NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Community engagement

Date of Quality Standards Advisory Committee post-consultation meeting:
21 September 2016

2 Introduction

The draft quality standard for community engagement was made available on the NICE website for a 4-week public consultation period between 25 July 2016 and 22 August 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 28 registered and 7 non registered stakeholders which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any treatment. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statement 1 to 3: Statements 1 to 3 focus on the responsibilities of commissioners to work with local communities to plan health and wellbeing initiatives, do you agree with this focus or should the statements also apply to the providers of the initiatives?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Quality standard welcomed and supported in principle
- Suggestion to reorder statements
- Greater emphasis needed on the colabarative nature of communities and the importance of building good relationships
- Suggestion to start statements with “Communities, commissioners and service providers…”; concern that commissioner initiated perspective could undermine the process from the outset
- Concerns that the QS describes a polarised and health orientated approach to community engagement.
- Concerns that the language used in the QS is process driven and may result in box ticking exercise
- Specific equalities groups highlighted who need further consideration while engaging communities
- Role of specific groups/professionals in engaging with communities and supporting health and wellbeing initiatives was highlighted

Consultation comments on data collection

- Data collection theoretically feasible
- Local systems, skills, resources and processes not currently in place to collect health data to support evaluation for the proposed quality measures –
- Tools and resources should be made available to support implementation of data collection

Consultation comments on resource impact

- Training in participatory working needed for commissioners, providers and community members.
- Resources needed to support implementation of the initiatives – money and people with relevant skills and time
- Requires a shift in commissioning priorities from crisis intervention to delivering community engagement

Consultation comments on question 5

For draft quality statement 1 to 3: Statements 1 to 3 focus on the responsibilities of commissioners to work with local communities to plan health and wellbeing initiatives, do you agree with this focus or should the statements also apply to the providers of the initiatives?

- Support for the statement to apply to providers of services - not all services go through the commissioning processes, commissioner provider distinction varied and moveable across sectors and across the country.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Commissioners of health and wellbeing initiatives work with local communities to agree the aims for the initiative.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Address development and delivery not only engagement in identifying priorities
- Expand to include involving communities in agreeing all stages, not just the aims, of an initiative in line with NG44 1.1.1

- Suggested wording update ‘commissioners of health and wellbeing initiatives work with local communities to agree local priorities, identify initiatives and aims for each initiative’
- Further guidance could be added for commissioners on levels of engagement
- Measures are potentially feasible but require more detail about the data sources

5.2 Draft statement 2

Commissioners of health and wellbeing initiatives agree with local communities how to measure the impact of the initiatives once the aims are agreed.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Statement seen as measurable, useful and sensible
- ‘designing, developing and delivering’ should be inserted after ‘Communities whose members are involved in’
- The evidence that evaluation has informed improvements to local initiatives was queried
- Additional outcome measure suggested ‘Commissioners and communities benefit from the collection of relevant data which explains how impact is achieved’

5.3 Draft statement 3

Commissioners of health and wellbeing initiatives work with local communities to identify the skills, knowledge, networks, relationships and facilities within the local community.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Statement should go further and support asset-based approach that nurtures and empowers these assets
- Complexity of the assets based approach - national template for the audit needed to support consistency
- Resource intensive approach, continuous updates needed to remain relevant – major challenge in current financial circumstances
- Additional measures suggested
- Specific professions highlighted as important community assets

5.4 *Draft statement 4*

Providers of health and wellbeing initiatives identify community members who can take on bridging roles.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- The statement should also address supporting the connectors/bridging roles within the community
- It should be more prominent that it’s a two way communication/support
- Additional measures suggested
- Asset mapping should identify people who already act in these roles specific professions, elected members and Healthwatch highlighted as having potential to take on/already taking on bridging roles

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Involving communities in developing Joint Strategic Needs Assessment
- Co-production of service design and delivery and increased employment opportunities for community members

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Organisation name	Statement No	Comments
1	RCSLT	General	The Royal College of Speech and Language Therapists (RCSLT) would emphasise that in order to ensure inclusive community engagement it is crucial that speech, language and communication barriers are addressed and that people who need support in order to contribute are able to access it. Nearly 20% of the population may experience communication difficulties at some point in their lives. In addition, Up to 90% of people with learning disabilities have communication difficulties, with half having significant difficulties.
2	Action on Hearing Loss	General	Action on Hearing Loss welcomes that health inequalities are expected to improve as one of the outcomes of the quality standard. People with hearing loss face health inequalities throughout their life course, for example in accessing healthcare, education and the work place, and so their needs should be addressed to help achieve this outcome. The NHS England report[9] highlights that by 2020, older people will account for approximately a third of the working age population[10]and around three-quarters will have some kind of disability before the age of 68. Over a quarter of people in their 50s and 60s have hearing loss[11] and much greater action will be needed to raise the general level of health, reduce health inequalities and provide the level of support needed if people are to work longer.[12] In addition to this, estimates suggest that, in 2013, the UK economy lost more than £24.8 billion in potential output because people with hearing loss were unable to work. [13] Nearly two-thirds of deaf children (64%) failed to achieve the government benchmark of five GCSEs (including English and Maths) at grades A* to C, compared with less than half (43%) of all pupils. People with hearing loss are less likely to have a job than others, and hearing loss often means people having problems finding a job, fulfilling their potential at work and staying in work. Communication barriers also lead to missed NHS appointments and increased health and social care costs. [14]

3	Action on Hearing Loss	General	Action on Hearing Loss welcomes that the quality standard recognises that equality and diversity should be considered; more specifically that there are barriers that may prevent people from taking part in setting priorities for health and wellbeing initiatives and that these barriers must be addressed to increase equity. People with hearing loss often have specific communication needs that must be met but often aren't, so it is important that these are considered and offered when engaging with people in local communities and setting priorities for health and wellbeing initiatives. NHS England's Accessible Information Standard[17] provides clear guidance on what providers of what health and social care providers must do under equality law 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 communications such as BSL video translations on websites or through direct engagement with local Deaf clubs and other community groups.
4	Action on Hearing Loss	General	Action on Hearing Loss welcomes that the standards recognise that commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high quality services and that other standards should be considered. The NICE guidance on older people with long term conditions and on mental wellbeing in care homes make clear that hearing loss should be diagnosed early and managed well, and that relatively simple steps can be taken to ensure that people with hearing loss can access services and be able to participate in activities in care homes. These should be referenced here. The Commissioning Framework for adult hearing aid services[15] details important guidance for CCGs on how to commission cost-effective services that meet the needs of people with hearing loss, including the benefits of local community services and integrated working between local groups. It also sets out the importance of identifying and addressing hearing loss as soon as possible in order for people to gain the maximum benefits from hearing aids, and so that unaddressed hearing loss doesn't pose risks to their independence and mental and physical health. We believe that this should be used as a resource for developing high quality services for adult hearing loss.
5	Action on Hearing Loss	General	Action on Hearting Loss welcomes that the definition of a community group is also inclusive of those who are socially isolated. 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[16] and the likelihood of people with hearing loss becoming socially isolated should be recognised when looking at this group. Furthermore, many people with profound or severe hearing loss consider themselves part of the Deaf Community, with a shared history, language and culture. It is very important that this group has their communication needs met, but also that they have culturally sensitive care and contact with the Deaf community so that they can avoid becoming withdrawn or isolated.
6	Compassionate Communities UK	General	No comments received around the quality standard . They provided a Publication – Each Community is prepared to Help: Community Development in End of Life Care – Guidance on Ambition Six and did indicate that they would like to support the QS.

7	Co-operatives UK	General	About Co-operatives The United Nations recognised definition of a co-operative is as follows: A co-operative is an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise. Co-operatives are driven by mutual purpose, not profit, and are owned and controlled by the people who benefit from that purpose. Co-operatives are committed to a set of Values and Principles, which stress the importance of equality, fairness, social responsibility and empowerment. They often fall into the voluntary, community and social enterprise VCSE category. Co-operatives are often excellent vehicles for community empowerment, allowing people to meet their needs and aspirations through organisations they own and control. In recent years the UK has experienced very significant growth in the number of community co-operatives; with high impact social action in areas as diverse as regeneration, arts and culture, sports and leisure and renewable energy. There is a growing number of co-operatives, mutuals, other VCSEs with ‘co-operative approaches’ providing health, care and wellbeing services inside communities across the UK.
8	Co-operatives UK	General	About the Co-operative Care Forum Co-operatives UK is the host organisation for the Co-operative Care Forum (the Forum), a grouping of practitioners and organisations established in 2014 and working together to identify, support and champion co-operative approach to care. The Forum is particularly interested in approaches that are rooted in communities where the starting point is nurturing the relationships between people including neighbours, family, paid carers and volunteers. The Forum is keen to support NICE in the development of this quality standard, in contributing further whenever possible and appropriate on this agenda, and helping to ensure that the quality standard plays its part in moving towards integrated, people-centred services. Below we set out why members of the Forum are eager to contribute to this consultation: Co-operative and mutual organisations are based on people in communities taking action to address their individual and collective needs. Such organisations are based on individual participation and involvement, through membership, democratic representation and governance. As such both the Forum and Co-operatives UK are legitimate, informed and expert contributors to the development of this quality standard. Above all co-operatives are vehicles to facilitate social action, usually through economic means, in a participative, empowering and democratic way. We are therefore delighted to see that the Quality Standard begins by citing the World Health Organisation (WHO) and the importance it places on social capital and community agency in relation to health and wellbeing outcomes. As the draft consultation document rightly states, the Government “has advocated changes in the relationships between local services and citizens, so that individuals and communities can play a bigger role in improving health and wellbeing.” This echoes the Five Year Forward View which sets out “how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and

			prevent ill-health.” Both of these statements reflect a recognition of problematic power relationships which can inhibit effective reform in care. For example, the need for patients to gain far greater control of their own care, and for the NHS to take decisive steps to break down the barriers in how care is provided, are both cited in the Five Year Forward View. The recent WHO Framework on integrated, people-centred health services sets out as the first of its five interdependent strategies “empowering and engaging people and communities”. Included in this is the aim to enable communities to become actively engaged in co-producing health environments, as well as reaching the underserved and marginalised groups of the population in order to guarantee universal access to and benefit from quality services that are co-produced according to their specific needs. Community engagement is fundamentally concerned with addressing power imbalances and building better relationships. It strives to enable individuals to collectively find their voice, to influence those things which contribute to holding them back, and to support a constructive process to improve relationships and services for the common good. It seeks to address top-down decision making by empowering bottom-up engagement and voice.
9	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	General	The document is simply put but is lengthy and there is a lot of repetition for example the definitions of terms given at the end of each quality statement
10	Older People’s Advocacy Alliance (OPAAL UK)	General	It is positive that the QS equality statement references advocacy as a way to support people to be engaged in community engagement, but this should be referenced within the standard itself. We recommend that advocacy be referenced as one of the key services that can support community and patient engagement. Older people tell us that they often feel they are not listened to, that they are hurried into making decisions about important issues that really matter to them, and feel that their views don’t matter. Independent advocacy supports people to exercise their rights, express their views and make informed choices in all aspects of their lives, it can also play a vital part in helping people the get involved in their communities and respond to community engagement opportunities, so it would help in the achievement of the QS to encourage professionals to think about referring to independent advocacy services.

11	Optical Confederation and Local Optical Committee Support Unit	General	We support the identifying of local priorities to improve health and wellbeing. In doing so it is important that eye health is prioritised as adults in the UK are more afraid of losing their sight than they are of developing Alzheimer's, Parkinson's, or heart disease, or of having to use a wheelchair.[25] When identifying local priorities, the role community optical practices can play in helping to address them should be understood. Community optical practices are trusted local health care providers and are part of primary care networks across all localities. As such, optical practices are often people's first point of contact for eye care and indeed can often be a person's only contact with a healthcare professional. This may include those who are socially isolated. A good way to ascertain local eye health provision in order to ensure that demand is being met is with an Eye Health Needs Assessment (EHNA). We would encourage local authority (LA) Health and Wellbeing Boards (HWBs) to ensure that these are in place and up-to-date. LAs and clinical commissioning groups (CCGs) should work with local optical committees (LOCs) and local eye health networks to understand gaps in local eye health commissioning.
12	Public Health Agency, Northern Ireland	General	PHA supports the approach to implement quality standards for community engagement. However, we are also mindful that in Northern Ireland a set of Standards has been developed for Personal and Public Involvement (PPI). Whilst there are similarities between community engagement approaches, there are also differences that we need to be mindful of and give recognition to. Community development approaches advocate for engagement with local communities and this is reflected in the Standards. From a PPI perspective, we advocate for engagement from an individual, ie a service user or carer perspective which can be lost if a community engagement approach is adopted which will be a collective voice. Northern Ireland has a Statutory Duty of Involvement and Consultation (Health and Social Care (Reform) Act (Northern-Ireland) 2009 and the PHA has responsibility for leading implementation of policy on PPI across the HSC. We would like to express an interest in further discussions regarding the quality standards and the implications of implementation.
13	Public Health Bristol	General	These quality standards don't seem to have captured the collaborative nature of community engagement that is expressed in NG44 (1.2). The result is a potential inference that consultation alone would meet the outcomes. It also doesn't draw out the suggestion in NG44 that local approaches are built on (1.4.2 bullet point 5).
14	Public Health Bristol	General	Add: The importance of involvement in communities being based on the principles of good relationships. Not 'flying' in when information is needed.
15	Public Health Bristol	General	In addition to bullets points: psycho social reasons, people need to feel they belong and are included. Agencies should be engaging people in a way that builds their confidence, self-esteem or self-efficacy (This can sometimes be forgotten when the emphasis is on consultation in order to inform services). Only the evaluation quality statements seem to address this... perhaps the Q. outcome should include What is the evidence that the engagement process is, in its self, beneficial for the individuals and communities involved?

16	Royal College of General Practitioners	General	Community Engagement, involvement and ownership of health by society makes primary prevention possible, secondary prevention understandable and tertiary prevention an expression of a caring and mature society. This document sets the outline. Probably specific strategy will be required by age group (0-5,5-18,18-30,30-65, 65+) involving nursery, school, university, workplace, church as per the Healthy City, Healthy workplaces initiatives. The Internet is now a major source of information, teaching and learning, a new generation interacts effortlessly and there is a need to provide appropriate self learning and group learning materials which are accurate and informative. It is surely important too to build on previous experience and success from Boy Scouts to Parish Councils. In particular the real successes in the last 20 years of Patient participation Groups in General Practice and The Sure Start schemed in deprived areas need to be sustained and developed. (PS) There should be reflection here on demedicalising models of care and noting how our health and social care systems contribute to our local communities and support these supportive networks. In order to form supportive networks within local communities there needs to be a longer term commitment than typical 1 year commissioning intentions require. Otherwise there is a risk of premature decommissioning without allowing networks to develop and realise their potential. (CM)
17	Royal College of General Practitioners	General	This comprehensive list is helpful and very straightforward. However there is not enough robust evidence to tell us how this agenda can be implemented, who should be undertaking the work, what can be achieved. Initiatives to encourage meaningful work in this area are needed. (DJ)
18	The Chartered Society of Physiotherapy	General	The Chartered Society of Physiotherapy welcome this quality standard. We will support our members to implement the relevant standards, and contribute to the wider initiative to improve health and wellbeing.

19	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. 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 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. 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, British Sign Language (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. We are disappointed that specific needs and interventions targeting people with hearing loss are considered out of remit of this quality standard. We have identified areas of the quality standard where we believe people with hearing loss and deaf people should be considered, and ask for these to be included.

20	Action on Hearing Loss	General	Action on Hearing Loss support the recognition that "There is a compelling case for a shift to more people and community centred approaches to health and wellbeing" and strongly believe that people should have a greater say in their lives and health. We believe that it is vital that those with hearing loss, including those that are culturally Deaf are not excluded or isolated from these important discussions. All steps should be taken to ensure that the communication needs of people with hearing loss and those using BSL are considered so that they are able to access information and have their say about their health, decisions about treatments and wellbeing. NHS England's Accessible Information Standard[8] 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 from proactive communications such as BSL video translations on websites or through direct engagement with local Deaf clubs and other community groups.
21	Action on Hearing Loss	General	Action on Hearing Loss supports the recognition that "social isolation and loneliness are a major public health issues associated with higher risks of mortality and morbidity". A significant body of evidence shows that hearing loss is a serious condition that can have significant adverse impacts on a person's health and quality of life[3]. Research shows that people with hearing loss often find it difficult to communicate with other people and as a consequence hearing loss is linked to loneliness, emotional distress and withdrawal from social situations[4]. 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[5]. 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[6]. There is strong evidence of link between hearing loss and dementia. Research shows that people with mild hearing loss are 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[7].
22	Department of Health	General	The Department of Health welcomes the draft NICE quality standard as it recognises the important role the voluntary, community and social enterprise (VSCE) sector can play in reaching communities, reducing health inequalities and delivering health and care services. The recent Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector, produced in partnership by representatives of the VCSE sector, Department of Health, NHS England and Public Health England (May 2016), also supports strengthening the relationship between communities and local statutory bodies. We will bear these standards in mind when implementing the review's recommendations.

23	The National LGB&T Partnership	General	The National LGB&T Partnership is concerned that the specific and often unique needs of lesbian, gay, bisexual and trans (LGBT) communities are completely excluded from the draft quality standard. It is extremely disappointing that most other protected characteristics are mentioned whilst sexual orientation and gender reassignment are excluded. There are severe – and well evidenced – health inequalities facing LGBT communities. LGBT people are more likely to be isolated than the general population; this is particularly so for older LGBT people who are twice as likely to be living alone, and ten times more likely to not have somebody to call in times of crises (LGBT Foundation, Building Health Partnerships report, 2014). They also face significant health & wellbeing inequalities compared to national averages, from higher rates of physical and emotion bullying, significantly higher rates of suicide and self-harm, and social isolation and extreme loneliness in old age (The National LGBT Partnership, LGBT Companion to the Public Health Outcomes Framework, 2016). The high level of inequalities faced by LGBT communities indicates the standard should specify the need to engage with LGBT groups, at least within its equality and diversity considerations, which are otherwise likely to be excluded. Within the LGBT bracket there are communities increasingly likely to be excluded, such as homeless LGBT people and consideration must be given to how to engage with such groups. As a community of identity rather than place, it is likely that targeted work will be necessary to engage with LGBT communities and individuals. It would be useful for similar consideration to be given to other groups that are disproportionately affected by poor health and wellbeing such as black and minority ethnic (BME) groups, as they should also be identified as a priority. Evidence into LGBT civic participation suggests that fears, negative preconceptions and expectations of homophobic and transphobic abuse were identified as barriers to engagement in public life and other community engagement processes (National Institute of Economic and Social Research, Inequality among LGBT groups in the UK: a review of evidence, 2016). At the same time, respondents to a survey conducted by Ryrie et al. (2010) self-reported positive consequences as a result of public and political engagement, including increased confidence and improved wellbeing. There are clear benefits to LGBT community engagement but these must be handled in targeted ways to ensure participants feel supported, empowered and safe.
24	RCN	General	This is to inform you that the Royal college of Nursing have no comments to submit to inform on the above QS consultation at this time. Thank you for the opportunity to participate.
25	RCPCH	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Community engagement consultation. We have not received any responses for this consultation.

26	Co-operatives UK	General (question 1)	There are many ways in which the Quality Standard reflects the published principles of community engagement and the NICE Guideline (NG44) more broadly. This is particularly the case when it comes to planning, design and evaluation, and in mandating partnerships between commissioners and voluntary, community and social enterprise (VCSE) providers. However, we believe the Quality Standard stops short of the ambitions behind NG44 in some crucial regards. Above all, we question whether the Quality Standard mandates a form of community engagement that transforms relationships (referred to in the Five Year Forward View, cited by NICE) or drives positive ‘community-owned’ change. We believe there is a risk that in some parts the Quality Standard provides a basis for a box-ticking approach to community engagement. Firstly, how communities are identified will have a significant impact on the quality and utility of any subsequent engagement. What mattes are communities of interest in relation to shared needs and aspirations; in this context with a shared stake in particular initiatives. This is a lens that can bring more diverse, harder to reach, disempowered, fragmented and hidden communities into focus. This is also a concept of community that is people-specific and practical, leading to engagement which gives the right people more ownership and control of initiatives and nurtures more social action. The starting point for community engagement in this context should be exploration of communities of interest, and an assessment of their existing ‘assets’ (currently Quality Statement 3). The identification of local priorities (currently Quality Statement 1), should be undertaken in the light of the communities of interest and assets identified. The order of the Statements is fundamental, and should be revised. There is a need to avoid starting from a pre-determined analysis of the needs to be met, and to avoid a tokenistic engagement with the ‘usual suspects’. Either or both of these are likely to perpetuate, rather than to change, relationships between local services and citizens. The aim should not just be to work with such local communities to agree the aims for the initiatives; it should be a more open process that starts with the existing assets, asking for the community’s views, and building the community’s engagement in the process. Furthermore the Quality Statements do not properly articulate that communities should be involved in the delivery of initiatives, in the way NG44 outlines. For instance Quality Statement 1 focuses in on engagement in identifying priorities but not in development and delivery. Similarly Quality Standard 3 says local community assets should be identified, but stops short of requiring an asset-based approach that actually nurtures and empowers these assets. On our reading, on delivery, building capacity, asset-based approaches, co-production, peer and lay roles and ‘making it integral’, NG44 sets the bar higher than this Quality Standard would suggest. We also note that while the ‘structure’ section of Quality Statement 4 discusses the roles and responsibilities of members of the community, it stops short of any evaluation of the impact these people might actually have on delivery and outcomes. Here again it is problematic that the Statement mandates identifying ‘community bridges’ but stops short of nurturing and empowering them. We also believe that it is important that responsibility for identifying community members who can take on bridging roles should not simply be sub-contracted to providers. There is a role for other intermediaries and those skilled and experienced in the field of community engagement.

			Furthermore, in relation to Quality Statement 4, we think the potential for bridging roles to offer sustainable, diverse engagement with end user communities rests on NICE avoiding the assumption that VCSE is shorthand for community. While in many cases VCSEs do engage and enable user communities, there are also times when speaking to a VCSE means speaking to professionals, trustees and volunteers from outside the user community. While both peer and lay roles are important we urge NICE to place greater value on peers, as this will enable the forms of social action that address more 'wicked issues' in relation to health, care and wellbeing. To avoid box-ticking the Quality Standard outcomes need to be strengthened, with more emphasis on the capacity for communities to change and ultimately 'own' commissioner and provider behaviour. In particular, the essential outcomes in the context of community engagement should be revised to include: Whether or not the local community has significantly influenced the initiative. If so, how? Whether the process had any impact on changing relationships between local services and citizens Whether the process nurtures and utilises social action on the part of service users and communities
27	National Voices	General (question 1)	Due to the short time available to respond we do not have any comments on this question.
28	NCT	General (question 1)	Does this draft Quality Standard accurately reflect the key principles for community engagement? NCT very much welcomes this Quality Standard and believes it is a concise and accurate summary of the key principles of community engagement. We are very much in favour of the multidisciplinary approach to service development where service users, health professionals and commissioners work together to enable innovative health services and initiatives.

29	NHS England	General (question 1)	It is questionable whether this draft QS truly reflects the key principles for community engagement. It appears to take a polarised and health orientated approach to community engagement by describing a relationship between commissioners of initiatives and communities requiring the identification of agreed aims, impact measurement, asset identification (by commissioners as described in Statement 3). Similarly it requires providers of initiatives to identify community members who can take on bridging roles. The language used to describe this is largely transactional and process driven. A different conception of community engagement is set out within the community planning toolkit: http://www.communityplanningtoolkit.org/sites/default/files/Engagement0815.pdf. This describes a different, more collaborative and less transaction approach. It sets out five key roles for community participation: users and beneficiaries, advisers, contributors to management, decision makers, and deliverers. Within the toolkit are a series of useful links which should ideally be considered in developing this draft QS further. Importantly there is a list of 10 Scottish Standards for Community Engagement http://www.scdc.org.uk/what/national-standards/10-national-standards which are focused on: involvement, support, planning, methodology, working together, information sharing, collaboration, improvement, feedback, monitoring and evaluation. I have concerns that being framed from a commissioner-initiated perspective could fundamentally undermine the process from the outset by focusing on system benefits (agreed aims, measurement of impact, asset identification and networking). While this approach describes the some of the key elements of a successful system it could lead to community disengagement by introducing the language of transaction and performance.
30	Parkinson’s UK	General (question 1)	Yes, Parkinson’s UK agrees that these are the right priorities for quality improvement. We welcome the broad definition of the key terms, which could empower local authorities to engage closely with local Parkinson’s UK groups to redesign or improve services. However, we remain concerned that the principles of community engagement could be misused by local authorities in order to shift the provision of services, or information about those services, to individuals in the community.
31	Public Health Agency, Northern Ireland	General (question 1)	PHA agrees that the draft quality standard accurately reflects the key principles for Community Engagement and welcomes the fact that NICE is focusing on this area. However, please see notes above re the need to ensure synergy with PPI.
32	Royal Pharmaceutical Society	General (question 1)	We agree in general with the key principles outlined but see our comments above.
33	The Big Life group	General (question 1)	Yes, it summaries them well and links into different guidance, theories and documents for more comprehensive understanding. However, the language used should reflect the principals to ensure a different relationship can be fostered and a move away from a transactional relationship between ‘service’ and ‘patient’

34	The UK Faculty of Public Health	General (question 1)	We suggest that to reflect the principles accurately each standards 1 – 4 need to be rephrased to read ‘Communities, commissioners and service providers need to…. We would suggest that missing from this list is Communities, commissioners and service providers, work together to build connections with other communities to build bridges between peoples, promote mutual understanding. The Joint Strategic Needs Assessment is developed collaboratively with local communities and demonstrates an understanding of the diversity and changing nature of communities in the area
35	Co-operatives UK	General (question 2)	We would argue that the quality measures need to be modified to include the outcomes referred to above. We believe that local systems and structures vary enormously, but that the proposed changes would not significantly impact the collectability of data.
36	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	General (question 2)	For all of the statements, it only looks at one source of evidence (locally collected data) and the statements don't give any indication on what 'good' should look like therefore LA's and Health Commissioners may struggle to routinely take stock of how well they are going against the quality statements. How will they measure success and failure, and how will this be communicated to the public. Customer Insight Strategies should reflect these issues and have a place in setting local standards.
37	National Voices	General (question 2)	Our experience is that local systems and structures to collect data on community engagement, and therefore on the draft statements, are not currently in place. There will be some areas where at least some of the desired data is being collected, but we have seen no evidence that this is widespread or systematic. In theory, we believe that it is feasible to put the required systems in place locally. This could be done through audit of things like the use of the Social Value Act; the percentage of spend on grants to community groups and organisations; and/or the recorded outcomes of commissioned projects. However, our experience is that there is currently a strong bias in the health system at least against introducing new data collections because of the burden this can place on organisations. To overcome this barrier, the national outcomes frameworks would need to change to drive and support people to collect data on community engagement. Without this, it will be hard to prioritise this necessary data collection and analysis locally.

38	NCT	General (question 2)	Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Whilst NCT supports this Quality Standard we also feel it is a very ambitious objective, particularly in the current economic climate. There are some structures in place such as Maternity Services Liaison Committees (https://www.nct.org.uk/sites/default/files/related_documents/MSLCs%20consensus%20statement%20NCT%2C%20RCM%2C%20RCOG.pdf) however these are no longer active in all trusts as the Health and Social Care Act of 2012 downgraded them from a statutory responsibility. In our experience of supporting maternity services user reps, trusts and commissioners often underestimate the time and resources required to initiate a conversation and increase trust in the process, particularly with seldom heard groups such as BME communities, asylum seekers and refugees, and those with a lower level of education. In addition, there are voluntary groups with good community links, but these are often undervalued, under resourced and not held to account, so do not work as effectively as they might. With regard to Statement 3 (Commissioners of health and wellbeing initiatives work with local communities to identify the skills, knowledge, networks, relationships and facilities within the local community) commissioners will almost certainly need to commission community development workers or specialist 'engagement' consultants with a focus on this work, connections, expertise, etc. Funding needs to be provided. Voluntary organisations and sessional workers, such as independent chairs of MSLCs could do some of this work, but a budget would need to be in place to pay them for their time. Similarly with regard to Statement 4 (Providers of health and wellbeing initiatives identify community members who can take on bridging roles to form effective relationships between statutory, community and voluntary organisations and those involved in the initiative). This is a hugely inspiring statement but again, this role needs to be recognised financially. Bridging roles are hugely important but seldom funded. All too often we find that commissioners and trusts rely on volunteer dedication and in some cases do not even pay expenses. One dedicated volunteer can achieve a huge amount, but if they move on the whole thing can fall apart. Alternatively, the volunteer base comes to be seen as too old and/ or middle class, but if little or no financial, emotional or administrative support is supplied these will be the only service users left. NCT believes that providing relatively small amounts of funding to direct to grassroots bodies and service user leaders, along with clear objectives and supportive monitoring, could result in clear gains.

39	NHS England	General (question 2)	Local systems are not currently in place to collect health data to support evaluation of the impacts of health and wellbeing initiatives for the proposed quality measures. For adults there is likely to be a delay in the implementation of community services data as set out currently by NHS Digital: 'The central flow of adult community data is now unlikely to take place before 2017. The intention is that the CIDS Information Standard will be retired, and the scope of the CYPHS data set expanded to include adult data (hence the need to keep the data sets in step). The new combined data set will be named the Community Services Data Set (CSDS)' http://digital.nhs.uk/comminfodataset While it may be feasible to collect data in respect of local structures, health outcomes data collected systematically and consistently for adults (in particular older adults who are key stakeholders and beneficiaries of successful community engagement) may not be available for a number of years to come. In addition local health and care systems reconfiguration through greater integration may also impact on the sustainability, quality and continuity of any evaluation processes put in place at local level. These issues should not per se in my view be viewed as reasons to discontinue developing the QS.
40	Public Health Agency, Northern Ireland	General (question 2)	Some local systems and structures are in place, although there is no one formalised mechanism across the organisation. PHA commissioners in Health Improvement regularly consult and engage with a wide range of community organisations and forums on a range of thematic areas, for example, drugs and alcohol and mental health, as well as more generic community organisations. PHA is currently consulting with every household in Belfast on emotional health and wellbeing, with a view to informing the range of services commissioned. There is no single agreed mechanism for engaging with the community, with each thematic area responding to local need. The PHA has responsibility for leading implementation of policy on PPI across Health and Social Care organisations in NI and has responsibility for ensuring that HSC Trusts meet their PPI statutory and policy responsibilities. The PHA then in turn provides assurances to the Department of Health in this regard. The PHA would be concerned if additional systems and structures were established to collect data which do not reflect the PPI Standards and also create another accountability mechanism. We therefore feel that it is not feasible for such measures to be put in place without a full discussion with PPI colleagues on the practicality and linkages to existing monitoring and accountability mechanisms.
41	Royal College of General Practitioners	General (question 2)	CCGs may not have capacity to take on an additional set of tasks. It may also not be feasible due to the cuts in public health services, where this king of work would normally be placed. (DJ)
42	Royal Pharmaceutical Society	General (question 2)	The implementation of the standards should be the main focus and there will need to be national guidance, tools and resources to support this. This will then help support local implementation.

43	The Big Life group	General (question 2)	The ways of collecting data for each of the quality standards appears vague i.e. stating local data source for all. Does this reflect the diversity of the breadth of organisations this will include? It may be useful for this to be more explicit or use some examples. Also, Healthwatch have a key role to play in this it may be concerning, that they will be used as a way of ensuring community engagement with statements 1 and 2 rather than other routes of engaging with communities, i.e.. having someone local on the health & wellbeing board and not having Health watch there to represent. The use of this asset will be essential in ensuring this local system works and has the infrastructure and resource to develop it further
44	The UK Faculty of Public Health	General (question 2)	Local systems are currently not well placed to collect data on the proposed quality measures, largely because measurement in this area is very underdeveloped. While continuing to develop methods and metrics, care needs to be taken to avoid a ‘tick box’ compliance culture. Different approaches will be useful for different aspects of community engagement. These are less likely to be routine data sources, and more likely to be more in depth methodologies such as Mental Wellbeing Impact Assessment; the WARM tool; or co- produced need assessments. These methods can be used by both provider organisations, NHS commissioners and local authorities. Developing some indicative measures might be helpful things like: Proportion of expenditure deployed in community grant funding Proportion of contracts awarded to a) local b) national VCS
45	National Voices	General (question 3)	We do not have any specific examples of the implementation of NICE Guideline 44 on community engagement. However, through our involvement in the national Realising the Value programme we have been further exploring the use of person centred and community based interventions in health and care. Some relevant links are as follows: Realising the Value main site: http://www.nesta.org.uk/project/realising-value Discussion of ‘value’ and the need to change outcomes frameworks: http://www.nesta.org.uk/publications/how-should-we-think-about-value-health-and-care Summary of the value of person centred, community based approaches, based on updated literature review: http://www.nesta.org.uk/publications/heart-health-realising-value-people-and-communities [NOTE: the new literature review is here: http://www.nesta.org.uk/sites/default/files/rtv-evidence-summaries.pdf] Evidence relating to peer support (one of the family of community interventions): http://www.nesta.org.uk/peer-support
46	Royal College of General Practitioners	General (question 3)	The efforts within primary care to set up and involve patient participation groups have had very variable results. It depends on the context, strategies need to be set up depending on the context. (DJ)

47	Royal Pharmaceutical Society	General (question 3)	We do not have any examples directly but will encourage our members to share any examples they may have.
48	Sheffield City Council	General (question 3)	In response to Questions for consultation Question 3: The use of an asset based approach underpins the Community Wellbeing Programme in Sheffield, working across communities to deliver population wide improvements in health and wellbeing that are sustainable because they draw on integral resources created by the community. Separate case study/example to be submitted.
49	The Big Life group	General (question 3)	Submitted through portal
50	Co-operatives UK	General (question 4)	We recognise that community engagement takes resources and time. However, having accepted that community engagement is important (by creating a Quality Standard), that it can contribute to health-related and social outcomes, and that it has a role to play in changing relationships between local services and citizens, it is important that through this standard NICE ensures the concept of community engagement is not neutralised on the grounds of resources. Crucially the quality of engagement at the provider level can be a significant factor here. While commissioners can create new engagement structures, at extra cost and complexity, and at some distance from the actual point of delivery, it would be more efficient and effective to partner with providers which themselves bring communities into direct engagement with both commissioning and delivery. There are a growing number of VCSE providers which empower service users and their communities, sometimes through participative membership, ownership and control. Such providers can genuinely bring service users and the community into the process at every level. These providers can reduce the need for commissioners to develop new costly and bureaucratic frameworks for engagement, and allow for partnerships to develop between commissioners, communities and providers in more efficient and effective ways.
51	National Voices	General (question 4)	We are concerned that it will be difficult to fully achieve the statements given the net resources available to local services, especially given the financial pressure facing both health services and local government. To take on new data collection and analysis alone would require either additional resourcing, or a decision to replace another data collection, rather than add to what is being collected. As the quality standard suggests, good quality community engagement requires a range of support. Where patients and the public are being asked to help develop local initiatives, or act as a ‘connector’ in a bridging role, they may need support to do this. This could be travel support, expenses/honorarium payments, information and training. We believe that this engagement, and investment in what is needed to do it right, as set out in the quality statement, can be cost effective, particularly where communities have been involved. However, we believe that done well, this investment can be cost effective – as well as beneficial to health and wellbeing.

52	NCT	General (question 4)	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary. Please describe any potential cost savings or opportunities for disinvestment. There is a huge potential for service improvement with the implementation of this QS, but it does require commissioners' to have the confidence to provide relatively small amounts of funding direct to grassroots bodies and service user leaders. MSLCs should have a minimum budget of £10,000 per annum, most of which should be used as an allowance for a chair or paid co-ordinator to organise community engagement activities and provide admin support. Here is an example of such an initiative on the Norfolk and Norwich MSLC: https://www.nct.org.uk/system/files/MSLC%20Case%20study%20-%20Paid%20coordinator%20-Norfolk%20-%20Norwich%20MSLC.pdf At the very least, a budget to pay service users' expenses should be ringfenced and claiming and payment of expenses made as simple and timely as possible. This may seem to be a very minor point, but it is a huge issue for user reps as those with the time and energy to devote to engagement work are often reliant on benefits, pensions or on their partner for financial support.
53	NHS England	General (question 4)	I have concerns that the QS does not take enough note of the shifting demography and needs of an ageing population as set out in the Foresight Report 2016: https://www.gov.uk/government/publications/future-of-an-ageing-population . This highlights that Healthy Life Expectancy at ages 65 and 85 are not keeping pace with increasing Life Expectancy. This means that with present trends an ageing population will mean increased overall demand for health and care services. PSSRU projects those users of publicly funded home care services will have grown by 86% by 2035. These demands may become the sole focus of commissioning going forwards risking the sustainability of resources to deliver community engagement even though this will help to offset the growing demand. In short net resources can be anticipated not to be available to deliver the statements set out in the standard due to shifts in commissioning priority towards crisis intervention. I suggest drawing attention to this potential risk in the QS. The Foresight report also helpfully draws attention (at Chapter 7) to the requirement for greater connectivity to meet the needs of an ageing population. This QS properly framed could help to improve support to communities in meeting the challenges facing different age groups in relation to transportation, housing and technology. In my view there will be no foreseeable opportunity for cost savings from the public purse or for public service disinvestment. However successful community engagement could feasibly permit the public purse to be deployed on social care and support for an ageing population more efficiently through community collaboration and social activation.

54	Public Health Agency, Northern Ireland	General (question 4)	The standards are challenging if they are to be adhered to fully. In depth community engagement takes a lot of time, energy and resources if it is done properly. With increasingly competing demands on time, there is a danger that community engagement will be carried out at a superficial level.
55	Royal College of General Practitioners	General (question 4)	It may be unlikely to achieve each of the statements in this draft quality standard by local services given the net resources needed to deliver them. It may be necessary further support in the current climate. (DJ)
56	Royal Pharmaceutical Society	General (question 4)	The net resources available have not been clarified so it is difficult to comment on whether or not the quality standards would be achievable by local services. In order to be successful, early involvement of all interested parties such as local communities, commissioners and providers in developing initiatives is crucial. We have concerns that Local Authority funding has effectively been cut in recent years and it would be counter productive to use much needed resources to collect data at the expense of providing services.
57	Sheffield City Council	General (question 4)	In response to Questions for consultation Question 4: The statements will be achievable if resource is dedicated to provide training in participatory working for commissioners, providers and community members. There is a need for a strategically designed and implemented approach to staff training and development as it may involve organisational culture change in terms of a shift in “how things are usually done” to “how things will now be done” and there are resource (and time) implications for this. Resources are also needed to provide for the cost of training the members of the community so they are able to participate confidently in this process
58	The Big Life group	General (question 4)	I think that in order for the quality standards to be met there is going to be extra resource required to begin with. There needs to be an understanding by commissioning (and grant funding) bodies in asset based approaches. Not all funders are going to be au feu with this as a theory. It’s going to take extra resource in terms of time for statements one and two. In order to do meaningful community engagement in designing initiatives and planning for evaluating interventions there is going to be more time needed and also training for community members.
59	The UK Faculty of Public Health	General (question 4)	While investment needs to be made in supporting the engagement activity and in delivering action and change, greater emphasis could be given to system wide, place based approaches. This makes best use of community time, avoids duplication, and is more efficient.

60	Co-operatives UK	General (question 5)	We believe Quality Statements 1 to 3 should also apply to providers, because if they do the Quality Standard will better fulfil the ambition of NG44 and the Five Year Forward View, and better reflect the central findings of the WHO. Crucially NG44 is explicitly intended to cover both statutory and VCSE providers. What is more the first principle of community engagement in NG44 states that communities should be partners in delivery. We think this means that in practical terms all Quality Statements need to apply to providers if the Quality Standard to be fully effective. Quality Statement 1 should certainly require providers to work with local communities, not just to agree the aims of initiatives, but to develop and deliver these initiatives as well. This must apply to VCSEs as much as to statutory providers. It must not be assumed that all VCSEs will do this automatically, or to a degree that transforms the relationships user communities have with them. Similarly Quality Statement 2 should require providers to meaningfully involve user communities in the evaluation of initiatives. Not only will this increase engagement with more diversity at more points, but will also allow user communities to have more direct influence without having to go through separate engagement frameworks. We have already commented that Quality Statement 3 stops short of requiring local assets to be nurtured and empowered. It is important that providers themselves become genuinely embedded in communities and act as conduits for social action. This applies as much to VCSEs as to statutory providers. Again we urge caution against using VCSE as shorthand for community, when this not always the case. We also believe it is unfortunate that in many parts the Quality Standard (and this question) focusses on the rigid categorisation of commissioners, communities and providers; an approach which itself tends to maintain and perpetuate current relationships. Changing these relationships requires an approach which is willing to see things differently. For example through a nascent combination of personalisation and co-operative approaches, communities can become commissioners themselves. A co-operative approach recognises that an individual may be a professional care worker, a local resident, a voluntary carer, and somebody being cared for. It seeks to recognise each of those categories insofar as it is necessary to do so to run high quality services, but it seeks to look beyond such categorisation in search of a vision for a caring society. If we are to see truly integral, sustainable and diverse engagement that not only reaches but enables user communities at every point, with more peers playing more significant roles, then the Quality Standard as a whole must apply to providers and to delivery. Notably 1.4 of NG44 recognises that commissioners can promote such provision and help build such capacity. As NG44 also recognises, this takes time. NICE should not be put off applying Quality Statements 1 to 3 to providers because it feels there is a shortage of providers who currently do these things. From a co-operative perspective, we recognise that providers can be employee, community, and service-user led and owned, and that such organisations help to break down the barriers currently restraining reform. This Quality Standard should help drive change, not just reflect what we currently have.

61	MAC-UK	General (question 5)	Some of the statements should also apply to providers of services, as not all services go through the commissioning processes. MAC-UK projects have been independently funded because of lack of resources available for excluded young people’s mental health within the commissioning processes.
62	National Community Hearing Association	General (question 5)	Yes – we agree with the focus, and it should also apply to providers. We also agree with NICE that “there is a compelling case for a shift to more people and community centred approaches to health and wellbeing”. Communities have long supported accessing care closer to home and active ageing. Adult hearing care is one such example. The service can be successfully delivered in the community at scale and helps improve quality of life, health and mental wellbeing. The World Health Organisation, NHS England, Department of Health and Monitor (now NHS Improvement) and the Hearing Loss and Deafness Alliance all acknowledge what the hearing loss community wants; more accessible services for their long-term condition. This however is only happening in c.50% of England, even though NHS evidence shows 70% of patients want a choice of hearing service[24]. The challenge is that local people are seldom involved in commissioning decisions, despite a plethora of guidance documents and standards that state they should be. This unaccountable model of commissioning has meant CCGs often refuse to provide more care in the community, and/or fail to consult with their local communities before they restrict community services that promote health and wellbeing. There is still too much focus on organisational forms (i.e. putting providers ahead of service users), and the impact such planning logics/decisions have on health inequalities needs to be addressed urgently. To achieve the outcomes of this quality standard it is important commissioners involve members of the community and healthcare professionals to identify local priorities (p.7) – and focus on the needs of the community rather than institutional forms there is a focus on reducing health inequalities – this includes evaluating how to reduce inequity in access, e.g. understanding that having to travel further for care, other things being equal, is likely to worsen health inequalities. It is also important that providers explain to commissioners which service users are less likely to be able to access existing services – e.g. in hearing care, access to NHS home care is patchy across England and this means older people (who are more likely to have a severe hearing loss) are less likely to be able to access hearing care. Those that can afford to pay privately have better access, and because there is little to no community engagement many commissioners fail to understand this and other health inequalities. It is also critical that providers (incumbent and potential) and other experts (e.g. patient groups and associations) are involved in local Joint Strategic Needs Assessments – but of course that each declares any conflicts of interests to ensure effective use of scarce resources. This will minimise information failures and make community engagement more impactful at a local level.

63	National Voices	General (question 5)	Yes, we believe that quality statements 1-3 should also apply to providers. Local authorities tend to have more experience in understanding how to commission around the quality standards. The NHS wants to move in that direction, as demonstrated by the Five Year Forward View, including the ‘Six Principles for engaging people and communities’, developed by the Forward View People and Communities Board, and the recently published framework for multispecialty community provider vanguards. In healthcare, we know from studies of health care commissioning* that while commissioners can move the conversation on about shared aims locally, innovation is much more often done by providers. For example, it is rare for commissioners to commission specifically high quality peer support, but in mental health we have seen that this is something that providers are very often involved in developing. *[see for example, ‘Commissioning high quality care for people with long term conditions’, Smith J et al, Nuffield Trust, London 2013]
64	NCT	General (question 5)	Statements 1 to 3 focus on the responsibilities of commissioners to work with local communities to plan health and wellbeing initiatives, do you agree with this focus or should the statements also provide to the providers of the initiatives? These statements should apply to providers as well as commissioners, however care needs to be taken that it does not result in a plethora of different user groups all struggling to recruit. For example, in maternity alone service users can be invited to join general groups such as a trust’s stakeholder group and their GP’s user forum, along with specialist service groups such as an MSLC supported by the commissioner and Head of Midwifery, and a user forum run by the provider of the health visiting service. Maternity service users appear to be particularly sought after as their presence usually significantly reduces the average age of the membership on general groups. Commissioners and providers should be encouraged to share networks and resources in order to avoid user involvement overkill.
65	NHS England	General (question 5)	I suggest, as set out in the answer to Question 1, the approach used in the QS is very commissioner/provider system focused (in other words transactional) and consideration should be given to whether the QS can be formulated to reflect the collaborative approaches required of an effective community engagement process.

66	Public Health Agency, Northern Ireland	General (question 5)	The statements should also apply to providers as it will be important for engagement to be an ongoing process and involve all stakeholders. We believe there needs to be a co-ordinated and not a duplicated approach to working with local communities. There is an onus on the commissioners of services to work with local communities to plan health and wellbeing initiatives to ensure that services are commissioned and developed based on need. However, there is also a need to ensure that the providers of services are engaging with local communities to adapt and respond to changing need to deliver health and wellbeing initiatives. There is a need to ensure that engagement activity is not duplicated and that commissioners and providers are in communication to review what action has already been undertaken.
67	Royal College of General Practitioners	General (question 5)	The providers of the services should also work with commissioners and the local community to develop the aims and objectives, outcome measures and identify the ‘building blocks’ with which to work. An inclusive approach will help ensure that the provider has some buy-in and understanding of the community they are serving. (MB)
68	Royal Pharmaceutical Society	General (question 5)	Commissioners should work with both local communities and local providers to plan health and wellbeing initiatives. It would be useful to have a requirement in annual reports and plans that demonstrates delivery of these quality statements on a consistent and continuous basis. This will ensure that work is ongoing and not just done once and forgotten. It will also create an accountability for commissioners to the community and lead to sustainable behaviour change.
69	The Big Life group	General (question 5)	Some focus should go to the providers around quality statements 1- 3. Commissioners may involve communities in the processes of deciding on an initiative and designing how it will be measured but providers should be part of this. The process should be circular and continuous and include all the assets in the community that are stakeholders in the initiative. The principals 1-3 should be included in ITT for tenders
70	The Chartered Society of Physiotherapy	General (question 5)	We would suggest that there should be a joint onus on the commissioners and providers of the initiatives, to ensure the feasibility of the service/how it is evaluated.

71	The UK Faculty of Public Health	General (question 5)	References to commissioner and provider may be misleading as the commissioner provider distinction is varied and moveable across sectors and across the country. We would suggest that the terms ‘Public sector’, ‘Voluntary Sector’; and ‘Communities’ may be more generic terms, which need to be reflected in the standards allowing for a broader perspective. We also suggest that the standards will be strengthened if communities themselves were given more prominence.
72	The National LGB&T Partnership	General	It would be useful to outline the scope of community engagement and its limitations. There absolutely is a compelling case for a shift to more people and community centred approaches to health and wellbeing, yet these must be used in tandem with overarching national initiatives tackling social determinants of health through legislation.
73	The Royal College of Midwives	General	The RCM is of the view that this quality standard accurately reflects the key areas for improvement
74	The Royal College of Midwives	General	If the systems and structures were available, it should be possible to collect the data for the proposed quality measures
75	Sheffield City Council	Statement 1	I understand that Data source has been left general, referring to ‘local data collection’, but for this statement and others people may find it helpful to be cross referenced to the sorts of local data that are useful. For example, transcriptions of priority setting meetings; documents listing who was invited to contribute to priority setting; who commented on drafts; who attended public meetings.
76	Parkinson’s UK	Statement 1	We agree that it is important for local communities to be directly involved in the identification of the aims of a particular initiative, We also strongly support the broad definition of ‘communities’ to include people with a particular health condition. This is of particular importance to people with Parkinson’s, given the complexity of the condition, which includes over 40 motor and non-motor symptoms, such as fatigue, pain, stiffness, freezing, tremor, confusion and dementia, and could enable local authorities and commissioners to engage with local Parkinson’s groups to design and improve health and care services.

77	Public Health Agency, Northern Ireland	Statement 1	A definition of community is given, but further guidance may be necessary to help commissioners and providers decide on level of engagement. For example, when working in a small defined geographic community of a few hundred people, working with 6 or 7 people may be considered appropriate. However, is that number still appropriate if designing a programme for a large city? Consideration could also be given to deciding who speaks for a community – is it formal community sector organisations, schools, churches, local individuals? How are individuals chosen, and what feedback mechanisms are in place to ensure that they are feeding information back and bringing forward the views of the wider community? Many communities contain gatekeepers and the voices of ordinary residents are rarely heard.
78	Action on Hearing Loss	Statement 1	Action on Hearing Loss welcomes the statement within the quality standard for improving health and wellbeing, that "members of the community and professionals from the community have an equal chance to contribute to the process of identifying aims for the initiative and that their opinions are values equally". We believe that it is vital that those with hearing loss, including those that are culturally Deaf are not excluded or isolated from these important discussions. All steps should be taken to ensure that the communication needs of people with hearing loss and those using BSL are considered so that they are able to access information and have their say about their health, decisions about treatments and wellbeing.
79	Sheffield City Council	Statement 1	suggested changes to text in italics:The process for involving communities starts with (1) priority setting, moving on to (2) identifying initiatives to address priorities and (3) developing aims for each initiative. This is important because there are cases where an initiative has already been decided by commissioners, which doesn't reflect local priorities. The language for Quality statement 1 would align with the header better if it said 'commissioners of health and wellbeing initiatives work with local communities *to agree local priorities, identify initiatives and aims for each initiative'*. The next section could then be rephrased to say "When a community is involved in identifying its needs *and priorities* form the start, the initiatives *that are developed to reflect local priorities* will be more meaningful…
80	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	Statement 1	Agree that mechanisms and approaches need to be put in place to be able to evidence how local communities work with commissioners to identify aims for health and wellbeing initiatives and to monitor the impact. In reality, this often proves difficult to achieve and is often an area of weakness – how should this be evidenced and promoted so that informed communities are able to hold commissioners to account if they do not work with local communities.
81	Public Health Agency, Northern Ireland	Statement 1	These will be quite difficult to measure without an agreed format. Levels of engagement could vary widely.

82	Public Health Bristol	Statement 1	a) Evidence of the arrangements being long term or ongoing
83	Public Health Bristol	Statement 1	b) Community ‘ownership’ as an outcome measure will need a lot of thought about how it is evidenced.
84	Public Health England	Statement 1	Agree that these measures are relevant and possible to collect. Could be collected via the VCSE sector rather than by the commissioners.
85	Sheffield City Council	Statement 1	Structure a) Evidence of local arrangements to identify local community *priorities* for health and wellbeing; (b) evidence of local arrangements for how commissioners and communities *work together to develop initiatives and define aims for them.*
86	Sheffield City Council	Statement 1	Outcome a): *Priorities for* local health and wellbeing initiatives *agreed between commissioners and* local communities. This statement would reflect the political nature of priority setting and acknowledge that there is likely to be disagreement about what is most important to address given limited resources. Getting this agreement is a key part of gaining ownership (Outcome b).
87	Public Health England	Statement 1	This could be expanded to include involving communities in agreeing all stages, not just the aims, of an initiative in line with NG44 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 . Involvement in designing the methodology is particularly important (as evaluation covered in quality statement 2)

88	Action on Hearing Loss	Statement 1	Action on Hearing Loss supports the rationale related to statement 1 that it will enable communities to get involved early; helping them to build positive relationships between commissioners, providers and communities. Social services and audiology services for people with hearing loss in England are commissioned locally and we believe that more should be done to ensure that these services are publicised and well planned, and patients using these services are given the right to be involved in and know how to be involved in discussions related to their adult hearing aid service. Due to the lack of access and increasing prevalence and impact of hearing loss, NHS England has made clear that tackling hearing loss should be a priority across government and specifically that it should be included in local Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.[18] NHS England's Commissioning Framework for adult hearing aid services[19] details important guidance for CCGs on how to commission cost-effective services that meet the needs of people with hearing loss and the importance of identifying and addressing hearing loss as soon as possible in order for people to gain the maximum benefits from hearing aids, so that unaddressed hearing loss doesn't pose risks to their independence and mental and physical health. The principles within the Commissioning framework for hearing aid services are that they are designed and based on the needs and preferences of the populations they serve; promote health and wellbeing rather than solely treat ill health; drive up quality and deliver better outcomes and value for people, making the most effective use of available resources; are based on collaboration and co-production. It should therefore be considered as one of the key documents for health and wellbeing initiatives related to hearing loss. Another crucial point is that people with hearing loss often have specific communication needs and so it is important that these are considered and met when engaging with people in local communities and setting priorities for health and wellbeing initiatives. The NHS England Accessible Information Standard[20] provides clear guidance on what providers of 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 from proactive communications such as BSL video translations on websites or through direct engagement with local Deaf clubs and other community groups.
89	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	Statement 1	Fully support the rationale for Statement 1 and agree that encouraging communities to be involved in identifying local priorities helps to build better relationships and improve outcomes.
90	Public Health Agency, Northern Ireland	Statement 1	It may be useful to highlight that there should also be pre-engagement on the needs of the community before agreeing aims for the initiative.
91	Public Health Agency, Northern Ireland	Statement 1	The focus on all services being publicly procured can make it more challenging to engage with the community as commissioners are wary of speaking about new programmes in case there is the perception that they have given undue advantage to an organisation which may apply to deliver the service.

92	Public Health Bristol	Statement 1	This still assumes that commissioners are initiating all interventions. Often interventions are growing in a community and with the right support could become. Commissioners should be looking for these opportunities.
93	Royal College of General Practitioners	Statement 1	It may be worth it to reword to: ‘Commissioners of health and wellbeing initiatives work with local communities to identify and agree aims for initiatives to improve health and wellbeing’ as the emphasis on this standard is that the local community has ownership over the aims and deciding what matters to them, rather than just agreeing to the aims of an initiative selected by the commissioners. (MB)
94	Royal Pharmaceutical Society	Statement 1	We agree with this statement in general but feel that health and care professionals should also be engaged at the beginning of the process together with local communities. A joint consultation with local communities and health and care professionals is likely to lead to more integrated working and solutions that can be delivered. However, it would be useful to define “local community” so that any engagement is not simply a tick box exercise with the same few individuals who are working to their own agenda rather than being truly representative.
95	Sheffield City Council	Statement 1	“ensure that members of the community and professionals from the community have an equal chance to contribute to the process of identifying priorities and setting aims’
96	Sheffield City Council	Statement 1	“People who are socially isolated are also considered to be a community group.” Do people who are socially isolated identify themselves as a distinct group? Perhaps this could be replaced with …”*Communities may also be defined by other common bonds, for example people who are socially isolated may define themselves as a group according to the health need or disadvantage.*” But it is questionable, and may be better addressed by changing the next section instead, as suggested in 7 below.
97	Sheffield City Council	Statement 1	Under Equality and diversity considerations, can *social exclusion and social isolation* be added

98	The Big Life group	Statement 1	Health inequalities disproportionality effect those furthest away from engaging with services, in communities that are the most deprived and with people who are the most isolated. The statement is an essential one but in order for it to gain success in supporting the reduction on health inequalities it should recommend how it will be achieved with a variety of communities, through examples of good practice, updated and promoted continually. The statement will only effect those in which it was possible to engage with. Therefore it is essential to asset map communities, with those communities to understand what their assets, cultural norms and priorities are before attempting work on initiatives. When we talk about commissioners – who do we mean? In working with communities we may realise that a community most prioritises initiatives that fall within a different commission framework, so some thought should be given to overcome this. For example, a public health commissioner, engages with a community regarding a wellbeing initiative and the community responded with priorities regarding employment or young people's provision. How do we ensure we can offer true coproduction in this situation? Also, should it just be commissioners or grant funders as well and other awarding bodies. These bodies also need to link into the work of statutory bodies to create a process which doesn't become fragmented (for example, many bodies / organisations doing the same thing, when it would be more efficient to do it together – for example asset mapping processes by CCG and Local Authority). Big Life group manage health living centres in Salford and Manchester and children centres across greater Manchester where community engagement at the start to identify and initiative and agree the aims is essential. Including organisations or community structures in the process of engagement from commissioner to community is an important way into communities
99	The National LGB&T Partnership	Statement 1	It would be useful to have examples of how community engagement might be conducted by providers and commissioners. This is particular useful when thinking about such as the LGBT community, where Stonewall recommend that service providers should encourage local LGBT people to participate in public consultations, including by publicising them in LGBT venues (Stonewall, Gay in Britain, 2013). Commissioners and providers should be encouraged to work with local LGBT voluntary organisations As mentioned in the equality and diversity considerations in the statement, many groups of people are likely to find it difficult to engage in these processes, and this is likely to include many LGBT people as discussed above. It is therefore disappointing that the standard concentrates on local data collections which often disregard LGBT people by not recognising the need to monitor sexual orientation or trans status. It would be useful to therefore have a quality measure that recommends data collection of the demographics of community members, including by monitoring sexual orientation and trans status. This would ensure that community engagement programmes are reflective of the diverse populations we have. Once analysed, data would allow gaps to be identified and targeted recruitment to begin.

100	Parkinson’s UK	Statement 2	Parkinson’s UK agrees that commissioners should seek agreement from local communities when measuring the impact of initiatives. We also welcome the fact that there is no prescriptive definition of how a project should be evaluated, which could enable people with Parkinson’s to self-report their experiences concerning a new service or pilot.
101	Public Health England	Statement 2	What’s missing is evidence that evaluation, especially data from the community, has informed improvements to local initiatives.
102	Optical Confederation and Local Optical Committee Support Unit	Statement 2	It is important that any initiative is measurable and so this statement is sensible. There will be a challenge to determine precisely what constitutes effective measurables as different entities will have different focuses. Local representative committees including LOCs will have a role in this because of their local knowledge and experience of the commissioning landscape.
103	Action on Hearing Loss	Statement 2	Action on hearing Loss welcomes that the evaluation of the health and wellbeing initiatives is included as one of the standards. We believe that this is vital in determining whether an initiative has made an impact or not on the local community. We believe that all parties involved from the local communities, service providers and commissioners can play an active role in ensuring that evaluation is considered from the off set of any health and wellbeing initiative in order to help drive change and ensure improvements are made and can be learned from.
104	Royal Pharmaceutical Society	Statement 2	Local communities are likely to have variable skills and knowledge on impact assessments. Again we would advocate for the early involvement of health and care professionals in the development of measures to assess the impact of the initiatives.
105	Sheffield City Council	Statement 2	Under Structure (a) add “how to *assess the process* and measure the impact”. Data on impact alone will not explain how health and wellbeing are achieved.
106	Public Health Bristol	Statement 2	Communities whose members are involved in (insert) ‘designing, developing and delivering’ initiatives
107	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	Statement 2	Local measures and data collection often just focuses on capturing outputs or numbers and less on measuring impact or the benefits being realised by the individual or communities. A better understanding on benefit realisation and impact monitor is needed. There is a real difficulty that when communities' aims and the views of decision makers don't match, this approach is not supported by the decision makers.

108	The Big Life group	Statement 2	The principal of engagement on evaluating the outcome with the local communities is a good one and follows on from the process outlined above. As a continuation of this process and a fundamental component of success is the use of language and used to discuss these issues with communities and communication processes that make sense to them – not all communities are the same and will have different levels of experience, understanding, different ways of communicating and use of language. What is certain is that for many communities who engagement is essential to reduce health inequalities, the language of services – such as evaluation or measurement – will reduce the likely hood of engagement. Using a 'people like us approach' – such as the approach of Health trainers or Coaching as seen in Being Well Salford, can help to remove these barriers and support people, to set goals in ways that are meaningful to them. Being Well Salford is a test site for Realising the Value. Find out more about the service at www.beingwellsalford.com
109	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	Statement 2	Full support the rationale for Statement 2 and agree that plans on how to evaluate health and wellbeing initiatives need to be decided with the community as soon as the aims are decided by the community.
110	Sheffield City Council	Statement 2	Outcomes: Can an Outcome (c) be added stating Commissioners and communities benefit from the collection of relevant data which explains how impact is achieved.
111	Sheffield City Council	Statement 2	Add *process and* to each of the remaining statements about impact in this section.
112	Sheffield City Council	Statement 2	Under Definitions of terms there is this sentence "Identify and agree process and output evaluation objectives with members of target communities and community and voluntary organisations". This would be better placed as the first statement under Quality Measures Structure e.g. to be placed before the current statement a) Evidence of local arrangements for commissioners to agree with local communities how to measure the impact of the initiatives once the aims are agreed.
113	The National LGB&T Partnership	Statement 2	It's key that the impact of the evaluation is measured against aims decided upon by the community. As mentioned above, it's crucial that in accordance with the Equality Act (2010) and public sector duty, community engagement initiatives consider how they are meeting the needs of LGBT communities. The monitoring of sexual orientation and trans status is therefore imperative. There is guidance on how to monitor sexual orientation on LGBT Foundation's website (http://lgbt.foundation/som), where there's also a briefing sheet on trans status monitoring.
114	Public Health Bristol	Statement 3	Structure b: As well as identifying community skills it should read 'using and promoting'

115	Public Health England	Statement 3	Additional outcome – evidence that local initiatives continue to build the assets (especially amongst the most marginalised communities) – their skills, knowledge, networks, relationships and access to facilities.
116	Action on Hearing Loss	Statement 3	Action on Hearing Loss welcomes the rationale for statement 3 which states that health inequalities can be addressed by drawing on assets from people from marginalised and deprived communities by identifying and building on assets of local people, communities can be engaged more effectively and help to reduce stigma attached to some health conditions and diseases. The NHS England Action Plan on Hearing Loss[21] highlights that deafness or loss of hearing at any age isolates individuals, cutting them off from society, life and the things they need to thrive. Hearing loss can impact on the development of language in children, reduce chances of employment, restrict aspirations and life chances, increase the risk of mental health problems and interfere with peoples' ability to care for their own and their families' long term health conditions[22]. This can lead to low achievement, low self-esteem, isolation, loneliness and depression. People with hearing loss also often suffer stigma from the hearing population. As detailed in comment 4, people with hearing loss face health inequalities throughout their life course in accessing healthcare, education and during their working life. Ensuring that people with hearing loss are included within health and wellbeing initiatives may help reduce some these inequalities and reduce stigma attached to hearing loss.
117	Public Health England	Statement 3	Because it leads to more participatory approaches and can increase wellbeing and resilience (self esteem, self efficacy, sense of control, meaning and purpose.). Last sentence not clear.

118	Optical Confederation and Local Optical Committee Support Unit	Statement 3	When identifying existing assets, commissioners should be sure to include community optical practices as they can contribute as a key public health resource. Optometrists have a crucial role to play in detecting, diagnosing and treating eye problems and disease. Sight tests, free at the point of need to 13 million people, with a further 5m having a private sight test, are a vital tool for preventing avoidable sight loss.[26] By providing this service in all communities, practices can also help to combat health inequalities. Poor eye health can often lead to depression or other mental health issues, particularly when a patient is already suffering from loneliness or isolation, as can be the case for elderly people. In these situations, optical professionals can assist the patient by ensuring correct and appropriate refraction or identifying a mental health issue. Poor eye health can also be a factor in a number of other public health issues, such as falls among the frail elderly. Falls are the most common cause of hospitalisation for people aged over 65 and the biggest cause of accidental death in people aged over 75.[27] Optical professionals can play an important role by detecting the risk of falls and informing GPs who can then enrol patients in falls prevention programme. Optical practices can deliver both eye health and wider health messages and interventions to the public. Practices can play a key role in prevention; high on health agendas. Firstly, they can provide information and advice about risk factors to people who do not currently have eye health problems. This information also helps reinforce general public health messages stressing the importance of making good lifestyle choices, such as weight management and avoiding smoking. Secondly, where a patient has an identified problem optical professionals can carry out essential checks to help determine appropriate intervention. Thirdly, optical professionals can monitor conditions and suggest ways to mitigate impacts. We would encourage local commissioners to commission ‘Healthy Living Opticians’ to ensure that their populations’ health needs are being met. In many cases practices also provide community services outside of core primary care, such as minor eye conditions services and pre and post cataract operative checks. Other services include dispensing opticians and optometrists helping patients with low vision to achieve the best possible quality of life. As well as these community services providing patients’ local choice, they help to reduce the burden on secondary care.
119	Royal Pharmaceutical Society	Statement 3	The work to identify the skills, knowledge, networks, relationships and facilities within the local community is a significant and complex audit. We feel that this will potentially be passed to the local healthwatch to complete but consideration needs to be given to resources, including funding, to undertake such an audit. It would also be useful to have a national template to provide some standardisation across the country.

120	The Big Life group	Statement 3	This is an essential statement and should come before the first two. This is asset mapping and should be done with the community, through organisations or people that have reach within communities or have the skills, experience and values to do so. Again it is important that this work is community lead and includes an ethnographic approach to gathering the information
121	Public Health Agency, Northern Ireland	Statement 3	We warmly welcome the asset-based approach being proposed. PHA now includes in all Service Specifications a requirement that Service Providers engage with any organisations or individuals working in the target communities. Local Commissioning Groups (of which PHA is a member) have community representation, as do the Integrated Care Partnerships.
122	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	Statement 3	Fully support the principle of an 'asset based approach' to supporting health and wellbeing initiatives and the Local Authority (LA) Community Engagement team is ideally placed to support this work through community asset mapping but this is very resource intensive and because communities constantly evolve, as do the assets, this needs constant updating to remain relevant. This becomes a challenge given the current financial climate and therefore needs to be relevant and in proportion to the scale of the initiative.

123	London Fire Brigade	Statement 3	The LFB embrace the principles set out in the draft quality standard Community Engagement: Improving Health & Wellbeing as we have a particular interest in this area due the established link between the indicators of poor health and the factors that increase a person's risk from fire1. Our home fire safety visit programme aims to address this by visiting people in their homes to provide advice on how to reduce the risk of fire but we recognise the need to work in partnership with other organisations operating within local communities to raise awareness of the fire risk factors and the means to reduce them on a wider scale. Therefore, we welcome the overarching principles of Quality Statement 3 aimed at encouraging, identifying and working with existing and new community networks and organisations and would ask that the fire service is recognised as an 'asset' with established links, skills, knowledge, networks, relationships and facilities within the local community that commissioners of health and wellbeing initiatives, service providers and practitioners can utilise. There is increasing recognition at a national level of the fire service's role in contributing to improving health and wellbeing as evidenced by the joint consensus statement between NHS England, the Chief Fire Officers Association, the Local Government Association, Public Health England and Age UK signed in October 2015 and which sets out a national commitment to improving health and wellbeing.2 The aim is that, through collaborative use of resources and joint strategies for intelligence-led prevention and early intervention initiatives, vulnerable people and those with complex needs will be able to access the integrated care and support they need to live full lives and maintain their independence for longer. This approach will reduce not only current demand on fire, health and social care services but also future demand by equipping those not yet in need with information and support to change their behaviour and promote independence. For the fire service, this will mean a move away from the established home fire safety visit model toward 'Safe And Well' visits which aim to identify a significantly wider range of contributors to avoidable accidents and ill-health than just fire risk and either refer the person to local agencies for support or take remedial action such as fitting risk-reduction equipment like grab rails and window locks. 1 Review Of Accidental Dwelling Fires and Fatalities – FEP 2484 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=4384 2 Working Together – how health, social care and fire & rescue services can increase their reach, scale and impact through joint working (NHS England – June 2016).

124	The National LGB&T Partnership	Statement 3	Asset- based approaches can be highly successful in improving health and wellbeing in many circumstances. However, assets aren't always equally distributed across communities and marginalised groups tend to have fewer assets to draw from in the first place; plans should be put in place to support the development of assets where they don't already exist to avoid amplifying divisions to parts of the community that already have resources. For example, many areas don't have LGBT specific services or other assets, whilst in other cases they may exist but be unknown to commissioners or local authorities. Without explicitly identified the need to engage with LGBT communities, these assets (or lack of assets) are likely to go unnoticed. It must also be made sure that asset-based approaches are resourced appropriate. Volunteers aren't a free resource and neither is the expertise and knowledge of VCSE organisations.
125	Sheffield City Council	Statement 4	Under Definition of terms the phrase but "they are not necessarily peers" may need to be clarified as it hasn't been used previously in the document. Do you mean that they are not necessarily peer support workers?
126	RCSLT	Statement 4	This section suggests that people who take on bridging roles in the community should support people to overcome various barriers, including language barriers. RCSLT would recommend that support is provided to those carrying out such bridging roles from qualified speech and language therapists where initiatives aim to engage parts of the community who may have speech, language or communication needs, in order to ensure greater likelihood of success of such initiatives.
127	Public Health Bristol	Statement 4	Structure: As well as identifying there should be an expectation that relationships will be built with the community connectors
128	Public Health England	Statement 4	Structure – this may not be feasible or relevant for ALL initiatives.
129	Public Health England	Statement 4	Outcome b) – Bridging roles might not necessarily achieve this. BUT could lead to better (appropriate/ needed) access to services.
130	Parkinson's UK	Statement 4	Although we welcome the principle of this quality statement, we are concerned that 'finding people who can carry out a 'bridging' role – that is, provide a link between their community and the statutory, community and voluntary organisations' could place a significant responsibility on individuals, particularly people with Parkinson's, to facilitate connections between groups and commissioners, which may impact their health. We are also concerned that this role could be misused by local authorities and commissioners. It may place the responsibility for signposting to information and services on volunteers in the community, and therefore absolving local authorities of this requirement. This would not be acceptable. It is of particular concern, given the publication of recent research by Parkinson's UK*, which surveyed over 350 people with Parkinson's and their carers to better understand how social care services are working for these

			individuals in England. We were alarmed to find that 74% of respondents with Parkinson's and 59% of carers were unaware of their local authority's social care information service, and many people with Parkinson's and carers did not know how to request a social care assessment. Parkinson's UK recommends that this bridging role is undertaken by a member of the local authority team, rather than a person in the community. * https://www.parkinsons.org.uk/sites/default/files/care_act_experience_report_executive_summary.pdf
131	Public Health Agency, Northern Ireland	Statement 4	We would propose that Commissioners should be included in this statement as well as providers.
132	Royal College of General Practitioners	Statement 4	The provider and commissioners should agree how the bridging role will be accomplished. In some circumstances it may be appropriate for the provider but it may happen that the commissioner would want to have someone they know too to assess and give feedback independently. We are aware of some volunteering schemes where sometimes one of the volunteers' supervisors might give a over optimistic report in order to keep the funding, so the commissioner needs to be able to measure feedback from the volunteers independently. (JA)
133	Royal Pharmaceutical Society	Statement 4	Community members should be part of CCG and HWB boards so they are up to date on local initiatives and can undertake the bridging role. The Governor role of Foundation Trust could be considered in this context.
134	The Big Life group	Statement 4	This statement appears to describe a formal intervention (i.e. a health trainer which is a procured servce) but also a peer in the community who helps to connect people to services (which could happen naturally). It may not be good enough to use a commissioned service (i.e. a health trainer) to act as a conduit of information back to commissioners as there is a potential conflict of interest. The statement that says 'community members who take on this role act 'connector', signposting to services and information and supporting them to improve their health & wellbeing as well as relaying community opinion to the providers" I think this is two things: One working in the community One working with providers While this can be the same person but they don't have to be. There may be a risk of formalising something that shouldn't be formalising. The statement should also recognise that these roles will already exist in communities and ethnographic approaches and asset mapping will help to draw these out. It is important not to impose a system on a community that doesn't want it or need it but much better to use the assets and strengths within it and use these already formed structures to build on. Again use of language is important here – particularly around the use of ' a service' where things are 'being done to people' therefore the principal should be adaptive and have examples of adaptation for better understating. The understating of good productive relationships, particularly

			those that may not be understood by mainstream society and how they support good health should be a key element this standard
135	Public Health Agency, Northern Ireland	Statement 4	Although mentioned elsewhere, it should be highlighted in this definition that this is a two-way role: community members provide information and support to their communities, but should also be bringing forward information to commissioners and providers from the community to inform practice.
136	Sheffield City Council	Statement 4	Under Rationale: Community engagement can be supported by finding people who can carry out a 'bridging' role: The phrasing implies that the community needs to look for volunteers. There are already many people in community who act as bridges. Should this be re-phrased to say supported by identifying people who *already act in a bridging role or who are interested in taking on the role of providing a link* …"
137	Public Health Agency, Northern Ireland	Statement 4	We would propose that 'identify members of the community' should be changed to 'identify and support members of the community' and the wording should also reflect that this should be done in collaboration with the community.
138	Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council	Statement 4	There is an issue with capacity within local communities. Whilst a community bridging roles could potentially provide a link between community and the statutory, community and the voluntary organisations often it comes down to the same people within local communities picking taking this on. Community infrastructure groups are struggling due to cuts in funding and have cut back on their commitments. What is not clear from the consultation is if they are expected to fulfil some of this role for free or are the commissioners expected to fund this. There is no mention of the role of elected members or Healthwatch – both currently act as 'connectors' helping to signpost people to services and information and supporting them to improve their health and wellbeing as well as relaying community opinion to the providers. But they are not the only 'connectors'

139	Action on Hearing Loss	Statement 4	Action on Hearing Loss welcomes statement 4 that providers of health and wellbeing initiatives identify community members who can take on bridging roles; providing a link between their communities and the statutory, community and voluntary organisations involved in providing health and wellbeing initiatives. Age related damage to the cochlear is the single biggest cause of hearing loss. Over 70% of people over 70[23] 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. Having links between the hearing loss and deaf communities to providers of health and wellbeing initiatives can help to ensure that their needs are met and may also help improve uptake/engagement in the sessions.
140	London Fire Brigade	Statement 4	At a local level, LFB borough commanders sit on a range of local multi-agency partnership Boards including Safeguarding Adult Boards, Hoarding Intervention Groups, Domestic Violence Multi-Agency Conferences, and eight sit on their Health and Well-Being Boards. All of these partnerships operate on the principle of developing mutual information sharing and referral pathways to deliver a joined up approach to health and wellbeing interventions. Borough commanders also request their local SAB to hold a serious case review when an individual known to the board dies in a fire, in order to increase multi-agency understanding of how to improve partnership working and identify where the potential intervention points were to provide preventative measures e.g. arson proof letterboxes, fire retardant bedding or assisted living technology (AST). With this in mind, LFB has developed an assisted living technology catalogue to be used as a reference guide by both our own staff and partner agencies to identify AST devices to address not only fire risk but, in some cases, also help an individual to live independently and reduce or prevent their need for care and support. All of this makes our Borough Commanders ideally placed to take on the 'Bridging Role' as set out in Quality Statement 4 by providing a link between their community and the statutory, community and voluntary organisations involved in providing health and wellbeing initiatives so would ask that this is given consideration by commissioners of health and wellbeing initiatives, service providers and practitioners when identifying candidates for this role.

141	Optical Confederation and Local Optical Committee Support Unit	Statement 4	LOCs are statutory local organisations that represent NHS ophthalmic performers and contractors. They are both adept and versed in bridging roles, because they are made up of local healthcare professionals and community members who contract with the NHS to deliver primary care. LOCs already have significant interaction with CCGs, LAs and other bodies and should therefore be seen as important local bodies in terms of this statement.
142	The National LGB&T Partnership	Statement 4	Community connectors are extremely important in community engagement, and there are good examples of how this can work well with the LGBT community as a community of identity. For example, LGBT Foundation's Community Leaders programme (http://lgbt.foundation/Take-Action/community-leaders/) empowers volunteers to facilitate interaction between LGBT voices and NHS organisations, by training A recent, independent review of the 3-year Department of Health funded programme found that the 80 community leaders attended many meetings, forums and events, and that the programme was successful in generating greater direct LGB voice in health and social care design and delivery. However, it is worth recognising that community members engaging in these ways are being relied upon to achieve specific outcomes, and as such providers should consider providing payment or other formal recognition for their time. By nature many 'connectors' are likely to be from marginalised groups and therefore be more in need of payment for their time.
143	MAC-UK	Additional areas	These statements do capture some of the core principles of community engagement. But we would also like to see a principle about co-production of service design and delivery. We believe community members, especially of excluded groups, should also be employed within a range of roles in health provision within their own communities and supported to gain and sustain these employment roles. This should not just encompass 'bridging or connector' roles but many other roles besides. At MAC-UK we employ excluded young people in our projects with a range of responsibilities. Part of their roles are connectors, but those with lived experience can offer a wide range of skills for co-production. Employment of community members and co-production are an important part of community engagement and relieving health inequalities as per Marmot's evidence.

144	MAC-UK	Additional areas	The time it takes to develop relationships with members of excluded groups eg young people affected by 'gangs' (as with MAC-UK) in the UK is lengthy, often taking at least a year before young people trust staff members of new projects/services entering into their communities. We put at least a year in service development for community engagement, community asset mapping and relationship building. Similarly co-production of services with excluded young people is appropriately slow because young people and staff are developing new skills and ways of working and may have multiple outcomes, as led by the services users. Young people may need a lot of support to learn the skills of service design and delivery and other practitioners need a lot of support to learn how to co-produce. For this reason, the principle outlined in this quality standard need to ensure that new services are sufficiently resourced for lenthy and sustainable periods, not just short cycles. Also resources need to be provided to support those community members taking up new employment roles or volunteer roles as part of the community engagement processes. At MAC-UK we provide a lot of extra support for staff and young people to enable them to co-produce and engage in community asset mapping and community development. It is currently very difficult to gain resourcing for such processes because they are not captured necessarily by conventional health 'targets'.
145	RCSLT	Additional areas	We also suggest that there is a need to require commissioners to commission services which have close relationships with third sector and charitable organisations in the locality
146	RCSLT	Additional areas	We also think it is important to promote the development of self-management approaches for people with long-term conditions.
147	RCSLT	Additional areas	We believe it is important that individuals with speech, language, and communication (including hearing) impairments have access and opportunities for social engagement and participation in such.
148	RCSLT	Additional areas	The RCSLT suggests adding the need to encourage health and social care providers to be fully aware of the third sector/voluntary initiatives within their localities in order to inform/encourage service users to participate in such opportunities.

Registered stakeholders who submitted comments at consultation

- Action on Hearing Loss
- Compassionate Communities UK
- Co-operatives UK
- Department of Health
- Lincolnshire Health and Wellbeing Board / Public Health, Lincolnshire County Council
- London Fire and Emergency Planning Authority
- Music and Change MAC-UK
- National Childbirth Trust (NCT)
- National Community Hearing Association
- National Voices
- NHS England
- Older People’s Advocacy Alliance (OPAAL UK)
- Optical Confederation and Local Optical Committee Support Unit
- Parkinson’s UK
- Public Health Agency, Northern Ireland
- Public Health Bristol
- Public Health England
- Royal College of General Practitioners

- Royal college of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Speech & Language Therapists
- Royal Pharmaceutical Society
- Sheffield City Council
- The Big Life group
- The Chartered Society of Physiotherapy
- The National LGB&T Partnership
- The Royal College of Midwives
- The UK Faculty of Public Health