NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Community engagement: improving health and wellbeing
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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for community engagement: improving health and wellbeing.

It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Community engagement: improving health and wellbeing and reducing health inequalities. NICE guidance 44 (2016)

2 Overview

2.1 Focus of quality standard

This quality standard will cover community engagement approaches to improve health and wellbeing, reduce health inequalities and initiatives to change health behaviours.

2.2 Definition

Communities

A community is a group of people who have common characteristics or interests. Communities can be defined by: geographical location, race, ethnicity, age, occupation, a shared interest or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage. People who are socially isolated are also considered to be a community group.

Community engagement

Community engagement encompasses a range of approaches to maximise the involvement of local communities in local initiatives to improve their health and wellbeing and reduce health inequalities. This includes: needs assessment, community development, planning, design, development, delivery and evaluation.

2.3 Policy context

Involving local communities, particularly disadvantaged groups, is central to local and national strategies in England for promoting health and wellbeing and reducing health inequalities (Healthy lives, healthy people: our strategy for public health in England Department of Health; Fair society, healthy lives The Marmot Review).

Statutory obligations on public bodies included in the Localism Act (2011), Health and Social Care Act (2012) and Public Services (Social Value Act) (2012) recognise that the NHS and local government cannot improve people's health and wellbeing on their own. Working with local communities will lead to services that better meet people's needs, improve health and wellbeing and reduce health inequalities.

In addition to their statutory responsibilities, NHS England's Five year forward view proposes that public sector organisations should find ways to involve the voluntary sector in promoting health and wellbeing. But the Cabinet Office Community life survey 2014 to 2015 shows there has been a decline in informal volunteering since 2013/14. Levels of participation generally decrease as the level of local deprivation increases ('Community life survey 2014 to 2015').

2.4 Background

The quality of community life, social support and social networks are major influences on individual and population health, both physical and mental. The recent WHO European review on social determinants and the ‘health divide’ states: “How people experience social relationships influences health inequities. Critical factors include how much control people have over resources and decision-making and how

much access people have to social resources, including social networks, and communal capabilities and resilience."[1]

Good social relationships and engagement in community life are necessary for good mental health, and may offer protection in adversity or where there is exposure to stressors. The ability to form positive relationships is an integral part of wellbeing and individuals are recommended to connect with those around them as one of the 'five ways to wellbeing'.

There is a social gradient across the social factors that support good health. A WHO Europe review of mental health, resilience and inequalities reports that high levels of social capital can buffer some of the effects of stress, but at the same time deprivation and inequalities 'erode' the resources needed for good mental health. The Marmot review shows under a fifth of people (19%) living in the most deprived areas of England have a severe lack of social support and around a quarter (26%) have some lack, compared to 12% and 23% in the least deprived areas.[2]

2.5 Community engagement approaches for health and wellbeing

Community-centred approaches are not just community-based, they are about mobilising assets within communities, promoting equity and increasing people's control over their health and lives. A new family of community-centred approaches represents some of the available options that can be used to improve health and wellbeing, grouped around four different strands:

- strengthening communities – where approaches involve building on community capacities to take action together on health and the social determinants of health
- volunteer and peer roles – where approaches focus on enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities

[1] A guide to community-centred approaches for health and wellbeing, PHE (2015)
[2] A guide to community-centred approaches for health and wellbeing, PHE (2015)

- collaborations and partnerships – where approaches involve communities and local services working together at any stage of planning cycle, from identifying needs through to implementation and evaluation
- access to community resources – where approaches connect people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation[3]

2.6 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[3] A guide to community-centred approaches for health and wellbeing, PHE (2015)

Table 1 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.1 Children in poverty 1.2 School readiness 1.3 Pupil absence 1.4 First time entrants to the youth justice system 1.5 16–18 year olds not in education, employment or training 1.11 Domestic abuse 1.13 Re-offending levels 1.15 Statutory homelessness 1.16 Utilisation of outdoor space for exercise/health reasons 1.17 Fuel poverty 1.18 Social isolation* 1.19 Older people's perception of community safety
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.2 Breastfeeding 2.3 Smoking status at time of delivery 2.4 Under 18 conceptions 2.5 Child development at 2–2$^{1}/_{2}$ years 2.6 Excess weight in 4–5 and 10–11 year olds 2.9 Smoking prevalence – 15 year olds 2.11 Diet 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults 2.14 Smoking prevalence – adults (over 18s) 2.15 Successful completion of drug treatment 2.18 Alcohol-related admissions to hospital 2.19 Cancer diagnosed at stage 1 and 2 2.22 Take up of the NHS Health Check programme 2.23 Self-reported well-being
3 Health protection	***Objective*** The population's health is protected from major incidents and other threats, whilst reducing health inequalities ***Indicators*** 3.3 Population vaccination coverage
4 Healthcare public health and	***Objective***

preventing premature mortality	Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.2 Tooth decay in children aged 5 4.3 Mortality rate from causes considered preventable** 4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* 4.5 Under 75 mortality rate from cancer* 4.6 Under 75 mortality rate from liver disease* 4.7 Under 75 mortality rate from respiratory diseases* 4.9 Excess under 75 mortality rate in adults with serious mental illness* 4.10 Suicide rate 4.13 Health-related quality of life for older people 4.15 Excess winter deaths
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 The Adult Social Care Outcomes Framework 2015–16

Domain	**Overarching and outcome measures**
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life** ***Outcome measures*** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework ** Indicator is complementary	

Table 3 NHS Outcomes Framework 2016-17

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1b Life expectancy at 75 i Males ii Females 1c Neonatal mortality and stillbirths ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* 1.2 Under 75 mortality rate from respiratory disease* 1.3 Under 75 mortality rate from liver disease* 1.4 Under 75 mortality rate from cancer*
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions*, ** **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** **Enhancing quality of life for people with mental illness** 2.5 i Employment of people with mental illness** *ii Health-related quality of life for people with mental illness*** **Enhancing quality of life for people with dementia** 2.6 i Estimated diagnosis rate for people with dementia* *ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life*, *** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

3 Summary of suggestions

3.1 Responses

In total 19 stakeholders responded to the 2-week engagement exercise 21/03/2016-6/04/2016.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 2 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Effective engagement • Engagement from the start • Allocating resources • Overcoming barriers • Asset based community development (ABCD)	SCMs, PCFT, EPA, JT, DHFT, Age UK, ACNEW, AHL
Peer and lay roles • Volunteering and peer support • Skills/capacity building • Parity between lay and professional knowledge	EPA, SCMs, DHFT, Age UK,
Evaluation • Evaluation from the start • Cost effectiveness	SCMs, EPA, PCFT
Additional areas • Hearing loss • Visual assessments • Healthy diets • Taboo issues • Complimentary healthcare therapies • Terminology	AHL, JT, TCO, TSL, UH, EPA,
ACNEW, Association of Catholic Nurses England and Wales AHL, Action on Hearing Loss DHFT, Derbyshire Healthcare NHS Foundation Trust EPA, Esoteric Practitioners Association JT, JT Healing PCFT, Pennine Care NHS Foundation Trust SCM, Specialist Committee Member TCO, The College of Optometrists TSL, Together for short lives UH, University of Hertfordshire	

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in the UK; 781 papers were identified for community engagement: improving health and wellbeing. In addition, 25 papers were suggested by stakeholders at topic overview and 60 papers internally at project scoping.

Of these papers, 5 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Effective engagement

4.1.1 Summary of suggestions

Engagement from the start

Stakeholders highlighted the importance of engaging the community at the start of the process so that community members are part of the planning and design of the health and wellbeing initiative. They also highlighted the importance of understanding the community and making sure that the care and support are always person centred.

Overcoming barriers

Stakeholders highlighted numerous barriers that members of the community (vulnerable groups in particular) are likely to encounter and stressed the need to support people to overcome these barriers in order to facilitate engagement. Examples of barriers highlighted included poverty, childcare support, literacy levels, accessible transport, accessible information, mobility and a range of facilities that are needed to encourage people to be out and about.

Allocating resources

Stakeholders highlighted the importance of allocating sufficient resources for developing the relationships. They pointed out that these are often underestimated and may have implications for delivery.

Asset based community development (ABCD)

Stakeholders highlighted the importance of identifying local community assets in strategic planning processes and changing focus from a deficit/needs based model to assets/strengths based model.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations or specific parts of the recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented after table 5 to help inform the Committee’s discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	**Suggested source guidance recommendations**
Engagement from the start	NICE NG44 Recommendations 1.1.2 (bullet 2), 1.1.3
Overcoming barriers	NICE NG44 Recommendations 1.5.2
Allocating resources	NICE NG44 Recommendations 1.1.2 (bullet 1)
Asset based community development (ABCD)	NICE NG44 Recommendations 1.4.2

Overarching principles of good practice

NICE NG44 Recommendation 1.1.2

Recognise that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs time:

- plan to provide sufficient resources (see identifying the resources needed)
- start community engagement early enough to shape the proposed initiative

NICE NG44 Recommendation 1.1.3

Support and promote sustainable community engagement by encouraging local communities to get involved in all stages of a health and wellbeing initiative. Do this by:

- involving communities in setting priorities.

Making it as easy as possible for people to get involved

NICE NG44 Recommendation 1.5.2

Provide the support people need to get involved. This includes:

- Involving community members in the initiative's recruitment process (see section 1.3).
- Offering to phone, write, email, use social media or call round to see people.
- Providing information in plain English and locally spoken languages for non-English speakers (see NHS England's Accessible Information Standard). This could include encouraging members of the community who speak a community language to get involved in translating it.
- Ensuring the timing of events meets people's needs.

- Establishing and meeting the needs of participants with disabilities. For example, using venues that are fully accessible to them and providing the equipment they need.
- Providing childcare support, such as crèche facilities.
- Using places familiar to community participants and creating an informal atmosphere.
- Helping them meet mandatory requirements, for example to get disclosure and barring service checks if necessary (see the government's information on the disclosure and barring service).

Local approach to making community engagement an integral part of health and wellbeing initiatives

NICE NG44 Recommendation 1.4.2

Follow the principles of good practice (see section 1.1) and work with local communities and community and voluntary organisations to:

- identify the 'assets' (skills, knowledge, networks and relationships) and facilities available locally
- plan how to build on and develop these assets as part of the joint strategic needs assessment (see learning and training)

4.1.3 Current UK practice

Engagement from the start

No current practice reviews identified.

Overcoming barriers

a) Transport

The English Longitudinal Study of Ageing (ELSA) found that 32% of those 65 and over never use public transport, whilst another 27% use it once a month or less. The study found that access to key amenities, including banks, supermarkets, post offices and hospitals, has improved slightly in recent years. However the improvements have been relatively small and a significant minority still do not find it easy to make essential trips. Furthermore the marked increase in difficulty in making essential trips for those aged 80+ has remained. For example in 2012 48% of people

aged 80 and over in England, which is more than 620,000 people, found it difficult to travel to their nearest supermarket[4].

Many loneliness initiatives, such as Contact the Elderly provide transport to their activities as part of the service. However experts highlighted that this can be extremely costly and complex, and concerns were expressed about the ongoing lack of appropriate transport in some areas, and the far-reaching implications of this gap in provision in terms of older people's health and wellbeing[5].

b) Internet access

Statistics produced by the ONS in May 2015 showed that whilst 86% of adults in the UK had used the internet in the last 3 months, 11% of adults (5.9 million) had never used the internet. What is more, the proportion of adults who were recent internet users was lower for those that were disabled (68%), compared with those that were not disabled (92%). The proportion of adults aged 75 years and over who were recent internet users was also lower for those that were disabled (27% recent users) compared with those that were not disabled (40% recent users). Of the 5.9 million adults who had never used the internet just over half (3.0 million) were aged 75 years and over.

Allocating resources

No current practice reviews identified.

Asset based community development (ABCD)

No current practice reviews identified.

4.1.4 Resource impact assessment

The resource impact report for NG44 states costs may be incurred to provide sufficient resources for community engagement. The implementation section of the guideline gives information on identifying the resources needed and lists the following as areas where costs may be incurred by statutory organisations and their partners:

- Providing specific time, resources and support for staff involved in health and wellbeing initiatives
- Recruitment, learning and training, ongoing support, development opportunities and supervision of volunteers

[4] George Holley-Moore and Helen Creighton, The Future of Transport in an Ageing Society (2015)
[5] Kate Jopling, Age UK, Promising approaches to reducing loneliness and isolation in later life (2015)

- Reimbursing volunteers' expenses.

However, it was not identified as an area that would have a significant resource impact (>£1m in England each year) because any cost is likely to be offset by savings and benefits to the public sector as a whole.

4.2 Peer and lay roles

4.2.1 Summary of suggestions

Volunteering and peer support

Stakeholders highlighted the importance of engaging lay stakeholders and volunteers in the delivery of the health and wellbeing initiatives. They stressed the importance of peer support in getting vulnerable people involved with the community as well as the importance of volunteering opportunities to enhance health and wellbeing of the individuals.

Skills/capacity building

Stakeholders highlighted the importance of skills and capacity building among the community as well as the providers working within the community.

Parity between lay and professional knowledge

Stakeholders highlighted the importance of partnership working and effective collaboration for successful community engagement. They stressed that lay member knowledge must have equal status to professional knowledge.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations or specific parts of the recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Volunteering and peer support	NICE NG44 Recommendation 1.3.1
Skills/capacity building	NICE NG44 Recommendation 1.3.2
Parity between lay and professional knowledge	NICE NG44 Recommendations 1.1.1, 1.2.2

Involving people in peer and lay roles to represent local needs and priorities

NICE NG44 Recommendation 1.3.1

Draw on the knowledge and experience of local communities and community and voluntary organisations to identify and recruit people to represent local needs and

priorities. Ask those recruited to take on peer and lay roles as part of the health and wellbeing initiative. Effective peer and lay approaches are:

- Bridging roles to establish effective links between statutory, community and voluntary organisations and the local community and to determine which types of communication would most effectively help get people involved.
- Carrying out 'peer interventions'. That is, training and supporting people to offer information and support to others, either from the same community or from similar backgrounds (see learning and training).
- Community health champions who aim to reach marginalised or vulnerable groups and help them get involved.
- Volunteer health roles whereby community members get involved in organising and delivering activities.

NICE NG44 Recommendation 1.3.2

Consider offering training and mentoring support to community members (see learning and training). Also consider providing formal recognition of their contribution and other opportunities for development. This could include, for example, accredited training.

Overarching principles of good practice

NICE NG44 Recommendation 1.1.1

Ensure local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives (see sections 1.2 and 1.3). Do this by:

- Recognising, valuing and sharing the knowledge, skills and experiences of all partners, particularly those from the local community (see learning and training).

Developing collaborations and partnerships to meet local needs and priorities

NICE NG44 Recommendation 1.2.2

Base collaborations and partnerships on local needs and priorities. Effective approaches are:

- Co-production methods – to ensure statutory organisations and the community can participate on an equal basis to design and deliver health and wellbeing initiatives.

4.2.3 Current UK practice

Volunteering and peer support

The Taking part survey found that between October 2014 and September 2015, 24.2% of adults had volunteered in the last 12 months. The proportion of urban respondents who had volunteered (23.0%) was significantly lower than it was for rural respondents (29.4%) over the same time period. The survey also indicates a relationship between volunteering and deprivation with people from least deprived areas volunteer significantly more (30.2%) than people from the most deprived areas (17.1%)[6].

Skills/capacity building

No current practice reviews identified.

Parity between lay and professional knowledge

No current practice reviews identified.

4.2.4 Resource impact assessment

This area was not included in the resource impact report for NG44. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

[6] The Taking Part survey 2015/16 quarter 2

4.3 Evaluation

4.3.1 Summary of suggestions

Evaluation from the start

Stakeholders highlighted the importance of building the evaluation into the process from the start. They also suggested use of emerging evaluation tools to support the process. Stakeholders highlighted the importance of measuring effectiveness of health and wellbeing interventions and suggested that health outcomes should be measured among the participants of the health and wellbeing intervention.

Cost effectiveness

Stakeholders highlighted the importance of measuring cost effectiveness of community engagement initiatives that should be built into evaluation. The suggested approaches were cost consequence analysis and social return on investment tools.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations or specific parts of the recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Evaluation from the start	NICE NG44 Recommendation 1.1.2, 1.1.5
Cost effectiveness	NICE NG44 Recommendation for research

Overarching principles of good practice

NICE NG44 Recommendation 1.1.2

Recognise that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs time:

- start evaluating community engagement activities early enough to capture all relevant outcomes (see evaluation and feedback).

NICE NG44 Recommendation 1.1.5

Feed back the results of engagement to the local communities concerned, as

well as other partners. This could be communicated in a range of ways, for example, via the local newspaper or community website, via community groups or via public events in community venues or other widely accessible places. (See evaluation and feedback.)

4.3.3 Current UK practice

Evaluation from the start

No current practice reviews identified.

Cost effectiveness

No current practice reviews identified.

4.3.4 Resource impact assessment

This area was not included in the resource impact report for NG44. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

4.4 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 18th May 2016.

Hearing loss

A stakeholder highlighted the importance of recognising the growing prevalence and impact of hearing loss, the importance of improving diagnosis and the importance of improving access to services that support people with hearing loss. Specific needs and interventions targeting people with hearing loss are outside of the remit of this quality standard.

Visual assessment

A stakeholder suggested the importance of visual assessment among people with dementia as well as including it as part of falls prevention assessment. The same stakeholder suggested that counselling services about the effect of smoking on Age-related Macular Degeneration (AMD) and cataracts should be improved. Specific needs and interventions on visual impairment are outside of the remit of this quality standard.

Healthy diets among young people.

A stakeholder highlighted the issue of food related behaviours among children and young people moving to secondary schools. Healthy diets and transforming environments are outside the remit of this quality standard. Preventing obesity among children and young people and lifestyle weight management programmes have already been addressed by another quality standard (QS94).

Taboo issues

A stakeholder suggested that lack of community awareness and support around issues of death and dying can lead to feelings of social isolation and exclusion for those who are dying and their families. The stakeholder felt that Community engagement could encourage communities to help care people in their community at the end of their life. Specific needs and interventions on end of life care would be better addressed in quality standards on end of life care (QS13).

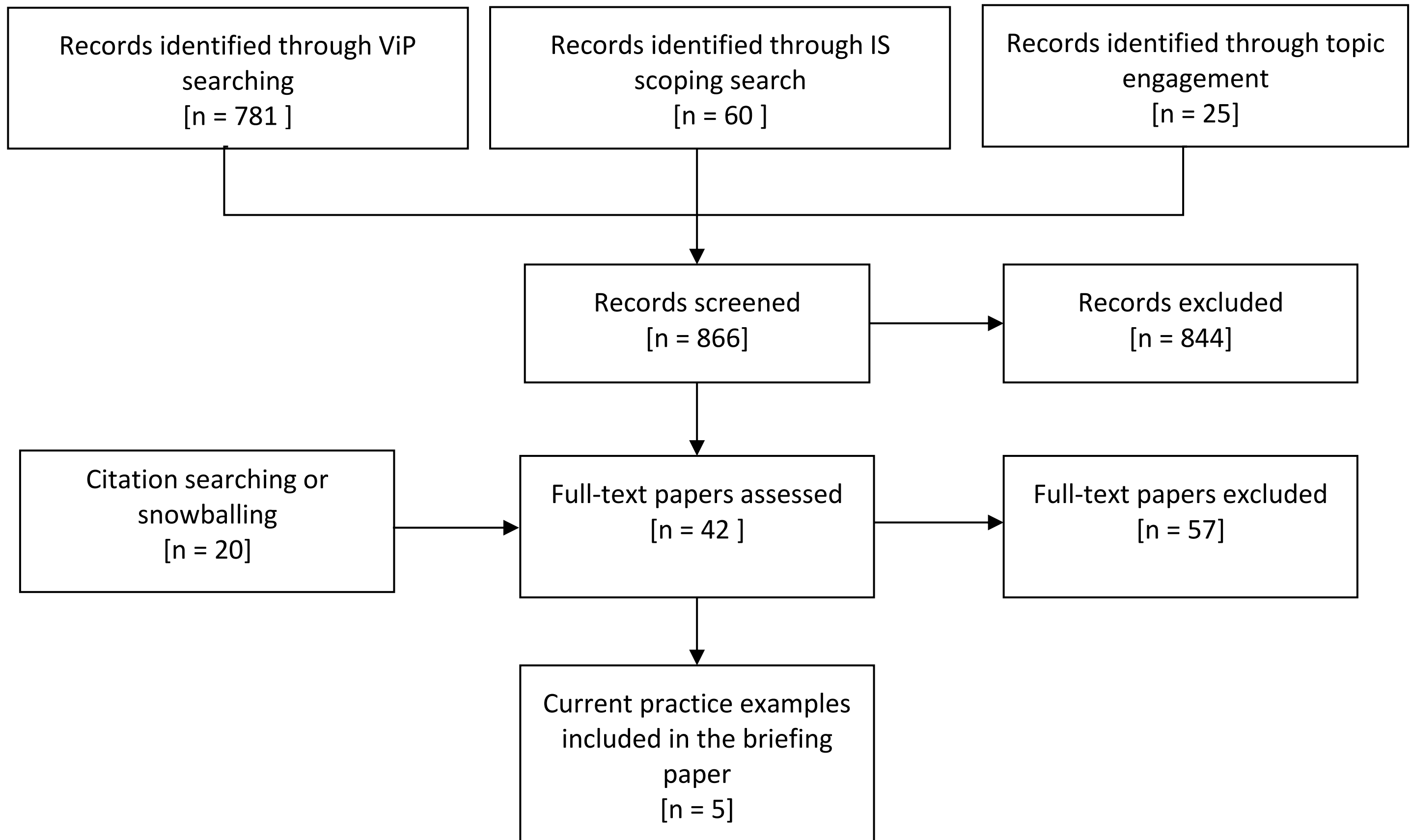
Complementary Healthcare Therapies

A stakeholder suggested a range of improvements in the way complementary healthcare therapies are perceived by the NHS employees. Discussions about complementary healthcare therapies are outside the remit quality standards programme.

Terminology

A stakeholder suggested that the term community engagement should be changed to something more meaningful like ‘our health is in our hands’ – or ‘our health and wellbeing’. The stakeholder thought that the term is not well understood even by healthcare practitioners. Discussion about the terminology used within NICE guidline as well as most recent PHE reports is outside of the remit of quality standards programme.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Section number	Name	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	4.1	SCM1	SCM	Key area for quality improvement 1 Support and promote sustainable community engagement by encouraging local communities to get involved in all stages of a health and wellbeing initiative 1.1.3	A top down approach throughout an initiative is not as effective as an approach which engages communities at an early stage and throughout the initiative. The greater the levels of control that residents have over decisions affecting their lives, the more likely there are to be positive impacts Instrumental approaches, which try to engage residents in agendas that are not theirs, will have relatively little positive impact and that community cohesion and well-being may be undermined	Doing this is in top down way can make the situation worse. It is an area which could be assessed. By determining the type of engagement and at which point the community was engaged. (It is important to consider that in some initiatives the topic and approach may be determined in advance and the opportunities for engagement may be well into the project development. However, the community engagement approach can still make a difference to the effectiveness of the initiative.)	The impact on health inequalities of approaches to community engagement in the New Deal for Communities regeneration initiative: a mixed-methods evaluation Jennie Popay,et al, 2015 The top down approach is similar to 'authoritarian' approach described in Janet Harris et al- Can community-based peer support promote health literacy and reduce inequalities? A realist review
2	4.1	SCM2	SCM	Key area for quality improvement 4 Commissioning the process of local consultation about local needs and priorities, followed through into action	Authentic community engagement can bring local buy-in that can be used to reduce local health inequalities	The fourth recommendation in the community engagement guidance refers to "making community engagement an integral part of health and wellbeing initiatives". This requires listening to local people from the beginning and acting on what they say.	Community engagement guidance (2016), recommendation 4
3	4.1	SCM3	SCM	Key area for quality improvement in Effective Community Engagement at the beginning of processes which affect people's lives	There is evidence that if community engagement is not done effectively there can be a negative impact or no impact on communities as a hole along with individual's wellbeing being affected. Often people are not effectively engaged in processes. Organisations need the resources to engage effectively. Community members		

					must be part of the planning and design processes		
4	4.1	SCM 4	SCM	Key area for quality improvement 3 Making community engagement mainstream	NICE guidance on community engagement NG44 recommends community engagement is made integral to health and wellbeing initiatives and it is built in at all stages from planning and priority setting to evaluation and feedback (1.4). There are statutory duties for the NHS and local government to involve communities and individuals in their care and shaping local services/areas. It is important that community engagement is seen as a core process for health improvement and tackling inequalities. It should not be seen as an add-on.	Community engagement is seen as important for achieving public health goals but it is not always implemented in a systematic way across local health systems. For example, the NHS Five Year Forward View states that more could be done to harness the 'renewable energy of patients and communities' and community empowerment is part of the ambition of the new NHS vanguards. Currently there is a lot of good practice in statutory services around community engagement, however much more could be done to ensure community engagement is integral to public health and that community-centred approaches are used systematically to address public health issues. Many public health programmes are still developed and delivered top-down, with little evidence that communities are routinely setting health priorities. Some local authorities and Health and Wellbeing Boards are developing and implementing strategic and system-wide approaches to community engagement as part of improving health and wellbeing. This suggests that there is scope for more consistent application of NICE guidance to bring all areas up to this level. This would involve local areas improving the quality of local commissioning and strategic plans relating to	Think Local Act Personal initiative have resources and tools for Building Community Capacity for those panning and commissioning community engagement and empowerment approaches: http://www.thinklocalactpersonal.org.uk/Browse/Building-Community-Capacity/ There are a range of methods/approaches can be used for community engagement. See PHE/NHS England Guide to Community-centred approaches for health and wellbeing: https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

						community engagement in health and wellbeing initiatives.	
5	4.1	Lisa Jowitt & Carlos Tait	Pennine Care NHS Foundation Trust	Key area for quality improvement 1 Understand and engage effectively with communities	Get to know a community Facilitate community research and consultations Analyse and disseminate findings from community research Organise community events and activities Support communities who want to bring about positive social change Facilitate community leadership Ensure competence around engagement across the local workforce.	The National Occupational Standards outline clearly the skills, values and processes required for effective and appropriate community development practice. Community development is undertaken by a wide range of people in different settings and roles. Although the role of this document is not focused on community development per se, community engagement is a fundamental component in engaging communities to support behaviour change.	http://www.fcdl.org.uk/
6	4.1	SCM5	SCM	Co-production of positive health outcomes	A 2007 report on co-production and social capital (Cummins and Miller) noted that “services do not produce outcomes, people do”.	Too often, statutory health and social care agencies engage with communities primarily in order to enlist those communities in meeting their (ie statutory) outcomes and targets. Professional staff, politicians and others in positions of power need to be willing to share power. People in communities are not only the real experts in the things that matter in their daily lives, they will also engage much more actively on matters that they care about. An empowered community may not necessarily choose to act on the same issues that NHS or local authorities see as priorities; instead, they may identify other factors producing or contributing to poor health outcomes (eg air quality, urban design) that single focus agencies might miss or underestimate.	Jude Cummins and Clive Miller (2007) Co-production and Social Capital: The role that users and citizens play in improving local services. OPM October 2007

7	4.1	SCM3	SCM	Community Engagement building relationships which relates to point 1 and 2	Once again the resources need to be in place. Often we can think they are but when it comes to implementation we find we have underestimated the resources needed to build relationships and trust	Public sector cuts must be considered as they will have implications for delivery	
8	4.1	SCM1	SCM	Key area for quality improvement 3 Address health inequalities by ensuring additional efforts are made to involve local communities at risk of poor health. This includes people who are vulnerable, marginalised, isolated or living in deprived areas. 1.4.3	Public health interventions using community engagement for disadvantaged groups are effective in terms of health behaviours, health consequences, participant self-efficacy and perceived social support outcomes	This could be turned into an indicator for planning and subsequent performance management. A Health Impact assessment process could be used. Although this looks like an EIA process the groups included do not usually include deprived communities or those at risk of poor health.	O'Mara-Eves et al 2013 Access toolkit In Sheffield we are developing and piloting a tool for services to use with regard to achieving appropriate access for at risk groups. This is being tested on a range of services such as carers and mental health services and is being well received as a practical tool. Could also be used with regard to community wellbeing initiatives. Can send you the document – C Nield , S Horsley
9	4.1	Jane Keep	Esoteric Practitioners Association (EPA)	Key area for quality improvement 5 Make lifestyle key – practical daily living and make it about the whole person, and whole families, and all of our lives, not compartmentalising it. Keep the guidelines, and initiatives simple and related – not compartmentalised.	There has been much research including by Cancer Research UK that have found lifestyle choices and daily living has an impact on our health. For many, it is not easy to navigate around that research, and we still have many conflicting 'research reports' that are published in our newspapers and social media. Some focus on consistency on what is available, and keeping the publications simple so as to support the public/all of us to understand the basic fundamentals of our health and wellbeing is part of this. It is our daily living choices that affect our health. How can we work nationally and locally on simple things like posture, stretching, exercise, food, and have simple	By working together side by side with local families, with all sectors involved, we can start conversations about our health in our hands, our daily living choices, and support for simple fundamentals whether it be cooking utensils or pantry essentials. Often we have initiatives for instance for obesity, or diabetes but they are all separate, unrelated, and it may help to pull them altogether into 'our daily living' as if you focus even on one thing e.g. nutrition or hydration, or exercise, to begin with that is the catalyst to make other simple practical changes. We know lifestyle makes a difference, how can we work together with our local communities to support lifestyle	There is much research about lifestyle choices to draw upon, have we collated it all? Have we simplified it for us all and connected it up as a holistic approach to healthy living rather than specifically by condition for example?

					local schemes on gardening together, cooking together, grants from charities for cooking utensils, or basic pantry essentials.	choices – particularly for those who are ready? If we start where people are ready there is also a ripple effect too. Also keep health education/social media/websites very simple and practical – without jargon and focused on daily living choices.	
10	4.1	SCM4	SCM	Key area for quality improvement 1 Addressing barriers to engagement for those at risk of poor health/vulnerable groups	Community engagement is often undertaken to address inequalities in health through those directly at risk of poor health. Yet evidence shows that a wide range of social factors such as poverty, low literacy, language barriers and social exclusion can affect people's ability and capacity to participate. Also organisational barriers such as lack of resources or lack of trust between communities and services (see Harden et al 2015 Evidence review of barriers to, and facilitators of, community engagement approaches and practices in the UK – undertaken for NICE)	The Marmot review (2010) highlighted the importance of community engagement for addressing inequalities and recommended removing barriers to community participation. NICE Guidance NG44 on community engagement recommends making it easy for people to take part (1.5). There is a social gradient in participation, volunteering, social isolation etc (see Community Life survey, Citizenship survey, PHE/UCL report on 'Reducing social isolation across life course'). This suggests that there is scope to improve community engagement processes where socio-economic inequalities exist. In particular there is scope for services to adopt more consistent approaches to removing barriers and supporting disadvantaged groups at risk of poor health.	Marmot Review: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review PHE/UCL report on 'Reducing social isolation across life course': https://www.gov.uk/government/publications/local-action-on-health-inequalities-reducing-social-isolation Social Care Institute for Excellence. Seldom heard: developing inclusive participation in social care. Position Paper 10. 2008.
11	4.1	Julie Tasker	JT Healing	Key area for quality improvement 1 Health & social care needs to become a regular part of daily life for everyone. This needs to be health awareness and understanding of how to	People need to engage with health and social care before they actually are particularly aware that they have a problem so the problems are addressed earlier rather than later. Then when they are accessing they will hopefully not be in such a stressed state & therefore will be able to be supported to make	People tend to try to hand their health & social care problems to the professionals rather than being empowered to take more of a role in addressing them themselves. There's a tendency to wait until they really have a problem rather than addressing signs & symptoms earlier for a more	My experience working with clients & living in our society. e.g. Typically eating an excess of sweet things are related to under-exercising and over-thinking. Traditional Chinese Medicine recognises this. Our approach to work & life with its stresses reinforces this behaviour. Develop our home & work

				help self rather than blame for e.g. obesity; diabetes etc	more reasoned decisions as to what is right for themselves as they are guided by the professionals. There is mainly emphasis on reprimanding people for their health state. We need to emphasise health awareness: e.g. notice what you are eating & how you feel when you have eaten; notice when you are drawn to eating sweet things: what is happening in your life?	beneficial outcome or even to cope better with whatever they are experiencing. When I ask people what they need to support them to improve their own health, the responses I typically get are, e.g. eat less sugar; eat more fibre. However when I question as to why they think that or how that will help them/why they don't feel inclined to do that anyway when they already are thinking it, they tend to be confused & unsure why they have such an approach to life when they know 'better'.	communities so they are neighbourly & supportive. We used to have the stereotypical matriarchal support & yet this has generally gone as work-emphasis has changed. People would perhaps call on such neighbours to run things passed them & yet that facility has mainly gone. Often GPs are not the most appropriate first port of call & we could have lesser trained, whilst equally professional & more appropriately informed community based access who could then refer on to GP or others as & when needed e.g see Nailcare information below. Clients typically over-exercise & under-stretch to balance the exercise they have done. Often people will access me a week or so before they are due to complete a marathon they have been preparing for because they do not have an overall balanced approach to exercise e.g. book 'Total fitness in 30 minutes per week.' By Laurence Morehouse & Leonard Gross. http://www.amazon.com/Total-Fitness-30-Minutes-Week/dp/0671729934 People often don't realise drinking more than about 150ml of water in 20 minutes will not rehydrate them but flushes their system including flushing out vitamins & minerals needed for their good health.

12	4.1	Julie Tasker	JT Healing	Key area for quality improvement 4 Really listening, hearing and understanding the patient voice – ideally engaging with public before they become patients.	Medics still often continue to think that they are expected to have the answer & yet many will acknowledge we only know the probable path that a disease / injury will take. Patients may tend to hand their health & social care over to the professionals to be 'fixed' rather than empowered in their own role.	NHSEngland recognises the importance of patient voice & how we need training both of the public to understand the healthcare system & also nhs staff to engage & really understand how to support the public/patient voice. This includes enabling people to become more conscious of what their needs & thoughts are which often they are just busy coping rather than really understanding themselves & the different options that may be available.	NHSEngland pilot training for patient representatives including the module I have undertaken recently: Facilitation and Engagement in the Health and Social Care Environment (FEHSCE) e.g. Patient choice has been to not have hernia operations despite being fully informed that death may result. Medics thought this choice would not be made by patients.
13	4.1	Karen Wheele r	Derbyshire Healthcare NHS Foundation Trust	Key area for quality improvement 1 Person centred care planning and self management	Evidence shows that when care is person centred health outcomes are improved. In relevance to this NICE guidance it is essential that we find out the communities that are important to the person and which help support and maintain their health so that they can then be supported to engage within their community	Person centred care within mental health services is essential, however the quality of these approaches does vary across services . This approach is essential if we are to successfully tackle health inequalities ,to be able to understand the valued communities that people engage within.	Person centred care , Heath foundation http://www.health.org.uk/sites/default/files/PersonCentredCareFromIdeasToAction.pdf
14	4.1	Léa Renoux	Age UK	Key area for quality improvement 1 Person-centred care models	Age UK has demonstrated that person-centred care models improves wellbeing and resilience while also helping to build local community capacity. Age UK's Personalised Integrated Care Programme brings together voluntary sector organisations and health and social care services in local areas to provide an innovative combination of medical and non-medical support for older people living with long-term conditions. It is based on shared care management plans which	The first results of the pilot in Cornwall have been very promising, with a 31% reduction in all hospital admissions. It has also contributed to improve older people's quality of life, with a 20% average increase in wellbeing among participants. Specifically, the project has helped to demonstrate how older people are more likely to respond positively to preventative/self-care strategies when they are actively engaged in their health It also acknowledges once again the fact that older people may	Vital signs, The Richmond Group of Charities, 2015 Integrated Care Services - Bringing together leaders to transform services and outcomes for people living with long-term conditions, Age UK, 2015

					involve a local Age UK working closely with the local health and care multi-disciplinary team; guided conversations with an older person to co-produce a care plan that outlines the primary goals regarding their health, home and life and to address their social needs; and a package of ongoing 'wrap-around' voluntary sector services helping people to re-engage with their local community, complementing the work of health and care agencies. By fostering a culture of person-centredness and shared decision making, health and care services can play an important role in improving the health and wellbeing of their local communities, and supporting behaviour change towards healthier lifestyles.	have additional challenges, whether due to the environment they live in, their health condition(s) or mental wellbeing, and that addressing these in parallel is crucial. Hence the importance of forging strong partnerships across sectors, including with voluntary sector organisations. Despite a growing consensus towards shared decision-making, co-production and person-centred care, too many people living with long term conditions are still treated as passive recipients and not equal partners in their care. Far too few patients are given the opportunity to articulate their needs, agree priorities and set goals through care and support planning. For example, more than one in four (27%) people living with dementia report not being involved in decisions about their care. One third of patients in general practice say they are not fully involved in decisions about their care (Richmond Group of Charities, 2015)	

15	4.1	Léa Renoux	Age UK	Key area for quality improvement 5 Universal access to information	Providing universal access to information, together with support to understand and use it, is essential to community engagement. To achieve this, the following factors must be considered. We know that many older people are digitally excluded, with 4.5 million people aged 65 and over never having been online. Relying on online-only communications channels can disadvantage older people in participating in local engagement opportunities and risks embedding social isolation and loneliness. Additionally, we also know that older people, particularly those living with cognitive impairment and those from BME groups, may have difficulties reading and filling in forms, may suffer language barriers, and may not wish to trouble others by asking for help. Finally, although written information can be sufficient for many older people, they often tend to prefer communication to be delivered personally (face to face or by telephone). Efforts to ensure universal access to information should therefore look at using different channels and adapting formats and languages to different audiences so that no-one is excluded from engaging with their local community.	Opportunities for older people to be engaged in decision-making at national and local government level are getting increasingly sparse. Since 31 March 2016, Government has discontinued its engagement of older people through the UK Advisory Forum on Ageing (UKAFA). Local government engagement is also increasingly online and limited. This could further disadvantage older people who tend to prefer other information channels unless additional steps are taken to support them to get online. While almost all (99%) UK adults aged 16 to 24 years in the UK have recently used the internet, this applies to only seven in ten (71%) people aged 65-74 and just a third (33%) of people aged 75+. Although the number of people aged 75+ who have never used the internet has fallen from 76% in 2011 to 61% in 2015, this hides wide socio-economic variations whereby those from deprived areas usually have poorer online access (ONS, 2015).	Internet users 2015 – Statistical bulletin, ONS, 2015 Ageing: the silver lining - The opportunities and challenges of an ageing society for local government, Local Government Association, 2015 Agenda for Later Life 2015: A great place to grow older, Age UK, 2015 Information and advice for older people – Evidence review, Age UK, 2012 Digital inclusion – Evidence review, Age UK, 2013 Accessible formats guidance, Department for Work and Pensions, 2014 Liberating the NHS: table of issues for the information revolution and related policies Initial - Analysis of the Impact on Equalities, Department of Health, 2011 Equality Act 2010

16	4.1	Léa Renoux	Age UK	Key area for quality improvement 3 Transport	Safe, affordable and accessible transport allows older people to remain independent, active and involved in their local community. Our report jointly published with the Campaign to End Loneliness, Promising approaches to reducing loneliness and isolation in later life, highlighted the importance of adequate transport in supporting older people to maintain direct social connections, such as visits to family and friends, as well as a way of supporting engagement with other services that foster wellbeing, for example access to community groups and services (Campaign to End Loneliness/Age UK, 2015). The results of a 2014 survey by Populus of approximately 2,000 bus travellers in the UK indicate that social activities (day trips for leisure, social events and hobbies, and visiting friends and family) make up almost 60% of the reasons why those over 65 travel by bus (Populus (2014) Health Benefits of Bus Travel Survey, Greener Journeys). It is also important to consider other forms of transport including community transport and driving. A number of voluntary sector organisations provide community transport services, which can be flexible and responsive, and notably helpful in rural communities.	There are varying levels of service depending on where people live, particularly when it comes to public transport for older people living in rural areas. 18% of those over 65 living in rural areas don't use public transport because none is available, compared to 2% of those living in urban areas (ILC, 2015). Limited local transport services mean, for example, that older people experience difficulties in getting to hospital appointments. 1.45 million of those 65 and over in England find it difficult to travel to hospital. Researchers also found that it is the people with the worst health and the lowest incomes who struggle the most to travel to health services (ILC, 2015). In addition, we know that public transport services are often ill-adapted to older people's range of mobility and sensory needs, including those living with dementia. Age UK has been made aware of examples where staff have lacked understanding and compassion towards passengers with dementia who had lost their way. As such, it will be important to highlight the central role of safe, affordable and accessible transport in enabling community engagement and supporting health and wellbeing.	Promising approaches to reducing loneliness and isolation in later life, Campaign to End Loneliness/Age UK, 2015 The Future of Transport in An Ageing Society, International Longevity Centre (ILC), 2015

					Driving can also be an essential option for older people, particularly for those living in remote areas. However, heavy traffic, poor road conditions and inadequate street lighting, parking facilities or signage can all be barriers to older people's opportunities to drive.		
17	4.1	Léa Renoux	Age UK	Key area for quality improvement 2 Age-friendly communities	Older people's ability to remain engaged in their community depends on the inclusiveness of their local community and environment. This includes whether these are age-friendly and dementia-friendly. While many older people continue to play an active part in their community, problems with mobility, vision and memory can make neighbourhoods difficult to navigate. Lack of public transport, or somewhere to sit down, or access to clean public toilets limits how far people are able to get around and poor quality pavements, poor street lighting or fear of crime can stop people feeling confident enough to go out at all. Research suggests that age-friendly approaches help to foster a positive mentality amongst organisations and institutions within a local area. Such inclusive approaches encourage them to think creatively about how to ensure services and facilities enable older people to remain actively involved in their community. For example, the Age-Friendly	Fair Society Healthy Lives (the Marmot Review) recognised there are social determinants of health at a neighbourhood level, such as barriers associated with community participation, being able to access green spaces, public transport and active travel. Older people encounter specific challenges across all of these areas. Indeed researchers have found that while most older people want to remain living at home the danger is that, unless they are supported to get out and about, they will be effectively trapped inside (ILC, 2011; E Burton and L Mitchell, 2006). In 2011 several cities around the world, including Manchester and Newcastle in England, signed the Dublin Declaration for Age Friendly Cities, agreeing to meet actions based on the WHO Age Friendly Cities Guide. More communities across the UK are now adopting age-friendly strategies. The Government has also been promoting the idea of Dementia Friendly Communities, with 142 signed up to date and a target of a further 100 by 2018.	Global Age-Friendly Cities: a guide. WHO 2007 World report on Ageing and Health, WHO, 2015 The long wait for a home, Leonard Cheshire Disability, 2015 Building dementia-friendly communities: A priority for Everyone, Alzheimer's Society, 2013 Agenda for Later Life 2015: A great place to grow older, Age UK, 2015 Promising approaches to reducing loneliness and isolation in later life, Campaign to End Loneliness/Age UK, 2015 Growing Older In Urban Environments: Perspectives from Japan and the UK, ILC, 2011 Inclusive Urban Design – Streets for Life, Elizabeth Burton and Lynne Mitchell, 2006

					Manchester scheme supports older people to become “culture champions”, linking up with their community to encourage their peers to engage with art and cultural events. An evaluation of the project showed people were more confident and connected as a result of their involvement (Campaign to End Loneliness/Age UK, 2015). NICE’s quality standard should recognise the importance of age-friendly communities. In simple terms, it means designing an inclusive environment for all ages to lead independent lives and continue participating in society. This also includes adopting approaches that will enable people with cognitive impairment and/or dementia to remain active in their communities.	Most recently, the Healthy New Towns initiative between NHS England and Public Health England is working with 10 housing developments to test how good urban and housing design can promote healthy lifestyles and prevent illness.	

18	4.1	Mary C Farnan	Association of Catholic Nurses England and Wales		There is poor access in many instances to support services such as healthy minds . There is also often a lack of childcare or crèche facilities where services are provided that frequently prevent attendance at appointments. Depressed women may be reluctant through low self esteem depression and associated low motivation to access local services so health services may need other partners such as family support workers on board to sufficiently encourage mothers to attend or to accompany them to a local group . Some will not access local services if they feel they are going to be stigmatised . Mothers who have excessive weight gain due to pregnancy or anti-depressant medication are particularly at risk of low self esteem which may affect their ability to engage with local services.	Health visitors are aware that where mental health support services were available locally in childrens' centres with onsite crèche availability funding cuts have resulted in Healthy Minds and similar services no longer being commissioned into childrens centre service provisions. By re-establishing or providing more mental health support services in childrens' centres community engagement could be improved as it is easier for mothers to be able attend without feeling stigmatised and to have family support workers based there on board to provide extra help and support around attendance at these meetings . Child care is often a concern and the availability of a crèche in Childrens' centres is also another positive factor towards extending services within childrens' centres. Corporate funding for nursery time children less than 3 years also needs to be more easily available to mothers with depression to enable those that need a break to be more easily able to get one.	
19	4.1	Tom Bailey	Action on Hearing Loss	4. Improving the accessibility of services	People with hearing loss may need additional support to participate fully in local health and wellbeing initiatives. When contacting services, people with hearing loss may find it difficult or impossible to use the telephone and may benefit from alternative contact options such as email, SMS text, text relay or BSL video relay services.	Our Access All Areas[25] research shows that many people with hearing loss are often forced to struggle with the telephone or visit their GP in person to book an appointment. The research also shows that poor deaf awareness by care staff and the lack of communication support can lead to missed appointments and ineffective care. A majority of respondents to our	Calton (2011) Calton (2012) Life Support: The provision of social care for people with hearing loss. Available at: www.actiononhearingloss.org.uk/life support Ringham (2012) Access All Areas, available at: www.actiononhearingloss.org.uk/ac cessallareas

					At events, people who wear hearing aids may benefit from technology such as electronic hearing loop systems that improve speech clarity by reducing the level of background noise. People who use BSL may need support from communication professional to help them communicate well and understand written information, such as BSL interpreter. Directors of public health and bodies responsible for the development of health and wellbeing initiatives should be mindful of their requirements under the Equality Act 2010 to make reasonable adjustments if people with hearing loss experience substantial difficulties when accessing services. This should be supported by staff and volunteer training on the legal requirements of the Equality Act and also different forms of support that may help people with hearing loss communicate well and understand written information. NHS England Accessible Information Standard[24] also provides clear guidance on what providers of what health and social care providers must do to make their services accessible for people with sensory loss and learning disabilities – including people with hearing loss. People who use BSL in particular may benefit proactive	survey (72%) contacted their GP by phone, yet just under half (44%) said this was their preferred method of communication. Just under half (46%) visit their GP in person to book an appointment, but less than one in 10 (9%) preferred to book an appointment in this way. One in seven (14%) respondents had missed an appointment because they didn't hear their name being called in the waiting room. After attending an appointment with the GP, more than a quarter (28%) had been unclear about their diagnosis and approximately a fifth (19%) had been unclear about their medication. Survey research by the Our Health in Your Hands campaign[26] exploring the experience of people who use BSL when accessing health services also found that two thirds (68%) of survey respondents who asked for a sign language interpreter to be booked for a GP appointment didn't get one. When accessing local authority services, our Life Support[27] research found that in most cases, an under-qualified BSL interpreter was provided during adult social care assessments. Almost a quarter (25%) of respondents in England and three quarters of respondents in Wales (75%) did not offer a bespoke telephone or minicom service.	https://www.actiononhearingloss.org.uk/supporting-you/when-you-need-to-see-a-gp.aspx NHS England (2015) The Accessible Information Standard SCCI 1605 https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

					communications such as BSL video translations on websites or through direct engagement with local Deaf clubs and other community groups.	Our Open to All?[28] research shows that over two-thirds (79%) of respondents said that hearing loss makes it harder for them to take part in art, entertainment and leisure activities. The main causes were the poor deaf awareness of staff (46%), the lack of subtitles/captioning (37%), and the lack of induction loops /loops switched off (45%). Aside from the availability BSL video translations, research suggest that people who use BSL may also benefit from proactive engagement by directors of public health and bodies responsible for developing health and wellbeing initiatives. Research on the Deaf community's understanding of Dementia suggests that cultural aspects of the Deaf community such as strong links between individuals or groups even across large geographical distances mean that information and experiences shared within the Deaf community may be seen as more culturally valid[29].	
20	4.1	SCM1	SCM	Key area for quality improvement 5 Build on assets – building capacity in individuals. Be aware of the needs for planning but use an assets based approach with regard to engagement	Whilst it is important to access information about needs of the neighbourhood or group. Needs do not give you an approach to tackling the needs and can often describe a series of negative indicators with regard to the communities concerned. It can be disempowering for the communities concerned. An asset based approach provides information about what the communities have available and how we can engage	It would be possible to develop quality indicators about undertaking an asset based approach. Engaging communities is central to ABCD In addition it is also important to engage communities with needs assessment	

					communities in addressing these needs.		
21	4.1	SCM3	SCM	Promoting sustainable community engagement	Do we understand what sustainable community engagement looks like	Not enough evidence to say how this is done	
22	4.1	Jane Keep	Esoteric Practitioners Association (EPA)	Key area for quality improvement 3 All engagement is based on relationships	Any engagement – patient, public, community, staff, clinician engagement all start with relationships. We have a lot of policies, systems, processes, documents, research, standards, guidelines, organisations focusing on engagement yet after a decade or more we are still talking about 'engagement' as an add on – and we haven't yet fundamentally build strong relationships amongst us all to tackle these seemingly difficult to tackle issues – of building truly healthy local populations, healthy families, healthy workplaces and healthy people. When we focus on building relationships simply so, the engagement naturally comes as does participation. We have a massive workforce from all sectors out there in our communities – we could look at how every workforce builds relationships with local people.	If we change the focus from community engagement and processes/infrastructure to how do we build relationships so that we can all work together to tackle our health and wellbeing, the focus would change. We could start with local hubs in peoples homes, or workplaces, or community places simply of groups of people from all walks of life/all sectors getting together to look at what locally could work in regards to building health and wellbeing. There are many out there who would be examples, and many who would love to learn – informally, but who may take a while to engage. When we have relationships we naturally want to work together, and commit to a shared purpose. Focus on building relationships (without imposing) naturally where we are already in communities. We could have health champion local families for instance who share amongst friends and relatives and their networks too.	There is a lot of literature, research and policy papers about engagement – staff engagement, clinician engagement, patient and public engagement, community engagement etc. Fundamentally within all of it it is about relationships. There is also research on loneliness, isolation, and many related aspects in terms of building relationships. There is much that could be drawn from as to how we build relationships – and those that will know best are the very families and communities that we engage with.

23	4.1	SCM4	SCM	Additional developmental areas of emergent practice Documentation of local assets as part of Joint Strategic Needs and Assets Assessments (JSNAA) and other local asset mapping exercises	Undertaking assessments of local community assets is an area of emerging practice. This is used to complement more traditional approaches to assessing population needs. NICE guidance on Community Engagement NG44 highlights the importance of asset-based approaches (1.2.2) and the need to identify local community assets in strategic planning processes (1.4.2).	Identifying assets is an important step in planning and developing locally relevant approaches that recognise the skills and insights and capacities of communities. Some local authorities have successfully piloted asset mapping exercises as part of priority setting, but this is not routinely done as part of JSNA across all local authorities.	PHE have developed the SHAPE tool-Strategic Health Asset Planning and Evaluation. SHAPE is described as a web-enabled, evidence-based application which informs and supports the strategic planning of services and physical assets across a whole health economy. https://shape.phe.org.uk/ 'A glass half-full: how an asset approach can improve community health and well-being' is a Local Government Association publication on using asset based approaches for health and social care. http://www.local.gov.uk/health/-/journal_content/56/10180/3511449/ARTICLE
24	4.1	Karen Wheeler	Derbyshire Healthcare NHS Foundation Trust	Key area for quality improvement 2 Community mental health services transform / develop collaboratively with community services	This NICE guidance supports the development of a neighbourhood approach to practice and encourages collaborative work with local community development so that services can develop according to people's needs in collaboration with community support . Asset based community development approach. Bridging roles into community resources.	As part of transformation of health services ,it is important that mental health services in the community become more integrated within the community, historically with mental health and stigma this has been challenging . The directives within the 5 year forward plan for mental health & the recent Kings fund document provide evidence that this is essential if we are to improve health and tackle health inequalities	Kings fund report : bringing together physical and mental heath http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf Five year forward plan for mental health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

25	4.1	Lisa Jowitt & Carlos Tait	Pennine Care NHS Foundation Trust	Key area for quality improvement 3 ABCD (asset based community development)	Asset-based approaches to health nurture, sustain, protect and build the health assets in every individual, family and community in order to improve people's life chances and enhance positive health and wellbeing. To ensure frontline staff have a change in focus from a 'deficit / needs' based model to an 'ABCD / Strength' based model. This is a fundamental shift which workers that are based in communities need to understand.	ABCD utilises the communities themselves by identifying and mobilising existing, but often unrecognised assets, and responding to and creating local opportunity. ABCD builds on the assets that are already found in communities and mobilises individuals, groups, and organisations to come together to build on their assets – not concentrate on their need and deficits. Head, hands and heart' refers to a well-known asset-mapping technique, in which participants are asked to respond to three questions: What knowledge do you have? ('Head') What skills do you have? ('Hands') What are you passionate about? ('Heart') These questions are a way of drawing out and organising knowledge, at both the personal and community levels	The 2012 White Paper Caring for our future: Reforming care and support recognised that 'strong communities can improve our health and wellbeing and reduce health inequalities. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf The King's Fund handbook for health and wellbeing boards, Improving the public's health: a resource guide for local authorities, includes a chapter on the evidence for strong communities, wellbeing and resilience as one of the nine priorities for local action. http://www.kingsfund.org.uk/publications/health-and-wellbeing-boards NICE guidance on behaviour change recommends interventions and programmes that 'identify and build on the strengths of individuals and communities and the relationships within communities' and which help individuals 'feel positive of the benefits of health-enhancing behaviours and changing their behaviour' and 'recognise how their social contexts and relationships may affect their behaviour'. https://www.nice.org.uk/guidance/ph6 https://www.nice.org.uk/guidance/ph49 The Department of Health's Wellbeing: Why it matters in health policy? makes the case for a stronger focus on action for

							wellbeing to improve health outcomes. In doing so, it argues that this 'may ultimately reduce the healthcare burden... High levels of wellbeing directly affect good health. It is estimated that high levels of subjective wellbeing can increase life by four to 10 years compared with low levels of subjective wellbeing.' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277566/Narrative__January_2014_.pdf http://www.health.org.uk/sites/default/files/HeadHandsAndHeartAssetBasedApproachesInHealthCare.pdf

26	4.1	Phil Tavern er	SCM	Processes for commissioning health and social care services in communities	A Local Government Association report on using an asset approach to improving community health and wellbeing recommended “designing out the structures, processes and systems that stop this future being achieved”	The competitive tendering approach and its associated procurement rules that sit behind much commissioning tend to favour large organisations with resources and experience to exploit funding opportunities. There is an increasing trend for empire building amongst such organisations, which then parachute into local communities. All too often, local communities are starved of direct resource to build community capital as a result, and existing assets are squeezed out or taken over by these organisations with no real history, connection or empathy with the communities into which they drop. To build a successful asset approach to community engagement, different systems need to be found to distribute resources within those communities, systems that give power and autonomy to the communities themselves. The current system for commissioning runs directly counter to genuine community engagement.	Improvement and Development Agency, LGA (2010): *A glass half-full: how an asset approach can improve community health and wellbeing.*

27	4.1	SCM5	SCM	Mobilising community assets to achieve whole system change	The 2010 Marmot review recommended concentrating on the “causes of the causes” of health inequalities.	Although integration of services is slowly improving, silos and organisational boundaries often get in the way of community engagement. In particular, individuals and communities are less inclined to disaggregate their lives into specific health conditions in the way that professionals are prone to do by virtue of their specialisms. In addition, this latter focus leads to a deficit model of communities and individuals as defined by their needs as opposed to their assets. Focussing on assets draws out knowledge, skills and connections to help get at the causes of the causes to which Marmot refers.	Marmot (2010) Fair Society Healthy Lives. Final Report and Executive Summary
28	4.2	SCM1	SCM	Key area for quality improvement 2 Engagement lay workers and volunteers in the delivery of the initiative. Consider mechanisms that can ensure community engagement is an integral part of health and wellbeing initiatives. This could include: Processes that make it as easy as possible for people to get involved. See section 1.5. Service contracts for providers that specify the need to collaborate with local communities. 1.4.1	Trend suggesting that peer-delivered/lay-delivered interventions are more effective but cannot conclude that one particular model of community engagement or theory of change is clearly more effective than any other	This could be assessed and indicators determined. It does relate to the previous point about a top down approach. Lay workers and volunteers increase ownership and are able to offer their lived experience and can be an inspiration for others in a similar particularly if they are from that community or a similar community. It is desirable to have a collaborative approach between professionals and lay workers. This improves both the quality of the service the access and recruitment to the service and sustainable change and improvement in wellbeing.	O/Mara-Eves et al – see NICE CE evidence base

29	4.2	Jane Keep	Esoteric Practitioners Association (EPA)	Key area for quality improvement 4 Start with staff in healthcare, the third sector/charitable sector and in all our local workplaces	In local communities we have employers, businesses, hospitals, even small local corner shops. Health and wellbeing starts there. If we engaged local shop keepers, local employers, and local staff to feel more committed to their own health and wellbeing, there is a substantial ripple effect. If I am served in Sainsbury's by a check out operator who ask me (without imposition or judgement) about the food I eat, and I as that member of staff look well and vibrant, I am going to be inspired to be curious – and I may learn just one simple thing like how to cook something from that moment at the check out – if we multiply that x 1000s who pass through the check outs we have a lot of conversations about food for instance. If we start conversations like this we naturally become more curious.	If staff are naturally more vibrant, more informed about healthy options whether simply about food, exercise, rest, sleep etc then the ripple effect is enormous. We maybe inspired to be like them, we may feel to have a conversation with them about how they cook or exercise etc. And as employees/staff if we encourage conversations about our health, and the simple practical daily things like hydration, food, posture etc that in itself has a ripple effect. It is by nature engaging, and it has more practical currency in our local communities than organising 'community engagement' events for instance. Healthy Staff are our best public health initiative we have. Unhealthy staff give no incentive (particularly in healthcare) for us to start to change the way we make our daily living choices. Health Champions (p 13 of 'Community engagement: improving health and wellbeing and reducing health inequalities) would naturally emerge from this.	There have been reports (e.g. Boorman, Black) about healthy staff which could be drawn upon to support us to look locally at supporting healthy staff.

30	4.2	SCM4	SCM	Key area for quality improvement 2 Creating opportunities for people to take up lay and peer roles and other volunteering activities	Peer and lay roles in health and wellbeing initiatives are recommended in NICE guidance NG 44, based on evidence. Also NICE guidance on promoting independence and mental wellbeing in older people NG32, recommends providing older people with opportunities to volunteer.	There are a number of volunteer programmes related to health and wellbeing, but very few of these have national coverage. The Royal Society of Public Health (RSPH) report on tackling health inequalities with the wider workforce highlighted the potential contribution of volunteer health champions and the variety of existing programme models. It called for more investment in the wider workforce. Whilst local areas will need to adapt volunteering programmes to local health needs and priorities, there is scope to increase the range and geographical spread of opportunities available to people to volunteer.	The Sheffield Community Health Champions programme (see NICE Shared Learning database) is an example of a sustainable programme that builds the capacity and skills of local people to take on health roles in their communities: https://www.nice.org.uk/sharedlearning/sheffield-community-health-champions-programme-addressing-obesity-through-community-engagement The Royal Society of Public Health (RSPH) report on tackling health inequalities with the wider workforce: https://www.rsph.org.uk/en/about-us/latest-news/index.cfm/pid/3918700F-84EE-4BB3-9B13FEB7E38EDFB4
31	4.2	Karen Wheeler	Derbyshire Healthcare NHS Foundation Trust	Key area for quality improvement 3 Peer support within Mental health services	There is wide evidence that peer support makes a difference to people using mental health services . It can reduce use of in patient services,improve personal hope ,confidence and empowerment and facilitate better access to community activities	Nationally mental health services are transforming to include peer support and lay roles , but this is still very limited , requires changes in cultures and not available across all services Peer supporters training , support and involvement in service design and facilitation varies nationally	Literature review of peer support within mental health http://cosb.countyofsb.org/uploadedFiles/admhs_new/resources/Systems_Change/Peer_Action_Team/repper.pdf Centre for Mental health publication http://www.centreformentalhealth.org.uk/recovery-wellbeing

32	4.2	Karen Wheele r	Derbyshire Healthcare NHS Foundation Trust	Key area for quality improvement 4 Bridging roles between mental health services and community	Enabling people to become involved in the communities that support their wellbeing and are meaningful to them in their lives is important for mental wellbeing. The bridging role to enable this reconnection is an essential element.	This bridging role is a key function of occupational therapy in mental health services. Occupational therapists work with people to enable them back into meaningful occupations within their communities. The OT role is not always well recognised within service design or planning , but evidence shows improved health outcomes through occupational therapy Collaboration and joint working with voluntary sector and third sector is an essential component	Recovering ordinary lives publication College of Occupational therapy https://www.cot.co.uk/publication/books-standards-strategy/recovering-ordinary-lives-strategy-occupational-therapy-mental-health http://www.cot.co.uk/sites/default/files/commissioning_ot/public/ot-evidence-fact-sheet-mental-health.pdf Local emerging good practice
33	4.2	Léa Renoux	Age UK	Key area for quality improvement 4 Volunteering opportunities	Later life is a time when many people wish to volunteer and make an active contribution to civic and community life. Indeed many community groups are almost totally dependent on older people's involvement. As such, the contribution of older volunteers to community engagement should be recognised and supported. This requires more imagination in the way older people can be involved, including learning from informal volunteering that emerges independently of any organisation. Volunteering is both an enabler of community engagement and a way of directly enhancing older people's health and wellbeing. For example, our joint Promising approaches report identified volunteering as a key 'structural enabler' of social connections and an essential component of strategies to tackle loneliness and isolation	28%of people aged 65–74 and 19% of 75+ in England have participated in formal volunteering at least once in the last 12 months. Many more volunteer informally, and many older people take an active role in the life of their communities through campaigning and other forms of social action (DCMS, 2015). Despite these positive figures older people do face potential barriers when volunteering, not least the discriminatory policies and practices of some organisations that impose upper age limits on volunteers. There may also be physical challenges for older people with visual, auditory and cognitive impairment, or it could be something as simple as a lack of transport, or the timing of a meeting at night. Additionally, cultural and language differences or confusing internal processes and infrastructures of organisations can lead to disengagement, or may lead	Older people: independence and mental wellbeing, NICE guideline NG32, 2015 Taking Part Survey 2014/15, England, Department for Culture, Media and Sport, 2015 Agenda for Later Life 2015: A great place to grow older, Age UK, 2015 The impact of volunteering in later life, A report to WRVS, Professor James Nazroo and Katey Matthews, 2012

					(Campaign to End Loneliness/Age UK, 2015). As well as enhancing social networks, volunteering may be particularly important in providing opportunities to remain engaged in socially meaningful and valued roles, including for those older people who are making the transition from work into retirement, or those who are seeking to improve their skills to return to work. Volunteering should be seen not as a way of reducing the costs of delivering interventions but as a way of involving older people in service delivery and improving their wellbeing.	volunteers to feel that they have a lack of influence. A flexible and inclusive approach to developing, recruiting and managing volunteers will help to encourage older volunteers. Finally, many voluntary sector organisations that provide vital support to volunteers have been hit hard by government funding cuts. It will therefore be important to recognise the role of maintaining such opportunities to support community engagement, and enhance people's health and wellbeing.	
34	4.2	SCM5	SCM	Strengthening community resilience	Communities under pressure from the falling investment and reductions in services of recent years are vulnerable to fracturing into conflicting interest groups.	Much of the writing assumes that communities are homogeneous entities with a high degree of consensus. The reality can be far from that, especially in times of dwindling resources. Developing cohesive communities takes time and resource in its own right.	

35	4.2	SCM1	SCM	Key area for quality improvement 4 Build and develop skills foe Community engagement. Ensure providers have these skills and are putting in place training and development to grow these skills in communities. Working in partnership with local communities and community and voluntary organisations and groups to plan a series of learning, development and support opportunities for community Participants. The aim would be to gradually build on local skills.	It is important to have this as a quality measure to check if programmes concerned have the skills experience and knowledge to engage communities. In addition they need to ensure there is training to build this knowledge and skills with communities including Voluntary sector providers. This is important with regard to the quality of the engagement and to support the community to work in partnership. It can also have other positive outcomes and development opportunities for members of the community. For example previous interventions have led to local people getting jobs, undertaking volunteering or pursuing other training.	It could be turned into an indicator and Commissioners could include in specifications for initiatives to include health and wellbeing.	LGA – Healthy Communities – Glass half full
36	4.2	SCM3	SCM	Partnership working community engagement	Partnership working and effective collaboration are essential for successful community engagement .Lay member knowledge must have equal status as professional knowledge.	Collaborations and partnerships(recommendations#collaboration-and-partnerships	NICE Guidences
37	4.3	SCM1	SCM	Additional developmental areas of emergent practice	To consider emergent evaluation tools which could add to quality standards – social capital		

38	4.3	SCM2	SCM	Key area for quality improvement 2 The commissioning of evaluation of community engagement/community development frameworks	A more rigorous understanding is needed of the value and impact of different sorts of community engagement/community development activity. One key aspect of the evaluation process is the assessment of the health impact on those local people participating in the evaluation process itself, in other words, the reflective process of engaging in setting up a project and then engaging in reviewing it holds huge promise for challenging health inequalities.	Jane South's family describes well the range of activity involved. Funded evaluation of different sorts of activity are needed to develop the evidence and inform the commissioning process. those local people participating in the evaluation process itself, in other words, the reflective process of engaging in setting up a project and then engaging in reviewing it holds huge promise for challenging health inequalities.	PHE England, Professor Jane South - See evidence in the NICE Community engagement guidance (2016)
39	4.3	SCM2	SCM	Key area for quality improvement 3 Commissioning the assessment of the health outcomes on participants in the evaluation process itself	Inherent in the community engagement guidelines is the point that community engagement, in and of itself, brings health benefits to participants.	Jane South presented a paper on the health benefits for participants, recommending more research here. The action of reflecting on the process of becoming engaged in setting up a project and then engaging in reviewing that project holds huge promise for health improvement. Often commissioners only recognise end-user impact. Such research could influence the breadth of acceptable evidence of impact.	Prof. Jane South in the evidence schedule of the Community engagement guidance (2016)
40	4.3	SCM3	SCM	All processes should be evaluated from conception	What do we understand to be effective evaluation and whose needs does it serve. The service provider or the members of the community. Is there a way to evaluate that has positive outcomes for all. Once again partnership and collbrative working are essential.		

41	4.3	Jane Keep	Esoteric Practitioners Association (EPA)	Key area for quality improvement 1 Clear understanding of what works at grass roots level and why (and what doesn't work)	In NICE Guideline 'Community engagement: improving health and wellbeing and reducing health inequalities – there are a number of unanswered questions and potential for future research e.g. pages 27 – 30. In addition Community engagement, patient and public engagement involvement, self management and many other initiatives have been running for over a decade now, and yet we still find ourselves with the same questions and issues – and the health of the population is not improving (though people are living longer in poorer health.) Understanding what works, how people in local populations actually feel inspired to take their health into their own hands. There are also related quality standards already e.g. for obesity, but do they work?	There are pockets in our society, and in our communities where there is more engagement in taking our own health and wellbeing into our hands – how much are we building on these? On small local community schemes, or even families who do it well? There are people and families who naturally take care of their health and wellbeing more than others, and there is much we can learn from them at grass roots level. How much do we share what made it work well? And how much do we support it to spread e.g. via health champions (as in page 13 in the Nice Guideline 'Community engagement: improving health and wellbeing and reducing health inequalities'). Can we learn from all we have learnt so far so a to avoid doing the same things over again.	In 'Community engagement: improving health and wellbeing and reducing health inequalities' and the many guidance documents quoted related to these standards there is an abundance of resources, research, etc – have we made the most of these and do we understand all we need to support local communities to take their health into their hands? Or engage in health and wellbeing?

42	4.3	SCM4	Jane South	Key area for quality improvement 4 Evaluation of community engagement within health and wellbeing initiatives	There is a growing evidence base for community engagement, nonetheless there is a need for better quality evidence that assesses the different elements of community engagement and the full range of outcomes that can result. Much of the public health evidence comes from North America. The NICE guidance NG 44 made a number of research recommendations.	Improving evaluation would help decision-makers commission more effective community engagement as part of health and wellbeing initiatives and check it is working well. One key issue is that the current formal evidence base is focused on individual behavioural change and there is less evidence on social-economic outcomes such as increased social capital, community cohesion, empowerment, education and employment which are also beneficial for health. Improving the evaluation of community engagement in health and wellbeing initiatives would help stakeholders understand what works, why and what the health impacts are. It is important to involve communities in identifying outcomes that are important for them. Many local community projects lack the capacity and resources to evaluate their community engagement work and consequently transferable learning is ‘lost’. Improving the quality of evaluation would help improve practice.	The review of community engagement practice (Bagnall et all 2015) undertaken for NICE used detailed case studies to identify facilitating factors, key processes and impacts.

43	4.3	SCM5	SCM	Evidence of what works	It is notoriously difficult to demonstrate clear causal effects in this area, and yet health and social care agencies need confidence as to what is most likely to produce good outcomes.	Research that sets out to evaluate individual interventions (eg a weight loss programme) in isolation and by trying to reduce "confounders" such as context may be missing the point. What we need is evidence of how community interventions interact to impact on a whole range of health outcomes in order to build up a picture of the way in which communities successfully produce good health outcomes.	Ongoing work by the National Institute of Health Research Public Health Research programme to produce guidelines on how to factor context in to scientific evaluation of public health. Outputs of the new "What Works" centres.
44	4.3	SCM5	SCM	Key area for quality improvement 5 Commissioning that builds in a cost consequence analysis of local collaborations and partnerships, that build up local resources and promote long term relationships	Such CCA's would make a useful contribution to the evidence for bottom up community development. Collaborations between community and voluntary organisations and between them and local public agencies is key to the success of community engagement.	The second recommendation in the guidance encourages "developing collaborations and partnerships to meet local needs and priorities." Commissioners need help to understand why working with local groups is important in building a sustainable and durable community infrastructure.	Community engagement guidance (2016) , recommendation 2
45	4.3	SCM2	SCM	Key area for quality improvement 1 The commissioning of cost consequence analyses of community engagement or community development initiatives	They represent a less reductionist approach to a highly complex area of activity, taking account of health outcomes, quality of life, wellbeing and cost savings not just in relation to health but the social determinants and public resources more broadly.	In the CCA report presented by Optimity, p.45, it is said that the suggested indicators (covering outcomes, financial and l and descriptive consequences) of potential impact can be used by "local decision-makers to inform investment decisions based on their own trade-offs between limited resources and benefits of various types." There is currently poor understanding of the value and whole systems potential impact of community engagement and so funding is niot currently seen as an investment in local communities, and local health and social care services.	See Optimity Cost Consequence Report in the schedule of evidence in the NICE Community Engagement Guidance (2016)

46	4.3	Lisa Jowitt & Carlos Tait	Pennine Care NHS Foundation Trust	Key area for quality improvement 2 To ensure that social return on investment tools (ROI) are embedded throughout all aspects of projects and interventions.	To quantify the true monetary benefit and value to individuals, communities, organisations and society. To measure and account for a broader concept of value, taking into account social, economic and environmental factors. To be used as a decision making tool. Enables quantitative analysis of project outcomes such as cost benefit analysis. Value the things that matter to local residents, and commissioners. Understand the difference that makes a difference. To justify the spend against the wider social impact.	In times of austerity, limited resources can encourage more creative thinking around how to do things differently. This can positively influence the achievement of outcomes (such as improving health), whilst optimising value for money. By considering the longer term impact of interventions, SROI can demonstrate savings to stakeholders across the health and social care arena. This in turn can demonstrate the true value of a project or intervention beyond the initial project costs.	QALY - http://publications.nice.org.uk/how-nice-measures-value-for-money-in-relation-to-public-health-interventions-lgb10b/nices-approach-to-economic-analysis-for-public-health-interventions HM Treasury: green Book overview http://the-sra.org.uk/wp-content/uploads/SRA-Wales-May-2012-JPrice-and-RThurston-slides.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220541/green_book_complete.pdf Social value publications from HACT http://www.hact.org.uk/social-value-publications http://www.health.org.uk/newsletter/can-austerity-and-innovation-go-hand-hand#sthash.MCFay91v.dpuf https://www.nice.org.uk/advice/lgb10/chapter/judging-the-cost-effectiveness-of-public-health-activities

47	4.4	Tom Bailey	Action on Hearing Loss	2. The impact of hearing loss on health and wellbeing	People with hearing loss may find it difficult to communicate with other people, which may lead to withdrawal from social situations and people becoming isolated. People with hearing loss also have an increased risk of poor health and premature death. BSL users in particular often cannot access information including public health campaigns. People with hearing loss are therefore more likely experience significant health inequalities and may particularly benefit from health and wellbeing initiatives. However, successful engagement will depend on improving the diagnosis and management of hearing loss and also the accessibility of local services (for more information, please key areas for quality improvement 3 and 4)	A significant body of evidence shows that hearing loss is a serious condition that can have an adverse impact on a person's health and quality of life[5]. Research shows that people with hearing loss may find it difficult to communicate with other people and this may lead to feelings of loneliness, emotional distress and withdrawal from social situations[6]. Hearing loss has been shown to have a negative impact on overall health. Studies have found that hearing loss is independently associated with increased use of health services, an increased burden of disease amongst adults and an increased risk of mortality[7]. People with hearing loss are more likely to develop paranoia, anxiety and other mental health issues – for example, evidence shows that hearing loss doubles the risk of developing depression[8]. Hearing loss has also been associated with more frequent falls[9], diabetes[10], stroke[11] and sight loss[12]. Evidence suggests that up to 40% of those with a learning disability have some level of hearing loss, and that this often goes undiagnosed or is misdiagnosed[13]. There is also evidence of link between hearing loss and cardiovascular disease[14]. There is strong evidence of link between hearing loss and dementia. Research shows that people with mild hearing loss are	Our Joining up report provides further information on the relationship between hearing loss and other long term health conditions such dementia, stroke and cardiovascular disease. The report found that at least £28 million could be saved every year by properly managing hearing loss in people with dementia. For more information, please visit www.actiononhearingloss.org.uk/joi ningup Monzani et al (2008) Psychological and social behaviour of working adults with mild or moderate hearing loss'. Acta Otorhinolaryngologica Italica, 28 (2), 61-6. Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society, 58 (1), 93-7. Lin FR et al. (2011) 'Hearing loss and incident dementia'. Archives of Neurology, 68 (2), 214-220; Gurgel et al (2014) Relationship of Hearing Loss and Dementia: A Prospective, Population-Based Study. Otology & Neurotology. 35 (5), 775-781. SignHealth (2014) Sick of it. Available at: http://www.signhealth.org.uk/sickofit /

						almost twice as likely to develop dementia compared to people with normal hearing. The risk increases threefold for people with moderate hearing loss and fivefold for people with severe hearing loss[15]. Research shows that hearing loss can be misdiagnosed as dementia or make the symptoms of dementia appear worse[16]. Research shows that people who use BSL may have worse outcomes for cardiovascular disease due to the lack of health information in accessible formats, communication challenges, financial constraints and stress[17] Research by the charity Signhealth[18] also suggests that people who use BSL are at risk of poor health due to inaccessible public health information. Over a third (34%) of people who use BSL who had a health assessment were unaware they had high or very high blood pressure, and of those who had already had a diagnosis of hypertension, around two thirds (62%) had high blood pressure compared to a fifth (20%) of the general population.	
48	4.4	Tom Bailey	Action on Hearing Loss	1. Recognition of the growing prevalence and impact of hearing loss	There are 11 million people with hearing loss, about one in six of the population[1]. Hearing loss is caused by a number of factors which could include regular and prolonged exposure to loud sounds, ototoxic drugs, genetic predisposition or complications from injuries or other health	People with hearing loss may find it difficult to communicate with other people, and have an increased risk of other health problems. Despite good evidence on the benefits of hearing aids[3], many people are waiting too long to get their hearing tested[4]. People with hearing loss, BSL	Our Hearing Matters report provides up to date evidence on the prevalence and impact of hearing loss across the UK. For more information, please visit www.actiononhearingloss.org.uk/hearingmatters Davis (1995) Hearing in adults

					conditions. Age related damage to the cochlear is the single biggest cause of hearing loss. Over 70% of people over 70[2] have hearing loss and due to the ageing population, the number of people with hearing loss is set to grow in the years to come. By 2035, we estimate there will be approximately 15.6 million with hearing loss. There are also an estimated 900,000 people in the UK with severe or profound hearing loss. Some people with severe or profound hearing loss may use British Sign Language (BSL) as their main language and may consider themselves part of the Deaf Community, with a shared history language and culture. Based on the 2011 census, we estimate that there are at least 24,000 people across the UK who use BSL as their main language – although this is likely to be an underestimate. When developing health and wellbeing initiatives, directors of public health and other bodies responsible for developing health and wellbeing initiatives must consider the health needs of people with hearing loss and the barriers to communication they may face when accessing services. For more information, please see key areas for quality improvement 2, 3 and 4.	users in particular, may benefit from proactive communications by directors of public health or other bodies responsible for developing health and wellbeing initiatives. For more information and a full list of references please key areas for quality improvement 2,3 and 4	Chisholm et al (2007) A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology, 18, 151-183 Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment, 11, 1–294.

49	4.4	Tom Bailey	Action on Hearing Loss	3. Improving the diagnosis and management of hearing loss	Undiagnosed hearing loss is significant barrier, preventing people from participating in and benefiting from health and wellbeing activities and also increasing the risks of poor health. There is good evidence that hearing aids help people communicate well, improve quality of life and reduce health risks. However, many people are waiting too long to get their hearing tested. In line with NICE's quality standard for the mental wellbeing of older people in care homes[19] all staff and volunteers involved in health and wellbeing initiatives should be alert to the early signs of hearing loss and also be aware of the GP referral pathway for assessment and treatment.	Research shows that hearing aids improve quality of life[20] and help people with hearing loss communicate, stay socially active and reduce the risk of loneliness and depression[21]. New evidence suggests they may even reduce the risk of dementia[22]. Evidence suggests that many people are waiting too long to get their hearing tested. Research shows that people wait on average ten years before seeking help for their hearing loss. Hearing aids are most effective when fitted early[23].	Chisholm et al (2007) A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology, 18, 151-183. Mulrow et al (1992) Sustained benefits of hearing aids. Journal of Speech and Hearing Research, 35 (6), 1402-5. Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment, 11, 1–294. NICE (2013) Mental wellbeing of older people in care homes. QS50 NICE (2015) Older people with social care needs and multiple long-term conditions. NG22
50	4.4	Julie Tasker	JT Healing	Key area for quality improvement 2 Nailcare for affordable regular nail cutting to reduce amputations, increase mobility, improve quality of life and other benefits	Podiatry waiting lists are too long & often patients needing the podiatry level of healthcare are not able to access early enough whilst others are being seen by podiatrists who could have benefitted from earlier appointments with level 2 trained nailcarers supported by podiatrists if urgent referral were needed.	The current health & social care system actually does not allow carers to cut nails & this leads to amputations, lack of mobility and other detrimental effects. Birmingham Podiatrists have shown that they have reduced waiting lists and are seeing the patients that need podiatry care. This has reduced amputations, increased mobility and other benefits.	The Birmingham Podiatry department have developed Level 2 Nailcarers working in care homes & the community for affordable nailcare since established in 2009. http://www.bhamnailcare.co.uk/ This has reduced amputations & increased mobility as well as other benefits.

51	4.4	Julie Tasker	JT Healing	Key area for quality improvement 3 Complementary Healthcare Therapies need to be regarded as complementary (completing healthcare) as opposed to Alternative Medicine	Currently stereotypically the nhs employees often talk about Alternative Medicine which unconsciously will build a barrier & separate complementary therapies from nhs healthcare. I know this is improving in some areas of the country but this is not uniform. Regarding these therapies as Alternative can lead to the danger of patients accessing either nhs / allopathic medicine OR complementary therapies.	We need a truly integrated healthcare system which is accessed including affordable complementary healthcare therapies. As I work I encourage my clients to be more self-health-aware so they are empowered to help themselves & understand perhaps why they are feeling like they are as they reflect on what is happening in their life at that time, what they have been through / are preparing for. e.g. The power of therapeutic touch has been shown through research. My experience of medical professionals working or even trained in complementary healthcare therapies is that often they are trained as an ‘add on’ to their previous medical training which means they are insufficiently trained in the actual therapy & then may come to feel they are ineffective or inappropriate yet each person needs the proper professional training to an appropriate standard for specific therapy.	Ancient approaches to healthcare which we need to acknowledge & update / integrate rather than denigrate. I am contacted by nhs to work for staff health & wellbeing events & often expected for me to work for free. If nhs realise that staff benefit & then hope that they will access me as clients when I will be paid why have we not raised the profile of therapies for use in nhs?

52	4.4	Julie Tasker	JT Healing	Key area for quality improvement 5 A balanced approach to the medicinal benefits which may be gained from herbs and other plants. Each home & work community ultimately would benefit from a herb garden overseen by herbalist professionals to empower & inform people. Media support to promote balanced use of substances rather than the current blame etc.	The current legislation is resulting in people accessing illegal drugs inappropriately which may be harmful & even lethal. The reasons people are using illegal drugs and alcohol are not being addressed sufficiently. The blame culture adds to the stress and hidden use of the substances which is even more dangerous.	We need to address the root underlying reasons for people accessing illegal drugs & alcohol. The main drug abuse addictions are actually to prescribed drugs which often are not addressing the root cause that prompted the sign & symptoms being addressed by the prescription.	The work I have been involved with for a few years working with clients rehabilitating from drug / alcohol addictions.

53	4.4	Jo Mullin	The College of Optometrists	Improvement of visual assessment services tailored to people with dementia.	Dementia has been identified as a major health problem and became a priority for the UK government and NHS initiatives. Dementia prevalence increases with age. With an ageing population, it is estimated that by 2021 over one million people in the UK will have dementia (approximately 750,000 today). The potential effects of dementia and visual impairment comorbidity are considerable. The ability of someone with dementia to cope with visual impairment is reduced when compared to someone with an otherwise similar health profile, but without dementia. This can impact significantly on activities of daily living and cognitive performance1.	Promoting and maintaining independence of people with dementia should be included as well as a reference to the importance of assessment and care-planning advice regarding vision and eye health from an optometrist. Dementia alone has a significant impact on quality of life, and visual impairment in older people can lead to functional impairment which may adversely affect quality of life2. The effect of having both sight loss and dementia concurrently are much more severe than those resulting from either dementia or sight loss alone3. In the case of cataract, earlier removal while a patient can consent might be helpful, while the procedure is sometimes avoided, arguably unnecessarily, in some dementia patients. In such cases it is important to consider the two conditions together and how improved vision can still improve quality of life in patients with dementia.4	McKeefry D, Bartlett R (2010) Improving Vision and Eye Health Care to People with Dementia. London: Thomas Pocklington Trust Binns A, Bunce C, Dickinson C et al. (2012) How effective is low vision service provision? A systematic review. Surv Ophthalmol 57, 34–65 Trigg R, Jones R (2007) Dementia and Serious Sight Loss. Report no. 11. London: Thomas Pocklington Trust Hancock B et al. (2015) A proposal for a UK Dementia Eye Care Pathway. Optometry in Practice 16, 71-76

54	4.4	Jo Mullin	The College of Optometrists	Increase in visual assessment as part of falls prevention assessments	The chances of having reduced vision greatly increases with age and older people with reduced vision are more likely to fall. Vision is fundamental to coordinating our movement – balance and postural stability are directly affected by vision. In addition, vision is fundamental to adapt gait to enable safe travel through the environment, avoiding obstacles and negotiating steps and stairs.	We are pleased that the NICE Guideline 161 asserts that vision should be a part of any falls multi-factorial assessment and a core part of falls interventions. However, emerging evidence shows that standard falls rehabilitation strategies may not be effective for people where vision was a factor. We feel that vision should be a consideration in all aspects of a patient pathway through falls services –including prevention and rehabilitation programmes.	Thomas Pocklington Trust's report Falls in older people with sight loss: a review of emerging research and key action points published June 2013. The College of Optometrists' Focus On Falls report which looks specifically at the relationship between falls and vision, making several practical recommendations for falls services and the optometric sector. The College of Optometrists and The British Geriatric Society. The importance of vision in preventing falls, available from http://tinyurl.com/vision-falls. Abdelhafiz, A.H. and Austin, C.A Visual factors should be assessed in older people presenting with falls or hip fracture Age and Ageing 2003 32(1), 26-30 Ivers RQ, Cumming RG, Mitchell P et al. Visual impairment and falls in older adults: the Blue Mountains Eye Study. J. Amer Ger. Soc. 1998 46(1): 58-64 Cummings SR. Treatable and untreatable risk factors for hip fracture. Bone 1996 18(3 suppl): 165S-167S Jack DI, Smith T, Neoh C et al. Prevalence of low vision in elderly patients admitted to an acute geriatric unit in Liverpool: elderly people who fall are more likely to have low vision Gerontology 1995 41(5), 280-5 - Patino CM, McKean-Cowdin R, Azen SP et al Central and peripheral visual impairment and the risk of falls and falls with injury Ophthalmology 2010 117(2) 199-

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55	4.4	Jo Mullin	The College of Optometrists	Increase in counselling services about the effect of smoking on Age-related Macular Degeneration (AMD) and cataracts	The complex links between eye health and the broader public health agenda are strong and often overlooked. There is good evidence of the important causal relationship between smoking, sight loss and blindness. Smoking accelerates the likelihood of AMD and cataracts. Optometrists have a major and influential role. Some optometrists are commissioned to counsel smokers on their increased risk, the benefits of stopping and, where appropriate, referral to a local stop smoking service.	Smokers have triple the incidence of AMD1 compared with non-smokers and smoking is strongly associated with cataracts2. Eye disease is a significant morbidity burden in the UK expected to grow as society ages but which could be significantly mitigated through better prevention, earlier identification and early intervention. AMD is the biggest cause of sight loss in the UK and thought to be responsible for 32 disability-adjusted life years per 100,000 up from 21 in 19903. Smoking cessation can reduce morbidity4. Research elsewhere suggest the public have little awareness that smoking increases the risk of sight loss and that such campaigns can be effective5; especially among vulnerable group like teenagers who are more scared of losing sight than of lung or heart disease6.	1. Cong, R, et al (2008). Smoking and the risk of age-related macular degeneration: a meta-analysis. Ann Epidemiol; 18:647-656. Kelly, SP, et al (2004). Smoking and blindness: strong evidence for the link, but public awareness lags. BMJ; 328:537-8. Murray, et al (2013). UK health performance: findings of the Global Burden of Disease Study 2010, Lancet; 381: 997-1020. http://www.college-optometrists.org/filemanager/root/site_assets/guidance/amd_guidance_25_11_13.pdf Carroll, T, Rock, B. (2003). Generating Quitline calls during Australia's National Tobacco Campaign: effects of television advertisement execution and programme placement. Tobacco Control; 12(Suppl II): ii40-ii44. Moradi, P, et al (2007) Teenagers' perceptions of blindness related to smoking: a novel message to a vulnerable group. Br J Ophthalmol; 91:605-607.

56	4.4	Patrick McKenna	Together for short lives	Community openness regarding 'taboo' issues	Community engagement should enable communities to talk about subjects that are often seen as taboo, such as death and dying – especially for children and young people. Community engagement can encourage communities to help care people in their community at the end of their life – which is often the preferred place for that person to be cared for. A lack of community awareness and support around issues of death and dying can lead to feelings of social isolation and exclusion for those who are dying and their families.	The Dying Matters coalition reports that 70% of people in England and Wales would prefer to die at home, yet 60% of people currently die in hospital. They also note that this has been inhibited by communities' lack of openness when talking about death as discussions about how we would like to die remain a taboo. Community engagement approaches should therefore encourage communities to discuss traditionally taboo subjects such as death and dying.	The Dying Matters Community pack is available at: http://www.dyingmatters.org/sites/default/files/user/documents/Resources/Community%20Pack/1-Introduction-1.pdf

57	4.4	Professor Wendy Wills	University of Hertfordshire	Encouraging healthy diets among young people in secondary schools	A healthy, balanced diet from childhood is important for health and wellbeing. Parents exert a strong influence over what their children eat and drink when at primary school. However, when these children move up to secondary school things change. The social environment is of much greater value and the food and drink environment both within the school and immediately surrounding it takes on a new importance for young people. During this period, 11 to 16 year olds are making food and drink choices that may shape life-long habits and have lasting health consequences. In recent years education and health authorities have launched several new initiatives aimed at increasing the availability of healthier food within schools. Progress has been made yet research carried out at the University of Hertfordshire has found that despite positive changes to food options within schools, a large proportion of young people are still turning their backs on the school canteen	Research led by Professor Wendy Wills of the Food and Public Health Research Unit at the University of Hertfordshire, found that more than three quarters of 13-15 year olds buy food or drink outside school at least twice a week, often favouring cheap, fast and less healthy food and drink options than are available in schools. Two thirds said they purchased food and drink from the school cafeteria either only once a week or never at all. Whilst a broad package of measures is required to make progress overall, including pressing for changes to the food environment on our high streets, a stronger emphasis on transforming school food environments to reduce incentives to venture beyond the school gate is likely to have a bigger impact on a greater number of young people. Key findings: - A wholesale shift in food culture in schools is required through improving the food, service and the physical and social environment. - Schools can learn from local retailers in the way that they value young people; schools seem less	Please see this research briefing by Professor Wendy Wills for more details: https://www.herts.ac.uk/__data/assets/pdf_file/0020/116471/healthy-eating-healthy-learning-food-and-public-health-policy-briefing.pdf The full research, commissioned by Food Standards Scotland, is detailed in this report: The Influence of Deprivation and the Food Environment on Food and Drink Purchased by Secondary School Pupils Beyond the School Gate. http://www.foodstandards.gov.scot/sites/default/files/Beyond%20The%20School%20Gate%20-%20FSS%20-%20W.%20Wills%20et%20al%20-%20March%202015_0.pdf A short film featuring interviews with young people about their food choices 'beyond the school gate' is here: https://www.youtube.com/watch?v=mHqYzixQZrA A Food Research Collaboration briefing paper Within Arm's Reach: School Neighbourhoods and Young People's Food Choices can be accessed here: http://foodresearch.org.uk/wp-content/uploads/2016/01/Marketing-foods-to-secondary-school-children-final-draft-2.pdf

58	4.4	Profess or Wendy Wills	University of Hertfordshire	Encouraging healthy diets among young people in secondary schools continued..	for fast food cafés beyond the school gate. Given fast food outlets and convenience stores are commonly concentrated around schools, particularly in areas of relative socio-economic deprivation, introducing effective measures to reduce the number of young people choosing to buy food and drink outside of school during the school day is of prime importance.	likely to prioritise the building of relationships with young 'customers' than businesses but young people highly value these relationships. - Spending time with friends is a crucial part of the lunch break; schools struggle to address a common view among young people that the school dining environment is anti-social and a barrier to spending time with friends. - Schools could do more to encourage young people to champion the need for better food and drink at lunchtime and engage their peers in its importance. - Community initiatives are required to reduce the consumption of sugar sweetened soft drinks and energy drinks; the study showed more than a quarter of young people bought sugar sweetened beverages. - Socio-economically deprived areas should be prioritised. While 77% of young people purchased food or drink outside school at least twice a week, this exceeded 90% in the most deprived areas. - 41% of those entitled to Free School Meals bought something at lunchtime outside school; FSM can be seen as stigmatising, further encouraging young people to 'escape' school at lunchtime.	

59	4.4	Karen Wheele r	Esoteric Practitioners Association (EPA)	Key area for quality improvement 2 -Change the term 'community engagement' to something very practical like 'our health is in our hands' – or 'our health and wellbeing'	In the NICE guideline for instance ''Community engagement: improving health and wellbeing and reducing health inequalities' there is a suggestion to change the term/name 'community engagement' For too long we have phrases that are out of reach of grass roots – 'community engagement' is not practical, nor meaningful for any of us on the street. When you ask even healthcare practitioners about 'community engagement' they glaze over. We need something very simple to describe what we are trying to achieve. In the end we are looking to achieve healthy populations, healthy communities, and that starts with healthy individuals who understand the very basics of health and wellbeing from a practical view. 'My health' or 'our health' or something very simple could work.	Community engagement is about building relationships – fundamentally we want our local people and communities to understand what they can for themselves do to look after their/their family health and wellbeing. Having an 'engagement' process feels like an extra link in the chain that may now not be needed, and hasn't so far been proven to work in a way that has drastically improved the health of our local population. Any standard, or initiatives need to come from grass roots level. E.g. if we asked a group of school children to design something, and asked other local groups e.g. mums, dads, elderly, other groups to design simple initiatives to improve health and wellbeing we may not actually need the 'engaging communities' aspect – more a joined up approach where we all work together, professionals, charities, healthcare, education and local people alike. Let's make the initiative start with a simple title.	
60	4.5	SCM1	SCM	Additional evidence sources for consideration	Models for lay /peer engagement		
61	4.5	Paul O'Mear a	Royal College of Speech and Language Therapists	Key area for quality improvement 1		RCSLT would like to ensure that the early year's document contains mention of children's speech/language development. (Its inclusion may already be planned but the documents do not show any detail about this)	

62	4.5	Tom Bailey	Action on Hearing Loss	General	Action on Hearing Loss is the charity formerly known as RNID. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose. We enable them to take control of their lives and remove the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality. Our response will focus on key issues that relate to people with hearing loss. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf who may use British Sign Language (BSL). We are happy for the details of this response to be made public. Action on Hearing Loss welcomes the quality standard for Community engagement, improving health and wellbeing. We support the broad aim of the quality standard to increase public and voluntary sector involvement in health and wellbeing initiatives. Hearing loss is serious health condition that can have an adverse impact on a person’s health and quality of life. People with hearing loss, BSL users in		

					particular, may also require support to communicate well and participate in community activities. Better awareness of the impact of hearing loss on health and wellbeing and also ensuring services are accessible are crucial to make sure people with hearing loss can get involved in and benefit from local health and wellbeing initiatives. Below, we set out four key areas of improvement which would reduce health inequalities and remove barriers to participation for people with hearing loss.		
63	4.6	Aishah Malik	NHS England		Thank you for the opportunity to comment on the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.		
64	4.6	Sara Havero n	Royal College of Paediatrics and Child Health		Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Community Engagement QS topic engagement exercise. We have not received any responses for this consultation.		