

# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## PUBLIC HEALTH GUIDELINE

### DRAFT SCOPE

#### **1 Guideline title**

Community engagement: approaches to improve health and reduce health inequalities

##### **1.1 Short title**

Community engagement

#### **2 Background**

- a) In 2005, the Department of Health asked the then National Institute for Health and Clinical Excellence (NICE) to develop guidance on public health approaches aimed at promoting community engagement to improve health. Following a review of the guidance in 2011, NICE (now known as the National Institute for Health and Care Excellence) has decided to update the recommendations.
- b) This guideline will be informed by both Amartya Sen's 'capability' approach (Sen 2009; Venkatapuram 2011) and the 'asset-based' approach (Morgan et al 2010). It will focus on people's ability – and opportunity – to have meaningful, fulfilling relationships and so realise their potential. The relationships could be with other individuals, local groups and organisations within the community. The idea is to determine how a range of 'assets' (for example, individual skills and competencies, family and friendship networks and environmental resources necessary for creating opportunities for health) can help individuals and communities to thrive. It will also look at the role that community structures and processes play

in creating viable networks of people working together for the common good.

- c) This guideline will support a number of related policy documents including:
- 'A public health outcomes framework for England 2013–2016' [Parts 1A and 2] (Department of Health 2012)
  - 'Building a stronger civil society: a strategy for voluntary and community groups, charities and social enterprises' (HM Government 2010)
  - 'Equality Act 2010' (HM Government 2010)
  - 'Equity and excellence: liberating the NHS' (Department of Health 2010)
  - 'Fair society, healthy lives – tackling health inequalities. The Marmot review' (Marmot et al. 2010)
  - 'Health and Social Care Act 2012' (HM Government 2012)
  - 'Healthy lives, healthy people: our strategy for public health in England' (Department of Health 2010)
  - 'Local Government Act 2000' (HM Government 2000)
  - 'Local Government and Public Involvement in Health Act 2007' (HM Government 2007)
  - 'Localism Act 2011' (HM Government 2011)
  - 'Our Health, our care, our say: a new direction for community services' (Department of Health 2006)
  - 'Public Health England: our priorities for 2013/14' (Public Health England 2013).
- d) This guideline will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. It is aimed at local people and community advocates, as well as commissioners, elected members and officers and others in local authorities with community engagement as part of their remit. It also applies to the NHS, parish councils and

the wider public, private, voluntary and community sectors. In addition, it will be of interest to members of the public.

- e) The guideline will supersede 'Community engagement: approaches to improve health', NICE public health guidance 9 (2008). Note: many NICE public health guidelines, both [published](#) and [in development](#), are concerned with involving communities to help prevent and tackle disease and illness.

This guideline will be developed using the process and methods described in [Methods for development of NICE public health guidance](#) (2012) and [The NICE public health guidance development process](#) (2012).

### 3 The need for guidance

- a) For the purposes of this guideline, 'community engagement' is used as an umbrella term encompassing a range of activities. It is about people improving their health and wellbeing by helping to develop, deliver and use local services. It is also about being involved in the local political process. Community engagement can involve varying degrees of participation: for example, from giving views on a local health issue to helping deliver or manage and control services. The more a community of people is supported to take control of activities to improve their lives, the more likely their health will improve (Popay et al. 2007).
- b) Since publication of NICE's [community engagement](#) guidance there has been considerable research and review activity on the general subject – and on the effectiveness of specific approaches and techniques for tackling different issues. For example, a recent review (O'Mara-Eves et al. 2013) suggested that community engagement interventions are 'effective in improving health behaviours, health consequences, participant self-efficacy and

perceived social support for disadvantaged groups'. The review will be used to inform the evidence reviews for NICE's update.

- c) There are many barriers and challenges to community engagement, including the:
- lack of an infrastructure that encourages local organisations, such as the police, local authorities, schools, community groups and representatives of the faith and voluntary sectors to work together with communities to achieve common goals
  - dominance of professional cultures and ideologies (often professionals impose their own structures and solutions on communities)
  - capacity and willingness of the public to get involved
  - skills of people representing communities and staff working in publicly funded services (Popay et al. 2007).
- d) Community engagement is one important way to improve health, address the social determinants of health and reduce health inequalities, according to the World Health Organization (WHO 2013). Involving communities, particularly disadvantaged groups, is central to local and national strategies in England for promoting health and wellbeing and reducing health inequalities (DH 2010; Marmot et al. 2010). All local authorities have a duty to inform, consult and involve the public in the delivery of services and decision-making. They must also ensure everyone has an equal opportunity to get involved (HM Government 2007). In addition, the Localism Act (HM Government 2011) has introduced 'new rights and powers for communities and individuals' to shape services to meet their needs
- e) Recent surveys indicate that the decline in formal volunteering (regular unpaid help given at least once a month in the previous 12 months) has reversed. In 2005, 44% of people volunteered on a regular basis. This dropped year-on-year until 2010/11 (39%). The

most recent survey, in 2012/13, indicates that rates of volunteering have now returned to 2005 levels (44%). People in managerial or professional occupations are about twice as likely to volunteer as those in routine and manual occupations (37% compared with 17%). Levels of participation generally decrease as the level of local deprivation increases (Cabinet Office 2013).

## **4 The guideline**

This document defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider.

### **4.1 *Who is the focus?***

#### **4.1.1 Groups that will be covered**

a) Communities defined by at least 1 of the following, but in particular, where there is an identified need to address health inequalities:

- geographical area
- interest
- health need
- disadvantage
- shared identity.

Examples of communities or groups include:

- new mothers
- older people living alone
- people concerned about local substance misuse
- people living in a disadvantaged area
- people of a particular faith, nationality or ethnicity
- people with a mental health problem
- schoolchildren.

#### **4.1.2 Groups that will not be covered**

a) None.

## **4.2 Activities**

### **4.2.1 Activities/measures that will be covered**

- a) Activities that ensure community representatives are involved in developing, delivering or managing services to improve the community's health. Examples of where this might take place include: care or private homes, community centres or public spaces, cyberspace, health clinics or hospitals, leisure centres, schools and colleges, and Sure Start centres. Examples of community engagement roles include:
- Community (health) champions. These people are community entrepreneurs, mentors or leaders who 'champion' the priorities and needs of their communities and help them get involved by building on their existing skills.
  - Community or neighbourhood committees or forums. These are non-political bodies that represent all residents in an area and are usually made up of local councillors, members of community and voluntary groups.
  - Community lay or peer leaders. These people work with others of the same age, background, culture or social status, for example, to educate them about how to improve their health.

An example of a community engagement activity is community-based participatory research. This involves community members in research on, and development of, public health interventions.

- b) Local activities to improve health by supporting community engagement. Examples include (delivered separately or in combination):
- activities to raise awareness of, and encourage participation in, community activities
  - evaluation and feedback mechanisms
  - funding schemes and incentives

- programme management
  - resource provision (such as meeting rooms or equipment)
  - training for community members and professionals involved in community engagement.
- c) The Committee will take reasonable steps to identify ineffective measures and approaches.

#### **4.2.2 Activities/measures that will not be covered**

- a) The guideline will not cover community engagement activities that:
- do not aim to improve individual- and population-level health
  - do not report on primary or intermediate health outcomes
  - target individuals (rather than a specified community, as defined in 4.1.1).

### **4.3 *Evaluating interventions and outcomes***

#### **4.3.1 Key questions and outcomes**

Below are the overarching questions that will be addressed, along with some of the outcomes that would be considered as evidence of effectiveness.

**Question 1:** How effective and cost effective are community engagement approaches at improving health and wellbeing and reducing health inequalities?

**Question 2:** How effective and cost effective are community engagement approaches at encouraging people to participate in activities to improve their health and wellbeing and realise their capabilities – particularly people from disadvantaged groups?

**Question 3:** What processes and methods help communities and individuals realise their potential and make use of all the resources (people and material) available to them?

Subsidiary questions may include:

- What impact do the following have on the effectiveness, cost effectiveness and acceptability of different interventions:
  - deliverer
  - community representative or group
  - health topic
  - setting
  - timing
  - theoretical framework?

**Question 4:** Are there unintended consequences from adopting community engagement approaches?

**Question 5:** What barriers and facilitators affect the delivery of effective community engagement activities – particularly to people from disadvantaged groups?

Subsidiary questions may include:

- What factors lead to greater participation in community life and services?
- What systems are needed to encourage or ensure community engagement mechanisms are used to improve health?

### **Expected health outcomes**

- Improvement in individual- and population-level health and wellbeing.

### **Expected intermediate outcomes**

- Positive changes in health-related knowledge, attitudes and behaviour.
- Improvement in process outcomes, such as service acceptability and uptake, efficiency, productivity and partnership working.
- Increase in the number of people involved in community activities to improve health.
- Increase in the community's control of health promotion activities.
- Improvement in personal outcomes, such as self-esteem and independence.



- Improvement in the community's ability and capacity to make changes and improvements to foster a sense of belonging (social cohesion).
- Views on the experience of community engagement, including what supports and encourages people to get involved and how to overcome any barriers to engagement.

#### **4.3.2 Logic model**

- a) The model (see below) focuses on a range of community engagement roles and activities that aim to improve health. It sets out the conceptual link between local community engagement interventions, the immediate service delivery outcomes and other intermediate outcomes, such as empowerment and social cohesion. These outcomes in turn link to effects on health.
- b) Note: the primary purpose of an intervention, initiative or service may be community engagement rather than health improvement. In addition, any anticipated health outcomes may not be realised until after the community engagement programme or associated evaluation has been completed.
- c) The model highlights how local funding, resources and other factors influence intervention delivery and outcomes. Note: the model does not provide comprehensive lists of, for instance, interventions or outcomes.

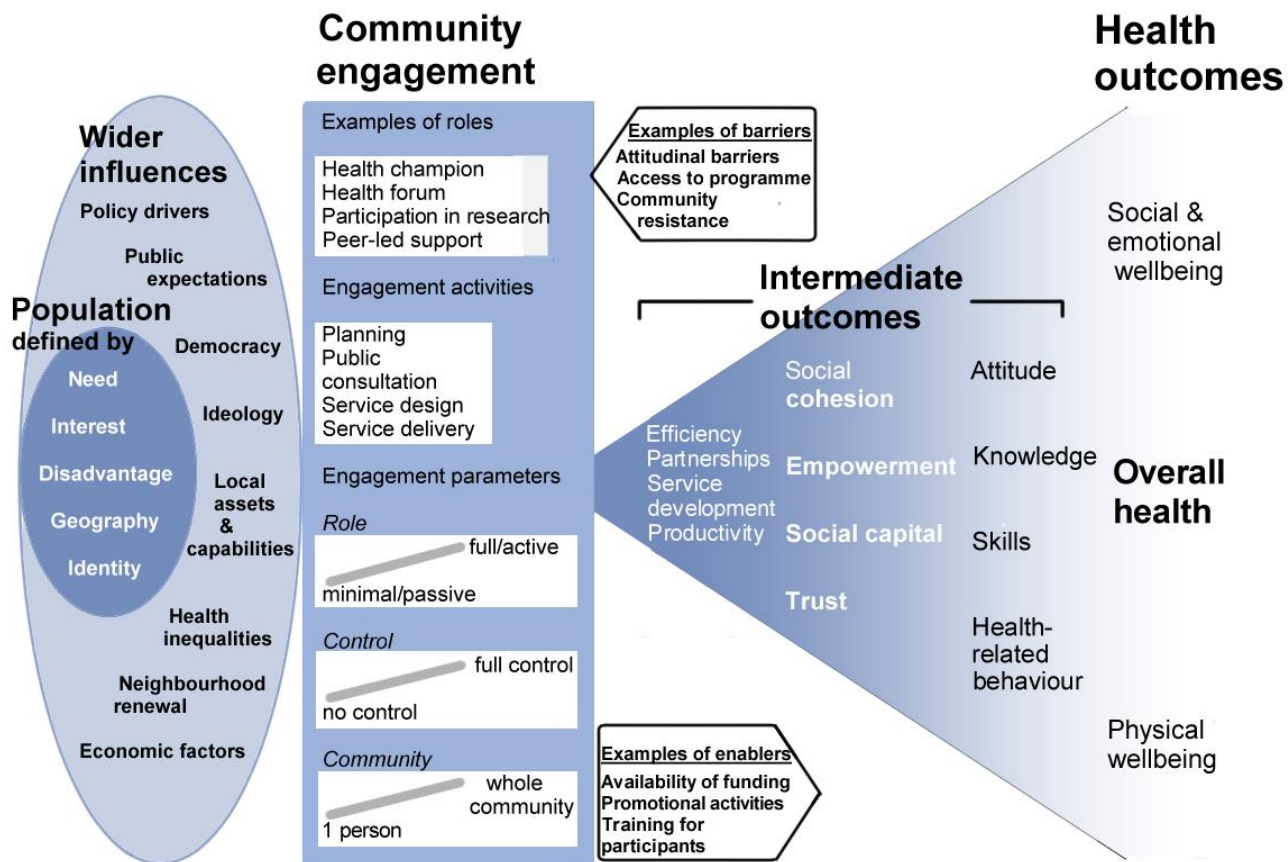


Figure 1 Logic model

### **4.3.3 Economic analysis**

It may not be practical to convert all intermediate outcomes (such as empowerment or social cohesion) into health gain outcomes, so the cost effectiveness of the approaches or methods considered may be underestimated. Also, community engagement approaches may have a net benefit for the whole community but, when aggregated across individuals, may lead to disbenefits for a particular subgroup. For example, some community engagement activities may improve the health of wealthier members of the community but not those who are poorer, so exacerbating health inequalities.

## **4.4 *Status of this document***

This is the draft scope, released for consultation from 19 February until 19 March 2014. Following consultation, the final version of the scope will be available on NICE's website from 30 April 2014.

## Appendix A Potential considerations

It is anticipated that the Public Health Advisory Committee (PHAC) will consider the following issues:

- Whether community engagement is based on an underlying theory or conceptual model.
- Whether it is effective and cost effective.
- Critical elements. For example, whether the effectiveness and cost effectiveness of the approach varies according to:
  - diversity of the population (for example, in terms of people's age, gender or ethnicity)
  - status of the person delivering it and the way it is delivered
  - its frequency, length and duration, where it takes place and whether it is transferable to other settings
  - its intensity.
- Any trade-offs between equity and efficiency.
- Any factors that prevent – or support – effective implementation.
- Any adverse or unintended effects, for example, community resistance or general apathy caused by 'intervention overload'.
- Range and variability of current practice.
- Availability and accessibility for different groups.

## Appendix B References

Cabinet Office (2013) Community life survey: August 2012–April 2013 statistical bulletin. London: Cabinet Office

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