



*National Institute for  
Health and Clinical Excellence*

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# **Community engagement to improve health**

## **NICE public health guidance 9 Community engagement to improve health**

### **Ordering information**

You can download the following documents from [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

- The NICE guidance (this document) which includes all the recommendations, details of how they were developed and evidence statements.
- A quick reference guide for professionals and the public.
- Supporting documents, including an evidence review and an economic analysis.

For printed copies of the quick reference guide, phone NICE publications on 0845 003 7783 or email [publications@nice.org.uk](mailto:publications@nice.org.uk) and quote N1477.

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

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## Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE or the Institute) to produce public health guidance on community engagement and community development approaches to health improvement, including use of the collaborative methodology and community champions.

Community engagement and community development are two complementary but different terms. Lack of detailed evidence meant it was not possible to make recommendations which distinguish between them. For the purposes of this guidance, the umbrella term 'community engagement' has been used. A glossary of the terms used is included in section 9. Click on the term in bold to link to the glossary.

The guidance is for those working in the NHS and other sectors who have a direct or indirect role in – and responsibility for – community engagement. This includes those working in local authorities and the community, voluntary and private sectors. It may also be of interest to members of the public.

The Programme Development Group (PDG) has considered reviews of the evidence, an economic appraisal, stakeholder comments and the results of fieldwork in developing these recommendations.

Details of membership of the PDG are given in appendix A. The methods used to develop the guidance are summarised in appendix B. Supporting documents used in the preparation of this document are listed in appendix E. Full details of the evidence collated, including fieldwork data and activities and stakeholder comments, are available on the NICE website, along with a list of the stakeholders involved and the Institute's supporting process and methods manuals. The website address is: [www.nice.org.uk](http://www.nice.org.uk)

This guidance was developed using the NICE public health programme process.

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# 1 Public health need and practice

A number of national strategies and targets aiming to improve health and [wellbeing](#) and reduce [health inequalities](#) highlight the importance of involving local [communities](#) in health-related activities, particularly those experiencing disadvantage (Department for Communities and Local Government 2006; DH 2006; DH 2004; Electoral Commission 2005; Gillies 1998; HM Treasury 2007a; 2007b; Rifkin et al. 2000; Wallerstein 2006).

Community engagement refers to the process of getting communities involved in decisions that affect them. This includes the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities (Popay 2006).

A variety of approaches are used. These include [citizens' panels and juries](#), [neighbourhood committees and forums](#), [community champions](#) and the [collaborative methodology](#) (used in initiatives such as the [Healthy Communities Collaborative](#)). Although these approaches have been in existence for several decades, many factors prevent them from being implemented effectively, including:

- the culture of statutory sector organisations
- the dominance of professional cultures and ideologies in imposing their own structures and solutions on communities
- competing and conflicting priorities
- the skills and competencies of staff working in public services
- the capacity and willingness of service users and the public to get involved (Pickin et al. 2002).

Formal evaluations of initiatives such as health action zones, New Deal for Communities and Sure Start schemes have also pointed to implementation difficulties (Bridge Consortium 2005; Pickin et al. 2002; Popay and Finegan 2005; Sullivan et al. 2004).

Where the evidence permits, this guidance looks at how communities can be effectively involved in the planning (including priority setting and resource allocation), design, delivery and [governance](#) of:

- [health promotion](#) activities
- activities and initiatives to address the [wider social determinants of health](#).

It also addresses the barriers to using community engagement as an element of the above activities.

The theoretical framework devised to guide the evidence reviews is outlined in the figure on page 6 ([‘Pathways from community participation, empowerment and control to health improvement’](#)). It outlines why, in principle, different levels of community engagement (for example, informing or consulting) could directly and indirectly affect health in both the intermediate and longer term. In theory, a variety of approaches can contribute to successful community engagement at the different levels identified in this framework.

The framework proposes that those community engagement approaches used to inform (or consult with) communities may have a marginal impact on their health. Nevertheless, these activities may have an impact on the appropriateness, accessibility and uptake of services. They may also have an impact on people’s [health literacy](#) (their ability to understand and use information to improve and maintain their health).

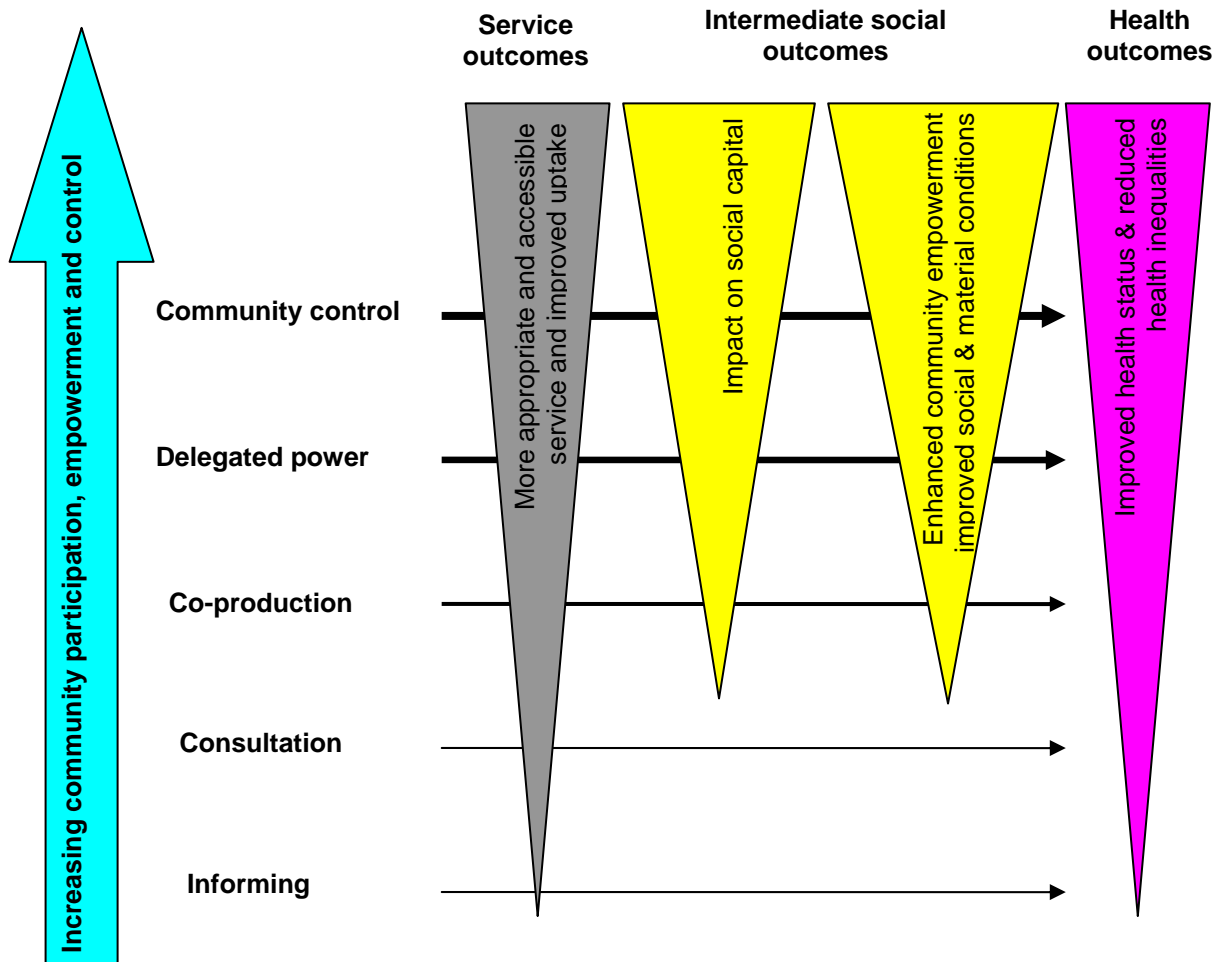
Approaches that help communities to work as equal partners ([co-production](#)), or which [delegate some power](#) to them – or provide them with total control – may lead to more positive health outcomes. (They may also improve other aspects of people’s lives, for example, by improving their sense of belonging to a community [[social capital](#)], empowering them or otherwise improving their sense of wellbeing). This is achieved because these approaches:

- utilise local people's [experiential knowledge](#) to design or improve services, leading to more appropriate, effective, cost-effective and sustainable services
  - empower people, through, for example, giving them the chance to co-produce services: participation can increase confidence, self-esteem and self-efficacy (that is, a person's belief in their own ability to succeed). It can also give them an increased sense of control over decisions affecting their lives
  - build more trust in government bodies by improving accountability and [democratic renewal](#)
  - contribute to developing and sustaining social capital
  - encourage health-enhancing attitudes and behaviour
- (Attree and French 2007).

However, effectiveness will depend on the context in which the approach is used and the process used to implement it. For example, in some situations it may be more appropriate to use 'informing' approaches rather than co-production or [community control](#). It will also depend on other factors, such as the timescale of the activity.

It is important to note that this framework is just one of a number of ways of describing the levels of engagement needed to support the development of healthy communities.

## Pathways from community participation, empowerment and control to health improvement



(Source: Popay 2006)

## 2 Considerations

The PDG took account of a number of factors and issues in making the recommendations.

### **Context**

2.1 The original DH referral asked NICE to look at the approaches used for 'community engagement' and '[community development](#)'. Lack of detailed evidence meant the PDG could not make recommendations which distinguished between these two complementary but different terms. Both community engagement and

development can be used to encourage local communities to get involved in a range of activities. This may include activities to improve health and general quality of life and may range from a one-off consultation (such as a workshop) to longer-term participation in the planning and delivery of services. For the purposes of this guidance, the umbrella term 'community engagement' has been used.

- 2.2 The PDG acknowledged that multiple terms have been used in the evidence to describe the different approaches to community engagement. Sometimes, different terms have been used to describe very similar approaches. Different levels of – and approaches to – community engagement can be underpinned by different value systems. For the future, it is important that those involved in community engagement activities clearly define and describe the approaches they use and the underpinning value system.
- 2.3 The PDG acknowledged that the different approaches used to involve communities in decisions that affect them (community engagement) have evolved from a mix of politics, policy, theory and evidence. It is often difficult to separate these components and learning is a continuous process. The PDG also recognised the complexities of evaluation (as outlined by the work of the King's Fund [Coote et al. 2004] and the Aspen Institute [Auspos and Kubisch 2004]). It noted that research in this area has often been the result of haphazard and unrelated decisions by both funders and researchers. Despite these difficulties the PDG recognised the need to assess systematically which community engagement approaches (and what characteristics of these approaches) are successful and any barriers to using them.
- 2.4 The PDG has based the recommendations on the principles of involvement and engagement detailed in a range of government policies. These include the: white paper 'Stronger and prosperous communities'; Local Government and Public Involvement in Health Act 2007; ['Local involvement networks explained'](#) (Department for

Communities and Local Government 2006; 2007; DH 2007a); recent public service agreement targets outlined in 'Build more cohesive, empowered and active communities' (HM Treasury 2007a).

- 2.5 The current government seeks to ensure that local authorities and NHS organisations, as part of their mainstream activity, consult and involve local communities in decisions related to policy, service delivery and general quality of life. The recommendations reflect this policy context.
- 2.6 The recommendations also reflect the available evidence on area-based [regeneration](#) initiatives. The PDG acknowledged that community engagement approaches could be used to tackle a range of issues with different communities (not just regeneration).
- 2.7 The recommendations promote a consistent approach to community engagement and the PDG would like to see this approach reflected in existing public sector governance structures and the mechanisms used to involve people. These include: [local strategic partnerships](#) (LSPs), [local authority overview and scrutiny committees](#) and local involvement networks (LINKs). It should also be reflected in strategic planning processes, for example: [joint needs assessments](#), the commissioning framework for health and wellbeing and sustainable community strategies and [local area agreements](#). Implementation tools will help support inter-agency working on community engagement. (For further details see section 5.)
- 2.8 The PDG has also based the recommendations on a number of programme theory and evaluation principles (Pawson 2006; Weiss 1995). These include the need to agree, in collaboration with the community and prior to implementation:
- clear and specific aims, objectives and outcomes
  - the content of the activity, the processes used, the outcome/s

that will be measured and the link/s between content, process and outcomes

- the people who will be involved in design and delivery, including community members and the supporting organisational infrastructures
- the target audience and/or the ultimate beneficiaries
- the social context and how it might affect any outcomes
- the likely facilitators or barriers to effective implementation
- proposals for implementation and evaluation, based on explicit content, process and outcomes and the theoretical links between them
- the need to record any unintended outcomes.

2.9 Practitioners working with local communities need a range of skills, knowledge and values which, ideally, meet national standards and guidelines (Office of the Deputy Prime Minister 2004; PAULO 2003). They also need a willingness and capacity to change. This may require investment in training. For further details on implementation see section 5.

2.10 Community engagement requires resources (financial, time, equipment and people). Those involved need to understand and agree in advance what will be needed to ensure the long-term [sustainability](#) of the activity.

2.11 The total package of recommendations represents the best possible scenario for community engagement. The evidence reviews have identified that harm may be caused when elements of the pre-requisites are not implemented. However, individual recommendations can be used to improve the way communities are involved in activities to promote health and to tackle the wider social determinants of health. It is important to note that the numbering of the recommendations does not imply a hierarchy of importance.

2.12 In some cases, the evidence was linked to specific population groups. However, the PDG decided to extrapolate this evidence to the general population and consequently, the recommendations do not refer to specific groups or communities. However, the PDG stressed the importance of identifying and taking into account the needs of those who are under-represented and/or at increased risk of poor health when implementing the recommendations. (This may include people from black and minority ethnic communities, people of a certain age, those with HIV or a disability and those living in rural communities.)

## ***Evaluation***

2.13 The guidance has drawn on a wide range of evidence (including quantitative and qualitative research from a range of study designs). However, further research and evaluation is needed to develop the evidence base (see 2.13 to 2.24 and section 6.)

2.14 The PDG acknowledged that community-based activities are difficult to evaluate because of their complexity, size, the speed of rollout, their (usually) limited duration and the multiple problems they try to address. Experimental evaluations (such as randomised control trials or studies with a control or comparison group) are rare, but not impossible. The PDG also recognised that new ways of evaluating complex community interventions are constantly being developed.

2.15 A number of methodological problems were identified when generating the evidence reviews, making it difficult to determine whether or not the community engagement approach used had improved health or reduced health inequalities. These difficulties are outlined below.

- There is no universal definition for the term 'community' or 'engagement'.
- No two definitions of the same approach are the same. Similarly,

no two descriptions (or characteristics) of the same approach are identical – and they are rarely described in detail. Consequently, in many cases it was impossible to identify which community engagement approach was used.

- The approach used to involve the community (whether as part of an activity to promote health or to address the wider social determinants of health) was not usually the main focus of evaluation. Also, other delivery mechanisms were sometimes used (in conjunction with a community engagement approach) to plan, design, deliver or manage the activity. In some studies, communities were also the target of multiple activities as well as multiple [area-based initiatives](#). In these situations, it was not possible to determine how the impact of the activity or initiative was influenced by the community engagement approach used.
- Only a small number of studies attempted to evaluate the direct impact of the community engagement approach on either intermediate or longer-term health outcomes. Studies either lacked a control or comparison group (or used no approach as a comparator). In some cases, they assessed the effects of a number of components (not just community engagement).

### ***Synthesising the evidence***

2.16 The reviews included a range of evaluation studies, from randomised control trials to case studies. These provided valuable details on the experience of, and processes involved in, community engagement, the conditions needed to support it and its impact. Synthesising data from diverse study types was complex but fruitful.

2.17 It was possible to identify a range of evidence using the methods outlined in appendix B. It was also possible to generate a series of evidence statements to guide development of the recommendations (see appendix C). However, a number of pragmatic decisions were

made to ensure the guidance was delivered to deadline. This included identifying a number of exclusion criteria (see appendix B). For example, the following were excluded:

- activities that use a one-to-one approach (for example, the delivery of one-to-one – as opposed to group – smoking cessation advice)
- evidence from less economically developed countries.

It would be useful to assess these areas in future NICE guidance.

2.18 It was not possible, within the time available, to retrieve all the literature identified as potentially relevant for the two substantive effectiveness reviews. In addition, a sampling approach was used to manage the large number of studies identified for the social determinants effectiveness review (see appendix B).

2.19 Some of the evidence considered originates from interim evaluations (reporting within weeks, months or 1–2 years), as final evaluations were not available. Most activities involving community engagement will only be effective in the longer term (1 year and beyond): assumptions based on the extrapolation of short-term (under a year) effects to the longer term need to be treated with caution. Consequently, limited information was available on how community engagement activities improve health or reduce health inequalities. Once the final evaluations for some of these activities are published it is anticipated that part of the gap in the evidence will be addressed.

2.20 Conventional cost effectiveness analysis can rarely be carried out on community engagement work: the effects of such approaches are often diffuse, occur far into the future and are not easily measured and a range of other factors also hinder the process (see 2.2, 2.14, 2.15 above). In addition, few studies report costs and, where they do, it is difficult to apportion those costs to the various benefits (including health). Overall, as a result, the reviews found limited (and

problematic) evidence on the economic costs and benefits of community engagement.

2.21 Each community engagement approach has many components; if any aspect is badly run it can have a significant impact on the effectiveness of the whole approach. For that reason, no approach can be said to be universally cost effective.

2.22 Cost effectiveness modelling analysis may be useful, particularly when there is:

- a careful and detailed description of the activity
- a comparator (which may be a 'before-intervention' observation)
- one or more validated outcome measures
- a careful and comprehensive account of the costs or resources used
- a sufficiently long follow-up time.

Modelling is also possible without these conditions, but the results will be less useful as a guide to decision-making.

2.23 Two pieces of economic modelling were carried out. (One was on a project that used peer educators to encourage gay and bisexual men to practice safer sex. The other was a project involving the local community in flood prevention plans in the Teign estuary.) In both cases the community engagement approach that was used would be highly cost effective under one set of assumptions. However, if a key assumption was changed (such as the length of time the effect lasts) it could alter the results dramatically. (An approach which was previously deemed very cost effective could then be judged to be 'cost ineffective'). In addition, as it was rare to find two similar applications of the same approach the results from modelling one application should not be used to generalise about other applications of a similar approach (or to generalise about other approaches). The studies could nevertheless be useful to decision makers who must

weigh up the likelihood of one or other set of assumptions being the more appropriate.

- 2.24 Many of the recommendations are perceived as best practice by experienced practitioners and this is supported by the published evidence. Provided that there is no additional cost for conducting better practice, recommendations for such practice will be cost effective (because they will yield additional benefits for no additional cost). The economic modelling supports the conviction that when community engagement is done well, it can be extremely good value for money. If barriers to effective engagement can be removed, the approach is far more likely to be cost effective.
- 2.25 Some evidence came from other developed countries (such as Canada and the US) and, where this is the case, the question of its applicability to England must be taken into account.
- 2.26 It was not possible to identify evidence on the effectiveness of a range of community engagement approaches, either because they had not been evaluated or the evaluations had not been made publicly available. (These approaches include the use of the collaborative methodology, health trainers and citizen juries and panels.) Therefore, if an approach has been omitted from the recommendations, it does not follow that it should be discontinued.
- 2.27 There is a gap between the theory (as outlined in section 2) and the empirical evidence. This is due to a lack of information on the level of involvement achieved using the approaches identified (or the lack of detail describing the approaches). Where possible, the PDG drew on its expertise to supplement the evidence (for example, by extrapolating results on studies from specific population groups to the general population). This is indicated by the use of 'inferences derived from the evidence' (IDE) in appendix C.

- 2.28 A range of good practice toolkits are available that may provide helpful tips on how to implement the recommendations. Implementation advice from NICE will signpost people to these toolkits. For further details see section 5.
- 2.29 Community engagement may have a positive impact on a range of intermediate and long-term health outcomes. Some of the evidence reviewed for this guidance relates to specific approaches used to tackle specific issues. These approaches and the associated outcomes are outlined in Appendix C.
- 2.30 Drawing on experiential knowledge as well as the evidence, the PDG has concluded that the community engagement approaches described in the recommendations could probably be applied to other groups and topics – and to achieve other outcomes (even though these are not specifically mentioned in the evidence). It is also likely that other community engagement approaches, not identified when developing this guidance, may achieve similar outcomes to the ones identified in appendix C. Finally, involving the local community in area-based and regeneration activities is likely to lead to benefits beyond those listed in appendix C.

### **3 Recommendations**

This document is the Institute’s formal guidance on community engagement. When writing the recommendations, the PDG (see appendix A) considered the evidence of effectiveness and cost effectiveness, fieldwork data and comments from [stakeholders](#). Full details are available on the Institute’s website at [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

The evidence statements that underpin the recommendations are listed in appendix C.

The evidence reviews, supporting evidence statements and economic appraisal are available on the Institute’s website at [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

The PDG also considered whether a recommendation should only be implemented as part of a research programme, where evidence was lacking. For the research recommendations see section 6 and appendix D respectively.

A glossary of the terms used is included in section 9. Click on the term in bold to link to the glossary.

Together, the recommendations present the ideal scenario for effective community engagement. They cover four important, interlocking themes: prerequisites for success (including policy development); infrastructure (to support practice on the ground); approaches (to support and increase levels of community engagement); and evaluation.

The first five recommendations cover the prerequisites for effective community engagement and include: coordinated implementation of the relevant policy initiatives (recommendation 1); a commitment to long-term investment (recommendation 2); openness to organisational and cultural change (recommendation 3); a willingness to share power, as appropriate, between statutory and community organisations (recommendation 4); and the development of trust and respect among all those involved (recommendation 5).

Once the prerequisites have been met, it is easier to set up the infrastructure required to implement effective practice. This infrastructure includes: support for appropriate training and development for those working with the community – including members of that community (recommendation 6); formal mechanisms which endorse partnership working (recommendation 7); and support for effective implementation of area-based initiatives (recommendation 8).

The provision of appropriate training and development will help improve communications between the local community and service providers and may attract more people to community groups. (For example, by offering the opportunity to gain new skills and potential employment in the health and

social care sector.) Partnerships (both between sectors and with the local community) and local input into area-based initiatives and regeneration activities are essential to ensure community engagement activities are coordinated and reflect the community's views.

A further three recommendations outline how '[agents of change](#)' (recommendation 9) and a range of other approaches (recommendations 10–11) can be used to encourage local communities to become involved in health promotion activities and area-based initiatives to address the wider social determinants of health.

Finally, improving the quality of evidence is a continuing process. Better evaluation processes are needed to increase understanding of how community engagement and the different approaches used impact on health and social outcomes (recommendation 12).

### ***Main beneficiaries***

Learning how to ask communities what they have to offer in terms of their existing skills and knowledge leads to opportunities for them to work with professionals for mutual benefit. As a result, the main beneficiaries of the recommendations will also play a key role in implementing them. They are:

- Communities and groups with distinct health needs.
- Communities that experience difficulties accessing health services or have health problems caused by their social circumstances.
- People living in [disadvantaged areas](#), including those living in social housing or who live in areas where national and neighbourhood renewal initiatives operate.

## ***Prerequisites for effective community engagement***

### **Recommendation 1: policy development**

#### ***Who should take action?***

Those involved in the planning (including coordination), design, funding and evaluation of national, regional and local policy initiatives.

#### ***What action should they take?***

- Plan, design and coordinate activities (including area-based initiatives) that incorporate a community involvement component across – as well as within – departments and organisations.
- Take account of existing community activities and area-based initiatives, past experiences and issues raised by the communities involved.

### **Recommendation 2: long-term investment**

#### ***Who should take action?***

- [Providers and commissioners](#) in public sector organisations such as the NHS (including primary care, hospital and acute trusts), local authorities (including officers and elected members) and the voluntary sector who seek to involve communities in planning (including priority setting and funding), designing, delivering, improving, managing and the governance of:
  - health promotion activities
  - activities which aim to address the wider social determinants of health
  - area-based initiatives.
- Members of community organisations and groups and community representatives involved in the above.

### **What action should they take?**

- Understand the gradual, incremental and long-term nature of community engagement activities. Ensure mechanisms are in place to evaluate and learn from these processes on a continuing, systematic basis.
- Align this long-term approach with local priorities (such as those defined by local area agreements).
- Identify how to fund community engagement activities and identify lines of accountability. This could include arrangements for multiple funding sources. It may also include funds for shorter-term activities.
- Set realistic timescales for the involvement of local communities and plan activities within the available funding. Recognise that a short-term focus on activities and area-based initiatives can undermine efforts to secure long-term and effective community participation.
- Build on past experiences to mitigate the possibility of communities experiencing 'consultation fatigue'.
- Agree and be clear about how community engagement can influence decision-making and/or lead to improved services. Anticipate the degree of impact it can have on the wider social determinants of health and health inequalities.
- Negotiate with all those involved to determine which community engagement approaches are most appropriate for different stages of the initiative.
- Clearly state the intended outcomes of the activity.

### **Recommendation 3: organisational and cultural change**

#### ***Who should take action?***

Refer to recommendation 2.

### ***What action should they take?***

- Work with the target community to identify how the culture of public sector organisations (their values and attitudes) supports or prevents community engagement. Make any necessary changes (for example, change the performance management structure) to encourage successful engagement.
- Acknowledge the skills and knowledge in the community by encouraging local people to help identify priorities and contribute to the commissioning, design and delivery of services.
- Draw on the expertise of the particular communities concerned. Consider diversity training and other activities to raise cultural awareness within the organisation. Do not stereotype the target community or community groups with regard to age, sex/gender, disability, race/ethnicity, sexual orientation, religion or belief, or any other characteristic.
- Encourage all communities and individuals (including those whose views are less frequently heard) to express their opinions, regardless of whether they disagree – or are dissatisfied – with national, regional or local policy and strategy.
- Give weight to the views of local communities when decisions affecting them are taken. Make lines of accountability clear so they can see the response to their views. Where community views have been overridden by other concerns, this should be explicitly stated.
- Manage conflicts between communities (and within them) and the agencies that serve them.

### **Recommendation 4: levels of engagement and power**

#### ***Who should take action?***

Refer to recommendation 2.

### ***What action should they take?***

- Identify how power is currently distributed among all those involved (including public sector agencies/organisations and representatives and individuals from the community). Negotiate and agree with all relevant parties how power will be shared and distributed in relation to decision-making, resource allocation and defining project objectives and outcomes. (Recognise that 'power' takes many forms including: access to and use of data, information and people; responsibility for setting agendas; responsibility for allocating resources and funds; and skills and capacity.)
- Make all parties aware of the importance, value and benefit of community involvement in decision-making, service provision and management. This includes public sector agencies and organisations, representatives and individuals from the community.
- Identify and recognise local diversity and local priorities (both within and between communities). Ensure diverse communities are represented (particularly those that tend to be under-represented or at risk of poor health). Clearly state the responsibilities of all parties involved and put in place mechanisms to track accountability.
- Identify and change practices that can exclude or discriminate against certain sectors of the community (for example, short-term funding, organisational style and timing of meetings).
- Let members of the local community decide how willing and able they are to contribute to decision-making, service provision and management (recognise that this may change over time). The allocation of responsibilities should match this. Training and support should be available to help all those involved meet their responsibilities.
- Recognise that some groups and individuals (from the public, community and voluntary sectors) may have their own agendas and could monopolise groups (so inhibiting community engagement).

- Jointly agree ways of working with relevant members of the community at both a strategic and operational level. This should include:
  - identifying who will be involved in decisions concerning the scope, vision and focus of initiatives
  - identifying and agreeing project priorities, objectives and outcomes and what can be realistically achieved by involving community members
  - selecting the community engagement approach most likely to achieve the project's objectives and outcomes
  - agreeing governance structures and systems (including how each party will be represented and involved)
  - agreeing the criteria that will be used to allocate, control and use resources
  - using a variety of methods to elicit the views and concerns of different communities such as black and minority ethnic groups, older people and those with disabilities
  - agreeing to hold meetings in accessible, suitable venues and timing and conducting them in a way that allows community members to participate fully and is sensitive to their needs. (For example, where necessary, translation and other services such as Braille and the loop system should be used or crèche facilities provided)
  - agreeing to avoid technical and professional jargon
  - building feedback mechanisms into the process (to ensure achievements are reported and explanations provided when proposals are not taken forward or outcomes are not achieved).

## **Recommendation 5: mutual trust and respect**

### ***Who should take action?***

Refer to recommendation 2.

### ***What action should they take?***

- Learn from and build on previous or existing activities and local people's experiences to engage them, using existing community networks and infrastructures.
- Identify and provide the structures and resources needed to help community organisations and their representatives participate fully.
- Working with the community, assess its broad and specific health needs. In particular, work with groups that may be under-represented and/or at increased risk of poor health, such as black and minority ethnic groups, older people, those with disabilities and people living in rural communities.
- Tailor the approach used to involve and reach out to under-represented groups, but respect the rights of individuals and communities not to become involved. Recognise that some individuals or groups may create barriers to community engagement and identify ways to overcome these barriers.
- Negotiate and agree how much control and influence community members have and the commitment required from them (in terms of their time and workload).
- Regularly inform communities about the progress being made to tackle issues of concern. Use mechanisms such as existing community networks or forums.

### ***Infrastructure***

#### **Recommendation 6: training and resources**

##### ***Who should take action?***

Refer to recommendation 2.

### ***What action should they take?***

- Develop and build on the local community's strengths and assets (that is, its skills, knowledge, talents and capacity).
- Provide public sector agencies and those working with communities (including community representatives and organisations) with the opportunity to develop the knowledge and skills they need for community engagement. Where possible, training should be undertaken jointly by all those involved and should cover:
  - organisational change and development
  - community engagement
  - community leadership
  - communication and negotiation (including how to deal with conflicts of interest and confidentiality)
  - partnership working and accountability
  - business planning and financial management
  - [participatory research](#) and evaluation skills.
- Provide information on the policy context, how public sector organisations work and on other relevant organisational issues.
- Provide opportunities and resources for networking so that all those involved can share their learning and experiences.
- Identify funding sources for community engagement training.
- Identify support for community engagement. This includes working with existing community networks and voluntary organisations that can reach groups that are traditionally under-represented.
- Where necessary, work with local and national non-governmental organisations (NGOs) and those in the voluntary sector to provide small community organisations with the assistance they need to get involved (this includes the provision of training and resources).

- Address any constraints facing members of the community who want to be involved. This may include helping them to develop knowledge and skills, including the ability to deal with discrimination and stigma (this could be an issue, for example, if someone has HIV). It may also involve dealing with practical issues such as the time they have available, their financial constraints, caring responsibilities or any difficulties they have with transport.
- Provide appropriate, accessible meeting spaces and equipment (such as telephones, computers and photocopying facilities) as required.
- Consider training individual members of the community to act as mentors.

### **Recommendation 7: partnership working**

#### ***Who should take action?***

Refer to recommendation 2.

#### ***What action should they take?***

Develop statements of partnership working for all those involved in health promotion or activities to address the wider social determinants of health (including community groups and individuals). This will help increase knowledge of – and communication between – the sectors and improve the opportunities for joint working and/or consultation on service provision. A [compact](#) drawn up between local government and voluntary and community organisations is an example of how this could be achieved.

### **Recommendation 8: area-based initiatives**

#### ***Who should take action?***

Refer to recommendation 2.

#### ***What action should they take?***

- Encourage local people to be involved in the organisation and management (including financial management) of area-based and regeneration activities, by recognising and developing their skills.

- Give community groups the power to influence local authority decisions and regional and national issues related to area-based initiatives. Also give them the power to help improve communication across sectors. Both can be achieved by:
  - providing resources (such as access to community facilities and help from voluntary and community groups) to support community participation in area-based initiatives
  - involving communities in decision-making and the planning and delivery of services to address the wider social determinants of health (via structures and mechanisms such as LSPs, local area agreements and comprehensive area assessments).

## ***Approaches***

### **Recommendation 9: community members as agents of change**

#### ***Who should take action?***

Refer to recommendation 2.

#### ***What action should they take?***

- Recruit individuals from the local community to plan, design and deliver health promotion activities and to help address the wider social determinants of health. These ‘agents of change’ could take on a variety of roles, for example, as [peer leaders and educators](#), community and [health champions](#), community volunteers or [neighbourhood wardens](#). Where necessary, offer training in how to plan, design and deliver community-based activities. Encourage them to recruit other members of their community to work on community-based interventions (so retaining the skills and knowledge gained within the community).
- Encourage local communities to form a group of ‘agents of change’ (or use existing groups) to plan, design and deliver health promotion activities. The

groups could include neighbourhood or community committees, [community coalitions](#) and [school health promotion councils](#).

- Recruit people to act as a conduit between local communities and organisations in the public, voluntary and community sectors. Ideally, recruit members of the local community. The recruit(s) may be described as [neighbourhood managers](#) or something similar. They should work with neighbourhood partnerships, [community forums](#) and community representatives to identify local needs in relation to employment, education, training, income, crime and other issues. They also need to help members of the local community to develop their capacity for involvement in community activities.
- Use mechanisms such as tenant-controlled organisations, estate housing associations, housing boards and committees, as well as working with neighbourhood managers and renewal advisers to ensure the community's views are heard (including the views of those who are often under-represented). In addition, use these methods to help residents tackle and improve:
  - housing (reducing repair and re-letting times and improving rent collection)
  - community facilities and youth activities
  - perceptions of the environment and crime (tackling rubbish, graffiti and fly tipping)
  - local service delivery (by improving links and partnership working with the community and across and within sectors).

## **Recommendation 10: community workshops**

### ***Who should take action?***

Refer to recommendation 2.

### ***What action should they take?***

Run community workshops (for example, community arts and health workshops) or similar events. These should be used to identify local community needs and to maintain a high level of local participation in the planning, design, management and delivery of health promotion activities. The events should be co-managed by professionals and members of the community and held at a local venue.

### **Recommendation 11: resident consultancy**

#### ***Who should take action?***

Refer to recommendation 2.

#### ***What action should they take?***

Draw on the skills and experience of individuals and groups previously involved in regeneration activities (for example, via resident consultancy initiatives) to improve social cohesion and people's general wellbeing. These skills and experience should be drawn from as wide a range of individuals and groups as possible and used to:

- engage with local residents and secure their trust
- work 'with' rather than 'for' the local community
- identify and work with local structures and organisations
- offer advice, guidance, mentoring and training, if necessary
- empower local people to build partnerships and run community organisations.

### ***Evaluation***

#### **Recommendation 12**

#### ***Who should take action?***

Those who commission, plan, design, deliver and manage community engagement activities.

### ***What action should they take?***

- Identify and agree the objectives of evaluation in collaboration with members of the target community and those involved in the planning, design and implementation of the activity. This should be agreed before the activity is introduced.
  
- Involve members of the community in the planning, design and, where appropriate, the implementation of an evaluation framework that:
  - encourages joint development (by commissioners and the local community) of baseline measurement indicators and methods of monitoring the whole activity
  - considers the theory of change required to achieve success
  - embraces a mixed-method approach which uses appropriate research designs according to the questions asked (and makes use of participatory research methods)
  - includes a range of indicators that help to evaluate not only what works but in what context, as well as the costs and the experiences of those involved
  - ensures outcomes match the resources available and the time invested in the activity
  - identifies the comparators that will be used (if appropriate).

## 4 Implementation

NICE guidance can help:

- NHS organisations meet DH standards for public health, as set out in the seventh domain of 'Standards for better health' (updated in 2006) and for accessible and responsive care, specifically, core standard C17. This states that: 'the views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services'. Performance against these standards is assessed by the Healthcare Commission, and forms part of the annual health check score awarded to local healthcare organisations.
- National and local public sector organisations meet government indicators and targets to improve health and reduce health inequalities. These indicators and targets are set out in the 3-year public service agreements outlined in 'Promote better health and well-being for all' and 'The NHS in England: the operating framework for 2008/09' (HM treasury 2007b, DH 2007b).
- Local authorities fulfil their remit to promote wellbeing in line with the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.
- Public bodies to meet their obligations under legislation on unlawful discrimination and equality in relation to race, disability, sex, religion or belief, sexual orientation and age.
- Local NHS organisations, local authorities and other local public sector partners to benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.
- Provide a focus for children's trusts, health and wellbeing partnerships and other multi-sector partnerships working on health within a local strategic partnership.

NICE has developed tools to help organisations implement this guidance. For details, see our website at [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

## **5 Recommendations for research**

The PDG recommends that the following research questions should be addressed to plug the most important gaps in the evidence.

### ***Recommendation 1: methodology***

#### **Who should take action?**

Research councils, national and local research commissioners and funders of research.

#### **What action should they take?**

Commission research studies to establish the link between effective approaches to community engagement and longer-term health outcomes. The studies should:

- define appropriate process and outcome measures for baseline measurement and evaluation of intended, unintended, positive and negative outcomes related to:
  - intermediate impacts (such as acceptability and coverage)
  - long-term impacts (such as health)
- describe the theoretical links between the context, process, structure and impact
- use qualitative and quantitative methods to collect information on the context, process (including the experiences of those involved), structure and impact (including costs) of the activity
- collect short- and long-term outcome data (using validated outcome measures, where possible)
- conduct combined impact and process evaluations
- where possible, use longitudinal designs and comparison/control groups

- where possible, measure personal health, social economic, cultural and psychological impacts at the individual and community level and include all outcomes (positive, negative, intended and unintended)
- evaluate outcomes among different subpopulations.

## ***Recommendation 2: impact evaluation of area-based initiatives***

### **Who should take action?**

Research councils, national and local research commissioners and funders and research workers.

### **What action should they take?**

Commission research studies on area-based initiatives to evaluate how community engagement can help to improve health and address the wider social determinants of health. These studies should:

- define and describe the different community engagement approaches used
- use qualitative and quantitative methods to collect information on the context, process (including the experiences of those involved), structure and impact (including costs) of the activity
- where possible, use longitudinal designs and comparison/control groups
- match outcomes to the resources available and the time invested in the activity (health outcomes often require long follow-up periods)
- where possible, measure personal health, social economic, cultural and psychological impacts at the individual and community levels and include all outcomes (positive, negative, intended and unintended)
- identify whether the approach meets its stated aims (for example, to improve services, social capital and health)
- test how effectively different approaches achieve the various levels of community engagement
- assess how different approaches differentially affect communities and individuals within those communities.

### ***Recommendation 3: barriers and facilitators***

#### **Who should take action?**

See recommendation 2.

#### **What action should they take?**

Commission research to:

- evaluate communities' (and community members') experiences of different approaches to community engagement, including the relative benefits and disadvantages
- identify the factors which can hinder or support effective community engagement
- pinpoint which barriers relate to specific approaches and identify mechanisms to overcome these barriers.

### ***Recommendation 4: economic evaluation***

#### **Who should take action?**

See recommendation 2.

#### **What action should they take?**

Gather evidence on the costs and benefits of community engagement approaches, in particular:

- wherever appropriate, include economic evaluation as an integral part of funded evaluation studies
- use before and after study designs with comparators
- identify and describe the community engagement approach under investigation (including its underpinning value system)
- where possible, use validated intermediate and long outcomes to measure the direct impact of the approach used
- consider the appropriate follow-up period needed before outcomes are measured (public health outcomes often require long follow-up periods)
- take careful account of the costs and other resources used

- consider the wider benefits of involving local communities (including changes in employment prospects, income and health).

More detail on the evidence gaps identified during the development of this guidance is provided in appendix D.

## **6 Updating the recommendations**

NICE public health guidance is updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guidance should be updated. If important new evidence is published at other times, we may decide to update some recommendations at that time.

## **7 Related NICE guidance**

Much of NICE guidance, both published and in development, is concerned with involving communities to help prevent and tackle disease and illness. For a list of the relevant publications go to: [www.nice.org.uk/guidance](http://www.nice.org.uk/guidance)

## **8 Glossary**

For the purposes of this guidance the following definitions have been used.

### **Agents of change**

Agents of changes are local individuals or groups responsible for encouraging communities to engage in activities to improve their health and tackle the wider social determinants of health. They can gain commitment for change from the community and statutory organisations; identify barriers to change; promote and facilitate monitoring and evaluation activities; and encourage the dissemination of learning.

### **Area-based initiatives**

Area-based Initiatives focus on geographic areas of social or economic disadvantage. These publicly-funded initiatives aim to improve the quality of life of residents and their future opportunities. They are managed through

regional, subregional or local partnerships. Examples include Sure Start and New Deal for Communities.

### **Citizens' juries**

Citizens' juries are a way of involving people in a public body's decision-making process. They usually involve 12–16 people. They look at a particular issue and answer a predetermined question after hearing evidence from a range of speakers.

### **Citizens' panels**

Most citizens' panels aim to represent the local population. Typically, they comprise a cross-section of 1000–2000 residents who complete three or four questionnaires a year on a range of local issues. Some panels are set up by partnerships involving different agencies or local authorities and some are developed by just one local authority. They help local authorities clarify community priorities and provide a means of evaluating services.

### **Collaborative methodology (including Healthy Communities Collaborative)**

The collaborative methodology was developed in the US and Sweden. It has been used by the Healthy Communities Collaborative in England to reduce falls among older people and to widen access to a healthy diet. It is used to develop new ways of working based on existing good practice. A reference panel develops a set of principles, ideas and actions that are introduced during a series of learning workshops. At the same time, practice is implemented on participating sites using small, rapid, incremental changes.

### **Commissioners and providers**

Commissioners may work in PCTs, local authorities and a range of other organisations. They decide who should provide services and what form these should take. As part of this role they carry out needs assessment and service reviews (including seeking feedback from service users), contracting and procurement. Organisations or departments that provide services are known

as 'providers'. Again, they could be part of a PCT, local authority or another organisation in the community, voluntary and private sectors.

### **Communities**

A community is defined as a group of people who have common characteristics. Communities can be defined by location, race, ethnicity, age, occupation, a shared interest (such as using the same service) or affinity (such as religion and faith) or other common bonds. A community can also be defined as a group of individuals living within the same geographical location (such as a hostel, a street, a ward, town or region).

### **Community champions**

Community champions are inspirational figures, community entrepreneurs, mentors or leaders who 'champion' the priorities and needs of their communities and help them get involved by building on their existing skills. They drive forward community activities and pass on their expertise to others. They also provide support, for example, through mentoring, helping people to get appropriate training or by helping to manage small projects.

### **Community coalition**

Community coalitions are formal arrangements set up to support collaboration between groups or sectors of a community. Each group retains its identity but they work together to build a safe and healthy community.

### **Community control**

Community control means community-based organisations have been given total responsibility for a particular service or activity.

### **Community development**

Community development is about building active and sustainable communities based on social justice, mutual respect, participation, equality, learning and cooperation. It involves changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives.

### **Community/neighbourhood committees or forums**

Community/neighbourhood committees or forums are non-political bodies that represent all residents in an area. They provide the community with a forum for discussion and consultation on local issues, based on information provided by the local authority. They are usually made up of local councillors and members of community and voluntary groups.

### **Compact**

The compact is an agreement made between the government and the voluntary and community sectors in 1998. The aim was to improve the relationship between government and local public bodies and the voluntary and community sectors.

### **Co-production**

Co-production is the process whereby clients or service users work alongside professionals as partners to create and deliver services.

### **Delegated power**

Delegated power means limited decision-making powers for a particular policy or service have been delegated to individuals from a community, community-based groups, or groups specifically established for the purpose.

### **Democratic renewal**

Democratic renewal, as defined in the context of the local authority modernisation agenda, involves finding innovative and cost effective ways of encouraging communities, families and individuals to get involved in local plans and activities. The Local Government Act 2000 requires local authorities to set up overview and scrutiny committees to ensure mechanisms are in place to achieve this and to improve people's trust in public sector organisations. The aim is to ensure people's views can influence public affairs and local services.

### **Disadvantaged area**

A disadvantaged area is located within – and defined by – specific geographical boundaries or landmarks. It can feature poor services (both statutory and otherwise), poor housing, a poor environment (in terms of vandalism and lack of green space), high unemployment and high crime rates. Residents living in a disadvantaged area tend to suffer poorer health and wellbeing than those living in other areas.

### **Empowerment**

Empowerment may be a social, cultural, psychological or political process. It is a means of allowing individuals and social groups to express their needs, present their concerns and take action to meet those needs. It can be achieved by increasing people's confidence in their own abilities and equipping them to influence the decisions that affect their lives.

### **Experiential knowledge**

Experiential knowledge is the wisdom and understanding that people acquire through everyday experiences.

### **Governance**

The term governance refers to the overall exercise of power in a corporate, voluntary or state context. It covers action by executive bodies, assemblies (for example, national parliaments) and judicial bodies.

### **Health champions**

Health champions are individuals who possess the experience, enthusiasm and skills to encourage and support other individuals and communities to engage in health promotion activities. They also ensure that the health issues facing communities remain high on the agenda of organisations that can effect change. Health champions offer local authorities and community partnerships short-term support as consultants, encourage them to share good practice and help them develop activities to improve the health of local people.

### **Healthy communities collaborative**

See 'Collaborative methodology'.

### **Health inequalities**

Health inequalities are the result of a complex and wide-ranging set of factors. These factors include: material disadvantage, poor housing, low educational attainment, insecure employment and homelessness. People who experience one or more of these factors are more likely to suffer poor health outcomes and an earlier death compared with the rest of the population.

### **Health literacy**

Health literacy means individuals have the cognitive and social skills necessary to access, understand and use information to improve and maintain their health.

### **Health promotion**

Health promotion comprises non-pharmacological activities that seek to prevent disease or ill health or improve physical and mental wellbeing. An example is the provision of advice to help communities reduce accidental injuries.

### **Joint needs assessment**

Joint needs assessments are carried out by PCTs and local authorities to determine the future health needs of the local population. They also describe the services being put in place to meet those needs and to improve general wellbeing.

### **Local area agreements**

Local area agreements set out the priorities agreed between central government and key local partners including the local authority and the local strategic partnership.

### **Local authority overview and scrutiny committees**

Overview and scrutiny committees have been developed in response to the Health and Social Care Act 2001 and the NHS Reform and Health Care Professions Act 2002. These give county and unitary authorities, as well as others with social service responsibilities and statutory power to: '...review and scrutinise, in accordance with regulations, matters relating to the health service in the authority's area, and to make reports and recommendations on such matters in accordance with the regulations.'

### **Local involvement networks (LINKs)**

LINKs are networks of local organisations that aim to provide a conduit for open, transparent communications between local people and health and social care organisations – and to make those organisations more accountable to the public. From April 2008, each local authority with social service responsibilities has a new statutory duty to establish a LINK.

### **Local strategic partnerships (LSPs)**

Local strategic partnerships bring together organisations and agencies from the public, private, community and voluntary sectors within a local authority area. The aim of these non-statutory partnerships is to improve joint working.

### **Neighbourhood committees**

Neighbourhood committees are usually made up of councillors representing the relevant wards and up to five co-opted members (usually local residents elected to represent their community). They discuss council priorities. They can also raise matters of concern within the local community, as well as taking the lead on neighbourhood development activities. They are often supported by a community development officer.

### **Neighbourhood managers**

Neighbourhood managers offer a single point of contact for local residents, agencies and businesses. They have the authority to negotiate with service providers and to negotiate for change both locally and at senior level.

### **Neighbourhood wardens**

Neighbourhood wardens provide a uniformed, semi-official presence in residential and public areas, town centres and high-crime areas. The aim is to reduce crime and the fear of crime, deter anti-social behaviour and generally improve the community's quality of life.

### **Participatory research**

Participatory research is a collaborative process whereby people are encouraged to define the problems and issues of concern. They are also encouraged to help gather and analyse data and apply the research findings.

### **Pathways for community participation**

Pathways for community participation include: informing, consultation, co-production, delegation of power and community control. The focus on community empowerment becomes more explicit as the process moves from informing and consultation to delegation of power (involving communities in decision-making) and community control (the community governs the programme or organisation).

### **Peer leaders and educators**

Peer leaders and educators work with people of the same age, background, culture or social status.

### **Regeneration**

Regeneration is the process of improving an area by making changes to – and investing in – the social, economic and environmental infrastructure. It can also define action to tackle urban and rural problems in areas which have gone into decline.

### **School health promotion councils**

School health promotion councils give pupils the chance to tell teachers and staff their ideas and opinions about health promotion activities within their school. They represent each class in the school and meet regularly to talk about important issues and projects. They put forward the class views at

council meetings and take forward the views of the very young classes, who may find it difficult to put forward other's opinions.

### **Social capital**

Social capital is the degree of social cohesion in communities. It refers to the interactions between people that lead to social networks, trust, coordination and cooperation for mutual benefit. There are three forms of social capital: 'bonding' comprises the strong links often seen, for example, among family members or members of an ethnic group; bridging comprises weaker but more cross-cutting ties such as those seen among business associates or friends from different ethnic groups; linking comprises connections between people with different levels of power or social status, for example, the links between statutory organisations and the general public.

### **Stakeholders**

Everyone (including agencies and organisations) with an investment or 'stake' in the health of the community and the local public health system. This includes those who benefit from and those who help deliver services to promote health and wellbeing.

### **Sustainability**

The long-term health and vitality – cultural, economic, environmental and social – of a community.

### **Wellbeing**

A state of complete physical, mental, social and emotional wellbeing – not merely the absence of disease or infirmity.

### **Wider social determinants of health**

The wider social determinants of health encompass a range of social, economic, cultural and environmental factors known to be among the worst causes of poor health and inequalities between and within countries. They may include: unemployment, housing, unsafe workplaces, urban slums, globalisation and lack of access to healthcare.

## 9 References

Attree P, French B (2007) Testing theories of change associated with community engagement in health improvement and health inequalities reduction. Report prepared for NICE. (Available on request by emailing Pam Attree at [p.attree@lancaster.ac.uk](mailto:p.attree@lancaster.ac.uk) )

Auspos P, Kubisch A (2004) Building knowledge about community change – moving beyond evaluations. Washington: The Aspen institute Roundtable on Community Change.

Bridge Consortium (2005) The evaluation of the big lottery fund healthy living centres. London: Big Lottery Fund.

Coote A, Allen J, Woodhead D (2004) Finding out what works – building knowledge about complex, community-based initiatives. London: King's Fund.

Department for Communities and Local Government (2006) Stronger and prosperous communities – the local government white paper. London: Department for Communities and Local Government.

Department for Communities and Local Government (2007) Local Government and Public Involvement in Health Act 2007. London: Department for Communities and Local Government.

Department of Health (2004) Choosing health: making healthy choices easier. London: Department of Health.

Department of Health (2006) Our health, our care, our say: a new direction for community services. London: Department of Health.

Department of Health (2007a) Local involvement networks explained. London: Department of Health.

Department of Health (2007b) The NHS in England: the operating framework for 2008/09. London: Department of Health.

Electoral Commission (2005) Social exclusion and political engagement. Research report. London: Electoral Commission.

Gillies P (1998) Effectiveness of alliances and partnerships for health promotion. *Health Promotion International* 13 (2):99–120.

HM Treasury (2007a) PBR CSR public service agreements. PSA delivery agreement 21: build more cohesive, empowered and active communities. London: HM Government.

HM Treasury (2007b) PBR CSR public service agreements. PSA delivery agreement 18: promote better health and wellbeing for all. London: HM Government.

Office of the Deputy Prime Minister (2004) The Egan review: skills for sustainable communities. London: Office of the Deputy Prime Minister.

PAULO (2003) National occupational standards for community development work [online]. Available from:

[www.fcdl.org.uk/publications/index.htm#StandardsSummary](http://www.fcdl.org.uk/publications/index.htm#StandardsSummary)

Pawson R (2006) Evidence based policy: a realist perspective. London: Sage.

Pickin C, Popay J, Staely K et al. (2002) Developing a model to enhance the capacity of statutory organisations to engage with lay communities. *Journal of Health Services Research and Policy* 7:(1).

Popay J, Finegan H (2005) Learning about effective community engagement from selected national initiatives: NCCCE working paper 5. Report prepared for NICE (available on request by emailing [antony.morgan@nice.org.uk](mailto:antony.morgan@nice.org.uk) or [lorraine.taylor@nice.org.uk](mailto:lorraine.taylor@nice.org.uk)).

Popay J (2006) Community engagement and community development and health improvement: a background paper for NICE (available on request by emailing [antony.morgan@nice.org.uk](mailto:antony.morgan@nice.org.uk) or [lorraine.taylor@nice.org.uk](mailto:lorraine.taylor@nice.org.uk)).

Rifkin SB, Lewando-Hundt G, Draper AK (2000) Participatory approaches in health promotion and planning: a literature review. London: Health Development Agency.

Sullivan H, Judge K, Sewel K (2004) Tackling health inequalities and the HAZ smoking cessation programme: the perfect match? *Social Science and Medicine* 59:1603–12.

Wallerstein N (2006) What is the evidence on effectiveness of empowerment to improve health? WHO Europe: Health Evidence Network.

Weiss CH (1995) Nothing as practical as good theory: exploring theory-based evaluation for comprehensive community initiatives for children and families, in Connell JP, Kubisch A, Schorr LB et al. editors. *New approaches to evaluating community initiatives: concepts, methods and context*. Washington DC: Aspen Institute.

## **Appendix A: membership of the Programme Development Group, the NICE Project Team and external contractors**

### ***The Programme Development Group***

PDG membership is multidisciplinary. It comprises researchers, practitioners, stakeholder representatives and members of the public as follows:

**Ms Karen Bellamy** Development Manager, Psychiatric System Survivors Together (PSS Together)

**Mrs Tina Bishop** Non-Medical Prescribing Lead and Senior Lecturer, Anglia Ruskin University

**Mr Jez Buffin** Principal Lecturer, Centre for Ethnicity and Health, University of Central Lancashire

**Dr Paul Burton** Senior Lecturer and Head of the School of Policy Studies, University of Bristol

**Ms Lindsey Colbourne** Commissioner, Sustainable Development Commission

**Ms Anna Coote (Chair)** Head of Patient and Public Involvement, Healthcare Commission

**Professor Chris Drinkwater** Emeritus Professor of Primary Care Development, Northumbria University

**Professor Walid El Ansari** Professor of Public Health, Faculty of Sport, Health and Social Care, University of Gloucestershire

**Ms Frances Fakes** Member of Offley Women's Institute

**Mr Liam Hughes** National Adviser for Healthy Communities, Improvement and Development Agency (IDeA)

**Ms Amanda Inverarity** Chief Executive, The Community Development Exchange

**Dr Catherine Mackereth** Programme Officer, Newcastle New Deal for Communities. Expert Adviser, Community Practitioners and Health Visitors Association

**Dr Anne Scoular** Clinical Research Fellow, MRC Social and Public Health Services Unit

**Ms Razia Shariff** Member of the National Community Forum

**Dr Amanda Sowden** Associate Director/Reviews Manager, Centre for Reviews and Dissemination, University of York

**Ms Gerry Stone** Community Governance Officer, Salford Local Strategic Partnership

**Mr Patrick Vernon** Director, Every Generation Media Ltd (Independent Management Consultant). Councillor, London Borough of Hackney

**Mr Harry Wade** Participation Team Manager, the National Youth Agency

**Ms Alice Wilcock** Co-director of Policy and Research, Community Development Foundation (CDF)

**Ms Winnie Williams** Community Health Development Assistant, Kensington and Chelsea PCT

**Mr Maurice Wilson** Healthy Communities Collaborative Volunteer (Improvement Foundation)

**Expert cooptee to the PDG**

**Professor Jennie Popay**, Institute for Health Research, Lancaster University

## ***NICE Project Team***

### **Mike Kelly**

CPHE Director

### **Antony Morgan**

Associate Director

### **Lorraine Taylor**

Lead Analyst

### **Alastair Fischer**

Technical Adviser (Health Economics)

### **Melanie Iddon**

Analyst

### **Dylan Jones**

Analyst

### **Amanda Killoran**

Analyst

### **Geraldine McCormick**

Analyst

### **Clare Wohlgemuth**

Analyst

## ***External contractors***

### **External reviewers: effectiveness reviews**

Review 1: 'Community engagement in initiatives addressing the wider social determinants of health: a rapid review of evidence on impact, experience and process' was carried out by the universities of Lancaster, Liverpool and Central Lancashire. The principal authors were: Pam Attree, Beverley French and Jennie Popay.

Review 2: 'The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid review phase 3' was carried out by the University of Teesside. The principal authors were: Carolyn Summerbell and Katherine Swainston.

### **External reviewers: economic appraisals**

Economic appraisal 1: 'A rapid review of the economic evidence for community engagement in health promotion' was carried out by the University of York. The principal authors were: Roy Carr-Hill, Anne Mason and Lindsey Myers.

Economic appraisal 2: 'A rapid review of the economic evidence for community engagement and community development approaches in interventions or initiatives seeking to address wider determinants of health' was carried out by the University of York. The principal authors were: Roy Carr-Hill, Anne Mason and Lindsey Myers.

Economic appraisal 3: 'An economic analysis/modelling of cost-effectiveness of community engagement to improve health' was carried out by the University of York. The principal authors were: Roy Carr-Hill and Andrew Street.

### **Fieldwork**

The fieldwork was carried out by the British Market Research Bureau. The principal authors were: Clare McAlpine, Sue Clegg and Daren Bhattachary.

## **Appendix B: summary of the methods used to develop this guidance**

### ***Introduction***

The reports of the reviews and economic appraisals include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the PDG meetings provide further detail about the Group's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available from the NICE website at: [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

### ***The guidance development process***

The stages of the guidance development process are outlined in the box below:

1. Draft scope
2. Stakeholder meeting
3. Stakeholder comments
4. Final scope and responses published on website
5. Reviews and cost-effectiveness modelling
6. Synopsis report of the evidence (executive summaries and evidence tables) circulated to stakeholders for comment
7. Comments and additional material submitted by stakeholders
8. Review of additional material submitted by stakeholders (screened against inclusion criteria used in reviews)
9. Synopsis, full reviews, supplementary reviews and economic modelling submitted to the PDG
10. The PDG produces draft recommendations
11. Draft recommendations published on website for comment by stakeholders and for field testing
12. The PDG amends recommendations
13. Responses to comments published on website
14. Final guidance published on website

## ***Key questions***

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and facilitated the development of recommendations by the PDG. The overarching questions were:

- What community engagement and development approaches and methods are effective and cost effective for the planning (including priority setting and resource allocation), design, delivery or governance of:
  - health promotion interventions
  - interventions/initiatives seeking to address the wider social, economic, cultural and environmental determinants of health?
- What are the barriers to using community engagement and development approaches and methods for health promotion interventions or interventions/initiatives seeking to address the wider social, economic, cultural and environmental determinants of health? What interventions have successfully overcome these barriers?

The subsidiary questions included:

1. What is the aim/objective of the approach/method?
2. What theoretical framework or value system underpins the design, content and/or delivery of the approach/ method?
3. How does the content influence effectiveness?
4. How does delivery influence effectiveness?
5. Does effectiveness depend on the intervener? What are the significant features of an effective intervener? (Does effectiveness depend on whether they are a community member, volunteer or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)
6. Does the site/setting influence effectiveness and, if so, how?

7. Does the intensity (or length) of the approach or method influence effectiveness or duration of effect?
8. Does impact vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?
9. To what extent is effectiveness influenced by the level of participation and control offered to the community?
10. What is the experience of engagement for the community members who get involved?
11. Is there any differential impact on inequalities in health within and between communities?
12. How acceptable is the approach or method to the target community?
13. What approaches or methods do not work?
14. What are the barriers and facilitators to implementation (for example, resistance from professionals or members of the public, policy drivers, funding or staff)?
15. What are the unintended (positive and negative) outcomes of the approach or method (negative unintended outcomes might include disruption of community cohesion, damage to the self-esteem and/or the subjective health state of the individuals concerned)?
16. How much does it cost (in terms of money, people and time)? What evidence is there on cost effectiveness?

These questions were refined further in relation to the topic of each review (see reviews for further details).

### ***Reviewing the evidence of effectiveness***

Two reviews of effectiveness were conducted.

## Identifying the evidence

The following databases were searched for interventions using a community engagement approaches to promote health or to tackle the wider social determinants of health. Searches were carried out from January 1990 onwards on studies covering interventions in economically developed countries and published in English:

- Active Citizenship
- ASSIA (Applied Social Science Index and Abstracts)
- Campbell c2 databases: C2-spectr1 and C2-ripe
- CDSR (Cochrane Database of Systematic Reviews)
- CINAHL (Cumulative Index of Nursing and Allied Health Literature)
- DARE (Database of Abstracts of Reviews of Effectiveness)
- EMBASE (Excerpta Medica)
- EPPI Centre databases: Bibliomap, DoPHER and TRoPHI
- HMIC (Health Management Information Consortium)
- ISI Proceedings
- JRF Findings (Joseph Rowntree Findings)
- Medline
- National Research Register (NRR)
- PAIS (Public Affairs Information System)
- PsychInfo (Psychological Information)
- Research Findings Electronic Register (ReFER)
- SIGLE (System for Index of Grey Literature in Europe)
- Social Policy and Practice
- Sociological Abstracts
- SSCI (Social Science Citation Index)
- The following websites were searched for interventions using a community engagement/development method or approach to promote health or to tackle the wider social determinants of health:
- Engaging Communities Learning Network:  
[www.natpact.nhs.uk/cms/116.php](http://www.natpact.nhs.uk/cms/116.php) and [www.networks.nhs.uk](http://www.networks.nhs.uk)

- Healthy Living Centres: [www.healthylivingonline.org.uk/](http://www.healthylivingonline.org.uk/)
- New Deal for Communities: [www.neighbourhood.gov.uk/page.asp?id=617](http://www.neighbourhood.gov.uk/page.asp?id=617)
- Single Regeneration Budget:  
[www.communities.gov.uk/index.asp?id=1128086](http://www.communities.gov.uk/index.asp?id=1128086)
- Social Care Online: [www.scie-socialcareonline.org.uk/](http://www.scie-socialcareonline.org.uk/)
- Sure Start: [www.surestart.gov.uk/](http://www.surestart.gov.uk/) and [www.ness.bbk.ac.uk](http://www.ness.bbk.ac.uk)
- Renewal.net: [www.renewal.net/](http://www.renewal.net/).

References submitted by stakeholders and experts were also considered.

Further details of the databases, search terms and strategies are included in the review reports.

### **Selection criteria**

Studies were included in the effectiveness reviews if they used community engagement approaches to promote health or to tackle the wider social determinants of health. The type of interventions included are outlined below.

- Planning (including resource allocation and priority setting), design, delivery and governance of health promotion activities.
- Planning (including resource allocation and priority setting), design, delivery and governance of area-based- initiatives and activities which aim to address the wider social determinants of health including:
  - neighbourhood/community regeneration/renewal/development
  - housing/built environment
  - transport
  - employment/work/job creation
  - social inclusion/exclusion/capital/empowerment/capacity building
  - income/poverty/financial exclusion.
- Overcoming barriers to using community engagement approaches for health promotion or activities to address the wider social determinants of health.

Studies were excluded if they covered interventions, initiatives or services which:

- targeted individuals rather than a specific community
- assessed the effectiveness of screening programmes
- covered treatment in healthcare settings (including pharmacological interventions)
- focused on secondary prevention or prevention of relapse
- assessed the effectiveness of tools such as health impact assessment (HIA) and healthy equity audit (HEA). (However, studies which assessed the effectiveness of community engagement/development approaches or methods used as part of the HIA or HEA process were accepted.)
- took place in developing countries
- were not published in English
- were published before 1990.

### **Quality appraisal**

For the health promotion review, all retrieved papers were assessed for methodological rigour and quality using either the NICE methodology checklists, as set out in the NICE technical manual 'Methods for development of NICE public health guidance' (see appendix E).

For the wider social determinants review, titles and abstracts that met the inclusion criteria were organised according to the intervention topic (for example, housing and the built environment, transport and employment). Within each topic area, records were then categorised according to the focus of the study (impact, process or experience). Only UK studies were included. A sampling strategy was adopted to retrieve papers. A purposive sampling approach was used to retrieve a small number of national interventions that evaluated impact. A random sampling approach was used to retrieve papers for the process and experience categories.

The impact records were assessed for methodological rigour and quality using checklists (or adapted forms of these checklists), as set out in the NICE

technical manual 'Methods for development of NICE public health guidance' (see appendix E). The methodological rigour and quality assessment tools used for the impact data were adapted for the process and experience records.

For both reviews, each study was described by study type and graded (++, +, -) to reflect the risk of potential bias arising from its design and execution:

### ***Study type***

- Meta-analyses, systematic reviews of RCTs or RCTs (including cluster RCTs).
- Systematic reviews of, or individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies.
- Non-analytical studies (for example, case reports, case series).
- Expert opinion, formal consensus.

### ***Study quality***

- ++ All or most of the criteria have been fulfilled. Where they have not been fulfilled the conclusions are thought very unlikely to alter.
- + Some criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.
- Few or no criteria fulfilled. The conclusions of the study are thought likely or very likely to alter.

The studies were also assessed for their applicability to the UK.

### **Summarising the evidence and making evidence statements**

The study data was summarised in evidence tables (see full reviews).

The findings from the studies were synthesised and used as the basis for a number of evidence statements relating to each key question (with the

exception of 'minus quality' studies from the social determinants review). The evidence statements reflect the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

### ***Economic analysis***

The economic analysis consisted of two reviews of the literature and a discussion of modelling issues.

#### **Reviews of economic evaluations**

In addition to scanning the effectiveness evidence for economic data, the following databases were searched:

- EconLit
- HEED
- NHS EED
- RePEc (working papers).

Reference lists of all records were checked and public health economics experts were consulted.

Studies were reviewed if they provided economic evidence linked to the effectiveness reviews. To be eligible for inclusion, studies needed to:

- report on the use of community engagement approaches to plan, design, deliver or manage health promotion interventions to or activities/initiatives to address the wider social determinants of health
- include a control or suitable comparator group
- assess health outcomes
- assess costs.

Published studies that met the inclusion criteria were rated to determine the strength of the evidence, using the NICE algorithm and the Drummond checklist.

#### **Cost-effectiveness analysis**

A simple economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. However, the results were not

informative and it does not appear in the final report. Other approaches were attempted and most were eventually discarded due to the following:

- it was difficult to find a comparator for community engagement
- attribution of effect was often difficult or not possible to define
- lack of data.

However, two community engagement 'vignettes' were prepared by NICE. One discusses the cost effectiveness of using trained unpaid peer educators or experienced paid leaders to promote safer sex among gay and bi-sexual men in part of the US. The other vignette discusses the cost effectiveness of using community engagement as part of the development of a flood mitigation scheme on the south coast of England. More details of these vignettes appear in Appendix C.

A general discussion of the issues involved in estimating cost effectiveness is reported in economic appraisal 3. It is available on the NICE website at:

[www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

### ***Fieldwork***

Fieldwork was carried out to evaluate the relevance and usefulness of NICE guidance for practitioners and the feasibility of implementation. It was conducted with practitioners and commissioners who are involved in community engagement services. They included those working in the NHS, local authorities, community and voluntary organisations.

The fieldwork comprised:

- a series of focus groups and indepth interviews with professionals working in the public, community and voluntary sectors
- an electronic survey with professionals working in the public, community and voluntary sectors.

The fieldwork was commissioned to ensure there was ample geographical coverage. The main issues arising from the study are set out in appendix C

under 'Fieldwork findings'. The full fieldwork report is available on the NICE website: [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

### ***How the PDG formulated the recommendations***

At its meetings in May and July 2007, the PDG considered the evidence of effectiveness and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgement
- whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether its equivocal
- where there is an effect, the typical size of effect.

The PDG developed draft recommendations through informal consensus, based on the following criteria:

- Strength (quality and quantity) of evidence of effectiveness and its applicability to the populations/settings referred to in the scope.
- Effect size and potential impact on population health and/or reducing inequalities in health.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of risks and benefits.
- Ease of implementation and the anticipated extent of change in practice that would be required.

The PDG also considered whether a recommendation should only be implemented as part of a research programme where evidence was lacking.

Where possible, recommendations were linked to an evidence statement(s) (see appendix C for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

The draft guidance, including the recommendations, was released for consultation in August 2007. At its meeting in October 2007, the PDG considered comments from stakeholders and the results from fieldwork, and amended the guidance. The guidance was signed off by the NICE Guidance Executive in December 2007.

## Appendix C: the evidence

This appendix sets out the evidence statements taken from two reviews and links them to the relevant recommendations (see appendix B for the key to study types and quality assessments). The evidence statements are presented here without references – these can be found in the full review (see appendix E for details). It also sets out a brief summary of findings from the economic appraisal and the fieldwork.

The two reviews of effectiveness are:

- Review 1: 'Community engagement in initiatives addressing the wider social determinants of health: a rapid review of evidence on impact, experience and process'
- Review 2: The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid review phase 3'

**Evidence statement number HP1** indicates that the linked statement is numbered 1 in review 2. Evidence statement number **SD process 1** indicates that the linked statement is numbered 1 in the process section of review 1. **SD experience 10** indicates that the linked statement is numbered 10 in the experience section of review 1. **SD impact 3** indicates that the linked statement is numbered 3 in the impact section of review 1.

The reviews and economic appraisals are available on the NICE website ([www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)).

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

**Recommendation 1:** evidence statements HP19, SD process 21, IDE.

**Recommendation 2:** evidence statements HP17, HP19, HP 20, SD experience 15, SD experience 16, SD impact 20, SD impact 35, SD process 3, SD process 8, SD process 17, SD process 23, SD process 27, IDE.

**Recommendation 3:** evidence statements SD process 2, SD process 11, SD process 12, SD process 13, SD process 14, SD process 24, HP19, IDE.

**Recommendation 4:** evidence statements SD process 1, SD process 2, SD process 3, SD process 4, SD process 6, SD process 7, SD process 9, SD process 11, SD process 13, SD process 15, SD process 16, SD process 17, SD process 18, SD process 19, SD process 20, SD process 23, HP16, HP18, HP20, HP21, HP22, IDE.

**Recommendation 5:** evidence statements SD process 6, SD process 7, SD process 8, SD process 25, SD process 28, HP22, IDE.

**Recommendation 6:** evidence statements SD impact 7, SD impact 8, SD impact 9, SD impact 11, SD impact 15, SD impact 16, SD impact 17, SD impact 19, SD impact 20, SD impact 21, SD process 4, SD process 5, SD process 7, SD process 9, SD process 10, SD process 12, SD process 22, SD process 25, SD process 26, HP18, IDE.

**Recommendation 7:** evidence statements SD impact 8, SD impact 11, SD impact 14, IDE.

**Recommendation 8:** evidence statements SD impact 7, SD impact 9, SD impact 11, SD impact 12, SD impact 13, SD impact 20, SD impact 22, SD impact 23, SD impact 24, SD impact 29, SD impact 30, SD impact 32, SD impact 33, SD impact 34, IDE.

**Recommendation 9:** evidence statements HP1; HP2; HP3, HP4, HP5, HP6, HP7, HP8, HP10; HP11; HP12, HP13, HP14, SD impact 1, SD impact 2, SD impact 3, SD impact 4, SD impact 5, SD impact 6, SD impact 11, SD impact 12, SD impact 14, SD impact 15, SD impact 17, SD impact 18, SD impact 20, SD impact 22, SD impact 25, SD impact 29, SD impact 30, SD impact 33, SD impact 34, SD impact 35, IDE.

**Recommendation 10:** evidence statement HP15, IDE.

**Recommendation 11:** evidence statements SD impact 11, SD impact 14, SD impact 20, SD impact 23, IDE.

**Recommendation 12:** IDE.

### ***Evidence statements***

#### **Evidence statement HP1**

The evidence from six studies (two pre and post test studies [+ & -], one controlled before and after study [-], three case studies [-]) suggests that community coalitions used in the planning and design of an intervention may contribute to reducing the number of alcohol-related crashes, and contribute to improving a number of alcohol-related behaviours as well as improving the prevention of injuries to children, and in promoting a healthy diet in children. In terms of changing bicycle helmet use in children, community coalitions contribute to effective use; although girls are twice as likely as boys to wear helmets. Community coalitions also appear to contribute to effective promotion of physical activity through walking.

#### **Evidence statement HP2**

The evidence from one study (case study [-]) further suggests that community coalitions may result in increasing feeling within coalition members of being included in the planning and implementation of health education programmes, and thus enabling them to contribute their knowledge to others, particularly the younger generations.

#### **Evidence statement HP3**

The evidence from one study (case study [-]) indicates that community coalitions appear to be associated with the integration of a healthy lifestyle into a community norm.

#### **Evidence statement HP4**

The evidence from two studies (both RCTs [+]) suggests that peer educators may be effective in delivering health promotion related education/support in improving vaccination uptake, and decreasing unsafe sex and increasing safe sex practices.

**Evidence statement HP5**

The evidence from one study (controlled non-randomised trial [-]) suggests that in relation to increasing bicycle helmet use, peer educators may be effective for high-income groups but not low-income groups.

**Evidence statement HP6**

The evidence from one study (controlled non-randomised trial [-]) suggests that peer educators would seem to be ineffective in changing injury prevention behaviours in high-risk adolescents, although those receiving the intervention report having increased knowledge, realisation of consequences and awareness of a need for caution.

**Evidence statement HP7**

The evidence from one study (qualitative process evaluation [+]) tends to suggest that in projects that aim to improve access to healthcare through access and training in information communication technology (ICT), peer educators/community volunteers perceive ICT as a potentially useful tool to combat problems of social exclusion and social isolation.

**Evidence statement HP8**

The evidence from one study (case study [-]) also suggests that engaging peer educators in projects that specifically bring together people from different parts of a deprived city can help to dispel some of the prejudices against an area which is deemed a rough and unpopular place to live.

**Evidence statement HP10**

The evidence from three studies (one RCT [+], one controlled non-randomised trial [-] and one controlled non-randomised evaluation [-]) indicates that neighbourhood/community committees used in the planning/design of an intervention may be effective in contributing to improving diet and reducing alcohol-impaired driving, related-driving risk, traffic deaths, and injuries.

**Evidence statement HP11**

The evidence from one study (RCT [+]) suggests that a health promotion council used to plan and design activities may enable young people to make safer sex choices.

**Evidence statement HP12**

The evidence from one study (RCT [+]) further indicates that a health promotion council may be more effective with some population groups e.g. higher risk youth, and for particular approaches, for example condom promotion.

**Evidence statement HP13**

The evidence from one study (case study [-]) suggests that peer leadership groups used in planning/design may have benefits for the peer leaders in terms of enjoyment and increased confidence in undertaking planning activities.

**Evidence statement HP14**

The evidence from one study (case study [-]) suggests that community champions used in planning/design or delivery can increase their level of knowledge, skills and confidence following training and feel that they make the greatest impact in areas in which they have ownership and a stronger voice within their communities.

**Evidence statement HP15**

The evidence from one study (case study [-]) suggests that community workshops used in design and delivery of an intervention can maintain a high level of participation. In doing so they can contribute to the development of a sustainable healthy community (by improving awareness and the adoption of healthy lifestyles), to improve the image of an area, strengthen community relations and promote social inclusion.

**Evidence statement HP16**

The evidence from one study (qualitative process evaluation [+]) suggests that the devolvement of power during a project where control over the project

becomes more centralised and dominated by the interests of the statutory sector, was a barrier to the community engagement method employed.

#### **Evidence statement HP17**

The evidence from five studies (one qualitative process evaluation [+], four case studies [-]) suggests that short-term funding, with the risk of not being able to secure further funding to guarantee the long-term survival of a project, was perceived to be a major barrier to the use of community engagement methods/approaches.

#### **Evidence statement HP18**

The evidence from one study (case study [-]) further indicates that finding suitable facilities in which to hold coalition meetings and securing access to appropriate meeting places were barriers to the use of community coalitions and the delivery of interventions.

#### **Evidence statement HP19**

One study (case study [-]) tends to suggest that a major barrier to the acceptance of program design was from those community treatment and service organisations that felt threatened by the policy-based strategies.

#### **Evidence statement HP20**

The evidence from two studies (one controlled before and after study [-], one case study [-]) suggests that pre-existing groups coming to the table with their own agendas (and opposing implementation and prevention efforts) and the tendency for some individuals (related to personality and educational status) to monopolise coalition groups is a barrier to this community engagement method.

#### **Evidence statement HP21**

One study (case study [-]) also described how overwhelming coalition members with community-related responsibilities could result in a loss of such members.

**Evidence statement HP22**

The evidence from one study (case study [-]) suggests that a lack of trust by the community in service organisations was a barrier to implementing community engagement methods/approaches.

**Evidence statement SD impact 1**

Evidence from three studies (one national outcome evaluations [++], one outcome evaluation [++], one retrospective evaluations [+]) suggests that community engagement may have a positive impact on housing management.

**Evidence statement SD impact 2**

The evidence from two studies (one national outcome evaluation [++], one retrospective evaluation [+]) suggests that community involvement in housing management may have positive benefits for the completion of repairs.

**Evidence statement SD impact 3**

The evidence from one (national outcome evaluation [++]) quality study suggests that community involvement in housing management may have positive benefits in terms of re-letting times.

**Evidence statement SD impact 4**

The evidence from one (national outcome evaluation [++]) quality study suggests that community involvement in housing management may have positive benefits for rent collection.

**Evidence statement SD impact 5**

The evidence from one (outcome evaluation [++]) quality study suggests that community involvement in housing management may have positive benefits for overall performance in housing management.

**Evidence statement SD impact 6**

Evidence from one (national outcome evaluation [++]) study, with a primary focus on housing, suggests that community engagement may have a positive impact on perceptions of crime.

**Evidence statement SD impact 7**

Evidence from five studies (one rapid participatory assessment [++], three national evaluations [+] and one case study [+]) suggests that community engagement may have a positive impact on information flows and community involvement in service delivery.

**Evidence statement SD impact 8**

The evidence from two studies (rapid participatory assessment [++], qualitative case study [+]) suggests that community engagement may have positive benefits for information flows between the community and service providers.

**Evidence statement SD impact 9**

The evidence from four studies (one rapid participatory assessment [++], three national evaluations [+]) suggests that community engagement may have positive benefits for community involvement in the planning and delivery of services.

**Evidence statement SD impact 11**

Evidence from seven studies (one outcome evaluations [++], one national outcome evaluation [++], one national outcome evaluation [+], two national evaluations [+], one rapid participatory assessment [+] and one qualitative case study [+]) suggests that community engagement may have a positive impact on social capital and social cohesion.

**Evidence statement SD impact 12**

The evidence from three studies (one national outcome evaluation [++], two national evaluations [+]) suggests that community engagement may have positive benefits for 'bonding' social capital (strengthening relationships and trust among participants).

**Evidence statement SD impact 13**

The evidence from two studies (both national evaluations [+]) suggests that community engagement may have positive benefits for 'bridging' social capital (helping participants make links across sectors).

**Evidence statement SD impact 14**

The evidence from three (one national outcome evaluation [+], one national evaluation [+] and one qualitative case study [+]) studies suggests that community engagement may have positive benefits for partnership working.

**Evidence statement SD impact 15**

The evidence from two studies (one outcome evaluation [++], one rapid participatory assessment [++]) suggests that community engagement may have positive benefits for social cohesion.

**Evidence statement SD impact 16**

Evidence from four studies (one national outcome evaluation [++], one rapid participatory assessment [++], two national evaluations [+]) suggests that initiatives that aim to involve and engage communities can be successful.

**Evidence statement SD impact 17**

The evidence from two studies (one rapid participatory assessment [++], one national evaluation [+]) suggests that initiatives that aim to promote community engagement may enable community groups to successfully recruit and retain other community members as volunteers.

**Evidence statement SD impact 18**

The evidence from one (national outcome evaluation [++]) quality study suggests that initiatives that aim to promote community engagement may be more successful in involving black and minority ethnic community members than local authority initiatives without a specific community engagement focus.

**Evidence statement SD impact 19**

On the basis of two studies (one rapid participatory assessment [++], one national evaluation [+]), there is insufficient evidence to assess the 'reach' of community involvement beyond existing community groups, but those two studies tend to suggest that in some instances the 'reach' of community involvement can be limited.

**Evidence statement SD impact 20**

Evidence from seven studies (one outcome evaluation [++], one rapid participatory assessment [++], four national evaluations [+] and one national outcome evaluation [+]) suggests that community engagement may have a positive impact on the empowerment of communities

**Evidence statement SD impact 21**

The evidence from two studies (one rapid participatory assessment [++], one national evaluation [+]) suggests that direct community engagement (CE) initiatives can build capacity among participants in general terms.

**Evidence statement SD impact 22**

The evidence from three studies (national evaluations [+]) suggests that direct CE initiatives can develop the skills and knowledge of participants, particularly in terms of equipping them for regeneration activities.

**Evidence statement SD impact 23**

The evidence from two studies (one national outcome evaluation [+] and one national evaluation [+]) suggests that funding initiatives associated with community engagement can help to promote community development activities.

**Evidence statement SD impact 24**

The evidence from one (national outcome evaluation [+]) study suggests that local strategic partnerships can help to build a stronger and more united local 'voice'.

**Evidence statement SD impact 25**

The evidence from one study (outcome evaluation [++]) suggests that direct CE initiatives may empower communities by increasing community members' sense of political efficacy.

**Evidence statement SD impact 29**

Evidence from four studies (outcome evaluations [++]) (New Deal for Communities [NDC], neighbourhood management [NM], neighbourhood

wardens [NW], single regeneration budget [SRB]) suggests that indirect CE initiatives may have a positive impact on residents' perceptions of the areas in which they live.

**Evidence statement SD impact 30**

Evidence from four studies (outcome evaluations [++]) (NDC, NM, NW, SRB) suggests that indirect CE initiatives may have a positive impact on environmental and socioeconomic indicators such as employment, education and training, income, and crime.

**Evidence statement SD impact 32**

Evidence from two studies (outcome evaluations [++]) (NDC, SS) suggests that indirect CE initiatives may have a positive impact on the relationship between communities and local services.

**Evidence statement SD impact 33**

Evidence from four studies (outcome evaluations [++]) (NDC, NM, NW, SRB) suggests that indirect CE initiatives may have a positive impact on social capital.

**Evidence statement SD impact 34**

Evidence from three studies (outcome evaluations [++]) (NDC, NW, SRB) suggests that indirect CE initiatives have had no measurable impact on the level of community engagement or involvement with voluntary or community activities. However, authors from two studies (outcome evaluations [++]) note that the initiatives have led to increased access to community facilities and increased support for voluntary and community groups.

**Evidence statement SD impact 35**

Evidence from three studies (outcome evaluations [++]) (NDC, NM, NW) suggests that indirect CE initiatives may not increase residents' belief that they can influence decisions taken in their area.

### **Evidence statement SD process 1**

Fourteen good quality studies (one survey and focus groups [++], one mapping, observation of meeting and interviews [+], one interviews, survey, document analysis and observation of meetings [++], one narrative review of evaluation reports [+], one semi-structured interviews and document analysis [++], two national evaluations [+], two case studies [+], one national evaluation [++], one interviews [+], one document analysis and focus groups [+], one literature review and interviews [+]) and one observation and analysis of meetings and interviews [++]) identify the (mis)use of power by officials and elected members of local authorities as a key constraint on the process and outcome of community engagement initiatives.

### **Evidence statement SD process 2**

Two good quality studies (semi-structured interviews and document analysis [++], mapping, observation of meetings and semi-structured interviews [+]) suggest that unequal power relationships may directly affect the process and outcomes of CE initiatives by, for example, excluding marginalised groups and/or counter-voices, preventing community knowledge from modifying decision-making in transport planning and translating deliberative outputs so that they legitimise the official position rather than challenging it.

### **Evidence statement SD process 3**

One (semi-structured interviews and document analysis [++]) study also reports that some community members may be involved with officials in excluding other community members through discursive mechanisms. This study also suggests that the acquisition of knowledge about how systems work by a small number of community 'representatives' may contribute to increased inequalities and exclusion within communities.

### **Evidence statement SD process 4**

Fourteen good quality studies (one survey and focus groups [++], one mapping, observation of meeting and interviews [+], one interviews, survey, document analysis and observation of meetings [++], one narrative review of evaluation reports [+], one interviews, survey, focus groups and document

analysis [+], two national evaluations [+], one case study [+], two national evaluations [++], one interviews and survey [++], one interviews and focus groups [++], one literature review and interviews [+] and one postal survey, interviews and documentary analysis [+) provide evidence on the importance of professionals and community members having access to training in key skills for engagement (for example, community development, community leadership, negotiation, enterprise, partnership working and participatory research) and to relevant knowledge (for example, technical, policy context, understanding public sector and organisational systems and structures). The majority of these studies reported a lack of communicative knowledge and resources as a barrier to engagement.

#### **Evidence statement SD process 5**

Six good-quality studies (one face to face and telephone interviews [++], one national evaluation [++], two national evaluations [+], one postal survey, semi-structured interviews and document analysis [+], one literature review and interviews [+) provide evidence that opportunities for networking between communities and sharing experience and learning are important for the sustainability of CE processes and initiatives.

#### **Evidence statement SD process 6**

Fourteen good-quality primary studies (one survey and focus groups [++], one mapping, observation of meeting and interviews [+], one interviews, survey, document analysis and observation of meetings [++], one narrative review of evaluation reports [+], one interviews, survey, focus groups and document analysis [+], two national evaluations [+], one observation and analysis of meetings and interviews [++], two national evaluations [++], one interviews [++], one interviews and survey [++], one interviews and survey [+] and one document analysis and focus groups [+) and a narrative review (+) provide evidence that common practices in community engagement may create significant barriers across different types of social determinants initiatives and with different types of communities. These problematic practices include the organisation, style and timing of meetings, a lack of diversity in methods for engagement, inflexible funding regimes, discriminatory practices, failure to

accommodate cultural diversity, formidable time demands leading to consultation fatigue, the complexity of structures and processes for engagement and the public sector's failure to develop effective and transparent mechanisms to translate community expertise into action and ensure feedback.

#### **Evidence statement SD process 7**

Four good quality studies (one observation and analysis of meetings and structured conversations [++], one national evaluation [+]), one narrative review [+] and one case study [+) provide evidence on the particular difficulties created for groups with special access or technology needs (for example, people with disabilities, [2 {+}]; older people [2 {++}] and people living in rural areas [2 {+}, 1 {+}]).

#### **Evidence statement SD process 8**

Six good quality studies (one survey, face to face interviews, document analysis and observation of meetings [++], two national evaluations [+], one survey, interviews, focus groups and document analysis [++], one document analysis and focus groups [+] and one narrative review [+) highlight the relevance of the historical context, suggesting that practices of community engagement in the past can influence contemporary initiatives positively or negatively by affecting the level of trust and the quality of the relationship communities have with local public agencies. One study (national evaluation [+]) reports that this is a particularly severe problem in disadvantaged areas with previous experience of regeneration programmes.

#### **Evidence statement SD process 9**

Ten good quality studies (one narrative review [+], one telephone survey and face to face interviews [+], one interviews, survey, document analysis and observation of meetings [++], one narrative review of evaluation reports [+], one interviews, survey, focus groups and document analysis [+], one national evaluations [+], one case study [+], one interviews and document analysis [++], one interviews [+] and one postal survey, interviews and documentary analysis [+) evaluating initiatives covering a range of social determinants of

health and community types highlight the potential material constraints on a community's capacity to engage. These include time constraints, problems caused by poverty, low income and inflexible welfare rules and transport difficulties.

#### **Evidence statement SD process 10**

One good quality study (case study [+]) provides evidence on the particular transaction costs which may be experienced by communities living in rural areas; by BME communities (interviews, survey, focus groups and document analysis [+]) and by low-income communities (narrative review of evaluation reports [+]). However, one good quality study (telephone survey and face to face interviews [+]) and a narrative review (+) suggest that while transaction costs are important in shaping people's decisions to engage in initiatives focusing on the social determinants of health, the availability of a range of options to engage, and the quality of relationships between public agencies and communities, can be equally important.

#### **Evidence statement SD process 11**

One good quality study (mapping, observation of meetings and semi-structured interviews [+]) highlights a dichotomous image of the public among professionals and elected officials with the notion of 'the general public interest' being privileged over the concerns of particular communities, serving to marginalise their voices. Another study (national evaluation [++]) reported ambiguous attitudes among officials complaining on the one hand about the dominance of the 'usual suspects' and on the other about the lack of relevant experience among community representatives.

#### **Evidence statement SD process 12**

Three good quality studies (one mapping, observation of meetings and semi-structured interviews [+], one case study [+]) and one narrative review of evaluation reports [+]) report that a view of communities as in need of 'skilling up' and 'empowering' is dominant among professionals involved in CE initiatives, who may fail to recognise the expertise communities have or the need for organisational change to facilitate engagement. One study

(interviews [++]) suggests that public agencies tend to see community partnership as a service delivery mechanism rather than relevant to broader policy issues.

#### **Evidence statement SD process 13**

One narrative review (+) reported that women, BME communities and disabled people may experience particular problems associated with stereotyping by professionals involved in CE initiatives. Another study (survey and focus groups [++]) reported that community groups felt their legitimacy depended on how far they supported the agenda of the public and private sector interests. This was reported to be a particular problem for BME groups. Another study (interviews, survey, focus groups and document analysis [+]) suggests that funders of black voluntary and community groups fail to see the link with community engagement.

#### **Evidence statement SD process 14**

One very good quality study (national evaluation [++]) found that men's participation in a Sure Start project could be adversely affected by stereotypical attitudes towards parenthood among Sure Start workers.

#### **Evidence statement SD process 15**

Four good quality studies (one national evaluation [+], one semi-structured and depth interviews [+], one document analysis and focus groups [+]) and one semi-structured interviews and documentary analysis [++]) in the housing field suggest that communities may resist taking direct responsibility for service provision and management. However, one of these studies (semi-structured and in-depth interviews [+]) reported that despite feeling burdened by housing demolition decisions, many residents felt they should be involved.

#### **Evidence statement SD process 16**

Most of the studies reviewed made some reference to widespread frustration among community members but four good quality studies (one mapping, observation of meetings and semi-structured interviews [+], one narrative review of evaluation reports [+], one document analysis and focus groups [+]) and one semi-structured interviews and document analysis [++]) report that

the failure of CE initiatives to have any direct and discernible impact on services and/or decision-making may cause frustration among community members and lead to resistance to becoming involved on subsequent occasions. Another (national evaluation [++]) study stressed the particular difficulties of engaging with marginalised groups and suggested that this may be linked to communication failures on the part of public agencies.

#### **Evidence statement SD process 17**

At a macro strategic level two good quality studies (one survey, interviews, document analysis and observation of meetings [++] and one process evaluation [++]) suggest that the effectiveness of community engagement may be compromised when expectations are too high and, in particular, when too much reliance is placed on the ability of planning structures such as health action zones to alleviate relatively intractable social problems and tackle health inequalities.

#### **Evidence statement SD process 18**

Four good quality studies (one narrative review of evaluation reports [+], one semi-structured interviews and document analysis [++], one interviews and focus groups [++], and one semi-structured and in-depth interviews and survey [+]) raise questions about the appropriateness of deliberative approaches to community engagement, suggesting that an unrealistic emphasis placed on the pursuit of consensus undermines the process of community engagement.

#### **Evidence statement SD process 19**

Six good quality studies (one narrative review of evaluation reports [+], one semi-structured interviews and document analysis [++], one semi-structured and depth interviews and survey [+], one document analysis and focus groups [+], one national evaluation [+], and literature review and interviews [+]) report that public agencies and/or officials may be confused about the distinction between representative and participative governance, and unclear about how representation should be defined in relation to community engagement.

### **Evidence statement SD process 20**

A narrative review (+) supports the review team's impression that there is little evidence on the relative experience of different approaches to community engagement.

### **Evidence statement SD process 21**

There is good quality evidence from five studies (one survey, interviews, document analysis and observation of meetings [++], one process evaluation [++], one national process and outcome evaluation [++], one case studies [+] and one national evaluation [+]) that changes in government policy can contradict and undermine the relationship and trust between initiatives and the community members. Changes in the direction of government policy can undermine direction of established initiatives creating contradictions between an initiatives strategic direction and current government policy demands.

### **Evidence statement SD process 22**

Five good quality studies (one survey and focus groups [++], one semi-structured and in-depth interviews and survey [+], one semi-structured interviews and documentary analysis [++], one national evaluation [+] and one postal survey semi-structured interviews and documentary analysis [+]) provide direct evidence that community development skills, whether provided by specialist workers or as part of the competencies of generic workers, may play a vital role in the development and sustainability of community engagement initiatives in housing.

### **Evidence statement SD process 23**

Two good quality studies (one document analysis and focus groups [+], one semi-structured interviews and documentary analysis [++] [++]) and one narrative review (+) highlight the value of public agencies spending time building trust and relationships with communities, rather than pursuing instrumental objectives from the outset.

### **Evidence statement SD process 24**

There is good quality evidence from four studies (one postal survey semi-structured interviews and documentary analysis [+], one national evaluation

[+], one national evaluation [++] and one narrative review [+) that highlights the importance of corporate support from public agencies for community engagement initiatives and a culture that puts CE at the heart of the organisation.

#### **Evidence statement SD process 25**

Good-quality evidence from four studies (one telephone and face to face interviews [+], one postal survey semi-structured interviews and documentary analysis [+], one national evaluation [++] and one case study [+) highlights the enabling role of national and local NGOs/voluntary organisations in providing technical assistance, training and communication skills, procuring resources and acting as an 'honest broker' for smaller community initiatives.

#### **Evidence statement SD process 26**

One study (interviews, survey, focus groups and document analysis [+]) reports that membership of black voluntary and community groups may provide a pathway into wider community engagement such as becoming school governors. Similarly a (national evaluation [++]) suggests that the funding available to community engagement networks (CEN) is reaching groups previously not engaged and there is evidence of individuals progressing from CEN into other initiatives.

#### **Evidence statement SD process 27**

Six good quality studies (one interviews, survey, focus groups and document analysis [+], one document analysis and focus groups [+], two national evaluations [+], one national evaluation [++] and one survey, interviews, document analysis and observation of meetings [++]) and one narrative review (+) suggest that practices of community engagement in the past may influence contemporary initiatives positively or negatively by affecting the level of trust and the quality of the relationship communities have with local public agencies. Additionally, a (interviews [++]) study reported that in areas with past experience, officials tended to see a wider role for community engagement than those lacking this experience.

### **Evidence statement SD process 28**

One study (interviews and focus groups [++]) reports that participatory appraisal methods can be used successfully to engage large and diverse groups of people, to strengthen partnership working, to build capacity, and to develop the knowledge and skills of a community to understand issues and find sustainable solutions.

### **Evidence statement SD experience 15**

Evidence from three studies (one telephone survey, document review, focus groups and interviews [+], one interviews [++], one semi-structured interviews [+]) suggests that participants involved in consultation exercises may experience consultation fatigue.

### **Evidence statement SD experience 16**

Evidence from two studies (one interviews [++], one focus groups and questionnaires [++]) suggests that community members may experience disillusionment with engagement initiatives if their expectations of influencing decision-making are not fully realised.

### ***Additional evidence***

The evidence reviews suggest that the following community engagement approaches can achieve a number of outcomes.

### **Agents of change**

Individuals who work as 'agents of change' may benefit from new skills, increased confidence, improvements to their health and general quality of life and an improved perception of their neighbourhood. They may help:

- tackle social exclusion/isolation and crime
- develop employment, education and training opportunities
- prevent accidental injuries
- promote vaccines and safer sex.

Groups working as 'agents of change' can help:

- reduce alcohol misuse

- prevent accidents
- promote a healthy diet
- promote physical activity
- improve people's sexual health
- provide a conduit for the community's views (including the views of local black and minority ethnic groups)
- improve social cohesion
- improve people's general satisfaction with an area.

### **Neighbourhood managers**

Neighbourhood managers or people adopting similar roles can help:

- improve the quality of public services
- build community capacity (defined as the community's ability to define and solve its own problems using its various skills, assets and strengths)
- promote neighbourhood renewal
- improve people's quality of life and general perception of (and satisfaction with) the area
- empower local people to build partnerships and run community organisations.

### **Community workshops**

Running a community workshop (or similar event) can help to improve the image of an area, strengthen community relations, promote social inclusion and improve awareness of the benefits of a healthy lifestyle.

The evidence reviews also suggest that the following outcomes can be achieved when involving the local community in area-based initiatives and formal partnerships.

### **Area-based and regeneration activities**

Involving local communities in area-based and regeneration activities will help build trust and a stronger, united community 'voice'. Local input can also help:

- improve residents' perceptions of (and satisfaction with) their neighbourhood
- improve access to (and satisfaction with) community facilities and NHS services
- increase opportunities for voluntary and community groups support
- improve relations and trust within the community
- improve community relations and trust with the police and local authority
- reduce lawlessness
- reduce the number of derelict properties.

### **Formal partnerships**

Formal partnership statements can help:

- increase opportunities for joint working (both formal and informal)
- increase opportunities for consultation (on the provision of services)
- raise the profile and confidence of all those involved
- improve communications and knowledge among participants
- ensure partnership working practices are consistent.

### ***Cost-effectiveness evidence***

Only one study was found that compared the effectiveness or cost effectiveness of one community engagement approach against another – and against no intervention.

This particular study concluded that, overall, it was more cost effective to use unpaid but trained peer educators than paid experienced leaders to promote safer sex among gay and bi-sexual men. However, their cost effectiveness (compared with doing nothing) depends on how long the effect of the intervention lasts. It was estimated that if the effect only lasted 2–3 months it would not be cost effective. If, however, it lasted for a lifetime it would be very

cost effective. This study took place in North America, but similar conclusions are likely if the intervention was applied to the UK.

Few researchers have measured the effectiveness of community engagement approaches due to the following factors:

- a community engagement exercise usually takes months, years or even generations to take full effect
- it is difficult to attribute a particular outcome to engagement itself or to any particular episode of engagement
- it is difficult to define the exact engagement approach used
- it is difficult to know which component of a community engagement intervention was responsible for the accrued benefits
- it is difficult to predict what might have happened if the intervention had not taken place.

It is difficult to determine cost effectiveness because the intensity and duration of approaches may differ to a small or large degree; apparently small changes in an approach may be crucial to success. These factors cannot be controlled in a study, making it difficult to generalise. It is also difficult to use a comparator in any non-controlled situation, as it is not usually possible to say what would have happened if the intervention had not taken place.

Nevertheless, there are a few exceptional situations. For example, a flood defence project which has potential health and other benefits may be rejected by a local community because it lacks information on these benefits (or objects to specific aspects of it). If a community engagement approach were used to persuade it to accept a modified version of the project, that approach could be considered extremely cost effective.

No such examples were found in the literature, but a vignette of an ongoing project in the Teign estuary, Devon, was developed by the NICE team with assistance from the Environment Agency. This found that community engagement would be a very cost effective use of resources if it led to local agreement for new flood defence barriers.

## ***Fieldwork findings***

Fieldwork aimed to test the relevance and usefulness of the guidance and in particular the recommendations, as well as the feasibility of implementing the recommendations. The fieldwork findings were considered by the PDG in developing the final recommendations. For details, go to the fieldwork section in appendix B and visit the nice website at [www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)

Fieldwork participants were positive about the recommendations. The fact that NICE was involved was seen to reinforce the importance of engaging with local communities. The recommendations were seen to fit well with the current policy agenda.

Some participants felt they were overwhelmed with guidance in this area and did not believe the NICE document covered any 'new ground'. However, it was acknowledged that organisations less familiar with the concept of community engagement would find it useful, particularly as a 'blueprint' to check action against.

There were concerns that the guidance contained a lot of technical terms and that it was too long. Participants were also concerned that unless adequate resources were identified it would not be feasible to implement all the recommendations.

Participants felt that wider and more systematic implementation would be achieved if:

- the recommendations always implied that community engagement is 'undertaken with' rather than 'done to' communities
- there was an explanation of how the recommendations link together and whether or not some are more important than others
- there was an explanation of what resources are needed to implement the recommendations.

## **Appendix D: gaps in the evidence**

The PDG identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence.

These gaps are set out below.

1. The community engagement component of area-based and other activities to promote health or to address the wider social determinants of health was rarely defined or assessed. Research is needed to determine its contribution to long-term, population-based changes.
2. Few studies linked the mechanisms of effective community engagement with longer-term health outcomes by:
  - conducting impact and process evaluations together
  - using longitudinal designs and comparison/control groups
  - providing explicit links to theory.
3. There is a lack of evidence on how effectively different approaches achieve the various levels of community engagement. This is due both to evaluation difficulties and lack of a clear definition of terms.
4. There is a lack of evidence on how different approaches differentially affect communities and individuals within those communities.
5. There is little evidence on the costs and benefits of community engagement approaches. There is a particular lack of evidence on how involvement in community engagement approaches and area-based initiatives benefits individuals in terms of their employment prospects, subsequent income levels and health.
6. There is little publicly available evidence on the effectiveness of a variety of community engagement approaches, including the collaborative methodology and the use of health trainers and citizens' juries.

7. Few studies assess the effectiveness of using community engagement approaches to aid priority setting, resource planning or governance of an activity.
8. Many important questions about how to engage communities to improve their health remain unanswered. For example, how much time and investment (including funding) is needed before community engagement leads to health improvements?
9. There is a lack of evidence on the specific components that make a community engagement approach effective. For example, very few studies provide data to answer secondary research questions such as: 'Does effectiveness depend on the intervener?' or 'Does the intensity or duration influence effectiveness or duration of effect?'
10. There is a gap between the theory and the empirical evidence. More detail is needed on the level of involvement achieved using the various approaches identified. Most studies fail to distinguish between 'higher' degrees of community engagement (for example, providing communities with control of service planning, design, delivery or governance), and more limited involvement (such as taking part in a community arts project). In addition, there is often a lack of detail on how the community was engaged. This detail is required to validate the theoretical framework outlined in section 2 of the guidance.
11. Few studies evaluate the factors that hinder or encourage community engagement. In addition, few studies pinpoint which barriers to engagement relate to specific approaches, or which approaches overcome any barriers to engagement.
12. There is little information on what it is like to participate in community engagement initiatives at any level, or on the benefits and disadvantages of different approaches as viewed by participants.

The Group made 5 recommendations for research. These are listed in section 5.

## Appendix E: supporting documents

Supporting documents are available from the NICE website ([www.nice.org.uk/PH009](http://www.nice.org.uk/PH009)). These include the following.

- Reviews of effectiveness:
  - Review 1: ‘Community engagement in initiatives addressing the wider social determinants of health: a rapid review of evidence on impact, experience and process’
  - Review 2: ‘The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid review phase 3’.
- Economic analysis:
  - Economic appraisal 1: ‘A rapid review of the economic evidence for community engagement in health promotion’
  - Economic appraisal 2: ‘A rapid review of the economic evidence for community engagement and community development approaches in interventions or initiatives seeking to address wider determinants of health’
  - Economic appraisal 3: ‘An economic analysis/modelling of cost-effectiveness of community engagement to improve health.’
- A quick reference guide (QRG) for professionals whose remit includes public health and for interested members of the public. This is also available from NICE publications (0845 003 7783 or email [publications@nice.org.uk](mailto:publications@nice.org.uk) – quote reference number N1477).

For information on how NICE public health guidance is developed, see:

- ‘Methods for development of NICE public health guidance’ available from: [www.nice.org.uk/phmethods](http://www.nice.org.uk/phmethods)

- 'The public health guidance development process: an overview for stakeholders including public health practitioners, policy makers and the public' available from: [www.nice.org.uk/phprocess](http://www.nice.org.uk/phprocess)