Community engagement: improving health and wellbeing and reducing health inequalities

NICE guideline

Draft for consultation August 2015

This guideline covers approaches to community engagement to help communities improve their health and wellbeing and reduce health inequalities.

Community engagement aims to empower people in communities to gain more control over their lives and to play a part in decisions that affect their health and wellbeing. The aim is to maximise community involvement in planning, designing, developing, delivering and evaluating local initiatives to achieve this. Activities can range from giving views on a local health issue to jointly delivering services with public service providers (co-production), or establishing community-based control of services.

Community engagement can improve people's health and wellbeing and reduce health inequalities, even if this was not the intended aim. For example, it can improve people's confidence and may lead to people socialising or helping each other more.

Who is it for?

Providers of health and social care and services affecting the wider determinants of health such as housing, education, business and law and order. It will also be useful for those who commission, lead or scrutinise these services. This includes community and voluntary sector organisations.

This guideline contains the recommendations, context, the Guideline Committee's discussions and recommendations for research. For details of

the evidence, see the evidence reviews.

Other information about how the guideline was developed is on the project page on our website. This includes the scope, and details of the Committee and any declarations of interest.

This guideline will update and replace NICE guideline PH9 (published February 2008).

1

Contents ..... Error! Bookmark not defined.

Recommendations

Using NICE guidelines to make decisions explains how we use words to show the strength of our recommendations, and has information about safeguarding, consent and prescribing medicines.

1.1 Overarching principles of good practice

1.1.1 Adopt processes to ensure local communities, community and voluntary sector organisations and statutory services work in partnership to plan, design, develop, deliver and evaluate (co-produce) health and wellbeing initiatives. These processes should:

- Recognise the value of the knowledge, skills and experiences of all partners.
- Help partners share their knowledge, skills and experience.
- Make each partner's goals for community engagement clear.
- Respect the rights of local communities not to get involved.
- Promote social networks and the exchange of information and ideas (such as different cultural priorities and values).
- Make it clear how all partners work together.

1.1.2 Allow sufficient time and resources to implement a comprehensive community engagement approach. Building relationships, trust, commitment and capacity across communities and statutory organisations is likely to be a gradual process.

1.1.3 Support and promote sustainable community engagement by identifying and working with existing and new community networks and organisations, particularly those reaching vulnerable groups.

1.1.4 Encourage local communities to get involved in as many stages of the health and wellbeing initiative as possible. For example:

- Ensure decision-making and steering groups include members of the local community who reflect the diversity of that community.
- Listen to and act on community preferences and take account of changes over time.

1.2 Developing the local approach to community engagement

The following recommendations are for directors of public health and other strategic leads.

1.2.1 Develop a community engagement approach as an integral part of all health and wellbeing initiatives. Follow the principles of good practice, see section 1.1 and:

- map the assets (skills, knowledge, networks) and facilities on offer in the local community
- think about how to build on and develop these assets as part of the joint strategic needs assessment
- think about how the approach can meet statutory obligations.

1.2.2 Identify and support local communities to get involved in local health and wellbeing initiatives. Address health inequalities by ensuring communities at risk of poor health, or their representatives, are involved. This includes people who are vulnerable, marginalised, isolated or living in deprived areas.

1.2.3 Identify and work with communities to establish processes to ensure they can fully participate in health and wellbeing initiatives. Put mechanisms in place to monitor and evaluate the community engagement approach (see recommendation 1.7).

1.2.4 Encourage and support local organisations to build the principles of good practice for community engagement into their work. (see section 1.1).

1.2.5 Ensure service providers are contractually obliged to work in partnership with relevant communities to support development and delivery of the service.

1.2.6 Ensure services reflect the results of engagement of local communities (for example, in how they are designed or targeted).

1.2.7 Ensure mechanisms are in place to monitor, evaluate and report on engagement with the relevant communities.

1.3 Collaborations and partnerships

1.3.1 Develop collaborations and partnerships to encourage communities to take part in local initiatives to improve their health and wellbeing and reduce health inequalities

1.3.2 Use local networks, partnerships and community or voluntary organisations to develop a partnership approach to engaging communities.

1.3.3 Choose recognised models for collaborations and partnerships based on local needs and priorities. These include:

- Asset-based approaches to engage the local community in developing and establishing health and wellbeing initiatives.
- Community development approaches to address health inequalities, by ensuring communities at risk of poor health can identify their needs and take action together to tackle the root causes.
- Community-based participatory research to provide ongoing training for community participants and statutory sector staff working in partnership to collect information to use to improve health and wellbeing.
- Area-based initiatives to develop a sustainable, community-wide community engagement approach as an integral part of all local health and wellbeing initiatives.

- Co-production methods to ensure a balance of representatives from statutory organisations and the local community.

For more details, see the Implementation section and A guide to community-centred approaches for health and wellbeing (Public Health England).

1.4 Peer and lay roles

1.4.1 Develop lay or peer support interventions that reflect local needs and priorities to establish better links between professionals and the local community.

1.4.2 Consider using community health champions or other local representatives to talk to marginalised or vulnerable groups about getting involved (outreach).

1.4.3 Draw on the knowledge of local communities to identify and recruit people to take on peer or lay roles to support health and wellbeing initiatives. Options include:

- Bridging roles to determine which communication channels would work best to get local people involved.
- Peer interventions to plan a series of learning activities to gradually build on local skills .
- Volunteer health roles to listen to and act on local preferences and take account of changes over time .

1.4.4 Offer training and mentoring support to people in a peer or lay role. Also consider providing formal recognition of their contribution. This could include, for example, training accredited by the Royal Society for Public Health.

1.4.5 Consider offering local people in peer or lay roles wider opportunities for involvement in community collaboration and partnership.

1.5 Making it as easy as possible for local people to get involved

1.5.1 Draw on the knowledge and insight of the local community to decide which communication channels would work best as a way of getting local people interested and involved. Possibilities include:

- Putting posters up in local shops, community halls and local restaurants.
- Using local groups, workshops, cultural festivals and community events for children and families to talk to local people about the initiative.
- Advertising using online community forums, events listings and other social media channels.
- Leafleting the local neighbourhood.

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

- Involving peer or lay workers and volunteers.
- Providing information in plain English and locally spoken languages for non-English speakers. This could include encouraging members of the community who speak community languages to get involved in translating the information.
- Ensuring the timing of events meets local people's needs.
- Establishing the requirements for participants with disabilities. For example, using venues that are accessible for people with disabilities and having hearing loops for those who need them.
- Providing childcare support, such as crèche facilities.
- Using places familiar to community participants and creating an informal atmosphere.
- Helping them meet mandatory requirements, for example, to get disclosure and barring service checks where necessary.

Terms used in this guideline

Collaborations and partnerships

For this guideline, collaborations and partnerships are alliances between community members and others to improve health and wellbeing and reduce health inequalities. They may include community and voluntary organisations and statutory services. See 'collaborations and partnerships' and 'strengthening communities' approaches in A guide to community-centred approaches for health and wellbeing (Public Health England).

Community engagement

For this guideline, ‘community engagement’ encompasses a range of approaches to maximise the involvement of local communities in local initiatives to improve their health and wellbeing and reduce health inequalities. This includes: planning, design, development, delivery and evaluation. These initiatives will be developed and run by statutory organisations in partnership with local communities. Ideally, community representatives work as equal partners, and power is shared with, or delegated to, them.

Initiatives

In this guideline, initiatives covers all strategies, programmes, services, activities, projects or research that aim to improve health and wellbeing and reduce health inequalities.

Peer or lay roles

For this guideline, 'peer and lay roles' includes any role where somebody seeks to use their empathy and understanding of a community to support initiatives to improve health and wellbeing. The role may be paid or unpaid. See 'volunteer and peer roles' approaches in 'A guide to community-centred approaches for health and wellbeing'.

Implementation: getting started

NICE is working with the Committee to identify areas in this draft guideline that could have a big impact on practice and be challenging to implement. If

the draft recommendations are not changed after consultation we think the following 3 areas may pose the most significant challenges for implementation:

- resourcing
- learning and training
- monitoring and evaluation.

During consultation please let us know if you agree with these choices or if you would choose other areas of the draft guideline to focus on.

We would also like you to send us your suggestions on how these challenges (or others you may identify) could be met. For example, this might include examples of good practice, or existing educational materials or other relevant resources that you have found useful.

In addition, we would welcome details of successful community engagement projects that we could draw upon to provide brief examples of the type of action we are advocating in draft recommendations 1.3 and 1.4.

Please use the stakeholder comments form to send us your comments and suggestions. We will use your responses to create a targeted implementation section in the final guideline.

Challenges for implementation

The Context section has more details on current practice.

Identifying the resources needed

When supporting local community engagement activities, it may be helpful to:

- Work in partnership with community and voluntary organisations and groups to help identify funding requirements, sources and resources.
- Provide support to help them make funding applications for community engagement activities or any related evaluation.
- Ensure staff involved in health and wellbeing initiatives are allocated specific time for community engagement work.

- Recognise that volunteers may need to be paid expenses so that their participation does not leave them out of pocket.

Learning and training

All those involved in local health and wellbeing initiatives may benefit from shared learning or training to support community engagement. This could include:

- Helping them to continually share their learning, knowledge and experiences throughout the initiative. For example, by setting up networks and forums between different communities – and between and within those communities and statutory sector staff.
- Working in partnership with community and voluntary organisations and groups to plan a series of learning and developmental activities for the community participants. The aim would be to gradually build on local skills.
- Training local people to become health champions and volunteers.
- Providing ongoing training for community participants and statutory sector staff working in partnership to improve health and wellbeing.
- Providing joint training and opportunities for shared learning for community participants and statutory sector staff working in partnership to improve health and wellbeing. Topics might include:
  - community development and health
  - empowering people to be involved in decisions that may influence their health and wellbeing
  - organisational change and development
  - communication and negotiation skills
  - volunteer management
  - partnership working and accountability
  - safeguarding
  - business planning and financial management
  - participatory research and evaluations
  - UK policy context for community engagement
  - barriers and facilitators to statutory sector and community organisation partnerships.

Evaluation

To support ongoing monitoring and evaluation of local health and wellbeing initiatives and to encourage joint development between strategic leads and the local community it may be helpful to:

- Involve community members in planning, designing and implementing an evaluation framework for health and wellbeing initiatives.
- Routinely evaluate community engagement activities to see what impact they have on health and wellbeing and health inequalities, including any unexpected effects. Local, regional or national bodies may be able to provide advice on evaluation (for example, on the availability and use of validated tools).
- Use a range of indicators to evaluate not only what works but in what context, as well as the costs and the experiences of those involved. For example, indicators might include measures of social capital, health and wellbeing in addition to indicators identified by the community.
- Identify and agree process and output evaluation objectives with members of the target community and those involved in running it.
- Provide regular feedback to the communities involved (including people and groups outside the target community) about the positive impact of their involvement and any issues of concern.
- Find ways to record, share and publish local evaluations with other statutory organisations that commission, set up and manage initiatives to improve health in partnership with local communities. This includes initiatives to tackle the wider determinants of health.
- Document and record learning and any insights into community needs and norms to develop future ways of involving communities in health and wellbeing initiatives. Information could be fed back to strategic leads for approaches to be amended as necessary.

Context

Since 'Community engagement: approaches to improve health', NICE guideline PH9 (2008) was published there has been a substantial increase in

the evidence on how community engagement can improve health and wellbeing.

In addition, there has been increasing recognition that the NHS and local government cannot improve people's health and wellbeing on their own. It has become clear that working with communities will lead to services that better meet local people's needs and provide better health and wellbeing outcomes or reduce inequalities.

The Localism Act 2011 introduced ‘new rights and powers for communities and individuals’ to shape services.

The Health and Social Care Act 2012 stipulated that clinical commissioning groups and NHS England must commission services that promote the involvement of people and carers in decisions relating to their health.

The Public Services (Social Value Act) (2012) encourages greater collaboration between communities and statutory public sector organisations to improve economic, social and environmental wellbeing. It means all local authorities have a duty to inform, consult and involve the public in the delivery of services and decision-making.

Five year forward view (NHS England) argues for a closer relationship between statutory services and communities by finding ways to get the voluntary sector involved in promoting health and wellbeing. The strategy recognises that without actively involving those most affected by inequalities, the health and wellbeing gap in England is unlikely to narrow.

But the Community life survey for 2013/14 (Cabinet Office) shows there has been a decline in formal volunteering since 2012/13. The number participating in local consultations and other civic activities at least once in the past year has also decreased. Levels of participation generally decrease as the level of local deprivation increases (‘Community life survey’).

This update reflects the importance of reciprocal relationships. It aims to strengthen partnerships and establish better links between statutory

organisations and local communities so they can work effectively together to deliver health and wellbeing initiatives.

The Committee's discussion

Background

Community engagement is a highly complex area with several important purposes. These include empowering people within communities to gain more control over their lives and to play a part in decisions that affect their health and wellbeing.

The focus of community engagement in this guideline is to maximise involvement of local communities in the planning, design, development, delivery and evaluation of local initiatives to improve health and wellbeing and reduce health inequalities. In this guideline 'initiatives' covers all strategies, programmes, services, activities, projects or research that aim to improve health and wellbeing and reduce health inequalities.

The Committee noted that community engagement can be an end in itself, leading to a range of important health-related and social outcomes, such as improved self-confidence, self-esteem, social networks and social support.

Local authorities have considerable experience in the area of community engagement. However, the evidence-based recommendations in this guidance could help strengthen their relationships with the communities they serve, and aid delivery of health and wellbeing initiatives.

The Committee noted the importance of not seeing communities simply as recipients of health and social care services but rather, as active participants with a vital contribution to make to improving health and wellbeing.

The Committee was aware that many statutory organisations are looking for new ways to get local communities involved in activities to improve their health and wellbeing and to tackle the wider determinants of health. For example, agencies involved with tackling crime and providing housing and education. But members were concerned that these well-intentioned activities

will only be effective if properly planned, designed, implemented and resourced.

The Committee recognised there are running costs associated with engaging local communities in health and wellbeing initiatives. Whether peer or lay roles are paid or unpaid is a local decision. However the Committee recognised that unpaid roles are not 'free'. For example, volunteers will require their expenses to be paid and they may require training.

The Committee recognised the difficulties small community and voluntary organisations face in getting funding from local and non-governmental organisations. It also recognised that they need other help to get involved (this includes training and resources).

The Committee was aware that many public health workers, including community development workers, are highly skilled in working with economically or geographically disadvantaged communities to bring about social change and improve their quality of life.

Community engagement activities and approaches

The Committee recognised that many successful community engagement activities are being undertaken across the country. This guideline aims to highlight effective practices and processes.

Various terms and conceptual frameworks are used for community engagement. But the Committee agreed that A guide to community-centred approaches for health and wellbeing (Public Health England) provides a useful framework for understanding how different approaches work and for deciding on the most appropriate activities to use locally.

Members noted the need to make community engagement an integral part of local strategies and services for health and wellbeing and discussed the need for resources to achieve this. The Committee also discussed the benefits of an 'asset-based' approach, in which communities identify and solve issues that affect their health and wellbeing. This is in contrast to models that focus on outside agencies identifying needs and fixing problems.

The Committee was aware that when statutory bodies and communities work together they face many barriers and challenges. These will vary depending on local circumstances but may include: cultural differences; statutory agencies being unwilling to share power and control of services; lack of time for statutory organisations to develop relationships and build trust with communities; and a lack of suitable venues for community engagement activities.

The Committee acknowledged that local people may not want to get involved in community activities. Members also recognised that some people, particularly from disadvantaged communities, may need help to participate. This involves overcoming barriers such as having English as a second language.

The Committee noted that if disadvantaged communities have well established social networks, a 'bridge' is needed between these and other networks run by community and statutory organisations.

Equalities

The Committee recognised the importance of ensuring a fair allocation of resources to local community engagement activities to benefit people and communities most at risk of poor health.

The Committee noted that most evidence on community engagement came from studies of interventions to promote health among disadvantaged communities. But it also recognised that looking at populations in isolation may not reflect the dynamics of how communities interact to improve their health and wellbeing.

Internet-based social media is becoming a commonplace means of communication and sharing information among ‘virtual communities’ and it is a potentially efficient way of helping people to get involved. But the Committee flagged that using social media could also increase health inequalities.

Evidence

Over recent years, there has been a significant increase in published evidence on community engagement. There is also a growing informal evidence base about what people are doing in practice. But the latter is difficult to capture and formally evaluate.

There is good evidence that community engagement improves health and wellbeing. A recent review (Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis 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'.

There was good evidence from the effectiveness reviews and expert papers that 'collaborations and partnerships' and 'peer/lay roles' are effective approaches to involving communities in local health and wellbeing initiatives.

It was not possible for the Committee to draw specific conclusions on which community engagement models within each approach should be recommended for a particular population in a particular set of circumstances. However, the reviews present evidence of potential options within each approach.

Evidence on the use of social media came from a search strategy designed to find studies about community engagement, not online social media or social networks. The Committee was unable to make a recommendation on these approaches due to the resulting lack of evidence. But members agreed to make a research recommendation on the use of social media to further explore this method of engagement (see recommendation for research 3).

There was evidence that different approaches are used to target different types of health or wellbeing issues. Peer or lay roles were most often used in initiatives targeting individual behaviour change (such as physical activity, healthy eating or substance misuse). Collaborations and partnerships were

more often used in initiatives focused on community wellbeing, improving social capital or making use of community assets.

The effectiveness reviews revealed variation in how much local people were involved in health projects, from early development through to delivery and evaluation. This variation provided an opportunity to indirectly compare the effects of different levels of engagement across studies: generally, the more stages of a project local people were involved in, the greater the benefits.

Based on this evidence, the Committee made no recommendations on using consultation approaches alone to get communities involved in health and wellbeing initiatives. There was good evidence from expert papers that communities who received local services driven by statutory priorities were less empowered to contribute to local decisions over time than communities who worked in partnership with statutory services (see Expert paper 4).

There was good evidence from the effectiveness reviews that community engagement activities lead to more than just traditional improvements in health and behaviour. For example, they also improve people's social support, wellbeing, knowledge and self-belief. The Committee agreed that these wider outcomes need to be taken into account. Members also agreed that future research should place greater emphasis on individual and community wellbeing and these kinds of social outcomes.

Studies of community engagement activities and processes did not always exactly describe the populations involved and the actions being taken. This proved a challenge when trying to interpret which components of an activity were linked to successful outcomes.

The Committee highlighted the complex nature of the evidence. In particular, members pointed to the inter-relationships between inputs and outputs. They also pointed to the problems involved in making direct comparisons of initiatives that differed in many ways – and not only in the community engagement approach adopted.

In addition, the Committee recognised that some of the wider health outcomes – such as empowerment and social capital – were important in their own right. That is to say, such outcomes should not be treated as 'intermediate' in a simple linear causal chain between the 'intervention' (that is, the community engagement approach) and the recipients (that is, the local population).

In the absence of a method to capture a more complex system, with outcomes occurring at individual and community level, the Committee agreed that the economic analysis would oversimplify the scope of community engagement activities and outcomes. The Committee also noted that the benefits that communities themselves may value, such as gaining a sense of belonging and empowerment, or expanding their social networks and support, may often be overlooked in formal evaluations.

To overcome this, the Committee made recommendations on involving communities at every stage of the evaluation process.

The effectiveness reviews focused on context-specific evidence from Organisation for Economic Cooperation and Development (OECD) countries. This meant that evidence from non-OECD countries and qualitative evidence from outside the UK was not included in the evidence reviews. So potentially effective or innovative approaches – along with any findings – from other sociocultural settings applicable to the UK may have been missed.

The Committee noted that volunteers play a valuable role in community engagement activities to improve health. But members also recognised that community organisations do not always have the resources to support volunteers and there was not enough evidence to make a recommendation on how this support could be provided.

Health economics

The Committee recognised the opportunity costs of prioritising community engagement activities over other public health activities. Members also valued the wider health benefits of community engagement, such as improved social support and social networks, wellbeing, knowledge and self-belief. In addition,

they recognised the indirect benefits, in terms of increasing participation in other healthcare and welling programmes.

The Committee noted significant challenges in attempting to assess the cost effectiveness of community engagement approaches. These include problems:

- identifying comparators
- measuring benefits
- costing activities
- attributing changes in the community to the approaches deployed.

The cost effectiveness evidence identified in the literature reviews was mixed and difficult to interpret. So it was supplemented with several bespoke cost–consequence analyses and a rapid review of relevant social return on investment studies.

The Committee considered that a cost–consequence analysis was the most appropriate type of economic analysis, given the wide range of outcomes relevant to community engagement.

The Committee also agreed that evidence on the social return on investment analysis should be considered because it is used to analyse ‘value’ beyond the financial cost (although some of the value it captures may have been paid for). Just as importantly, social return on investment aligns well with the concept of community engagement as: ‘the process of getting communities involved in decisions that affect them’ (see NICE guideline PH9 [published February 2008]).

The evidence reviews identified a range of different activities and interventions. The interventions selected for cost–consequence analyses represented the different types of approach identified in the original Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI) review ('Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis').

As with any economic analysis undertaken during guideline development, the results are subject to uncertainty and numerous assumptions. In terms of its impact on health and wellbeing, members considered that community engagement is probably cost effective. But they highlighted the need for better research on cost effectiveness and that this should include any associated opportunity costs.

Based on all the evidence presented, the Committee is confident that community engagement offers economic benefits for communities.

Evidence reviews

Details of the evidence discussed are in the evidence reviews. The evidence statements are short summaries of evidence, in a review, report or paper (provided by an expert in the topic area). Each statement has a short code indicating which document the evidence has come from.

Evidence statement number 1.1 indicates that the linked statement is numbered 1 in review 1. **Evidence statement number 2.3.1** indicates that the linked statement is numbered 3.1 in review 2. **Evidence statement** ER1 indicates that expert report 1 is linked to a recommendation. EP1 indicates that the linked statement is numbered xx in expert paper 1. **Evidence statement** PR1 indicates that primary research report 1 is linked to a recommendation.

If a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

Recommendation 1.1.1: evidence statements 1.1.; 1.2; 1.3; 2.1; 2.3.1; 2.4; 2.5, 5.2.3; 5.2.5; 5.3.1; 5.3.2; 5.3.11; 5.3.14, 5.3.15; 5.5.4; 5.6.2; PR1; ER1; EP1; EP2; EP3; EP4

Recommendation 1.1.2: evidence statements 2.3.1, 5.1.4, 5.2.1, 5.3.3, 5.3.6, 5.3.14; PR1

Recommendation 1.1.3: evidence statements 1.1.3, 1.4–1.13, 2.2.3, 2.3.1, 5.5.4; PR1; EP2, EP4

Recommendation 1.1.4: evidence statements 1.1, 1.2, 1.3, 2.1, 2.3.1, 2.4, 2.5; PR1; EP2, EP4

Recommendation 1.2.1: evidence statements 5.3.9; PR1; EP3

Recommendation 1.2.2: evidence statements 1.1–1.13, 2.1, 2.2.3, 2.3.1, 5.3.5, 5.3.9; PR1; ER1, EP1, EP2, EP3, EP4

Recommendation 1.2.3: evidence statements 1.1–1.13, 2.1, 2.2.3, 2.3.1, 5.3.5, 5.3.9; PR1; ER1, EP1, EP2, EP3, EP4

Recommendation 1.2.4: evidence statements 1.1–1.13, 2.1, 2.2.3, 2.3.1, 5.3.5, 5.3.9; PR1; ER1, EP1, EP2, EP3, EP4

Recommendation 1.2.5: evidence statements 1.1, 1.2, 1.3, 2.3.1, 5.3.10; EP3

Recommendation 1.2.6: evidence statements 1.1, 1.2, 1.3, 2.3.1, 5.3.10; EP3

Recommendation 1.2.7: evidence statements 1.1, 1.2, 1.3, 2.3.1, 5.3.10; EP3

Recommendation 1.3.1: evidence statements 1.1, 1.2 1.3, 2.3.1, 2.4, 2.5, 4.5, 5.3.12; PR1; ER1, EP1, EP2, E3, EP4

Recommendation 1.3.2: evidence statements 2.3.1, 5.5.4, 5.5.5; PR1; IDE

Recommendation 1.3.3: evidence statements 5.5.5; PR1; EP1

Recommendation 1.4.1: evidence statements 4.5, 5.5.4, 5.5.5; PR1; ER1, EP1, EP2, EP3

Recommendation 1.4.2: evidence statements 2.3.1, 5.1.4, 5.5.6; PR1; IDE

Recommendation 1.4.3: evidence statements 2.3.1, 5.5.4, 5.5.5; PR1; EP1, EP2; IDE

Recommendation 1.4.54: evidence statements 2.3.1, 5.4.3, 5.4.6; PR1; EP2

Recommendation 1.4.5: PR1; IDE

Recommendation 1.5.1: evidence statements 1.5.1, 2.3.1, 5.5.3, 5.5.5, 5.6.6; PR1; EP2

Recommendation 1.5.2: evidence statements 5.2.2, 5.5.1, 5.5.2, 5.6.2, 5.6.3, 5.6.4, 5.6.5, 5.6.7, 5.6.8, 5.6.9; PR1; EP2

Gaps in the evidence

The Committee identified a number of gaps in the evidence related to the initiatives under examination based on an assessment of the evidence. These gaps are set out below.

1. Studies of effectiveness of collaborations and partnerships involving older people.

(Source: evidence review 1)

2. Studies of effectiveness of collaborations and partnerships that address reproductive health, parenting or violence prevention.

(Source: evidence review 1)

3. Studies that identify and evaluate the components of community engagement.

(Source: evidence reviews 1, 2 and 3)

4. Studies of effectiveness and cost effectiveness that compare using community engagement with not using this approach.

(Source: evidence review 1)

5. Studies of community engagement in a rural environment.

(Source: evidence review 4; primary research report 1)

6. Studies that outline the unintended or harmful effects of community engagement.

(Source: evidence review 4)

7. Studies on the needs of newly established communities, such as economic migrants, asylum seekers and refugees.

(Source: primary research report 1

8. Studies of community engagement approaches that have failed.

(Source: primary research report 1)

9. Studies on the comparators to use in a community engagement study.

(Source: evidence review 1; evidence review 7)

Recommendations for research

The Guideline Committee has made the following recommendations for research.

1 Effectiveness and cost effectiveness

How effective and cost effective are community engagement approaches at improving health and wellbeing and reducing health inequalities?

Why this is important

Community engagement is known to improve health and wellbeing and reduce inequalities. However, evidence on the effectiveness and cost effectiveness of different approaches is limited and of poor quality.

It is not clear which logic models and theories of change can be used to evaluate the impact on health and wellbeing. It is also unclear which methodologies could be used to explore whether changes in health and wider outcomes can be attributed to the community engagement approach used.

Studies are needed that use combined impact and process evaluations and measure both health and non-health (such as social) outcomes, as well as outcomes defined by the communities.

2 Collaborations and partnerships

What are the components of collaborations and partnerships between local people, communities (including community representatives, such as peers) and organisations that lead to improved health and wellbeing?

Why this is important

Effective collaborations and partnerships are fundamental for community engagement and associated improvements in health and wellbeing and to reduce health inequalities.

Studies are needed to determine the key components of an effective partnership and what makes for a successful partnership between different groups. There is also a lack of evidence on how these components affect the wider determinants of health (such as social support and empowerment).

3 Social media

How effective are online social media and other online social networks at improving health and wellbeing and reducing health inequalities when they are used:

- as a method of community engagement?
- to support an existing community engagement approach?

Why this is important

Social media is a potentially useful way to engage communities. But there is a lack of evidence on how effective it is at reaching different audiences and delivering initiatives. In particular, there's a lack of evidence on how its use compares with face to face approaches. In addition, it is not clear whether or not its use could have an impact on health inequalities.

4 Prioritising resources

How can communities prioritise resources for local health and wellbeing initiatives and does prioritising particular approaches or activities impact on the wider determinants of health (such as social outcomes)?

Why this is important

There are limited resources available to support community engagement and so particular approaches may be adopted. It is important to ensure that prioritising the use of certain approaches over others does not increase inequalities in health.

5 Community engagement: wider outcomes

How effective and cost effective is community engagement as a positive endpoint in itself in relation to wider outcomes for example, increased social capital, capacity and empowerment?

Why this is important

The evidence has focused mainly on health outcomes, but community engagement may have wider implications for wellbeing. Research to evaluate the full impact of community engagement could feed into strategies to tackle health inequalities more broadly.

Update information

This guideline is an update of NICE guideline PH9 (published February 2008) and will replace it.

See the original NICE guideline and supporting documents.

Glossary

Area-based initiatives

Publicly-funded initiatives that focus on geographic areas of social or economic disadvantage. They aim to improve a community's quality of life and

their future opportunities. An example of an area-based initiative is the New Deal for Communities (see expert paper 4).

Assets

Assets refers to community resources that can be used to improve the quality of life for local people. For example, local skills, knowledge, talents and capacity, and family and friendship networks.

Asset-based approaches

Ways members of the local community can identify local assets to help solve issues affecting their health and wellbeing – rather than statutory organisations identifying the community's needs and fixing their problems. An asset-based approach was used, for example, to help a group of travellers identify how they could improve their own education, employment opportunities and health and wellbeing.

Bridging roles

A 'bridging' role is carried out by local people, usually working as community health champions or community health workers. They tell people where to find health and other services, or give them information to help them improve their health and wellbeing. An example is the use of community health champions to increase awareness of the importance of national screening programmes for cervical, breast and bowel cancer among local people from minority ethnic communities.

Communities

A community is a group of people who have common characteristics or interests. Communities can be defined by: geographical location (such as a hostel, street, ward, town or region), race, ethnicity, age, occupation, a shared interest or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage.

Community-based participatory research

Research that establishes partnerships between communities and academic researchers to help communities participate as equal partners in research to

improve their health and quality of life. For example, it has been used to work with migrant African communities to help control the spread of tuberculosis.

Community development approaches

Approaches that help community members identify local people's concerns and priorities, feed these into statutory organisation processes and involve them in developing potential solutions. Community development approaches have been used to develop effective relationships between statutory organisations and communities in areas of deprivation.

Community health champions

Volunteers who, with training and support, help improve the health and wellbeing of their families, communities or workplaces. They do this by: motivating and empowering people to get involved in healthy social activities; creating groups to meet local needs; and directing people to relevant support and services.

Co-production

Co-production is the process whereby people who use services work alongside professionals as partners to design and deliver those services. An example is a project where steering groups have been established between frontline service providers and residents to help improve the local neighbourhood.

Peer support workers

Peer support workers provide advice, information and support, and organise health and wellbeing activities for people from communities sharing similar characteristics (such as age group, ethnicity or health condition).

Peer interventions

Interventions led by peer educators or peer support workers who may share similar social backgrounds or life experiences. An example is a community mentoring service for socially isolated older people.

Social capital

Social capital is the degree of social cohesion in communities. It refers to the interactions between people that lead to social networks, trust, coordination and cooperation for mutual benefit.

Volunteer health roles

Volunteers who are supported to help run health-promoting activities that often focus on reducing health inequalities. Examples include: walking for health or befriending schemes.