National Institute for Health and Care Excellence Review 4: Community engagement – approaches to improve health: map of the literature on current and emerging community engagement policy and practice in the UK

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Conflicts of interest

Professor Jane South was a member of the NICE Public Health Advisory Committee (PHAC) developing the community engagement guideline and was seconded to Public Health England to develop the family of community centred approaches during development of the guideline. There were no other conflicts of interest in the writing of this report.

Contributions

The opinions expressed in this publication are not necessarily those of Leeds Beckett University or of the funders (NICE). Responsibility for the views expressed remains solely with the authors.

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Contents

Glossary

Asset-based approaches

An asset based approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital (Glasgow Centre for Population Health, 2011).

Community engagement

The direct or indirect process of involving communities in decision making and/ or in the planning, design, governance and delivery of services, using methods of consultation, collaboration and/ or community control (O'Mara-Eves et al. 2013)

Community mobilisation/ action

A capacity building process, through which communities plan, carry out and/ or evaluate activities on a participatory and sustained basis to achieve an agreed goal. Includes community development and asset based approaches.

Community development

A process where community members come together to take collective action and generate solutions to common problems (United Nations 1995[1])

Community organisations

New and existing service development; connecting people to community resources and information.

Extent of community engagement

Taken from Stream 1 (Brunton et al. 2014): HIGH if level of CE = HIGH in all 3 of design, delivery and evaluation; MODERATE if level of CE = HIGH in 2 out of 3 of design, delivery and evaluation; LOW if level of CE = HIGH in 0 or 1 out of 3 of design delivery or evaluation.

Level of community engagement

Taken from Stream 1 (Brunton et al. 2014), for each of design, delivery and evaluation: Community members leading or collaborating = HIGH; Community members consulted or informed = LOW

Mining

In this review, this refers to screening reference lists of relevant systematic reviews to find further primary studies that may meet the review inclusion criteria. These are then retrieved as full text and screened for inclusion.

[1] http://unterm.un.org/DGAACS/unterm.nsf/8fa942046ff7601c85256983007ca4d8/526c2eaba978f007852569fd00036819?OpenDocument

Mixed methods evaluation

An evaluation that uses both quantitative methods (e.g. questionnaires) and qualitative methods (e.g. interviews).

Non-peer health advocacy

Possible roles are similar to those under “peer involvement” but involve members of the community that are not peers of the target participants.

Peer involvement

Peers are defined as people sharing similar characteristics (e.g. age group, ethnicity, health condition) who provide advice, information and support and/ or organise activities around health and wellbeing in their or other communities. Can include “bridging roles” (e.g. health trainers, navigators) or peer-based interventions (e.g. peer support, peer education and peer mentoring).

Public health

All organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases (World Health Organisation)

Social capital

The disposition to create, develop and maintain networks that may be used for the purpose of social integration (The Social Capital Foundation)

Social exclusion

Social exclusion is a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole' (Levitas et al., 2007)

Social networks

Explicit use of the term in study reports. Community mobilisation/ action approaches could use social networks (e.g. time banks).

Targeted approaches

Eligibility and access to services are determined by selection criteria, such as income, health status, employment status or neighbourhood (National Collaborating Centre for Determinants of Health, 2013).

Universal approaches

Eligibility and access are based simply on being part of a defined population such as all women, all children under age six, or all people living in a particular geographic area, without

any further qualifiers such as income, education, class, race, place of origin, or employment status (National Collaborating Centre for Determinants of Health, 2013).

Volunteers

Used when this term is explicitly used in study reports. Peer and non-peer roles could involve volunteers but may not be explicitly labelled as such.

Abbreviations

CE	Community engagement
CBPR	Community based participatory research
CRD	Centre for Reviews and Dissemination, University of York
DARE	Database of Abstracts of Reviews of Effects
DOPHER	Database of Public Health Effectiveness Reviews
TROPHI	Trials of Public Health Interventions database
CPH	Centre for Public Health
NICE	National Institute of Health and Care Excellence
PHAC	Public Health Advisory Committee
PPI	Patient and Public Involvement
HTA	Health Technology Assessment
NIHR	National Institute of Health Research
EPPI-Centre	Evidence for Policy and Practice Information and Co-ordinating Centre
PCT	Primary Care Trust
RCT	Randomised Controlled Trial
C2	Connecting Communities
LTC	Long term condition

Executive summary

Background

Community engagement has been defined as the 'direct or indirect process of involving communities in decision making and/or in the planning, design, governance and delivery of services, using methods of consultation, collaboration, and/or community control' (O'Mara-Eves et al. 2013). Community engagement for health was defined in the scope for this work ((National Institute for Health and Care Excellence, 2014) as being 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 and control: for example, giving views on a local health issue, jointly delivering services with public service providers (co-production) and completely controlling 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) .

Since the publication of The National Institute for Health and Care Excellence's guidance on community engagement in 2008 (National Institute for Health and Care Excellence, 2008) there has been considerable research activity in this topic area. A recent NIHR review (O'Mara-Eves et al., 2013) which focused on community engagement for health inequalities found 319 relevant studies, and concluded that community engagement interventions "are effective in improving health behaviours, health consequences, participant self-efficacy and perceived social support for disadvantaged groups".

The Centre for Public Health at NICE are now updating the 2008 guidance, and this update includes three streams of evidence:

Stream 1 (Reviews 1, 2 and 3): Community engagement: a report on the current effectiveness and process evidence, including additional analysis.

Stream 2 (Reviews 4 and 5 and Primary Research Report 1): Community engagement: UK qualitative evidence, including one mapping report and one review of barriers and facilitators.

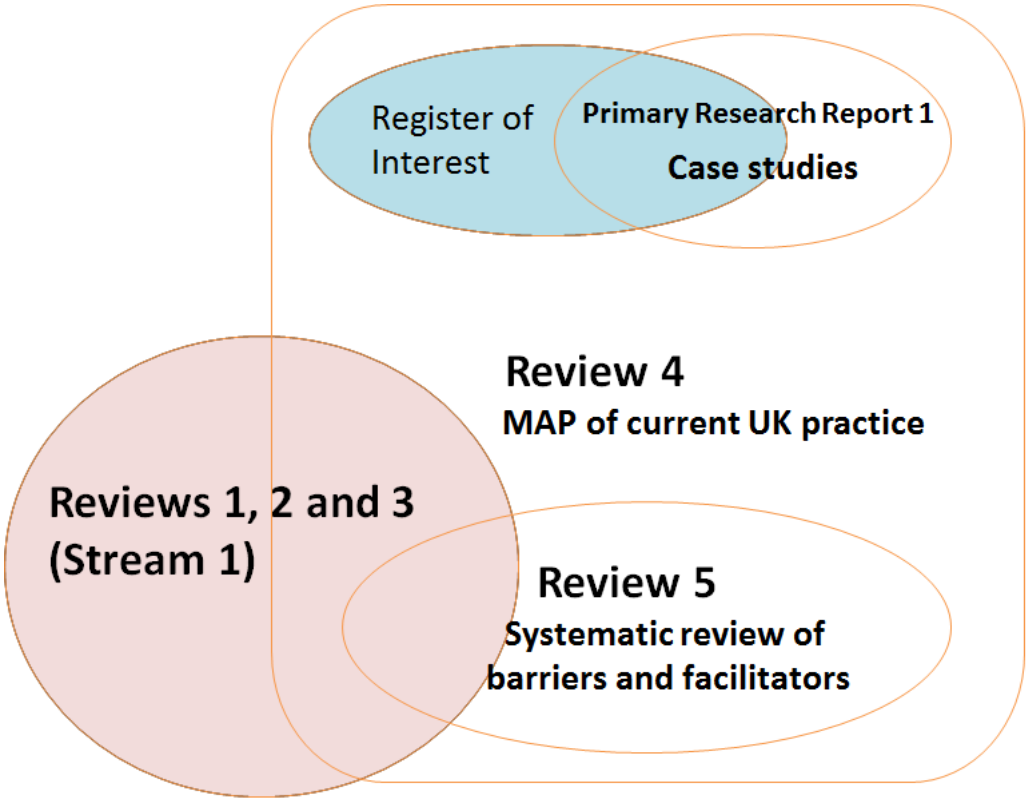
Stream 3: An economic analysis (Reviews 6 and 7).

Stream 2 includes three components:

> *Review 4*: a map of the literature on current and emerging community engagement policy and practice in the UK.
>
> *Primary Research Report 1*: a map of current UK practice based on a case study approach. This consists of a series of six case studies of current or recent community engagement projects;
>
> *Review 5*: Evidence review of barriers to, and facilitators of, community engagement approaches and practices in the UK.

Figure 1 demonstrates how Reviews 4 and 5 and Primary Research Report 1 are related to each other and to the evidence from Reviews 1-3.

Figure 1: Relationship of Stream 2 components with each other and with Stream 1.



This report is of Review 4: Community engagement – approaches to improve health: map of the literature on current and emerging community engagement policy and practice in the UK.

Aims and objectives

This mapping review provides a synopsis of the key findings from documentary analysis (including grey literature) of the current evidence base for UK local and national policy and practice for community engagement. It aims to identify, describe and provide insight into current and emerging community engagement policy and practice in the UK.

In addition to the main aim above, the review set out to address any or all of the following research questions, from the final NICE Guidance scope:

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?

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?

In terms of the research questions, as this is not a review of effectiveness, this component on its own is unable to answer any of the review questions fully. Question 3 is answered in part by Reviews 1-3, and more specific UK-focused answers will be provided by Primary Research Report 1 (case studies) and Review 5 (systematic evidence review of barriers and facilitators). Primary Research Report 1 and Review 5 will also seek to answer review questions 4 and 5.

Methods

a) Search strategy

Our search strategy was designed in collaboration with our consortium partner, the EPPI-Centre, who carried out the systematic review of effectiveness for Stream 1. Given the difficulties of identifying studies via traditional electronic database searches we focused our search efforts on

- Specialised research registers and websites;
- The pool of included and excluded studies from the recent NIHR review (O'Mara-Eves et al., 2013);
- An update of the searches from the recent NIHR review (O'Mara-Eves et al., 2013) carried out for Stream 1 which included a search of specialist systematic review websites and databases (DoPHER; DARE; the Cochrane Database of Systematic Reviews, the Campbell Library, the HTA programme website) and a search of the TRoPHI database of studies in health promotion and public health;
- The results of searches carried out for a recent review of community based interventions for Public Health England (Public Health England and NHS England, 2015);
- Mining of the reference lists of relevant systematic reviews obtained from any of these sources;
- Website searches of relevant organisations;
- Direct calls for evidence by NICE and by Leeds Beckett University via networks of contacts with community practitioners and groups.

b) Screening

Records identified from all searches were assessed by hierarchical inclusion screening. Inclusion criteria covered populations, interventions, outcomes, study design, country, date and language.

1 DATE: studies published before 2000[2] (or for policy and conceptual papers, before 2006)[3] were excluded.

[2]*Search date of 2000 onwards would capture relevant and appropriate records related to community engagement as conceived in the scoping document. The date range is informed by various legislation (e.g. The

2 COUNTRY: UK only. Studies of non-UK projects or communities or policies were excluded.

3 INTERVENTION: only studies of community engagement in public health topics were included (see glossary and Chapter 2 for working definitions)

4 STUDY DESIGN: Empirical or theoretical research, or practice descriptions, or policy documents were included. Secondary research (e.g. systematic reviews) and discussion or commentary papers that did not present empirical or theoretical research were excluded. The reference lists of systematic reviews were "mined" for relevant studies.

Records were first screened on title and abstract. The inclusion criteria were tested and refined after piloting them on a random sample of 10% of the titles and abstracts. All reviewers independently screened these records and any differences were resolved by discussion and where necessary, informed by the advice of the NICE CPH team. Further pilot screening was conducted until at least 80% agreement between reviewers was reached. Once this level of reliability was reached the remaining records were randomly divided between reviewers for single screening. All included records were marked for full text retrieval. Any disagreements were discussed or if necessary resolved by the lead researcher.

All full text studies were screened by one reviewer using the agreed inclusion criteria, with a random sample of 30% being double screened. Any disagreements were resolved by discussion and recourse to a third reviewer. Those documents that passed the inclusion criteria on the basis of full text screening were included in the review.

c) Coding

As this was a mapping review, which encompasses a wide range of evidence rather than focussing in depth on a narrower topic, data extraction was limited to coding within categories, with limited explanatory text. Quality assessment was not undertaken.

Included studies were coded by one reviewer and a random selection of 20% checked by a second reviewer, using piloted pre-agreed forms. Any disagreements were resolved by discussion with reference to the full paper and, where necessary, a third reviewer.

Coding categories included:

- Document type, summarised in this report as
    - **S = research (research or evaluation studies), or**
    - **D = non-research (conceptual papers, policy documents or practice descriptions);**

Health & Social Care Act, Section 11: Public Involvement & Consultation; Local Government Act) published at this time which generated research activity.

[3] Date chosen to avoid duplication of effort with a previous review commissioned by NICE (Popay et al. 2007) to inform the previous NICE guidance on community engagement (National Institute of Health and Care excellence 2008). Searches for that review ended in 2007; we included articles from 2006 to allow for any delays in articles being indexed on electronic databases.

- Study design (if research/ evaluation study);
- Type of community engagement (see glossary);
- Level and extent of community engagement (low, medium, high: see below);
- Name of initiative;
- Lead organisation;
- Type of activity;
- Setting;
- Targeted or universal approach;
- Health or wellbeing issues;
- Population group(s) (PROGRESS-Plus categories (Kavanagh et al., 2008))[4];
- Outcomes reported (for research/ evaluation studies only):

Level of community engagement in design, delivery or evaluation:

Taken from Reviews 1-3 (Brunton et al., 2014), for each of design, delivery and evaluation:

Community members leading or collaborating = HIGH;

Community members consulted or informed = LOW.

Extent of community engagement:

HIGH – if level of CE = HIGH in all 3 of: design AND delivery AND evaluation.

MODERATE – if level of CE = HIGH in 2 out of 3 of: design, delivery and evaluation.

LOW – if level of CE = HIGH in 0 or 1 out of: design, delivery and evaluation.

d) Synthesis

[4] The PROGRESS-plus framework highlights several social and personal dimensions that may affect health inequalities i.e.: Place of residence; Race/ ethnicity; Occupation; Gender; Religion; Education; Socio-economic position; Social capital; Other (e.g. age, disability, sexual orientation, being "looked after", etc.). Recommended by the Cochrane/Campbell Health Equity Group (Kavanagh J et al. 2008)

The key findings of the mapping review were summarised narratively in the first instance, with frequencies and proportions of documents in certain categories also being presented. The literature was mapped, grouping papers using categories from the coding process. Areas where there were multiple papers, or conversely, limited research were noted. Any findings that related directly to the research questions were noted.

Further narrative synthesis was undertaken of policy and conceptual documents.

Main findings

4441 (91% of total) records were identified through searches of electronic databases, and 456 records (9% of total) were identified from additional sources (see below), making 4897 records for initial screening. After screening 577 full text articles, 316 articles (6.5% of initial number) were included in the map.

Source: Less than half (39%, n=123) of the 316 included articles came from electronic database searches. 108 (34%) came from "mining" the reference lists of identified systematic reviews and other secondary research articles, 37 (12%) came from website searches (including our own institutions), 20 (6%) came from NICE's call for evidence, 21 (7%) from the Register of Interest, three (<1%) from citation searches carried out for Review 5 (Harden et al., 2015) and four (1.3%) came directly from Reviews 1-3 (Brunton et al., 2014).

Document type: 227 of the 316 included articles (72%) were coded as research or evaluation, 77 (24%) were coded as practice description, 40 (13%) as policy-related documents, and 30 (9%) as conceptual or theoretical papers. Articles could be coded in more than one of these categories, most commonly policy combined with practice description or research/ evaluation.

Study design: Of the 227 research or evaluation documents, the majority were coded as either mixed methods evaluation (n=90, 40%) or qualitative studies (n=88, 39%). Seventeen studies (7%) were coded as questionnaires or surveys, fifteen (7%) were randomised controlled trials, seven (3%) were before and after studies and five (2%) were non-randomised controlled trials. Twenty studies (9%) were coded as "other": the majority of these were case studies, or the methods were not described. There was some overlap between these categories, with some studies being coded as more than one study design.

Policy: There are a number of consistent themes relating to the UK policy context for community engagement and health, based on analysis of 42 policy publications*

Firstly, policy documents, reviews and commentary concerning community engagement and health can be mapped across a wide range of policy areas and sectors. These include: health policy and the NHS, local government policy and regeneration, third sector and volunteering and also health inequalities as a cross cutting policy issue. Very few publications were focused exclusively on community engagement and public health, but all related to in some way to the active participation of individuals and communities as a mechanism to improve health, community life or quality of local services or alternatively to reduce inequalities and area disadvantage.

Secondly, since 2006 there are consistent themes across government policy relating to the significance of community engagement and empowerment. The review has highlighted a number of specific policy initiatives from both Labour government 2005-2010 and the Conservative-Liberal Democrat Coalition government of 2010-2015. These include changes in patient and public involvement (PPI) structures and public involvement mechanisms affecting health planning and services; neighbourhood management, Localism aimed at devolution of power to local communities and health inequalities policy. There are also relevant policies from the devolved assemblies (Scottish Government, 2013, Welsh Assembly Government, 2008). Overall, publications relating to inequalities and community

empowerment, whether originating from government or from independent sources, like the Marmot review (Marmot, 2010), called for new relationships between services and communities that give more power to communities, enabling individuals to play a greater part in local decisions that affect their health and lives.

Thirdly, the review has identified a consistent theme around the contribution of individuals and communities to health and to society in general. Discussion and commentary cluster round various concepts which are frequently cross-referenced to each other. These include asset-based approaches, co-production and volunteering.

**(Atkinson, 2012, Barnes et al., 2008a, Blank et al., 2007, Boydell and Rugkåsa, 2007, Boyle et al., 2010, Bridgen, 2006, Communities and Local Government, 2007, Department for Communities & Local Government, 2006b, Department for Communities & Local Government, 2007a, Department for Communities & Local Government, 2007b, Department of Health, 2006a, Department of Health, 2006b, Department of Health, 2007a, Department of Health, 2008b, Department of Health, 2008a, Department of Health, 2009a, Department of Health, 2010, Department of Health, 2012a, Department of Health, 2012b, HM Government, 2007, HM Government, 2010b, HM Government, 2010a, HM Government, 2011, HM Government, 2012, Kennedy, 2006, Lawless et al., 2007, Local Government Information Unit, 2012, Mauger and et al., 2010, Nesta, 2013, NHS England, 2013, Office of the Deputy Prime Minister, 2006, Public Health England, 2013, Scottish Community Development, 2013, Scottish Community Development Centre, 2013, Scottish Government, 2013, Sustainable Development Commission, 2010, Thraves, 2013, Wait and Nolte, 2006, Wallace, 2007, Welsh Assembly Government, 2008, Whitehead and Dahlgren, 2007)

Concepts: 30 articles explored concepts and theories related to community engagement**. A diverse range of concepts are used to explain and critique aspects of power and participation. There is no common terminology and a number of papers point to the challenges of defining what are complex sets of ideas. Only four papers specifically dealt with community engagement as a defined topic (Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Sheridan and Tobi, 2010, South and Phillips, 2014). Empowerment continues to be a significant theme – both how it can be achieved and what it means. Since 2006, other relevant concepts, such as co-production and volunteering, have gained some prominence in public health literature. The implications are that community engagement, as proposed in the earlier NICE guidance (National Institute for Health and Care Excellence, 2008), is best seen as an umbrella term that covers a range of concepts relating to participation and empowerment.

*(Jones, 2004, Attree et al., 2011, Beresford, 2007, Boydell and Rugkåsa, 2007, Boyle et al., 2010, Brownlie et al., 2006, Burton et al., 2006, Cabinet Office, 2011, Chadderton et al., 2008, Chirewa, 2012, Communities and Local Government, 2007, Department of Health, 2006b, Draper et al., 2010, Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Hardill et al., 2007, Kennedy, 2006, Laverack, 2006, Local Government Information Unit, 2012, Mahoney et al., 2007, McDaid, 2009, Nesta, 2013, Office of the Deputy Prime Minister, 2006, Scottish Government, 2013, Sheridan and Tobi, 2010, Spencer, 2014, Truman and Raine, 2001, Wait and Nolte, 2006, Wallace, 2007, South and Phillips, 2014)

Communities: The largest group of articles (n=112, 36%), both research (n=89, 39%) and non-research (n=28, 31%), looked at initiatives in urban settings. A large number (n=90,

29%) also looked at initiatives in both urban and rural settings. Only 11 articles (4%) looked at initiatives in rural settings alone (Bromley, 2014, Davis, 2008, Dickens Andy et al., 2011, East Midlands Regional Empowerment Partnership, 2009a, Elliott et al., 2007, Halliday and Asthana, 2005, Hoddinott et al., 2006a, Hoddinott et al., 2006b, Osborne et al., 2002, Starkey et al., 2005, Stutely, 2002). In 43 studies, the setting was not clear.

As this was a mapping review, we did not undertake detailed data extraction on the populations other than to code for indicators of health inequalities using the PROGRESS-plus tool (see Health Inequalities below). However, the UK map includes articles on communities of place (e.g. Well London (Phillips et al., 2012)), communities of culture (e.g. Roma support group (Roma Support Group, 2009)), ethnicity, age (e.g. Youth.com (Craig, 2010); MAC UK (Mental Health Foundation, 2013); Partnerships for Older People (Williamson et al., 2009, Windle et al., 2009) or health and wellbeing issues (e.g. long term conditions (Hills et al., 2007)).

The health and wellbeing issues addressed most frequently by UK community engagement initiatives were community level or wellbeing outcomes, rather than individual behaviour change outcomes:

Social capital or social cohesion (n=129, 41%) e.g. improved social networks (Burgess 2014), reduction in crime (Stutely and Cohen 2004);

Community wellbeing (n=110, 35%) e.g. community resilience (Cinderby et al. 2014), empowerment (Hothi et al. 2007) ;

Personal wellbeing (n=82, 26%) e.g. positive mental health (IRISS 2012, Tunariu et al. 2011), quality of life (Nazroo and Matthews 2012);

General health – personal (n=99, 31%) e.g. weight management (Jennings et al. 2013), healthy lifestyle promotion (Robinson et al. 2010; and

General health – community (n=95, 30%) e.g. setting up group activities (Woodall et al. 2012), reducing health inequalities (Race for Health 2010).

This seems to be a different pattern from initiatives in included studies in the systematic reviews of effectiveness (Reviews 1-3 (Brunton et al. 2014)), which have focused on individual health issues such as physical activity and healthy eating.

Health Inequalities: Indicators of potential health inequality observed most frequently in the included articles were socioeconomic (n=89 S; 35 D) and “other” indicators of disadvantage (n= 95 S, 28 D) – these included a range of groups such as:

People with disabilities (e.g. Edwards 2002, inclusion in regeneration);

People with learning difficulties (LD) (e.g. McCaffrey 2008, commissioning from the perspective of people with LD);

Older people (e.g. Williamson et al. 2009, Partnerships for Older People);

Offenders (e.g. Dooris et al. 2013, health trainer service);

People with long term health conditions (e.g. Hills et al. 2007, healthy living centres);

People with substance use disorders (e.g. Elliott et al. 2001, involving peer interviewers in research);

Gay Lesbian Bisexual or Transgender groups (e.g. Flowers et al. 2002, bar-based peer-led sexual health promotion with gay men);

Mental health service users (e.g. O'Brien et al. 2011, volunteering in nature);

Refugees and asylum seekers (e.g. Bhavnani and Newburn 2014, NCT peer support).

Other indicators of inequality were race/ ethnicity (n= 53 S, 16 D), lack of social capital or social exclusion (n= 37 S, 9 D). This demonstrates that community engagement initiatives in the UK go beyond the approach of targeting the most obvious indicators of inequality (i.e. those that are included in health equity profiles such as ethnicity, gender and occupational or socioeconomic status) and seek to engage some of the most marginalised, disadvantaged or excluded population groups. This is true of both research and non-research articles.

Community engagement initiatives for populations with "Other indicators of disadvantage" were more likely to use peer (45S (47%), 6D (21%)) or volunteer (34S (36%), 4D (14%)) involvement approaches than those for populations coded as having socioeconomic indicators of disadvantage (Peer involvement 31S (34%), 6D (17%); Volunteers 11S (12%), 3S 11%)), which were similar to the percentages given across the range of UK initiatives in this mapping review (see "Approaches" below). Initiatives targeting populations with any indicators of health inequalities were more likely to use a targeted than a universal approach (other than populations with low social capital, where a universal approach was more likely to be used).

As for all initiatives included in this map, initiatives for populations with "other" indicators of disadvantage were also most likely to address social capital or cohesion issues (46S (48%), 11D (39%)), but individual issues such as physical activity (24S (25%), 1D (4%)), healthy eating (28S (29%), 1D (4%)), mental health (28S (29%), 4D (14%)) and substance use (23S (24%), 2D (7%)) were also commonly targeted. "Personal assets" was a health and wellbeing category that was more commonly addressed in this group than any other (14S (15%), 1D (4%))

Examination of trends over time (from 2000 to 2014) revealed that socioeconomic indicators and other indicators of disadvantage were consistently the most targeted indicators of health inequality in the UK community engagement literature on policy and practice.

Approaches to community engagement: The mapping review found a wide range of approaches to community engagement in the 316 included articles, which were grouped into seven types: Community mobilisation/ action; Community partnerships/ coalitions; Peer involvement; Community organisations; Non-peer health advocacy; Social networks; Volunteers (see Glossary for definitions). Community mobilisation/ action (138 articles, 89S, 49D; 44%) and community partnerships/ coalitions (180 articles, 113S, 67D; 57%) were the most commonly used approaches in both research and non-research articles. Peer involvement (n=97, 82S, 15D; 31%) and volunteers (n=64, 50S, 14D; 20%) were common approaches in research articles, but less so in non-research articles. In more than half of these articles, peer involvement approaches were combined with other community

engagement approaches. Different approaches seemed to be used to target different types of health or wellbeing issues, for example peer involvement was most often seen in interventions targeting individual behaviour change (e.g. physical activity, healthy eating, substance use), whereas community mobilisation/ action or partnership/ coalition approaches were more often seen in initiatives that focused on community wellbeing, social capital or community assets.

Most included initiatives reported a low (n=141 (45%), 110S (48%), 31D (35%)) or moderate (n=124 (39%), 85S (37%), 39D (44%)) extent of community engagement, with only 33 initiatives (10%, 17S (7%), 16D (18%)) reporting a high extent of CE (defined as community leading or collaborating in all three of: design; delivery; evaluation). Most of the initiatives with a high extent of CE took a community mobilisation/ activation approach (n=21 (64%)), and/ or a collaboration/ partnership approach (n=26 (79%)) to community engagement. The comparatively high proportion of these initiatives which were reported in the non-research literature (20% of all non-research articles, compared to 8% of research articles) may be indicative of a gap between the types of organisations which usually write and publish research articles (e.g. academics and health professionals), and the types of organisations which usually involve community members in the evaluation process (e.g. community-based, non-academic), and/or may indicate challenges in the evaluation or publication process of high community engagement initiatives. It is worth noting due to the potential for publication bias if non-research articles had not been included in this map of UK practice.

Examination of trends over time (from 2000 to 2014) revealed that there has been an increase in approaches using peer involvement since 2009 and that non-peer health advocacy approaches (such as health trainers) seen to have been increasing in frequency since 2007.

Outcomes: In the 227 research and evaluation studies, the most frequently reported outcome type was process outcomes (n=187 S (82%)) such as recruitment of lay workers, followed by wellbeing outcomes (n=116 S (51%)) such as confidence, self-efficacy and quality of life, and health outcomes (n=102 S (45%)) such as increased awareness and uptake of cancer screening. Community level outcomes (n=92 S (41%)) were reported more frequently than outcomes at the individual level (n=83 S (37%)). Harmful or unintended effects (n=12 S (5%)) and economic outcomes (n=11 S (5%)), such as unit costs and funding, were reported less frequently.

Effects: Direction of effect was not routinely coded for in this systematic mapping review, so we are unable to comment on effectiveness.

Unintended or harmful effects: There is some evidence in this component 1a to contribute to review question 4, with 12 studies (5%) coded as reporting unintended or harmful consequences. Evidence from these 12 studies suggests that unintended effects can be positive (e.g. improved mental health in community members delivering interventions) but may also be negative or harmful, either to community deliverers (e.g. volunteers feeling overburdened), to organisations or partnerships (e.g. tensions between lay and professional role boundaries), or to the wider community (e.g. community members becoming so attached to projects that there are no places left for newer members).

Examination of trends over time (from 2000 to 2014) revealed that reporting of mental health and wellbeing outcomes have increased in frequency since 2007.

Structure and focus of existing evidence base: There is a substantial amount of information in the following topic areas: Urban or mixed settings (i.e. both urban and rural); socioeconomically deprived groups or areas; socially excluded or isolated groups; areas that lack social cohesion; other potentially disadvantaged groups (e.g. older people; people with disabilities; people in poor physical or mental health); black or minority ethnic groups; initiatives targeting health behaviours (physical activity, healthy eating, substance use), mental health, personal and community wellbeing, general health (personal and community), social capital or cohesion; initiatives with low or moderate extent of community engagement; process, wellbeing, health and community level outcomes.

There seems to be little information in the following areas: rural settings; unintended or harmful effects; cultural adaptation; initiatives with a high extent of community engagement; population groups that may experience health inequalities due to religion, culture or educational reasons.

Summary Statements

Summary statement 1: Conceptual

A number of overlapping terms are used to cover concepts and approaches that relate to the active participation of people in decisions about their health and lives (based on 30 conceptual/ theoretical papers*). This includes community engagement (4 papers: Fountain et al. 2007; Glasgow Centre for Population Health 2007; Sheridan and Tobi 2010; South and Phillips 2014), community participation (2 papers: Mahoney et al. 2007; Draper et al. 2010), community or public involvement (4 papers: Burton et al. 2006; Chadderton et al. 2008; Department of Health, 2006b; Wait and Nolte 2006) and empowerment: (3 papers: (Communities and Local Government, 2007, Laverack, 2006, Spencer, 2014). Empowerment is a complex concept that has different dimensions both relating to process and outcomes (Laverack, 2006, Spencer, 2014). The review of conceptual papers suggests that community engagement also relates to social action by communities through volunteering and building social capital (based on 11 conceptual/ theoretical papers (Cabinet Office, 2011, Communities and Local Government, 2007, Dobbs and Moore, 2002, Nesta, 2013, Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Hardill et al., 2007, Laverack, 2006, Local Government Information Unit, 2012, Sheridan and Tobi, 2010, Wallace, 2007)).

*(Jones, 2004, Attree et al., 2011, Beresford, 2007, Boydell and Rugkåsa, 2007, Boyle et al., 2010, Brownlie et al., 2006, Burton et al., 2006, Cabinet Office, 2011, Chadderton et al., 2008, Chirewa, 2012, Communities and Local Government, 2007, Department of Health, 2006b, Draper et al., 2010, Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Hardill et al., 2007, Kennedy, 2006, Laverack, 2006, Local Government Information Unit, 2012, Mahoney et al., 2007, McDaid, 2009, Nesta, 2013, Office of the Deputy Prime Minister, 2006, Scottish Government, 2013, Sheridan and Tobi, 2010, Spencer, 2014, Truman and Raine, 2001, Wait and Nolte, 2006, Wallace, 2007, South and Phillips, 2014)

Summary statement 2: Policy

Policy interest in community engagement and health can be mapped across a wide range of policy areas and sectors (based on 42 policy-related articles**). These include: health policy and the NHS, local government policy and regeneration, third sector and volunteering and also health inequalities as a cross-cutting policy issue. Community engagement in public health continues to be supported through these various policy drivers (4 publications: (Department of Health, 2010, Department of Health, 2012a, Department of Health, 2012b, HM Government, 2010b)); however, there appears to be a greater policy emphasis on patient and public involvement (PPI) structures in relation to the NHS (6 publications: (Department of Health, 2006b, Department of Health, 2006a, Department of Health, 2007a, Department of Health, 2010, HM Government, 2012, NHS England, 2013)).

The key role of local government in leading community engagement and supporting public participation in local decision making has been a major policy theme throughout the period covered by the review (based on 4 publications: (Department for Communities & Local Government, 2006b, Department for Communities & Local Government, 2007a, Department for Communities & Local Government, 2007b, HM Government, 2007)). Community

engagement and empowerment have been consistently linked to strategies to address health inequalities (3 publications: (Department of Health, 2008b, Department of Health, 2008a, Department of Health, 2009a), with emphasis given to enabling individuals to play a greater part in local decisions that affect their health and lives. Two specific policy initiatives identified in the review were New Deal for Communities (Lawless et al., 2007, Wallace, 2007) and Neighbourhood Management/partnerships (Blank et al., 2007, Office of the Deputy Prime Minister, 2006, Sustainable Development Commission, 2010).

The contribution of individuals and communities to health and to society in general is a policy theme, with the importance of social action on health being endorsed in government documents and policy commentary. Interrelated concepts found in the map of policy include asset-based approaches, co-production, volunteering and peer support, and a number of (non-governmental) documents advocate for methods that draw on community strength and build on the lay contribution.

******(Atkinson, 2012, Barnes et al., 2008a, Blank et al., 2007, Boydell and Rugkåsa, 2007, Boyle et al., 2010, Bridgen, 2006, Communities and Local Government, 2007, Department for Communities & Local Government, 2006b, Department for Communities & Local Government, 2007a, Department for Communities & Local Government, 2007b, Department of Health, 2006a, Department of Health, 2006b, Department of Health, 2007a, Department of Health, 2008b, Department of Health, 2008a, Department of Health, 2009a, Department of Health, 2010, Department of Health, 2012a, Department of Health, 2012b, HM Government, 2007, HM Government, 2010b, HM Government, 2010a, HM Government, 2011, HM Government, 2012, Kennedy, 2006, Lawless et al., 2007, Local Government Information Unit, 2012, Mauger and et al., 2010, Nesta, 2013, NHS England, 2013, Office of the Deputy Prime Minister, 2006, Public Health England, 2013, Scottish Community Development, 2013, Scottish Community Development Centre, 2013, Scottish Government, 2013, Sustainable Development Commission, 2010, Thraves, 2013, Wait and Nolte, 2006, Wallace, 2007, Welsh Assembly Government, 2008, Whitehead and Dahlgren, 2007).

Summary Statement 3: Communities

Most community engagement activity in the UK takes place in urban or mixed (urban and rural) settings (based on 209 articles).

The health and wellbeing issues addressed most frequently by UK community engagement initiatives were community level or wellbeing outcomes, rather than individual behaviour change outcomes:

> Social capital or social cohesion (n=129, 41%) e.g. improved social networks (Burgess 2014), reduction in crime (Stutely and Cohen 2004);
>
> Community wellbeing (n=110, 35%) e.g. community resilience (Cinderby et al. 2014), empowerment (Hothi et al. 2007);
>
> Personal wellbeing (n=82, 26%) e.g. positive mental health (IRISS 2012, Tunariu et al. 2011), quality of life (Nazroo and Matthews 2012);
>
> General health – personal (n=99, 31%) e.g. weight management (Jennings et al. 2013), healthy lifestyle promotion (Robinson et al. 2010; and

General health – community (n=95, 30%) e.g. setting up group activities (Woodall et al. 2012), reducing health inequalities (Race for Health 2010).

Summary Statement 4: Health inequalities

Much UK practice in community engagement is directly relevant to health inequalities (based on 124 studies coded as socioeconomic indicators (n=89 S; 35 D) e.g. deprivation (Greene 2007; Hills et al. 2013) and 123 studies coded as "other" indicators of disadvantage (n= 95 S, 28 D) – these included a range of characteristics such as:

People with disabilities (e.g. Edwards 2002, inclusion in regeneration);

People with learning difficulties (LD) (e.g. McCaffrey 2008, commissioning from the perspective of people with LD);

Older people (e.g. Williamson et al. 2009, Partnerships for Older People);

Offenders (e.g. Dooris et al. 2013, health trainer service);

People with long term health conditions (e.g. Hills et al. 2007, healthy living centres);

People with substance use disorders (e.g. Elliott et al. 2001, involving peer interviewers in research);

Gay Lesbian Bisexual or Transgender groups (e.g. Flowers et al. 2002, bar-based peer-led sexual health promotion with gay men);

Mental health service users (e.g. O'Brien et al. 2011, volunteering in nature);

Refugees and asylum seekers (e.g. Bhavnani and Newburn 2011, NCT peer support).

This demonstrates that community engagement initiatives in the UK go beyond the approach of targeting the most obvious indicators of inequality (i.e. those that are included in health equity profiles such as ethnicity, gender and occupational or socioeconomic status) and seek to engage some of the most marginalised, disadvantaged or excluded population groups.

Peer- and volunteer-based approaches to community engagement were more common in populations with "other" indicators of disadvantage than in any other group (based on 51 articles on peer approaches (45S (47%), 6D (16%)), such as peer education for preventing falls in older people (Allen 2004) and 38 articles on volunteer approaches (34S (36%), 4D (14%)), such as volunteering for mental health (Institute for Volunteering Research 2003).

Summary statement 5: Approaches to community engagement

The mapping review found a wide range of approaches to community engagement in the 316 included articles. Approaches aligned to community development and empowerment and/ or participatory principles are commonly used in the UK, with peer and volunteer

involvement also being prominent approaches. Different approaches seem to be appropriate to address different health and wellbeing issues, for example peer, volunteer or lay involvement for targeting individual behaviour change; community mobilisation/ action or community partnerships/ coalitions for targeting community level outcomes, such as wellbeing, community assets or social capital.

Most of the initiatives with a high extent of CE took a community mobilisation/ activation approach (n=21 (64%))*, and/ or a collaboration/ partnership approach (n=27 (79%))** to community engagement. Health or wellbeing issues most frequently addressed were community wellbeing (n=15 (45%) 8D, 7S), social capital/ cohesion (n=14 (42%) 6D, 8S), general health personal (n=8 (24%) 5D, 3S), general health community (n=11 (33%) 7D, 4S). A comparatively high proportion of these initiatives were reported in the non-research literature (n=16 (20%) compared to n=17 (8%) in research literature).

* Anastacio et al. 2000; Boyle et al. 2006; Christie et al. 2012; Phillips et al. 2012; Platt et al. 2003; Quinn and Knifton 2012; Reeve and Peerbhoy 2007; Roma Support Group 2011; Spencer 2014; Webster and Johnson 2000; Coulter 2010; Coulter 2014; Fountain et al. 2007; GCPH 2007; Jones 2014; Laverack 2006; Nesta 2012; Scottish Government 2009; Stuteley 2014; Sheridan & Tobi 2010; Spencer 2014)

** Anastacio et al. 2000; Boyle et al. 2006; Christie et al. 2012; JRF 2011; Marais 2007; Murray 2010; Phillips et al. 2012; Quinn and Knifton 2012; Race for Health 2010; Reeve and Peerbhoy 2007; Roma Support Group 2011; NHS Greater Glasgow & Clyde 2010; Baines et al. 2006; Webster and Johnson 2000; Beresford 2007; Boyle et al. 2010; Brownlie et al. 2006; Coulter 2010; Coulter 2014; Fountain et al. 2007; GCPH 2007; Mahoney et al. 2007; McDaid 2009; Nesta 2012; Stutely 2014; Sheridan & Tobi 2010; Spencer 2014)

Summary statement 6: Outcomes

In the 227 research and evaluation studies, the most frequently reported outcome type was process outcomes (n=187 S (82%)) such as recruitment of lay workers (e.g. Chapman 2010), followed by wellbeing outcomes (n=116 S (51%)) such as confidence, self-efficacy and quality of life (e.g. White et al. 2010), and health outcomes (n=102 S (45%)) such as increased awareness and uptake of cancer screening (Curno 2012). Community level outcomes (n=92 S (41%) e.g. Barnes et al. 2004 (Health Action Zones)) were reported more frequently than outcomes at the individual level (n=83 S (37%) e.g. Platt et al. 2003 (smoking cessation)). Harmful or unintended effects (n=12 S (5%)) and economic outcomes (n=11 S (5%)), such as unit costs and funding, were reported less frequently.

Unintended or harmful effects: Evidence from 12 studies (Andrews et al., 2003, Ball and Nasr, 2011, Boydell and Rugkåsa, 2007, Bridge Consortium, 2002, Lawless et al., 2007, Lorenc and Wills, 2013, McLean and McNeice, 2012, Muscat, 2010, New Economics Foundation, 2002, Skidmore et al., 2006, Steven and Priya, 2000, Ward and Banks, 2009) on unintended or harmful effects suggests that these can be positive (e.g. improved mental health in community members delivering interventions) but may also be negative or harmful, either to community deliverers (e.g. volunteers feeling overburdened), to organisations or partnerships (e.g. tensions between lay and professional role boundaries), or to the wider

community (e.g. community members becoming so attached to projects that there are no places left for newer members).

Summary statement 7: Structure and focus of existing evidence base

There is a substantial amount of information in the following topic areas: Urban or mixed settings (i.e. both urban and rural); socioeconomically deprived groups or areas; socially excluded or isolated groups; areas that lack social cohesion; other potentially disadvantaged groups (e.g. older people; people with disabilities; people in poor physical or mental health); black or minority ethnic groups; initiatives targeting health behaviours (physical activity, healthy eating, substance use), mental health, personal and community wellbeing, general health (personal and community), social capital or cohesion; initiatives with low or moderate extent of community engagement; process, wellbeing, health and community level outcomes.

There is very little information, either from research, or from other sources, on what is being done in terms of community engagement in rural settings (n=11 (3%) 7 S, 4 D), or in communities that may experience health inequalities due to religion/ culture (n= 12 (4%) 6 S, 6 D) or educational reasons (n= 17 (5%) 14 S, 3 D). There is little information on harmful or unintended effects of community engagement initiatives (n = 12 S (5%)), or on economic outcomes (n = 11 S (5%)).

Conclusions

This mapping review found a substantial evidence-base on current and emerging UK policy and practice in community engagement, encompassing a diverse range of populations and approaches to community engagement. The use of community engagement as an “umbrella” term to encompass different approaches and activities for different population and health or wellbeing issues seems to fit well with the UK perspective.

The key role of local government in leading community engagement and supporting public participation in local decision making has been a major policy theme throughout the period covered by the review. Community engagement and empowerment have been consistently linked to strategies to address health inequalities, with emphasis given to enabling individuals to play a greater part in local decisions that affect their health and lives. Dominant concepts include asset-based approaches, co-production, volunteering and peer support.

There was a high volume of evidence from: qualitative and mixed methods studies; initiatives targeting health inequalities via socioeconomically deprived areas and groups, and via “hard to reach” groups (such as people with disabilities, substance users, homeless people). Community level outcomes (e.g. improved housing) and wellbeing outcomes (e.g. improved self-esteem) were most commonly addressed, and community mobilisation/ action and community partnerships/ coalitions were the types of community engagement most commonly employed.

Recommendations for practice: A varied “toolbox” of approaches to community engagement in the UK is needed in order to engage with a wide range of populations and health and wellbeing issues.

Communities targeted by community engagement initiatives in the UK include a substantial proportion who are at risk of health inequalities (such as people with mental health issues, offenders, homeless people, Gay, Lesbian, Bisexual or Transgender), but who are not routinely fully represented in health equity profiles/ audits, which tend to focus on age, gender, ethnicity and deprivation indices. Consideration should continue to be given to these “marginalised” groups, in terms of both initial engagement and measurement of impact.

Recommendations for research: The lack of initiatives found in rural settings, and the lack of evidence on cultural adaptation, groups at risk of health inequalities due to religion/ culture or lack of education suggests that it would be beneficial to explore community engagement in practice for these groups. Future research studies should report any harmful or unintended effects.

1. Introduction

1.1 Review context

The Centre for Public Health (CPH) at the National Institute for Health and Care Excellence (NICE) is developing a guideline on 'Community engagement – approaches to improve health'. The guideline is being developed by a Public Health Advisory Committee (PHAC) in 2014-15 in line with the final scope for this work. The guideline is expected to be published in January 2016 and will contain recommendations based on the evidence considered by the PHAC. There are three streams of work associated with the guideline's development that the CPH has commissioned:

Stream 1 (Reviews 1-3): Community engagement: a report on the current effectiveness and process evidence, including additional analysis.

Stream 2 (Reviews 4 and 5, and Primary Research Report 1): Community engagement: UK qualitative evidence, including one mapping report and one review of barriers and facilitators.

Stream 3: An economic analysis (Reviews 6 and 7).

Component 1 of Stream 2 comprises a mapping report (Review 4, and Primary Research Report 1) to identify, describe and provide insight into current and emerging community engagement policy and practices in the UK. Component 2 (Review 5) is a systematic review of barriers and facilitators to community engagement.

The mapping review (component 1) consists of the following two parts:

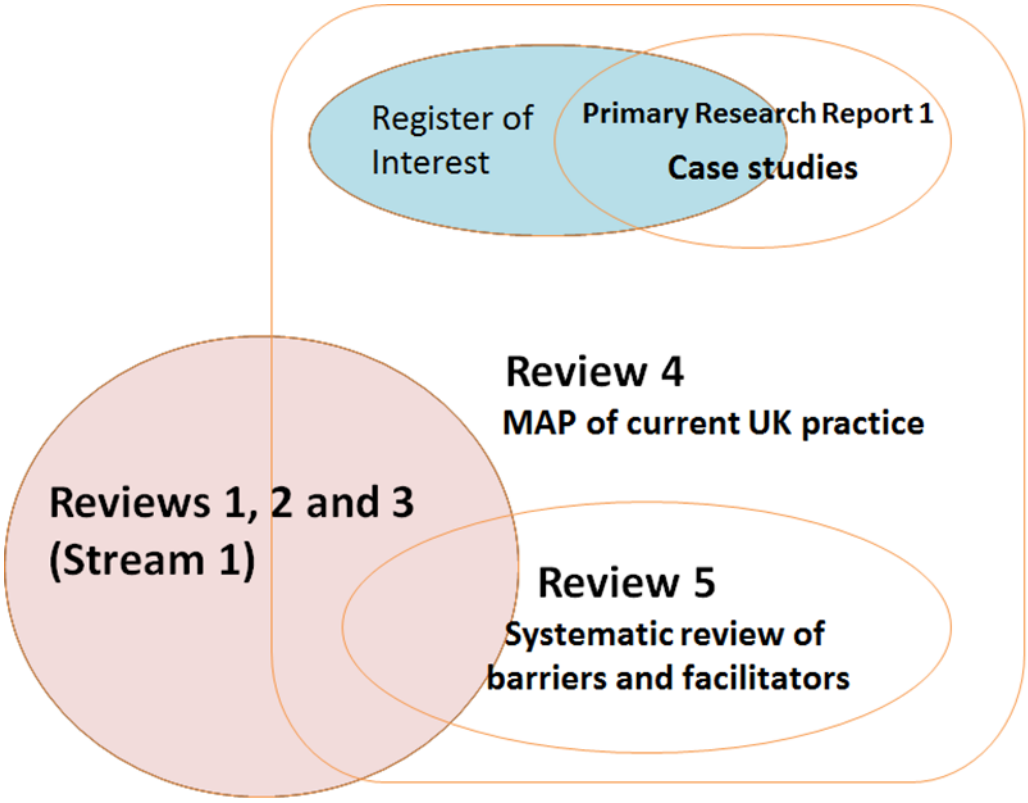
(a) **Review 4: map of the literature on current and emerging community engagement policy and practice in the UK.** This provides a synopsis of the key findings from documentary analysis (including grey literature and practice surveys) of the current evidence base for UK local and national policy and practice for community engagement, as well as an assessment of the extent to which relevant scope questions can be answered by the evidence base.

(b) Primary research report 1: Map of current practice based on a case study approach. This consists of a series of six case studies of current or recent community engagement projects to improve health and reduce health inequalities. The focus will be on processes of community engagement and barriers and facilitators to these, and will include: practitioner and community members' views on inclusion, involvement and decision making; structures and processes; background (local culture, resources, needs and priorities); outcomes (perceived benefits/ disbenefits and impacts on individuals and wider community); unanticipated effects; measures of success identified by communities and professionals; wider connections. Case studies were identified and selected to reflect different approaches of current community engagement within the UK, in particular those approaches targeted at disadvantaged groups or communities, and other evidence gaps identified in Reviews 1-5.

Figure 1 demonstrates how Reviews 4 and 5, and primary research report 1 are related to each other and to the evidence from Reviews 1-3. The work was entered into as part of a

consortium, with the EPPI-Centre (University of London) delivering Reviews 1-3 and Leeds Beckett University and the University of East London delivering Reviews 4 and 5, and Primary Research Report 1. As such there has been a common approach and sharing of evidence between the two Streams.

Figure 1: Relationship of Stream 2 components with each other and with Stream 1.



1.2 Aims and objectives of the review

This mapping review provides a synopsis of the key findings from documentary analysis (including grey literature) of the current evidence base for UK local and national policy and practice for community engagement. It aims to identify, describe and provide insight into current and emerging community engagement policy and practice in the UK.

1.3 Research questions.

In addition to the main aim above, the mapping review set out to address any or all of the following research questions, from the final Guidance scope:

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?

This question could include sub-questions to explore the impact on the effectiveness and acceptability of different interventions conferred by: those delivering the intervention; community representatives or groups; health topic; setting; timing; or 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?

Question 5 will encompass the following overarching questions:

> Q5.1 To what extent do these barriers and facilitators vary according to key differences in community engagement approaches and practices, the health outcomes and populations to which they are targeted, and the context in which they are delivered?
>
> Q5.2 How can the barriers and challenges be overcome?

1.4 Operational definitions

The scope of the evidence covered by this project is outlined in the final Guidance scope document (http://www.nice.org.uk/nicemedia/live/14266/67533/67533.pdf).

'Community engagement' is used as an umbrella term covering community engagement and community development. 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 and control: for example, giving views on a local health issue, jointly delivering services with public service providers (co-production) and completely controlling services.

For this map, we have used the definition of community engagement from a recent NIHR-funded systematic review (O'Mara-Eves et al., 2013), in line with the work carried out for Reviews 1-3 as part of this guidance (Brunton et al., 2014): 'direct or indirect process of involving communities in decision making and/or in the planning, design, governance and delivery of services, using methods of consultation, collaboration, and/or community control' (O'Mara-Eves et al. 2013).

The eligible population is communities defined by at least one of the following, especially where there is an identified need to address health inequalities: geographical area or setting, interest, health need, disadvantage and/or shared identity.

The eligible interventions/ activities are defined as: activities to ensure that community representative are involved in developing, delivering or managing services to promote, maintain or protect the community's health and wellbeing. An example of a community engagement activity is community-based participatory research. Examples of where this might take place include: care or private homes, community or faith centres, public spaces, "cyberspace", leisure centres, schools and colleges and Sure Start centres. Examples of community engagement roles include: community (health) champions; community or neighbourhood committees or forums; community lay or peer leaders.

Eligible activities also include local activities to improve health by supporting community engagement. Examples include (can be delivered separately or in combination): raising awareness of, and encouraging participation in, community activities, evaluation and feedback mechanisms, funding schemes and incentives, programme management, resource provision, training for community members and professionals involved in community engagement.

The guideline will not cover community engagement activities that: do not aim to reduce the risk of disease or health condition, do not aim to promote or maintain good health, do not report on primary or intermediate health outcomes, focus on the planning, design, delivery or governance of treatment in healthcare settings, target individual people (rather than community).

The eligible outcomes are defined as: improvement in individual and population level health and wellbeing. Other expected intermediate outcomes may include: positive changes in health related knowledge, attitudes and behaviour, improvement in process outcomes, 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, improvement in community's ability and capacity to make changes and improvements to foster a sense of belonging, views on the experience of community engagement (including what supports and encourages people to get involved and how to overcome barriers to engagement).

1.5 Identification of possible equality and other equity issues

This mapping review of UK practice includes community engagement in all contexts and is not limited to communities experiencing health inequalities. However, much of the identified literature and practice does target disadvantaged groups and those groups experiencing health inequalities. The PROGRESS-Plus tool (Kavanagh et al., 2008) was used to categorise articles in terms of which disadvantaged groups were targeted[5].

1.6 Review team

The review team comprised researchers led by Dr Anne-Marie Bagnall at the Centre for Health Promotion Research at Leeds Beckett University, working in partnership with a team of researchers led by Professor Angela Harden at the Institute for Health and Human Development, University of East London. The Centre for Health Promotion Research has a long history of research that has community engagement at its heart. The team, under the leadership of Jane South, Professor of Healthy Communities, has recently delivered two high quality NIHR-funded systematic reviews on the roles of lay people in public health (South et al. 2010), and on peer interventions in prison settings (South et al., 2014). We also

[5] The PROGRESS-plus framework highlights several social and personal dimensions that may affect health inequalities i.e.: Place of residence; Race/ ethnicity; Occupation; Gender; Religion; Education; Socio-economic position; Social capital; Other (e.g. age, disability, sexual orientation, being "looked after", etc.). Recommended by the Cochrane/Campbell Health Equity Group (Kavanagh J et al. 2008)

delivered a series of rapid evidence reviews for Altogether Better, on: Community Health Champions and Older People; Empowerment and Health and Wellbeing (see: http://www.altogetherbetter.org.uk/evidence-and-resources).

The CHPR team members and their roles for the current review were as follows: Anne-Marie Bagnall is a Reader in Evidence Synthesis (Heath Inequalities), acting as principal investigator, lead and project manager for the review, developing codes and undertaking screening, coding and overall narrative synthesis. Jane South is Professor of Healthy Communities, who is a co-investigator with a specific role in the synthesis of the conceptual and policy documents. Joanne Trigwell is a Research Fellow whose role included acquisition, screening and coding of articles. Karina Kinsella is a Research Assistant whose role included acquisition, screening and coding of articles. Judy White is a Senior Lecturer in Health Promotion and Director of Health Together – her role included linking to practice to acquire grey literature and advertise the Register of Interest. Each team member, apart from Jane South, has declared no conflict of interest. Jane South is a member of the NICE Public Health Advisory Committee and has declared this.

2. Methodology

2.1 Search Strategy

Our search strategy was designed in collaboration with our consortium partner, the EPPI-Centre, who carried out the systematic reviews of effectiveness (Reviews 1-3) (Brunton et al., 2014). Given the difficulties of identifying studies via traditional electronic database searches (terms for community engagement are not well indexed or applied in uniform) (O'Mara-Eves et al., 2013, O'Mara-Eves et al., 2014) we focused our search efforts on specialised research registers and websites.

We searched the following sources:

1. The pool of studies (both included ***and*** excluded studies) that were identified within the recent NIHR funded review on community engagement (O'Mara-Eves et al., 2013). The searching for this review identified many potentially relevant UK studies. The search syntax originally used for these searches (including date of searches) is presented in Appendix A.

2. Updating the original searches that were carried out for the O'Mara-Eves et al. (2013) review. This part of the search strategy had the following two elements. The search syntax that was used in updating the search process is presented in Appendix B:

   a) A systematic search for existing systematic reviews which include studies of community engagement through specialist websites and databases dedicated to systematic reviews: DoPHER (the *Database of Promoting Health Effectiveness Reviews* developed and maintained by the EPPI-Centre); the *Cochrane Database of Systematic Reviews (CDSR); Database of abstracts of reviews of effects (DARE)*; the *Campbell Library; the* NIHR Health Technology Assessment (HTA) programme website; and Health Technology Assessment (HTA) database hosted by CRD.

   b) A systematic search of the EPPI-Centre database of studies in health promotion and public health that the EPPI-Centre has built up over many years as a result of carrying out systematic reviews (known as TRoPHI). The studies in this database are the product of systematic searches in core NICE databases and have already been systematically classified.

      Both of these elements were run from January 2011 onwards.

3. The results of searches that were carried out in April 2014 for a Public Health England mapping review of community-based interventions (Public Health England and NHS England, 2015; Bagnall et al. 2015) were rescreened for primary research (only secondary sources were included in the PHE review). The search strategy for this review is presented in Appendix C.

4. Systematic reviews identified from any of the above sources were "mined" for relevant primary studies.

a. The following internet sources were searched:

National organisations

- Open Grey
- healthevidence.org
- UK government (gov.uk) portal
- NICE Evidence (including NICE website and former Health Development Agency documents)
- Public Health Observatories
- ESRC research investments: health and wellbeing (http://www.esrc.ac.uk/research/major-investments/health-wellbeing.aspx)
- Local Government Association – health (http://www.local.gov.uk/health)
- Local Government Association and Department of Health – 'From transition to transformation in public health (http://www.local.gov.uk/health/-/journal_content/56/10180/3374673)
- NICE – 'support for local government' (http://www.nice.org.uk/localgovernment/localgovernment.jsp)
- NHS Scotland (http://www.healthscotland.com)
- NIHR Public Health Research Programme (http://www.nets.nihr.ac.uk/programmes/phr)
- NIHR School for Public Health Research (http://www.sphr.nihr.ac.uk)
- Policy Research Unit in Commissioning and the Healthcare System (http://www.prucomm.ac.uk)
- Public Health Agency (for Northern Ireland) - Health and social wellbeing improvement (http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement)
- Public Health England (http://www.gov.uk/government/organisations/public-health-england)
- Royal Society for Public Health (http://www.rsph.org.uk)
- The King's Fund – public health and inequalities (http://www.kingsfund.org.uk/topics/public-health-and-inequalities)
- Centre for Translational Research in Public Health (http://www.fuse.ac.uk/shifting-the-gravity-of-spending%3f-/3131)
- UCL Institute of Health Equity (http://www.instituteofhealthequity.org)
- UK Faculty of Public Health (http://www.fph.org.uk/)
- UK Healthy Cities Network (http://www.healthycities.org.uk/)
- Welsh Government – Health and social care (http://www.wales.gov.uk/topics/health/?lang=en)
- World Health Organisation Europe – Health 2020:the European policy for health and wellbeing (http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being)
- Altogether Better – evidence resources
- Association of Public Health Observatories (http://www.apho.org.uk)
- BIG Lottery wellbeing evaluation
- Centre for Public Scrutiny (http://www.cfps.org.uk)
- Charities Evaluation Service (http://www.ces-vol.org.uk)
- Community Development Exchange (http://www.cdx.org.uk)

- Community development foundation (http://www.cdf.org.uk)
- Department of communities and local government – Community empowerment division (http://www.togetherwecan.direct.gov.uk)
- Community Health Exchange (http://www.scdc.org.uk)
- Federation of Community Development learning (http://www.fcdl.org.uk)
- Health Link (http://www.health-link.org.uk)
- Improvement Foundation – healthy community collaborative (http://www.improvementfoundation.org)
- Improvement and development agency for local government (http://www.idea.gov.uk)
- NHS Involve (http://www.invo.org.uk/)
- National Council for Voluntary Organisations (http://www.ncvo-vol.org.uk)
- NHS Centre for Involvement (http://www.nhscentreforinvolvement.nhs.uk)
- National Social Marketing Centre (http://www.nsms.org.uk)
- National Support Team for health inequalities (http://www.dh.gov.uk/en/publichealth/healthinequalities/index.htm)
- NESTA – people powered health
- New economics foundation (http://www.neweconomics.org)
- Pacesetters programme (http://www.dh.gov.uk/managingyourorganisation/equalityandhumanrights/pacesetterprogramme/index.htm)
- Patient and public involvement specialist library (http://www.library.nhs.uk/ppi/)
- Picker institute Europe (http://www.pickereurope.org)
- Turning point (http://www.turning-point.co.uk)
- Joseph Rowntree Foundation
- Academy for Sustainable Communities (http://www.ascskills.org.uk/what-we-do.html)

Local organisations

- Bradford and Airedale PCT (http://www.bradfordandairdale-pct.nhs.uk)
- Bromley by Bow Centre (http://www.bbbc.org.uk)
- Community Health Action partnership (http://www.chalk-ndc.info/doing/ndc-health/chap)
- East Midlands community dialogue project (http://www.communitydialogue.typepad.com)
- Heart of Birmingham PCT (http://www.hobpct.nhs.uk)
- Herefordshire PCT (http://www.herefordshire.nhs.uk)
- Liverpool PCT (http://www.liverpoolpct.nhs.uk)
- Murray Hall Community Trust (http://www.murrayhall.co.uk)
- St. Mathews Project, Leicester (http://www2.le.ac.uk/departments/health-sciences/extranet/research-groups/nuffield/project_profiles/eqh.html)
- NHS Tower Hamlets (http://www.towerhamlets.nhs.uk)

Organisation with a specific focus on ethnic minority communities

- Apnee Sehat (http://www.apneeseehat.net)
- Black and ethnic minority community care forum (http://www.bemccf.org.uk)
- Communities in Action Enterprises (http://www.communitiesinaction.org)

- Community Health Involvement and Empowerment Forum (http://www.chiefcic.com)
- Delivery Race Equality in mental health (http://www.nmhdu.org.uk/our-work/promoting-equalities-in-mental-health)
- Social Action for Health (http://www.safh.org.uk/safh_php/index)

Universities

- Oxford University – Department of Social Policy and Social Work (http://www.ox.ac.uk)
- University of Central Lancashire – International school for communities, rights and inclusion (http://www.uclan.ac.uk)
- London School of Economics – Personal Social Services Research Unit (http://www.lse.ac.uk)
- Bath University – School for Health (http://www.bath.ac.uk)
- Durham University – School of Applied Social Science (http://www.dur.ac.uk/sass)
- Lancaster University – School of Health and Medicine (http://www.lancs.ac.uk)
- Liverpool University – School of population, Community and Behavioural Sciences (http://www.liv.ac.uk)
- York University – Social Policy Research Unit (http://www.york.ac.uk)
- University of Warwick
- Health Together www.leedsbeckett.ac.uk/healthtogether
- NIHR School for Public Health Research www.sphr.nihr.ac.uk

Citizens/public experiences

- Healthtalk online (http://healthtalkonline.org/home)
- Involve – (http://invo.org.uk/invonet/about-invonet)
- 10,000 voices – (http://www.publichealth.hscni.net/publications/10000-voices-improving-patient-experience)
- Amazing Stories (http://www.altogetherbetter.org.uk/amazing-stories-collection)
- Our Stories (http://www.bbbc.org.uk/)
- Our Communities (http://community.bhf.org.uk/).
- locality.org.uk
- Well London
- People's Health Trust

5. Contact was made with community practitioners and groups, and other academics, via established networks (People in Public Health database; Health Together database; Putting the Public back into Public Health database; Volunteering Fund database of projects; CHAIN; Healthwatch Leeds; CommUNIty; locality) and local authority, academic and practice mailing lists, to request published literature, grey literature, practice surveys and details of emerging practice. An online Register of Interest was placed on the Health Together website to invite and facilitate interested parties to submit evidence.

6. There was a call for evidence to the project stakeholders made by NICE (17 June - 15 July 2014).

2.2 Inclusion/exclusion criteria for review

The following inclusion criteria were used for screening titles and abstracts. Definitions reflect the eligibility criteria of populations, activities, outcomes as outlined in section 1.4 and the final guidance scope (https://www.nice.org.uk/guidance/GID-PHG79/documents/community-engagement-update-final-scope-2).

Inclusion (Titles and abstracts):

Population: UK only. Communities involved in interventions to improve their health; health or social care practitioners or other individuals involved in developing, delivering or managing relevant interventions. Studies which target individuals rather than a specific community (including self-management *e.g.* expert patient) were excluded.

Intervention: Focus on community engagement of any kind (for example, activities that ensure community representatives are involved in developing, delivering or managing or evaluating services; or local activities that support community engagement) **within public health;** or local or national policy or practice. See below for working definitions of community engagement and public health. Studies which do not aim to reduce the risk of a disease or health condition, or which do not aim to promote or maintain good health (by tackling, for example, the wider determinants of health) were excluded. Studies which focus on the planning, commissioning, design, delivery or governance of treatment in healthcare/ clinical care settings were excluded.

Outcomes: improvement/ change in individual and population-level health and wellbeing; positive changes in health-related knowledge, attitudes and behaviour; improvement/ change in process outcomes (*e.g.* service acceptability, uptake, efficiency, productivity, partnership working); increase/ change 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 wellbeing outcomes such as self-esteem and independence; improvement in the community's capacity to make changes and improvements to foster a sense of belonging; adverse or unintended outcomes; economic outcomes; changes in social capital, social inclusion and social determinants of health such as housing, employment.

Study designs: Empirical research: either quantitative, qualitative or mixed methods outcome or process evaluations. To include grey literature and practice descriptions or surveys. Relevant policy documents and theoretical/ conceptual models or frameworks were also included. Published in English. Discussion articles or commentaries not presenting empirical or theoretical research or policy were excluded.

Working definitions

Community engagement: We have used the same definition as Reviews 1-3 (Brunton et al., 2014) 'direct or indirect process of involving communities in decision making and/or in the planning, design, governance and delivery of services, using methods of consultation, collaboration, and/or community control' (O'Mara-Eves et al., 2013).

Whilst screening titles and abstracts for inclusion, and following discussion with NICE, with our Stream 2 partners at UEL and with the EPPI-Centre team producing Reviews 1-3, we added the following clarifications:

What Community Engagement is:

- People championing the public health needs and interests of local communities and citizens;
- Activities aimed at redesigning, reconfiguring or delivering public health care services;
- Effective participation of the public in the commissioning process of public health services that reflect the needs of the local population;
- Expert patient groups of patients with a condition/diagnosis where the purpose is to improve health and wellbeing and/or protect against other health conditions *(i.e.* public health interventions).

What Community Engagement isn't:

- Activities aimed at redesigning, reconfiguring or delivering clinical care services;
- Effective participation of the public in the commissioning process of clinical health services that reflect the needs of the local population;
- Patients and carers participating in planning , managing and making decisions about their own care and treatment;
- Expert patient groups where the purpose is to improve an individual's experience of managing their treatment / care.

Public health: NOT clinical health services, not social care. Interventions delivered at community level, outcomes measured at population level. Public health includes health protection and health improvement (both prevention of illness and promotion of health).

2.3 Study Selection Process

Records were first screened on title and abstract. The inclusion criteria were tested and refined after piloting them on a random sample of 10% of the titles and abstracts. All reviewers independently screened these records and any differences were resolved by discussion and where necessary, informed by the advice of the CPH team. Further pilot screening was conducted until a good level of reliability was reached. (A good level of reliability was defined as 80% agreement between reviewers assigning exclusion/inclusion codes. The percent agreement was calculated as the number of agreement scores divided by the total number of scores). Once this level of reliability was reached one reviewer screened all the remaining titles and abstracts, with a second reviewer screening a random selection of 5%. Any disagreements were discussed or if necessary resolved by the lead researcher.

Full text studies for those records that met the inclusion criteria were retrieved. All full text studies were randomly allocated between the review team members and screened using the agreed inclusion criteria, with a random sample of 30% being double screened. Any disagreements were resolved by discussion and recourse to a third reviewer. Those documents that passed the inclusion criteria on the basis of full text screening were included in the review.

Records identified from all searches were assessed by hierarchical inclusion screening. Inclusion criteria covered populations, interventions, outcomes, study design, country, date and language.

> DATE: studies published before 2000[6] (or for policy and conceptual papers, before 2006[7]) were excluded.
>
> COUNTRY: UK only. Studies of non-UK projects or communities or policies were excluded.
>
> INTERVENTION: only studies of community engagement in public health topics were included (see above for working definitions)
>
> STUDY DESIGN: Empirical or theoretical research, or practice descriptions, or policy documents were included. Secondary research (e.g. systematic reviews) and discussion or commentary papers that did not present empirical or theoretical research were excluded. Systematic reviews were "mined" for relevant studies (see Search Strategy).

We used EPPI-Reviewer 4 (ER4) (Thomas et al., 2010) to support the management and analyses of the references and the data extraction for all components.

[6] *Search date of 2000 onwards would capture relevant and appropriate records related to community engagement as conceived in the scoping document. The date range is informed by various legislation (e.g. The Health & Social Care Act, Section 11: Public Involvement & Consultation; Local Government Act) published at this time which generated research activity.

[7] Date chosen to avoid duplication of effort with a previous review commissioned by NICE (Popay et al. 2007)

2.4 Data extraction/ coding

Included studies were coded by one reviewer and a random selection of 20% checked by a second reviewer, using piloted pre-agreed forms on EPPI-Reviewer 4. Any disagreements were resolved by discussion with reference to the full paper and, where necessary, a third reviewer. Coding differed depending on the type of document being coded e.g. for research/ evaluation articles, codes on the type of outcomes presented were used. Quality assessment was not undertaken, as this was a mapping review.

Coding categories were:

- Bibliographic details;
- Coder;
- Year of publication;
- Document type (evaluation/research; practice description; policy document; conceptual or theoretical paper)

  Articles were classified as:

  - **Studies (S) – papers that include original data. These may be trials, surveys, meta- analyses, service audits or qualitative studies. S papers may be cited for their data, but also for issues flagged up in the discussion of the findings or implementation.**
  - **Discussions (D) – papers which do not present any new data but consist of descriptions of current practice, discussions of issues, policy documents, conceptual or theoretical papers or reviews of or commentaries on other papers.**
- Study design (if evaluation or research): RCT; Controlled trial; Before and after study; Qualitative study; Mixed methods evaluation; Survey/ questionnaire;
- Type of community engagement: Community action/ mobilisation; Community partnerships/ coalitions; Peer roles; Community organisations; Non-peer lay advocacy; Volunteers; Social networks; Cultural adaptation;
- Level of community engagement in design, delivery and evaluation;
- Extent of community engagement (low, medium, high);
- Name of initiative;
- Lead organisation;
- Type of activity;
- Setting;
- Targeted or universal;

- Health or wellbeing issues;
- Population group(s) (PROGRESS-Plus categories)[8];
- Outcomes reported (for research/ evaluation studies only):
    - Health outcomes reported?
    - Wellbeing outcomes reported?
    - Effects on social determinants reported?
    - Effects at individual level reported?
    - Effects at community level reported?
    - Harmful/ unintended outcomes reported?
    - Process or service delivery outcomes reported?
    - Economic outcomes reported?
    - Uptake outcomes reported
    - Overall effectiveness outcome (if relevant);
- markers for relevance to other streams

Further working definitions for type, level and extent of community engagement:

Level of community engagement in design, delivery or evaluation:

Taken from Reviews 1-3 (Brunton et al., 2014), for each of design, delivery and evaluation:

Community members leading or collaborating = HIGH;

Community members consulted or informed = LOW.

Extent of community engagement:

HIGH – if level of CE = HIGH in all 3 of: design AND delivery AND evaluation.

MODERATE – if level of CE = HIGH in 2 out of 3 of: design, delivery and evaluation.

LOW – if =level of CE = HIGH in 0 or 1 out of: design, delivery and evaluation.

[8] The PROGRESS-plus framework highlights several social and personal dimensions that may affect health inequalities i.e.: Place of residence; Race/ ethnicity; Occupation; Gender; Religion; Education; Socio-economic position; Social capital; Other (e.g. age, disability, sexual orientation, being "looked after", etc.). Recommended by the Cochrane/Campbell Health Equity Group (Kavanagh J et al. 2008)

Type of community engagement:

For type of community engagement, the typology developed in the NIHR systematic review of effectiveness (O'Mara-Eves et al., 2013) was used to ensure consistency between stream 1 (Reviews 1-3) and stream 2 (Reviews 4 and 5, and Primary Research Report 1), although the definitions were then expanded using a new typology that was developed in parallel with this work, for Public Health England (South 2014, Public Health England & NHS England 2015, and see Appendix H).

Figure 2: A typology of community engagement (adapted from O'Mara-Eves et al., 2013)*

Type of Community Engagement	Definition*
Community mobilization/action	A capacity building process, through which communities plan, carry out and/or evaluate activities on a participatory and sustained basis to achieve an agreed goal. Includes community development and asset based approaches
Community partnerships/coalitions	Working in partnership with communities to design and/or deliver services and programmes. Partnerships/ coalitions may be in the form of forums; committees; advisory groups, task forces
Peer involvement	Peers defined as people sharing similar characteristics (e.g. age group, ethnicity, health condition) who provide advice, information and support and/or organise activities around health and wellbeing in their or other communities. Can include 'bridging roles' (e.g. health trainers, navigators) or peer-based interventions (e.g. peer support, peer education and peer mentoring)
Community organisations – new and existing service development	Connecting people to community resources and information (e.g. social prescribing and other types of non-medical referral systems; community hubs, such as healthy living centres; community-based commissioning)
Non-peer health advocacy	Possible roles are similar to those under 'peer involvement' but involve members of the community that are not peers of the target participants
Social Networks	Explicit use of the term in study reports. Community mobilization/action approaches could use social networks (e.g. time banks)
Volunteers	Used when this term is explicitly used in study reports. Peer and non-peer roles could involve volunteers but may not be

	explicitly labeled as such
Cultural adaptation	Using knowledge of a community's norms, values and preferences to make an intervention more appropriate. Note: simply translating an intervention into the relevant language is not considered cultural adaptation, as this can potentially require no community engagement

*Definitions expanded using family of community-based interventions (Public Health England and NHS England, 2015)

2.5 Methods of synthesis and data presentation.

The findings of the review were summarised narratively, grouping papers using categories in the coding process, with frequencies and proportions of documents in certain categories being presented as bar charts. Topic areas where there were multiple papers, or alternatively, limited research were noted. A separate synthesis was undertaken of policy, theoretical and conceptual documents.

We have used the Reviews 1-3 typology of community-centred approaches as an initial framework to begin to explore the spread of intervention approaches used in the UK and how this has changed over time, together with summaries of which disadvantaged groups have been targeted, whether these are related to intervention approaches, what types of outcomes have been reported, and whether this has changed over time. The summary of policy, theoretical and conceptual documents feeds in to this analysis by identifying significant periods of change, and by highlighting the current context, within which we can identify “where we are” now.

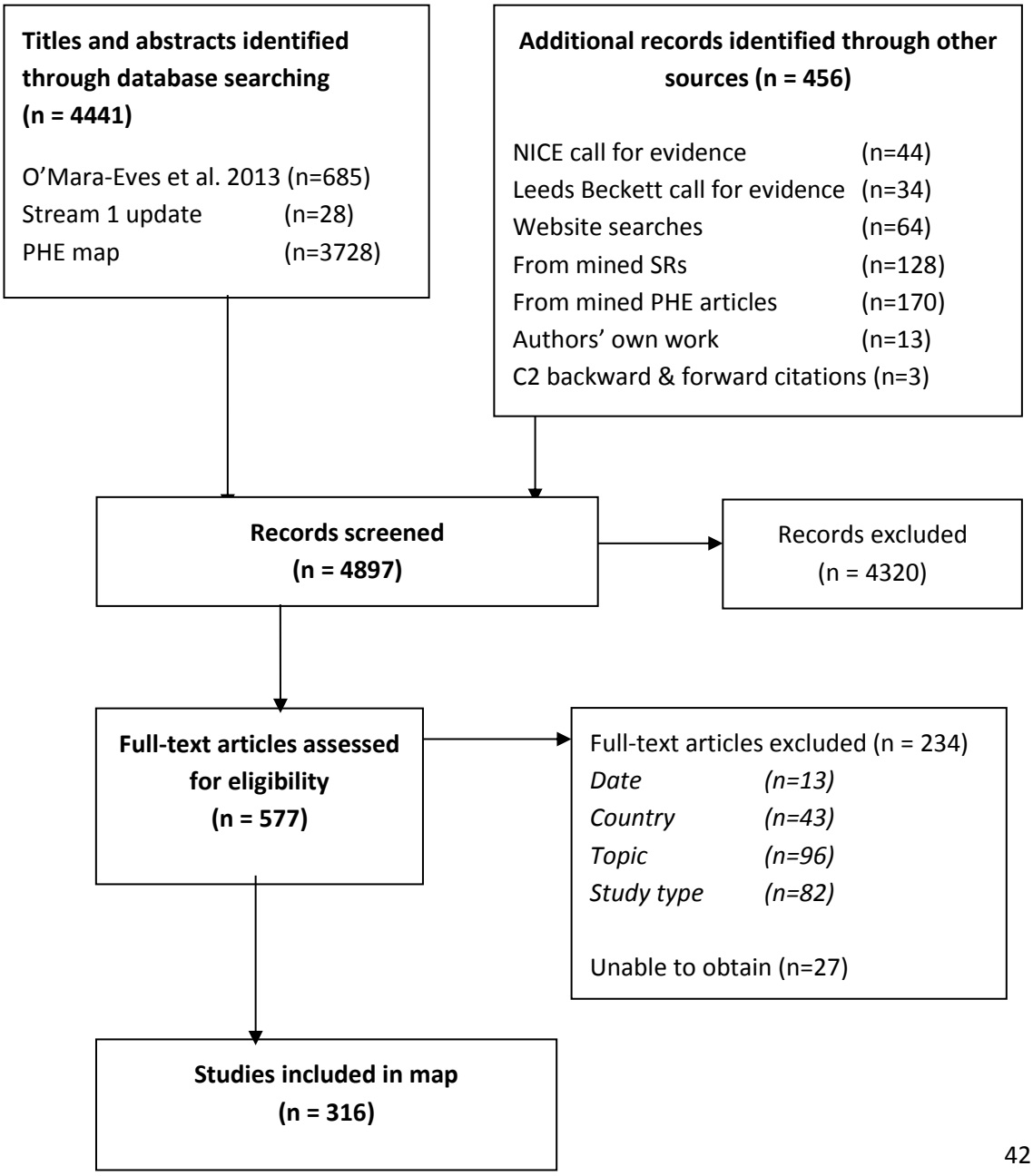
Evidence statements have been produced which summarise findings and the overall strength of the evidence with regard to the number and type (but not quality) of studies as per NICE guidance on systematic reviews.

3. Findings

3.1 Results of literature searches

4441 (91% of total) records were identified through searches of electronic databases, and 456 records (9% of total) were identified from additional sources (see below), making 4897 records for initial screening. After the first screening stage, 4320 records were excluded and 577 full text articles were obtained and screened again. 234 articles were excluded at this stage: 13 were from before 2000 (or before 2006 if policy or conceptual articles), 43 were non-UK, 96 were not about community engagement or not about public health, and 82 were not primary research, policy or practice description pieces. We were unable to obtain 27 articles. This left 316 articles that were included in the map (Figure 3). See Appendix D for a list of included studies, and Appendix E for lists of excluded studies, with reasons for exclusion.

Figure 3: Flow chart of study selection process

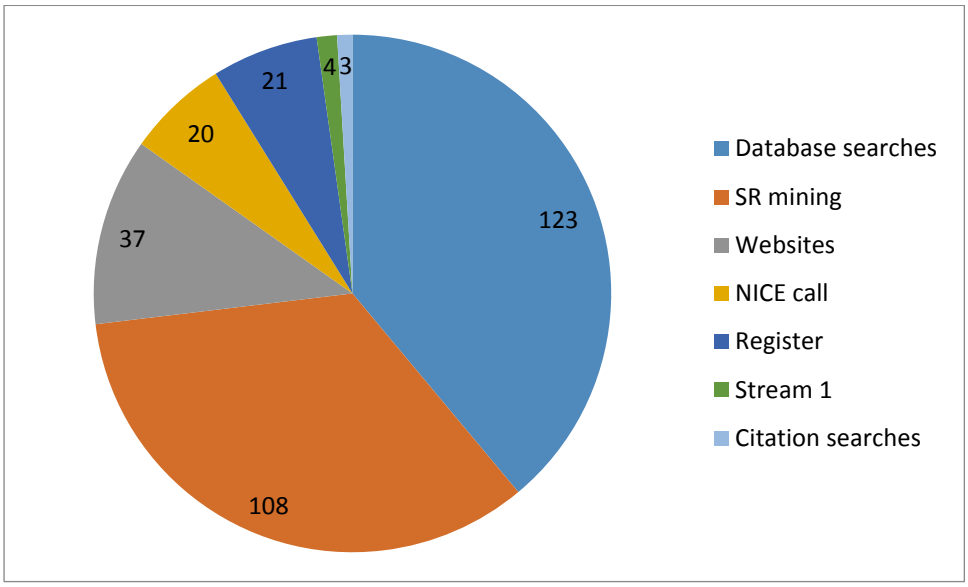


3.2 Overview of included articles

See Appendix G for a table of included study characteristics.

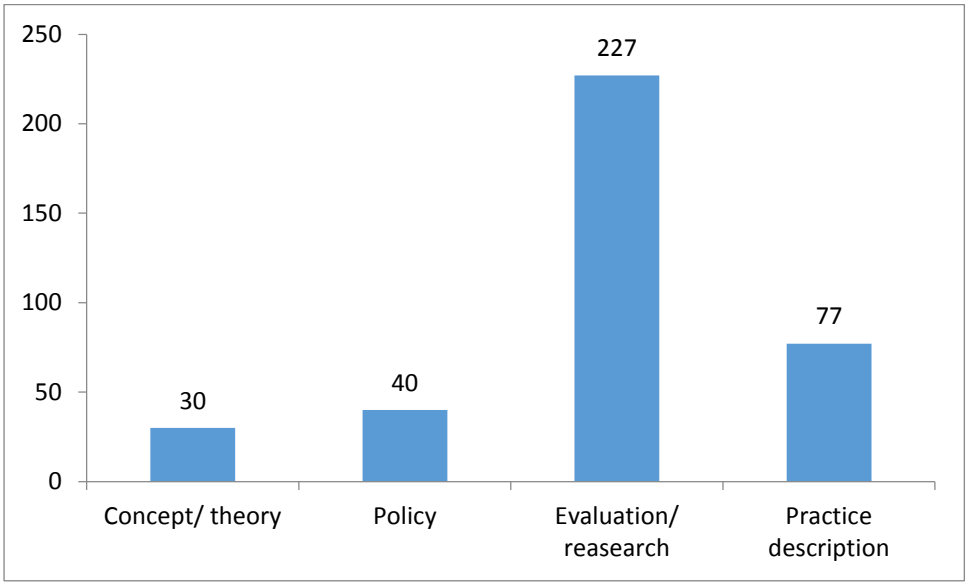
Source (Figure 4): Less than half (123 = 39%) of the 316 included articles came from electronic database searches. 108 (34%) came from "mining" the reference lists of identified systematic reviews and other secondary research articles, 37 (12%) came from website searches (including our own institutions), 20 (6%) came from NICE's call for evidence, 21 (7%) from the Leeds Beckett University Register of Interest, three (1%) from citation searches from Review 5 (Harden et al., 2015) and four (1.3%) came directly from Reviews 1-3 (Brunton et al., 2014).

Figure 4: Sources of evidence



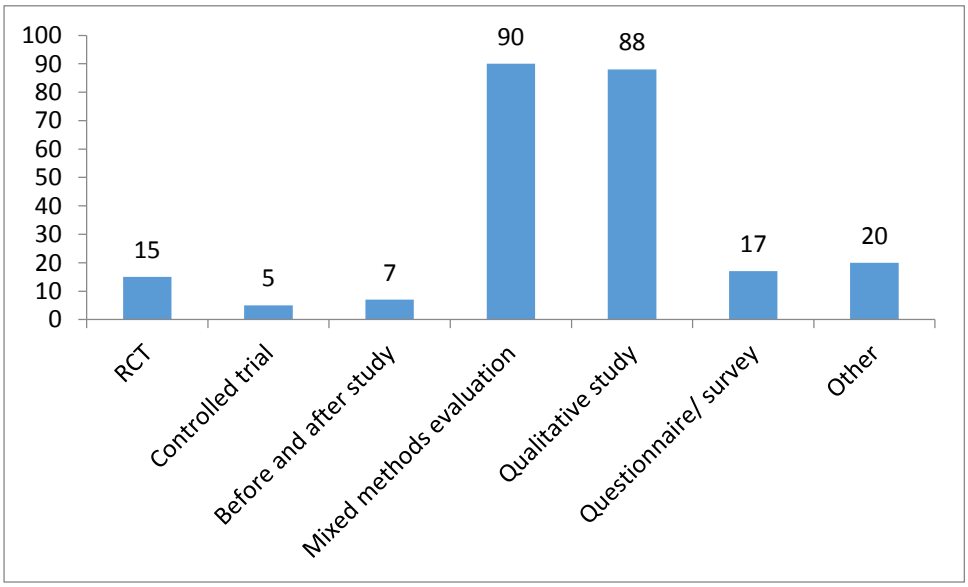
Document type (Figure 5): 227 of the 316 included articles (72%) were coded as research or evaluation, 77 (24%) were coded as practice description, 40 (13%) as policy-related documents, and 30 (9%) as conceptual or theoretical papers. Articles could be coded in more than one of these categories, most commonly policy combined with practice description or research/ evaluation.

Figure 5: Document type



Study design (Figure 6): Of the 227 research or evaluation documents, the majority were coded as either mixed methods evaluation (n=90, 40%) or qualitative studies (n=88, 39%). Seventeen studies (7%) were coded as questionnaires or surveys, fifteen (7%) were randomised controlled trials, seven (3%) were before and after studies and five (2%) were non-randomised controlled trials. Twenty studies (9%) were coded as "other": the majority of these were case studies, or the methods were not described. There was some overlap between these categories, with some studies being coded as more than one study design.

Figure 6: Study design



3.3 Policy and conceptual context

Concept map

Community engagement, as defined by NICE Guidance in 2008, is the process of involving communities in decisions that affect them through engagement in service planning and development or health improvement activities (National Institute for Health and Care Excellence, 2008). This aligns the term with community participation, which has been a central concept in the historical development of public health and health promotion (World Health Organisation, 2009). The Ottawa Charter, which continues to be influential as a framework for practice (Laverack and Mohammadi, 2011), has 'strengthening community action' as one of five areas for health promotion action.

In the mapping review, 30 conceptual or theoretical publications from the UK were identified (Jones, 2004, Beresford, 2007, Boydell and Rugkåsa, 2007, Boyle et al., 2010, Brownlie et al., 2006, Burton et al., 2006, Cabinet Office, 2011, Chadderton et al., 2008, Chirewa, 2012, Communities and Local Government, 2007, Department of Health, 2006b, Draper et al., 2010, Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Hardill et al., 2007, Kennedy, 2006, Laverack, 2006, Local Government Information Unit, 2012, Mahoney et al., 2007, McDaid, 2009, Nesta, 2013, Office of the Deputy Prime Minister, 2006, Scottish Government, 2013, Sheridan and Tobi, 2010, Spencer, 2014, Truman and Raine, 2001, Wait and Nolte, 2006, Wallace, 2007, South and Phillips, 2014, Attree et al., 2011). These included policy documents, research papers and discussions of community engagement theory or practice. Two publications focused specifically on the concept of community participation (Draper et al., 2010, Mahoney et al., 2007), one with an international perspective (Draper et al., 2010) and the other discussing participation in Health Impact Assessment (Mahoney et al., 2007). Four publications focused on community or public involvement (Burton et al., 2006, Chadderton et al., 2008, Department of Health, 2006b, Wait and Nolte, 2006) and four on the topic of community engagement (Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Sheridan and Tobi, 2010, South and Phillips, 2014). The publications on community engagement all discussed the significance of community engagement for health with two presenting frameworks to support engagement (Fountain et al., 2007, Sheridan and Tobi, 2010).

Empowerment is another enduring concept that describes the process and/or outcome of individuals and communities realising more control over their health and lives (Woodall et al., 2010). Empowerment requires active participation as it cannot be conferred by others. Most theoretical frameworks reflect the significance of shifts in power as a significant dimension of participation (Cornwall, 2008). In the mapping review, three conceptual publications focused on the topic of empowerment (Communities and Local Government, 2007, Laverack, 2006, Spencer, 2014), one of these taking an international perspective (Laverack, 2006). Spencer's paper, which focused on empowerment and young people, presented a conceptual framework for understanding the different dimensions of power that affect young people. Laverack's paper similarly presented a conceptual framework based on nine domains of empowerment: improves participation; develops local leadership; increases problem assessment capacities; enhances the ability to 'ask why'; builds empowering organizational structures; improves resource mobilization; strengthens links to other organizations and people; creates an equitable relationship with outside agencies; increases

control over programme management. These and other publications focusing on other aspects of engagement, reflect the importance of empowerment as both a process and a valued outcome in relation to health and wellbeing.

Community engagement concerns social relationships within a wider ecology or social setting (Trickett et al., 2011) and therefore other concepts, such as community cohesion, are of relevance (Elliott, 2012). Four conceptual publications covered aspects of social capital or social cohesion and seven covered aspects of community wellbeing. Other concepts identified in the mapping review included community resilience (Cabinet Office, 2011), volunteering (Hardill et al., 2007) and co-production (Boyle et al., 2006, Local Government Information Unit, 2012). Volunteering describes a specific feature of participation, that is time given freely by people to aid others. The theoretical paper by Hardill et al (Hardill 2007) on volunteering discussed how volunteering is associated with labour market policies. A publication by NESTA on Peer support (Nesta, 2013) linked the concept of peer support to volunteering.

Summary

In summary, the map of UK literature shows that a diverse range of concepts are used to explain and critique aspects of power and participation. There is no common terminology and a number of papers point to the challenges of defining of what are complex sets of ideas. Only four papers specifically dealt with community engagement as a defined topic (Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Sheridan and Tobi, 2010, South and Phillips, 2014). Empowerment continues to be a significant theme – both how it can be achieved and what it means. Since 2006, other relevant concepts, such as co-production and volunteering, have gained some prominence in public health literature. The implications are that community engagement, as proposed in the earlier NICE guidance, is best seen as an umbrella term that covers a range of concepts relating to participation and empowerment.

Map of UK policy from 2006 onwards

In total, 42 publications related to UK policy and community engagement; these were a mix of government documents, policy commentary and a small number of policy evaluations. Together they give an overview of dominant policy themes around community engagement from 2006 onwards. This covers the period of the Labour government 2005-2010 and the Conservative-Liberal Democrat Coalition government of 2010-2015 (see Table 1). Concepts referred to in government documents include community engagement, empowerment and participation. Of particular significance is the Coalition heath reforms which moved public health from NHS to local government.

The mapping review shows that health policy under both governments has endorsed the active involvement of communities and the wider public in local health planning and commissioning (see Table 1). The term ‘patient and public involvement’ (PPI) is used to describe the participation of service users and the wider public in health service and public health planning and decision making.

In total, six government publications (Department of Health, 2006b, Department of Health, 2006a, Department of Health, 2007a, Department of Health, 2010, HM Government, 2012, NHS England, 2013) relating to PPI were identified. One of the conceptual publications focused on the involvement of minority ethnic communities in both research and consultation (Fountain et al., 2007), while another focused on mental health and reported on a participatory action research project with mental health service users to overcome barriers to participation (McDaid, 2009). Public involvement is also used to describe the active involvement of members of the public in research, including public health research. Three conceptual papers published during 2006-7 discussed public or user involvement in research (Beresford, 2007, Brownlie et al., 2006, Fountain et al., 2007), with one focused on the involvement of children and young people as researchers (Brownlie et al 2006). Papers on public involvement in research discussed the value of involving people and the challenges of inclusion, with two describing approaches for practice (Brownlie et al., 2006, Fountain et al., 2007).

The review findings show how public involvement structures have undergone significant change in the last ten years. In 2006, the Labour government introduced new PPI structures including the creation of Local Involvement Networks (LINks) (Department of Health, 2006b). As part of the Coalition health reforms, Health and Wellbeing Boards were created as local structures overseeing public health strategy and also Healthwatch as one of the primary mechanisms for PPI (Department of Health, 2010, HM Government, 2012). The review identified four Coalition government documents relating to community engagement and public health (Department of Health, 2010, Department of Health, 2012a, Department of Health, 2012b, HM Government, 2010b) see Table 1, including the public health strategy 'Healthy Lives, Healthy People' which called for a new approach to empower individuals and communities (HM Government, 2010b). The most recent government publications identified in the review were NHS England's 'Transforming participation in health and care' (NHS England, 2013) and Public Health England's 2013/4 priorities (Public Health England, 2013).

Overall the review shows that there has been consistent policy interest in community engagement in health and in healthcare services from 2006 to the present day. There are some differences of emphasis between healthcare and public health policy. Policy on PPI has resulted in establishment of different involvement mechanisms, such as Healthwatch, underpinned by legislation (HM Government, 2012). In contrast, policy statements on community engagement in public health documents from the Coalition government signal the value of individuals and communities being empowered to make healthy choices, but there are no government proposals for the establishment of specific structures or public health programmes to effect those aspirations.

The key role of local government in leading community engagement and supporting public participation in local decision making has been a consistent policy theme throughout the period covered by the review. Four policy publications between 2006-7 were identified that focused on community empowerment and local government linked to the White paper 'Strong and prosperous communities' produced by the Department of Communities and Local Government in 2006 (Department for Communities & Local Government, 2006b, Department for Communities & Local Government, 2007a, Department for Communities & Local Government, 2007b, HM Government, 2007). The Coalition government has pursued a policy of localism, with the Localism Act of 2011 devolving powers and responsibilities to local authorities to engage with their communities and granting citizens' various rights to

participate and to challenge a local council (HM Government, 2011) (and see Department for Communities and Local Government, 2011 (Department for Communities and Local Government, 2011)). The review identified a further eight policy publications that provided policy commentary in relation to public participation in local planning and decision making; two of these focused on community engagement/empowerment in public health (Bridgen, 2006, Wait and Nolte, 2006) and six on broader themes around public participation, governance and localism (Barnes et al., 2003, Boydell and Rugkåsa, 2007, Local Government Information Unit, 2012, Mauger and et al., 2010, Sustainable Development Commission, 2010, Thraves, 2013).

Community engagement and empowerment have been consistently linked to strategies to address health inequalities. The review identified three Labour government documents relating to health inequalities and community engagement published between 2008-9 (Department of Health, 2008b, Department of Health, 2008a, Department of Health, 2009a) (see Table 1). The period of the Labour government also saw a focus on area based initiatives, resulting in much public health activity being targeted on disadvantaged neighbourhoods through regeneration initiatives and later through spearhead primary care trusts. Three conceptual (Burton et al., 2006, Office of the Deputy Prime Minister, 2006, Wallace, 2007) and three policy publications discussed the critical part community engagement plays in relation to area disadvantage and regeneration initiatives (Office of the Deputy Prime Minister, 2006, Sustainable Development Commission, 2010, Wallace, 2007). The key initiatives were New Deal for Communities (Wallace, 2007) and Neighbourhood Management/ partnerships (Blank et al., 2007, Office of the Deputy Prime Minister, 2006, Sustainable Development Commission, 2010).

Action on inequalities was given further prominence with the publication of the Marmot strategic review of inequalities in England post-2010. The Marmot review made an explicit link between inequalities and community empowerment. Creating and sustaining healthy and sustainable communities was one of six recommended policy objectives (The Marmot Review, 2010). The mapping review identified four conceptual (Attree et al., 2011, Beresford, 2007, Chirewa, 2012, Scottish Government, 2013) and three policy publications (Atkinson, 2012, Bridgen, 2006, Whitehead and Dahlgren, 2007) - one on children and young people (Atkinson, 2012) - that explicitly discussed community engagement as a means to address health inequalities. The most recent government document on community engagement and health inequalities is the Scottish Government's 'Equally Well review 2013' (Scottish Government, 2013) - a report of the Ministerial taskforce on Health Inequalities. Echoing some of the themes of Marmot review, it argues for radical changes in the way public services work with communities and a need to build those local services around people and communities.

Currently, the Coalition government is pursuing a policy of austerity which includes major cuts in government spending and restructuring of the public sector aimed at bringing the deficit under control. Local government, and particularly the larger urban authorities, have seen cuts in their funding of up to 40%. No publications in the review focused on community engagement and inequalities in the context of austerity.

Volunteering is an important concept for community engagement and from 2006, there has been an increasing emphasis on social action and volunteering within health (Department of Health, 2011). One conceptual paper discussed volunteering in relation to disadvantaged

areas (Hardill et al., 2007). The Coalition government introduced the concept of a 'Big Society' which emphasises an increased role for civil society. Two policy publications discussed the Big Society in depth, one concerned with co-production (Boyle et al., 2010) and one from the Cabinet office outlining the roles of individual citizens, communities and third sector organisations (Cabinet Office, 2010).

There has been a growing interest in lay and peer roles during the review period. In 2004, the White paper 'Choosing health' introduced health trainers as a new cadre of lay health worker recruited from, and working within, disadvantaged communities (Department of Health, 2004). One conceptual paper discussed the health trainer initiative in relation to health inequalities (Attree et al., 2011) and one further publication provided an analysis of lay health and food worker roles (Kennedy, 2006). Peer support was the focus of a publication by NESTA (Nesta, 2013).

Since 2006, new sets of ideas have emerged that have generated interest and informed practice. One of these is co-production, which describes approaches that seek to build equal and reciprocal relationships between service users, carers and professionals in the design and delivery of services (Boyle et al., 2010). Co-production has been particularly linked to management of long term conditions and the personalisation agenda within the social care sector. Two publications were identified that discussed co-production (Boyle et al., 2010, Local Government Information Unit, 2012).

Another emergent theme relates to the concept of health assets. While the notion of building on community strengths to promote positive health has a long history in international literature, there has been growing interest in the UK in asset-based approaches to health (Morgan, 2014). Asset-based approaches are described as 'place-based, relationship-based, citizen-led' and therefore involve some degree of community engagement (Foot, 2012). The review identified one policy publication by the Scottish Community Development Centre focused on asset-based approaches to health improvement. This argued that asset-based approaches are an integral part of community development and linked this to Scottish health policy (Scottish Community Development Centre, 2013). The NHS England publication 'Transforming Participation in health and care' (NHS England, 2013) also argued for an asset-based approach to health. The NESTA publication on peer support (Nesta, 2013) and a report on co-production (Boyle et al., 2010) linked to ideas about individual and community assets.

Summary

In summary, there are a number of consistent themes relating to the UK policy context for community engagement and health, based on analysis of 42 policy publications from 2006 onwards. Firstly, policy documents, reviews and commentary concerning community engagement and health can be mapped across a wide range of policy areas and sectors. These include: health policy and the NHS, local government policy and regeneration, third sector and volunteering and also health inequalities as a cross cutting policy issue. Very few publications were focused exclusively on community engagement and public health, but all related to in some way to the active participation of individuals and communities as a

mechanism to improve health, community life or quality of local services or alternatively to reduce inequalities and area disadvantage.

Secondly, since 2006 there are consistent themes across government policy relating to the significance of community engagement and empowerment. The review has highlighted a number of specific policy initiatives from both Labour government 2005-2010 and the Conservative-Liberal Democrat Coalition government of 2010-2015. These include changes in PPI structures and public involvement mechanisms affecting health planning and services; neighbourhood management, Localism aimed at devolution of power to local communities and health inequalities policy. There are also relevant policies from the devolved assemblies (Welsh Assembly 2008; Scottish Government 2013). Overall, publications relating to inequalities and community empowerment, whether originating from government or from independent sources, like the Marmot review, called for new relationships between services and communities that give more power to communities, enabling individuals to play a greater part in local decisions that affect their health and lives.

Thirdly, the review has identified a consistent theme around the contribution of individuals and communities to health and to society in general. Discussion and commentary cluster round various concepts which are frequently cross-referenced to each other. These include asset-based approaches, co-production and volunteering.

Table 1: Policy documents identified in mapping review

Year	Health policy	Other policy
2006	- Department of Health (2006). Our Health, our care, our say: a new direction for community services. - Department of Health (2006). *A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services*.	- Department for Communities and Local Government (2006). *Strong and prosperous communities: The Local Government White Paper.* - Office of the Deputy Prime Minister (2006). *Neighbourhood management – At the turning point? Programme review 2005-2006*.
2007	- Department of Health (2007). *Commissioning framework for health and well-being*.	- HM Government (2007). Local Government and Public Involvement in Health Act 2007. - Communities and Local Government (2007). *An Action Plan for Community Empowerment: Building on Success*. - Department for Communities and Local Government (2007). *Local Government and Public Involvement in Health Bill: statement of intent - statutory guidance. Community empowerment*.
2008	- Department of Health (2008). *Tackling Health Inequalities: 2007 status report on programme for action*. - Department of Health (2008). *Health inequalities: Progress and next steps.*	- Welsh Assembly (2008). *Designed to add value: a third dimension: a strategic direction for the voluntary and community sector in supporting health and social care*.
2009	- Department of Health (2009). *Tackling Health Inequalities: 10 Years On – A review of developments in tackling health inequalities in England over the last 10 years*.	
2010	- Department of Health (2010). *Equity and excellence: liberating the NHS*. - HM Government (2010). *Healthy lives, healthy people: Our strategy for public health in England*.	- HM Government (2010). *Building a stronger civil society: A strategy for voluntary and community groups, charities and social enterprises*. - HM Government (2010). *Equality Act 2010*.
2011		- HM Government (2011). Localism Act 2011
2012	- Department of Health (2012). *Improving outcomes and supporting transparency. Part 1A: A public health outcomes framework for England, 2013 to 2016*. - Department of Health (2012). *Improving outcomes and supporting transparency. Part 2: Summary of technical specifications of public health indicators*. - HM Government (2012). *Health and Social*	

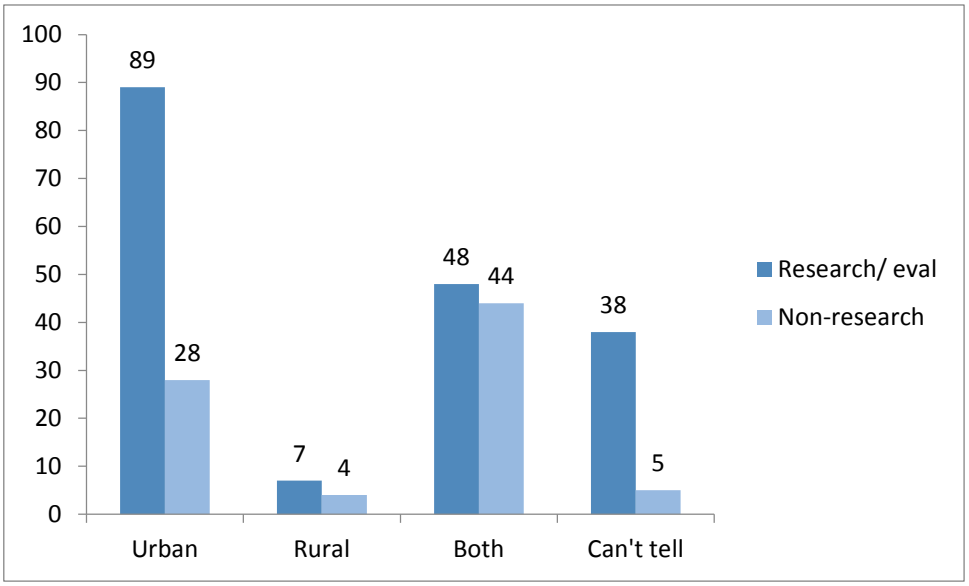
Year	Health policy	Other policy
	Care Act 2012.	
2013	- Public Health England (2013). P*ublic Health England: our priorities for 2013/14* - NHS England (2013). *Transforming Participation in health and care*. - Scottish Government (2013). *Equally well: review 2013 - report of the Ministerial Task Force on Health Inequalities*.	

3.4 Communities

Place (Figure 7): The largest group of articles (n=117, 37%), both research (n=89, 39%) and non-research (n=28, 31%), looked at initiatives in urban settings. A large number (n=92, 29%) also looked at initiatives in both urban and rural settings. Only 11 articles (3.5%) looked at initiatives in rural settings alone (Bromley 2014, Davies, 2009, Dickens et al., 2011, East Midlands Regional Empowerment Partnership, 2009a, Elliott et al., 2007, Halliday and Asthana, 2005, Hoddinott et al., 2006a, Hoddinott et al., 2006b, Osborne et al., 2002, Starkey et al., 2005, Stutely, 2002). In 43 articles (14%), the setting was not clear.

As this was a mapping review, we did not undertake detailed data extraction on the populations other than to code for indicators of health inequalities using the PROGRESS-plus tool (see below). However, the UK evidence base on community engagement includes articles on communities of place (see above and *e.g*. Well London), communities of interest, such as culture (*e.g.* Roma support group) or situation (*e.g.* NCT peer support training for refugees and asylum seekers), ethnicity, age (*e.g*. Youth.com; MAC UK; Partnerships for Older People), or health and wellbeing issues (*e.g.* long term conditions).

Figure 7: Place



Inequalities: Included articles were coded on PROGRESS-Plus (Kavanagh et al., 2008) indicators of health inequalities targeted by initiatives. In Figure 8, it can be seen that the indicators coded for the most frequently were socioeconomic indicators (n=124, 40%) and "other" indicators of disadvantage (n=123, 39%) – these included a range of characteristics such as disability; older people; mental health service users (see Table 2 for a full breakdown of groups included in this category). Other significant indicators of inequality targeted by included initiatives were race/ ethnicity (n=69, 22%), lack of social capital or social exclusion (n=46, 15%) and initiatives targeting a specific gender (n=39, 13%).

This demonstrates that community engagement initiatives in the UK go beyond the approach of targeting the most obvious indicators of inequality (*i.e.* those that are included in health equity profiles such as ethnicity, gender and occupational or socioeconomic status) and seek to engage some of the most marginalised, disadvantaged or excluded population groups, such as offenders, homeless people, people with poor physical or mental health, disabilities or learning difficulties, and older people (at risk of social isolation). This is true of both research and non-research articles.

Community engagement initiatives for populations coded as being in the category "Other indicators of disadvantage" were more likely to use peer (45S (47%), 6D (16%)) or volunteer (34S (36%), 4D (14%)) involvement approaches than those for populations coded as having socioeconomic indicators of disadvantage (Peer involvement 31S (34%), 6D (17%); Volunteers 11S (12%), 3S (11%)), which were similar to the percentages given across the range of UK initiatives in this mapping review (see "Approaches" below).

Figure 8: Population – PROGRESS-Plus indicators

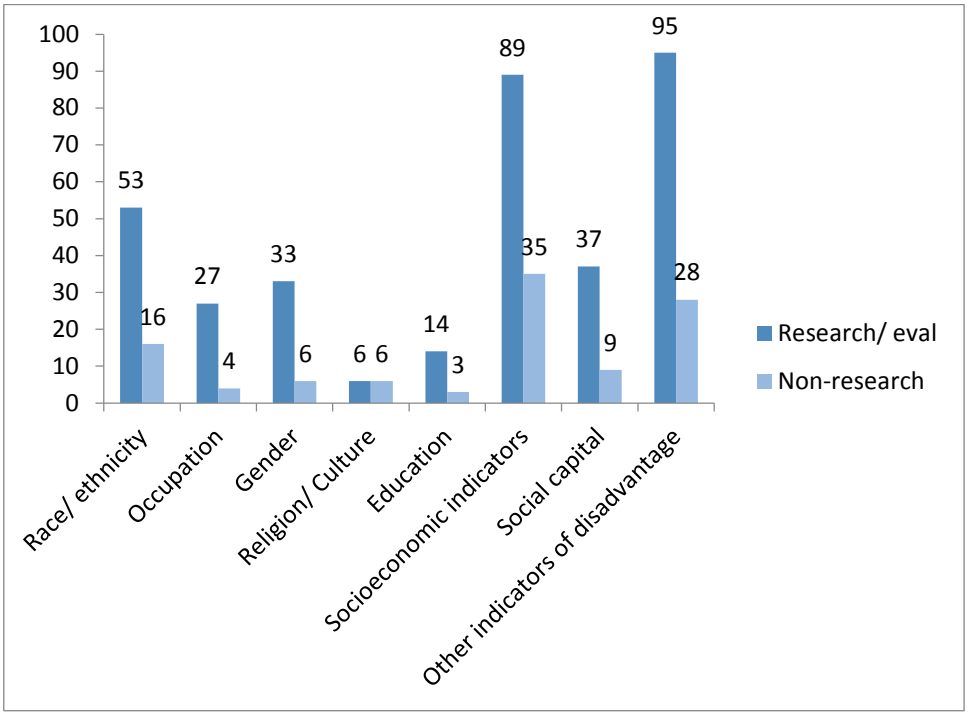


Figure 9 displays trends in the targeting of groups at risk of health inequalities over time. It can be seen that socioeconomic status and the "other indicators of disadvantage" categories were consistently the most targeted indicators of inequalities.

Figure 9: Trends over time in CE initiatives targeting groups at risk of health inequalities

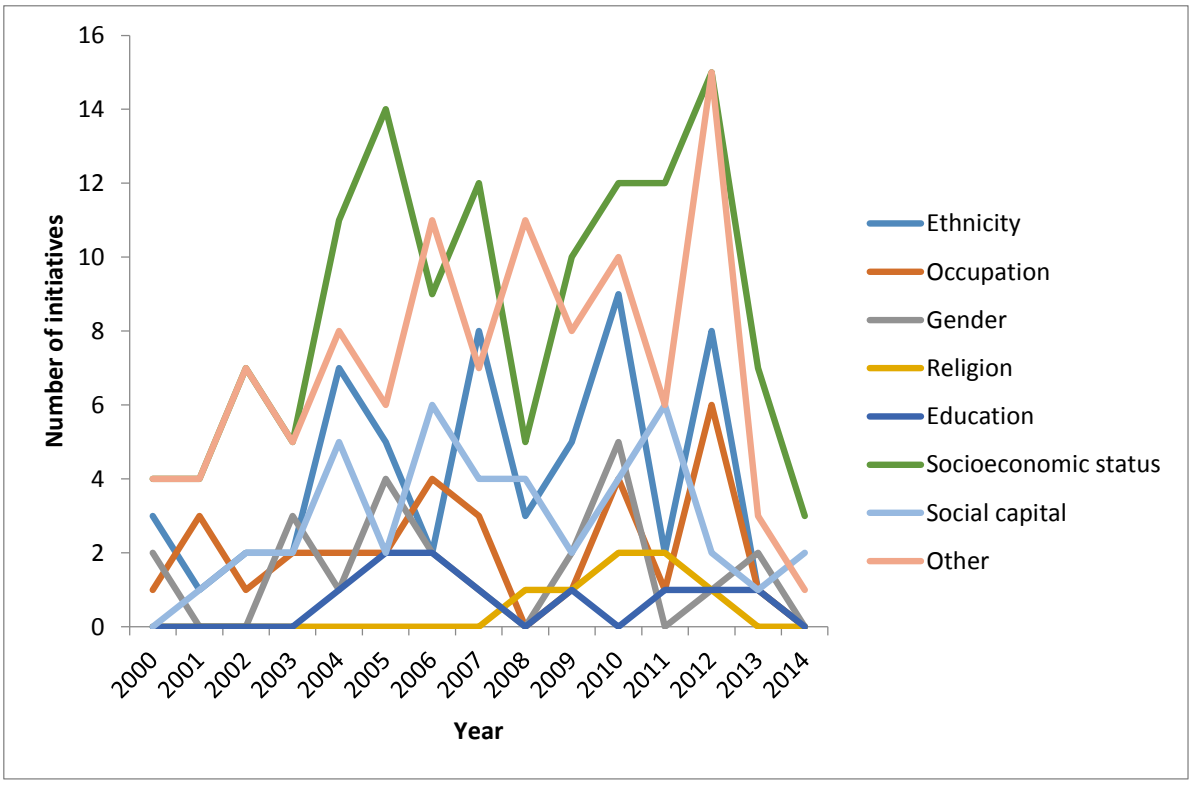


Table 2 Groups coded as "Other indicators of disadvantage" in PROGRESS-Plus

Group	Number of studies/ initiatives
Older people	36
Disability or learning difficulties	22
Poor health/ LTCs	20
Children and young people	20
Mental health difficulties	19
"disadvantaged" or "deprived"	18
Poor housing/ homeless	16
Offenders	9
Lone parents	9
Refugees/ asylum seekers	8
Substance abuse	8
Social isolation/ exclusion	8
Carers	6
High rates of teenage pregnancy	6
LGBT	5
"Hard to reach"	4
Crime	4
Low literacy	4
"Marginalised"	2
Low access to health or social care services	2
Gypsies, Travellers or Roma	2
"vulnerable"	2
Domestic violence	2
Sex workers	1
Looked after children	1

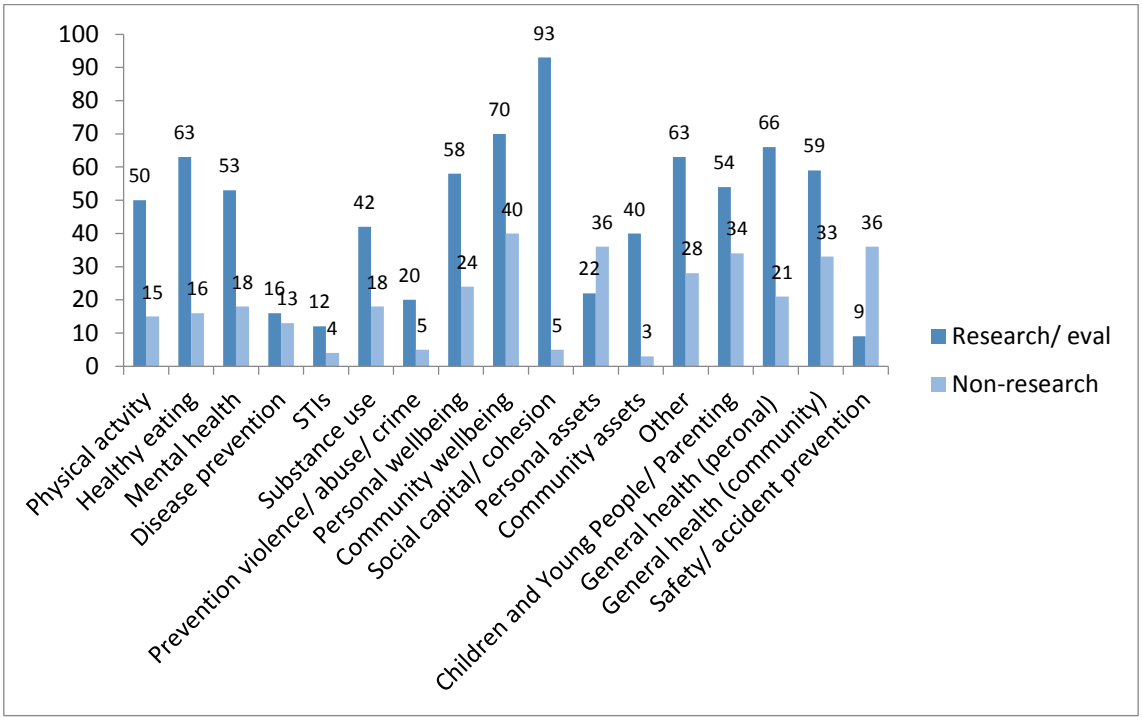
Group	Number of studies/ initiatives
Complex needs	1
Road accidents affecting mostly children	1
Fear & mistrust	1
Lack of access to good quality food	1

3.5 Health & Wellbeing issues

The issues addressed most frequently by the initiatives in the included articles were social capital or social cohesion (n=129, 41%), community wellbeing (n=110, 35%), personal wellbeing (n=82, 26%), general health – personal (n=99, 31%) and general health – community (n=95, 30%). There were no striking differences in the health and wellbeing issues looked at by research or non-research articles, as can be seen in Figure 10.

As for all initiatives included in this map, initiatives for populations with “other” indicators of disadvantage were also most likely to address social capital or cohesion issues (46S (48%), 11D (39%)), but individual issues such as physical activity (24S (25%), 1D (4%)), healthy eating (28S (29%), 1D (4%)), mental health (28S (29%), 4D (14%)) and substance use (23S (24%), 2D (7%)) were also commonly targeted. Personal assets was a health and wellbeing category that was more commonly addressed in this group than any other (14S (15%), 1D (4%))

Figure 10 Health and wellbeing issues



3.6 Approaches to community engagement:

The mapping review found a wide range of approaches to community engagement in the 316 included articles, which were grouped into seven types (see Glossary). Community mobilisation/ action (138 articles, 89S, 49D; 44%) and community partnerships/ coalitions (180 articles, 113S, 67D; 57%) were the most commonly used approaches to community engagement in both research and non-research articles (Figure 12). Peer involvement (n=97, 82S, 15D; 31%) and volunteers (n=64, 50S, 14D; 20%) were common approaches in research articles, but less so in non-research articles. Different approaches seemed to be used to target different types of health or wellbeing issues (Figure 13), for example peer involvement was most often seen in interventions targeting individual behaviour change (e.g. physical activity, healthy eating, substance use), whereas community mobilisation/ action or partnership/ coalition approaches were more often seen in initiatives that focused on community wellbeing, social capital or community assets.

Figure 12 Type of community engagement

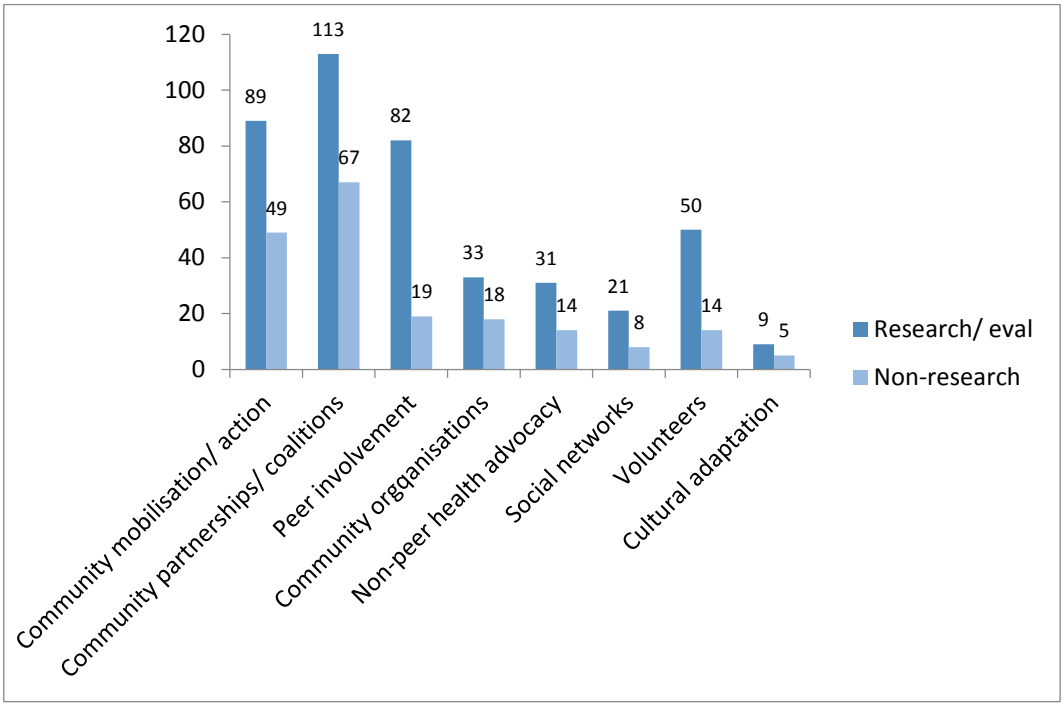


Figure 13 Health or wellbeing issue by type of CE

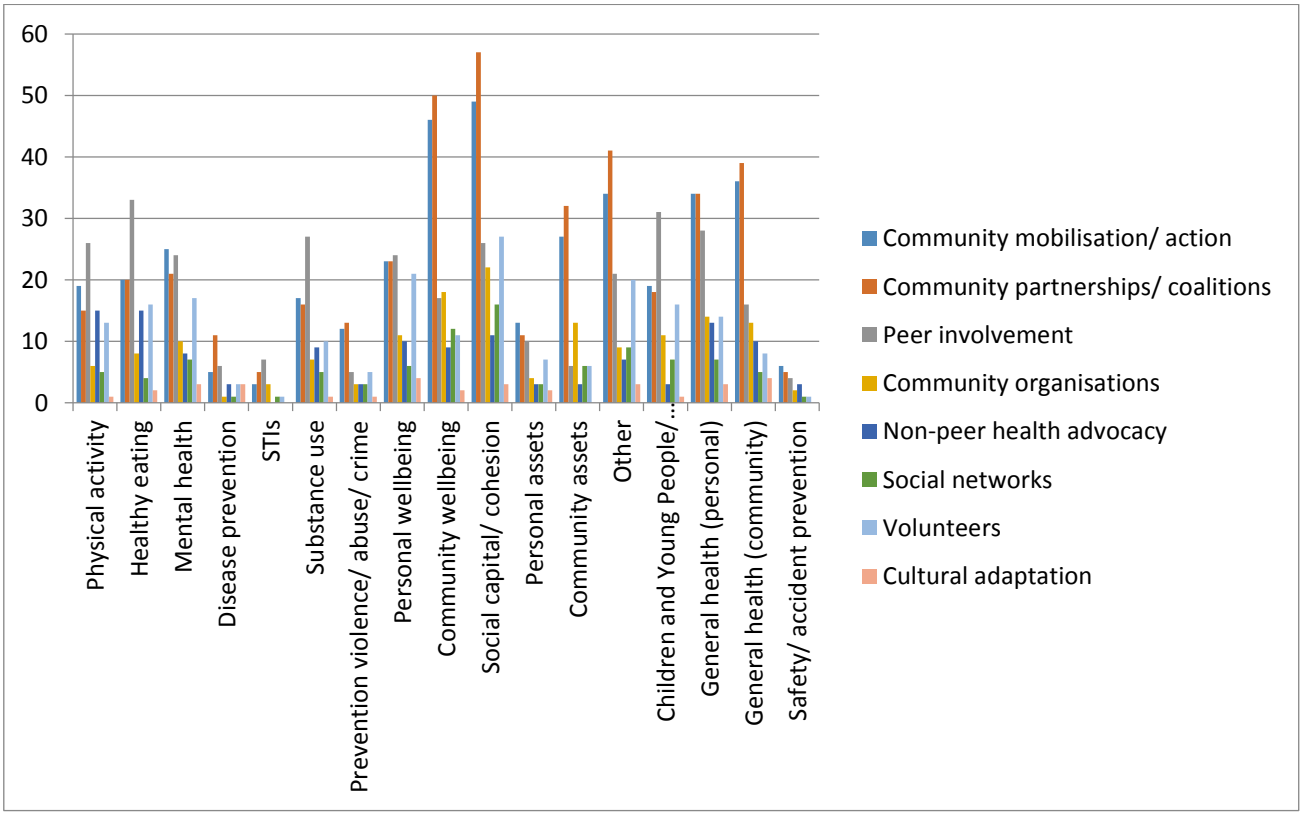


Table 3 displays the initiatives coded in each of the seven types of approach to community engagement, for years 2006 to 2013. Further description of the key initiatives in each approach is given below, although many of these have been coded under more than one type of approach (see Table 3, and Appendix G for full details of included articles).

Community mobilisation/ action: 138 articles were coded as including community mobilisation/ action, defined as a capacity building process, through which individuals, groups and families as well as organisations, plan, carry out and evaluate activities on a participatory and sustained basis to achieve an agreed goal. Some initiatives used innovative methods such as art, music and photography to engage with community members (Callard 2005, Curno 2012, Mental Health Foundation 2013). Examples include:

- Altogether Better - a five-year programme funded through the BIG Lottery that aimed to empower people across the Yorkshire and Humber region to improve their own health and that of their families and their communities. The regional programme was made up of a learning network and sixteen community and workplace projects with an emphasis on three themes: physical activity, healthy eating and mental health & well-being. Altogether Better was based on an empowerment model and at the heart of this model was the concept that community health champions can be equipped with the knowledge, confidence and skills to make a difference in their communities. This model was based on three elements: building confidence, building capacity and system challenge. (Altogether Better, 2010, White and Woodward, 2013, Woodall et al., 2012a).

- Well London Alliance: partnership headed by the London Health Commission and funded through the BIG Lottery's (BIG) Well-being fund (Chapman, 2010, Craig, 2010, Phillips et al., 2014, Phillips et al., 2012, Sadare, 2011, Tunariu et al., 2011, Well London and NHS Hammersmith &Fulham, 2011). The Well London programme used a community engagement and co-production approach to design and deliver a suite of community-based projects with the aim of increasing physical activity, healthy eating, and mental health and wellbeing in 20 of the most deprived neighbourhoods in London. The projects involved a mix of traditional health promotion interventions, community engagement activities, and changes to the physical neighbourhood environment.

- Other initiatives that used a **health champions** approach included: Life is Precious (Curno 2012); Health Literacy improvement (Liverpool John Moore's University, 2012); Sheffield All Being Well Consortium (Reece and Flint, 2012); Community Champions Fund (Watson et al., 2004).

- Health Improvement Programmes (Arora et al., 2000) – these were government-led three-year action plans, developed in each health authority district, aimed at improving the health of the local population.

- Healthy Living Centres (Bridge Consortium 2002, Hills 2007, Platt 2005) – which aimed to address health inequalities and social exclusion targeting people in deprived areas, via a number of different methods including various health based

activities. These were funded by the New Opportunities Fund, which became the Big Lottery Fund.

- National Empowerment Partnership Programme (Sender 2011): The NEP programme aimed to empower citizens and communities, and to demonstrate the difference that community empowerment can make to individuals, community groups, communities and public agencies, develop effective methods of quality assurance for community empowerment, promote good practice. To achieve these aims, the programme: supported individuals and communities in engaging and taking up opportunities to be involved in and influence local decisions; built the capacity of local authorities and other public agencies to engage and empower communities; and ensured a coordinated approach to empowerment activity across the voluntary and community sector (VCS) and public agencies.

- Neighbourhood Management Pathfinders Programme (Brown 2002, DCLG 2007, East Midlands Regional Empowerment Partnership, ODPM 2006) - community involvement in innovative ways of delivering diverse projects/ services, by: (i) establishing and supporting a wide range of local groups and activities, especially for children and young people; (ii) creating opportunities for people from different backgrounds and communities to come together and work towards common goals (*e.g.* a local radio station); (iii) giving residents more of a sense of local identity through festivals, community centres and through reclaiming local public spaces; (iv) tackling negative stereotypes of the neighbourhood and of particular groups within it.

- Assets-based approaches (*e.g.* IRISS 2012: asset mapping project to discover community assets in Kirkintilloch that were useful and available for positive mental health and well-being, but also to help others identify their own personal assets; McLean 2012: illustrating asset based approaches for health improvement in communities in Scotland, Scottish Community Development Centre 2013)

- Co-production initiatives
    - Boyle 2006: Rushey Green Time Bank, Cares of Life project, Rhymney Time Bank, Blaengarw Time Centre, Dinas Time Bank, Gorbals Time Bank, Peer tutoring project, Patch, Seal, Peer advocacy project, Roots.
    - Hatzidimitriadou 2012: offering Improved Access to Psychological Therapies (IAPT) services in the locality
    - Hough 2014: co-producing Cardiovascular health in Wandsworth

- Mental health initiatives:
    - National Institute for Mental Health in England Community Engagement Project (Fountain 2010): The community engagement strand of the Delivering Race Equality (DRE) action plan is a significant aspect of the work of DRE. As one of the three building blocks of the action plan and programme which developed to implement it, the work on community engagement is a good barometer to gauge – at a grassroots level – the extent to which people from Black and minority ethnic (BME)

communities feel engaged; feel that their views are taken on board by commissioners and providers of services; and feel that there is real improvement in how they access and experience mental health services.
    - Positive Mental Attitudes (Quinn 2005, Quinn 2010) ten year mental health inequalities programme in Scotland using community development principles.

- Local community projects developed for specific populations (Bandesha 2005; Christie 2012, Dickens 2011, Ewles 2001, Healthy Communities 2010, Hothi 2007, Kimberlee 2008, MacKinnon 2006, Power 2001) or specific health issues *e.g.* Breathing Space for smoking cessation (Ritchie 2001, Ritchie 2004).

- Community projects developed for specific cultures *e.g*. Roma Support Group 2009) which used Action Research in order to identify the barriers and enablers faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms.
- Health Action Zones (Barnes 2004, Barnes 2005, Bauld 2005, Benzeval 2003, Boydell 2007, Cole 2003) – these area-based initiatives aimed to reduce the effects of persistent disadvantage, by identifying and addressing the public health needs of the local area, increasing the effectiveness, efficiency and responsiveness of services, and developing partnerships for improving people's health and relevant services, adding value through creating synergy between the work of different agencies.
- Community Participation Programmes (Taylor 2005): The Community Empowerment Fund (CEF), Community Chests (CCs) and Community Learning Chests (CLCs). These were designed to: encourage more people to become involved in the regeneration of their neighbourhoods; help residents gain the skills and knowledge they need to play an active role in Neighbourhood Renewal; and support the involvement of the local community and voluntary sector as an equal partner in local strategic partnerships (LSPs).
- Communities that Care (Crow 2004, France 2001). This early intervention programme targets children living in communities and families that are deemed to put them at risk of developing social problems. The CTC approach focuses on specific geographical areas and involves bringing together local community representatives, professionals working in the area and senior managers responsible for service management.
- Area regeneration programmes. The most well -known of these is the New Deal for Communities (Blank 2007, Dinham 2007, Lawless 2004, Lawless 2007, Muscat 2010, ODPM 2005, Stafford 2008), an area-based initiative that aims to improve conditions in some of the most deprived neighbourhoods in England and reduce the gap between them and the rest of the country. There are 39 NDC areas, each with a budget of approximately £50 million with which to address five specific outcome areas (health, unemployment, education, crime and the physical environment) over 10 years. In order to be considered for NDC funding, community partnerships involving local residents, local authorities, public service providers, community and voluntary organisations and businesses had to prepare a proposal for regeneration.

Other smaller regeneration programmes were also included (Anastacio 2000, Berkeley 2011, Callard 2005, Cindersby 2014, CHEX 2014, Lawson 2009, Stutely 2004, Single Regeneration Budget Partnerships (Office of the Deputy Prime Minister 2002); Residents' Consultancy Pilot (ODPM 2004). The outcomes for regeneration programmes tended to be at community level and focused on social determinants of health, social capital and wellbeing, rather than individual health.

Community partnerships/ coalitions: 180 articles were coded as including community partnerships/ coalitions. Community members can be partnered with any combination of service providers, academics, government members, or industry. Examples include:

- Wirral Healthy Homes (Seymour 2014): holistic response to improving the health and wellbeing of vulnerable residents and improving the property condition. Referrals to the network of partners Healthy Homes has established can help achieve positive health outcomes for residents and reduce health inequalities.
- Sure Start (Anning 2007, Bagley 2006): multi-agency/ multi-disciplinary parenting and early years support; health, play and learning.
- Commissioning services and support for people with learning disabilities and complex needs (David 2008, McCaffrey 2008): supporting people with learning disabilities and complex needs to live their lives fully through the activities of commissioning.
- Have a Heart Paisley (Blamey 2004): The long-term aim of HaHP was to reduce the total burden and levels of inequality of Coronary Heart Disease (CHD) in the town of Paisley through an integrated programme of secondary and primary prevention. The combined interventions were to be delivered in partnership and in a manner that engaged the community at all levels of the programme. It was hoped that this integrated approach would be capable of saturating the town of Paisley with improved and new services, projects and opportunities that would, over the long term, reduce and prevent CHD amongst the Paisley population.
- Time banks (Burgess 2014, Cambridge Centre for Housing Planning Research 2013)): an exchange system in which time is the principal currency. For every hour participants 'deposit' in a time bank, perhaps by giving practical help and support to others, they are able to 'withdraw' an hour of support when they are in need.
- Social Exclusion Partnerships (Chapman 2001): community participation in multi-agency partnerships to improve social inclusion.
- Citizens' Juries (Gooberman-Hill 2008): public involvement: involving members of the public in citizen's jury setting priorities for health research.
- Boscombe Network for Change (Hamer 2000): a health-related forum of statutory and voluntary agency employees, volunteers and local residents, set up in 1996, born out of a concern to promote 'change' in the deprived ward of Boscombe.
- Govanhill Equally Well test site (Harkins 2012): a localised partnership approach (involving public and third sectors as well as community members) which aims to improve all aspects of life and conditions in the area.
- Healthy Weight Communities (Rocket Science Ltd 2011): The purpose of the Healthy Weight Communities Programme was to demonstrate the ways in which engaging communities in healthy eating, physical activity and healthy weight

activities as part of a single coherent programme may have a greater impact on health outcomes than current discrete activities.

- Health Impact Assessment (Mahoney 2007; Kearney 2004; Elliott et al. 2007; Chadderton et al. 2008): HIA is intended to support decision-making in choosing between options by predicting the future consequences of implementing the different options.
- Rural regeneration partnerships (Osborne 2002): community involvement in rural regeneration partnerships.
- Partnerships for Older People Projects (PSSRU 2009): aims to create a sustainable shift in the care of older people, moving away from a focus on institutional and hospital-based crisis care toward earlier and better targeted interventions within community settings.
- Mosaics of Meaning (NHS Greater Glasgow & Clyde 2010): a partnership to research and then address stigma relating to mental health problems with the four largest settled BME groups in Glasgow: Pakistani, Chinese, Indian and African and Caribbean.

Peer involvement

97 articles were coded as including peer involvement, defined as any peer involvement, *e.g.* peer counselling, peer education, peer leaders, peer leadership, role models, peer support. Examples include:

- Breastfeeding and parenting peer support (Alexander 2003, Curtis 2007, Hoddinott 2006, Ingram 2005, Ingram 2013, Jolly 2012, MacPerson 2010, MacArthur 2009, McInnes 2000, Newburn 2013, Raine 2003): various models both group and individual support *e.g.* Birth and Beyond community supporters programme (NCT), designed to recruit and train community volunteers to work as peer supporters for parents who are refugees or asylum seekers, with the aim of reducing isolation, stress and low mood during pregnancy and the first two years after birth.
- A Stop Smoking In Schools Trial (ASSIST) (Audrey 2006, Audrey 2008, Campbell 2008, Starkey 2005): Peer supporters in secondary schools encourage stopping smoking .
- Peer-led sex education (Stephenson 2008)
- Activity Friends (Corbin 2006): Activity Friends is a volunteer programme for the over 50s designed to help people achieve a healthier lifestyle through increasing physical activity and befriending to alleviate social isolation.
- Health Trainers (Dooris 2013) – health trainers in the criminal justice setting.
- Peer Power (Duffy 2012): Peer support group for people with mental illness.
- Peer education – popular onion leader “diffusion of innovation” model (Elford 2001, Flowers 2002, Kelly 2004): aimed at gay men, preventing HIV transmission.
- Active at 60 Community Agent Programme (Hatamian 2012): Community agents (community groups and their volunteers) to help people approaching and post retirement to stay or become more active and positively engaged with society, in particular those at risk of social isolation and loneliness in later life.

Community organisations

51 articles were coded as including community organisations (new or existing). Most of the initiatives in this section were also coded under at least one of the other types of community engagement. Examples include:

- Imagine East Greenwich (Callard 2005): a series of arts/health projects developed as part of a regeneration programme on two housing estates in a London borough.
- Peer Power (Duffy 2012): peer support group for people with mental illness.
- Healthy Living Centres (Hills 2007, Platt 2005): The Healthy Living Centre (HLC) programme was set up in 1998 to fund community level interventions to address health inequalities and improve health and wellbeing in innovative ways. The programme funded 351 HLCs, which in turn generated a wide range of different activities, tailored to the needs of their local communities. These operated on a number of different models – some based mainly within one central building, while others functioned as partnerships or networks of activities run by different organisations at a number of different sites. Some HLCs focused on specific health-related services, but in keeping with the broad, holistic vision of the programme, many have sought to address the wider determinants of health inequalities, such as social isolation, unemployment and poverty.
- Natural Choices for health and wellbeing (Wood 2013): a joint venture between Liverpool PCT and The Mersey Forest which aimed to promote health and wellbeing in Liverpool residents using natural environments and thus create a city focused upon natural choices for health and wellbeing.

Non-peer health advocacy

45 articles were coded as including non-peer health advocacy for members of the community that are NOT peers of the target participants, where 'peer' is defined as sharing the same age group or health risk/condition or similar in key aspects (*e.g.* race/ ethnicity). Examples include:

- Health Trainers (Green 2012, Ward 2009, Lorenc 2013, South 2007): a national programme introduced by the Department of Health in 2006. The aim of the programme is to recruit people from local communities with a good understanding of local issues who can offer tailored advice, motivation and practical support to individuals who want to adopt a healthier lifestyle and act as message bearers between professionals and communities. A national package of accredited training has been developed to support the work of the health trainers and develop their skills as part of the healthcare workforce.
- Lay food and health workers (Kennedy 2008, Kennedy 2010) Any lay health worker: indigenous to the communities being served, carrying out functions related to community-based public health initiatives designed to prevent disease or promote health and wellbeing, with specific focus on food and public health; trained in some way in the context of the intervention; but having no formal professional or paraprofessional qualifications.

- Lay led walking programmes (Lamb 2002): community-based lay led walking scheme.
- Roy Castle fag ends stop smoking service (Owens 2006): adult smoking-cessation service across Liverpool. Unique aspects are that the service is provided by trained lay advisors with a nonmedical background and there is no waiting list - clients can self-refer by calling a helpline or walking into a meeting.

Social networks

- 28 articles were coded as including social networks (explicit use of the term). Most of these articles were also coded under at least one of the other types of CE. Examples include: Time banks (Burgess 203, Cambridge Centre for Housing Planning 2014, NEF 2002): an exchange system in which time is the principal currency. For every hour participants 'deposit' in a time bank, perhaps by giving practical help and support to others, they are able to 'withdraw' an hour of support when they are in need.
- Community Participation Programmes (Taylor 2005): designed to encourage more people to become involved in the regeneration of their neighbourhoods, help residents gain the skills and knowledge they need to play an active role in Neighbourhood Renewal; and support the involvement of the local community and voluntary sector as an equal partner in local strategic partnerships (LSPs).

Volunteers

61 articles were coded as including volunteers (explicit use of the term). Examples include:

- Befriending schemes (Andrews 2003): voluntary sector local home visiting befriending service.
- Changing Minds (Cawley 2011): mental health awareness training.
- Walking for Health (Howlett 2000): an initiative to increase the health and fitness of sedentary people by promoting regular and brisk walking within local communities.

Table 3 Initiatives by type of community engagement approach (Brunton et al. 2014)

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
2006	Community development including people with learning difficulties (Kennedy et al., 2006); Co-production (Boyle et al., 2006) Roy Castle fag ends stop smoking service (Owens and Springett, 2006);	Pathfinder programme (neighbourhood management) (Office of the Deputy Prime Minister, 2006, Department for Communities & Local Government, 2006a); Co-production (Boyle et al., 2006); Public involvement in planning health care (Anderson et al. 2006); Sure Start (Bagley and Ackerley, 2006); Citynet project (Bolam et al. 2006); Community food initiatives (Pritchard et al. 2006)	ASSIST (peer-led smoking cessation in schools) (Audrey et al., 2006a, Audrey et al., 2006b); Breastfeeding peer support in rural Scotland (Hoddinott et al., 2006b, Hoddinott et al., 2006a); Activity Friends: peer mentor physical activity programme for over 50s (Corbin, 2006); Co-production (Boyle et al., 2006) Sure Start (Bagley and Ackerley, 2006); Community based peer education nutrition intervention (Hyland et al. 2006)	Citynet project: building social capital and improving ICT access for disadvantaged groups in Nottingham, UK.(Bolam et al., 2006); Sure Start (Bagley and Ackerley, 2006); Community food initiatives (Pritchard et al., 2006); Co-production (Boyle et al., 2006) Citynet project (Bolam et al. 2006);	Roy Castle fag ends stop smoking service (Owens and Springett, 2006); Lay food and health workers (Kennedy, 2006); Health Trainers(Visram et al., 2006); Citynet project (Bolam et al. 2006);	Co-production (Boyle et al., 2006); Sure Start (Bagley and Ackerley, 2006);	Volunteering (Bowers et al., 2006, Baines et al., 2006); Co-production (Boyle et al., 2006) Sure Start (Bagley and Ackerley, 2006); Community food initiatives (Pritchard et al. 2006)

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
2007	Healthy Futures (CE model) (Glasgow Centre for Population Health, 2007); Local Wellbeing Project (empowerment) (Hothi et al., 2007); Healthy Living Centres (Hills et al., 2007); Community development training course(Clay Christopher et al., 2007); New Deal for Communities (neighbourhood regeneration) (Blank et al., 2007, Dinham, 2007, Wallace, 2007, Lawless et al., 2007);	Sure Start (Anning et al., 2007); New Deal for Communities (neighbourhood regeneration) (Blank et al., 2007, Dinham, 2007, Wallace, 2007, Lawless et al., 2007); JRF Neighbourhood Renewal Programme (Taylor et al., 2007); Community based participatory research (Marais, 2007); Health Impact Assessment (Elliott et al., 2007, Mahoney et al., 2007); Pathfinders programme (neighbourhood management) (Department for Communities & Local Government, 2007b);	Breastfeeding peer support (Curtis et al., 2007)	Healthy Living Centres (Hills et al. 2007);	Health Trainers (South et al., 2007);		Breastfeeding peer support (Curtis et al., 2007); Healthy Living Centres (Hills et al. 2007);

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
	Health Impact Assessment (Elliott et al. 2007; Mahoney et al. 2007); Healthy Living Centres (Hills et al. 2007);	Public involvement in policy and practice (U. K. Coalition Against Poverty, 2007); Healthy Living Centres (Hills et al. 2007);					
2008	Community development and mental health (Seebohm and Gilchrist, 2008); Streets Ahead On Safety: Young people & road safety (Kimberlee, 2008); Engaging heard to reach families (Barrett 2008); Health Impact Assessment (Chadderton et al. 2008); New Deal for Communities	Health Impact Assessment (Chadderton et al., 2008); New Deal for Communities (neighbourhood regeneration) (Stafford et al., 2008); Involvement in commissioning for people with LD and complex needs (Davis, 2008, McCaffrey, 2008); Citizens' juries (Gooberman-Hill et al 2008); Streets Ahead On Safety: Young people & road safety (Kimberlee, 2008);	ASSIST (peer-led smoking cessation in schools) (Audrey et al., 2008, Campbell et al., 2008); RIPPLE (Peer-led sex education in schools) (Stephenson et al., 2008);	Sure Start and co-production (Pemberton and Mason, 2008) Citizens' Juries (Gooberman-Hill et al., 2008)	Lay food and health workers (Kennedy et al., 2008);		Volunteering (Community Service Volunteers (CSV), 2008); Engaging heard to reach families (Barrett 2008);

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
	(neighbourhood regeneration) (Stafford et al., 2008);						
2009	Healthy Living Centres (Taylor, 2009); Health/ Community Champions (Davies, 2009, East Midlands Regional Empowerment Partnership, 2009a); Coomunity development (East Midlands Regional Empowerment Partnership 2009b); Community-led health improvement (Taylor 2009);	Participatory Action Research (McDaid, 2009); Partnerships for Older People Programme (Windle et al., 2009, Williamson et al., 2009); Well London (World café) (Bertotti et al., 2009); Pathfinder programme (neighbourhood management) (East Midlands Regional Empowerment Partnership, 2009b); Neighbourhood regeneration (Lawson and Kearns, 2009); Co-production & Sure Start (Pemberton & Mason 2009); Community-led health improvement (Taylor	ASSIST (peer-led smoking cessation in schools) (Starkey et al., 2009); Social support for infant feeding (Watt et al., 2009); Breastfeeding peer support (MacArthur et al., 2009); Health/ Community Champions (Davies, 2009, East Midlands Regional Empowerment Partnership, 2009a)	Improving CE with Roma Community (Roma Support Group, 2009); Co-production & Sure Start (Pemberton & Mason 2009); Community-led health improvement (Taylor 2009);	Health/ Community Champions (Davies, 2009, East Midlands Regional Empowerment Partnership, 2009a); Health trainers (Ward and Banks, 2009);		Volunteers (home start) (Barnes et al., 2009); Partnerships for Older People Programme (Windle et al., 2009, Williamson et al., 2009); Community-led health improvement (Taylor 2009);

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
		2009);					
2010	Empowerment (Take Part approach) (Neumark, 2010) Empowerment (West Johnstone Digital Inclusion Project; Hearts of Salford) (Smith et al., 2010); Health Champions (Altogether Better) (Yorkshire & Humber Empowerment Project, 2010, White et al., 2010); Well London (youth.com & Young Ambassadors; Community Activators; World Cafe) (Craig, 2010, Chapman, 2010, Sheridan et al., 2010); Assets approaches (Foot & Hopkins	Co-production (Boyle et al., 2010); Social Inclusion Partnerships (Carlisle, 2010); New Deal for Communities (neighbourhood regeneration)(Muscat, 2010); Regeneration (Lawson 2010); The Black and Minority Ethnic (BME) Health Forum (community participatory research) (Race for Health, 2010); National Institute for Mental Health in England Community Engagement Project (Fountain and Hicks, 2010); Addressing stigma related to mental health problems with BME groups (NHS	Well London (youth.com & Young Ambassadors; Community Activators; World Cafe) (Craig, 2010, Chapman, 2010, Sheridan et al., 2010); The Black and Minority Ethnic (BME) Health Forum (community participatory research) (Race for Health, 2010); Healthy lifestyle programme (Sefton men's health project) (Robinson et al., 2010); Addressing stigma related to mental health problems with BME groups (NHS Greater	National Institute for Mental Health in England Community Engagement Project (Fountain and Hicks, 2010);	Lay food and health workers (Kennedy, 2010); Health trainers (Bpcssa, 2010, Carlson et al., 2010); Well London (Youth.com & Young Ambassadors; Community Activators; World Cafe) (Craig, 2010, Chapman, 2010, Sheridan et al., 2010); Health Champions (Altogether Better) (Yorkshire & Humber Empowerment Project, 2010, White et al., 2010);	Health Champions (Altogether Better) (Yorkshire & Humber Empowerment Project, 2010, White et al., 2010);	Volunteers (home start) (MacPherson et al., 2010);

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
	2010); National Institute for Mental Health in England Community Engagement Project (Fountain and Hicks, 2010); Community empowerment (Gregson & Court 2010); Regeneration (Lawson 2010);	Greater Glasgow and Clyde, 2010); Well London (youth.com & Young Ambassadors; Community Activators; World Cafe) (Craig, 2010, Chapman, 2010, Sheridan et al., 2010); Assets approaches (Foot & Hopkins 2010); Community empowerment (Gregson & Court 2010); Co-commissioning (Mauger et al. 2010); Patient public engagement (PPE) in sexual and reproductive health and HIV/ AIDS (SRHH) services (Robinson and Lorenc, 2010); Healthy lifestyle programme (Sefton men's health project) (Robinson et al., 2010);	Glasgow and Clyde, 2010); Health Champions (Altogether Better) (Yorkshire & Humber Empowerment Project, 2010, White et al., 2010);				
2011	National Empowerment Partnership Programme (Sender	National Empowerment Partnership Programme (Sender et al., 2011);	Health champions (Well London) (Well London and NHS Hammersmith	Healthy Weight Communities programme (Rocket	Health Trainers (Attree et al., 2011, Ball and Nasr, 2011, Institute for Criminal	Localism – housing associations (Place Shapers	Volunteering (O'Brien et al., 2011);

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
	et al., 2011); NHS Health Empowerment Leverage Project (HELP) (Chanan, 2011); Health champions (Well London) (Well London and NHS Hammersmith &Fulham, 2011, Cawley and Berzins, 2011, Sadare, 2011, Tunariu et al., 2011); Localism – housing associations (Place Shapers Group 2011); Action Research (Roma Support Group 2011); Youth health champions (RSPH 2011);	NHS Health Empowerment Leverage Project (HELP) (Chanan, 2011); Neighbourhood regeneration (Jarvis et al., 2011); Neighbourhood approaches to loneliness (JRF 2011); Healthy Weight Communities (Rocket Science Ltd 2011); Action Research (Roma Support Group 2011); Social Housing (Rosenburg, 2011); Public agencies and faith communities partnerships (SCDC 2011);	&Fulham, 2011, Cawley and Berzins, 2011, Sadare, 2011, Tunariu et al., 2011); Community Mentoring service for older people (Dickens Andy et al., 2011); Localism – housing associations (Place Shapers Group 2011); Youth health champions (RSPH 2011);	Science Ltd, 2011); Social Housing (Rosenburg, 2011); Housing Associations (Place Shapers Group, 2011)	Policy Research, 2011, North West Public Health Observatory, 2011, Royal Society for Public Health, 2011); Health champions (Well London) (Well London and NHS Hammersmith &Fulham, 2011, Cawley and Berzins, 2011, Sadare, 2011, Tunariu et al., 2011);	Group 2011); National Empowerment Partnership Programme (Sender et al., 2011); NHS Health Empowerment Leverage Project (HELP) (Chanan, 2011);	Big Lottery Fund national wellbeing programme (CLES Consulting, 2011); Localism – housing associations (Place Shapers Group 2011); NHS Health Empowerment Leverage Project (HELP) (Chanan, 2011);
2012	Asset-based approaches (McLean and McNeice, 2012,	Co-production (people powered health) (Nesta, 2012b, Nesta, 2012a,	Well London (co-production/ health champions) (Phillips	Training course: Health Issues In the community	Well London (co-production/ health champions) (Phillips		Volunteering (Nazroo and

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
	Iriss, 2012); Community development and mental health (Seebohm et al., 2012); Equally Well (Harkins and Egan, 2012); Well London (co-production/ health champions) (Phillips et al., 2012); Health Champions (Sheffield All-Being Well Consortium, Woodall et al. 2012) (Reece and Flint, 2012); Health Champions (health literacy) (Liverpool John Moore's University, 2012); Social marketing, road safety (Christie	Local Government Information Unit, 2012, Hatzidimitriadou et al., 2012); Well London (co-production/ health champions) (Phillips et al., 2012); Service user involvement in social care (Beresford & Carr 2012); Participatory Action Research (Chirewa 2012); Social marketing, road safety (Christie et al., 2012); Equally Well (Harkins and Egan, 2012); Women in Govan fighting inequality (Mackintosh 2012); Positive Mental Attitudes (mental health inequalities programme) (Quinn and Knifton, 2012);	et al., 2012); Community agents (Active at 60 programme) (Hatamian et al., 2012); Breastfeeding peer support (Jolly et al., 2012); Peer power for people with mental illness (Duffy, 2012); Social marketing, road safety (Christie et al., 2012); Positive Mental Attitudes (mental health inequalities programme) (Quinn and Knifton, 2012); Community development and mental health (Seebohm et al., 2012);	(Community Health Exchange, 2012a); Positive Mental Attitudes (mental health inequalities programme)(Quinn and Knifton, 2012); Service user involvement in social care (Beresford & Carr 2012); Participatory Action Research (Chirewa 2012); Women in Govan fighting inequality (Mackintosh 2012);	et al., 2012); Health Champions (Sheffield All-Being Well Consortium 2012; Woodall et al. 2012) (Reece and Flint, 2012); Health Champions (health literacy) (Liverpool John Moore's University, 2012); Health trainers (White et al., 2012, Cook and Wills, 2012, Data Collection Reporting System, 2012, Gardner et al., 2012, Green, 2012);		Matthews, 2012); Community agents (Active at 60 programme) (Hatamian et al., 2012);

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
	et al., 2012); Co-production and mental health (Hatzidimitriadou 2012); Women in Govan fighting inequality (Mackintosh 2012); Positive Mental Attitudes (mental health inequalities programme) (Quinn and Knifton, 2012);						
2013	Assets based approaches (SCDC 2013a, b; Fenton 2013); Equally Well (Scottish Government 2013); Music and Change – mental health and young people in gangs (MHF 2013); Localism (Thraves 2013); Health champions (White & Woodward	Timebanks (Cambridge Centre for Housing and Planning Research 2013); Assets-based approaches (SCDC 2013a, b);: Equally Well (Scottish Government 2013); Localism (Thraves 2013); Natural Choices for Health and Wellbeing (Wood 2013)	Health trainers (Dooris 2013); Breastfeeding peer support (Ingram 2013); NCT peer support (Newburn 2013,Bhavnani 2013, McCarthy 2013) Music and Change – mental health and young people in gangs (MHF 2013);	Localism (Thraves 2013);	Advocacy for pedestrian safety (Hills et al. 2013); Health trainers (Jennings et al. 2013; Lorenc & Wills 2013; Shircore 2013); Health champions (White & Woodward 2013);	Timebanks (Cambridge Centre for Housing and Planning Research 2013)	Volunteering in health and care (Naylor et al. 2013);

	Community mobilisation/ action	Collaborations & partnerships	Peer involvement	Community organisations	Non-peer health advocacy	Social Networks	Volunteering
	2013);		Peer support (NESTA 2013); Health champions (White & Woodward 2013);				
2014	Community resilience: the good life initiative (Cinderby et al. 2014); Assets-based end of life care (Matthiesen et al. 2014); Well London (Phillips et al. 2014);	Timebanks (Burgess 2014); Community resilience: the good life initiative (Cinderby et al. 2014); Assets-based end of life care (Matthiesen et al. 2014); Well London (Phillips et al. 2014); Co-production in Wandsworth (Hough 2014)	NCT peer support (Newburn 2014, Bhavnani 2014)		Assets-based end of life care (Matthiesen et al. 2014);		

Targeted vs universal approaches

Figure 14 shows trends over time in targeted versus universal approaches. It can be seen that the popularity of targeted approaches peaked in 2005 and again in 2012. Universal approaches were relatively rare before 2005.

Initiatives targeting populations with any indicators of health inequalities were more likely to use a targeted than a universal approach (other than populations with low social capital, where a universal approach was more likely to be used).

Figure 14 Trends over time in use of targeted and universal approaches

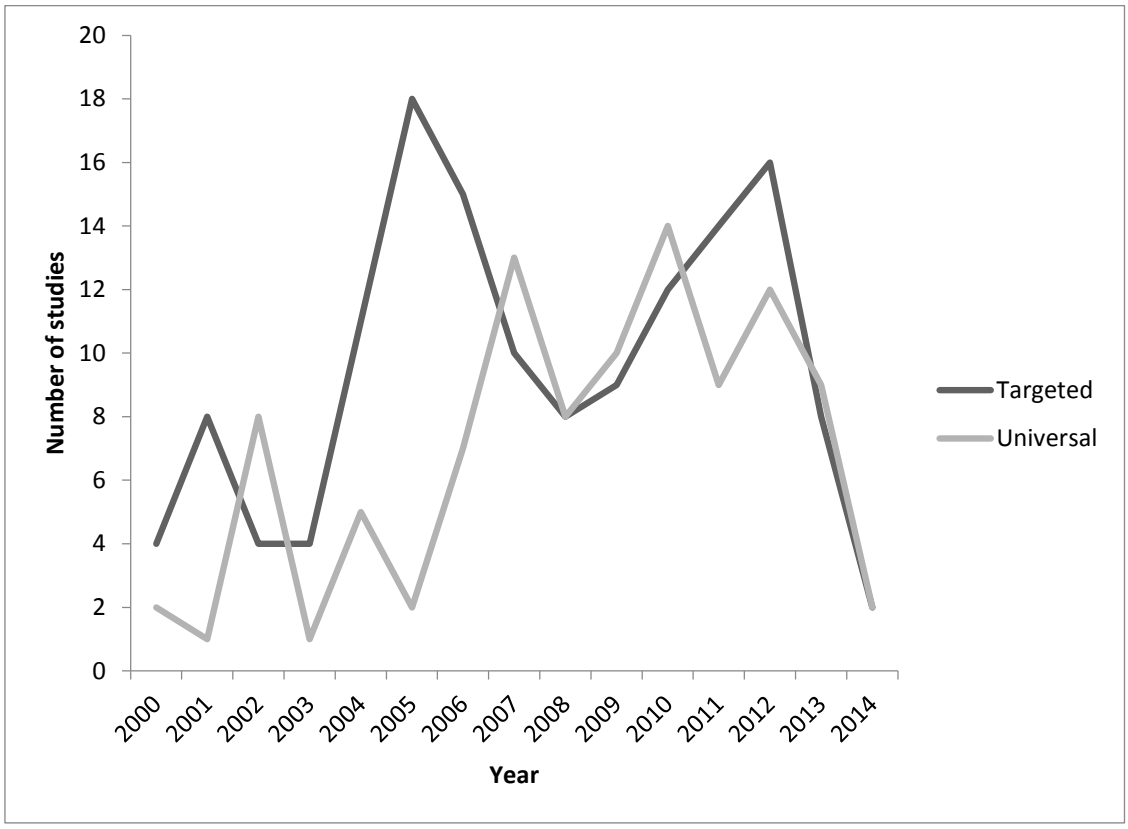
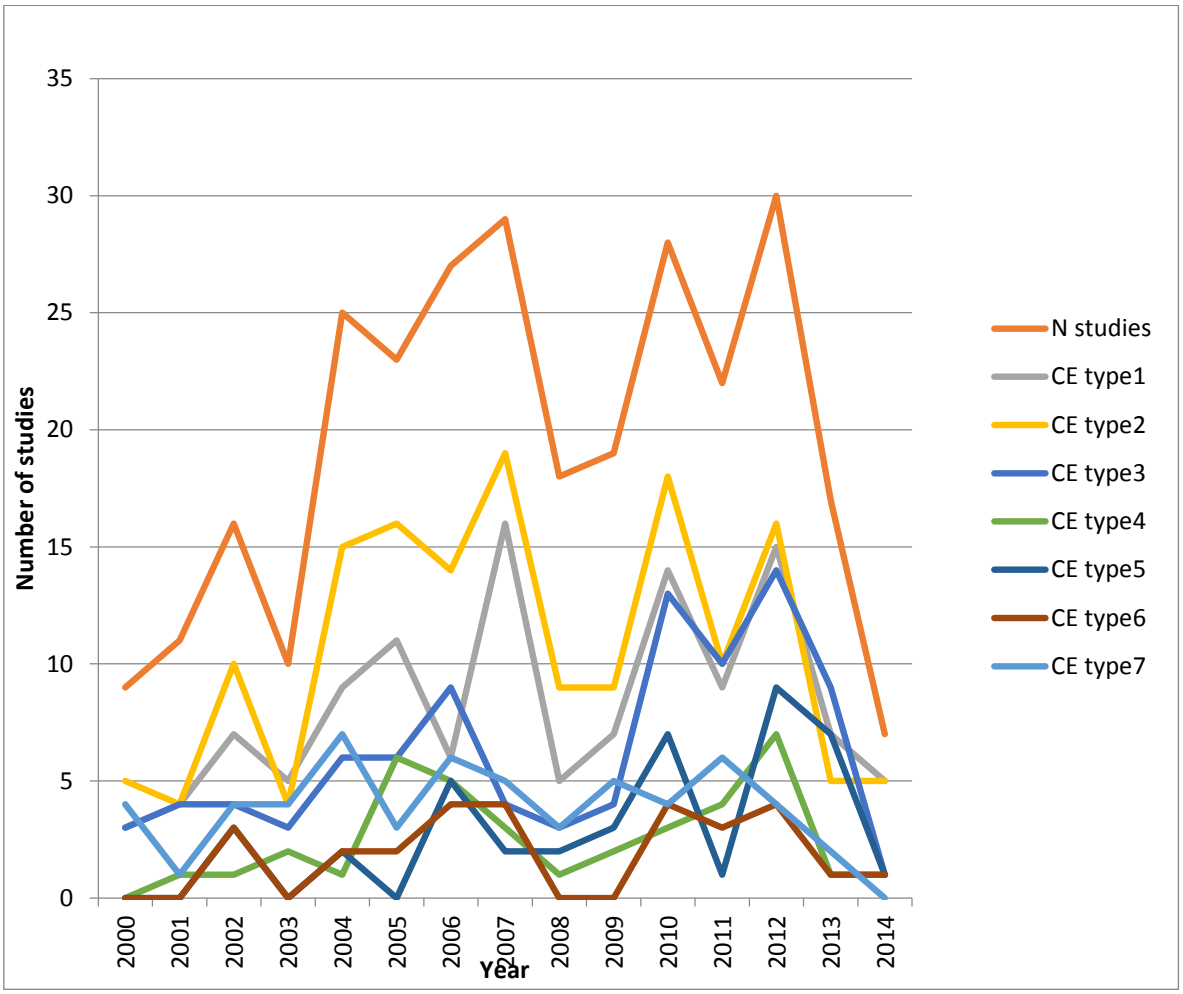


Figure 15 shows trends in types of community engagement over time. It can be seen that there has been an increase in approaches using peer involvement since 2009, and that non-peer health advocacy approaches (e.g. health trainers) seem to have been increasing in frequency since 2007.

Figure 15: Trends in types of CE over time



CE type 1 = community mobilisation/ action; CE type 2 = community partnerships; CE type 3 = peer involvement; CE type 4 = community organisations; CE type 5 = non-peer health advocacy; CE type 6 = social networks; CE type 7 = volunteers

Extent of community engagement (Figure 16):

Most included initiatives reported a low (n=141 (45%), 110S (48%), 31D (35%)) or moderate (n=124 (39%), 85S (37%), 39D (44%)) extent of community engagement, with only 33 initiatives (10%, 17S (7%), 16D (18%)) reporting a high extent of community engagement (defined as community leading or collaborating in all three of: design; delivery; evaluation). Most of the initiatives with a high extent of community engagement took a community mobilisation/ activation approach (n=21 (64%)), and/ or a collaboration/ partnership approach (n=26 (79%)) to community engagement (Table 4). The comparatively high proportion of these initiatives which were reported in the non-research literature (20% of all non-research articles, compared to 8% of research articles) may be indicative of a gap between the types of organisations which usually write and publish research articles (*e.g.* academics and health professionals), and the types of organisations which usually involve community members in the evaluation process (*e.g*. community-based, non-academic), and/or may indicate challenges in the evaluation or publication process of high engagement initiatives. It is worth noting due to the potential for publication bias if non-research articles had not been included in this map of UK practice.

Figure 16 Extent of community engagement

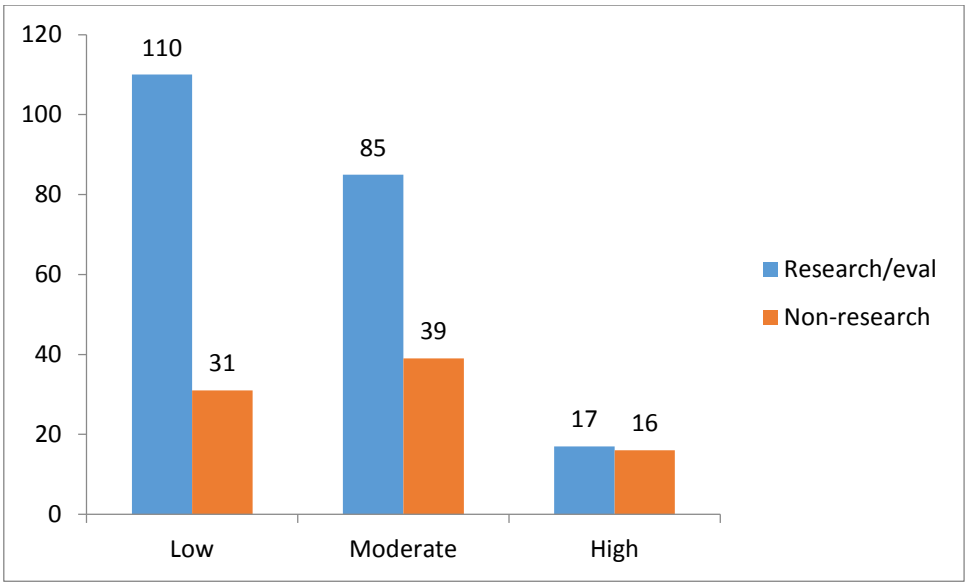


Table 4: Type of CE approach used by articles reporting a high extent of CE

Type of CE	Research	Non-research
Community mobilisation/ action	- Small area regeneration programmes (Anastacio et al., 2000) - Co-production approaches (Boyle et al., 2006, Nesta, 2012b); - A road safety awareness project in the local Somali community (Christie et al., 2012); - Well London programme RCT (Phillips et al., 2012); - Breathing Space community based anti-smoking programme (Platt et al., 2003); - Positive Mental Attitudes – a mental health inequalities initiative in Glasgow (Quinn and Knifton, 2005, Quinn and Knifton, 2012) - Healthy Living Centre project catchon2us! (Reeve and Peerbhoy, 2007); - Action Research to identify barriers and enablers to empowerment in the Roma community (Roma Support Group, 2009); - Ethnographic study on empowerment and young people's health (Spencer, 2014); - Community mapping to tackle social exclusion and food poverty (Webster and Johnson, 2000);	- Small area regeneration programmes (Anastacio et al., 2000) - Co-production approaches (Boyle et al., 2006, Nesta, 2012b); - Creative consultation with children and young people for community development (Coulter 2014); - Leeds Gypsy and Traveller Exchange (Jones 2014); - Community empowerment policy (Scottish Government, 2009); - Connecting Communities (Stuteley 2014)
Community partnerships/ coalitions	- Co-production approaches (Boyle et al., 2006, Nesta, 2012b); - A road safety awareness project in the local Somali community (Christie et al., 2012); - Community activity to address loneliness (Joseph Rowntree Foundation, 2011); - CBPR in TB control (Marais, 2007); - CALL-ME arts and gardening projects for older people (Murray 2014); - Well London programme RCT (Phillips et al., 2012); - Positive Mental Attitudes – a mental health inequalities initiative in Glasgow (Quinn and Knifton, 2005, Quinn and Knifton, 2012) - The Black and Minority Ethnic (BME) Health Forum (Race for Health, 2010); - Healthy Living Centre project catchon2us!	- Co-production approaches (Boyle et al., 2006, Nesta, 2012b); - User involvement research (Beresford, 2007); - Children as researchers (Brownlie et al., 2006); - Creative consultation with children and young people for community development (Coulter 2014); - Participatory action research in mental health policy and planning (McDaid, 2009); - Connecting Communities (Stuteley 2014)

Type of CE	Research	Non-research
	(Reeve and Peerbhoy, 2007); - Action Research to identify barriers and enablers to empowerment in the Roma community (Roma Support Group, 2009); - Mosaics of Meaning – partnerships with BME communities to promote mental health (NHS Greater Glasgow and Clyde, 2010); - Older people and volunteering research (Baines et al., 2006) - Community mapping to tackle social exclusion and food poverty (Webster and Johnson, 2000);	
Peer involvement	- A road safety awareness project in the local Somali community (Christie et al., 2012); - Positive Mental Attitudes – a mental health inequalities initiative in Glasgow (Quinn and Knifton, 2005, Quinn and Knifton, 2012) The Black and Minority Ethnic (BME) Health Forum (Race for Health, 2010); - Mosaics of Meaning – partnerships with BME communities to promote mental health (NHS Greater Glasgow and Clyde, 2010); - Older people and volunteering research (Baines et al., 2006)	- Co-production (Boyle 2010) - Creative consultation with children and young people for community development (Coulter 2014);
Community organisations	- CALL-ME arts and gardening projects for older people (Murray 2014); - Positive Mental Attitudes – a mental health inequalities initiative in Glasgow (Quinn and Knifton, 2005, Quinn and Knifton, 2012) - Healthy Living Centre project catchon2us! (Reeve and Peerbhoy, 2007);	- Leeds Gypsy and Traveller Exchange (Jones 2014);
Non-peer health advocacy	- Changing Minds – a mental health awareness project (Cawley and Berzins, 2011)	
Social networks	- Older people and volunteering research (Baines et al., 2006)	
Volunteers	- Changing Minds – a mental health awareness project (Cawley and Berzins, 2011) - Older people and volunteering research (Baines et al., 2006) - Community mapping to tackle social exclusion and food poverty (Webster and Johnson, 2000);	

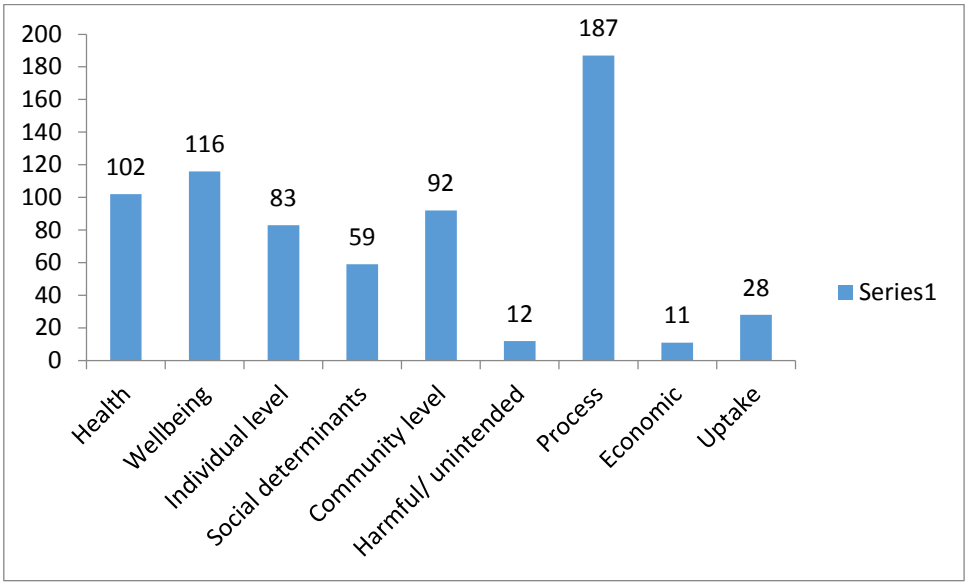
In addition, some articles used a range of community engagement and participation models (Fountain et al., 2007, Coulter, 2010, Glasgow Centre for Population Health, 2007, Laverack, 2006, Mahoney et al., 2007, Sheridan and Tobi, 2010).

3.7 Type of outcomes reported (research/ evaluation studies only):

In the 227 research and evaluation studies, the most frequently reported outcome type was process outcomes (n=187 S (82%)) such as recruitment of lay workers, followed by wellbeing outcomes (n=116 S (51%)) such as confidence, self-efficacy and quality of life, and health outcomes (n=102 S (45%)) such as increased awareness and uptake of cancer screening. Community level outcomes (n=92 S (41%)) were reported more frequently than outcomes at the individual level (n=83 S (37%)). Harmful or unintended effects (n=12 S (5%)) and economic outcomes (n=11 S (5%)), such as unit costs and funding, were reported less frequently (Figure 17).

Effects: Direction of effect was not routinely coded for in this systematic mapping review, so we are unable to comment on effectiveness.

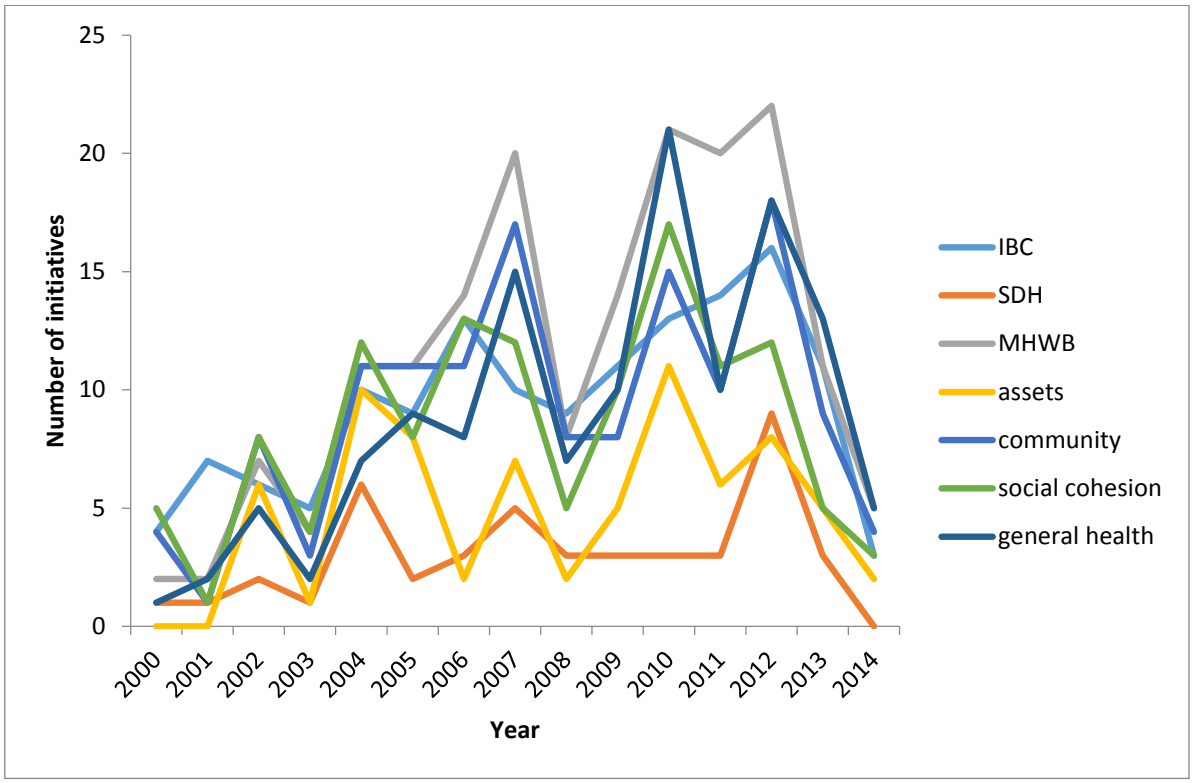
Figure 17 Types of outcomes reported



Harmful or unintended effects were reported in twelve studies (Andrews et al., 2003, Ball and Nasr, 2011, Boydell and Rugkåsa, 2007, Bridge Consortium, 2002, Lawless et al., 2007, Lorenc and Wills, 2013, McLean and McNeice, 2012, Muscat, 2010, New Economics Foundation, 2002, Skidmore et al., 2006, Steven and Priya, 2000, Ward and Banks, 2009). In some studies, the unintended effect was potentially harmful for community members delivering interventions, in that volunteers were doing more than was expected of them (Andrews et al., 2003) or felt a "burden of responsibility", having little time to themselves and feeling afraid of letting people down (Bridge Consortium, 2002, Steven and Priya, 2000) In others, the unintended effects were felt to be potentially harmful to other community members, for example becoming dependent on the project and preventing new participants from accessing a place (McLean and McNeice, 2012). Unintended effects could also be positive, for example improvements in mental health were reported by some community members delivering interventions (New Economics Foundation, 2002). Some harmful effects were due to organisational issues, for example, the speed at which one Health Trainer programme developed and delays around some aspects impacted negatively on the morale and confidence of health trainers. There were also tensions between lay and professional workers with regard to role boundaries in relation to advice giving (Ward and Banks, 2009). One report found that "the key factor influencing levels of participation in governance was the existing patter of linking social capital – those already well connected tend to get better connected" (Skidmore et al., 2006). This would not help to decrease health inequalities and might have the opposite effect, of increasing them.

Figure 18 shows trends in type of outcomes reported in research/ evaluation studies over time. It can be seen that mental health or wellbeing outcomes have increased in frequency since 2005.

Figure 18 Trends in types of outcome reported in CE research/ evaluation studies over time



IBC = individual behaviour change; SDH = social determinants of health; MHWB = mental health and/ or wellbeing

3.8 Summary

This map of current and emerging UK practice in community engagement has attempted to draw together all the UK-based research evidence and theories, with non-research practice descriptions and policies to give an overview of what is happening in terms of community engagement in the UK today. The knowledge comes from a wide range of sources – from randomised controlled trials to personal communications from small projects. These vary in depth of description and in methodological quality, but as this is a mapping review, no formal assessment of quality was undertaken, so we cannot comment further on this aspect. In terms of applicability this review is obviously very relevant to the UK setting and seems to fill in a number of evidence gaps highlighted by Reviews 1-3, for example, it includes a high proportion of interventions aimed at improving social determinants of health and a high proportion of articles recording community-based outcomes. A diverse range of population groups are included, and the evidence is dominated by initiatives that target health inequalities through working with socioeconomically disadvantaged populations, and "hard to reach" groups such as older people and those with disabilities.

316 articles have contributed to this review, the majority being research or evaluation, with the majority of these being mixed method evaluations or qualitative studies.

Policy

There are a number of consistent themes relating to the UK policy context for community engagement and health, based on analysis of 42 policy publications from 2006 onwards. Firstly, policy documents, reviews and commentary concerning community engagement and health can be mapped across a wide range of policy areas and sectors. These include: health policy and the NHS, local government policy and regeneration, third sector and volunteering and also health inequalities as a cross cutting policy issue. Very few publications were focused exclusively on community engagement and public health, but all related to in some way to the active participation of individuals and communities as a mechanism to improve health, community life or quality of local services or alternatively to reduce inequalities and area disadvantage.

Secondly, since 2006 there are consistent themes across government policy relating to the significance of community engagement and empowerment. The review has highlighted a number of specific policy initiatives from both Labour government 2005-2010 and the Conservative-Liberal Democrat Coalition government of 2010-2015. These include changes in PPI structures and public involvement mechanisms affecting health planning and services; neighbourhood management, Localism aimed at devolution of power to local communities and health inequalities policy. There are also relevant policies from the devolved assemblies (Scottish Government, 2013, Welsh Assembly Government, 2008). Overall, publications relating to inequalities and community empowerment, whether originating from government or from independent sources, like the Marmot review, called for new relationships between services and communities that give more power to communities, enabling individuals to play a greater part in local decisions that affect their health and lives.

Thirdly, the review identified a consistent theme around the contribution of individuals and communities to health and to society in general. Discussion and commentary cluster round various concepts which are frequently cross-referenced to each other. These include asset-based approaches, co-production and volunteering.

Concepts

The map of UK literature found 30 articles that explored concepts and theories related to community engagement. A diverse range of concepts are used to explain and critique aspects of power and participation. There is no common terminology and a number of papers point to the challenges of defining of what are complex sets of ideas. Only four papers specifically dealt with community engagement as a defined topic (Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Sheridan and Tobi, 2010, South and Phillips, 2014). Empowerment continues to be a significant theme – both how it can be achieved and what it means. Since 2006, other relevant concepts, such as co-production and volunteering, have gained some prominence in public health literature. The implications are that community engagement, as proposed in the earlier NICE guidance, is best seen as an umbrella term that covers a range of concepts relating to participation and empowerment.

Communities

The largest group of articles (n=117, 37%), both research (n=89, 39%) and non-research (n=28, 31%), looked at initiatives in urban settings. A large number (n=92, 29%) also looked at initiatives in both urban and rural settings. Only 11 articles (3.5%) looked at initiatives in rural settings alone (Bromley 2014, Davies, 2009, Dickens et al., 2011, East Midlands Regional Empowerment Partnership, 2009a, Elliott et al., 2007, Halliday and Asthana, 2005, Hoddinott et al., 2006a, Hoddinott et al., 2006b, Osborne et al., 2002, Starkey et al., 2005, Stutely, 2002). In 43 articles (14%), the setting was not clear. As this was a mapping review, we did not undertake detailed data extraction on the populations other than to code for indicators of health inequalities using the PROGRESS-plus tool. However, the UK evidence base on community engagement includes articles on communities of place (see above and e.g. Well London), communities of interest, such as culture (*e.g.* Roma support group) or situation (*e.g.* NCT peer support training for refuges and asylum seekers), ethnicity, age (*e.g.* Youth.com; MAC UK; Partnerships for Older People), or health and wellbeing issues (*e.g.* long term conditions).

The health and wellbeing issues addressed most frequently by UK community engagement initiatives were community level or wellbeing outcomes, rather than individual behaviour change outcomes:

> Social capital or social cohesion (n=129, 41%) *e.g.* improved social networks (Burgess 2014), reduction in crime (Stutely and Cohen 2004);
>
> Community wellbeing (n=110, 35%) *e.g.* community resilience (Cinderby et al. 2014), empowerment (Hothi et al. 2007) ;
>
> Personal wellbeing (n=82, 26%) *e.g.* positive mental health (IRISS 2012, Tunariu et al. 2011), quality of life (Nazroo and Matthews 2012);
>
> General health – personal (n=99, 31%) *e.g.* weight management (Jennings et al. 2013), healthy lifestyle promotion (Robinson et al. 2010; and
>
> General health – community (n=95, 30%) *e.g.* setting up group activities (Woodall et al. 2012), reducing health inequalities (Race for Health 2010).

This seems to be a different pattern to initiatives included in the systematic reviews of effectiveness (Reviews 1-3 (Brunton et al. 2014)), which have focused on individual health issues such as physical activity and healthy eating.

Inequalities

Health inequalities indicators most frequently observed were socioeconomic indicators (n=89 S; 35 D) and “other” indicators of disadvantage (n= 95 S, 28 D) – these included a range of characteristics such as:

> People with disabilities (*e.g.* Edwards 2002, inclusion in regeneration);

People with learning difficulties (LD) (*e.g*. McCaffrey 2008, commissioning from the perspective of people with LD);

Older people (*e.g.* Williamson et al. 2009, Partnerships for Older People);

Offenders (*e.g*. Dooris et al. 2013, health trainer service);

People with long term health conditions (*e.g.* Hills et al. 2007, healthy living centres);

People with substance use disorders (*e.g.* Elliott et al. 2001, involving peer interviewers in research);

Gay Lesbian Bisexual or Transgender groups (*e.g.* Flowers et al. 2002, bar-based peer-led sexual health promotion with gay men);

Mental health service users (*e.g.* O'Brien et al. 2011, volunteering in nature);

Refugees and asylum seekers (*e.g.* Bhavnani & Newburn 2011, NCT peer support).

Other indicators of inequality targeted by included initiatives were race/ ethnicity (n= 53 S, 16 D), lack of social capital or social exclusion (n= 37 S, 9 D). This demonstrates that community engagement initiatives in the UK go beyond the approach of targeting the most obvious indicators of inequality (*i.e.* those that are included in health equity profiles such as ethnicity, gender and occupational or socioeconomic status) and seek to engage some of the most marginalised, disadvantaged or excluded population groups, such as offenders, homeless people, people with poor physical or mental health, disabilities or learning difficulties, and older people (at risk of social isolation). This is true of both research and non-research articles.

Community engagement initiatives for populations coded as being in the category "Other indicators of disadvantage" were more likely to use peer or volunteer involvement approaches than those for populations coded as having socioeconomic indicators of disadvantage, which were similar to the percentages given across the range of UK initiatives in this mapping review. Initiatives targeting populations with any indicators of health inequalities were more likely to use a targeted than a universal approach (other than populations with low social capital, where a universal approach was more likely to be used).

Approaches to community engagement

The mapping review found a wide range of approaches to community engagement in the 316 included articles, which were grouped into seven types (see Glossary). Community mobilisation/ action (138 articles, 89S, 49D; 44%) and community partnerships/ coalitions (180 articles, 113S, 67D; 57%) were the most commonly used approaches to community engagement in both research and non-research articles. Peer involvement (n=97, 82S, 15D; 31%) and volunteers (n=64, 50S, 14D; 20%) were common approaches in research articles, but less so in non-research articles. Different approaches seemed to be used to target different types of health or wellbeing issues, for example peer involvement was most

often seen in interventions targeting individual behaviour change (*e.g.* physical activity, healthy eating, substance use), whereas community mobilisation/ action or partnership/ coalition approaches were more often seen in initiatives that focused on community wellbeing, social capital or community assets.

Only 33 initiatives (11%, 17S, 16D) reported a high extent of CE (defined as community leading or collaborating in all three of: design; delivery; evaluation). Most of the initiatives with a high extent of CE took a community mobilisation/ activation approach (n=21*, 64%), and/ or a collaboration/ partnership approach (n=27**, 79%) to community engagement. The comparatively high proportion of these initiatives which were reported in the non-research literature (20% of all non-research articles, compared to 8% of research articles) may be indicative of a gap between the types of organisations which usually write and publish research articles (e.g. academics and health professionals), and the types of organisations which usually involve community members in the evaluation process (e.g. community-based, non-academic), and/or may indicate challenges in the evaluation or publication process of high engagement initiatives. It is worth noting due to the potential for publication bias if non-research articles had not been included in this map of UK practice.

* Anastacio et al. 2000; Boyle et al. 2006; Christie et al. 2012; Phillips et al. 2012; Platt et al. 2003; Quinn and Knifton 2012; Reeve and Peerbhoy 2007; Roma Support Group 2011; Spencer 2014; Webster and Johnson 2000; Coulter 2010; Coulter 2014; Fountain et al. 2007; GCPH 2007; Jones 2014; Laverack 2006; Nesta 2012; Scottish Government 2009; Stuteley 2014; Sheridan & Tobi 2010; Spencer 2014)

** Anastacio et al. 2000; Boyle et al. 2006; Christie et al. 2012; JRF 2011; Marais 2007; Murray 2010; Phillips et al. 2012; Quinn and Knifton 2012; Race for Health 2010; Reeve and Peerbhoy 2007; Roma Support Group 2011; NHS Greater Glasgow & Clyde 2010; Baines et al. 2006; Webster and Johnson 2000; Beresford 2007; Boyle et al. 2010; Brownlie et al. 2006; Coulter 2010; Coulter 2014; Fountain et al. 2007; GCPH 2007; Mahoney et al. 2007; McDaid 2009; Nesta 2012; Stutely 2014; Sheridan & Tobi 2010; Spencer 2014)

Outcomes

In the 227 research and evaluation studies, the most frequently reported outcome type was process outcomes (n=187 S (82%)) such as recruitment of lay workers, followed by wellbeing outcomes (n=116 S (51%)) such as confidence, self-efficacy and quality of life, and health outcomes (n=102 S (45%)) such as increased awareness and uptake of cancer screening. Community level outcomes (n=92 S (41%)) were reported more frequently than outcomes at the individual level (n=83 S (37%)). Harmful or unintended effects (n=12 S (5%)) and economic outcomes (n=11 S (5%)), such as unit costs and funding, were reported less frequently.

Effects: Direction of effect was not routinely coded for in this systematic mapping review, so we are unable to comment on effectiveness.

Unintended or harmful effects: There is some evidence in this component 1a to contribute to review question 4, with 12 studies (5%) coded as reporting unintended or harmful consequences. Evidence from these 12 studies suggests that unintended effects can be positive (*e.g.* improved mental health in community members delivering interventions) but may also be negative or harmful, either to community deliverers (*e.g.* volunteers feeling overburdened), to organisations or partnerships (*e.g.* tensions between lay and professional role boundaries), or to the wider community (*e.g.* community members becoming so attached to projects that there are no places left for newer members).

Structure and focus of existing evidence base

There is a substantial amount of information in the following topic areas: Urban or mixed settings (*i.e.* both urban and rural); socioeconomically deprived groups or areas; socially excluded or isolated groups; areas that lack social cohesion; other potentially disadvantaged groups (*e.g.* older people; people with disabilities; people in poor physical or mental health); black or minority ethnic groups; initiatives targeting health behaviours (physical activity, healthy eating, substance use), mental health, personal and community wellbeing, general health (personal and community), social capital or cohesion; initiatives with low or moderate extent of community engagement; process, wellbeing, health and community level outcomes.

There seems to be little information in the following areas: rural settings; unintended or harmful effects; cultural adaptation; initiatives with a high extent of community engagement; population groups that may experience health inequalities due to religion, culture or educational reasons.

3.9 Summary statements

Summary statement 1: Conceptual

A number of overlapping terms are used to cover concepts and approaches that relate to the active participation of people in decisions about their health and lives (based on 30 conceptual/ theoretical papers*). This includes community engagement (4 papers: Fountain et al. 2007; Glasgow Centre for Population Health 2007; Sheridan and Tobi 2010; South and Phillips 2014), community participation (2 papers: Mahoney et al. 2007; Draper et al. 2010), community or public involvement (4 papers: Burton et al. 2006; Chadderton et al. 2008; Department of Health 2006b; Wait and Nolte 2006) and empowerment (3 papers: Communities and Local Government 2007; Laverack 2006; Spencer 2014). Empowerment is a complex concept that has different dimensions both relating to process and outcomes (Laverack 2006; Spencer 2014). The review of conceptual papers suggests that community engagement also relates to social action by communities through volunteering and building social capital (based on 11 conceptual/ theoretical papers (Cabinet Office, 2011, Communities and Local Government, 2007, Dobbs and Moore, 2002, Nesta, 2013, Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Hardill et al., 2007, Laverack, 2006, Local Government Information Unit, 2012, Sheridan and Tobi, 2010, Wallace, 2007)).

*(Jones, 2004, Attree et al., 2011, Beresford, 2007, Boydell and Rugkåsa, 2007, Boyle et al., 2010, Brownlie et al., 2006, Burton et al., 2006, Cabinet Office, 2011, Chadderton et al., 2008, Chirewa, 2012, Communities and Local Government, 2007, Department of Health, 2006b, Draper et al., 2010, Fountain et al., 2007, Glasgow Centre for Population Health, 2007, Hardill et al., 2007, Kennedy, 2006, Laverack, 2006, Local Government Information Unit, 2012, Mahoney et al., 2007, McDaid, 2009, Nesta, 2013, Office of the Deputy Prime Minister, 2006, Scottish Government, 2013, Sheridan and Tobi, 2010, Spencer, 2014, Truman and Raine, 2001, Wait and Nolte, 2006, Wallace, 2007, South and Phillips, 2014)

Summary statement 2: Policy

Policy interest in community engagement and health can be mapped across a wide range of policy areas and sectors. These include: health policy and the NHS, local government policy and regeneration, third sector and volunteering and also health inequalities as a cross cutting policy issue. Community engagement in public health continues to be supported through these various policy drivers (4 publications: (Department of Health, 2010, Department of Health, 2012a, Department of Health, 2012b, HM Government, 2010b)); however, there appears to be a greater policy emphasis on patient and public involvement (PPI) structures in relation to the NHS (6 publications: (Department of Health, 2006b, Department of Health, 2006a, Department of Health, 2007a, Department of Health, 2010, HM Government, 2012, NHS England, 2013)).

The key role of local government in leading community engagement and supporting public participation in local decision making has been a major policy theme throughout the period covered by the review (based on 4 publications: (Department for Communities & Local Government, 2006b, Department for Communities & Local Government, 2007a, Department for Communities & Local Government, 2007b, HM Government, 2007)). Community engagement and empowerment have been consistently linked to strategies to address health inequalities (3 publications: (Department of Health, 2008b, Department of Health, 2008a, Department of Health, 2009a), with emphasis given to enabling individuals to play a greater part in local decisions that affect their health and lives Two specific policy initiatives identified in the review were New Deal for Communities (Lawless, 2004, Lawless et al., 2007, Wallace, 2007) and Neighbourhood Management/partnerships (Office of the Deputy Prime Minister, 2006, Sustainable Development Commission, 2010).

The contribution of individuals and communities to health and to society in general is a policy theme, with the importance of social action on health being endorsed in government documents and policy commentary. Interrelated concepts found in the map of policy include asset-based approaches, co-production, volunteering and peer support, and a number of (non-governmental) documents advocate for methods that draw on community strength and build on the lay contribution.

Summary Statement 3: Communities

Most community engagement activity in the UK takes place in urban or mixed (urban and rural) settings (based on 209 articles).

The health and wellbeing issues addressed most frequently by UK community engagement initiatives were community level or wellbeing outcomes, rather than individual behaviour change outcomes:

Social capital or social cohesion (n=129, 41%) *e.g.* improved social networks (Burgess 2014), reduction in crime (Stutely and Cohen 2004);

Community wellbeing (n=110, 35%) *e.g.* community resilience (Cinderby et al. 2014), empowerment (Hothi et al. 2007);

Personal wellbeing (n=82, 26%) *e.g.* positive mental health (IRISS 2012, Tunariu et al. 2011), quality of life (Nazroo and Matthews 2012);

General health – personal (n=99, 31%) *e.g.* weight management (Jennings et al. 2013), healthy lifestyle promotion (Robinson et al. 2010; and

General health – community (n=95, 30%) *e.g.* setting up group activities (Woodall et al. 2012), reducing health inequalities (Race for Health 2010).

Summary Statement 4: Health inequalities

Much UK practice in community engagement is directly relevant to health inequalities (based on 125 studies coded as socioeconomic indicators (n=89 S; 35 D) *e.g.* deprivation (Greene 2007; Hills et al. 2013) and 123 studies coded as "other" indicators of disadvantage (n= 95 S, 28 D) – these included a range of characteristics such as:

People with disabilities (*e.g.* Edwards 2002, inclusion in regeneration);

People with learning difficulties (LD) (*e.g.* McCaffrey 2008, commissioning from the perspective of people with LD);

Older people (*e.g.* Williamson et al. 2009, Partnerships for Older People);

Offenders (*e.g.* Dooris et al. 2013, health trainer service);

People with long term health conditions (*e.g.* Hills et al. 2007, healthy living centres);

People with substance use disorders (*e.g*. Elliott et al. 2001, involving peer interviewers in research);

Gay Lesbian Bisexual or Transgender groups (*e.g*. Flowers et al. 2002, bar-based peer-led sexual health promotion with gay men);

Mental health service users (*e.g.* O'Brien et al. 2011, volunteering in nature);

Refugees and asylum seekers (*e.g*. Bhavnani and Newburn 2011, NCT peer support).

This demonstrates that community engagement initiatives in the UK go beyond the approach of targeting the most obvious indicators of inequality (*i.e*. those that are included in health equity profiles such as ethnicity, gender and occupational or socioeconomic status) and seek to engage some of the most marginalised, disadvantaged or excluded population groups.

Peer- and volunteer-based approaches to community engagement were more common in populations with "other" indicators of disadvantage than in any other group (based on 57 articles on peer approaches (45S (47%), 6D (16%)), such as peer education for preventing falls in older people (Allen 2004) and 38 articles on volunteer approaches (34S (36%), 4D (14%)), such as volunteering for mental health (Institute for Volunteering Research 2003).

Summary statement 5: Approaches to community engagement

The mapping review found a wide range of approaches to community engagement in the 316 included articles. Approaches aligned to community development and empowerment and/ or participatory principles are commonly used in the UK, with peer and volunteer involvement also being prominent approaches. Different approaches seem to be appropriate to address different health and wellbeing issues, for example peer, volunteer or lay involvement for targeting individual behaviour change; community mobilisation/ action or community partnerships/ coalitions for targeting community level outcomes, such as wellbeing, community assets or social capital.

Most of the initiatives with a high extent of community engagement took a community mobilisation/ activation approach (n=21 (64%))*, and/ or a collaboration/ partnership approach (n=27 (79%))** to community engagement. Health or wellbeing issues most frequently addressed were community wellbeing (n=15 (45%) 8D, 7S), social capital/ cohesion (n=14 (42%) 6D, 8S), general health personal (n=8 (24%) 5D, 3S), general health community (n=11 (33%) 7D, 4S). A comparatively high proportion of these initiatives were reported in the non-research literature (n=16 (20%) compared to n=17 (8%) in research literature).

* Anastacio et al. 2000; Boyle et al. 2006; Christie et al. 2012; Phillips et al. 2012; Platt et al. 2003; Quinn and Knifton 2012; Reeve and Peerbhoy 2007; Roma Support Group 2011; Spencer 2014; Webster and Johnson 2000; Coulter 2010; Coulter 2014; Fountain et al. 2007; GCPH 2007; Jones 2014; Laverack 2006; Nesta 2012; Scottish Government 2009; Stuteley 2014; Sheridan & Tobi 2010; Spencer 2014)

** Anastacio et al. 2000; Boyle et al. 2006; Christie et al. 2012; JRF 2011; Marais 2007; Murray 2010; Phillips et al. 2012; Quinn and Knifton 2012; Race for Health 2010; Reeve and Peerbhoy 2007; Roma Support Group 2011; NHS Greater Glasgow & Clyde 2010; Baines et al. 2006; Webster and Johnson 2000; Beresford 2007; Boyle et al. 2010; Brownlie et al. 2006; Coulter 2010; Coulter 2014; Fountain et al. 2007; GCPH 2007; Mahoney et al. 2007; McDaid 2009; Nesta 2012; Stutely 2014; Sheridan & Tobi 2010; Spencer 2014)

Summary statement 6: Outcomes

In the 227 research and evaluation studies, the most frequently reported outcome type was process outcomes (n=187 S (82%)) such as recruitment of lay workers (*e.g.* Chapman 2010), followed by wellbeing outcomes (n=116 S (51%)) such as confidence, self-efficacy and quality of life (*e.g.* White et al. 2010), and health outcomes (n=102 S (45%)) such as increased awareness and uptake of cancer screening (Curno 2012). Community level outcomes (n=92 S (41%) *e.g.* Barnes et al. 2004 (Health Action Zones)) were reported more frequently than outcomes at the individual level (n=83 S (37%) *e.g.* Platt et al. 2003 (smoking cessation)). Harmful or unintended effects (n=12 S (5%)) and economic outcomes (n=11 S (5%)), such as unit costs and funding, were reported less frequently.

Unintended or harmful effects: Evidence from 12 studies (Andrews et al., 2003, Ball and Nasr, 2011, Boydell and Rugkåsa, 2007, Bridge Consortium, 2002, Lawless et al., 2007, Lorenc and Wills, 2013, McLean and McNeice, 2012, Muscat, 2010, New Economics Foundation, 2002, Skidmore et al., 2006, Steven and Priya, 2000, Ward and Banks, 2009) on unintended or harmful effects suggests that these can be positive (*e.g.* improved mental health in community members delivering interventions) but may also be negative or harmful, either to community deliverers (*e.g.* volunteers feeling overburdened), to organisations or partnerships (*e.g.* tensions between lay and professional role boundaries), or to the wider community (*e.g.* community members becoming so attached to projects that there are no places left for newer members).

Summary statement 7: Structure and focus of existing evidence base

There is a substantial amount of information in the following topic areas: Urban or mixed settings (i.e. both urban and rural); socioeconomically deprived groups or areas; socially excluded or isolated groups; areas that lack social cohesion; other potentially disadvantaged groups (e.g. older people; people with disabilities; people in poor physical or mental health); black or minority ethnic groups; initiatives targeting health behaviours (physical activity, healthy eating, substance use), mental health, personal and community wellbeing, general health (personal and community), social capital or cohesion; initiatives with low or moderate extent of community engagement; process, wellbeing, health and community level outcomes.

There is very little information, either from research, or from other sources, on what is being done in terms of community engagement in rural settings (n=11 (3%) 7 S, 4 D), or in communities that may experience health inequalities due to religion/ culture (n= 12 (4%) 6 S, 6 D) or educational reasons (n= 17 (5%) 14 S, 3 D). There is little information on harmful or unintended effects of community engagement initiatives (n = 12 S (5%)), or on economic outcomes (n = 11 S (5%)).

4. Discussion

4.1 Main findings

This systematic mapping review found a substantial evidence-base on current and emerging UK policy and practice in community engagement, encompassing a diverse range of populations and approaches to community engagement.

The key role of local government in leading community engagement and supporting public participation in local decision making has been a major policy theme throughout the period covered by the review. Community engagement and empowerment have been consistently linked to strategies to address health inequalities, with emphasis given to enabling individuals to play a greater part in local decisions that affect their health and lives. Dominant concepts include asset-based approaches, co-production, volunteering and peer support.

There was a high volume of evidence from: qualitative and mixed methods studies; initiatives targeting health inequalities via socioeconomically deprived areas and groups, and via "hard to reach" groups (such as people with disabilities, substance users, homeless people). Community level outcomes (e.g. improved housing) and wellbeing outcomes (e.g. improved self-esteem) were most commonly addressed, and community mobilisation/ action and community partnerships/ coalitions were the types of community engagement most commonly employed.

4.2 Wider context

The previous NICE guidance on community engagement (NICE 2008) made 12 recommendations which covered policy development, long-term investment, organisational and cultural change, levels of engagement and power, mutual trust and respect, infrastructure, partnership working, area-based initiatives, community members as agents of change, community workshops, resident consultancy and evaluation.

A recent systematic review of community engagement to reduce inequalities in health (O'Mara-Eves et al., 2013) found solid evidence that community engagement interventions have a positive impact on health behaviours, health consequences, self-efficacy and perceived social support outcomes, across a wide range of contexts and using a variety of mechanisms.

The 2008 guidance on community engagement (NICE 2008) found that the approach used to involve the community was not usually the main focus of the evaluation. With this in mind, the other two components of Stream 2 (Primary Research Report 1: map of current practice based on a case study approach (Bagnall et al., 2015), and Review 5: Evidence review of barriers to, and facilitators of, community engagement approaches and practices in the UK ((Harden et al., 2015)) sought to evaluate the process of community engagement, rather than the delivery of the intervention or its effects.

The 2008 guidance also made detailed recommendations for further research, including methodology for future community engagement research studies, impact evaluation of area-based initiatives, research into barriers and facilitators to community engagement, and economic evaluation. Primary Research Report 1 (Bagnall et al. 2015) and Review 5 (Harden et al. 2015) also address the third of these objectives: research into barriers and facilitators.

The NICE guidance published in 2008 did not include a range of newer community engagement approaches, because they had not yet been evaluated. These included health trainers, collaborative methodology and citizens' juries and panels. Evaluations of all of these approaches are included in this systematic map.

4.3 Limitations of the review

Protocol deviations: We had stated in the protocol that we would do forwards and backwards citations of all included studies, but given the large number of included studies, we did not do this, nor did we contact authors to ask for more details of included studies. This may have led to some initiatives being missed out of the map. A delay in publication (time lag bias) may also have led to more recent and emerging practice being left out of the map, but we sought to avoid this by extensive website searches and by contacting practitioners through many different sources to obtain details of projects that had not yet (or in some cases ever would have) been published.

Theory: There was some development in conceptual thinking around community engagement terminology as part of this project, which stemmed from a lack of clarity around terms used for community engagement. A similar issue with identifying which community engagement approach was used was identified in the 2008 NICE guidance on community engagement (NICE 2008). There was also debate over whether interventions were "targeted" or "universal" with team members finding it difficult to reach agreement in some cases. The lack of a standard set of terms for community participation presents difficulties in interpretation of research and practice. Some phrases are used effectively as synonyms *e.g.* community involvement and community engagement, while other terms lack an agreed definition. Also theoretical constructs used with some precision in academic literature may be conceptualised differently in professional practice and also by the public (Yerbury, 2011). Clusters of literature can occur as a field of practice develops. This review mapped how community engagement and related concepts have been operationalised in UK policy and practice.

Due to the methodology and timescale of the systematic map, we could not extract detailed data on the theoretical underpinnings of various approaches to community engagement. However, the typology we used was based on the recent NIHR review (O'Mara-Eves et al., 2013) which described three conceptualisations of community engagement:

- Theories of change for patient/ consumer involvement: engagement with communities or members of communities in strategies for service development, in which empowering individuals enhances their engagement with service professionals to effect sustainable changes in services. It involves community members in the planning or design of an intervention.

- Theories of change for peer-/lay-delivered interventions: services engage communities or individuals within communities to deliver interventions, thereby empowering them by enhancing their skills. This approach aims to effect sustainable change amongst individuals and their peers.
- Theories of empowerment to reduce health inequalities: when people are engaged in a programme of community development, an empowered community is the outcome sought by enhancing their mutual support and their collective action to mobilise resources of their own and form elsewhere to make changes within the community. An empowered community can do much to sustain its own efforts.

Another typology was developed in parallel with the 7 types of community engagement used in Reviews 1-3 (Brunton et al., 2014). This typology was developed as part of a report for Public Health England (Public Health England and NHS England, 2015), and was also based on the 2013 NIHR review but placed different types of community interventions into a "family" with four main themes: Strengthening communities; Volunteer & peer roles; Collaborations & partnerships; Access to community resources (see Appendix H for further details). Arguably, the "family" of community based interventions (Public Health England and NHS England, 2015) may be more applicable to the UK context than the seven types of community engagement that we have used in this review. For the subsequent component 1b (case studies) we have used the South 2014 typology in our sampling frame as it was felt that this was more applicable to UK practice. Appendix I also shows the distribution of the initiatives in this UK mapping review across the four main categories in the South 2014 "family" of community based interventions.

What the review does not cover: The date cut-off of 2000 for research, evaluation and practice descriptions, and of 2006 for policy or conceptual papers may have led to some relevant studies from before these dates being missed, however as this is intended to be a map of current and emerging practice this is probably not very important.

As this was a systematic mapping review, with many included articles, we did not undertake detailed data extraction and therefore did not examine all the included articles in as much detail as for a standard systematic review. This led to difficulties in assigning coding categories to some of the articles, as alluded to above, and may mean that some of the categories assigned to some of the articles may be subject to discussion and change. The lack of time to examine all the articles in detail (many of which were large reports) means that we are unable to say with certainty that we have detected (for example) all mentions of harmful or unintended effects, and it is possible that these were included in more than 12 articles.

As is appropriate for a systematic mapping review (Gough et al., 2012), and in order to code all 316 included articles within the short time available, we did not undertake quality assessment for included research and evaluation studies. Because of this limitation, we did not routinely code for whether an initiative had positive effects, as it was felt that without the quality assessment and detailed data extraction, any such findings would be relatively meaningless and potentially misleading if taken out of context. This is something that could be addressed in future systematic reviews of this topic, which could focus on (for example) the effectiveness of one type of community engagement approach within or across certain population groups.

The lack of detailed data extraction meant that the map also lacks detailed descriptions of populations, settings, activities etc. and there is no detail of whether particular approaches were underpinned by particular theories.

4.4 Strengths of the review

This systematic map of the UK literature on community engagement policy and practice in the UK aimed to include all the community engagement initiatives that have been taking place since 2000. Previous experience in this field (O'Mara-Eves et al. 2013, South et al. 2010) suggests that there is a publication bias in that professionally-led (sometimes referred to as "top-down") initiatives are more likely to be evaluated and then published in peer reviewed journals than community-led ("bottom-up" or "Grass-roots") initiatives, such as those that result in community empowerment. We tried to overcome this publication bias by making every effort to find and include "grey" literature (reports and other documents from organisational repositories and websites) and two "calls for evidence" were made, from NICE to stakeholders, and from the review teams to networks of community organisations, public health practitioners and academics. We had 21 relevant projects contact us via our Register of Interest, and 20 via the NICE call for evidence, some of which did not have any related publications or evaluation reports, and would not have been picked up even in our website searches. While we know of other relevant projects that did not sign up to the Register, we hope that this map comes closer to presenting a realistic picture of what is happening in practice than if we had only included published journal articles.

The inclusion of a range of evidence from non-RCT study designs, which are so often excluded from systematic reviews of effectiveness, is a real strength of this map of practice. It has been argued that measuring "outcomes" alone does not measure the impact on people's lives or the context in which changes (if any) take place (Lowe 2013), and that qualitative research is better placed to explore these aspects of effectiveness. It is also often noted that "hard to reach" groups are often excluded from traditional research studies such as RCTs, whether deliberately or by default. The inclusion of other types of information has ensured that a wider range of population groups and approaches to community engagement are represented in this map and in fact "hard to reach" groups together form the largest population group.

4.5 Implications of the findings

The diversity of populations, health and wellbeing issues, approaches and activities that are involved in recent and current community engagement policy and practice in the UK suggests that the use of community engagement as an "umbrella" term, as proposed in the 2008 guidance (National Institute for Health and Care Excellence, 2008), seems to still be appropriate, as different approaches fit best with different populations and/ or health and wellbeing issues.

Use of the PROGRESS-Plus tool (Kavanagh et al., 2008) in this systematic map has highlighted differences in the populations targeted by community engagement initiatives in

the UK compared to those targeted in the international literature. For example, in the 2013 NIHR review (O'Mara-Eves et al., 2013), ethnicity was the most frequent PROGRESS-Plus characteristic across all the included studies, although for UK studies only, the most frequent characteristic was socioeconomic status. In our map, the most frequent PROGRESS-Plus characteristic was "Other" vulnerable groups, followed by socioeconomic status. Our review and the 2013 review of effectiveness (O'Mara-Eves et al., 2013) also found that populations often had more than one characteristic of PROGRESS-Plus. The high volume of initiatives taking place in these "Other" vulnerable groups in the UK deserves recognition by policy makers and decision makers, practitioners, professionals and researchers, in terms of resources, evaluation and opportunities for shared learning. It may also indicate a need for a specific community engagement add-on to the PROGRESS-Plus tool, so that future research and evaluation is more likely to capture the finer details of the communities involved.

The map has indicated that there is a high volume of evidence in the following categories: process evaluations; qualitative and mixed methods studies; population – socioeconomic indicators, other indicators of disadvantage (disability; older people; service users; substance users; homeless; etc.), BME; Issues – social capital, community wellbeing, community health (community level outcomes). Types of community engagement: community mobilisation/ action; community partnerships/ coalitions. It may be beneficial to carry out a full systematic review focused on any of these areas to examine in-depth the effectiveness of UK-based initiatives.

The map has also indicated that there are evidence gaps in the following areas: rural settings; Harmful/ unintended effects; health inequalities related to religion/ culture or educational issues. It may be beneficial to focus UK-based primary research and/ or practice in these areas.

5. Conclusion and recommendations

This mapping review found a substantial evidence-base on current and emerging UK policy and practice in community engagement, encompassing a diverse range of populations and approaches to community engagement. The use of community engagement as an "umbrella" term to encompass different approaches and activities for different population and health or wellbeing issues seems to fit well with the UK perspective.

The key role of local government in leading community engagement and supporting public participation in local decision making has been a major policy theme throughout the period covered by the review. Community engagement and empowerment have been consistently linked to strategies to address health inequalities, with emphasis given to enabling individuals to play a greater part in local decisions that affect their health and lives. Dominant concepts include asset-based approaches, co-production, volunteering and peer support.

There was a high volume of evidence from: qualitative and mixed methods studies; initiatives targeting health inequalities via socioeconomically deprived areas and groups, and via "hard to reach" groups (such as people with disabilities, substance users, homeless people). Community level outcomes (e.g. improved housing) and wellbeing outcomes (e.g. improved self-esteem) were most commonly addressed, and community mobilisation/ action and community partnerships/ coalitions were the types of community engagement most commonly employed.

Recommendations for practice: A varied "toolbox" of approaches to community engagement in the UK is needed in order to engage with a wide range of populations and health and wellbeing issues.

Communities targeted by community engagement initiatives in the UK include a substantial proportion who are at risk of health inequalities (such as people with mental health issues, offenders, homeless people, Gay, Lesbian, Bisexual or Transgender), but who are not routinely fully represented in health equity profiles/ audits, which tend to focus on age, gender, ethnicity and deprivation indices. Consideration should continue to be given to these "marginalised" groups, in terms of both initial engagement and measurement of impact.

Recommendations for research: The lack of initiatives found in rural settings, and the lack of evidence on cultural adaptation, groups at risk of health inequalities due to religion/ culture or lack of education suggests that it would be beneficial to explore community engagement in practice for these groups. Future research studies should report any harmful or unintended effects. There is scope for future systematic reviews on community engagement in the UK context to examine the effectiveness of each type of community engagement approach.

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APPENDIX A Sample search strategy from O'Mara-Eves et al. 2013

Search strategy: Database of Promoting Health Effectiveness Reviews

Keyword search: Health promotion OR inequalities AND (Aims stated AND search stated AND inclusion criteria stated)

Search strategy: Trials Register of Promoting Health Interventions

"disadvantage" OR "disparities" OR "disparity" OR "equality" OR "equity" OR "gap" OR "gaps" OR "gradient" OR "gradients" OR "health determinants" OR "health education" OR "health inequalities" OR "health promotion" OR "healthy people programs" OR "inequalities" OR "inequality" OR "inequities" OR "inequity" OR "preventive health service" OR "preventive medicine" OR "primary prevention" OR "public health" OR "social medicine" OR "unequal" OR "variation"

AND

"change agent" OR "citizen" OR "community" OR "champion" OR "collaborator" OR "disadvantaged" OR "lay community" OR "lay people" OR "lay person" OR "member" OR "minority" OR "participant" OR "patient" OR "peer" OR "public" OR "representative" OR "resident" OR "service user" OR "stakeholder" OR "user" OR "volunteer" OR "vulnerable"

AND

"capacity building" OR "coalition" OR "collaboration" OR "committee" OR "compact" OR "control" OR "co-production" OR "councils" OR "delegated power" OR "democratic renewal" OR "development" OR "empowerment" OR "engagement" OR "forum" OR "governance" OR "health promotion" OR "initiative" OR "integrated local development programme" OR "intervention guidance" OR "involvement" OR "juries" OR "local area agreement" OR "local governance" OR "local involvement networks" OR "local strategic partnership" OR "mobilisation" OR "mobilization " OR "neighbourhood committee" OR "neighbourhood managers" OR "neighbourhood renewal" OR "neighbourhood wardens" OR "networks" OR "organisation" OR "panels" OR "participation" OR "participation compact" OR "participatory action" OR "partnerships" OR "pathways " OR "priority setting" OR "public engagement" OR "public health" OR "rapid participatory assessment" OR "regeneration" OR "relations" OR "support"

Search strategy: Cochrane databases

CDSR (Cochrane reviews).
DARE (other reviews).
HTA database (technology assessments).

NHS EED (economic evaluations).

“disadvantage” OR “disparities” OR “disparity” OR “equality” OR “equity” OR “gap” OR “gaps” OR “gradient” OR “gradients” OR “health determinants” OR “health education” OR “health inequalities” OR “health promotion” OR “healthy people programs” OR “inequalities” OR “inequality” OR “inequities” OR

“inequity” OR “preventive health service” OR “preventive medicine” OR “primary prevention” OR “public health” OR “social medicine” OR “unequal” OR “variation”

AND

“change agent” OR “citizen” OR “community” OR “champion” OR “collaborator” OR “disadvantaged” OR “lay community” OR “lay people” OR “lay person” OR “member” OR “minority” OR “participant” OR “patient” OR “peer” OR “public” OR “representative” OR “resident” OR “service user” OR “stakeholder” OR “user” OR “volunteer” OR “vulnerable”

AND

“capacity building” OR “coalition” OR “collaboration” OR “committee” OR “compact” OR “control” OR “co-production” OR “councils” OR “delegated power” OR “democratic renewal” OR “development” OR “empowerment” OR “engagement” OR “forum” OR “governance” OR “health promotion” OR “initiative” OR “integrated local development programme” OR “intervention guidance” OR “involvement” OR “juries” OR “local area agreement” OR “local governance” OR “local involvement networks” OR “local strategic partnership” OR “mobilisation” OR “mobilization “ OR “neighbourhood committee” OR “neighbourhood managers” OR “neighbourhood renewal” OR “neighbourhood wardens” OR “networks” OR “organisation” OR “panels” OR “participation” OR “participation compact” OR “participatory action” OR “partnerships” OR “pathways “ OR “priority setting” OR “public engagement” OR “public health” OR “rapid participatory assessment” OR “regeneration” OR “relations” OR “support”

Search strategy: The Campbell Library

“disadvantage” OR “disparities” OR “disparity” OR “equality” OR “equity” OR “gap” OR “gaps” OR “gradient” OR “gradients” OR “health determinants” OR “health education” OR “health inequalities” OR “health promotion” OR “healthy people programs” OR “inequalities” OR “inequality” OR “inequities” OR “inequity” OR “preventive health service” OR “preventive medicine” OR “primary prevention” OR “public health” OR “social medicine” OR “unequal” OR “variation”

AND

“change agent” OR “citizen” OR “community” OR “champion” OR “collaborator” OR “disadvantaged” OR “lay community” OR “lay people” OR “lay person” OR “member” OR “minority” OR “participant” OR “patient” OR “peer” OR “public” OR “representative” OR “resident” OR “service user” OR “stakeholder” OR “user” OR “volunteer” OR “vulnerable”

AND

“capacity building” OR “coalition” OR “collaboration” OR “committee” OR “compact” OR “control” OR “co-production” OR “councils” OR “delegated power” OR “democratic renewal” OR “development” OR “empowerment” OR “engagement” OR “forum” OR “governance” OR “health promotion” OR “initiative” OR “integrated local development programme” OR “intervention guidance” OR “involvement” OR “juries” OR “local area agreement” OR “local governance” OR “local involvement networks” OR “local strategic partnership” OR “mobilisation” OR “mobilization “ OR “neighbourhood committee” OR “neighbourhood managers” OR “neighbourhood renewal” OR “neighbourhood wardens” OR “networks” OR “organisation” OR “panels” OR “participation” OR “participation compact” OR “participatory action” OR “partnerships” OR “pathways “ OR “priority setting” OR “public engagement” OR “public health” OR “rapid participatory assessment” OR “regeneration” OR “relations” OR “support”

Appendix B Sample search strategy from Stream 1 update

Appendix 1: Sample search strategies

Search strategy: Database of Promoting Health Effectiveness Reviews

Scan the title and abstracts of all items published since 2011.

Search strategy: Trials Register of Promoting Health Interventions

The search is based on broad terms for Population AND Intervention

Free text search of titles and abstracts, 2011 onwards:

“change agent*” OR “citizen*” OR “communit*” OR “champion*” OR “collaborator*” OR “disadvantaged” OR “lay worker” or lay health” OR “lay people” OR “lay person” OR “member*” OR “minorit*” OR “participant*” OR “patient*” OR “peer*” OR “public” OR “representative*” OR “resident*” OR “stakeholder*” OR “user*” OR “volunteer*” OR “vulnerable”

AND

“capacity building” OR “coalition*” OR “collaboration*” OR “committee*” OR “compact” OR “co-production” OR “council*” OR “delegated power*” OR “democratic renewal” OR “development” OR “empower*” OR “engag*” OR “forum*” OR “governance” OR “initiative*” OR “intervention guidance” OR “involve*” OR “juries” OR "jury" OR “local area agreement*” OR “local governance” OR “mobilisation” OR “mobilization “ OR “neighbourhood committee*” OR “neighbourhood manager*” OR “neighbourhood renewal” OR “neighbourhood warden*” OR “neighborhood committee*” OR “neighborhood manager*” OR “neighborhood renewal” OR “neighborhood warden*” OR “network*” OR “organisation*” OR “organization*” OR “panel*” OR “participation” OR “participatory action” OR “partnership*” OR “pathway*“ OR “priority setting*” OR “public engagement” OR “public health” OR “rapid participatory assessment*” OR “regeneration” OR “relations” OR “support”

Search strategy: Cochrane/Centre for Reviews and Dissemination databases

Cochrane Database of Systematic Reviews (Cochrane Library); DARE (CRD); HTA database (CRD); NHS EED (CRD).

The search is based on broad terms for Topic AND Population AND Intervention.

Search 2011 onwards. Search all fields:

"disadvantage*" OR "disparities" OR "disparity" OR "equalit*" OR "equit*" OR "gap" OR "gaps" OR "gradient" OR "gradients" OR "health determinant" OR "health determinants" OR "health education" OR "health inequalities" OR "health promotion" OR "healthy people program*" OR "inequalities" OR "inequality" OR "inequit*" OR "preventive health service*" OR "preventive medicine" OR "primary prevention" OR "public health" OR "social medicine" OR "unequal" OR "variation*"

AND

"change agent*" OR "citizen*" OR "communit*" OR "champion*" OR "collaborator*" OR "disadvantaged" OR "lay communit*" OR "lay people" OR "lay person" OR "member*" OR "minorit*" OR "participant*" OR "patient*" OR "peer*" OR "public" OR "representative*" OR "resident*" OR "service user*" OR "stakeholder*" OR "user*" OR "volunteer*" OR "vulnerable" OR "lay worker" OR "lay health"

AND

"capacity building" OR "coalition*" OR "collaboration*" OR "committee*" OR "compact" OR "control" OR "co-production" OR "council*" OR "delegated power*" OR "democratic renewal" OR "development" OR "empoWermert" OR "engagement" OR "forum*" OR "governance" OR "health promotion" OR "initiative*" OR "intervention guidance" OR "involvement" OR "juries" OR "jury" OR "local area agreement*" OR "mobilisation" OR "mobilization" OR "neighborhood committee*" OR "neighborhood manager*" OR "neighborhood renewal" OR "neighborhood warden*" OR "neighbourhood committee*" OR

“neighbourhood manager*” OR “neighbourhood renewal” OR “neighbourhood warden*” OR “networks” OR “network” OR “organisation*” OR “organization*” OR “panel*” OR “participation” OR “participatory action” OR “partnership*” OR “pathway*“ OR “priority setting*” OR “public engagement” OR “public health” OR “rapid participatory assessment” OR “regeneration” OR “relations” OR “support”

Search strategy: Campbell Collaboration Library

All reviews published since 2011 scanned by title, and then by title and abstract.

Search strategy: NIHR Health Technology Assessment (HTA) programme website/journals library.

All reviews published since 2011 scanned by title, and then title and abstract.

Appendix C Sample search strategy from PHE mapping review

Databases searched (from January 2004 to April 2014): MEDLINE, IDOX Information Service; CINAHL, Social Policy and Practice; Academic Search Complete. The following search strategy was used:

1. (communit* or lay or public or citizen* or people or empower* or social or emancipat* or volunt*or “asset-based” or peer)

2. (concept* or framework or definition* or theory or theories or model or typolog* or categoris* or categoriz* or dimension* or domain* or construct or review or “evidence base*” or effective* or outcome*)

3. (intervention* or prevention* or engagement or involve* or participat* or action or development or mobilisation or commissioning)

4. ("health promotion" or "health improvement" or "healthy communit*" or wellbeing or “quality of life” or “self-care” or resilience)

5. (determinant* N2 (social or health)) or (health N2 (inequality or equity or exclu*)) or (underserved or “hard to reach” or “seldom heard”)

6. MeSH terms: (MH "Community Networks") OR (MH "Community-Based Participatory Research") OR (MH "Voluntary Health Agencies") OR (MH "Voluntary Programs") OR (MH "Volunteers") or (MH "community health worker") or (MH "public health practice")

Combinations

6 (MeSH) and 2 (TI)

(1 N2 3) and 2 and 4

(1 N2 3) and 2 (Title only)

(1 N2 3) and 5

1 and 2 and 5 (Title only)

An additional cross-cutting search was run in MEDLINE (January 2004 to April 2014):

((communit* or citizen* or empower* or emancipat* or “asset-based” or "co-production") n2 (intervention* or engagement)) AND (health or wellbeing or "well being")

(concept* or framework or definition* or theory or theories or theoriz* or typolog*) AND (intervention* or engagement or involve* or participat*) AND (health or wellbeing or "well being")

communit* and (empower* or engage* or involv* or participat* or emancipat*) and (health or wellbeing or "well being")

APPENDIX D Bibliography of included studies.

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APPENDIX F List of Systematic Reviews mined for relevant studies

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APPENDIX G Table of included studies/ projects

KEY: *Extent of CE*: + Low; ++ Moderate; +++ High.

Type of CE: 1 Community mobilisation/action; 2 Community partnerships/coalition; 3 Peer involvement; 4 Community organisations; 5 Non-peer health advocacy; 6 Social networks; 7 Volunteers; 8 Cultural adaption.

Outcomes reported: H – Health; WB – Wellbeing; SDH – Social Determinants of Health; I – Individual level; C – Community level; P – Progress; E – Economic; U – Uptake.

Short Title	Type	Name of initiative	Type of activity	HWB issues	Target group	Extent of CE	Type of CE	Outcomes reported
Adams and Cumming, 2002)	• Practice description • Discussion		*Health promotion using a social model of health. Essentially there were 3 strands to the model: 5 levels of work including working with communities and taking a community development approach, principles and domains*	• Community wellbeing • Community assets • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *health inequalities; deprived areas*		• 1 • 2	
Alborz et al., 2002)	Research Mixed methods evaluation		*PCG/Trusts are dominated by health professionals, but are responsible for representing the interests of the local community. This paper assesses how they have informed and consulted local communities and the perceived impact of this consultation on decision-making.*	• Other [Info] *Consultation through involvement with primary care groups and trusts*	• Place/ Location	+	• 2	P
Alexander et al., 2003)	Research Questionnaire/ survey	*Bosom Buddies*	*A support group run by lay 'Bosom Buddies', a midwife and a breast-feeding counsellor*	• Healthy eating [Info] *breast feeding* • Personal assets [Info] *women trained* • Children and Young People/ Parenting	• Gender	+	• 3	H, P, U
Allen, 2004)	Research	*Positive Action on Falls Programme*	*Peer education approach to preventing falls in older people. Peer education programme in Bradford gave one-off sessions to groups of older people providing information about falls*	• Physical activity • Other [Info] *falls prevention* • General health (personal)	• Socioeconomic indicators • Other indicators of disadvantage [Info] *older people*	+	• 3	H, WB, I, P

			prevention and demonstrating simple balance and strength building exercises.					
Altogether Better, 2010)	Research • Qualitative study	*Altogether Better--Health Champions: Community-based projects*	*Community health champions - aims to empower people across the Yorkshire and Humber region to improve their own health and that of their families and their communities.*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Personal assets [Info] *TRAINING OF HEALTH CHAMPIONS* • Other [Info] *6, employment; weight, organising events* • General health (personal) • General health (community)	• Other indicators of disadvantage [Info] *communities and target groups are generally those with the poorest health and who make the least use of preventive services, for example residents of mobile homes and elders; disability.*	+	• 1 • 3 • 6 • 7	H, WB, SDH, I, C, P
Anastacio et al., 2000)	Research •Qualitative study [Info] *case studies*		*community participation*	• Community wellbeing • Other [Info] *area-based regeneration; community partnerships*	• Occupation [Info] *areas of +++ unemployment* • Socioeconomic indicators [Info] *areas of deprivation*	+++	• 1 • 2	WB, P
Anderson and Shepherd, 2005)	Research •Qualitative study		*public involvement in planning primary health care*	*public involvement in planning health services* • General health (community)	• Socioeconomic indicators [Info] *deprived areas*	++	• 2	P
Andrews et al., 2003)	Research •Qualitative study	] *befriending service provided by Age Concern Buckinghamshire*	*voluntary sector local home-visiting befriending service*	• Mental health • Personal wellbeing • Social capital/ cohesion	• Occupation [Info] *clients aged 80+ (retired)* • Gender [Info] *Most volunteers reported to be female* • Social capital [Info] *frail and isolated older people*	• +	• 7	WB, I, H, P
Anning et	Research • Mixed	*Sure Start Local*	*program variability study*	• Children and Young People/	• Place/ Location	• +	• 2	H, WB, I, P

al., 2007)	methods evaluation	*Programmes*		Parenting	• Socioeconomic indicators			
Anon	• Other [Info] *case studies*	] *The Black and Minority Ethnic (BME) Health Forum*	*Forum and community participatory research; health promotion pilot which engaged BME women from a local GP practice to ascertain and improve historically + levels of uptake in breast screening appointments*	• Disease prevention • Prevention violence/ abuse/ crime • Social capital/ cohesion • Personal assets • Other [Info] *The BME Health Forum is an example of a well established model of community engagement which informs the commissioning process by representing, commissioning research, and lobbying on behalf of the needs of BME communities, public health campaigns, obesity* • General health (community)	• Place/ Location [Info] *London, Bristol* • Race/ ethnicity [Info] *BME* • Gender [Info] *WOMEN*	• +++	• 2 • 3 • 8	**H, SDH, I, C, P**
Arora et al., 2000)	•Qualitative study	*Health Improvement Programmes*	*Three-year action plans, developed in each health authority district, aimed at improving the health of the local population.*	• General health (personal) • General health (community)		• ++	• 1 • 2	H, I, C, P
Assembly Goverment Wales Council for Voluntary Action (2004)	•Questionnaire/ survey• Concept/ theory •Evaluation/ research • Discussion	*Volunteering for Health/ Building Strong Bridges*	*volunteering for health in health and social care services in partnerships between the voluntary and health sectors*	• Personal wellbeing • General health (personal)		• +	• 2 • 7	H, WB, P, U
Atkinson, 2012)	Research Policy Discussion			• Children & Young People/ Parenting	• Other indicators of disadvantage [Info] *children & young people*			
Attree et al., 2011	• Concept/ theory •	*Health Trainers*	*health inequalities*	• General health (personal)	• Place/ Location • Other indicators of disadvantage	• +	• 3	

	Discussion				[Info] *deprived areas*			
Attree, 2004	• Qualitative study	*Sure Start*	*Based on a local evaluation of a Sure Start programme, the present paper describes the development of a community support project aimed at engaging local people in supporting the parents and carers of young children.*	• Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets • Children and Young People/ Parenting • General health (personal) • General health (community)	• Place/ Location *deprived area in the North West - Barrow* • Other indicators of disadvantage *disadvantaged communities; suffers many of the problems associated with economic and social disadvantage, such as an above-average percentage of families receiving welfare benefits and +++ rates of teenage pregnancy*	• +	• 3 • 7	WB, SDH, P
Audrey et al., 2006a	• Mixed methods evaluation	*ASSIST (A Stop Smoking in Schools Trial)*		• Substance use • Children and Young People/ Parenting	• Place/ Location [Info] *schools in south-east Wales and the west of England* • Other indicators of disadvantage [Info] *12-13 year olds*	• +	• 3	P
Audrey et al., 2006b	• Mixed methods evaluation	*A Stop Smoking in Schools Trial (ASSIST)*	*Peer supporters in secondary schools encourage stopping smoking*	• Substance use [Info] *smoking*	• Education [Info] *In secondary school*	• +	• 3	H, C, P
Audrey et al., 2008)	• Mixed methods evaluation	*Teachers' perspectives on (ASSIST) A Stop Smoking In Schools Trial*	*Stop smoking in schools peer advice*	• Substance use	• Place/ Location • Education [Info] *Year 8 secondary students*	• +	• 3	H, C, P
Bagley and Ackerley, 2006)	•Qualitative study	*Third way initiative Sure Start study on one programme given the pseudonym Mazebrook*	*multi-agency/ multi-disciplinary parenting and early years support; health, play and learning*	• Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *social exclusion; empowerment* • Children and Young People/ Parenting	• Socioeconomic indicators [Info] *states that the area is classified as a deprived community, according to Government socioeconomic indicators* • Social capital [Info] *the area had a tradition of community activity and a pre-*	• ++	• 2 • 3 • 4 • 6 • 8	WB, SDH, I, C, P, E

					existing range of active groups and organisations • Other indicators of disadvantage [Info] *described as a disadvantaged community*			
Ball and Nasr, 2011)	•Qualitative study [Info] *interviews and focus groups*	*health trainer service*	*health trainer service*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Other • General health (personal) [Info] *weight* • General health (community)	*"hard to reach", substance abuse, homeless, deprived communities*	• +	• 3	H, WB, SDH, I, H, P
Bandesha and Litva, 2005)	•Qualitative study	*The Asian Health Development Project*		• Physical activity • Healthy eating • Social capital/ cohesion • Personal assets • General health (personal) • General health (community)	• Race/ ethnicity [Info] *local South Asian community*	• +	• 1 • 2	WB, SDH, I, C, P
Barnes et al., 2003)	• Mixed methods evaluation	*ESRC democracy and participation programme. 4 case studies: The Ward Advisory Board; The Single Regeneration Budget Group (SRB Group); The older people's group; the women's group;*	*Looks at forums within which dialogue takes place. 2 case studies defined as locality based initiatives and 2 formed around presumed communities of interest or identity*	• Social capital/ cohesion [Info] *citizen empowerment* • Community assets [Info] *Advice and information source for women in the city* • Other [Info] *neighbourhood renewal* • Children and Young People/ Parenting	• Race/ ethnicity [Info] *minority ethnic groups; White European predominantly Pakistani Muslim population; Black and white volunteers* • Occupation [Info] *Volunteers; Working class* • Gender [Info] *women's group* • Other indicators of disadvantage [Info] *older people; Older than the city average; Youth; older and younger volunteers*	• ++	• 1 • 2 • 4 • 7	C, P

Barnes et al., 2004)	•Qualitative study	*Power, Participation and Political Renewal*	*The project ran from 2000–2002 and explored the development of 'deliberative forums' through which the state attempts to engage citizens in dialogue about policies and services: for example area-based forums within local government, user forums in health, senior citizens or youth forums, and a range of community or identity-based organisations that the local state draws in to consultation exercises.*	• Social capital/ cohesion • Community assets	• Race/ ethnicity [Info] *included minority ethnic group forum*	• +	• 2	P
Barnes et al., 2005)	• Mixed methods evaluation	*national evaluation of Health Action Zones*	*health action zones; area based initiatives*	• Other [Info] *social determinants* • General health (personal) • General health (community)	• Socioeconomic indicators	• ++	• 1 • 2	H, I
Barnes et al., 2005, Barnes et al., 2004)	• Mixed methods evaluation	*Health Action Zones*	*area- based initiatives to reduce the effects of persistent disadvantage*	• Community wellbeing • Social capital/ cohesion • Community assets • General health (personal) • General health (community)	• Socioeconomic indicators [Info] *areas of persistent disadvantage*	• ++	• 1 • 2	H, WB, SDH, C, P
Barnes et al., 2008b)	• Policy • Practice description •Discussion	*citizen-centred governance*	*Reflects on how to create flexible and effective organisations for delivering public services that also reflect the values of local democracy.*	• Community wellbeing • Social capital/ cohesion • Community asset	• Place/ Location • Socioeconomic indicators [Info] *areas of disadvantage*	• ++	• 2	
Barnes et al., 2009)	• RCT	*Home-start*	*volunteer unstructured home visiting support post-natally*	• Mental health • Personal wellbeing • Children and Young People/ Parenting	• Race/ ethnicity [Info] *fewer mothers accepting home start support were white* • Occupation [Info] *more mothers accepting home start support were unemployed* • Gender [Info] *women - mothers* • Education [Info] *mothers accepting home start support had on average more*	• +	•7	H, I

					qualifications			
Barrett, 2008)	•Qualitative study		*Working with hard to reach families*	• Children and Young People/ Parenting	• Socioeconomic indicators [Info] *'Hard to reach', parents*		• 1	
Bauld et al., 2005a)	• Mixed methods evaluation Policy	*Health Action Zones*	*area- based initiatives to reduce the effects of persistent disadvantage*	• Community wellbeing • Community assets • General health (personal) • General health (community)	• Socioeconomic indicators [Info] *areas of persistent disadvantage*	• ++	• 1 • 2	H, SDH, C, P
Bauld et al., 2005b)	• Mixed methods evaluation	*Health Action Zones*	*to identify and address the public health needs of the local area; - to increase the effectiveness, efficiency and responsiveness of services; - to develop partnerships for improving people's health and relevant services, adding value through creating synergy between the work of different agencies*	• Community wellbeing • Community assets • General health (personal) • General health (community)	• Socioeconomic indicators [Info] *areas of persistent disadvantage*	• ++	• 1 • 2	H, SDH, C, P
Baxter et al., 2001)	•Qualitative study	Small voices, big noises	*The case studies: 1. Barrow Community Gym – evaluation of gym for mental health service users. 2. Finding Out – people with learning difficulties found out about the experiences of other self-advocacy groups. 3. Briardale Community Centre – local people were recruited to carry out a door-to- door survey of people's wishes for facilities in the new community centre. 4. Preston Road Estate – local people used participatory appraisal to find out what needed to be done to improve quality of life on the estate. 5. Holderness Youth Initiatives – young people used participatory appraisal to investigate a number of issues relevant to them and their community. 6. Totnes Traffic Appraisal – local people formed a group to try to find solutions to the local traffic problems. 7. Barriers to Independence – older people are currently investigating the barriers to independence for people of their age. 8. Alternative Choices – an investigation into alternative strategies of coping with mental*					

			health problems.					
Beavington	• Practice description	*Health Improvement neighbourhood work*	*Three health improvement teams work in the deprived areas of Bristol. They take a community development approach and work on issues that are important to the local community that will improve health. This includes work at the individual and community level. Community is engaged by community outreach, being based in the community, having a good reputation and known commitment in the areas. In addition, a structured approach of communication centres in the Inner City provide a two way dialogue between voluntary and community sector organisations in the Inner City. This model is going to be replicated in other areas of the city.*	• Personal wellbeing • Community wellbeing • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *deprived areas*	• ++	•1 • 2	
Beck et al., 2005)	•Qualitative study		*Sexual health*	• STIs [Info] *Sexual health*	• Race/ ethnicity [Info] *Bangladeshi*	• ++	• 2	C, P
Benzeval, 2003a)	• Mixed methods evaluation	*Health Action Zones (HAZs)*	*Generally to improve health outcomes and reduce inequalities. 26 HAZ with different strategies to address health inequalities*	• General health (community)	• Other indicators of disadvantage [Info] *HAZ were universally deprived, with +++ levels of average ill health and + levels of internal inequalities.*	• +	• 1 • 2 • 4	P
Benzeval, 2003b)	• Mixed methods evaluation	*health action zones*	*area based initiative*	• Disease prevention [Info] *reducing health inequalities - assume this refers to the main indicators such as mortality, cancer etc.* • Other [Info] *tackling health inequalities; raising the profile of marginalised groups* • General health (personal) • General health (community)	• Socioeconomic indicators [Info] *socio-economic and health inequalities between different parts of Sheffield*	• ++	• 1 • 2	C, P
Beresford and Carr, 2012)	• Practice description • Discussion		*user involvement/ service user participation in social care*	• Substance use • Personal wellbeing • Social capital/ cohesion • Other [Info] *older people*	• Place/ Location • Race/ ethnicity • Other indicators of disadvantage [Info] *drug addiction; mental health; older people; life limiting illness;*	• +	• 2 • 4	

				• Children & Young People/ Parenting	*LGBT people*			
Beresford, 2007)	• Concept/ theory		*user involvement research*		• Place/ Location • Other indicators of disadvantage [Info] *particularly those with learning difficulties, disabilities, mental health service users and elderly people*	• +++	• 2	
Bertotti et al., 2009)	•Qualitative study	*Well London participation in World Cafes*	*community cohesion- To capture the views of residents*	• Community wellbeing • Community assets	• Socioeconomic indicators [Info] *The target areas were identified on the basis of their ranking within the 2004 Index of Multiple Deprivation and position within the top 13% most deprived LSOAs in London*	• ++	• 2	WB, C, P
Bhavnani and Newburn, 2013)	Practice description	*NCT breastfeeding peer support*	*Breastfeeding peer support*	• Children and Young People/ Parenting • Healthy eating	Women (mothers) in East Lancashire	+	3,7	n/a
Bhavnani and Newburn, 2014)	Mixed methods evaluation	*Birth and Beyond Community Supporters Programme*	*recruit and train community volunteers to work as peer supporters, provide a strengths-based, empowering volunteer peer support service for parents with the aim of reducing isolation, stress and low mood during pregnancy and the first two years after birth*		Race/ ethnicity: 59% identified themselves as from a Black and Minority Ethnic (BME) group; 48% asylum seekers or refugees; Women (mothers); Social exclusion	+	3,7	WB, SDH, I, P, E
Blamey et al., 2004)	• Mixed methods evaluation	*Have a Heart Paisley*	*The combined interventions were to be delivered in partnership and in a manner that engaged the community at all levels of the programme. It was hoped that this integrated approach would be capable of saturating the town of Paisley with improved and new services, projects and opportunities that would,*	• Physical activity • Healthy eating • Disease prevention • STIs • Substance use • Social capital/ cohesion • Personal assets	• Other indicators of disadvantage [Info] *suffered from +++ unemployment and socio-economic deprivation.*	• ++	• 2	H, WB, SDH, I, P

			over the long term, reduce and prevent CHD amongst the Paisley population. The long-term aim of HaHP was to reduce the total burden and levels of inequality of Coronary Heart Disease (CHD) in the town of Paisley through an integrated programme of secondary and primary prevention.	• Community assets • Children and Young People/ Parenting				
Blank et al., 2007)	•Questionnaire/ survey Policy	*New Deal for Communities*	*New Deal for Communities: a major UK government funded initiative*	• Physical activity • Healthy eating • Mental health • General health (personal)	• Socioeconomic indicators [Info] *deprived English communities*	• ++	• 1 • 2	H, WB, I
Bolam et al., 2006)	•Qualitative study	*Nottingham City Net project*	*The present article presents an exploratory qualitative process evaluation study of 'Ambassador' participation in City Net, an innovative information communication technology-based (ICT) project that aims to build aspects of social capital and improve access to information and services among disadvantaged groups in Nottingham, UK.*	• Community wellbeing • Social capital/ cohesion • General health (community)	• Race/ ethnicity [Info] *young African-Caribbean men with mental health difficulties* • Occupation [Info] *long-term unemployed men* • Gender • Other indicators of disadvantage [Info] *socially isolated carers and older people; those living in deprived wards.*	• ++	• 2 • 4 • 5	WB, SDH, I, P
Bowers et al., 2006)	• Mixed methods evaluation		*objective of identifying and +++lighting the distinctive contribution of volunteers involved in providing support to people also receiving different health and social care support from statutory services Ð mainly within or connected to home and intermediate care services.*	• Personal wellbeing • Social capital/ cohesion • General health (personal)	• Social capital • Other indicators of disadvantage [Info] *older people*	• +	• 7	WB, I
Boydell and Rugkåsa, 2007)	• Mixed methods evaluation •Qualitative study• Policy • Concept/ theory • Practice	*2 health action zones in Northern Ireland*	*Health action zones; partnerships. One partnership involved over 30 partners from statutory agencies, voluntary and community organizations and local councillors, and met on a six-monthly basis. In addition, most partners met more frequently in project subgroups. The other partnership involved a smaller group of partners from statutory and voluntary agencies and other local area-based partnerships, and met monthly. Both partnerships were supported*	• General health (community)	• Socioeconomic indicators [Info] *deprived areas*	• ++	• 1 • 2	H, P

	description		*by senior representation from member organizations*					
Boyle et al., 2006)	• Mixed methods evaluation [Info] *3 case studies*	*Rushey Green Time Bank, Cares of Life project, Rhymney Time Bank, Blaengarw Time Centre, Dinas Time Bank, Gorbals Time Bank, Peer tutoring project, Patch, Seal, Peer advocacy project, Roots*	*Co-Production*	• Physical activity • Healthy eating • Mental health • Substance use • Prevention violence/ abuse/ crime • Social capital/ cohesion [Info] *Peer advocacy project (helping to welcome and settle refugees and asylum seekers in Glasgow)* • Personal assets • Other [Info] *Roots (refugee community organisation involved in a range of local activities, including social enterprise).* • Children and Young People/ Parenting • General health (personal)	• Race/ ethnicity [Info] *South-East London is densely populated, multicultural: almost a third of the population is Black African and Black Caribbean; Welsh Valleys - As much as 99 per cent of the population is white* • Occupation [Info] *Scotland: There is a substantial group of young people who are not in education, employment or training on leaving school, and a +++ proportion of residents on long-term healthor sickness-related benefits* • Education [Info] *Welsh Valleys - As many as 40 per cent of the working population of Caerphilly have no qualifications ; Scotland: There is a substantial group of young people who are not in education, employment or training on leaving school, and a +++ proportion of residents on long-term healthor sickness-related benefits* • Other indicators of disadvantage [Info] *The three study sites were similarly excluded socially and economically, but their social mix was extremely diverse, though with particular common issues related to public health; Southwark, Lambeth and Lewisham – the boroughs involved – are among the poorest in the UK; Welsh Valleys: Merthyr Tydfil and Neath*	• +++	• 1 • 2 • 3 • 4 • 6 • 7	H, WB, SDH, I, C, P

					have 30 per cent of the population with chronic health problems.Nearly half of all households have one or more people living with a limiting lifelong illness; Scotland - lone parents; Unemployment rates have fallen significantly in recent years (including a 50 per cent cut in long-term unemployment since 1999) but rates of economic inactivity or 'worklessness' remain a problem; There is a substantial group of young people who are not in education, employment or training on leaving school, and a +++ proportion of residents on long-term health or sickness-related benefits; refugees			
Boyle et al., 2010)	• Concept/ theory • Policy • Discussion		*co-production*	• Personal wellbeing [Info] *service users*		• +++	• 2 • 3	
BPCSSA (2010)	• Practice description	*health trainers*	*health trainers: lay workers supporting individual behaviour change*	• Physical activity • Healthy eating • Mental health • Substance use • General health (personal)	• Place/ Location • Race/ ethnicity • Socioeconomic indicators	• +	• 3 • 5	
Bridge Consortium , 2002)	• Mixed methods evaluation	*New Opportunities Fund Healthy Living Centres*	*Addressing health inequalities and social exclusion targeting people in deprived areas, via a number of different methods including various health based activities.*	• Physical activity • Healthy eating • Mental health • Disease prevention	• Race/ ethnicity [Info] *Cultural and multi-ethnic character is described* • Occupation	• +	• 1 • 2 • 3 • 6	H, WB, C, H, P

				• Substance use • Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *Increasing opportunities for employment – either directly or indirectly through education and training.* • Children and Young People/ Parenting • General health (community)	[Info] +++ *unemployment was reported in 147of the 200 HLCs; + income in 156 or the 200 HLCs* • Socioeconomic indicators [Info] *142 out of 200 HLCs currently entered into the database are targeting 'deprived' people in urban areas and 51 out of 200 are targeting 'deprived' people in rural areas.* • Other indicators of disadvantage [Info] *Repeated themes concerned the prevalence of poor mental health (three HLCs), poor housing (three HLCs), and young single parent families (two HLCs).*		• 7	
Bridgen, 2006)	• Policy	*UK health policy - developments relating to social capital since 1997*	*critique of the influence of social capital on policy development in the UK*	• Social capital/ cohesion	**Population: PROGRESS-Plus** • Place/ Location • Social capital		• 1 • 2 • 4 • 6	
Bromley, 2014	• Practice description	*Stronger Communities*	*Providing support around all aspects, especially mental health and wellbeing and social isolation*	• Mental health • Personal wellbeing • Social capital/ cohesion	**Population: PROGRESS-Plus** • Place/ Location • Other indicators of disadvantage [Info] *Many, but not all, of the initiatives focus on older people*	• +	• 2 • 4	
Brown, (2002)	• Other [Info] *case studies - methods not reported*	*Working for Communities pathfinders*	*community involvement/ engagement in innovative ways of delivering diverse projects/ services*	• Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *regenerat*	• Other indicators of disadvantage [Info] *young people*	• +	• 1 • 2 • 4 • 5 • 6 • 7	SDH, C, P

				ion				
Brownlie et al., 2006)	• Concept/ theory •Evaluation/ research • Practice description • Discussion Qualitative study •Questionnaire/ survey		*The principal aim of this project was, therefore, to explore the problems and possibilities of incorporating a 'children as researchers' perspective into the agenda of government social research in Scotland.*	• Children & Young People/ Parenting	• Other indicators of disadvantage [Info] *children and young people*	• +++	• 2	
Burgess, 2014)	• Mixed methods evaluation	*4 timebanks - Cambridgeshire project, Somersham,Cambourne, Littleport and March.*	*Time banking - an exchange system in which time is the principal currency. For every hour participants 'deposit' in a timebank, perhaps by giving practical help and support to others, they are able to 'withdraw' an hour of support when they are in need*	• Community wellbeing • Social capital/ cohesion	• Social capital	• ++	• 2 • 6	WB, SDH, C, P, E
Burton et al., 2006)	• Concept/ theory		*community involvement in area based initiatives*	• Community wellbeing • Other [Info] *Local economy and labour market Local housing market Education, including pre-school provision Public health Crime and community safety Physical environment Delivery of*	• Place/ Location • Socioeconomic indicators [Info] *areas of economic disadvantage*		• 2	

				local public services				
Cabinet Office, 2011)	• Concept/ theory • Policy	*Strategic National Framework on community resilience*	*This framework explores the role and resilience of individuals and communities before, during and after an emergency.*	• Community wellbeing • Safety/ accident prevention • Community assets		• +	• 2	
Callard and Friedli, 2005)	•Qualitative study	*Imagine East Greenwich*	*a series of arts/health projects developed as part of a regeneration programme on two housing estates in a London borough*	• Mental health • STIs • Substance use • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Personal assets • Children and Young People/ Parenting • General health (personal) • General health (community)	• Race/ ethnicity [Info] *racially very diverse, with 23% of the population defining themselves as non-white at the last census* • Socioeconomic indicators [Info] *significant social and economic inequalities (some of the +++est deprivation levels are found in the two estates that were the focus for IEG)*	• +	• 1 • 4	H, WB, SDH, P
Cambridge Centre for Housing & Planning Research, 2013)	• Mixed methods evaluation [Info] *case studies of 4 projects*	*Time banks*	*Time banking is an exchange system in which time is the principal currency. For every hour participants 'deposit' in a time bank, perhaps by giving practical help and support to others, they are able to 'withdraw' an hour of support when they are in need*	• Personal wellbeing • Community wellbeing • Social capital/ cohesion • General health (personal)	• Race/ ethnicity [Info] *majority are white* • Occupation [Info] *23% retired; 22% unemployed* • Education [Info] *42% have +++er level qualification beyond A levels* • Socioeconomic indicators [Info] *58% of members have an income of less than £300 per week*	• ++	• 2 • 6	**H, WB, I, P**
Campbell et al., 2004)	**Research** •Qualitative study		*participation, barriers/ attitudes to*	• Mental health • Social capital/ cohesion	• Race/ ethnicity [Info] *African Caribbean* • Socioeconomic indicators [Info] *deprived community*	• ++	• 2	WB, C, P

					• Social capital [Info] *social capital*			
Campbell et al., 2008)	• RCT	*ASSIST (A Stop Smoking In Schools Trial)*	*school based peer-led intervention for smoking cessation in adolescence*	• Substance use • Children and Young People/ Parenting		• +	• 3	H, I, E, U
Carley et al., 2000)	• Other [Info] *case studies*			• Social capital/ cohesion • Other [Info] *urban regeneration; community safety; commissioning*	• Race/ ethnicity [Info] *ethnically diverse* • Socioeconomic indicators [Info] *Birmingham is the fifth most deprived out of 366 districts on the English deprivation index, with 25 of its 39 wards ranked in the most disadvantaged 10% in the country* • Other indicators of disadvantage [Info] *deprived borough*	• +	• 2	P
Carlisle, 2010)	•Qualitative study	*East Kirkland Social Inclusion Partnership (SIP)*	*Scottish Social Inclusion Partnerships (SIPs) funded to tackle local health inequalities and social exclusion using a health promotion, partnership and community-led approach.*	• Mental health • Substance use • Community wellbeing • Social capital/ cohesion • General health (community)	• Occupation [Info] *+++ unemployment* • Religion/ culture [Info] *sectarian divisions between Catholic and Protestant* • Socioeconomic indicators [Info] *health inequalities* • Social capital [Info] *social exclusion*	• +	• 2	P
Carlson et al., 2010)	• Mixed methods evaluation	*health trainers*	*health trainers: lay workers supporting individual behaviour change*	• Physical activity • Healthy eating • Substance use • General health (personal)	• Socioeconomic indicators [Info] *61% of clients reached by the Health Trainer Services come from the 40% most deprived social quintiles* • Social capital [Info] *In some parts of the service, such as those targeting rural areas, socially isolated individuals are also being reached.*	• +	• 3 • 5	H, I, C, P, E

Carr, 2005)	•Qualitative study	*Family Safety Scheme*	*childhood accident prevention in the home. Peer educators called 'safety advisers'. three local mothers were recruited through local advertising and trained to take on the role of peer educators*	• Children and Young People/ Parenting • Safety/ accident prevention [Info] *accident prevention within the home. Structured around four age specific accident issues; choking, drowning, falls and burns.*	• Race/ ethnicity [Info] *multi-ethnic community* • Socioeconomic indicators [Info] *"deprived"* • Other indicators of disadvantage [Info] *parents Multiple languages, a non-English speaking proportion of the population, an asylum seeker population mobile population*	• +	• 3	I, P
Cawley and Berzins, 2011)	•Qualitative study	*The Changing Minds Programme*	*mental health awareness training*	• Mental health • Substance use • Prevention violence/ abuse/ crime • Personal wellbeing	• Race/ ethnicity [Info] *Black and Minority Ethnic communities were prioritised*	• +++ [Info] *Graduates were offered opportunities to co-facilitate the next course*	• 5 • 7	H, WB, I, P, E, U
Centre (2013)	• Policy		*asset based approaches to health improvement*	• Community wellbeing • Community assets • General health (community)	• Place/ Location • Other indicators of disadvantage [Info] *health inequalities*	• ++	• 1 • 2	
Chadderton et al., 2008)	• Concept/ theory •Evaluation/ research • Practice description Qualitative study	*health impact assessment*	*community engagement in health impact assessment in the UK planning system*	• Community wellbeing • Safety/ accident prevention [Info] *waste incineration*	• Place/ Location		• 1	
Chanan, 2011)		*Health Empowerment Leverage Project.*	*To promote better collaboration between health agencies and local communities, with a particular interest in the potential for community development to play a wider role in relation to innovation, prevention and participation. For its field projects HELP decided to concentrate on a particular form of community development, the*					

			creation of a neighbourhood partnership.					
Chapman et al., 2001)	• Mixed methods evaluation		*community participation in multi-agency partnerships to improve social inclusion*	• Social capital/ cohesion	• Social capital	• +	• 2	C, P
Chapman, 2010)	•Qualitative study	*Community Activator Programme*	*The Programme comprised four elements – 1. Recruitment of Community Activators: Recruiting individuals from the 20 Well London communities 2. Training in Community activation: Delivery of an intensive four-day training course. 3. Mentor support: Each Activator who completed the training course was assigned a personal mentor. 4. A budget: While the Activators gave their time to the programme voluntarily (i.e. un-paid) a budget was made available to each Activator who successfully completed the training.*	• Physical activity • Personal wellbeing • Social capital/ cohesion	• Race/ ethnicity [Info] *two thirds of participants are from BME groups* • Occupation [Info] *The majority of participants are not in work or full time education or training and do not have further or +++er educational qualifications.* • Gender [Info] *nearly 3/4 of participants were female* • Socioeconomic indicators	• ++	• 1 • 3 • 5	H, WB, I, P
Chau, 2007)	•Qualitative study	*Shared expectations, shared commitment*	*an action-oriented and older-people-led study which took place from 2003 to 2005*	• Community wellbeing • Social capital/ cohesion • General health (community)	• Race/ ethnicity [Info] *Chinese older people* • Other indicators of disadvantage [Info] *older people*	• +	• 2 • 8	P
Chirewa, 2012)	• Concept/ theory		*Participatory action research. Development of a toolkit to support NGOs in tackling health inequalities.*	• Other [Info] *"health inequalities"*	• Socioeconomic indicators • Other indicators of disadvantage [Info] *marginalised groups*	• ++	• 2 • 4	
Christie et al., 2012)	Qualitative study		*social marketing intervention to improve road safety awareness in the Somali community*	• Safety/ accident prevention	• Race/ ethnicity [Info] *35% BME* • Socioeconomic indicators [Info] *has slightly above average levels of deprivation compared with other London boroughs and four of its 20 electoral wards have been identified as being in the 10% most deprived wards in the UK.*	• +++	• 1 • 2 • 3	P

Cindersby, 2014)	• before and after study •Qualitative study •Questionnaire/ survey • Other [Info] *action research*	*Good Life' initiative*	*The SEI approach was to develop the 'Good Life' initiative, which aimed to stimulate community building in relation to sustainability issues, considering improved use of resources, increased knowledge leading to +er carbon emissions and greater community connections encouraging shared action*	• Community wellbeing • Social capital/ cohesion • Community assets [Info] *to enhance local skills for self-sufficiency and build local resilience* • Other [Info] *sustainability issues, considering improved use of resources, increased knowledge leading to +er carbon emissions and greater community connections encouraging shared action* • General health (community)	• Other indicators of disadvantage [Info] *New Earswick is a +-income community that comprises predominantly social housing owned by the Joseph Rowntree Housing Trust; There have been changes in its demographics (including an increase in older people) over recent years resulting in some tensions between groups.*	• ++	• 1 • 2	WB, SDH, I, P, U
Clay et al., 2007)	•Qualitative study	*Health issues in the community (HIIC)*	*Health Issues in the Community is a training course informed by a community development approach to health promotion*	• Physical activity • Healthy eating • Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • General health (community)	• Socioeconomic indicators [Info] *The course can work with groups who are marginalised and who suffer the negative consequences of equality and discrimination*	• +	• 5	WB
CLES Consulting (2011) Consulting, 2011)	• Mixed methods evaluation	*projects from the Well-being programme and two Changing Spaces award partner programmes*		• Physical activity • Healthy eating • Mental health • Personal wellbeing • Social capital/ cohesion • Children and Young People/ Parenting			• 7	H, WB, I, C
Cole, 2003)	•Qualitative study	*Health Action Zone (Plymouth)*	*HAZs were one of several area-based initiatives (ABIs) introduced into localities with +++ levels of social and economic deprivation. HAZs had two strategic objectives: Identifying and addressing the public health needs of the local area, in particular trailblazing new ways of tackling health inequalities; and Modernising services by increasing their effectiveness,*	• Healthy eating • Mental health • STIs • Substance use • Social capital/ cohesion • Other [Info] *changes to primary care* • Children and Young People/	• Socioeconomic indicators [Info] *most deprived ward in England and Wales. Index of conditions.* • Social capital [Info] *socially excluded* • Other indicators of disadvantage [Info] *deprived*	• ++	• 1 • 2 • 4	H, WB, C, P, U

			efficiency and responsiveness. The HAZ approach was underpinned by seven principles (achieving equity; engaging communities; working in partnership; engaging frontline staff; adopting an evidence-based approach; developing a person-centred approach to service delivery; and taking a whole systems approach), which ministers asked all HAZs to reflect in their activities and plans.	Parenting • General health (personal) • General health (community) • Safety/ accident prevention				
Communities and Local Government, 2007	• Policy • Concept/ theory • Practice description		*empowerment*	• Community wellbeing		• ++	• 1 • 2	
Community ()	• Other [Info] *5 case studies*	*Burnfoot Community Hub; North Coast Connection; Health All Round; PAGES; Stepping Stones*	*community-led health*	• Disease prevention • Community wellbeing • Social capital/ cohesion • Community assets • Children and Young People/ Parenting • General health (personal) • General health (community)	• Socioeconomic indicators • Social capital	• +	• 1 • 2 • 3 • 4	SDH, C, P
Community Health Exchange, 2012a)	• Mixed methods evaluation	*Health Issues In the Community (HIIC)*	*Delivery of a course 'Health Issues In the Community' (HIIC)*	• Physical activity • Healthy eating • Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • General health (community)	• Place/ Location [Info] *Scotland* • Socioeconomic indicators [Info] *disadvantaged communities and groups traditionally seen as being difficult to reach. Examples include • In areas of multiple deprivation • Ex-Offenders • People with addictions issues • More Choices, More Chances school pupils • Older people • Young Homeless people • Ethnic minority women's groups • Parent's*	• ++	• 5	**WB, C, P, U**

					Groups • Young people • Tenant and Resident Groups • Women's groups			
Community Health Exchange, 2012b)	•Qualitative study		*community led health organisations working to tackle health inequalities at a local level*	• Personal wellbeing • Community wellbeing • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *health inequalities*	• ++	• 1 • 2 • 4	**P**
Community Service Volunteers (CSV), 2008)	• Mixed methods evaluation	*Capital Volunteering*	*Capital Volunteering is a pan-London programme which aims to tackle issues of mental health and social inclusion, through volunteering.*	• Mental health • Personal wellbeing • Social capital/ cohesion	• Place/ Location • Social capital [Info] *social inclusion* • Other indicators of disadvantage [Info] *mental health service users*	• +		• 7
Cook and Wills, 2012)	•Qualitative study	*health trainers*	*trainers are 'lay' people recruited to engage 'harder-to-reach' people from their communities, offering one-to-one support to enable them to make the healthy lifestyle changes of their choice*	• General health (personal) [Info] *individual behaviour change*	• Other indicators of disadvantage [Info] *marginalised communities*	• +	• 3 • 5 • 6	WB, C, P
Coote et al., 2004)	• Practice description	*The Healthy Communities Collaborative; The Social Action Research Project*	*Healthy Communities Collaborative: This is a model for introducing structured, evidence-based practice at local level, under the control of local people. The HCC engages communities to improve health and reduce inequalities, and aims to strengthen their capacity to address health risks.131 So far the collaboratives have focused on preventing falls among older people in disadvantaged neighbourhoods; The Social Action Research Project (SARP), Salford, was one of two action research projects in Salford and Nottingham that aimed to deepen understanding of how strengthening community capacity and community involvement in local policy and practice could help to improve health and reduce health inequalities*	• Safety/ accident prevention [Info] *fall prevention* • Social capital/ cohesion • Community assets	• Other indicators of disadvantage [Info] *disadvantaged neighbourhoods; older people;*			
Corbin, 2006)	• Mixed methods evaluation	*Activity Friends*	*Activity Friends is a volunteer programme for the over 50Õs designed to help people achieve a healthier lifestyle through increasing physical activity and befriending to alleviate social*	• Physical activity • Mental health • Personal wellbeing • Social capital/ cohesion	• Occupation [Info] *retired* • Social capital [Info] *social isolation*	• +	• 3 •7	WB, I, P

			isolation.		• Other indicators of disadvantage [Info] *older people*			
Coulter, (2014)	• Practice description	*Somerford Wellbeing Project*	*The main activity is in two phases: the first is a creative consultation with young people leading the activity, supported by a community development worker. An artist experienced in film, animation and audio (digital media) will work with the young people, developing their skills in interviewing and documentation. Out of the information gathered the young people will help to devise a phase 2 which will be more focussed interventions using the arts for health and wellbeing outcomes and to meet CCG needs. An artist experienced in creative consultations will be involved along with the artist working specifically with digital media. The young people are from the community and will lead the project. The community development worker has many years of working in this community and will provide the leads into the young people and extended family networks.*	• Healthy eating • Mental health • Disease prevention [Info] *managing long term conditions* • Substance use • Personal wellbeing • Community wellbeing • Children & Young People/ Parenting • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *area of social deprivation and health inequalities*	• +++		
Coulter, 2010)	• Practice description	*Liverpool's Big Health Debate; Connected Care in Hartlepool; Apnee Sehat; Health Action Zones;*	*Liverpool PCT organised a three stage community consultation for health strategy; audit of health needs; Apnee Sehat (our health) is a social enterprise pathfinder project that is tailoring lifestyle programmes to meet the needs of Britain's South Asian community; Health Action Zones; Healthy communities collaborative; NHS Tower Hamlets - lay diabetes educators; Oxfordshire PCT Priorities Forum*	• Disease prevention • Community wellbeing • Social capital/ cohesion • Personal assets [Info] *training of auditors* • Other [Info] *health strategy*	• Place/ Location [Info] *Liverpool; Owton Ward in Hartlepool; South Warwickshire; Tower Hamlets; Across the country; Oxford* • Race/ ethnicity [Info] *The views of people from specific priority groups were sought by means of 13 specially organised discussion groups. These included people from the Chinese, Sikh, Somali and Yemeni communities, homeless men, Irish*	• +++		

					development; community audit of health needs; reduce health inequalities • General health (personal) • General health (community)	*travellers, people with sensory disabilities and mental health service users.* • Other indicators of disadvantage [Info] *The views of people from specific priority groups were sought by means of 13 specially organised discussion groups. These included people from the Chinese, Sikh, Somali and Yemeni communities, homeless men, Irish travellers, people with sensory disabilities and mental health service users; Owton: The ward is ranked as one of the most deprived nationally, with most residents living in social housing*		
Craig (2010)	•Qualitative study	*Youth.comUnity Young Ambassadors programme*	*Recruiting, managing and supporting a Young Ambassador from each of the 20 communities. Young Ambassadors help Well London Partners by publicising their events and activities, by integrating the concerns of young people into Well London programmes generally and by developing projects in partnership with Well London Partners. Uniquely the Young Ambassadors plan and deliver their own projects in their own communities and, as a team, are planning the Wellnet Conference at City Hall in February 2010. (Wellnet is a learning network connecting all those working in health and well-being promotion across London and sharing fresh ideas for boosting well-being through community-led activities.) Youth Participation Seminars and Conferences Ð Part of the Wellnet project, these are designed to change attitudes and identify organisational challenges Youth Update Briefings Ð Policy briefings aimed at partners, including local partners, and informing them of youth related issues The Young Ambassadors*	• Community wellbeing • General health (personal) • General health (community)	• Other indicators of disadvantage [Info] *young people*	• ++	• 1 • 2 • 3 • 5	

			Programme is managed by two Youth.com Workers, each worker recruiting, supporting and managing 10 Young Ambassadors.				
CRESR ()	Mixed methods evaluation	*New Deal for Communities (NDC)*	*Neighbourhood Renewal- Each NDC is working with partner agencies and the local community to implement 10 year programmes to transform these neighbourhoods.*	• Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Other [Info] *Neighbourhood renewal* • General health (community)	• Place/ Location • Race/ ethnicity [Info] *the proportion of the non-white population across the Programme is about 26 per cent: for Birmingham Aston the equivalent figure is over 80 per cent: for Plymouth and Knowsley less than one per cent* • Socioeconomic indicators [Info] *39 generally deprived areas: nine would fall within the most deprived 1,000 of the 32,000 +er level Super Output Areas derived from the 2001 Census. The Knowsley NDC area would be the 117th most deprived SOA in England.* • Other indicators of disadvantage [Info] *• across the Programme 55 per cent of households live in social rented accommodation: in Southwark it is almost 85 per cent, but in Hartlepool less than 30 per cent.*	• ++	• 2
Crow (2004)	• before and after study	*Communities that Care (CTC) prevention initiative.*	*This early intervention programme targets children living in communities and families that are deemed to put them at risk of developing social problems. The CTC approach focuses on specific geographical areas and involves bringing together local community representatives, professionals working in the area and senior managers responsible for service management. Participants are given training and provided with evidence of the levels of risk and protection in their community.*	• Substance use • Personal wellbeing • Social capital/ cohesion • Other [Info] *disadvantaged neighbourhoods; educational achievement* • Children and Young People/ Parenting	• Place/ Location [Info] *Southside (located in Wales), Westside (West Midlands), Northside (North of England)* • Race/ ethnicity [Info] *Southside: predom white; The city of Westside has a significant ethnic population (12 per cent), mainly of Asian descent* • Occupation [Info] *Unemployment was the*	• ++	• 1 • 2 • 3

			From this they design an action plan that seeks to enhance existing services or introduce new ones likely to reduce risk		*+++est in the city in Westside* • Other indicators of disadvantage [Info] *Southside: It was predominately white, and the proportion of young people (under 18)*				
Crowley et al., 2002)	• Mixed methods evaluation [Info] *case study*		*promoting community participation in decision making about local services*	• Other [Info] *ways in which local health services are planned and delivered* • General health (community)	• Place/ Location • Race/ ethnicity [Info] *significant BME population (6%)* • Other indicators of disadvantage [Info] *area of social disadvantage; people with disabilities*	• ++			• 1 • 2
Curno 2012)	Research	*Life is Precious*	*Life is Precious is a cancer health improvement project commissioned by Dudley Public Health Community Health Improvement Team. The project used a creative arts approach to engage local people from minority ethnic communities in a dialogue around cancer. Includes community health champions.*	• Disease prevention • Personal wellbeing	• Place/ Location • Race/ ethnicity • Gender	++	• 1 • 2 • 5 • 8	H; WB; I; P	
Curtis et al., 2007)	•Qualitative study	*Breastfriends scheme*	*breast feeding peer-support project*	• Healthy eating • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *females, mothers* • Socioeconomic indicators [Info] *described as 'working class'*	• +			• 3 • 7
Data Collection Reporting System, 2012)	• before and after study	*Health Trainers Service*	*Health Trainer Service*	• Physical activity • Healthy eating • Substance use • Personal wellbeing • Other [Info] *weight; 'local issue'* • General health (personal)	• Place/ Location [Info] *National* • Race/ ethnicity [Info] *sees a strong White British majority - clients* • Gender [Info] *clear female majority - clients* • Socioeconomic indicators [Info] *most clients live in an area*	• +			• 3

					which falls within the 'Q1 – Most deprived' threshold • Other indicators of disadvantage [Info] *clear consistency of clients in the middle age bandings, with 36-45 being marginally the +++est (19.43%); a significant number of 'Long term condition' and 'Disability/ vulnerable group' clients are accessing the service.; offenders*				
Davies, 2009)	• Practice description • Discussion	*community health champions*	*community empowerment; health champions*		• Physical activity • Healthy eating • Mental health • Personal wellbeing • Community wellbeing • General health (personal) • General health (community)	• Place/ Location • Other indicators of disadvantage [Info] *targeting areas where health is currently poorest*	• ++		• 1 • 3 • 5
Davis, 2008)	Rese• Mixed methods evaluation		*to understand the commissioning process for people with learning disabilities and complex needs*	• Other [Info] *commissioning health services* • General health (personal) • General health (community)		*people with learning disabilities*	• ++	• 2	C, P
Dearden-Phillips and Fountain, 2005	• Practice description • Discussion	*Speaking Up*	*a voluntary organisation that has developed the 'Parliament' model to give people with learning difficulties a strong collective voice.*		• Other [Info] *commissioning/ influencing health services*	• Place/ Location • Other indicators of disadvantage [Info] *people with learning disabilities*	• ++		• 2

Department for Communities & Local Government, 2006a	•Questionnaire/ survey	*Neighbourhood Management Pathfinder Programme*	*neighbourhood management/ renewal/ regeneration*	• Prevention violence/ abuse/ crime • Community wellbeing	• Socioeconomic indicators [Info] *deprived neighbourhoods*	• ++	• 2
Department for Communities & Local Government, 2006a)	• Policy	*local area agreements*	*Paper proposes a new approach to local partnership to give local authorities more opportunity to lead their area, work with other services and better meet the public's needs. Reshape public services by giving citizens and communities a bigger say. a new framework for strategic leadership in local areas, bringing together local partners to focus on the needs of citizens and communities Stronger local leadership, greater resident participation in decisions and an enhanced role for community groups can help all local areas to promote community cohesion These reforms will empower citizens and communities.*	• Community wellbeing • Social capital/ cohesion	• Place/ Location • Social capital	• ++	• 2 • 4
Department for Communities & Local Government, 2007a	• Policy	*Strong and Prosperous Communities - The Local Government White Paper*	*The Government believes that public services are better, local people more satisfied and communities stronger if involvement, participation and empowerment is at the heart of public service delivery. 'Strong and Prosperous Communities - The Local Government White Paper' lays out the Government's proposals on how to local authorities can achieve community empowerment. One of the ways this will be achieved is through Statutory Guidance, as laid out in the approach to guidance in the White Paper Implementation Plan. This paper gives detail on a number of pieces of Statutory Guidance provided for within the Bill aimed to support local authorities in community empowerment.*	• Community wellbeing • Other [Info] *community empowerment*	• Place/ Location	• ++	• 1 • 2
Department for Communities & Local Government, 2007b	• Qualitative study	*(Neighbourhood Management and Social Capital) Neighbourhood Management*	*Neighbourhood management, various methods: -establishing and supporting a wide range of local groups and activities, especially for children and young people. -creating opportunities for people from different backgrounds and communities to come together and work towards common goals – examples include a local radio station, work with schools and faith communities to increase cross-cultural understanding and involving young*	• Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion	• Place/ Location • Race/ ethnicity [Info] *Blacon and Ovenden have a predominantly white population; Leyton is ethnically mixed.* • Social capital • Other indicators of disadvantage	• +	• 1

		Pathfinders Programme	*people and adults in debates about perceptions of anti-social behaviour; -giving residents more of a sense of local identity through festivals, community centres and through reclaiming local public spaces; -tackling negative stereotypes of the neighbourhood and of particular groups within it;*	• Children and Young People/ Parenting	[Info] *All three neighbourhoods report problems in relations between adults and young people, but while Blacon and Leyton have a fairly active voluntary and community sector, Ovenden – which has suffered from economic restructuring and the loss of major local industries – does not.*		
Department of Health, 2004	• Policy	*Choosing health*	*health policy*	• Physical activity • Healthy eating • Mental health • Disease prevention • STIs • Substance use • Children & Young People/ Parenting	• Place/ Location • Socioeconomic indicators [Info] *health inequalities*	• +	• 2
Department of Health, 2006b	• Policy • Concept/ theory		*a framework for creating a stronger local voice in the development of health and social care services. There are five elements of the new arrangements: local involvement networks; overview and scrutiny committees; more explicit duties on providers and commissioners of services to involve and consult; a stronger national voice; and a stronger voice in regulation*	• Other [Info] *planning, developing and making decisions about health and social care services* • General health (community)	• Place/ Location	• +	• 2
Department of Health, 2007a)	• Policy	*Commissioning framework for health and wellbeing.*	*Commissioning framework. Commissioning for health and well-being means involving the local community to provide services that meet their needs. Current reform of public services rests on increased investment and on devolving power to local people*	• Personal wellbeing • Community wellbeing	• Place/ Location	• ++	• 2

		Builds on the white paper 'Our health, our care, our say', providing a framework for action.	*so that they can make the choices that affect their communities Individuals and communities need to co-producers of information in order to make effective decisions for individuals and groups*	• General health (personal) • General health (community)			
Department of Health, 2007b	• Practice description	*Opportunities for Volunteering Scheme 2007*	*Volunteering in health and social care services.*	• Physical activity • Healthy eating • Mental health • Disease prevention • STIs • Substance use • Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Other [Info] *refugees and asylum seekers*	• Place/ Location • Race/ ethnicity [Info] *Mixed ethnicities* • Occupation [Info] *70% of volunteers were employed, 30% were unemployed* • Gender [Info] *36% of volunteers were male, 64% were female*	• +	• 1 •3 • 6 •7
Department of Health, 2008a)	• Policy • Discussion	*Health inequalities programme*	*Looks at government targets of reducing inequalities in health outcomes, what works and what does not work, and what needs to be done to carry forward progress. Engaging individuals, families and communities 'works'. A new primary and community care strategy as part of the NHS Next Stage Review which will move towards personalised, integrated and better quality service. Health Trainers are seen as important and the DH wants to roll them out to every community .Report recognises the work third sector organisations do in engaging communities.*	• Disease prevention • Community wellbeing • Safety/ accident prevention • Social capital/ cohesion • Other [Info] *educatio*	• Place/ Location • Socioeconomic indicators • Other indicators of disadvantage	• +	

				n, housing etc. (social determinants) • General health (personal) • General health (community) [Info] *health inequalities. Life expectancy/ mortality.*			
Department of Health, 2008b)	• Policy	*Tackling Health Inequalities: programme for action*	*policies to tackle health inequalities*	• Disease prevention • Substance use • Other [Info] *child poverty, housing quality, educational achievements, uptake of flu vaccinations* • General health (personal) • General health (community) [Info] *life expectancy/ mortality*	• Place/ Location • Socioeconomic indicators		• +
Department of Health,	• Policy • Practice description	*Communities for Health Programme*	*a programme led by local government to: • work with communities to help them to improve their own health; • promote partnership across local organisations; • al+ local*	• Social capital/ cohesion • Community	• Place/ Location • Socioeconomic indicators [Info] *includes all the health*	• ++	• 1 • 2

2009a			*areas to choose their priorities for health and provide support from the centre; and • create a climate for innovation.*	assets • General health (personal) • General health (community)	*inequalities Spearhead areas*			
Department of Health, 2009b)	• Policy • Discussion	*National health inequalities strategy, the 'Programme for Action'*	*policies to tackle inequalities; working in partnership*	• Disease prevention • Substance use • Social capital/ cohesion • Other [Info] *life expectancy/ mortality; education; child poverty; housing etc.* • Children & Young People/ Parenting • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators	• +	• 2	
Derges et al., 2004	•Qualitative study	*Well London*	*Well London is a multicomponent community engagement and coproduction programme designed to improve the health of Londoners living in socioeconomically deprived neighbourhoods*	• Physical activity • Healthy eating • Mental health • Personal wellbeing	• Place/ Location [Info] *London: Eastford, Hartfield and Mountside* • Race/ ethnicity [Info] *Ethnicity, age and length of time in the neighbourhood among the study population were mixed across all three neighbourhoods* • Other indicators of disadvantage [Info] *Ethnicity, age and length of time in the neighbourhood among the study population were mixed across all three neighbourhoods; socioeconomically deprived neighbourhoods.*	• ++		• 2 • 7
Dewar,	•Qualitative study	*Initiatives to support*	*to support older people in partnership working in research and development work*	• Other [Info] *Empowerment- support*	• Place/ Location • Other indicators of disadvantage	• +		• 3

2005	Practice description	*involvement of older people in research and development activity*		*older people in partnership working in research and development work*		[Info] *older people*		
Dews, (2014)	• Practice description	*Community Health Champions*	*Providing health information through brief intervention works and bridging programmes, supporting people to access mainstream services. Community health champions whose primary role is to engage at grassroots level with local communities, particularly those who are hard to reach with a view to raising awareness of the benefits of good health and lifestyle choices and referring them into mainstream support .*		• Physical activity • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Other [Info] *wider determinants e.g. employment; debt management* • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *areas of deprivation*	• ++	• 2 • 4 • 5
Dickens Andy et al., 2011)	• RCT	*Community Mentoring service*	*community mentoring service for socially isolated older people:*	• Mental health • Social capital/ cohesion • Other [Info] *Mentoring* • General health (personal)		• Place/ Location • Socioeconomic indicators [Info] *older people, socially isolated* • Social capital		**H , V E , C , F**

Dinham, (2007)	•Qualitative study	*New Deal for Communities*	*neighbourhood renewal/ regeneration*	• Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *neighbourhood renewal/ regeneration*	• Place/ Location • Socioeconomic indicators [Info] *39 most disadvantaged areas targeted by NDC* • Social capital [Info] *address issues of social exclusion*	• ++			**V B , C , P , U**
Dooris et al., 2013)	• Mixed methods evaluation	*Offender Health Trainer service*	*Offender Health Trainer service*	• Physical activity • Healthy eating • Mental health • Substance use • Prevention violence/ abuse/ crime • Personal wellbeing • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *People on probation*	• +	3	**H, WB, SDH, C, P**	
Draper et al., 2010)	• Concept/ theory •Evaluation/ research		*developing an evaluation framework that enables an analysis of the process of participation and links this with health and programme outcomes*						
Duffy, 2012)	• Mixed methods evaluation	*Peer Power (the personalisation forum group)*	*Peer support group for people with mental illness*	• Mental health	• Place/ Location	• ++	• 3 • 4 • 6	**H, WB, I, C, P**	
East Midlands Regional Empowerment Partnership, 2009a)	• Practice description	*Bagworth and Thornton Parish Plan Group, Leicestershire*	*The Parish Plan group was formed in 2006 to address community issues and bring facilities to the area that would benefit all residents*	• Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Socioeconomic indicators • Other indicators of disadvantage [Info] *no facilities*	• ++	• 4		

East Midlands Regional Empowerment Partnership, 2009b)	•Qualitative study	*Manton Community Alliance : Residents Building a Better Neighbourhood*	*A Neighbourhood Management Pathfinder (NMP) which aims to explore new ways of working at a neighbourhood level so that local services are better, more efficient and relevant to the locality.*	• Community wellbeing • Social capital/ cohesion • Other [Info] *Neighbourhood improvement*	• Place/ Location	• +	• 1	**WB, C**
Edwards, 2002)		*Single Regeneration Budget*	*Drawing on a questionnaire sent to 200 SRB partnerships across Britain, this paper addresses disabled people's involvement in SRB partnerships.*	• Community wellbeing • Social capital/ cohesion [Info] *The paper explores the extent, form of and barriers to, disabled people's involvement and consultation in the SRB, and challenges the notion that SRB partnerships are inclusive to all sectors.* • Other [Info] *tackling inequality*	• Place/ Location • Other indicators of disadvantage [Info] *Disability. SRB partnerships seek collaboration between public, private and community sectors but, for some minority groups, such inclusionary intentions have proved to be more rhetoric than reality.*	• ++	• 2	**P, U**
Eleftheriades, 2005)	• Practice description	*Renton Regeneration; Cordale Housing Association*	*regeneration*	• Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *regeneration*	• Place/ Location	• ++	• 1 • 2 • 4	
Elford et al., 2001)	•Controlled trial •Questionnaire/ survey		*peer education - popular opinion leader "diffusion of innovation" model*	• STIs [Info] *prevention of HIV infection* • Substance use	• Place/ Location • Other indicators of disadvantage [Info] *gay men*	• ++	• 3	**H, P**
Elliott et al., 2001)	•Qualitative study		*paper explores a number of key issues relating to the employment of peer interviewers by reflecting on a project designed to explore the views and experiences of parents who use*	• Substance use • Children and Young People/ Parenting	• Place/ Location • Other indicators of disadvantage [Info] *drug using parents*	• +	• 3	**H, P**

			illegal drugs					
Elliott et al., 2007)	• Practice description	*health impact assessment (HIA): informing decisions on the future of a landfill site in Wales*		• Community assets • Other [Info] *Decisions about a landfill sit*	• Place/ Location • Race/ ethnicity [Info] *Welsh*	• ++	• 1	
Ewles et al., 2001)	• before and after study	*the Hartcliffe Health and Environment Action Group*	*community health development project*	• Healthy eating • Substance use • Community wellbeing • Social capital/ cohesion • Community assets • General health (community)	• Place/ Location • Occupation [Info] *+++ unemployment* • Socioeconomic indicators [Info] *most families are on a + income*	• ++	• 1 • 4	**WB, SDH, C, P**
Farooqi and Bhavsar, 2001)	•Questionnaire/ survey	*Project Dil Primary Care & Community Health Promotion Programme - Reducing Risk Factors of Coronary Heart Disease Amongst the South Asian Community*	*A CHD training and awareness programme for health care professionals. -A public awareness campaign including a peer education programme for the South Asian community of Leicestershire.*		• Place/ Location • Race/ ethnicity [Info] *South Asian Community* • Socioeconomic indicators [Info] *deprived inner city areas.* • Other indicators of disadvantage [Info] *Studies have shown some South Asians to have poorer knowledge of risk factors for CHD, and also poorer access and uptake of services. This disadvantage is compounded by historically under-resourced primary care services in inner city areas where South Asians predominantly live.*	• +	• 2 • 3 • Volunteers	**WB**
Fenton, 2013)	• Mixed methods evaluation	*assets based approach to health promotion with young people in*	*Asset mapping/models*	• Personal assets • Community assets • Children and Young People/ Parenting	• Place/ Location			

		England						
Flowers et al., 2002)	•Controlled trial		*a bar-based, peer-led community-level intervention to promote sexual health amongst gay men. The intervention consisted of peer education within bars, gay specific genitourinary medicine (GUM) services and a free-phone hotline.*	• Disease prevention [Info] *HIV/ AIDS prevention* • STIs	• Place/ Location • Other indicators of disadvantage [Info] *gay men*	• +	• 3	**H, I, P**
Foot and Hopkins, 2010)	• Practice description •Discussion		*asset approach*	• Community wellbeing • Community assets • General health (community)	• Place/ Location	• ++	• 1 • 2	
Fountain and Hicks, 2010)	• Mixed methods evaluation	*National Institute for Mental Health in England Community Engagement Project*	*The community engagement strand of the DRE action plan is a significant aspect of the work of DRE. As one of the three building blocks of the action plan and programme which developed to implement it, the work on community engagement is a good barometer to gauge – at a grassroots level – the extent to which people from Black and minority ethnic (BME) communities feel engaged; feel that their views are taken on board by commissioners and providers of services; and feel that there is real improvement in how they access and experience mental health services. The project- 547 community researchers, 75 4, 935 Black and minority ethnic current or ex-mental service users, 344 carers and 4,472 other community members to contribute to the development of mental health policy and to the planning and provision of services.*	• Mental health • Personal wellbeing • General health (personal)	• Place/ Location • Race/ ethnicity • Other indicators of disadvantage [Info] *mental health service users*		• 1 • 2 • 4 • 8	**H, WB, I, P**
Fountain et al., 2007)	• Concept/ theory		*describes the community engagement model developed during the community engagement programme*	• Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Other indicators of disadvantage [Info] *"sociall y excluded*	• +++	• 1 • 2	

					communities"			
France and Crow, 2001)	• Mixed methods evaluation	*Communities That Care*	*programme designed to help children and young people to grow up in safer and more caring communities*	• Prevention violence/ abuse/ crime • Children and Young People/ Parenting	• Place/ Location • Other indicators of disadvantage [Info] *children and young people at risk of offending*	• ++	• 1	**H, P**
Gardner et al., 2012)	• before and after study	*NHS Health Trainer Service*	*Health trainer service*	• Physical activity • Healthy eating • Personal wellbeing • Other [Info] *OBESITY* • General health (personal)	• Place/ Location [Info] *Across England and Wales* • Race/ ethnicity [Info] *(17%) were of Asian or Black ethnicities; 83.2% White* • Gender [Info] *(79%) were female* • Socioeconomic indicators [Info] *Nearly, half (1836 clients; 43.2%) were from the most deprived quintile of the UK population, and a further quarter (1093 clients; 25.7%) were from the second most deprived quintile*	• +	• 3 • 7	**H, WB, I, U**
Gay, 2007)	• Mixed methods evaluation	*volunteering*	*Scoping study to investigate the nature, practice and extent of volunteering in health promotion (in Suffolk)*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing • Other [Info] *Support, advice and information Learning new skills such as art, language and IT classes Budgeting* • Children and Young People/ Parenting • General health (personal) • General health (community)	• Place/ Location • Race/ ethnicity [Info] *BME* • Other indicators of disadvantage [Info] *For the most part, organisations existed to support particular groups, for example, MS sufferers, people with mental health difficulties, older people or those with disabilities, young people, refugees or carers*	• +	• 4 • Volunteers • 8	**P**
Glasgow Centre for Population Health,	• Concept/ theory	*Healthy Futures*	*community engagement (model)*	• Community wellbeing • Social capital/ cohesion	• Place/ Location	• +++	• 1 • 2 • 6	

2007)				• Community assets • General health (community)				
Goddard, 2005)	• Mixed methods evaluation		*personal experience volunteers*	• Personal wellbeing • Other [Info] *support for people with cancer*	• Place/ Location	• +	• Volunteers	**WB, I**
Gooberman-Hill et al., 2008)	•Qualitative study	*Bristol Citizens' Jury*	*public involvement: involving members of the public in citizen's jury setting priorities for health research*	• Other [Info] *commissioning; defining health research priorities* • General health (community)	• Place/ Location	• ++	• 2	**P**
Graffy et al., 2004)	• RCT		*Support from volunteer counsellors for mothers considering breast feeding*	• Healthy eating • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *Women- mothers*	• +	• 7	**H, WB, C, P**
Green, 2012)	• before and after study • Mixed methods evaluation	*Health Trainer Service*	*Health trainer service*	• Physical activity • Healthy eating • Substance use • Personal wellbeing • Other [Info] *weight* • General health (personal)	• Place/ Location [Info] *East of England* • Race/ ethnicity [Info] *1/3 of clients were from minority groups.* • Occupation [Info] *84 clients (7.79%) were long term unemployed (over one year).* • Other indicators of disadvantage [Info] *deprived areas; 60.13% of clients fell within (any) one or more of the following indicators 1 income, employment, health deprivation threshold, disability, barriers to housing & services*	• +	• 5	**H, WB, I, P, U**
Greene, 2005)	•Qualitative study		*looking at factors that influence how and when young mothers participate in their communities as well as the barriers that young mothers experience regarding their inclusion in community based participation*	• Personal assets	• Place/ Location • Gender [Info] *interviews with 20 young mothers between the ages of 16 and 22*	• +	• 3 • 4	**WB, I, P**

					• Socioeconomic indicators [Info] *deprived communities*			
Gregson and Court, 2010)	• Practice description •Discussion		*community empowerment*	• Personal wellbeing • Community wellbeing • Community assets • Other [Info] *commissioning health services*	• Place/ Location	• ++	• 1 • 2	
Halliday and Asthana, 2005)	• Practice description •Discussion	*health action zone*	*partnership working*	• Physical activity • Personal wellbeing • Social capital/ cohesion • Children & Young People/ Parenting	• Place/ Location • Socioeconomic indicators	• +	• 1 • 2	
Hamer and Box, 2000)	• Mixed methods evaluation	*Boscombe Network for Change*	*Boscombe Network for Change, a health-related forum of statutory and voluntary agency employees, volunteers and local residents, set up in 1996, born out of a concern to promote 'change' in the deprived ward of Boscombe*	• Social capital/ cohesion • Other [Info] *promote change*	• Place/ Location [Info] *Boscombe* • Socioeconomic indicators [Info] *The Jarman Index of Deprivation Score is 31.4 for the area, and therefore general practitioners receive additional payment in recognition of their population's greater health needs.* • Other indicators of disadvantage [Info] *deprived neighbourhoods*	• +	• 2 • 7	**P**
Hardill et al., 2007)	• Concept/ theory		*volunteering*		• Socioeconomic indicators	• ++	• 7	
Harkins and Egan, 2012)	• Mixed methods evaluation	*Equally Well (Govanhill test site). Equally Well is a key Scottish Government policy to reduce the nation's health*	*Unlike the other Equally Well test sites throughout Scotland the Govanhill test site does not have a particular health related theme. Rather, the test site can be described as a localised partnership approach (involving public and third sectors as well as community members) which aims to improve all aspects of life and conditions in the area. Evaluation evidence indicates that test site partners*	• Community wellbeing • Social capital/ cohesion • Community assets • General health (community)	• Place/ Location • Race/ ethnicity *Govanhill is also a diverse and transient community and is currently playing host to the highest concentration of Eastern European Roma migrants seen in Scotland* • Socioeconomic indicators *Govanhill is an area on Glasgow's*	• ++	• 2	**H, P**

		inequalities	*believe that this 'complete' approach is the correct way to tackle the complexity of issues in the area and to improve the health and wellbeing of Govanhill residents.*		*Southside facing stark inequalities across a range of social, economic, health and environmental markers.* • Social capital [Info] *high levels of antisocial behaviour*			
Harris,	•Questionnaire/ survey	*Healthwatch Torbay*	*Healthwatch Torbay is the independent consumer watchdog for health and social care services in Torbay, ensuring the voice of the community is used to influence and improve services for local people.*	• Personal wellbeing [Info] *support for carers*	• Place/ Location • Other indicators of disadvantage [Info] *carers*	• +	• 2	**P**
Hatamian et al., 2012)	• Mixed methods evaluation	*the Active at 60 Community Agent Programme by Areenay*	*Community agents (community groups and their volunteers) to help people approaching and post retirement to stay or become more active and positively engaged with society, in particular those at risk of social isolation and loneliness in later life.*	• Community wellbeing • Social capital/ cohesion • General health (community)	• Place/ Location • Occupation [Info] *approaching and post retirement* • Other indicators of disadvantage [Info] *those at risk of social isolation and loneliness in later life*	• +	• 3 • 7	**WB, C, P**
Hatzidimitriadou et al., 2012)	•Qualitative study	*no name provided- a community-based mental health project*	*offering Improve Access to Psychological Therapies (IAPT) services in the locality*	• Mental health • Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Race/ ethnicity [Info] *Aimed at BME communities. 17 therapists were from BME background and spoke 7 languages between them*	• ++	• 1 • 2	**WB, C, P**
Healthy Communities, 2010)	• Mixed methods evaluation • Other [Info] *case studies*	*Bowmar Women and Girls Group; CAMGLEN Community Radio; Eyemouth and District First Responders; Girvan Youth Trust; Healthy Valleys*	*women and girls group; community radio; first responders; youth trust; healthy living centre; community garden; Healthy Communities Collaborative*	• Physical activity • Healthy eating • Mental health • STIs • Substance use • Prevention violence/ abuse/ crime • Personal wellbeing • Social capital/ cohesion • Personal assets • Other [Info] *first responder trainnig,*	• Place/ Location [Info] *Scotland* • Race/ ethnicity [Info] *travellers* • Gender [Info] *women and girls* • Other indicators of disadvantage [Info] *• travellers • people with learning difficulties • young people • older people • people with disabilities • people with mental health issues. There is a +++er*	• ++	• 1 • 2 • 3 • 4 • 6 • 7	**H, WB, SDH, I, P**

		Initiative; 'Make It Happen' – Girvan's community garden; Perth and Kinross Healthy Communities Collaborative		*arts* • Children and Young People/ Parenting • General health (personal) • Safety/ accident prevention	*rate of people deprived of employment than the national average, with 23% of children living in households where no adults work. There are comparatively +++ numbers of people living with limiting long term illness. Incidences of cancer and coronary heart disease are significantly +++er than the national average, as are the numbers of hospital admissions related to alcohol and drug misuse.*			
Henderson et al., 2002)	• Mixed methods evaluation •Qualitative study	*Sure Start*		• Children and Young People/ Parenting	• Place/ Location • Socioeconomic indicators [Info] *focused on deprived areas*	• +	• 2 • 3 • 5	**C, P**
Hills et al., 2007)	• Mixed methods evaluation	*Healthy Living Centres*	*Some HLCs focused on specific health-related services, but in keeping with the broad, holistic vision of the programme, many have sought to address the wider determinants of health inequalities, such as social isolation, unemployment and poverty.*	• Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *wider determinants of health inequalities, such as social isolation, unemployment and poverty* • General health (personal) • General health (community)	• Place/ Location • Race/ ethnicity [Info] *minority ethnic groups* • Occupation [Info] *unemployed* • Gender • Other indicators of disadvantage [Info] *"deprived" communities those with the poorest health children and young people families those with specific health conditions isolated, vulnerable, hard-to-reach or inactive adults disabilities.*	• ++	• 1 • 2 • 4 • 7	**H, WB, SDH, I, C, P, E**
Hoddinott et al., 2006a)	•Qualitative study		*peer support for breastfeeding (one to one or group-based)*	• Healthy eating [Info] *breastfeeding* • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *women - mothers*	• +	• 3	**H, P, U**

Hoddinott et al., 2006b)	•Controlled trial •Questionnaire/ survey [Info] *and diaries*		*breastfeeding peer coaching initiative*	• Healthy eating [Info] *breastfeeding* • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *women - mothers*	• ++	• 3	**H, C, P, U**
Holden and Craig, 2002)	• Practice description • Discussion	• *The Hull and East Riding Health Action Zone (HERHAZ)*	**Activity** *Community development workers focusing on various health issues. HAZ evaluation group, smoking cessation, sexual health promotion,*	• Physical activity • Healthy eating • Substance use • Community wellbeing • Social capital/ cohesion • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *Areas of deprivation*	• +	• 2	
Home Office, 2004)		*Leicester City's Multi- Cultural Advisory Group; The REWIND programme; Shoreditch Our Way New Deal for Communities Programme*	*Leicester City's Multi- Cultural Advisory Group, which acts as an unofficial monitoring body for the city's various initiatives aimed at tackling obstacles to community cohesion.; REWIND - The project is based on exposing the myths that have been created around issues of 'race'; Shoreditch NDC partnership - The partnership is not content with the current level of engagement, but actively seeks to increase the involvement and support of local residents.*	• Social capital/ cohesion [Info] *TACKLE RACISM* • Other [Info] *regeneration*	• Place/ Location [Info] *Leicester; Sandwell* • Race/ ethnicity • Other indicators of disadvantage [Info] *CHILDREN AND YOUNG PEOPLE*		• 2 • 7	
Hothi et al., 2007)	• Mixed methods evaluation	*The Local Wellbeing Project*	*The project covers five main strands: emotional resilience for 11 to 13 year olds; wellbeing of older people; guaranteed apprenticeships; neighbourhoods and community empowerment; and parenting.*	• Mental health • Community wellbeing • Children and Young People/ Parenting • General health (community)	• Place/ Location	• +	• 1 • 3 • 6	

Hough and Lyall, 2014)	Mixed methods evaluation	*Co-producing cardiovascular health in Wandsworth*	*three co-produced healthcare projects working with ethnic minority groups at high risk of cardiovascular disease (CVD) in Wandsworth. The three projects included two cook and eat projects for South Asian and Somali women, and an exercise project for African-Caribbean men, which met weekly over a six week period. Community leaders were involved in the project design and delivery, and community members co-produced the projects as they evolved over the six weeks*	• Physical activity • Healthy eating • Disease prevention • General health (personal)	Race/ ethnicity: South Asian and Somali women; African- Caribbean men Religion: Church networks and pastors were involved in the WCEN Deprived area	++	1, 2, 4, 6, 8	
Houghton)	• Practice description	*The People's Family Project*	*Providing opportunity for local families to attend free family based sessions al+ing opportunity to increase physical activity, increase education and awareness about various aspects of health and signpost to local services.*	• Physical activity • Healthy eating • Mental health • Substance use • Children & Young People/ Parenting • General health (personal)	• Place/ Location	• +	• 2 • 4 • 5 • 7	
Hyland et al., 2006)	• RCT [Info] *article reports on process data* •Qualitative study	*The Peer-Led Food Club (PLFC) project*	*peer educators in nutrition interventions with older people*	• Physical activity • Healthy eating • Mental health • Personal wellbeing • Social capital/ cohesion	• Place/ Location • Socioeconomic indicators [Info] *socially disadvantaged areas of northeast England as appropriate* • Other indicators of disadvantage [Info] *60+ - service users The study operated in sheltered accommodation schemes in areas of relative disadvantage identified using an index of multiple deprivation by UK postcode*	• +	• 3	**H, WB, SDH, I, P**
Ingram et al., 2005)	Mixed methods evaluation	*"Babes" breastfeeding support initiative*	*breastfeeding peer support*	• Healthy eating [Info] *breastfeeding* • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *women - mothers* • Socioeconomic indicators [Info] *area of social and economic deprivation in Bristol*	• ++	• 3	**H, I, P, U**

Ingram, 2013)	• Mixed methods evaluation	*Bristol Breastfeeding Peer Support Service*	**Type of activity** • Type of activity [Info] *peer support for breastfeeding*	• Healthy eating [Info] *breastfeeding* • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *women - mothers*	• +	• 3	**H, WB, I, P**
Institute for Criminal Policy Research(2011)	• Mixed methods evaluation	*offender health trainer service*	*The team delivers four main types of work: 1. Helping offenders register with GPs and dentists. 2. One-to-one work with offenders developing a personal health plan and facilitating health improvement particularly around diet, fitness, smoking cessation and alcohol use. 3. Delivering group work sessions on general health and well-being issues to offenders attending the CJDT or participating in offending behaviour group work programmes. 4. Participating in multiagency health promotion campaigns.*	• Physical activity • Healthy eating • Substance use • Personal wellbeing • Other [Info] *registering with GPs and other local health services* • General health (personal)	• Place/ Location • Other indicators of disadvantage [Info] *offenders*	• +	• 3	**H, WB, I, P**
Institute for Volunteering Research (2003)	•Questionnaire/ survey	*volunteering for mental health*	*volunteering*	• Mental health	• Place/ Location • Occupation [Info] *many respondents were unemployed* • Other indicators of disadvantage [Info] *people with direct experience of mental ill health*	• +	• 7	**H, WB, SDH, I**
Involve (2004)	• Practice description •Discussion	*The TRUE project- Training for Public Involvement in Research*		• Other [Info] *Seminar- how to involve people in research*	• Place/ Location	• +	• 1	
IRISS (2012)	•Qualitative study		*Asset mapping project to discover community assets in Kirkintilloch that were useful and available for positive mental health and well-being, but also to help others identify their own personal assets.*	• Mental health • Personal wellbeing • Community wellbeing • Personal assets • Community assets	• Place/ Location • Other indicators of disadvantage [Info] *people using mental health services*	• ++	• 1 • 2	**H, WB, I, C, P**

Jarvis et al., 2011)	•Qualitative study *case study*		*neighbourhood regeneration*	• Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Socioeconomic indicators [Info] *Canley is in the top 20 % most deprived neighbourhoods in England* • Other indicators of disadvantage [Info] *is characterized by: above-average proportions of young and older residents; a higher pro-portion of lone parents; lower rates of economic activity and car ownership; and a higher proportion of social or private-rented accommodation.*	• ++	• 1 • 2	**C, P**
Jennings et al., 2013)		*Health Trainers*	*Health trainer service*	• Physical activity • Healthy eating • Other [Info] *Weight change* • General health (personal) [Info] *blood pressure*	• Place/ Location [Info] *Great Yarmouth and Waveney* • Gender [Info] *The majority of participants were female* • Other indicators of disadvantage [Info] *their mean age at baseline was 48.2 years; 30% lived in the most deprived quintiles (20%) of national deprivation*	• +	• 3	**H, I**
Jolly et al., 2012)	• RCT		*peer support worker service for breastfeeding*	• Healthy eating [Info] *breastfeeding* • Children and Young People/ Parenting	• Place/ Location • Race/ ethnicity [Info] *multi-ethnic* • Gender [Info] *women - mothers* • Socioeconomic indicators [Info] *socioeconomically disadvantaged population*	• +	• 3	**H, U**
Jones, 2014	• Practice description	*Leeds Gypsy and Traveller Exchange (GATE)*	*Community led organisation with a range of projects and services. Focussing increasingly on asset based community development and co-production. The overall aim of Leeds GATE is to improve the quality of life for Gypsy and Irish Travelling people living in or resorting to Leeds and we have*	• Personal wellbeing • Community wellbeing • Social capital/ cohesion • Personal assets • Community assets	• Place/ Location • Race/ ethnicity [Info] *Gypsy*	• +++	• 1 • 4 • 8	

			four objectives: to improve accommodation provision; improve health and well-being; improve education, employment and financial inclusion; and to increase citizenship and social inclusion.		• Other [Info] *improving accommodation, education, employment and financial inclusion* • General health (personal) • General health (community)	*and Irish Travelling People living in Leeds* • Religion/ culture • Socioeconomic indicators			
Joseph Rowntree Foundation (2011)			*support and facilitate community activity which addresses loneliness amongst people at the neighbourhood level;*	• Personal wellbeing • Social capital/ cohesion	• Place/ Location • Social capital [Info] *social isolation/ loneliness*		• +++	• 2	
Kashefi and Mort, 2004)	• Qualitative study	*The South West Burnley citizens' jury on health and social care*	*Citizen jury -twelve local people aged between 17 and 70 were recruited to come together for a week to hear evidence, ask questions and debate what they felt would improve the health and well-being of people living in the area*	• Community assets • Other [Info] *Jury steering group-the jury process acted effectively as a grass-roots health needs assessment*	• Place/ Location • Socioeconomic indicators [Info] *An area suffering intractable health inequalities.* • Social capital [Info] *There is a strong sense of community in some parts of the area while other parts are fragmented* • Other indicators of disadvantage [Info] *• poverty and + pay; • poor housing and proliferation of empty properties; •high levels of death, illness and disability;*		• ++	• 2	**WB, P**
Kearney, 2004)	•Qualitative study	*HIA of the Castlefields Regeneration Masterplan*	*Health Impact Assessment; The aim of the current study, conducted before the Masterplan was completed, was to assess how community participation in the HIA would be affected by the attitudes and experiences of key stakeholders*	• Other [Info] *regneration* • General health (community) [Info] *Impact of regeneration work*		• Place/ Location [Info] *The Castlefields estate in Runcorn* • Other indicators of disadvantage [Info] *The Castlefields estate in Runcorn is in the*	• +	• 2	**P**

					top 2% most deprived wards in England			
Kelly (2004)	• Mixed methods evaluation • Other *discusses findings of research published in other papers*			• Disease prevention [Info] *HIV/ AIDS prevention* • STIs	• Place/ Location • Other indicators of disadvantage [Info] *gay men*	• +	• 3	**H, I, P**
Kennedy et al., 2006)	• Policy • Concept/ theory •Evaluation/ research	*Sustainable Dialogues initiative, Clackmannanshire; Quality Action Group,*	*community development including people with learning difficulties*	• Healthy eating • General health (personal)	• Place/ Location • Socioeconomic indicators [Info] *"less affluent neighbourhoods"*	• +	• 5	
Kennedy et al., 2006)	• Practice description	*Lay Food and Health Worker role*	*lay involvement in community nutrition*	• Community wellbeing • Social capital/ cohesion [Info] *social inclusion*	• Place/ Location • Social capital [Info] *social inclusion/ exclusion* • Other indicators of disadvantage [Info] *people with learning difficulties*	• ++		

Kennedy et al., 2008)	•Qualitative study	*lay food and health worker helping roles*	*community-based food initiatives*	• Healthy eating	• Other indicators of disadvantage [Info] *"hard to reach" neighbourhoods*	• +	• 5	**H, I, C, P**
Kennedy, 2006)	•Qualitative study	*Lay Food and Health Worker scheme*			• Place/ Location • Socioeconomic indicators [Info] *less affluent neighbourhoods*			WB, P, U
Kennedy, 2010)	•Qualitative study	*Lay Food and Health Workers*	*community nutrition*	• Healthy eating • Disease prevention • Social capital/ cohesion • General health (personal)	• Place/ Location • Socioeconomic indicators [Info] *less affluent neighbourhoods* • Other indicators of disadvantage [Info] *hard to reach groups*	• +	• 5 • 8	**H, WB, SDH, P**
Kimberlee, 2008)	• Qualitative study	*Birmingham City Council's Streets Ahead on Safety project*	*young people's participation in decision-making to address the European road injury 'epidemic'. aims to improve road safety and quality of life in an area of multiple deprivation*	• Children and Young People/ Parenting • Safety/ accident prevention	• Place/ Location • Race/ ethnicity • Religion/ culture [Info] *58% Muslim* • Other indicators of disadvantage [Info] *one third of residents are under 16 years old*	• ++	• 1 • 2	**H, C, P**
Kirkham, 2000)	• Practice description	*Breastfriends Doncaster*	*peer support for breastfeeding*	• Healthy eating [Info] *breastfeeding* • Children & Young People/ Parenting	• Place/ Location	• +		
Lamb et al., 2002)	• RCT	*health walks*	*a community based lay-led walking scheme, compared to advice from health care professional only*	• Physical activity	• Place/ Location	• +	• 5 • Volunteers	**H, I**
Laverack, 2006)	• Concept/ theory • Practice description		*provides a predetermined focus through each of nine 'empowerment domains': Improves participation; Develops local leadership; Increases problem assessment capacities; Enhances the ability to 'ask why'; Builds empowering organizational structures; Improves resource mobilization; Strengthens links to other organizations and people; Creates an equitable relationship with outside agents; and Increases control over programme*		• Place/ Location	• +++	• 1	

			management.						
Lawless et al., 2007)	•Qualitative study [Info] *6 case studies*	*New Deal for Communities*	*neighbourhood renewal, regeneration*	• Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *regeneration/ renewal*	• Place/ Location • Socioeconomic indicators [Info] *areas of deprivation* • Social capital		• ++	• 1 • 2	**SDH, C, H, P, U**
Lawless, 2004)	• Mixed methods evaluation	*New Deal for Communities*	*neighbourhood regeneration*	• Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Community assets • Other *neighbourhood regeneration*	• Place/ Location • Socioeconomic indicators [Info] *deprived areas* • Social capital		• ++	• 1 • 2	**P**
Lawson and Kearns, 2009)	•Qualitative study		*Regeneration.*	• Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Community assets • Other- *urban regeneration*	• Place/ Location • Race/ ethnicity [Info] *significant proportion of asylum seekers and refugees (up to 40%)*		• ++	• 1 • 2	**C, P**
Lee, 2014)	• Practice description	*Eye health community engagement projects*	*Working in partnership with communities particularly at risk of avoidable sight loss and service providers to trial a range of sight loss prevention interventions. RNIB has pilot projects throughout the UK working with South Asian, Black African and Caribbean and white + income communities designed to promote eye health and prevent avoidable sight loss. Range of interventions including eye health volunteers and champions; service redesign; supporting self management of diabetes; glaucoma case finding in primary care; community education and outreach,*	• Community wellbeing • Community assets • Other [Info] *improving local conditions* • General health (personal) • General health (community)		• Place/ Location • Socioeconomic indicators [Info] *"disadvantaged areas"*	• +++	• 1 • 2	
Liverpool John Moore's	• Mixed methods evaluation		*It explores the role and value of Health Improvement Practitioners employed by NHS Ashton, Leigh and Wigan, the training they*	• Physical activity • Healthy eating • Mental health	• Place/ Location [Info] *Ashton, Leigh and Wigan's* • Other indicators of disadvantage		• +	• 1 • 5 [Info] *health*	**WB, SDH, P**

University, 2012)			*have delivered, and the impact it has had. The evaluation also explores the development of the 'Health Champion approach' and the impact it has had on recipients at an individual and organisational level.*	• Disease prevention • Substance use • Social capital/ cohesion • Personal assets • Community assets • Other • General health (personal) • General health (community)	[Info] *disadvantaged groups, offenders, young mums, Deprivation is +++er than average and about 12,100 children live in poverty*		*champions*	
Local Government Information Unit, 2012)	• Policy • Concept/ theory • Practice description •Discussion		*co-production*	• Community wellbeing • General health (community)	• Place/ Location	• ++	• 2	
Lorenc and Wills, 2013)	• Mixed methods evaluation		*Health Trainer Case Stories (support around; healthy eating, physical activity, alcohol, smoking and stress management)*	• Physical activity • Healthy eating • Mental health • Substance use • General health (personal)	• Place/ Location	• +	• 1 • 3 • 5	**H, WB, SDH, C, H, P**
Lyons et al., 2013)	• RCT		*political advocacy approach to reduce pedestrian injuries in deprived communities*	• Safety/ accident prevention	• Place/ Location • Socioeconomic indicators [Info] *deprived*	• ++	• 5	**SDH, C**
MacArthur et al., 2009)	• RCT [Info] *Cluster RCT*	*Initiation of breast feeding?*	*Support to initiate breast feeding*	• Healthy eating • Children and Young People/ Parenting	• Place/ Location • Race/ ethnicity [Info] *multi-ethnic- The sample was multi-ethnic, with only 9.4% of women being white British, and 70% were in the +est 10th for deprivation.* • Socioeconomic indicators [Info] *multi-ethnic, deprived population.*	• +	• 3	**P, U**
Mackinnon et al., 2006)	•Qualitative study		*community based health improvement*	• Community wellbeing • Social capital/ cohesion • General health (personal)	• Place/ Location		• 1 • 2	**P**

				• General health (community)				
Mackintosh, 2012)	• Practice description	*GlasGrow project*	*The project aims to improve the health, nutrition and income-generating opportunities for communities in Govan. As well as offering nutritious meals, the new PI café will also enable people to buy fresh food locally, from local producers, and will hopefully generate a sustainable income to help the women's groups continue their vital work.*	• Healthy eating • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets • General health (personal) • General health (community)	• Place/ Location • Race/ ethnicity • Occupation [Info] +++ *unemployment* • Socioeconomic indicators [Info] *deprived*	• ++	• 1 • 2 • 4	
MacPherson et al., 2010)	•Qualitative study	*Home Start*	*parental support scheme*	• Social capital/ cohesion • Personal assets [Info] *training provided to mothers* • Children and Young People/ Parenting	• Place/ Location-*Throughout England* • Gender- *mothers* • Socioeconomic indicators -*Social Disadvantage Index* • Other indicators of disadvantage] *hard to reach; vulnerable families; Participants had all been identified in pregnancy as likely to have some vulnerability*	• +	• 3 • 7	**WB, I, P**
Mahoney et al., 2007)	• Concept/ theory	*Health Impact Assessment*	*typology of public involvement / community participation in HIA*		• Place/ Location	• +++	• 2	
Marais, 2007)	• Mixed methods evaluation	*Toward the Improvement of TB Control and Participatory Research*	A multi-method Community-based Participatory Research study of TB in migrant African communities	• Disease prevention T*B*	• Race/ ethnicity- *African*	• +++	• 2	

Marmot, 2010)	• Policy	*Marmot Review: Fair Society, Healthy Lives*	*Achieving health and wellbeing policy goals will not be achievable without action from local and national government, the NHS, the third and private sectors and community groups. Effective participatory decision making at a local level is required. Empowerment of communities and individuals is at the heart of action Creating an "enabling society that maximises individual and community potential" should be a policy goal (p.20). For some communities to take control of their own lives will require the removal of structural barriers to participation or developing capability through personal/community development. There needs to be a more systematic approach to engaging communities by local strategic partnerships; moving beyond brief consultations to effective participation where communities define problems and develop solutions. The review provides evidence and "directions of travel" (p.34), not detailed prescription of delivery.*	• Disease prevention • Substance use • Personal wellbeing • Safety/ accident prevention • Social capital/ cohesion • Children & Young People/ Parenting • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators • Social capital	• ++	• 1 • 2
Matthiesen et al., 2014)	• Practice description • Discussion	*Cumbria Conversations for Life Engaging 6 communities across one region Merseyside and Cheshire*	*Cumbria Conversations for Life: development of a public health campaign Engaging 6 communities: used a facilated asset based approach to engage 6 communities to lead their own awareness initiative, facilitating community-led awareness initiatives concerning end-of-life conversations and care by identifying and connecting existing skills and expertise.*	• Community assets • Other [Info] *end of life issues*	• Place/ Location	• ++	• 1 • 2 • 5
Mauger and et al.,	• Policy •Discussion	*user involvement*	*"think piece" on the process of user involvement*	• General health (personal)	• Other indicators of disadvantage [Info] *Older people*	• +	• 2

2010)									
McCaffrey, 2008)	Research Qualitative study [Info] *case studies*		*supporting people with learning disabilities and complex needs to live their lives fully through the activities of commissioning*	• Personal wellbeing • Social capital/ cohesion • Personal assets • General health (personal)	• Social capital • Other indicators of disadvantage [Info] *people with learning disabilities and complex needs*		• ++	• 2	H, WB, SDH, I, P
McDaid, 2009)	• Concept/ theory		*participatory action research in mental health policy and planning*	• Mental health	• Place/ Location • Other indicators of disadvantage [Info] *mental health service users*		• +++	• 2	
McInnes et al., 2000)	• Controlled trial •Questionnaire/ survey		*peer counselling to promote breastfeeding in the antenatal and postnatal periods. breastfeeding promotion programme comprising personal peer counselling of pregnant women, post-natal support and local awareness raising activities over a period of 2 year*	• Healthy eating [Info] *breastfeeding* • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *women - mothers* • Socioeconomic indicators		• +	• 3	
McLean and McNeice, 2012)	• Qualitative study [Info] *case studies*		*illustrating asset based approaches for health improvement*	• Physical activity • Mental health • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *Peer mentoring, crafts, homemaking, recycling, gardening* • General health (personal) • General health (community)	• Place/ Location • Other indicators of disadvantage [Info] *prisoners; ex-offenders; unemployed; people from disadvantaged backgrounds; older people; people with poor mental health; children and young people; young dads; homeless*		• ++	• 1 • 3 • 4 • 6	**H, WB, SDH, I, C, H, P, E**
Melhuish et al., 2005)	• Mixed methods evaluation	*Sure Start Local Programmes (SSLPs)*	*To enhance the life prospects of young children in disadvantaged families and communities. (150 SSLPs included in the study)*	• Children and Young People/ Parenting	• Place/ Location • Socioeconomic indicators [Info] *areas with +++ levels of deprivation.* • Other indicators of disadvantage				**WB, P**

				[Info] *all children under 4 years of age*				
Mellanby et al., 2001)	• Mixed methods evaluation	*A PAUSE experiment*	*programme of sex education for secondary schools*	• STIs • Other [Info] *sex education* • Children and Young People/ Parenting	• Place/ Location • Occupation [Info] *school pupils*	• +	• 3	**H, I, P**
Mental Health Foundation , 2013)	• Mixed methods evaluation	*Music and Change*	*MAC-UK developed an innovative model Integrate© which provides mental health and general support in a youth-led way, and considers young people experts in their own experience. Mental health promotion is at the centre of the model which aims to: (1) reduce serious youth violence and reoffending; (2) promote the treatment and mental health needs of young people; (3) engage young people in training, education and/or employment; and (4) bridge young people into appropriate existing services.*	• Mental health • Other [Info] *Young people involved in gangs* • Children and Young People/ Parenting	• Education-*absence of formal education* • Other indicators of disadvantage-*young people involved in gangs. By taking mental health services into the community, they reach young people who normally would not seek help, but present with a number of complex issues such as homelessness, domestic violence, leaving care, absence of formal education, poverty and unemployment.*	• ++	• 1 • 3	**WB, SDH, I, P**
Morgan et al., 2004)	• Mixed methods evaluation •Questionnaire/ survey	*Social capital for health*	*a collection of quantitative research projects that investigate the relevance of the concept of social capital to health development in England.*	• Social capital/ cohesion • Community assets	• Place/ Location • Social capital	• +	• 1 • 6	**I, C**
Murray, (2014)	• Mixed methods evaluation	*CALL-ME (Community Action in Later Life - Manchester Engagement)*	*The CALL-ME project is a three year collaborative and participatory research project that aims to: Describe the processes involved in developing local community-based strategies for promoting enhanced social interaction among older residents of four disadvantaged*	• Personal wellbeing • Community wellbeing • Social capital/ cohesion	• Place/ Location • Socioeconomic indicators [Info] *disadvantaged neighbourhoods* • Other indicators of	• +++	• 2 • 4	**WB, SDH, I, C**

			neighbourhoods in Manchester. Evaluate the impact of these activities on improving opportunities for older people. Develop policy and practice guidelines and procedures for entrenching and broadening these activities.		disadvantage [Info] *older people*			
Muscat, 2010)	• Other [Info] *methods not described*	*New Deal for Communities*	*Area based initiatives; neighbourhood renewal/ regeneration*	• Prevention violence/ abuse/ crime • Personal wellbeing [Info] *education* • Community wellbeing • Social capital/ cohesion • Personal assets • Other *regeneration* • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *deprived localities* • Social capital • Other indicators of disadvantage	• ++	• 1 • 2	**H, SDH, C, H, P**
Naylor et al., 2013)	• Mixed methods evaluation •Qualitative study		*volunteering*	• Community wellbeing • General health (community)	• Place/ Location	• +	• 1 • 3 • 5 • 7	**P**
Nazroo and Matthews, 2012)	• Other *longitudinal analysis*		• Type of activity [Info] *volunteering*	• Personal wellbeing	• Place/ Location • Occupation [Info] *retired* • Other indicators of disadvantage: *older people*	• +	• 7	**WB, I**
Nesta, 2012a)	• Practice description	*people powered health*	*co-production*	• Mental health • Personal wellbeing • Social capital/ cohesion • Other [Info] *self help* • General health (personal)	• Place/ Location	• ++	• 1 • 2	
Nesta, 2012b)	• Practice description •Discussion	*By us, for us- the power of co-design and co-delivery*	*'People powered approach' to co-production and co-delivery*	• Community assets • Other [Info] *Access to services*	• Place/ Location	• +++	• 1 • 2 • 3 • 5 • 6	

							• 7		
Nesta, 2013)	• Other	*People Powered Health*	*peer support*	• General health (personal) [Info] *long term conditions*	• Place/ Location	• +	• 3	**WB, I, P, E**	
Neumark, 2010)	• Practice description	*The Take Part approach*	*Community empowerment - helping people to; gain the skills, knowledge and confidence to become empowered, enabling them to make an active contribution to their communities and influence public policies and services.*	• Community wellbeing • General health (community)	• Place/ Location	• ++	• 1		
New Economics Foundation , 2002)	• Mixed methods evaluation	*community time bank*	*community time bank*	• Personal wellbeing • Social capital/ cohesion	• Place/ Location- *Rushey Green* • Race/ ethnicity- , *44 per cent are from minority ethnic group* • Gender- *29 per cent men, 71 per cent women. Of these, 44 per cent are from minority ethnic groups and 52 per cent have some kind of disability.* • Other indicators of disadvantage -*52 per cent have some kind of disability;*	• +	• 1 • 3 • 6	**WB, I, H, P**	
Newburn and Bhavnani, 2014)	Practice description	*Community parent befrienders*	peer support for pregnant and new mothers	Personal wellbeing; Children & Young People/ Parenting	South Asian women; new mothers; area of high deprivation	+	3		
Newburn et al., 2013)	Practice description	*Birth and Beyond Community supporters*	training refugees and asylum seekers as peer supporters for pregnant and new mothers in their communities. The role of the NCT community peer supporters is to engage with local parents as befrienders, offering empathy and encouragement, and to	Personal wellbeing; Children & Young People/ Parenting	women from the South Asian communities in East Lancashire and the West Midlands and	+	3, 8		

			signpost them to relevant services.		young army families in Catterick Garrison, North Yorkshire as well as refugee and asylum-seeking women in West Yorkshire.			
NHS (2012)	• Practice description	*community health champions*		• Personal wellbeing • Community assets • General health (personal) • General health (community)	• Place/ Location • Race/ ethnicity • Religion/ culture • Socioeconomic indicators • Social capital	• ++	• 1 • 2 • 3 • 5	
NHS Greater Glasgow and Clyde (2010)		*Mosaics of meaning*	*to research and then address stigma relating to mental health problems with the four largest settled BME groups in Glasgow: Pakistani, Chinese, Indian and African and Caribbean.*	• Mental health [Info] *address stigma related to mental health* • Personal assets	• Place/ Location [Info] *Scotland* • Race/ ethnicity [Info] *BME communities*	• +++	• 2 • 3 • 8	**WB, SDH**
NHS Greater Glasgow and Clyde 2010	• Practice description			• Physical activity • STIs • Substance use • Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Community assets • Children & Young People/ Parenting	• Place/ Location • Socioeconomic indicators • Social capital	• ++	• 1 • 2 • 6 • 7	
North West Public Health Observatory, 2011)	• Mixed methods evaluation	*Health Trainers*	*health trainers offering general support*	• Physical activity • Healthy eating • Mental health	• Place/ Location • Socioeconomic indicators [Info] *workless, homeless* • Other indicators of disadvantage [Info] *ex-offenders,*	• +	• 3	**H, WB, I**

					mental health issues			
O'Brien et al., 2011)	*2 separate studies*	Environmental volunteering	*Study 1: general environmental volunteering in Northern England and Southern Scotland. Study 2: mental health participants at Meanwhile Wildlife Garden in London.*	• Mental health • General health (community)	• Place/ Location • Other indicators of disadvantage [Info] *mental health issues. Volunteers from a range of ages and different socioeconomic backgrounds*	• +	• 7	**WB, SDH, I, P**
Office of the Deputy Prime Minister and Neighbourhood Renewal, 2005)	•Qualitative study *2 focus groups in each of the 39 NDC areas. those seeking work or people over 55.*	*New Deal for Communities*	*neighbourhood renewal/ regeneration*	• Community wellbeing • Social capital/ cohesion • Other [Info] *neighbourhood regeneration*	• Place/ Location • Socioeconomic indicators [Info] *NDC areas are generally "deprived"* • Social capital [Info] *NDC areas are generally areas of social exclusion*	• ++	• 1 • 2 • 7	**WB, C, P**
Office of the Deputy Prime Minister, 2002)	• Qualitative study •Questionnaire/ survey	*summarises the evaluation evidence drawn from ten case study Regeneration Budget partnerships*	*neighbourhood regeneration; area based initiative*	• Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *regeneration*	• Place/ Location • Socioeconomic indicators [Info] *targeting social need and deprivation* • Social capital	• ++	• 1 • 2	**SDH, C, P**
Office of the Deputy Prime Minister, 2004)	• Mixed methods evaluation • Other [Info] *case studies*	*residents' consultancy pilots initiative*	*The Residents Consultancy Pilot (RCP) initiative recognised this fact. It investigated the extent to which residents with experience of effective community-based regeneration could play a valuable role in providing advice and inspiration to others, and promoting good practice to bring about change; The aim was to test different approaches to engaging and transferring residents' expertise in order to promote*	• Personal assets-*Benefits for the 'consultants' have included increased confidence and enhanced skills, including the realisation of previously unrecognised*	• Place/ Location [Info] *Kent, Birmingham, London, Sheffield, Plymouth, Liverpool, Oldham, Sunderland*	• ++	• 1 • 2 • 5 • 7	**WB, SDH, U**

			neighbourhood renewal and community-led regeneration	*skills..*				
Office of the Deputy Prime Minister, 2006)	• Mixed methods evaluation	*The Pathfinder Programme*		• Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Safety/ accident prevention	• Place/ Location • Socioeconomic indicators	• ++	• 1	**WB, SDH, C, P**
Osborne et al., 2002)	*case studies*	*rural regeneration partnerships*	*rural regeneration partnerships in the UK*	• Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *regeneration*	• Place/ Location	• +	• 2	**C, P**
Owens and Springett, 2006)	• before and after study	*Roy Castle Fag Ends Community Stop Smoking Service*	*adult smoking-cessation service across Liverpool. Unique aspects are that the service is provided by trained lay advisors with a nonmedical background and there is no waiting list — clients can self-refer by calling a helpline or walking into a meeting.*	• Substance use [Info] *SMOKING CESSATION*	• Place/ Location [Info] *Liverpool*	• ++	• 1 • 5	**H, P, U**
Passan, (2014)	• Practice description	*Leeds Involving People*	*Leeds Involving People is an innovative organisation that leads on involving citizens in redesigning the health and social services. The organisation has strong links with CQC and Leadership Academy, and are a consortia partner within Healthwatch, CCGs, REACT, Leeds Teaching Hospital, Leeds Community Healthcare, NHS IR, WYCLRN, West Yorkshire Police. Aims to ensure the voice of the citizen is at the heart of service provision, commissioning and evaluation by working with a range of partners including regulatory bodies, providers, community sector and commissioners. Supporting and training citizens to be involved and organisations to involve citizens, in all their activities to meet emerging needs of increased population demands (in a co-production approach) by having policies and practises that*	• Other *redesigning health and social services. health and social care training organisations in citizen involvement and training citizens (patients and public) to be ready to be involved and ensure strong participation in a solution focused approach Mental Health* • General health (community)	• Place/ Location • Race/ ethnicity • Other indicators of disadvantage [Info] *Patients/ service users? Vulnerable communities Hard to reach and seldom heard, older people, mental health, dual diagnosis LIP works with Deaf communities, partially sighted, Older and other vulnerable groups incl BME whose representation is*	• +	• 2 • 4	

			encourage involvement.		*poor.*			
Pemberton and Mason, 2008)	•Qualitative study	*Sure Start Children's Centres*	*Sure Start children's Centres (SSCCs) - created to address child poverty and social exclusion with an emphasis on participatory approaches.*	• Social capital/ cohesion • Children and Young People/ Parenting	• Place/ Location • Race/ ethnicity • Social capital	• +	• 2 • 4	**C, P**
Personal (2009)	• Mixed methods evaluation	*Partnerships for Older People Programme*	*aims to create a sustainable shift in the care of older people, moving away from a focus on institutional and hospital-based crisis care toward earlier and better targeted interventions within community settings. Older people are involved in design but main partnerships are between professionals.*	• Disease prevention • Personal wellbeing • Social capital/ cohesion • General health (personal)	• Place/ Location • Other indicators of disadvantage [Info] *older people*	• +	• 2 • 7	**H, WB, P**
Phillips et al., 2012)	• RCT •Questionnaire/ survey	*Well London*	*The Well London program used a community engagement and co-production approach to design and deliver a suite of community-based projects with the aim of increasing physical activity, healthy eating, and mental health and wellbeing in 20 of the most deprived neighbourhoods in London.*	• Physical activity • Healthy eating • Mental health • Personal wellbeing • Community wellbeing • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *defined as UK census +er super output areas (LSOAs); ranked in the 11% most deprived LSOAs in London by the English Indices of Multiple Deprivation)*	• +++	• 1 • 2	**H, U**
Phillips et al., 2014)	**Study design** • RCT	*Well London*	*community engagement activity to promote health and wellbeing*	• Physical activity • Healthy eating • Mental health • Personal wellbeing • Community wellbeing • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *deprived inner city neighbourhoods*	• ++	• 1 • 2	**H, WB, I**
Place Shapers Group,	• Practice description		*Working with communities to improve homes, health, opportunities and aspirations*	• Mental health • Prevention violence/ abuse/ crime	• Place/ Location			•

2011)				• Other [Info] *support, advice, protection and alternative sources of finance to help people avoid and defeat illegal, doorstep lenders.*				
Platt et al., 2003)	• Mixed methods evaluation	*Breathing Space*	*community-based programme using innovative approach to try to achieve a significant shift in community attitudes towards non-smoking*	• Substance use [Info] *smoking*	• Place/ Location • Socioeconomic indicators	• +++	• 1	**H, I, C, P**
Platt et al., 2005)	• Mixed methods evaluation	*Healthy Living Centre Programme in Scotland*	*Findings cover six key aspects of HLC strategic and operational activity: initiation and development of the HLC; partnership working; community involvement; tackling inequalities in health; sustaining the HLC beyond the initial BLF funding period; and monitoring and evaluation.*	• Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location	• ++	• 1 • 2 • 4	**P**
Power and Hunter, 2001)	• Mixed methods evaluation	*A survey of 100 Big Issue newspaper vendors*	*Community-based health promotion targeting homeless populations*	• General health (personal)	• Place/ Location • Occupation [Info] *Big Issue vendors*	• +	• 1	**H, WB, I**
Pritchard et al., 2006)	• Other [Info] *methods used not stated*	*Greenwich Community Food Co-op*	*community food initiatives*	• Healthy eating	• Place/ Location [Info] *Greenwich* • Other indicators of disadvantage [Info] *Forty-five per cent of customers had a gross household income of less than £150 per week*	• ++	• 2 • 7	**H, SDH, I, P**
Quinn and Knifton, 2005)	• Mixed methods evaluation	*Positive Mental Attitudes Programme*				• ++	• 1 • 2	**H, WB, C, P**

Quinn and Knifton, 2012)	• Qualitative study	*Positive Mental Attitudes*	*mental health inequalities initiative: promoting mental health*	• Mental health • Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Occupation [Info] *over 50% of the adult population are economically inactive* • Education [Info] *58% have no qualifications* • Socioeconomic indicators [Info] *UK's highest concentrated area of socio-economic deprivation* • Other indicators of disadvantage [Info] *30% state that they have a long-term limiting illness*	• +++*;*	• 1 • 2 • 3 • 4	**C, P**
Race for Health, 2010)	• Practice description			• Disease prevention [Info] *eye health; managing diabetes* • Other [Info] *preventing avoidable sight loss*	• Place/ Location • Race/ ethnicity [Info] *South Asian, Black African and Caribbean* • Socioeconomic indicators [Info] + *income communities*	• ++	• 2 • 5 • 7	
Raine, 2003)	•Qualitative study		*peer-support intervention to promote breast-feeding in a deprived area*	• Healthy eating [Info] *breastfeeding* • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *Women - mothers* • Other indicators of disadvantage [Info] *"deprived*	• +	• 2 • 3	**H, I, P**

					area"			
Reece and Flint, 2012)	• Mixed methods evaluation		*community health champions*	• Physical activity • Healthy eating • Mental health • General health (community)	• Place/ Location	• +	• 1 • 5	**WB, I, P**
Reeve and Peerbhoy, 2007)	•Qualitative study *case study* • Other *discussion of evaluation methodology*	*catchon2us! (Healthy Living Centre)*	*Requirements included local involvement in all aspects of development and delivery of services, joint working between local agencies including the NHS, and evaluation of individual HLC projects to provide an evidence base*	• Personal wellbeing • Community wellbeing • Social capital/ cohesion • General health (personal) • General health (community)	• Place/ Location	• +++	• 1 • 2 • 4	**WB, C, P**
Ritchie et al., 2004)	•Qualitative study	*Breathing Space*	*The aim of the programme was to capitalize on local knowledge and encourage local involvement in the development of a programme of activities that would create a supportive environment to enable local people to make healthy choices.*	• Substance use [Info] *smoking*	• Place/ Location • Socioeconomic indicators	• ++	• 1 • 2	**P**
Ritchie, 2001)	•Qualitative study • Other [Info] *and mapping exercise*	*Breathing Space'*	*The aim of the intervention is to produce a significant cultural shift in the local community towards non-toleration and non-practice of smoking, through the development of an interlinked and co-ordinated response across a range of health promotion settings based on community action*	• Substance use [Info] *smoking*	• Place/ Location [Info] *Edinburgh* • Gender [Info] *men and women* • Socioeconomic indicators [Info] *+ income* • Other indicators of disadvantage [Info] *adults and young people 12-16 years; areas of disadvantage*	• ++	• 1 • 2	**P**
Robinson	• Mixed methods		*to review current policy, guidelines and practice on patient public engagement (PPE) in sexual*	• Disease prevention • STIs	• Place/ Location	• +	• 2	**C, P, U**

(2010)	evaluation		*and reproductive health and HIV/ AIDS (SRHH) services, and produce recommendations on how to effectively engage patients and the public in SRHH services in London in order to inform SRHH strategies.*	• General health (personal) [Info] *sexual and reproductive health*				
Robinson et al., 2010)	• Qualitative study	*Working our Way to Health*	*Enhancing the health of men in deprived areas. The programme was undertaken with men to increase their health knowledge, and encourage behaviour modification and access to health improvement services.*	• Physical activity • Healthy eating • Mental health • Disease prevention • Substance use • Social capital/ cohesion • General health (personal) • General health (community)		• Place/ Location • Occupation [Info] *+ paid manual occupations, unemployed, on incapacity benefit, or acting as carers,* • Gender [Info] *Males* • Socioeconomic indicators [Info] *men aged 35 years and above in + paid manual occupations, unemployed, on incapacity benefit, or acting as carers, in the most deprived areas of Sefton.*	• +	• 2 • 3	**H, WB, C, P**
Rocket Science Ltd, 2011)	•Qualitative study	*Health Weight Communities initiative*	*Pathfinders. The purpose of the Healthy Weight Communities Programme was to 'demonstrate the ways in which engaging communities in healthy eating, physical activity and healthy weight activities as part of a single coherent programme may have a greater impact on health outcomes than current discrete activities.'*	• Physical activity • Healthy eating • Community wellbeing • General health (personal)	• Place/ Location		• ++	• 2 • 4	**SDH, C, P**
Roma Support Group, 2009)	•Qualitative study *Action Research*	*Roma Support Group*	*Action Research in order to identify the barriers and enablers faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms.*	• Personal wellbeing • Community wellbeing • Other [Info] *engagement with public services, including health*		• Place/ Location • Race/ ethnicity [Info] *Roma refugee and migrant community*	• +++	• 1 • 2 • 8	**P**

				• General health (community)	• Religion/ culture • Socioeconomic indicators • Social capital			
Romeo-Velilla (2014)	• Practice description	*My Community Matters*	*MCM is a community-led intervention based on the Connecting Communities (C2) framework. This is a bottom-up approach of accelerated neighbourhood development that aims to improve health, wellbeing and local conditions in disadvantaged areas.*	• Prevention violence/ abuse/ crime • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets • Other • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *disadvantaged areas* • Social capital	• ++	• 1 • 2	
Rosenburg, 2011)		*Walterton and Elgin Community Homes (WECH)*	*community-owned and managed social housing agency*	• Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Socioeconomic indicators [Info] *poor neighbourhoods* • Social capital	• ++	• 2 • 4	**WB, SDH, C, P**
Royal Society for Public Health, 2011)	•Evaluation/ research •Discussion	*The Youth Health Champion (YHC)*	*Health Trainer Service, which enables young children to act as "health advisors" to their peers.*	• Physical activity • Healthy eating • Mental health • Substance use • Children & Young People/ Parenting • General health (community)	• Place/ Location • Education [Info] *Secondary school level* • Socioeconomic indicators [Info] *deprived areas*	• +	• 1 • 3	
Sadare, 2011)	• Mixed methods evaluation • Qualitative study	*Well London programme (World Cafe)*	*a 5 year health promotion programme incorporating mental wellbeing, physical activity and diet*	• Physical activity • Healthy eating • Mental health • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Socioeconomic indicators [Info] *multiple deprived neighbourhoods* • Social capital	• ++	• 1 • 4	**P**

Salisbury 2014	• Practice description	*Bristol Crisis Service for women*		• Mental health • Personal wellbeing • General health (personal)	• Place/ Location		• 4
Scottish Community Development Centre, 2011)	• Practice description	*Mungo Foundation; Toy Box; The Muslim Elderly Day Care Centre; Jewish Care; The Cranhill community project; Glasgow Community Planning Partnership*	*The Roman Catholic Church established the Mungo Foundation, which now runs over 50 different projects including care homes and hostel accommodation; The Quaker community set up the 'Toy Box' project in Barlinnie prison, an initiative designed to support volunteers to look after children of visitors to the prison visiting rooms, ensuring that the children's visit to a prison is a good experience. The Muslim Elderly Day Care Centre, community planning processes; Equality and Human Rights Commission; heritage work* *(Equality and Human Rights Commission, Calton Parkhead Parish Church; Orbiston Neighbourhood Centre)*	• Substance use • Social capital/ cohesion • Other [Info] *homelessness; offenders; socio-cultural activities, healthcare and welfare surgeries, adult education and advice and information; welfare, ESOL, COMMUNITY PLANNING; HERITAGE* • Children & Young People/ Parenting	• Place/ Location [Info] *Scotland* • Religion/ culture [Info] *Roman Catholic, Quaker, Muslim, Jewish community, Church of Scotland* • Other indicators of disadvantage [Info] *homeless, offenders, older people, children*	• ++	• 2 • 3 • 4 • 7
Scottish Community Development Centre, 2013)	• Other [Info] *not sure this is research!*	*asset based approaches*	*Draws on current debates on assets based approaches to health improvement to support the development of a 'culture of thoughtfulness'.*	• Community wellbeing • Social capital/ cohesion • Community assets • General health (community)	• Place/ Location	• ++	• 1 • 2
Scottish Government, 2009	• Policy	*Scottish Community Empowerment Action Plan*	*community empowerment policy*	• Community wellbeing • Social capital/ cohesion • Community assets • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *tackling health inequalities*	• +++	• 1
Scottish Government, 2013)	• Policy • Concept/ theory	*Equally Well*	*uniting policies to reduce health inequalities across Scotland*	• Physical activity • Healthy eating • Mental health • Disease prevention • Substance use	• Place/ Location	• +	• 2

				• Prevention violence/ abuse/ crime • Community wellbeing [Info] *social determinants* • Community assets • Children & Young People/ Parenting • General health (personal)				
Seebohm and Gilchrist, 2008)	• Mixed methods evaluation		*It explores how community development can contribute to an individual's 'recovery' from mental illhealth and also how it can promote 'community well-being' within a locality or community of interest.*	• Mental health • Other [Info] *community development*	• Place/ Location *DIFFERENT SETTINGS ACROSS uk* • Race/ ethnicity *CD PRACTITIONERS: About two thirds (12) described themselves as White British, and the rest were Australian (one), European (one) Pakistani (three), Caribbean (one) and African (one); The mental health survivors, activists, service users and carers- Nearly two thirds described themselves as White British, and the others were Caribbean, African, Turkish, African Asian, Pakistani, and Black Other (Nubian).* • Occupation *practitioners* • Gender • Other indicators of		•7	**P**

					disadvantage			
Seebohm et al., 2012)	• Qualitative study	*Initiatives- UTASS, Sharing Voices and Beat the Blues*	*community development*	• Physical activity • Healthy eating • Mental health • Community wellbeing • Social capital/ cohesion • General health (community)		• +	• 3	**P**
Sender et al., 2011)		*National Empowerment Partnership Programme*	*The NEP programme aimed to empower citizens and communities, and to: demonstrate the difference that community empowerment can make to individuals, community groups, communities and public agencies; develop effective methods of quality assurance for community empowerment; promote good practice networks.*	• Community wellbeing • Social capital/ cohesion	• Place/ Location • Social capital	• ++	• 1 • 2 • 6	**SDH, C, P**
Seyfang and Smith, 2002)	• Other [Info] *evaluation - methods not discussed*	*Time Banks*	*time bank is a way for people to come together and help each other. Participants 'deposit' their time in the bank by giving practical help and support to others and are able to 'withdraw' their time when they need something done themselves.*	• Social capital/ cohesion • Personal assets *Encouraging core public services to invest in building people's capacity to help themselves.* • Other	• Place/ Location [Info] *UK* • Other indicators of disadvantage [Info] *This report looks at time banking, a new government supported initiative which aims to tackle the problems of deprived neighbourhoods*	• +	• 1 • 7	**WB, SDH, P, U**
Seyfang, 2003)	• Mixed methods evaluation • Other [Info] *case study*	*Rushey Green Time Bank*		• Personal wellbeing • Social capital/ cohesion • General health (personal)	• Place/ Location [Info] *in East Lewisham, South London* • Race/ ethnicity [Info] *The ethnic mix of the time bank membership reflects*	• +	• 1 • 3 • 7	**WB, SDH, P**

					that of the local population: 53% are from ethnic minorities. • Occupation- *The majority of Rushey Green Time Bank members are not in paid employment: 80% are jobless, compared to 51% of the population (OPCS, 1993b).* • Gender- *Coordinators estimates show the membership has a majority of women (71%),* • Other indicators of disadvantage			
Seymour 2014)	Research Mixed methods evaluation	*Wirral Healthy Homes*	*Healthy Homes looks at a more holistic response to improving the health and wellbeing of vulnerable residents and improving the property condition. Referrals to the network of partners Healthy Homes has established can help achieve positive health outcomes for residents and reduce health inequalities.*	• Community assets • Other [Info] *improving housing* • Safety/ accident prevention	• Place/ Location • Other indicators of disadvantage [Info] *vulnerable households e.g. children, older people*		++	• 2 • 5	H, WB, SDH, I
Sheridan and Tobi, 2010)	• Concept/ theory		*outlines a framework that will help public bodies to approach engagement more strategically*	• Community wellbeing • Social capital/ cohesion • General health (community)			• +++	• 2	
Sheridan et al., 2010)	•Evaluation/ research • Practice description	*Community engagement using World Café: The Well London experience*	*To improve the health and well-being of residents living in some of the most deprived communities in London. Build a collaborative relationship with local communities*	• Community wellbeing • Social capital/ cohesion • Community assets • General health (community)		• Place/ Location • Socioeconomic indicators [Info] *deprived communities*	• ++	• 1 • 6	

Shircore, 2013)		*Health Trainers*	*health trainers: lay workers supporting individual behaviour change*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing [Info] *e.g. resilience; self-efficacy* • General health (personal)	• Place/ Location • Race/ ethnicity • Socioeconomic indicators [Info] *Results demonstrate an excellent capacity to engage with clients in the +est socio-economic Quintile 1. Many in this quintile being the most difficult to engage with in respect of health issues.*	• +	• 3 • 5	
Skidmore et al., 2006)	•Qualitative study [Info] *case studies*		*This report uses three key concepts: governance, participation and social capital, defined as : - Governance: any decision-making body or structure that exists within a local authority area and has a remit to affect public service planning and delivery.*	• Social capital/ cohesion	• Place/ Location • Social capital	• ++	• 2	**WB, C, H, P**
Smith 2014	• Practice description	*Leeds HIV prevention & testing service for Black African communities*	*Engagement with Black African communities in Leeds to promote behaviour change to reduce risk of HIV transmission, and to increase access to HIV testing, to ultimately reduce the number of Black Africans with undiagnosed HIV in Leeds. 121 information & advice in the community - Group information & advice in the community - HIV testing in the community - Engagement & development with community leaders & key people within the communities.*	• Disease prevention • STIs • Substance use	• Place/ Location • Race/ ethnicity [Info] *Black African communities*	• +	• 2	
Smith et al., 2010)	• Other [Info] *comparsion of 2 case studies*	*West Johnstone Digital Inclusion Project (DIP), based in Renfrewshire,Scotland, and*	*two area-based community empowerment initiatives in UK cities which had common social inclusion goals but operated at different scales (neighbourhood and city-wide) and in different domains (digital inclusion and health)*	• Personal wellbeing [Info] *self-efficacy* • Social capital/ cohesion [Info] *community empowerment and social inclusion* • Children and Young People/ Parenting • General health (personal)	• Place/ Location [Info] *Renfrewshire, Scotland; Salford, Greater Manchester* • Occupation [Info] *Priority to families with*	• +	• 3 • 4 • 6	**P**

		Hearts of Salford (HoS), based in Greater Manchester		[Info] *heart health*	*children, single parents, older people, disabled, people with learning difficulties, unemployed and volunteers* • Education [Info] *There are, however, fewer people with no formal qualifications than would be expected, which contrasts sharply with the DIP sample. - HOS* • Socioeconomic indicators [Info] *Residents of one 5 per cent deprivation zone (area 32 ha, population 2180), an 'outer-city' public housing scheme 6 km from Paisley* • Other indicators of disadvantage			
South (2014)	Concept/ theory							
South et al., 2007)	• Mixed methods evaluation	*health trainers*	*health trainers: lay workers supporting individual behaviour change*	• Personal wellbeing • General health (personal) [Info] *thematic analysis identified six core actions: listening, supporting, empathising, helping empower clients, giving clients confidence and signposting.*	• Place/ Location • Race/ ethnicity [Info] *In terms of ethnic profile, 11 HTs were White British, seven were Asian British/Asian*	• +	• 3 • 5	**H, WB, I, C, P**

					Pakistani and three were from Black or mixed background. • Socioeconomic indicators			
South et al., 2011)	• Other [Info] *Expert Hearings*		*study on lay people in public health roles*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing • General health (personal)	• Place/ Location • Socioeconomic indicators [Info] *Health trainers operate in areas of deprivation*	• +	• 2 • 3 • 7	**P**
Spencer, 2014)	• Qualitative study		*Drawing on findings from an ethnographic study on empowerment and young people's health, this article develops six conceptually distinct forms of empowerment (impositional, dispositional, concessional, oppositional, normative and transformative).*	• Children and Young People/ Parenting • General health (personal)		• +++	• 1	**P**
Stafford et al., 2008)	• Questionnaire/ survey	*New Deal for Communities*	*neighbourhood renewal/ regeneration*	• Physical activity • Healthy eating • Mental health • Community wellbeing • Other [Info] *Social determinants: employment, education, crime* • General health (personal)	• Place/ Location • Race/ ethnicity [Info] *20% non-white* • Socioeconomic indicators • Social capital	• ++	• 1 • 2	**H, WB, SDH, I, C**
Starkey (2005)	• RCT [Info] *Cluster RCT*	*ASSIST (A Stop Smoking in Schools Trial)*	*To encourage stopping smoking*	• Substance use [Info] *Smoking*	• Place/ Location • Education [Info] *Secondary school level, Year 8 aged 11-12*	• +	• 3 • 6	**P**
Starkey (2009)	• Questionnaire/ survey	*A Stop Smoking In Schools Trial (ASSIST)*		• Substance use	• Place/ Location • Race/ ethnicity [Info] *Welsh* • Education	• +	• 3	**H, P**

					[Info] *Secondary school level- Year 8 (aged 12–13 years).*			
Stephenson (2004)	• RCT	*RIPPLE study*	*Peer-led sex education. In intervention schools, peer educators aged 16-17 years delivered three sessions of sex education to 13-14 year-old pupils from the same schools.*	• Personal wellbeing • Other [Info] *sex education* • Children and Young People/ Parenting	• Place/ Location	• +	• 3	**WB, I**
Stephenson, (2008)	• RCT [Info] *Cluster RCT*	*RIPPLE (Peer-Led Sex Education Programme)*	*Peer-Led Sex Education Programme*	• STIs [Info] *sex education* • Children and Young People/ Parenting [Info] *sex education*	• Place/ Location • Education [Info] *Secondary school, Year 9 pupils (8th grade, aged 13–14 y)*	• +	• 3	**H, C, P**
Steven (2000)	• Mixed methods evaluation	*Walking for Health*	*Physical activity, walking*	• Physical activity • Mental health • Social capital/ cohesion	• Place/ Location • Race/ ethnicity [Info] *All walk leaders in the case studies were white* • Gender [Info] *Almost equal split of males and females* • Other indicators of disadvantage	• +	• 7	**H, WB, C, H, P**
Stuteley 2014)		*C2 (Connecting Communities)*	*C2 is short for Connecting Communities, delivering a practical 7-step application of an assets- based approach to community improvement. Essentially collaborative, it empowers both local residents and public service workers to improve health, wellbeing and local conditions in disadvantaged areas. It uses a tried and tested 7-step evidence-based model that works. C2 7 step programme supports delivery of a 2 year intervention designed to reverse the H & WB of disadvantaged communities*					

Stutely, (2002)		*The Beacon Project,*	*community regeneration- aim to tackle the rapidly declining health and social needs of a community in Cornwall*	• Physical activity • Healthy eating • Mental health • Substance use • Prevention violence/ abuse/ crime • Community assets • General health (community)	• Place/ Location • Social capital • Other indicators of disadvantage	• ++	• 2	**H, WB, C**
Stutely, (2004)	•Qualitative study	*the Falmouth Beacon Project*	*Multi-agency intervention in a community fraught with social and economic problems. The intervention devised by the health visitors was a mix of the 'formal' and the 'informal', for although it involved the statutory agencies, it also raised the capacity of ordinary residents on the Estate to have their voice heard, and to create entirely new pathways for consultation and involvement.*	• Prevention violence/ abuse/ crime • Community wellbeing • Social capital/ cohesion • Community assets • General health (community)	• Place/ Location • Socioeconomic indicators high *deprivation estate. Community fraught with social and economic problems. According to the Breadline Britain Index (MORI, 1998), of CornwallÕs 133 wards Penwerris had the highest proportion (30.8%) of poor households, and they were poorer than the national average. Payne et al further indicated that Penwerris had the high percentage in Cornwall of children living in households with no wage earner, and the second highest percentage of children living with lone parents.* • Social capital [*high incidence of*	• ++	• 1 • 2 • 4	**H, WB, SDH, C, P**

					violent crime, intimidation and drug-dealing and many children on the Child Protection Register.			
Summerfield, ()	• Practice description	*Safer Places Scheme*	*Community Development Team - promoting social inclusion for people with learning disabilities: • Safer Places scheme (detailed be+); • Researching and sourcing Opportunities, regular directories of all inclusive activities and events. • Valued Volunteer scheme, recruiting volunteers to support adults with a learning disability to take part in the activities of their choice. Recruited over 140 public, private and voluntary organisations to provide assistance to members if they feel uncomfortable or scared in the community. Members carry a card with the contacts of 2 relatives/friends.*	• Social capital/ cohesion • Other [Info] *disability awareness and safeguarding*	• Place/ Location • Other indicators of disadvantage [Info] *People with a learning disability from 14 upwards. It is planned to extend this to cover other vulnerable groups ie. People with physical disabilities, sensory impairment, dementia and mental health issues.*	• +	• 2 • 4 • 5	
Summerfield, ()								
Susan (2006)	• Mixed methods evaluation	*Age Concern Newcastle*	*The Big Lottery funded Age Concern Newcastle - in partnership with Newcastle University - to undertake research designed to increase understanding of volunteering amongst older people. The research team used a range of social science techniques (surveys, in-depth interviews and focus groups) to assess the conditions under which older people become volunteers, their capacity to remain volunteers, and constraints that impact on volunteering for them.*	• Community wellbeing [Info] *The mission of Age Concern Newcastle is 'to promote the status and well-being of all older people in the City of Newcastle upon Tyne and to*	• Place/ Location [*Newcastle* • Occupation *More than three fifths (62 per cent) of all the current volunteers who responded to the survey question about employment status described themselves as retired; Less than a fifth (19 per cent) of the volunteers across all the age ranges were in paid work* • Gender *largely women*	• +++	• 2 • 3 • 6 • 7	**WB, SDH, I, P**

				make later life a fulfilling and enjoyable experience'. • Social capital/ cohesion [Info] *promote social inclusion* • Other [Info] *older people*	• Education *Nearly two fifths (39 per cent) of the volunteers completed their schooling at age 15 and be+, all of whom were over the age of 55 at the time of the survey* • Other indicators of disadvantage		• ++	• 1 • 2	
Sustainable (2010)	• Policy •Discussion		*integrated, area-based approaches*	• Community wellbeing • Social capital/ cohesion • Community assets • Other [Info] *neighbourhood renewal/ upgrading infrastructure/ sustainability*		• Place/ Location • Social capital	• ++	• 1 • 2	
Sustainable (2010)									
Taylor (2005)	• Mixed methods evaluation	*(CPP): The Community Empowerment Fund (CEF), Community Chests (CCs) and Community Learning Chests (CLCs)*	*Neighbourhood renewal. They were designed to: • encourage more people to become involved in the regeneration of their neighbourhoods; • help residents gain the skills and knowledge they need to play an active role in Neighbourhood Renewal; and • support the involvement of the local community and voluntary sector as an equal partner in local strategic partnerships (LSPs).*	• Community wellbeing • Social capital/ cohesion • Community assets • General health (community)	• Place/ Location • Socioeconomic indicators [Info] *disadvantaged neighbourhoods* • Social capital		• ++	• 1 • 2 • 4 • 6	**SDH, C, P**
Taylor, ()	• Practice description	*The JRF Neighbourhood Programme : a 'light touch' learning*	*Neighbourhood renewal; capacity building, community empowerment and building social capital.*	• Physical activity • Community wellbeing • Social capital/ cohesion • Children & Young People/ Parenting • General health (community)			• ++	• 1 • 6	

		network					
Taylor, (2009)	• Practice description	*Healthy Living Centres; The Dundee Healthy Living Initiative;*	*Healthy Living Centres (HLCs); community-led health; Healthy Living Initiative*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing • Social capital/ cohesion • Personal assets [Info] *Health Issues in the Community training.* • Community assets • Other [Info] *Weight; healthy environments; improving facilities; wider outreach programmes* • Children & Young People/ Parenting • General health (personal) • General health (community)	• Place/ Location [Info] *Argyll and Bute; Dundee; Edinburgh; Falkirk; North Lanarkshire* • Gender [Info] *men and women's group*	• ++	• 1 • 2 • 4 •7
Thraves (2013)	• Policy	*localism*	*Examines the aims of integrating public health across all services, helping communities provide services themselves and investing in prevention. There is a growing recognition that community input in decision-making can help promote health outcomes. However, the key to realising these health gains is giving communities real decision-making power. One option is to employ community commissioners. Local authorities should instead focus on strengthening pre-existing networks in communities that could play a role in delivering services. Ward councillors are the direct link between the local authority and community. They are best placed to encourage people to get involved improving public health outcomes.*	• Disease prevention • General health (personal) • General health (community)	• Place/ Location	• ++	• 1 • 2 • 4
Truman, (2001)	• Concept/ theory		*involving users in evaluation*	• Mental health		• ++	• 2
Ward and Banks, 2009)	• Mixed methods evaluation	*health trainers*	*health trainers: lay workers to encourage individual behaviour change*	• Physical activity • Healthy eating • Mental health • Substance use	• Place/ Location • Socioeconomic indicators [Info] *deprived communities* • Other indicators of disadvantage	• +	• 3 • 5 **H, WB, P**

				• Personal wellbeing • General health (personal)	[Info] *older people*			

Tunariu (2011)	• Mixed methods evaluation • Qualitative study	*Well London DIY Happiness Project*	*Of the three projects specifically designed to address the theme of mental health and well-being, DIYH is the project that aims to improve individual and community health and well-being by exploring new ways to promote positive mental health from a whole population perspective by encouraging people to explore what subjective well-being and happiness means to them. The project aims to steer people away from the idea that mental health is synonymous with mental illness and begin to move people towards seeing mental health as a positive resource which can be improved and protected by making small effective changes*	• Physical activity • Healthy eating • Mental health • Personal wellbeing • Social capital/ cohesion • Personal assets • General health (personal)	• Place/ Location • Socioeconomic indicators [Info] *working with groups of women in 20 +er Super Output Areas facing the greatest health inequalities in London*	• +	•
Tunstill (2005)	• Mixed methods evaluation	*Sure Start Centres*	*Sure Start Centres*	• Healthy eating • Substance use • Children and Young People/ Parenting • General health (personal)	• Place/ Location [Info] *National* • Gender [Info] *Largely mothers* • Other indicators of disadvantage [Info] *deprived areas*	• ++	• • • •
UK (2007)	• Qualitative study	*Get Heard project*	*Get Heard is one of the largest projects undertaken in the UK to involve people with first-hand experience of poverty to give their views on government policies designed to combat poverty – and in doing so to attempt to shape those policies which affect their lives. It was set up by the Social Policy Task Force, comprising the European Anti-Poverty Network, England; Poverty Alliance, Scotland; Northern Ireland Anti-Poverty Network; Anti-Poverty Network Cymru, Wales; Oxfam's UK Poverty Programme; the UK Coalition Against Poverty; and Age Concern*	• Prevention violence/ abuse/ crime • Personal assets • Other [Info] *housing, benefits and into work, finance, transport, neighbourhood renewal* • Children and Young People/ Parenting [Info] *Benefits and into work* • General health (personal)	• Place/ Location [Info] *Northern Ireland, Scotland and Wales.* • Race/ ethnicity [Info] *BME* • Gender • Other indicators of disadvantage [Info] *lone parents; carers; disabled people, older people, migrants homeless; people living in poverty*	• ++	• •
Visram (2006)	• Mixed methods evaluation • Qualitative study	*health trainers*	*health trainers: lay workers supporting individual behaviour change*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing • General health (personal)	• Place/ Location • Socioeconomic indicators	• +	• •

Wait (2006)	• Policy • Concept/ theory		*This paper explores some of the underlying concepts, definitions, and issues underpinning public involvement policies and proposes a set of criteria and questions that need to be addressed to al+ for the evaluation of public involvement strategies and their impact on the health policy process*		• General health (personal) • General health (community) [Info] *public involvement policies in healthcare*			•
Wales (2008)	• Policy	*Designed to add value - a third dimension*	*to inform future directions and support the evidence base of the voluntary sector's contribution to health and social care. It will serve to inform planners and commissioners in the development of the Health, Social Care and Wellbeing Strategies and the commissioning process across Wales.*		• Personal wellbeing • Other [Info] *health and social care* • General health (personal) • General health (community)	• Place/ Location • Other indicators of disadvantage [Info] *vulnerable groups*	• ++	• • •
Wallace, (2007)	• Policy •Concept/ theory •Discussion	*New Deal for Communities*	*Regeneration. Conceptual paper.*		• Community wellbeing • Social capital/ cohesion • Community assets	• Place/ Location • Socioeconomic indicators [Info] *excluded neighbourhoods*		• •
Wanless (2002)	• Policy	*Wanless report*	*health policy; people being fully engaged with their own health care*		• Disease prevention • Other [Info] *long term conditions* • General health (personal)		• +	
Wanless (2004)	• Mixed methods evaluation		*It was asked to consider consistency of current policy with the public health aspects of the "fully engaged" scenario outlined in the 2002 report "Securing Our Future Health: Taking A Long-Term View"*	• Other [Info] *health services - prevention, wider determinants and reducing health inequalities* • General health (personal)			• +	•
Ward (2009)	• Mixed methods evaluation	*West Sussex Health Trainers service*	*Health Trainers service*	• Physical activity • Healthy eating • Mental health • Social capital/ cohesion • General health (community)		• Place/ Location • Socioeconomic indicators [Info] *deprived communities; Local Neighbourhood Improvement areas (LNIAs) and with older people in other areas.*	• +	•
Watson, (2004)	• Mixed methods evaluation	*community champions fund*	*The aim of CCF was to increase the skills levels of individuals to enable them to act as inspirational figures, community entrepreneurs, community mentors and community leaders; and to also increase*	• Community wellbeing • Social capital/ cohesion • Other [Info] *regeneration; learning activity* • Children and Young People/ Parenting		• Place/ Location • Race/ ethnicity	• ++	• • • • •

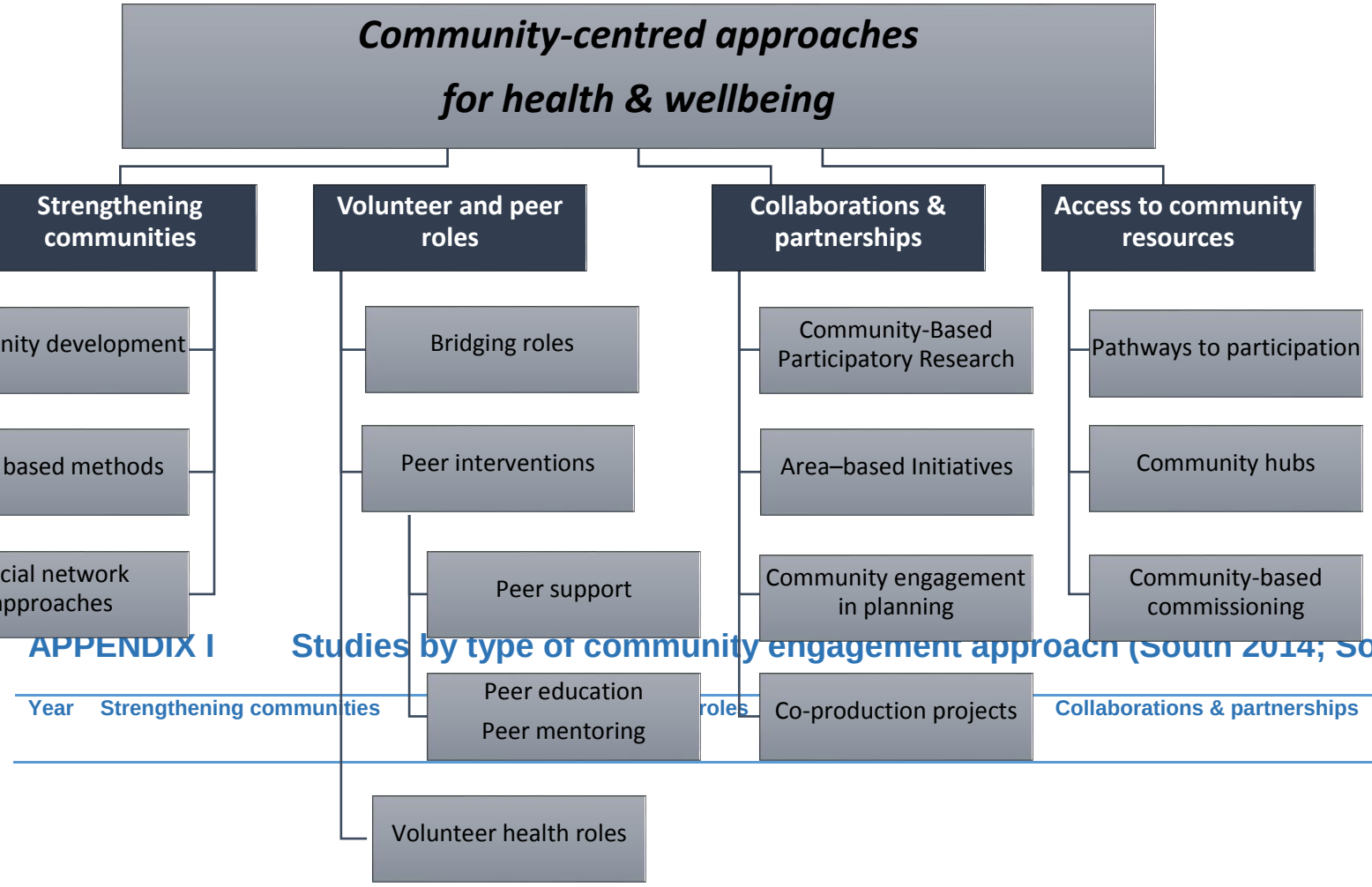
			the involvement of communities in regeneration and learning activity				
Watt (2009)	• RCT		*social support intervention*	• Healthy eating • Children and Young People/ Parenting	• Place/ Location • Gender [Info] *women* • Socioeconomic indicators [Info] *disadvantaged areas*	• +	•
Webster (2000)	• Mixed methods evaluation	*The Community Mapping project*	*community mapping*	• Healthy eating • Substance use • Prevention violence/ abuse/ crime • Social capital/ cohesion *Build the capacity of local people – by training or involving them in PA methods – to develop their knowledge and skills so that they can understand more about how their food economy works and how they can change it;* • Other	• Place/ Location [Info] *Brighton, Coventry and Leicester*	• +++	• • •
Well (2011)	• Qualitative study	*Well London*	*Tackling health inequalities- peer support tackling obesity, reducing smoking, cancer screening, improving mental health - health champions*	• Physical activity • Healthy eating • Mental health • Substance use • Community wellbeing [Info] *tackling health inequalities* • General health (community)	• Place/ Location • Race/ ethnicity *, the population of the White City Estate was measured at 6,300 residents with 2,450 households, twice the average borough density.* • Occupation *31% of residents (one in three adults aged between 16 and 74) have no formal educational qualifications.* • Religion/ culture • Socioeconomic indicators [*The estate is situated in the North Hammersmith area covering the eastern part of the Wormholt & White City ward. It is the second most deprived neighbourhood in the borough with +++ scores on most socio-economic indicators.* • Other indicators of disadvantage*"deprived"*	• ++	• • •
White (2012)	• Mixed methods evaluation	*Kirklees Health Trainer Service*	*Health Trainer Service General health and wellbeing, support for people with LTCs*	• Mental health • Substance use • Personal wellbeing • General health (personal) [Info] *People living with Long Term Conditions*	• Place/ Location [Info] *Kirklees community* • Socioeconomic indicators [Info] *Targeted areas of social deprivation* • Other indicators of disadvantage	• +	• •

					[Info] *People living with an LTC ; alcohol use?*		
White (2013)	• Qualitative study	*Community Health Champion' programmes*	*Health Champions*	• Physical activity • Healthy eating • Substance use • Personal wellbeing • Social capital/ cohesion [Info] *befrieding* • Personal assets [Info] *training* • Other [Info] *early detection of cancer* • General health (personal)	• Place/ Location [Info] *Lincolnshire* • Other indicators of disadvantage [Info] *A large proportion of volunteers were older or retired*	• +	•
Whitehead (2007)	• Policy • Discussion		*discussion paper on concepts and principles for tackling social inequities in health*	• Other [Info] *health care; access to health care* • General health (community)	• Place/ Location • Occupation • Education • Socioeconomic indicators		•
Williamson , (2009)	• Mixed methods evaluation	*Rochdale Partnerships for Older People Programme*	*Rochdale POPP, launched in May 2007, set out to enable 'older people to have power and control over their lives to sustain independence and well-being in older age'.*	• Disease prevention • Personal wellbeing • Social capital/ cohesion • General health (personal)	• Place/ Location • Other indicators of disadvantage [Info] *older people*	• +	
Wood (2013) (Wood et al., 2013)	Mixed methods evaluation	*Natural Choices for Health and Wellbeing Programme*	*The Natural Choices for Health and Wellbeing programme provides support for projects throughout Liverpool which can demonstrate that they are i) helping to improve wellbeing through as many of the five ways to wellbeing as possible and ii) making use of the natural environment in the delivery of the project. A variety of different community projects are involved including community food growing, helping*	• Physical activity • Personal wellbeing • Community wellbeing • Community assets	51% of projects were in areas within the most deprived 1% in the UK	++	

			vulnerable groups to access nature, forest schools, reducing the carbon footprint and tree planting, developing community and therapeutic gardens and helping the homeless.			
Woodall (2012)	• Mixed methods evaluation • Qualitative study	*community health champions*	*lay public health roles (including health champions)*	• Physical activity • Healthy eating • Mental health • Personal wellbeing • Community wellbeing • Social capital/ cohesion • General health (personal) • General health (community) • Safety/ accident prevention	• Place/ Location • Other indicators of disadvantage [Info] *older people*	• +
Woodall,J. , (2012)	• Qualitative study	*community health champions*	*Community health champions in Yorkshire and Humber are involved in a huge range of activities including, among others, leading organised health walks, working in allotment and food-growing initiatives, setting up social clubs, delivering health-awareness presentations on chronic conditions, and signposting.*	• Physical activity • Healthy eating • Personal wellbeing • Community wellbeing • General health (personal) • General health (community)	• Place/ Location • Socioeconomic indicators • Social capital	• ++
YHEP (2010)	• Practice description	*community health champions - Altogether Better*	*community health champions*	• Physical activity • Healthy eating • Mental health • Substance use • Personal wellbeing • Community wellbeing • Social capital/ cohesion • Community assets • General health (personal)	• Place/ Location • Race/ ethnicity • Religion/ culture • Socioeconomic indicators • Social capital	• ++

				• General health (community)		
Ziersch (2000)	•Controlled trial *quasiexperimental design.* •Qualitative study		*pilot peer education STI prevention programme*	• STIs • Personal assets [Info] *peer education training*	• Place/ Location-*London* • Race/ ethnicity • Gender- *males* • Education • Other indicators of disadvantage	• +

APPENDIX H The family of community-centred approaches (South 2014)



APPENDIX I Studies by type of community engagement approach (South 2014; South 2015).

Year	Strengthening communities	roles	Collaborations & partnerships	Access to community resources

Year	Strengthening communities	Volunteer & peer roles	Collaborations & partnerships	Access to community resources
2006	- Community development including people with learning difficulties (Kennedy et al., 2006) - - -	- ASSIST (peer-led smoking cessation in schools) (Audrey et al., 2006a, Audrey et al., 2006b); - Breastfeeding peer support in rural Scotland (Hoddinott et al., 2006b, Hoddinott et al., 2006a); - Roy Castle fag ends stop smoking service (Owens and Springett, 2006); - Community food initiatives (Pritchard et al., 2006); - Volunteering (Bowers et al., 2006, Baines et al., 2006); - Community Nutrition Assistants (Hyland et al., 2006); - Lay food and health workers (Kennedy, 2006); - Activity Friends: peer mentor physical activity programme for over 50s (Corbin, 2006); - Health Trainers(Visram et al., 2006);	- Pathfinder programme (neighbourhood management) (Office of the Deputy Prime Minister, 2006, Department for Communities & Local Government, 2006a); Co-production (Boyle et al., 2006)	- Citynet project: building social capital and improving ICT access for disadvantaged groups in Nottingham, UK.(Bolam et al., 2006); - Sure Start (Bagley and Ackerley, 2006)

Year	Strengthening communities	Volunteer & peer roles	Collaborations & partnerships	Access to community resources
2007	- Healthy Futures (CE model) (Glasgow Centre for Population Health, 2007); - Local Wellbeing Project (empowerment) (Hothi et al., 2007); - Healthy Living Centres (Hills et al., 2007); - Community development training course(Clay Christopher et al., 2007) -	- Health Trainers (South et al., 2007); Breastfeeding peer support (Curtis et al., 2007)	- New Deal for Communities (neighbourhood regeneration) (Blank et al., 2007, Dinham, 2007, Wallace, 2007, Lawless et al., 2007) - JRF Neighbourhood Renewal Programme (Taylor et al., 2007); - Community based participatory research (Marais, 2007); - Health Impact Assessment (Elliott et al., 2007, Mahoney et al., 2007); Pathfinders programme (neighbourhood management) (Department for Communities & Local Government, 2007b)	- Get Heard! –involving people with experience of poverty in shaping policies to combat poverty (U. K. Coalition Against Poverty, 2007); Sure Start (Anning et al., 2007)
2008	Community development and mental health (Seebohm and Gilchrist, 2008); - Streets Ahead On Safety: Young people & road safety (Kimberlee, 2008)	- ASSIST (peer-led smoking cessation in schools) (Audrey et al., 2008, Campbell et al., 2008); - RIPPLE (Peer-led sex education in schools) (Stephenson et al., 2008); - Lay food and health workers (Kennedy et al., 2008); Volunteering (Community Service Volunteers (CSV), 2008)	- Health Impact Assessment (Chadderton et al., 2008); - New Deal for Communities (neighbourhood regeneration) (Stafford et al., 2008); Sure Start and co-production (Pemberton and Mason, 2008)	- Involvement in commissioning for people with LD and complex needs (Davis, 2008, McCaffrey, 2008); Citizens' Juries (Gooberman-Hill et al., 2008)
2009	Healthy Living Centres (Taylor, 2009); Improving CE with Roma Community (Roma Support Group, 2009)	ASSIST (peer-led smoking cessation in schools) (Starkey et al., 2009); Social support for infant feeding (Watt et al., 2009); Health/ Community Champions (Davies, 2009, East Midlands Regional Empowerment Partnership,	Participatory Action Research (McDaid, 2009); Partnerships for Older People Programme (Windle et al., 2009, Williamson et al., 2009); Well London (World café) (Bertotti et al.,	

Year	Strengthening communities	Volunteer & peer roles	Collaborations & partnerships	Access to community resources
		2009a); Breastfeeding peer support (MacArthur et al., 2009); Volunteers (home start) (Barnes et al., 2009); Health trainers (Ward and Banks, 2009);	2009); Pathfinder programme (neighbourhood management) (East Midlands Regional Empowerment Partnership, 2009b); Neighbourhood regeneration (Lawson and Kearns, 2009);	
2010	- Empowerment (Take Part approach) (Neumark, 2010) - Empowerment (West Johnstone Digital Inclusion Project; Hearts of Salford) (Smith et al., 2010) - -	Lay food and health workers (Kennedy, 2010); Volunteers (home start) (MacPherson et al., 2010); - Health trainers (Bpcssa, 2010, Carlson et al., 2010); Health Champions (Altogether Better) (Yorkshire & Humber Empowerment Project, 2010, White et al., 2010)	- Co-production (Boyle et al., 2010); - Social Inclusion Partnerships (Carlisle, 2010); - New Deal for Communities (neighbourhood regeneration)(Muscat, 2010); - The Black and Minority Ethnic (BME) Health Forum (community participatory research) (Race for Health, 2010); - Well London (youth.com & Young Ambassadors; Community Activators; World Cafe) (Craig, 2010, Chapman, 2010, Sheridan et al., 2010); - National Institute for Mental Health in England Community Engagement Project (Fountain and Hicks, 2010); - Addressing stigma related to mental health problems with BME groups (NHS Greater Glasgow and Clyde, 2010)	patient public engagement (PPE) in sexual and reproductive health and HIV/ AIDS (SRHH) services (Robinson and Lorenc, 2010); - Healthy lifestyle programme (Sefton men's health project) (Robinson et al., 2010)

Year	Strengthening communities	Volunteer & peer roles	Collaborations & partnerships	Access to community resources
2011	- National Empowerment Partnership Programme (Sender et al., 2011); - Big Lottery Fund national wellbeing programme (CLES Consulting, 2011); - NHS Health Empowerment Leverage Project (HELP) (Chanan, 2011) - - -	- Health champions (Well London) (Well London and NHS Hammersmith &Fulham, 2011, Cawley and Berzins, 2011, Sadare, 2011, Tunariu et al., 2011); - Volunteering (O'Brien et al., 2011); - Health Trainers (Attree et al., 2011, Ball and Nasr, 2011, Institute for Criminal Policy Research, 2011, North West Public Health Observatory, 2011, Royal Society for Public Health, 2011); Community Mentoring service for older people (Dickens Andy et al., 2011)	- Neighbourhood regeneration (Jarvis et al., 2011)	- Healthy Weight Communities programme (Rocket Science Ltd, 2011); - Social Housing (Rosenburg, 2011); Housing Associations (Place Shapers Group, 2011)
2012	Asset-based approaches (McLean and McNeice, 2012, Iriss, 2012); Community development and mental health (Seebohm et al., 2012); Equally Well (Harkins and Egan, 2012); Community organisations (GlasGrow) (Mackintosh, 2012)	Well London (co-production/ health champions) (Phillips et al., 2012); Health Champions (Sheffield All-Being Well Consortium) (Reece and Flint, 2012); Health Champions (health literacy) (Liverpool John Moore's University, 2012); Health trainers (White et al., 2012, Cook and Wills, 2012, Data Collection Reporting System, 2012, Gardner et al., 2012, Green, 2012); Community agents (Active at 60 programme) (Hatamian et al., 2012);	Co-production (people powered health) (Nesta, 2012b, Nesta, 2012a, Local Government Information Unit, 2012, Hatzidimitriadou et al., 2012); Well London (co-production/ health champions) (Phillips et al., 2012)	Training course: Health Issues In the community (Community Health Exchange, 2012a); Positive Mental Attitudes (mental health inequalities programme) (Quinn and Knifton, 2012); Social marketing, road safety (Christie et al., 2012)

Year	Strengthening communities	Volunteer & peer roles	Collaborations & partnerships	Access to community resources
		Breastfeeding peer support (Jolly et al., 2012); Peer power for people with mental illness (Duffy, 2012); Volunteering (Nazroo and Matthews, 2012)		
2013	Asset based approaches (Scottish Community Development Centre, 2013, Fenton, 2013, Scottish Community Development, 2013); Equally Well (Scottish Government, 2013)	Breastfeeding peer support (Ingram, 2013); Volunteering (Naylor et al., 2013); Youth (peer)-led mental health and general support (Music and Change) (Mental Health Foundation, 2013); Health champions (White and Woodward, 2013, Woodall et al., 2012b) Health trainers (Dooris et al., 2013, Jennings et al., 2013, Lorenc and Wills, 2013, Shircore, 2013)	Co-production/ peer support (people powered health) (Nesta, 2013)	Time banks (Cambridge Centre for Housing & Planning Research, 2013); political advocacy approach to reduce pedestrian injuries in deprived communities (Hills et al., 2013)