'this is the information you need to know' and it's making sure that it's relevant." (Participant 8).*

The conscious effort to keep the principles in mind was much more apparent for those who interacted with the approach to wellbeing in a strategic manner, in line with the other aspects of their roles. Again, perhaps unsurprisingly, the way in which they interacted with the wellbeing approach was directly linked to the way in which they interacted with their role overall and reflected those things which were important within that role. As someone for whom one of the primary concerns of their role was evaluating and providing evidence, the participant below understood the approach to wellbeing and its constitutive principles in these terms:

> *"I have actually done a couple of self-assessments…and I think what that did was enable us to kind of look at the principles and the ways we were using the well-being approach. And it helped*

us to kind of formulate the evidence, I suppose, behind what we've done…and I think the beauty of the wellbeing approach is that it doesn't have to be everything. It's more of a toolkit, just as a reminder, because there's gonna be things that aren't possible. But what we have done is use feedback from service users and from stakeholders…and so for me that just having that framework is quite helpful." (Participant 11).

Although the principles as such may not have been at the forefront of the COVID-19 Champions' minds, that was not to say that they were not being upheld in the way(s) in which they interacted with the communities they worked with, and both the focus group and questionnaires showed this. Some examples from both are included below to give a greater idea of this phenomenon, as well as those areas that the COVID-19 champs felt greater improvements could be made, mapped against each of the wellbeing principles.

Using What Works **-**

"Conversations have taken place about how we best distribute messages in communities. For example, if I were just to use e-mail this may discriminate against the elderly community or those less IT literate. Therefore, a number of mediums are used to distribute key messages for example, door to door knocks, social media, e mail etc (Participant 3).

"I feel that I would have liked to have been involved in more conversations with the local community. I think a lot of people missed stuff when it was social media and things." (Participant 4).

Empowering Communities:

"People who don't normally get involved in community programmes voice their concerns to me / through me or if they have a legitimate…complaint I can direct them to the correct service to report it to." (Participant 1).

"I feel the programme has been very successful and has enabled residents to engage much more dynamically on a local level." (Participant 3).

"I wanted to use this role to better understand [the] community, but I feel like I don't know any more or anything better than before." (Participant 4).

Being Asset Focused:

> *"So I kind of see the community champions…as a one stop shop, because we're not expected to know everything about everything. But what we will do is find the information out and feed that back. It always surprises me how little information members the public Google, despite the fact that I think we constantly feed information out to members of the public by…social media, by posters by, you know, street posters, whatever or by word of mouth; there's still little pockets of communities where those messages aren't getting to them somehow." (Participant 6).*

> *"While I am out and about if members of the public make me aware of any other issues in communities, I will report them back to my manager who will refer them to the correct place. Also individuals / shops that require additional support in general have been made aware of services who have put that additional support in place which lets me know that my information is acted upon.." (Participant 1).*

Building Resilience:

> *"There is a vast range of support countywide to assist the community. However sometimes it's up to individuals or certain groups to access this support. For example, men are particularly difficult to engage in services for whatever reason and it is these identified groups where more work needs to be done to engage them. I would say more work could be done in communities to establish what they need rather than trying to pre-empt support" (Participant 3).*

> *"In my specific community, yes [we are engaging vulnerable people], due to engagement with our hyper-local wellbeing programme..." (Participant 1).*

Working Better Together:

> *"With certain groups, such as BAME communities, it's about…realising what, what's already there that can be kind of tapped into in terms of engagement." (Participant 7).*

> *"I see it [duplication of work] all of the time when partners/ organisations are working on the same projects but often work*

in silos reluctant to share their own information, rather than working together" (Participant 3).

Sharing Decision Making:

> *"Yes, I think that people are able to contribute to decisions from different places, and this is where social media is particularly effective." (Participant 9).*
>
> *"I think they can to some extent [get involved in decision-making] but my community is online, so people need access to a computer ." (Participant 2).*
>
> *"From memory, I haven't been involved in helping to design any services in my area, no." (Participant 6).*

Doing With, Not To:

> *"I would say they treat us as communities rather than as individuals." (Participant 1).*
>
> *"To some extent we do [encourage independence] but there are a lot of procedures to follow sometimes. (Participant 9).*

Embedding the Approach:

As can be seen from the comments of the COVID-19 Champions above, although many of the principles of the wellbeing approach were being fulfilled by their actions, this was not something that they were explicitly aware of. Furthermore, there were areas in which they highlighted certain areas in which they felt the programme, and DCC as a whole, needed to do more. One particular challenge that was highlighted throughout both focus groups and questionnaires, was the inconsistent nature of just how invested people were in delivering the services that were representative of the approach (and thus the approach itself).

Just how to ensure greater buy in across the county was an issue that was also recognised at management and strategic level as an area for improvement:

> *"I suppose there is a bit of friction there [about adopting the approach] because, and I have, you know, I have experienced it to a degree I wouldn't say massively…I think there has been a bit of friction and… for me personally, it shouldn't be a hard sell." (Participant 11).*

Counteracting the aforementioned friction that was felt in some areas when introducing the wellbeing approach was something that everyone was keen to achieve, as all were keen to see the principles shared across the county. One of the greatest challenges that was identified at all levels was trying to ensure that the principles made sense to those that were expected to use them to guide their everyday working:

> *Half of what I've done as a COVID champion is volunteering with vaccine buses and a lot of what we're doing is logistics, as opposed to…engagement. It's logistics as in: 'You need to come forward, now go straight to that person'. You might ask: 'How are you feeling?' but it's hard [to think about wellbeing] when that's what you're doing" (Participant 7).*

The key message being shared was that embedding the approach to wellbeing, at all levels was the thing which needed greatest investment from all levels of the local authority, but particularly those at executive or strategic level, in order to ensure that the approach to wellbeing and its principles permeated every aspect of DCC. How this embedding was to take place, and how best to ensure its success was largely dependent on the nature of the role to which the principles were being applied. For those in largely strategic roles, treating the approach to wellbeing in terms of engaging directly with the high-level principles that underpinned it yielded positive results:

> *Basically [we were] looking at the using the self-assessment framework…to find out what evidence we've got, and what we know: what we do. And what that did was it identified a massive gap…about working with people, and we had to develop strategy to develop and implement actions around that. So for me, that was really helpful." (Participant 11).*

However, in discussions with all participants (and as can be seen in the previous section) it emerged that the Self-Assessment Framework may not be the best way of evaluating the performance of COVID-19 Champions (and thus by extension other delivery-focused roles) against the approach to wellbeing, because, quite simply, the feeling was that the way in which they were currently presented was too abstract, and too 'high level' to be of practical use to them in their roles:

> *"There's a situation where there's the very high strategic level where they come up with the principles. And then there's people*

who are who are using them all the time. But…there's a big gap." (Participant 5).

"What I would say is, as a day-to-day community champion, it may underpin a lot of what we do, but it's not at the forefront, because quite honestly, the forefront [of my mind] is getting specific messages out to residents." (Participant 7).

The challenge then, was to try and embed the approach in such as way that is meshed with the overall timbre and priorities of the Champions' role so that they were able to track what they did against the approach to wellbeing. One suggestion for how this may be done was to make following the approach to wellbeing a key target of the role, not as a collection of principles that were apart from, or in addition to their role – but making those principles (and actively promoting them) an inherent part *of* their role:

At the moment they pledge to be a champion, which is fantastic. What does that mean? Well, that's up to me to explain what that means…So let's pledge against these principles. Then, let's pledge to say that you will adhere to empower your community…why not use that? In that format. You know, and then get those principles in right at the beginning. The reason why they're signing up is to make the difference in their community, so let's say this is how they will do that." (Participant 10).

Fundamentally, the successful integration of the wellbeing approach to the COVID-19 Champions role was seen to rely upon being able to embed it within the role itself which in turn relied on communicating the approach in a way that made sense. In this regard, particular training around the principles as a standalone concept (albeit one in which it's importance to their role was stressed) may not have been the best way to ensure this was something that stayed with those who participated. During discussions with the research team, participants from the Champions network did not remember a great deal about the training they had undergone, nor did they have a particular recollection of the wellbeing principles themselves. But, as we have also seen, these facts did not in large part hinder their adherence to those principles, even if they were not necessarily aware of it. One participant put it thus:

It's almost, and this might be on my part as standalone thing, but it's not embedded enough for me. It's a PowerPoint, it's a PowerPoint and it's information, but it's not sinking in…and obviously I'm not in that strategic position…but from a

operational point of view I can only speak that it will have been in conversations, but only when I've been prompted. Is that something that needs to be in the conversation continuously?" (Participant 10).

As well as making sure the approach to wellbeing was put at the heart of everything the COVID-19 Champions did from the outset, the way in which this was done, and the language used was seen as being of paramount importance:

"I think sometimes it is about language. And I think…we fall into the trap all the time of public health kind of speak, and it makes it less possible [to engage others]. So, I suppose…if you, if were to look at it, kind of as it is and then look at it going forward, the important thing would be engaging with those different departments, different service areas…[and] different stakeholders, to kind of tailor it to their needs. So it's, it's got those basic public health principles that underwrite it…But it's actually tailored to their kind of speaking and to their language"

Phase Two Conclusion:

After engaging with all participants throughout phase two of the evaluation, it is clear that there is a general commitment to see the aims of the wellbeing approach realised within the interactions that COVID-19 Champions have with the communities they serve. What is also clear however is that if this is to be set up and meaningfully continued in the future, then there is a need to translate the approach and its principles from their current state into a more practical form.

I'm looking at them [the wellbeing principles] altogether there and I'm keeping that up there…and maybe we need an element, a simplified element to pull it down to embed it continuously from the very top…so it's in their mind straight away. And then it's how we use those principles through the role of the champion and bring it down right down to where it is role descriptive rather than in the air. (Participant 10)

Part of making the approach less unwieldy may also lie in some of the specific issues that COVID-19 Champions encountered in their role. One of the

greatest challenges relayed by the COVID-19 Champions was in engaging some marginalised communities A particular difficulty in this regard revolved around the trust that members of such communities were prepared to place in individuals that were seen as from communities very much separate from their own:

> *"I think using the existing groups, is probably more effective than trying to get into that group ourselves because they are somewhat unwilling to have outsiders coming into their social group, because of the fear that they have from us. We all…get on with everybody. But they are still nervous. Given some of the comments I've seen shared on a personal level from them, I can understand why." (Participant 8).*

As well as utilising existing groups and channels of communication and community-based assets, another suggestion for how to engage marginalised groups was to attempt to recruit individuals who would be regarded as part of a community rather an outsider to it:

> *"I think going round with somebody who literally grew up on that street, it could immediately encourage the residents to talk to me…it kind of legitimises what I was saying, and I think that's possibly what we need to look at, if we look forward to doing sort of COVID champion visits door-to-door discussing things, at some point potentially having somebody who's literally from that streets or the neighbouring street with us, kind of legitimises it, especially when you're in these sort of disassociated disaffected communities that are almost separate, as opposed to seeing themselves as part of a bigger community." (Participant 7)*

What is also vital is that whenever or wherever the lack of engagement fro certain communities may constitute behaviour potentially detrimental to others, there is still the need to engage and understand these communities. Indeed, part of the virtues of community empowerment and the reduction of stigmatisation necessarily involves opening up dialogues even in situations where there may be fundamental disagreements between communities. As one account of an anti-vaccine protest taking place during a vaccine drive illustrates:

> *"And three quarters of the protesters were toothless, jobless, and really, it was all just found information that they just read on social media. Whereas we have professional doctors and nurses, and NHS staff present." (Participant 6)*

While doubtless the above incident is something that would be better not to occur at all, the attitude of judgment on the part of the individual supporting the vaccination event ultimately does nothing to seek to engage such individuals to hear their concerns and potentially address them. While the suggestion certainly would not be for an individual to seek to engage protesters in such a situation, the feeling that such individuals are unreachable and furthermore that they are quite different and apart from the 'rest of us' should be viewed as a missed opportunity to engage a disenfranchised section of the community.

What is integral for the embedding of the wellbeing approach across communities is to inform of the approach and integrating it into existing mechanisms within DCC, rather than creating new avenues to do this. This helps to eliminate duplication and ensures that information is reaching people from already trusted sources. Due to the success of the COVID-19 Champions programme, the relationships that have been built during this time are an excellent way to continue to engage the community in a meaningful way by expanding the remit of those working in their local areas:

> *"The more the community champions have grown…I think we're more and more demand for more diverse roles." (Participant 6).*

This promissory note, and the potential of the COVID-19 Champions to diversify and potentially even repurpose their role into more generalised areas of community support must be tempered by stressing the importance of communicating the approach to wellbeing properly to its success. This communication potentially needs to be better across the county because gaps have been identified. One of the challenges of expanding the COVID-19 Champions network (raised by the COVID-19 Champions themselves) lay in ensuring that access to the programme and its benefits was open to all, and not just in areas where enthusiasm was high. Rural or geographically isolated areas were identified as a specific setting in which this needed to be addressed:

> *"I think the best word I can use for the approach across the county is piecemeal. In that some areas are well exposed to the community champions programme…where we have got quite a lot of impact. We've got Facebook groups, we've got people who are engaging with the programme. On the other hand, there are places… I was speaking to someone, I'm not gonna say where…who had never even heard of the community champions programme. They were in a small settlement. And basically, they didn't know anything about it. There wasn't anybody in their community who was involved in it. And therefore they weren't*

aware even of it existing as a thing. And I think that's one of the things that going forward, needs to be addressed, whether that's existing champions having an area and going into those smaller settlements, or whether it's recruiting champions specifically in those areas. I think that's something that potentially going forward needs to be looked at." (Participant 7)

Key Findings/Recommendations:

- It is clear that the COVID-19 Champions provide much needed support and knowledge to the communities that they serve. On this basis, **it is recommended that they continue to provide this support for ongoing issues that may arise from the unknowns of the COVID-19 pandemic.**
- The nature of the support that the COVID-19 Champions provide goes beyond their primary function of providing support during the pandemic. As such **further opportunities to use the COVID-19 Champions** and the relationships they have developed **should be explored in the future.**
- Feedback from COVID-19 Champions is that they already provide a wealth of information and support across their areas, but there is also the recognition that some areas are less well supported. Rural and geographically isolated areas in particular were identified as those which may need further engagement.
- Trust is key to engaging any community, and we often find it easier to trust individuals that we share common experiences with. Because of this, **it is necessary to recruit as representative a populous of COVID-19 Champions as possible. Where there is particularly low engagement from a community, particular effort should be made to reach out and attempt to recruit Champions to aid engagement.** One particular community with whom this may be helpful is amongst those individuals sceptical or unwilling to be vaccinated against COVID-19.
- Although there is a clear commitment at all levels to follow the approach to wellbeing and apply its principles, in practice this can be difficult due to their, sometimes abstract, nature.
- While the Self-Assessment framework and wellbeing principles 'as is' are suitable at strategic level and provide a valuable instrument to guide and review decision-making and performance, these are often too time-consuming or too far removed from everyday practice in delivery settings.
- Because of this, **a further recommendation is to look at ways of embedding the wellbeing principles within role descriptions and** (if applicable) **have their adherence reflected in targets central to those roles.**

- **Including these elements during performance reviews will also aid in affecting whole system 'culture shift' towards the wellbeing approach. Appraising key role competencies in a manner that is wellbeing-driven can also be a valuable approach to affecting such culture shift.**
- It has been suggested that the communication of the approach to wellbeing may still be too abstract for use in community settings. **A recommendation in this regard** therefore **is to devise a variety of simpler and more instructive examples/case studies of the successful implementation of the wellbeing approach in addition to the soundbites model already developed.** These examples should illustrate the benefits of the wellbeing approach in relatable ways but should refrain from doing so in an abstract fashion. Ultimately, any explanation of the approach should make sense to the target audience.
- When dedicated training is delivered, it can sometimes be difficult to transport any learning from this environment to the 'real world'. Furthermore, the more time that passes following this training, the more difficult it becomes to recall its content and purpose. For this reason, **it is also recommended that dedicated training in the approach to wellbeing be replaced in favour of measures designed to place the approach at the heart of each role.**

Appendix (4):

Appraising current measures of wellbeing across DCC:

- *What existing measures are taken across systems in DCC?*
- *Are these measures suitable for measuring wellbeing or do bespoke measures need to be developed?*
- *(How) can these measures 'dovetail' with existing metrics within DCC?*

With help from colleagues from public health, a picture of the types of measure that were currently employed by various services within DCC was constructed. These measures were then appraised in order to find which would be most suitable for the suggested future monitoring within DCC.

As can be seen, there is a vast array of different measures and metrics currently collected across public health in County Durham. Due to the sheer range of these, some of the most prominent measures currently in use were appraised in order to ascertain the relative merits of each.

WEMWBS/SWEMWBS:

Service Name	WEMWBS / SWEMWBS
Bereavement Support	✓
Programme Management of Social Prescribing Link Workers	✓
Ways to Wellbeing	✓
Wellbeing for Life Service	✓

A number of services within Public Health currently use the *Warwick-Edinburgh Mental Well-being Scale* (WEMWBS) or the *Simplified* version of this (SWEMWBS).

What is it?

WEMWBS is either a 14- or 7- (simplified) -point scale which assesses a population's mental wellbeing. Questions centre around statements such as "*I've been feeling confident",* "*I've been feeling loved"* or *"I've been thinking clearly"* to which the respondent must indicate how often they have experienced these phenomena within the past 2 weeks on a 5-point Likert scale, ranging from *None of the time,* through to *All of the time.* Examples of both the 14-point and simplified 7-point scales can be found below:

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
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The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

"Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS)
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Advantages* and *Disadvantages:

Feasible

- *WEMWBS is already used by a number of large-scale services within DCC*
- *Although it can be presented in a shorter 7-point scale, the full 14-point scale could be too long for many to consider completing,*

Accessible

- *Readability is approx. 9 years (3.8 Flesch-Kincaid) for SWEMWBS.*
- *Both WEMWBS and SWEMWBS have been translated into a number of other languages.*
- *Although the language of the tests are simple to understand, there are a number of higher-order concepts such as feeling good about*

oneself. The questionnaire also asks respondents to summarise the last 2 weeks, which may prove difficult for some individuals.

Standardised

- *S(WEMWBS) has been validated for use across multiple scenarios*
- *Data generated is robust, and baselines could be created using data of existing DCC services.*

Transferable

- *Introducing either 14 or 7 point scales may make existing surveys carried out by some services long and unwieldy and may detract from other data they are trying to collect.*
- *Target measures of (S)WEMWBS are very specific to mental wellbeing, and as such may not be suitable for many services to adopt.*

EQ-5D-3L

Service Name	EQ-5D-3L
Wellbeing for Life Service	✓

What is it?

The *EQ-5D-3L* is a 5-item standardised measurement of health-related quality of life that covers 5 primary dimensions of health, namely: *Mobility, Self-Care, Usual Activities, Pain/discomfort* and *Anxiety/Depression* (Shah 2017). Questions in the *EQ-5D-3L* require respondents to tick whichever statement(s) they feel apply to them (Ronaldson and Ali 2010) and contain statements such as *"I have no problems in walking about"* or *"I am unable to perform my usual activities".* There are a number of *EQ-5D* tools available in addition to the *3L*, which are designed for use in young people (*EQ-5D-Y)* or with greater sensitivity *(EQ-5D-5L).* The *3L* is evaluated here due to its suitability for adults and its simplified nature.

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems in walking about	❑
I have some problems in walking about	❑
I am confined to bed	❑

Self-Care

I have no problems with self-care	❑
I have some problems washing or dressing myself	❑
I am unable to wash or dress myself	❑

Usual Activities (*e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities	❑
I have some problems with performing my usual activities	❑
I am unable to perform my usual activities	❑

Pain/Discomfort

I have no pain or discomfort	❑
I have moderate pain or discomfort	❑
I have extreme pain or discomfort	❑

Anxiety/Depression

I am not anxious or depressed	❑
I am moderately anxious or depressed	❑
I am extremely anxious or depressed	❑

Advantages* and *Disadvantages:

Feasible:

- *Although only used by one service currently, it is a large-scale service which employs the EQ-5D-3L*
- *A large amount of support exists for implementation of the EQ-5D-3Lwhich would facilitate its adoption*

- *Although technically only a 5-item questionnaire, the information it requires respondents to read is quite long (15 statements) especially if used in conjunction with any existing measures.*

Accessible:

- *Concepts are generally easy to understand and allow respondents to easily reflect their general health experiences on the day they respond.*
- *EQ-5D-3L is widely used, and currently exists in 98 languages*
- *Readability is 11 years (5.9 Flesch-Kincaid)*

Standardised:

- *The EQ-5D-3L has been subject to numerous academic studies, which have shown it to be valid and reliable (van Agt H. 2005)*
- *Although the EQ-5D-3L is widely used, there is not a large bank of data available at a local level.*

Transferable:

- *The EQ-5D-3L is highly specific to gauging health-related outcomes, and does not take general wellbeing into account.*
- *It is unlikely that this measure could be used in a variety of services.*

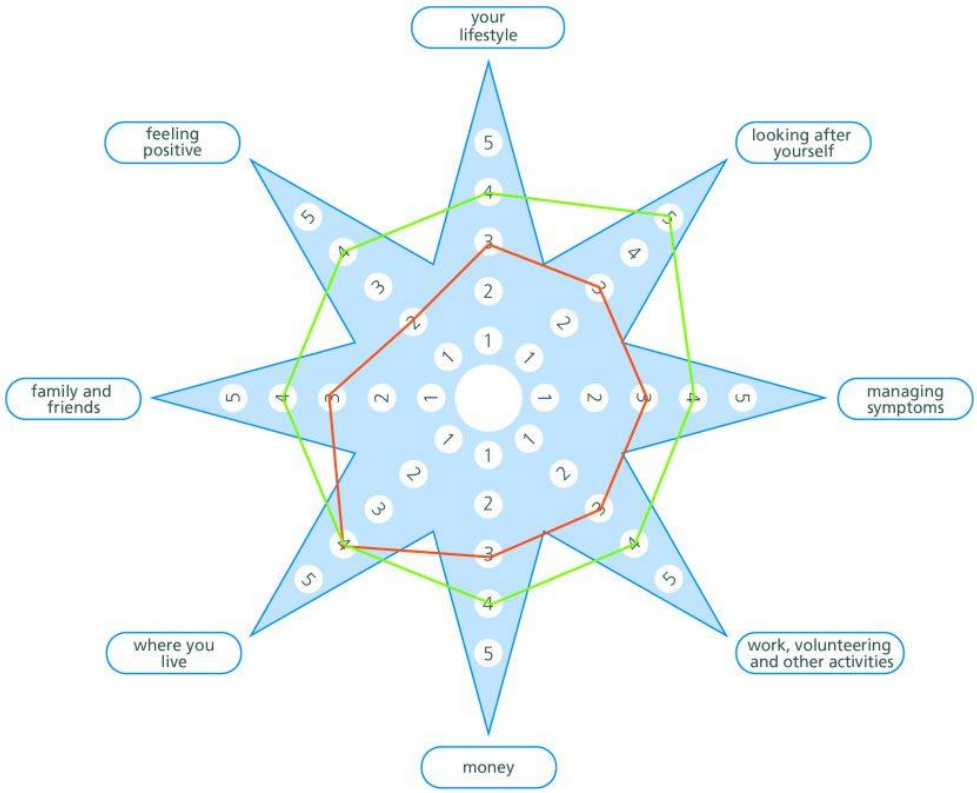
Outcomes Star:

Service Name	Outcomes Star
0-25 Family Health Service	✓
Children & Families Emotional Wellbeing Programmes	✓
Young Parent Support Programme	✓

What is it?

The outcomes star is a concept for evaluation rather than a single measure. The use of an outcomes star can be customised on any number of levels, from the content for each star, the gradient used in scoring each point – right down to the number of points each star will have. Because of this, the questions that are asked and the scales that are used are not uniform and could conceivably contain any questions and measures that it was felt were important. Outcomes stars are often developed in

conjunction with practitioners and service users/patients etc., and so are often co-produced.



Well-being Star™ (2nd Edition) © Triangle Consulting Social Enterprise Ltd
Authors: Sara Burns and Joy Mackeith
www.outcomesstar.org.uk

Advantages* and *Disadvantages:

Feasible:

- *Versions of outcomes stars are currently used by services within DCC.*
- *Because of its co-produced nature, the development and implementation of any such measure will take time and resources to do properly.*

- *Development of a truly co-produced measure of wellbeing amongst a certain population requires significant commitment from all involved.*

Accessible:

- *Due to its adaptability, language contained within any questions can be as simple as required. Outcomes can also easily be represented graphically to aid dissemination.*
- *Ensuring accessibility of concepts will have to be ensured by whoever devises content of the outcomes star.*
- *Any accessibility provision, such as translation, easy read resources etc., will need to be devised separately.*

Standardised:

- *Outcomes stars are ideal to measure impact over time, due to the way in which they work.*
- *Reliability of data depends entirely on quality of questions devised for each outcomes star.*
- *Data can only be used if it corresponds to identical outcomes star – thus any accurate baseline must be established over time.*

Transferable:

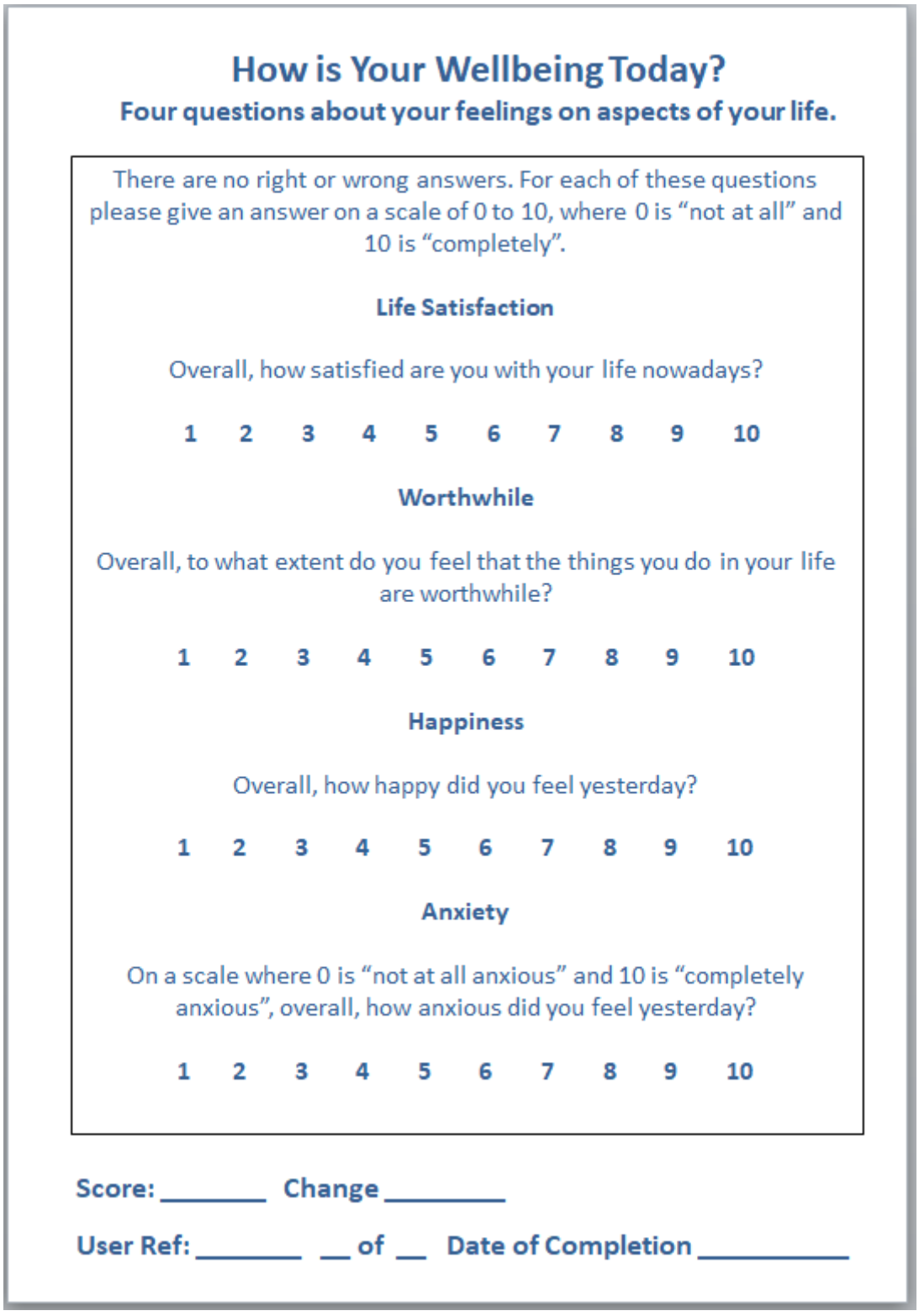
- *Applicability across systems must be written into outcomes star at the stage of conception.*
- *Data does not exist at a comparable national or local level.*

ONS-4

Service Name	ONS 4
Programme Management of Social Prescribing Link Workers	✓

What is it?

The *ONS-4* was introduced in 2011 by the Office of National Statistics (ONS) as part of the Annual population survey (Dolan and Metcalfe 2012) and consists of four subjective wellbeing questions (Tinkler 2015). Examples of questions in the full *ONS-4* are "Overall, how satisfied are you with your life nowadays?" to which respondents are asked to give a response on a scale from 0-10 where 0 is 'not at all' and 10 is 'completely'.



How is Your Wellbeing Today?

Four questions about your feelings on aspects of your life.

There are no right or wrong answers. For each of these questions please give an answer on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".

Life Satisfaction

Overall, how satisfied are you with your life nowadays?

1 2 3 4 5 6 7 8 9 10

Worthwhile

Overall, to what extent do you feel that the things you do in your life are worthwhile?

1 2 3 4 5 6 7 8 9 10

Happiness

Overall, how happy did you feel yesterday?

1 2 3 4 5 6 7 8 9 10

Anxiety

On a scale where 0 is "not at all anxious" and 10 is "completely anxious", overall, how anxious did you feel yesterday?

1 2 3 4 5 6 7 8 9 10

Score: _____ Change _____

User Ref: _____ __ of __ Date of Completion _____

Advantages* and *Disadvantages:

Feasible:

- *Although only used by the SPLW service in DCC, this is a significant amount of data. It is also used by Social Prescribers nationally.*
- *The ONS-4 only contains 4 items. This makes it much easier for services to use in conjunction with existing metrics.*
- *This brevity also makes it more likely that respondents will fill out questions.*

Accessible:

- *Concepts contained in the ONS-4 are clear – 'how satisfied/happy/worthwhile/anxious'*
- *Readability is 12 years (Flesch-Kincaid 6.5)*

Standardised:

- *ONS-4 data is collected every year in a systematic way.*
- *Data is standardised and harmonised. (Harmonisation is the process of making statistics and data more comparable, consistent and coherent. Harmonised standards set out how to collect and report statistics to ensure comparability).(Wey, Doiron et al. 2021)*
- ***A large dataset is already available to analyse at local authority level***
- *Due to having been used since 2011 by the ONS, there is currently a rich dataset with which to establish a baseline.*

Transferable:

- *ONS-4 is already used across a wide range of interventions and services for evaluative purposes nationally, thus demonstrating its suitability in a range of settings. These include the Cabinet Office, DWP, Department of Health, and MoD.*
- *ONS-4 questions are specifically designed to be used alongside more specialised metrics.*

As can be seen from the above, the *ONS-4* stands out as being the most suitable option to measure wellbeing across the whole of DCC services. Because of this, suggestions of how this may be introduced are examined below, as are suggestions for how to navigate the issue with the *ONS-4's* readability.

Readability Issues.

The primary issue affecting the introduction of the *ONS-4* wellbeing measure within DCC is its relative difficulty in readability. It is, in its original form the most complex to read:

Table 1 Number of items, word count, Flesch-Kincaid Grade and reading age for related measures

Measure	Number of items	Word count	Flesch-Kincaid Grade	Reading age (years)
Personal Wellbeing Score	4	42	3.7	9
ONS4 (standard version)	4	114	6.5	12
ONS4 (concise version)	4	62	6.5	12
OECD core questions	5	177	6.4	11
General Health Questionnaire	12	324	6.3	11
Short Warwick-Edinburgh Mental Wellbeing Score	7	89	3.8	9
ICECAP-A	5	264	5.1	10
Adult Social Care Outcome Tool	8	415	5.3	10
EQ-5D-3L (including VAS)	6	263	5.9	11

VAS, visual analogue scale.

While this may not be an issue for some potential participants in any survey, there may be others for who this complexity could be a barrier. In such instances, the *Personal Wellbeing Score* could be an alternative. “The Personal Wellbeing Score (PWS) is based on the Office of National Statistics (ONS) four subjective wellbeing questions (ONS4) and thresholds. PWS is short, easy to use and has the same look and feel as other measures in the same family of measures.” (Benson, Sladen et al. 2019). Perhaps most salient is that the *PWS* can be used in conjunction with the *ONS-4* (thus meaning either can be used) as it uses thresholds that correspond with the *ONS-4.* As can be seen below, the *PWS* is comparable to *SWEMWBS* in terms of readability but has clear advantages in terms of brevity over other standard measures of wellbeing. It also benefits from the widespread robust data of the *ONS-4* discussed above.

Personal Wellbeing Score

To what extent do you agree or disagree with these?

	Strongly agree	Agree	Neither agree nor disagree	Disagree
I am satisfied with my life				
What I do in my life is worthwhile				
I was happy yesterday				
I was NOT anxious yesterday				

Table 1 Number of items, word count, Flesch-Kincaid Grade and reading age for related measures

Measure	Number of items	Word count	Flesch-Kincaid Grade	Reading age (years)
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EQ-5D-3L (including VAS)	6	263	5.9	11

VAS, visual analogue scale.

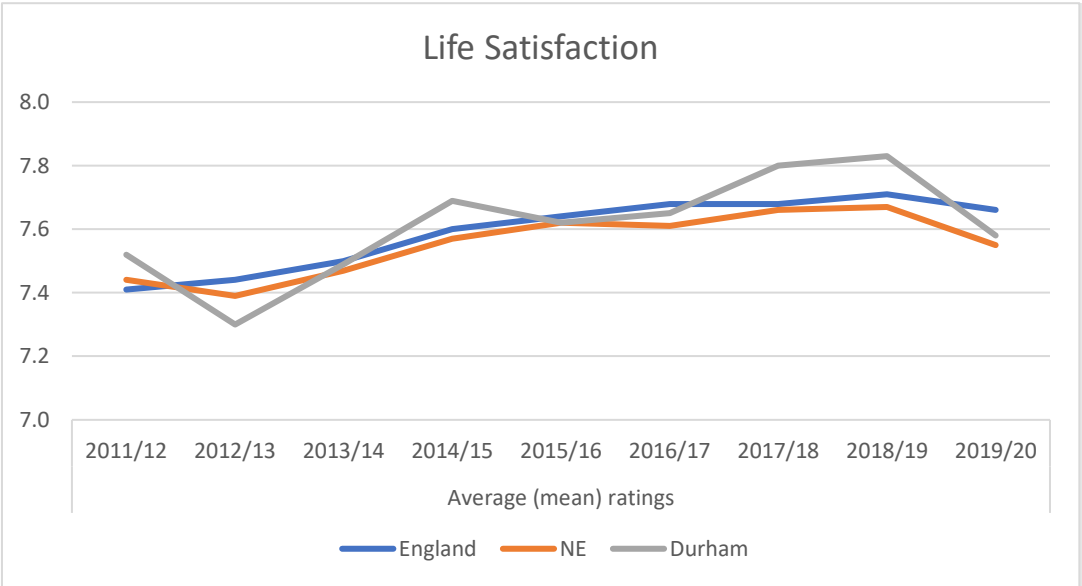
For ONS4 life satisfaction, worthwhile and happiness scores, responses 9–10 are grouped as *Very high*, 7–8 as *High*, 5–6 as *Medium* and 0–4 as *Low*. For anxiety scores, responses 6–10 are grouped as *High*, 4–5 as *Medium,* 2–3 as *Low* and 0–1 as *Very low* and correspond to each of the 'emojis' used on the *PWS*

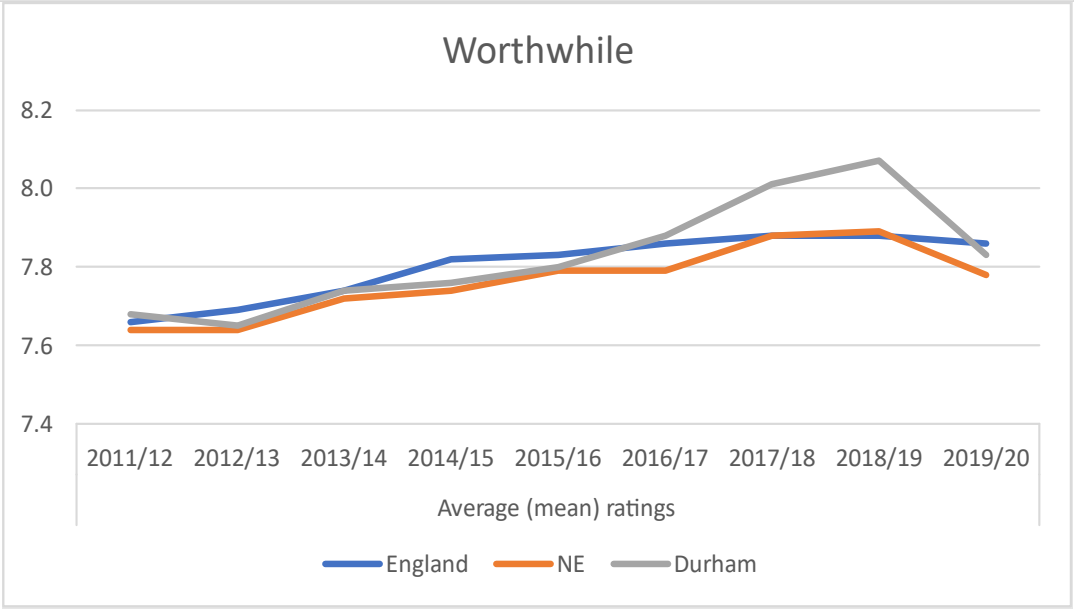
Creating a strong baseline

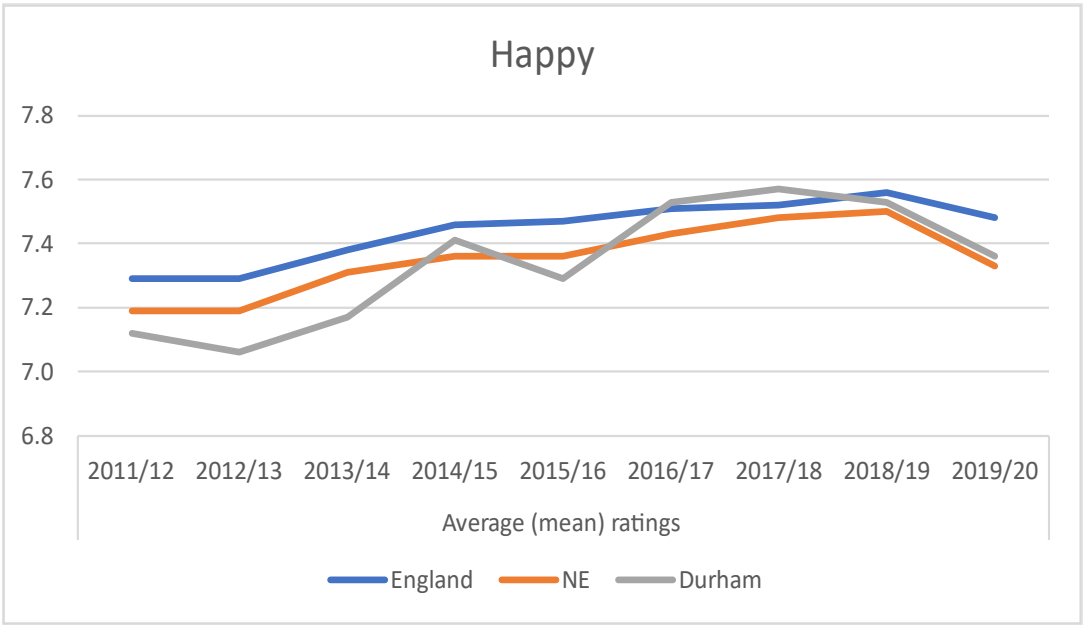
As previously stated, because the ONS-4 is so widely used, there is a wealth of data already available that can be used to create baselines. This data is taken at a local, regional and national level and has been for over a decade. This data presented below gives an insight into the value of the data to produce robust baseline data. A brief look at this data allows for the following conclusions relating to wellbeing in County Durham to be made (since 2011):

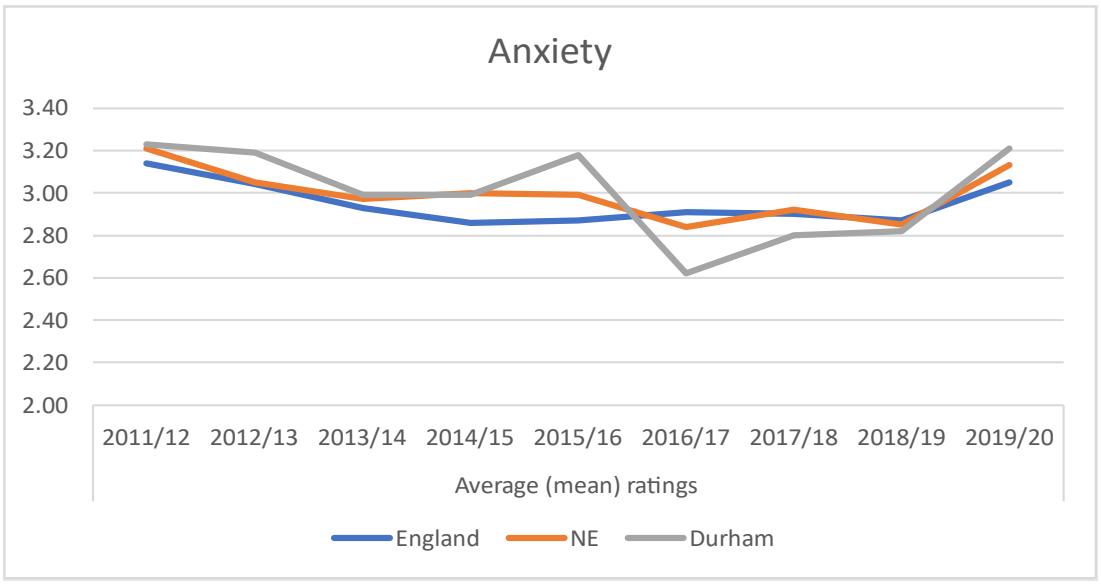
- *Life satisfaction in Durham is consistently 'High' and a little higher than national and regional averages.*
- *The feeling that life is worthwhile (Eudaemonic wellbeing) in Durham again is consistently 'High' and a higher than national and regional averages.*
- *Happiness' scores across the county have been considerably less consistent, and in 2012/13 almost dropped from 'High' to 'Medium'.*
- *Regarding anxiety, the picture is changeable. While a significant drop in reported anxiety levels from in 2016/17 may be a surprise, the rise in 2019/20 across all areas is perhaps less so. What is*

important here however, is that the ONS-4 data has captured this increase in anxiety over this time.









Using pre-existing data to draw such (quick) conclusions also helps to point to how the *ONS-4/PWS* can be used specifically by DCC to measure the impact of the wellbeing approach. *The first being tracking general changes over time across the whole population via publicly available ONS-4 data, much in the same (albeit more detailed) way to what has been done here.*

Secondly, the *ONS-4/PWS* allows for the monitoring of interim measures which could be undertaken either through DCC commissioned services or by ad-hoc surveys. These could potentially be set against the background of the ONS-4 measurements. This would allow DCC to ascertain whether or not the interventions they are making result in a positive contribution to

people's lives. Data collected by DCC in general could be compared to background data, to see if individuals who interact with DCC services experience greater wellbeing and could further be employed to measure and demonstrate the impact of specific services on wellbeing, by asking individuals to report their wellbeing (alongside any other data requested by any such service) at the beginning and then the end of their journey with the service, if applicable.

Appendix (5):
Internal Stocktake Paper – 2 Year Review:

Report of Amanda Healy, Director of Public Health (Chair of Approach to Wellbeing Steering Group)

Electoral division(s) affected:
None

Purpose of the Report

1 The purpose of the report is to reflect on the past two years since the Approach to Wellbeing was introduced; to highlight some of the achievements in embedding the Approach; to note the evaluations that have taken place and the subsequent recommendations; and to set out some proposals for developing the Approach further in the context of recent developments.

Executive summary

2 January 2019 saw the culmination of a year's work to develop the County Durham Approach to Wellbeing (A2W). Developed with partners in the voluntary and community sectors through the Resilient Communities Group, then further shaped by workshops and conversations with commissioners, colleagues in the NHS, public health, housing, children's services and in Area Action Partnerships, the Approach has changed over the course of the two years both in content and application.

3 The Approach has seen some notable achievements in being utilised as a means of devolving power to communities, with a view to achieving better outcomes. It has also been the subject of Audit and Evaluation which has resulted in a number of reflective questions being posed to the A2W steering group members as part of a 2-year stocktake on how it can be developed further.

4 Whilst the A2W principles have become embedded in the work of DCC, the VCS and many other partners, its aim to fully engage communities has not been fully realised. However, the emergence of the County Durham Together Partnership with its focus on working with communities provides a key opportunity to address this and to further mainstream the A2W principles.

5 As a starting point in furthering this alignment, two recommendations are made below. The outcome of these discussions should then be considered.

Recommendation(s)

6 CDT is recommended to:

(a) Ask the chairs of each CDT workstream to use the Approach to Wellbeing Self-Assessment Framework to undertake a mapping exercise, reflecting on the extent to which their vision and plan on a page is informed by each of the Wellbeing principles, and highlighting any further actions that may be needed to improve alignment. This can then be reported back to the next CDT meeting where a decision can be made on next steps.

(b) Share the proposed action plan on pages **10-12** with each CDT workstream, asking them to discuss its relevance.

(c) Ask workstream chairs to report back their findings to the next CDT and A2W meetings, enabling the CDT and A2W members to form a view on the value of greater alignment of the two and determining the appropriate next steps to be taken.

Background

7 January 2019 saw the culmination of a year's work to develop the County Durham Approach to Wellbeing. Developed with partners in the voluntary and community sectors through the Resilient Communities Group, then further shaped by workshops and conversations with commissioners, colleagues in the NHS, public health, housing, children's services and in Area Action Partnerships, the Approach has changed over the course of the two years both in content and application.

8 The Approach to Wellbeing (A2W) has been used by many teams across the County Durham Partnership, and embedded into some of our most fundamental policies and strategies such as the County Durham Vision, the Health & Care System Plan, the Joint Health and Wellbeing Strategy and County Durham Together.

9 The approach has also been subject to evaluation by Teesside Evaluation, of which two phases have been completed. Work has also been undertaken to compare the Approach to Wellbeing with guidance recently published by Public Health England on success factors for implementing community centred models.

10 Feedback received from colleagues using the model alongside the recommendations emerging from these more formal evaluations provide the impetus for this 2-year stocktake.

Development of the Approach to Wellbeing Model

11 The original Approach to Wellbeing was developed with partners in the Resilient Communities Group. At the time, it emerged as a conceptual model with a set of seven principles based upon the evidence at that time. This highlighted the importance of involving communities in the things that affected them, and the impact this could have in terms of individuals having more control over things in their lives, and ultimately impacting upon their resilience and wellbeing. **Put simply, the model supported the premise that if we empower people, then they will have better outcomes.**

12 As a conceptual model however, it proved difficult to operationalise and so after further consultation, the model was changed to one that proved more meaningful and was supported by a self-assessment framework which enabled people to use the model as a tool for reflection and change. This became known as the 'soundbites' model shown below.

Implementation through 12 Next Steps

13 In order to implement the model, twelve 'next steps' were suggested (see Appendix Two). A number of these have been taken forward and implemented, for example, the seven Wellbeing principles have been

used to inform the piloting of Alliance Contracting and a new way of working with the VCS by devolving greater power to them. It has also been used to shape the Child Poverty Action Plan and the Joint health and Wellbeing Strategy. However, many of the *'Next Steps'* were focused around working directly with communities, engaging them, sharing information with them and working with them to effect changes. These actions, set out on the left-hand side of the model above, have proven more difficult to progress due to the impact of COVID-19, although the pandemic has provided us with simply a different set of opportunities to explore implementation of the Approach to Wellbeing. This has included shaping the way in which support to communities has been offered through the community hub and Area Action Partnerships; through our efforts to develop and work through community organisations and mutual aid groups; and through the commitment embedded in County Durham Together to *'do with, not to'*.

Achievements to date

14 Notwithstanding the limitations imposed by the pandemic, there have been a number of significant achievements to date. These are detailed more fully in a summative annual report provided by the Approach to Wellbeing Programme Manager in Appendix 3. They include:

- Use of the Wellbeing Principles to audit and shape the Housing Strategy and operational delivery plan.
- Providing a structured framework for delivering the Holiday Activities with Food Programme and the development of the Place Based Approach to Early Help
- Integration of the wellbeing approach into the Joint Health and Wellbeing Strategy with all presentations to the Board being required to demonstrate how the Approach to Wellbeing is used.
- Integration into the Safe Durham Partnership Plan.
- Inclusion in the Strategic Planning Toolkit – ensuring that the Approach is considered in the writing of all new strategies.
- Fundamental changes to how services are commissioned including the piloting of Alliance Contracting for Community Mental Health Services.
- Using the Approach as the basis for reviewing the NHS Health Checks contract.

- DurhamEnable – using the model to shape service delivery for this new Supported Employment Scheme including the training of all job coaches.

- Child Poverty Plan – using the Approach to audit the current plan and shape the content of the new plan.

- COVID Community Champions – training the Community Champions in use of the model in order to work in ways that empower communities and build their resilience.

- Finally, the Approach to Wellbeing has underpinned our community response to COVID-19 and the emergence of our programme of cultural change and community engagement in the form of County Durham Together

Audit and Evaluation of the Approach to Wellbeing

15 In January 2020, Public Health England published a paper entitled 'Community-centred public health: Taking a whole system approach'.[1] The paper was intended to 'summarise the key elements, core values and principles needed to develop whole system approaches to community-centred public health', and also to 'improve the effectiveness and sustainability of action to build healthy communities, whilst embedding community-centred ways of working within whole systems'.

16 Taken as national guidance on the best approaches to community engagement, it was decided to look at how that guidance could then inform further changes to the Wellbeing Approach. This outcome of this audit can be found in Appendix 4.

17 Whilst the audit found a number of strengths in the Wellbeing Approach, (namely the ease of its practical application due to the development of the soundbites model, and the self-assessment framework), there were some areas where changes could be made to improve the impact of the Wellbeing Approach. This included strengthening the focus around a number of key strategic enablers to support successful implementation. For example, the PHE model emphasised:

8 leadership,

9 building skills across the workforce,

[1] https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach

10 the mainstreaming and scaling up of interventions,

11 structured approaches for engaging communities,

12 building capacity within communities and the VCS,

13 setting out long term ambitions with outcome frameworks,

14 and efforts to identify and lay the ground-work for successful whole system working.

18 These areas provide a useful steer for further shaping our work in relation to community engagement and empowerment.

19 The Approach to Wellbeing has also been subject to evaluation by Teesside university over four phases. These include:

a) interviews with early adopters on how they have used the wellbeing approach,

b) a case study of the approach being used in action to shape the response to COVID-19,

c) a review of the way in which the approach to wellbeing is used to inform the work of COVID-19 champions and their response to it,

d) and finally, a long-term comparison of indicators over time to consider the impact of the approach.

20 The first set of findings and recommendations have now been shared and are contained in Appendix 5. In summary, the recommendations include:

a) the need to develop a systematic approach to community engagement, complementing the work of AAPs,

b) refinement of the model and changes in terminology which could assist in the above,

c) ensuring ease of application of the model to other settings enabling mainstreaming and further scaling up,

d) and ensuring leadership buy-in.

Responding to the Audit and Evaluation

21 There is considerable consistency between the findings and recommendations arising from Teesside University and the PHE Community-centred model. Three areas particularly stand out, including the need to a) ensure leadership buy-in, b) the importance of developing a systematic approach to community engagement, and c) the importance of mainstreaming the approach.

22 The Approach to Wellbeing Steering Group has therefore asked itself the following reflective questions.

> Has enough been done to secure support for the Wellbeing Approach at senior level within the organisation(s)? Could more be done?
> Have we determined a structured and consistent approach for the way in which we engage communities?
> Do we have a system in place to mainstream and scale up those interventions we know work?

23 Five additional areas for discussion were also thrown up by the Audit against the PHE Community Centred guidance:

> Could more be done to build skills in community-centred working across the workforce?
> What are we doing to build capacity in communities and ensure our VCS is thriving? Can we do more?
> Have we set out a long-term vision for the Wellbeing Approach? What should that be?
> What outcomes are we working towards? How are we measuring our success?

24 A draft action plan containing some practical actions in response to these recommendations was presented and discussed at the Approach to Wellbeing Steering Group and is included in Appendix 6.

25 The Approach to Wellbeing Steering Group noted the 'gaps' in terms of how the model had been implemented and noted that whilst there has been strong take up across a range of sectors, it has not been used explicitly in our work with communities. In addition, colleagues in many sectors, in their day-to-day work, work with communities, seeking to empower them and build their resilience, but may not explicitly recognise this as using the Approach to Wellbeing principles. Hence, we still have some way to go in truly embedding the approach in a way that is recognised by everyone as a model to underpin their work.

26 In addition, structural changes emerging as a result of the pandemic, present further opportunities to align the Wellbeing Approach, and

ensure the best ‘fit’ of its principles to new ways of working. The emergence of County Durham Together (CDT) provides an opportunity for major cultural change including widespread uptake and implementation of the Wellbeing Principles across all sectors with its strong ethos of working with communities, strengthening the role of the VCS, and of co-production. This alignment is explored below.

Alignment of County Durham Together and the Approach to Wellbeing

27 The County Durham Together Partnership has embarked on a culture change and leadership programme that will enable people to help themselves in their local communities. Building upon and learning from the support to communities during the COVID-19 pandemic, the intention is to ensure that people know where to go for early support and advice when needed, and also to provide support to those who need it most. There is an underpinning ethos of there being ‘no wrong door’.

28 County Durham Together has nine workstreams taking forward specific areas of work as outlined below:

(a) Culture and leadership – joint work across the partnership to share values, behaviours, roles, expectations and joint commissioning – maximising the Durham pound.

(b) Data and insight – evidence-based approaches to support decision making

(c) Co-production – developing a framework for how we involve people in design and decision making

(d) Community book – a digital offer to signpost people to what is available in communities

(e) Community connectors – holistically supporting people in communities, opening up conversations based on Making Every Contact Count

(f) VCS sustainability and mutual aid – preventative approaches and harnessing what is already in communities to support resilience

(g) Skills and competence – trained workforce with a shared set of skills to know how to enable and empower whoever they are working with at the earliest opportunity

(h) Physical Presence – placed based approaches (eg Horden Together) and multi-functional buildings

(i) Triage, Step Up, Step Down – working across organisational boundaries and “at scale” approaches

29 County Durham Together has, at its heart, the principles from the Approach to Wellbeing, and an intent to involve communities in the decisions that affect them. Its reach, across the whole of the County Durham Partnership means that its programme of work is well placed to deeply embed the Approach to Wellbeing principles across the entire network of partners and in so doing, reach all of our communities. It would also address some of the concerns raised in the evaluation undertaken by Teesside University, and respond to the recommendations from PHE guidance to ensure that activities have strong leadership buy-in and can be mainstreamed and scaled up.

30 A strong argument could therefore be made to wholly embed and absorb the Approach to Wellbeing within the work of the CDT, but in order to do so, it would be helpful to better understand how the objectives of each of the 9 CDT workstreams, map against each of the Approach to Wellbeing principles. This will help to determine whether there are any gaps in applying the Wellbeing principles that need to be addressed, or that would be so significant as to make the ‘merger’ of the two approaches impractical.

31 **It is therefore recommended** that the chairs of each CDT workstream use the Approach to Wellbeing Self-Assessment Framework to undertake a mapping exercise, reflecting on the extent to which their vision and plan on a page is informed by each of the Wellbeing principles, and highlighting any further actions that may be needed to improve alignment. This can then be reported back to the next CDT meeting where a decision can be made on next steps.

32 In bringing these two programmes of work together, there would also be value in considering the relevance of the actions set out in the draft action plan in Appendix 6. These actions based upon PHE guidance would be highly translatable to CDT at a strategic level, and offer the opportunity for further embedding both CDT and the Approach to Wellbeing across the County Durham Partnership.

33 A suggested mapping of the A2W draft action plan against the CDT workstreams has been undertaken below for consideration. Note that some changes have been made to the text compared to the actions in Appendix 6, in order to highlight the relevance to CDT.

A2W action	Mapped to….	CDT workstream
Ensure leadership buy-in • Celebrate the success of the Approach to Wellbeing and its alignment with CDT through further discussion at CMT, County Durham Together Partnership, with the VCS and with other partner's senior teams, demonstrating learning, progress and next steps. • Ensure that CDT and the A2W principles are highlighted in the induction of all new Directors, Heads of Service and Strategic Managers. • Look at ways in which the CDT/A2W can be more visibly supported at a corporate level by senior leaders for example in publications and presentations. • Include the value of CDT and the A2W principles in leadership and management courses.		Culture and leadership Skills and competence Culture and leadership Skills and competence
Structured approaches for engagement • Review the current means we have of engaging citizens including Area Action Partnerships, the Youth Council, LD Parliament, Investing in Children, Patient Reference Groups and bring together the best of these in a single but flexible model.		Co-production approach employed by all workstreams.
Mainstreaming and Scaling up of Interventions • Use the Approach to Wellbeing as a development/reflective tool for		

looking at what has worked, building on the bank of case studies and worked examples of how this has been done. • Work with the Area Action Partnerships to identify successful projects that have the potential to be mainstreamed or scaled up across the County. • Put in place a systematic approach to enable successful projects to be considered for upscaling by those working at the appropriate decision-making level. • Put in place a system of review with commissioning colleagues to ensure successful applications of CDT/A2W are embedded into contracts as part of the Durham Procurement Family Network. • Look at opportunities to publicise success more widely. • Work with the Health and Wellbeing Board to ensure that those presenting are challenged on how they can upscale and mainstream their successes.		VCS Sustainability and Mutual Aid, and the Physical Presence workstreams feeding in recommendations to the CDT Chairs meeting. VCS Sustainability and Mutual Aid workstream Culture and leadership Culture and leadership Health and Wellbeing Board
Building skills across the workforce • Incorporate CDT and A2W principles into the induction programme for all staff (councillors and officers). • Undertake an audit of current training in community development, and encourage and support uptake for key staff where relevant. • Build a short e-learning course on CDT/A2W, accessible to all partners. • Consider how CDT/A2W could be built into or run alongside other		Skills and competence workstream Skills and competence workstream

programmes such as Making Every Contact Count.		Skills and competence workstream Community connectors
Building capacity within the VCS • Continue our work with the VCS on Alliance Contracting. • Continue our work on the County Durham Pound, securing commitments across the County Durham Partnership to support community wealth building. • Develop a VCS Sustainability Framework which outlines the way the statutory sectors will work with the VCS.		VCS Sustainability and Mutual Aid workstream Culture and leadership VCS Sustainability and Mutual Aid workstream
Setting out long term ambitions • To use this two-year stocktake as the starting point to develop a longer term 'Wellbeing Vision' with County Durham partners, and supported by County Durham Together.		Culture and leadership
Developing an outcomes framework and measuring our success • We will use the County Durham Vision 2035 to develop our measures for our success at 3, 5 and 10 years.		Culture and leadership

34 **It is recommended** that these proposed actions are shared and discussed at each of the relevant CDT workstreams to discuss their relevance and to consider how the Approach to Wellbeing could be mainstreamed within their work, and to feed back their conclusions to the next CDT and A2W steering group meetings.

Conclusion

35 The Approach to Wellbeing has seen some notable successes in the past two years and has continued to adapt and grow to ensure its continuing relevance. This approach can be seen in its response to both the audit against PHE good practice guidance, and the formal evaluation being undertaken by Teesside University.

36 Whilst the A2W principles have become embedded in the work of DCC, the VCS and many other partners, its aim to fully engage communities has not been fully realised. However, the emergence of the County Durham Together Partnership with its focus on working with communities provides a key opportunity to address this and to further mainstream the A2W principles.

37 As a starting point in furthering this alignment, two recommendations are made in this paper. The first is to map out the seven Wellbeing Principles against the 9 CDT workstreams to determine whether there are any gaps in their work programmes where greater take-up of the Wellbeing Approach can be considered. The second, is to consider the actions highlighted in the draft A2W action plan (Appendix 6) for their relevance to the work of each CDT workstream, and also as an aide to the strategic development of CDT. The outcome of these discussions should then be considered further by the County Durham Together Partnership and also the Approach to Wellbeing Steering Group with the aim of seeking greater alignment of the two and determining the appropriate next steps to be taken.

Appendix 5(a): Approach to Wellbeing Next Steps

Next Steps

- 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.

Appendix 5(b): Wellbeing Programme Manager's Report

Report of Cat Miller, Wellbeing Programme Manager, Partnerships and Community Engagement

Purpose of the Report

1 To update the Approach to Wellbeing Steering Group on progress made against the workplan for the Approach to Wellbeing.

Recommendation(s)

2 The Approach to Wellbeing Steering Group is recommended to:

(a) Note the progress made against the workplan to date from the start of the project.

(b) Note that the focus of the work has had to continue to change due to the impact of COVID.

(c) Note the future plans for the project evaluation and progress to date.

(d) Note that a Wellbeing Stocktake is being undertaken by Tracey Sharp which will inform the future direction of the Approach to Wellbeing work, including any dedicated support to the programme.

Background

3 The Programme Manager came into post on 9th March 2020. The initial workplan was updated and agreed on 10th September 2020 as Covid-19 meant we had to re-prioritise our work due to the limitations in terms of community engagement and working directly with organisations.

Integration into the Joint Health and Wellbeing Strategy

4 The Approach has been outlined in detail in the JHWBS and has been used to audit the strategy to ensure that all aspects of the approach are reflected in the narrative and the aims and outcomes. The proposed Ageing Well case study also derives from early work in the development of the Approach. This means that the approach will now be embedded in any delivery mechanisms linked to this plan. It is also an expectation of the Health and Wellbeing Board that anyone presenting to the board demonstrates how they are using the Approach to Wellbeing.

Integration into the Safe Durham Plan

5 As per how the model was used for the JHWBS the same format is being used for the Safe Durham Partnership Plan to ensure that the principles of the Approach are embedded in the plan. This will ensure

that the approach to Wellbeing is embedded in any delivery mechanisms related to this strategic document

Inclusion in the Strategic Planning Toolkit

6 Following a meeting with the Strategic Planning Group in December 2020 the Approach has now been formally adopted as part of the Strategic Planning Toolkit meaning that the approach will have to be considered as part of the writing of all new strategies. This will continue to ensure that the Approach is considered and embedded at a Strategic level.

Commissioning

7 The Approach to Wellbeing has been used to develop the high-level outcomes for Project Alliance for the Community Mental Health Services Contract. All the outcomes are directly linked to the principles which will ensure that the approach is embedded in service delivery and not just seen as a stand-alone model but a way of working.

8 All other work in relation to commissioning including the Durham System Plan is all ongoing however slowed in progress due to the most recent lockdown placing additional pressures on leads.

9 The Approach has been used as part of the review of the NHS health checks contract and will be used as the foundation for the new contract going forward. The review of this contract has very much demonstrated a “Doing with, Not to” approach with the level of consultation with people who use or have used this service to look at what the best solution is for individuals.

Project Evaluation

10 Phase 1 is complete and the interim report and recommendations has been shared with the steering group. These findings have also been shared with the Health and Wellbeing Board and County Durham Together Partnership.

11 Phase 2 Case Study has been completed and to be presented at the steering group on 7th April 2021 for agreement. It is hoped that the learning demonstrated through this will support other services to see how the approach could be used to both develop and operate a service delivery model.

12 Phase 3 is ongoing and this has commenced with the approach being introduced to the Covid Community Champions as a community of interest in relation to how the approach is applicable to their area of work and how working in the way they are is aligned to the principles. Andy Divers from Teesside University will follow this up as planned in focus groups and with a questionnaire later in the summer.

13 Phase 4 requires further discussion with the researcher going forward to decide what format this is going to take. It has been suggested it is aligned to the Joint Health and Wellbeing Strategy and the measurement of Self-Reported Wellbeing.

Work in other Areas

14 Durham Enable – the model has been used to help shape the service delivery model, particularly around service user involvement and how service users can help develop the service going forward. An induction session around the approach to wellbeing in relation to the job coaches role was also undertaken and this was a really useful exercise and helped link aspects of the job description to the model and highlighted the much wider impact of the way we deliver services to our residents.

15 Development of the model – is included as part of the evaluation and the Phase 1 recommendations and it is hoped to move on and look at how the approach can be used to support the workforce. The pandemic has allowed us to see that by supporting staff in a way that is aligned to the approach then outcomes are better for both staff wellbeing but also for the continued effective delivery of services likely due to staff feeling supported and empowered.

16 Child Poverty Plan – The Approach is being used to audit the existing plan and identify gaps and strengths to be carried forward into the new plan. This will ensure that the model is integrated into service delivery and is not a stand alone model it's just how things are done.

17 Covid Community Champions – This project is key part of Phase 3 of the Evaluation. The Project Manager has completed training sessions with Community Champions around the approach. The Project Manager has also delivered training sessions to the Covid Coordinators.

18 Comparison with PHE Wellbeing Tool – Tracey Sharp has developed a paper with recommendations for consideration. Please see this separate document for further updates.

19 Further work needs to be done, when restrictions allow, to work with VCS organisations – particularly those aligned to the Resilient Communities Group, around how the way they work is aligned to the approach to allow further understanding and embedding at a grassroots level.

20 Tracey Sharp has commenced a Wellbeing Stocktake on the work undertaken to date and will develop recommendations for how the Approach to Wellbeing work will continue, linked to the work of the County Durham Together Partnership.

Appendix 5(c): Comparison of Public Health England Community-centred model with Co Durham Approach to Wellbeing

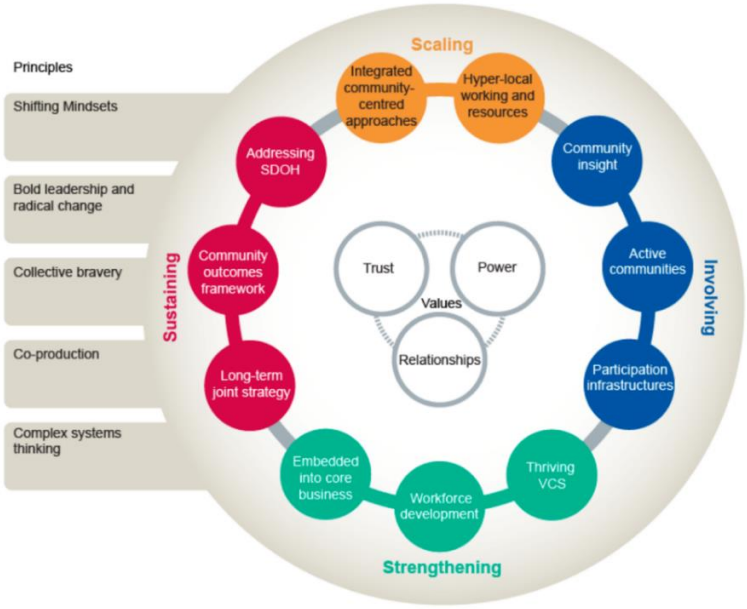
Background to paper

In January 2020, Public Health England published a paper entitled *'Community-centred public health: Taking a whole system approach'*.[2] The paper was intended to *'summarise the key elements, core values and principles needed to develop whole system approaches to community-centred public health'*, and also to *'improve the effectiveness and sustainability of action to build healthy communities, whilst embedding community-centred ways of working within whole systems..'*

Given the dynamic approach to developing the County Durham Approach to Wellbeing alongside the evaluation that was also being undertaken, it is hoped that insights gained from this publication may help in embedding the wellbeing approach. A comparison of the two models was therefore undertaken, highlighting any lessons that could be learned from the PHE model.

PHE community centred model

The PHE model contain 5 principles, 3 core values and 11 elements of change based around 4 domains which can all be seen in the graphic below:



The publication contains further detail elaborating on each of these concepts and explaining the rationale for their inclusion. It also contains a number of examples highlighting how the model has been applied and how it has helped to support change in communities. Descriptions of the 11 elements forms the majority of the document, but the 5 principles are intended to represent the

[2] https://www.gov.uk/government/publications/community-centred-public-health-taking-a-whole-system-approach

factors (or enablers) that are needed to underpin successful implementation of the model as a Whole Systems Approach.

County Durham Approach to Wellbeing

The County Durham Approach to Wellbeing consists of 7 core principles, across two domains (People and Places and Supporting Systems). Each of the principles is represented by a short statement intended to focus on the positive behaviours of those adopting the approach as seen in the graphic below:

The Wellbeing Approach was developed from a theoretical model but developed in such a way as to further operationalise the activities that people can take in order to put the model into practice. It is supported by a self assessment framework, against which people can test how far they have used the approach and offering suggestions for additional actions they can take.

Comparison of the two models

A comparative review of the two models was undertaken by mapping the 7 Wellbeing Principles, against the 11 Elements of the PHE Community-centred model (see below).

In summary, the PHE Community-centred model had a number of strengths focused around the strategic enablers that support success. For example, through its focus on leadership, on building skills across the workforce, the mainstreaming and scaling up of interventions, structured approaches for

engaging communities, building capacity within communities and the VCS, setting out long term ambitions and outcome frameworks, and efforts to identify and lay the ground work for successful whole system working.
The strengths of the County Durham Approach to Wellbeing include a focus around using the evidence base, explicit recognition of the need to devolve power, highlighting the importance of working with disadvantaged and marginalised groups in order to 'level-up' communities. The County Durham Approach also highlighted the importance of the systems needed to support this work through the alignment of strategies and policies across the system, coproducing and commissioning services jointly and ensuring person-centred approaches are used by all. The approach also includes the use of a practical self assessment framework to enable people to put the approach into practice.

Conclusions

In drawing out some overriding conclusions about the two, the PHE model sets out a more strategic approach to embedding the use of the model, whereas the County Durham approach is set at a more practical level to ensure ease of understanding and to aid implementation.
The lessons to be learned for County Durham are therefore around the strategic framework within which the Approach to Wellbeing was developed and implemented. This includes consideration being given to some of the strengths apparent in the PHE model. The steering group may therefore wish to consider some of the following:

PHE recommendations for success:

Leadership

Has enough been done to secure support for the Wellbeing Approach at senior level within our organisation(s)? Could more be done?

Building skills across the workforce

Could more be done to build skills in community centred working across our workforce?

Mainstreaming and scaling up of interventions

Do we have a system in place to mainstream and scale up those interventions we know work?

Structured approaches for engagement

Have we determined a structured and consistent approach for the way in which we engage communities?

Building capacity within the VCS

What are we doing to build capacity in communities and ensure our VCS is thriving? Can we do more?

Setting out long term ambitions

Have we set out a long-term vision for the Wellbeing Approach? What should that be?

Outcome frameworks

What outcomes are we working towards? How are we measuring our success?

CDA2W principles	Mapped to:	PHE elements
Using evidence/ /local conversations		No reference made to interventions needing to be evidence based. Involving element 3 - Reference is made to the use of insight from communities and participatory research
People and Place		
Engagement, development and empowerment and communities		No explicit reference to devolution of power. Scaling element 2 – refers to Hyper local working Involving element 3 – refers to insight work, active communities, capacity building, and participation structures Sustaining element 9 – refers to a long term ambition to strengthen communities.
Using assets as well as needs		Scaling element 2 - Neighbourhood working that taps into local resources Involving element 3 - Community insight that provides meaning to data
Support the most disadvantaged and vulnerable, addressing health inequalities, and building resilience		There is no reference to identifying the most marginalised or disadvantaged groups, nor the importance of social gradients in communities etc 5 core principles – refers to bold leadership to address health inequalities and also shifting mindsets to build resilient communities, but this is not one of the elements in the core model Sustaining element 11 - refers to actions to address social determinants as they impact on resilience. There is no explicit reference to 'building' resilience.
Supporting Systems		
Alignment of strategies and policies to reduce duplication and ensure greater impact		Not referred to.
Develop and deliver services together		Involving element 5 – refers to joint decision-making and co-production but no reference to commissioning
Person centred interventions that are empowering		The work of NHS England is referenced on page 12 in a contextual paragraph but doesn't appear to be part of the model.

PHE elements	Mapped to	CDA2W principles
Scaling up		
Scaled up services		CDA2W doesn't cover 'scaling up'. Principle 5 - Reference to co-production of services Principle 6 – reference to person-centred interventions (delivered by services)
Neighbourhood working that taps into local resources		Principle 1 – refers to working with communities (locations or COI) Principle 2 refers to identifying and using assets as well as needs
Involving		
Community insight		Underpinning principle of using evidence informed by local conversations
Active communities supported by community capacity building approaches		Principle 1 – supporting development and empowerment of communities Principle 3 – building resilience
Participation structures for engagement (eg neighbourhood forums)		Not referred to but the SAF does ask questions /prompts about how communities are engaged.
Strengthening		
Thriving VCS and growth of local capacity		Not explicitly referenced in the model but highlighted in Principle 5 in the supporting narrative relating to codesign and co-production. Our work on alliance contracting also builds on this.
Workforce development to build core skills in community-centred ways of working		Not included in the design – but taking place anyway – eg training for staff working as COVID-19 community champions. Do we need to make this more explicit?
Making community centred approaches mainstream		Not in the model but referenced in the underpinning narrative and now included in the underpinning Co Durham Vision, NHS system plan, and the HWB strategy.
Sustaining		
Long term ambition to strengthen communities shared across all agencies and communities		Not explicit in model
Outcome frameworks that include what matters to communities		Not explicit in model.
Addressing the social determinants of health		Not explicit in model but the need to address health inequalities are highlighted.

Appendix 5(d): Recommendations from Teesside University Evaluation

Recommendation 1: The soundbites model needs to be developed so that it can be understood at a community level. The first development was theoretical, and the second stage of revisions was to help with practical implementation. Further work is now needed to be able to communicate at the community level.

Response

(Community engagement and terminology) This is broadly consistent with the guidance from Public Health England relating to systematic community engagement. This work has begun with the COVID Community Champions and is in the process of being evaluated by Teesside University. The model and SAF will also be reviewed to further consider the terminology used.

Recommendation 2: There is fatigue in the community after the first phase of lockdown. It is perhaps not the right time to approach and involve the community in the next stage of model development. Therefore, it is suggested that the team start with a community of interest to develop the soundbites model. Asking '*What do these six principles mean to you? How will your community respond?'*

Potential response

(Community engagement) This work has begun with the COVID Community Champions and is in the process of being evaluated by Teesside University. Further consideration will be needed to determine which community (or community of interest) is next approached.

Recommendation 3: Make sure there is a good geographical spread when working with the selected community of interest (and beyond). Go to the north, central and south of County Durham, to cover rural, semi-rural and urban areas.

Potential response

(Community engagement) This will be done in conjunction with the COVID Champions work which is mapped into three areas – North, South and East.

Recommendation 4: The framework and model needs to be driven from the top, to ensure buy-in to trickle down, and that staff have the necessary directive within their workload.

Potential response

(Leadership and senior buy-in) This is consistent with the recommendations from Public Health England and will be addressed in the emerging action plan.

Recommendation 5: Both the framework and model need to be presented for various perspectives, not just a public health angle. The framework/model introduced needs to cut across departments and sectors. How can it translate to other services, such as the NHS?

Potential response

(Mainstreaming) Some of these comments may refer to the use of the earlier A2W 'pie chart' model and have already been addressed by development of the

soundbites model. However, the model and SAF will be reviewed further to consider the terminology used.

Recommendation 6: When refining the soundbites, thought needs to be given to how communities will understand the language. For example, Principle 5 uses the phrase 'co-designed'- what does that mean? There potentially needs to be an explanation of terminology.

Potential response

(Community engagement and terminology) Some of these comments may refer to the use of the earlier A2W 'pie chart' model and have already been addressed by development of the soundbites model. However, the model and SAF will be reviewed further to consider the terminology used.

Recommendation 7: Consideration also needs to be given to the language used in the model, as it needs to be appropriate across multiple sectors and organisations (e.g. using the word communities v patients). Principle 6 says 'health and social care', but the A2WB is for use across more than just this sector.

Potential response

(Community engagement and terminology) As above to review as part of the review of the soundbites model and include more inclusive terminology.

Recommendation 8: There is the potential to add a section at the end of the self-assessment framework, which measures outcomes. An example given was about 'accountability', with a question on '*Possible next steps and agreed timescales'.*

Potential response

(Implementation and refining the practical application) This will be included as part of a review to modify the terminology within the SAF and bring it into line with the soundbites model.

Recommendation 9: Worked, practical examples are needed, which shows how other sectors and organisations have applied principles and framework to their service area.

Potential response

(Mainstreaming and scaling up interventions) This is consistent with the PHE recommendations and will be addressed in the emerging action plan.

Appendix 6: Action plan in response to PHE Audit and Teesside Evaluation

PHE Audit		
	Reflective question arising from audit	**Potential actions in response**
	Has enough been done to secure support for the Wellbeing Approach at senior level within the organisation(s)? Could more be done?	• Celebrate the success of the Approach to date through further discussion at CMT, County Durham Together Partnership, with the VCS and with other partner's senior teams, demonstrating learning, progress and next steps. • Ensure that all the Wellbeing Approach is highlighted in the induction of all new Directors, Heads of Service and Strategic Managers. • Look at ways in which the Approach to Wellbeing can be more visibly supported at a corporate level by senior leaders for example in publications and presentations. • Include the Approach to Wellbeing in leadership and management courses.
	Have we determined a structured and consistent approach for the way in which we engage communities?	• Review the current means we have of engaging citizens including Area Action Partnerships, the Youth Council, LD Parliament, Investing in Children, Patient Reference Groups and bring together the best of these in a single but flexible model.
	Do we have a system in place to mainstream and scale up those interventions we know work?	• Use the Approach to Wellbeing as a development/reflective tool for looking at what has worked, building on the bank of case studies and worked examples of how this has been done. • Work with the Area Action Partnerships to identify successful projects that have the potential to be

		mainstreamed or scaled up across the County. • Put in place a systematic approach to enable successful projects to be considered for upscaling by those working at the appropriate decision-making level. • Put in place a system of review with commissioning colleagues to ensure successful applications of the Approach are embedded into contracts as part of the Durham Procurement Family Network. • Look at opportunities to publicise success more widely. • Work with the Health and Wellbeing Board to ensure that those presenting are challenged on how they can upscale and mainstream their successes.
	Could more be done to build skills in community centred working across the workforce?	• Incorporate the Approach to Wellbeing into the induction programme for all staff (councillors and officers). • Undertake an audit of current training in community development, and encourage and support uptake for key staff where relevant. • Build a short e-learning course on the Approach to Wellbeing, accessible to all partners. • Consider how the Approach could be built into or run alongside other programmes such as Making Every Contact Count.
	What are we doing to build capacity in communities and ensure our VCS is thriving? Can we do more?	• Continue our work with the VCS on Alliance Contracting and County Durham Together. • Continue our work on the County Durham Pound, securing commitments across the County

		Durham Partnership to support community wealth building. • Develop a VCS Sustainability Framework which outlines the way the statutory sectors will work with the VCS.
	Have we set out a long term vision? What should that be?	• To use this two-year stocktake as the starting point to develop a longer term 'Wellbeing Vision' with County Durham partners, and supported by County Durham Together.
	What outcomes are we working towards? How are we measuring our success?	• We will use the County Durham Vision 2035 to develop our measures for our success at 3, 5 and 10 years.
Teesside Evaluation		
	Recommendations arising from evaluation	**Potential actions in response**
	Some additional recommendations from Teesside related to further refinement of the model and the Self Assessment Framework with some suggested changes in the terminology used.	• Some of these recommendations referred to the first conceptual or 'pie-chart' model, and to a large degree have been addressed by adoption of the newer 'soundbites' model. However, there are further changes that could be made and some simple refinements to the language in the model. The self-assessment framework also needs to undergo revision to bring it into line with the soundbites model.

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