NICE National Institute for Health and Care Excellence

NICE guideline

# Community engagement: improving health and wellbeing and reducing health inequalities

NICE guideline
Published: 4 March 2016
nice.org.uk/guidance/ng44

## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

# Contents

This guideline replaces PH9.

This guideline is the basis of QS148 and QS167.

## Overview

This guideline covers community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations.

The guideline complements work by Public Health England on community engagement approaches for health and wellbeing.

### *Who is it for?*

- Health and wellbeing boards, directors of public health and other strategic leads who plan, commission, scrutinise or provide local health and wellbeing initiatives in collaboration with local communities
- Local authorities, the NHS and other public sector organisations with a statutory obligation to carry out community engagement activities
- Commissioners of community engagement initiatives
- Community and voluntary sector organisations
- Members of the public

This guideline updates and replaces NICE guideline PH9 (published February 2008).

# Recommendations

This guideline updates and replaces NICE guideline PH9 (published February 2008).

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## *1.1 Overarching principles of good practice*

1.1.1 Ensure local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives (see sections 1.2 and 1.3). Do this by:

- Using evidence-based approaches to community engagement (see collaborations and partnerships and peer and lay roles).
- Being clear about which decisions people in local communities can influence and how this will happen.
- Recognising, valuing and sharing the knowledge, skills and experiences of all partners, particularly those from the local community (see learning and training).
- Making each partner's goals for community engagement clear.
- Respecting the rights of local communities to get involved as much or as little as they are able or wish to.
- Establishing and promoting social networks and the exchange of information and ideas (on issues such as different cultural priorities and values).

1.1.2 Recognise that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs time:

- plan to provide sufficient resources (see identifying the resources needed)
- start community engagement early enough to shape the proposed initiative
- establish clear ways of working for all those involved

- start evaluating community engagement activities early enough to capture all relevant outcomes (see evaluation and feedback).

1.1.3 Support and promote sustainable community engagement by encouraging local communities to get involved in all stages of a health and wellbeing initiative. Do this by:

- identifying and working with community networks and organisations, particularly those reaching vulnerable groups or recently established communities
- involving communities in setting priorities.

1.1.4 Ensure decision-making groups include members of the local community who reflect the diversity of that community. Encourage individual members to share the views of their wider networks and others in the community. Groups should adhere to the key principles outlined in this section.

1.1.5 Feed back the results of engagement to the local communities concerned, as well as other partners. This could be communicated in a range of ways, for example, via the local newspaper or community website, via community groups or via public events in community venues or other widely accessible places. See evaluation and feedback.

## *1.2 Developing collaborations and partnerships to meet local needs and priorities*

The following recommendations are for directors of public health and other strategic leads who plan, commission or provide health and wellbeing initiatives in collaboration with local communities.

1.2.1 Support development of collaborations and partnerships to encourage local communities to take part in initiatives to improve their health and wellbeing and reduce health inequalities. Use local networks and community and voluntary organisations to help achieve this.

1.2.2 Base collaborations and partnerships on local needs and priorities. Effective approaches are:

- An asset-based approach – to build on the strengths and capabilities of local communities.
- Community development – to give local communities at risk of poor health support to help identify their needs and tackle the root causes. This support comes from statutory organisations.
- Community-based participatory research – to provide collaborations and partnerships with background knowledge and insights into the nature of the community they are working with.
- Area-based initiatives – to work with local communities to improve local health and education and support urban regeneration and development to tackle social or economic disadvantage.
- Co-production methods – to ensure statutory organisations and the community can participate on an equal basis to design and deliver health and wellbeing initiatives.

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

## *1.3 Involving people in peer and lay roles to represent local needs and priorities*

The following recommendations are for directors of public health and other strategic leads who plan, commission or provide health and wellbeing initiatives in collaboration with local communities.

1.3.1 Draw on the knowledge and experience of local communities and community and voluntary organisations to identify and recruit people to represent local needs and priorities. Ask those recruited to take on peer and lay roles as part of the health and wellbeing initiative. Effective peer and lay approaches are:

- Bridging roles to establish effective links between statutory, community and voluntary organisations and the local community and to determine which types of communication would most effectively help get people involved.
- Carrying out 'peer interventions'. That is, training and supporting people to offer information and support to others, either from the same community or from similar backgrounds (see learning and training).

- Community health champions who aim to reach marginalised or vulnerable groups and help them get involved.
- Volunteer health roles whereby community members get involved in organising and delivering activities.

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

1.3.2 Consider offering training and mentoring support to community members (see learning and training). Also consider providing formal recognition of their contribution and other opportunities for development. This could include, for example, accredited training.

## *1.4 Local approach to making community engagement an integral part of health and wellbeing initiatives*

Directors of public health, other strategic leads and strategic groups[1] who plan, commission or provide health and wellbeing initiatives should:

1.4.1 Consider mechanisms that can ensure community engagement is an integral part of health and wellbeing initiatives. This could include:

- Processes that make it as easy as possible for people to get involved. See section 1.5.
- Service contracts for providers that specify the need to collaborate with local communities. See statutory obligations.
- Help for local services and organisations to build community engagement principles into their work (see section 1.1).
- Planning to ensure the resources needed for community engagement are available. See identifying the resources needed.
- Methods of monitoring, evaluating and reporting on engagement with the relevant local communities. See evaluation and feedback.
- Processes to ensure learning from community engagement is reflected in health and wellbeing initiatives, for example, in the way they are designed or targeted.

1.4.2 Follow the principles of good practice (see section 1.1) and work with local communities and community and voluntary organisations to:

- use the joint strategic needs assessment and other data to understand the demographics of local communities
- plan ways to make it as easy as possible for people to get involved (see section 1.5)
- identify the 'assets' (skills, knowledge, networks and relationships) and facilities available locally
- plan how to build on and develop these assets as part of the joint strategic needs assessment (see learning and training)
- plan how the local approach can meet public bodies' statutory obligations (see sections 1.2 and 1.3, and statutory obligations)
- act on community needs and preferences and take account of changes in these needs and preferences over time.

1.4.3 Address health inequalities by ensuring additional efforts are made to involve local communities at risk of poor health. This includes people who are vulnerable, marginalised, isolated or living in deprived areas.

## *1.5 Making it as easy as possible for people to get involved*

The following recommendations are for all those who plan and provide health and wellbeing initiatives in collaboration with local communities.

1.5.1 Work with local communities and community and voluntary organisations to:

- Identify barriers to involvement, particularly for vulnerable groups and recently established communities.
- Decide which types of communication would get people interested and involved. Include ways of communicating that reflect the needs of: vulnerable or isolated groups, recently established communities, those with low literacy or learning difficulties, and people who do not use digital or social media.

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

- Involving community members in the initiative's recruitment process (see section 1.3).
- Offering to phone, write, email, use social media or call round to see people.
- Providing information in plain English and locally spoken languages for non-English speakers. This could include encouraging members of the community who speak a community language to get involved in translating it.
- Ensuring the timing of events meets people's needs.
- Establishing and meeting the needs of participants with disabilities. For example, providing information in formats that people can understand (see NHS England's Accessible Information Standard), using venues that are fully accessible to them and providing the equipment they need.
- Providing childcare support, such as crèche facilities.
- Using places familiar to community participants and creating an informal atmosphere.
- Helping them meet mandatory requirements, for example to get disclosure and barring service checks if necessary (see the government's information on the disclosure and barring service).

## *Terms used in this guideline*

### Collaborations and partnerships

Alliances between community members and others to improve health and wellbeing and reduce health inequalities. They may include community and voluntary organisations and statutory services.

### Communities

A community is a group of people who have common characteristics or interests. Communities can be defined by: geographical location, race, ethnicity, age, occupation, a shared interest or affinity (such as religion and faith) or other common bonds, such as health need or disadvantage. People who are socially isolated are also considered to be a community group.

### Community engagement

Community engagement encompasses a range of approaches to maximise the involvement of local communities in local initiatives to improve their health and wellbeing and reduce health

inequalities. This includes: needs assessment, community development, planning, design, development, delivery and evaluation.

## Community health champions

Volunteers who, with training and support, help improve the health and wellbeing of their families, communities or workplaces. They:

- motivate and empower people to get involved in health-promoting activities
- create groups to meet local needs
- direct people to relevant support and services.

## Health and wellbeing initiatives

Health and wellbeing initiatives cover all strategies, programmes, services, activities, projects or research that aim to improve health (physical and mental) and wellbeing and reduce health inequalities.

## Peer and lay roles

'Peer and lay roles' are carried out by community members working in a non-professional capacity to support health and wellbeing initiatives. 'Lay' is the general term for a community member. 'Peer' describes a community member who shares similar life experiences to the community they are working with. Peer and lay roles may be paid or unpaid (that is, voluntary).

For other public health and social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

[1] This may include health and wellbeing boards.

## Implementation: getting started

This section highlights 3 areas of the guideline that were identified as needing support for implementation. These were identified from the available evidence on what makes for effective community engagement. Note that the principles of good practice in section 1.1 focus on removing common barriers to community engagement, based on the available evidence.

### *Identifying the resources needed*

When supporting local community engagement activities, it may be helpful for statutory organisations and their partners to:

- Ensure staff involved in health and wellbeing initiatives are allocated specific time, resources and support for community engagement.
- Work in partnership with local communities and community and voluntary organisations and groups to help identify funding requirements, sources and resources. There may be costs associated with: recruitment, learning and training, ongoing support, development opportunities and supervision of volunteers.
- Recognise that volunteers will need their expenses to be paid so that participation does not leave them out of pocket.
- Work in partnership with local communities and community and voluntary organisations and groups to:
    - make funding applications for community engagement activities and evaluation.
    - help identify access to quality, affordable space (community centres, youth hubs, schools, churches, private venues, children centres, parks).

### *Learning and training*

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

- Helping all local partners and collaborators to continually share their learning, knowledge and experiences throughout the initiative. For example, by setting up networks and forums:
    - between different local communities and community and voluntary organisations

  - within and between statutory organisations
  - between and within local communities, community and voluntary organisations and statutory sector staff.

- Working in partnership with local communities and community and voluntary organisations and groups to plan a series of learning, development and support opportunities for community participants. The aim would be to gradually build on local skills.
- Training people to become community health champions and volunteers.
- Providing ongoing training for community participants, community and voluntary organisations and statutory sector staff working in partnership to improve health and wellbeing.
- Providing joint training and opportunities for shared learning for community participants, community and voluntary organisations and statutory sector staff working in partnership to improve health and wellbeing. Topics might include:
  - community development and health
  - evaluation
  - empowering people to be involved in decisions that may influence their health and wellbeing
  - organisational change and development
  - communication and negotiation skills
  - use of computers, tablets and smartphones
  - volunteer management
  - partnership working and accountability
  - safeguarding
  - business planning and financial management
  - participatory research and evaluations
  - UK policy context for community engagement

- barriers and facilitators to statutory sector and community collaborations and partnerships.

## *Evaluation and feedback*

To support ongoing monitoring and evaluation of local health and wellbeing initiatives and to encourage joint development between those leading and funding them and the local communities involved, it may be helpful to:

- Involve community members and community and voluntary organisations in planning, designing and implementing an evaluation framework for both community engagement approaches and health and wellbeing initiatives.
- Routinely evaluate community engagement activities to see what impact they have on health and wellbeing and health inequalities, including any unexpected effects. This could include a mixture of quantitative and qualitative evidence. Use existing evaluation tools if available. Examples include the School for Public Health Research's Public Health Practice Evaluation Scheme and HM Treasury's Magenta Book – guidance on evaluation. Use a range of indicators to evaluate not only what works but in what context, as well as the costs and the experiences of those involved. For example, indicators might include measures of social capital, health and wellbeing, in addition to those identified by local communities. Identify and agree process and output evaluation objectives with members of target communities and community and voluntary organisations.
- Provide regular feedback to the local communities involved (including people and groups outside the target communities) about the positive impact of their involvement and any issues of concern.
- Document and record learning and any insights into community needs and norms, to develop future ways of involving local communities and community and voluntary organisations in health and wellbeing initiatives. Find ways to regularly monitor health and wellbeing initiatives to ensure responsibility for delivery is shared by all partners and collaborators.
- Find ways to record, share and publish local evaluations and good practice relating to community engagement with other statutory, community and voluntary organisations involved in initiatives to improve health in partnership with local communities. This includes initiatives to tackle the wider determinants of health. This could be achieved, for example, through the Joint Strategic Needs Assessment.

## *Need more help?*

Further resources are available from NICE that may help to support implementation:

- Shared learning database.

## Context

Since 'Community engagement: approaches to improve health', NICE guideline PH9 (2008), was published there has been a substantial increase in the evidence on how community engagement can improve health and wellbeing.

Involving local communities, particularly disadvantaged groups, is central to local and national strategies in England for promoting health and wellbeing and reducing health inequalities (Healthy lives, healthy people: our strategy for public health in England Department of Health; Fair society, healthy lives The Marmot Review).

Statutory obligations on public bodies recognise that the NHS and local government cannot improve people's health and wellbeing on their own. Working with local communities will lead to services that better meet people's needs, improve health and wellbeing and reduce health inequalities.

In addition to their statutory responsibilities, NHS England's Five year forward view proposes that public sector organisations should find ways to involve the voluntary sector in promoting health and wellbeing. But the Cabinet Office Community life survey 2014 to 2015 shows there has been a decline in informal volunteering since 2013/14. Levels of participation generally decrease as the level of local deprivation increases ('Community life survey 2014 to 2015').

This update reflects the importance of reciprocal relationships, particularly in areas of high deprivation. It aims to strengthen collaborations and partnerships and establish better links between statutory organisations and local communities. The aim is to ensure they can work together to deliver health and wellbeing initiatives that improve health outcomes.

### *Statutory obligations*

Public bodies have a statutory obligation to undertake community engagement. See: Health and Social Care Act 2012, National Planning Policy Framework 2012, Public Services (Social Value Act) 2012, Localism Act 2011, Equality Act 2010, Local Government and Public Involvement in Health Act 2007 and Local Government Act 2000.

## *More information*

You can also see this guideline in the NICE pathway on community engagement.

To find out what NICE has said on topics related to this guideline, see our web pages on behaviour change and community engagement.

See also the evidence reviews and information about how the guideline was developed, including details of the committee.

## The committee's discussion

### *Background*

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

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

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

Many local authorities have considerable experience of involving local communities in tackling a range of issues in different ways. The committee also recognised the significant role that community and voluntary organisations play (both directly and indirectly) in community engagement activities to improve health and wellbeing and reduce health inequalities.

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

The committee was aware that many statutory organisations are looking for new ways to get local communities involved in activities to improve their health and wellbeing and to tackle the wider determinants of health. This includes, for example, agencies involved with increasing breastfeeding rates or reducing childhood accidents. But members were concerned that these well-intentioned activities will only be effective if properly planned, designed, implemented and resourced.

The committee recognised that there are running costs associated with engaging local communities. Whether peer and lay roles are paid or unpaid is a local decision. However, unpaid roles are not actually 'free'. For example, it is important to identify and provide incentives for volunteers, such as learning and training and other development opportunities (see learning and training). Volunteers' expenses also need to be paid.

The committee discussed that although planning for such costs may be challenging, community engagement need not necessarily cost more overall, but is about a different way of working using existing resources.

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

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

## *Community engagement activities and approaches*

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

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

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

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

The committee noted that if disadvantaged communities have well established social networks, a 'bridge' is needed between these and other networks run by community, voluntary and statutory organisations. It also recognised that there is very little infrastructure in place for networking in some local communities – and that establishing such a network may take time.

Given the limited evidence base in this area, the committee considered that a central source of information on effective approaches to community engagement would be helpful. Members felt this would be particularly useful if local organisations could use it to share their learning.

## *Health and social inequalities*

Community engagement is an important way to improve health, address the social determinants of health and reduce health inequalities. Members recognised that extra effort is needed to help some local communities to get involved. The committee recognised the importance of ensuring a fair allocation of resources to local community engagement activities to benefit those most at risk of poor health.

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

Social media is becoming a commonplace way to communicate and share information among 'virtual communities' and it is a potentially efficient way of helping people to get involved. But the committee flagged that using social media could also increase health inequalities.

## *Evidence*

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

There is good evidence that community engagement improves health and wellbeing. A recent review (Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis O'Mara-Eves et al. 2013) suggested that community engagement interventions are: 'effective in improving health behaviours, health consequences, participant self-efficacy and perceived social support for disadvantaged groups'.

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

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

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

Evidence on the use of social media came from a search strategy designed to find studies about community engagement, not social media or online social networks. The committee was unable to make a recommendation on online approaches due to the lack of evidence. But members agreed to make a research recommendation on the use of social media to further explore this method of engagement (see recommendation 4 in recommendations for research).

There was good evidence that different approaches are used to target different types of health or wellbeing issues. Peer and lay roles were most often used in initiatives targeting individual behaviour change (such as physical activity, healthy eating or substance misuse). Collaborations and partnerships were more often used in initiatives focused on improving general community wellbeing, (for example, by setting priorities for health and wellbeing initiatives or regeneration of deprived areas).

The effectiveness reviews revealed variation in how much people were involved in community engagement projects, from early development through to delivery and evaluation. This variation provided an opportunity to indirectly compare the effects of different levels of engagement across studies: generally, the more stages of a project people were involved in, the greater the benefits. Members agreed that getting local communities involved as much as possible is essential for the success and sustainability of initiatives to improve health and wellbeing and address health inequalities.

The committee noted there was good evidence from expert papers that communities that received local services driven by statutory priorities were less empowered, over time, to contribute to local

decisions than communities that worked in partnership with statutory services (see expert paper 4).

As a result, the committee did not make any recommendations on using consultation approaches alone to get local communities involved in health and wellbeing initiatives.

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

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

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

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

To ensure that outcomes of importance to the community are captured, the committee made recommendations on involving local communities at every stage of the evaluation process.

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

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

There was good evidence from expert papers that community engagement can help both local authorities and health bodies meet their statutory obligations on tackling inequalities and getting communities involved in local initiatives. (see expert paper 3). But members also noted that the term 'community engagement' may be misunderstood, and that opportunities to maximise the benefits may therefore be missed. Similarly, the committee noted that some people or organisations the guideline is for may not be aware of their potential role in community engagement initiatives.

## *Health economics*

The committee recognised the opportunity costs of prioritising community engagement activities over other public health activities. Members also valued the wider health benefits of community engagement, such as improved social support and social networks, wellbeing, knowledge and self-belief. In addition, they recognised the indirect benefits, in terms of increasing participation in other healthcare and wellbeing programmes.

The committee noted that attempting to assess the cost effectiveness of community engagement approaches posed a number of significant challenges. These include the following problems:

- how to identify comparators
- how to measure benefits
- how to cost activities
- how to attribute changes in the community to the approaches deployed.

The committee noted the cost-effectiveness evidence identified in the literature reviews was mixed. There was evidence from 5 studies suggesting that community engagement is cost effective. Two studies suggested it is not cost effective and 4 studies were inconclusive. The 2 studies that covered disadvantaged groups reported that community engagement approaches targeting low income groups and families are cost effective.

The committee had concerns about the quality of the published studies, especially how they were conducted. Members felt the evidence was weak on the potential wider benefits, and the mixed

findings made it difficult to interpret. As a result, this evidence was supplemented with several bespoke cost–consequences analyses and a rapid review of relevant social-return-on-investment studies.

The committee considered that a cost–consequence analysis was the most appropriate type of economic analysis, given the wide range of outcomes relevant to community engagement. The evidence from this analysis suggested that individual empowerment and the development of a feeling of belonging or 'social capital' provide direct health benefits.

The committee also agreed that evidence on the social-return-on-investment analysis should be considered because it is used to analyse 'value' beyond the financial cost (although some of the value it captures may have been paid for). Just as importantly, it aligns well with the concept of community engagement as: 'the process of getting communities involved in decisions that affect them'[2].

The committee noted the evidence reviews identified multiple examples of community engagement. The 3 case studies selected for cost–consequence analyses (see the cost-consequence analysis report) were chosen to represent the different types of theoretical approach identified in the original Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI) review ('Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis').

The committee noted the studies reported a range of benefits, including health benefits, from relatively low cost interventions (albeit based on retrospective estimates that may be incomplete). Health effects included: improved cancer awareness and mental wellbeing, increased breastfeeding rates, reduced postnatal depression, reduced childhood accidents and fewer cases of asthma. They also included improved access to health services and increased uptake of interventions known to be cost effective.

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

The committee considered that the costs involved in recruiting, training and providing ongoing support for volunteers could be offset by the value of the activities provided by the volunteers (as evidenced in the cost-consequences analyses). This view is supported by a national report

highlighted by the committee (Volunteering in the public services: health and social care Cabinet Office). This estimated that for each £1 of investment in volunteer support, small voluntary organisations gained between £2 and £8 of value from their volunteers.

In addition, the Cabinet Office calculated that the monetary value of volunteering, in terms of improvements in the wellbeing of the volunteers themselves, was £13,500 per person per year (Wellbeing and civil society: estimating the value of volunteering using subjective wellbeing data Department for Work and Pensions). Given this evidence of value for money, for both the volunteers and wider society, the committee believed it was important to support and sustain volunteering.

The committee noted that although the costs and benefits are picked up in different sectors, the public sector system as a whole is likely to benefit.

The committee believed that community engagement does not necessarily need extra money. Rather it considered community engagement to be a different way of working using existing resources. Indeed, the committee viewed the wide ranging benefits and virtuous cycle (such as volunteers going on to secure paid employment) as having the potential to make better use of scarce resources. In that regard, the committee considered community engagement good value for money.

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

## *Evidence reviews*

The guideline recommendations are based on the best available evidence. Listed below are the evidence statements that provide the best available evidence and are directly linked to the recommendations. Evidence from the health economics work underpins all recommendations in this guideline. The complete list of evidence statements includes an overview of the economic evidence.

### How the evidence and expert papers link to the recommendations

Details of the evidence discussed are in the evidence reviews, reports and papers from experts in the area. Expert reports are reports that have been commissioned; expert papers are from expert testimony provided freely. The evidence statements are short summaries of evidence. Each statement has a short code indicating which document the evidence has come from.

**Evidence statement (ES) 1.1** indicates that the linked statement is numbered 1 in review 1. **ES2.3.1** indicates that the linked statement is numbered 3.1 in review 2. **ER1** indicates that expert report 1 'Community engagement strategies to reduce health inequalities: a multi-method systematic review of complex interventions' is linked to a recommendation. **EP1** indicates that expert paper 1 'The family of community-centred approaches for health and wellbeing' is linked to a recommendation. **EP2** indicates that expert paper 2 'Can community-based peer support promote health literacy and reduce inequalities? A realist review' is linked to a recommendation. **EP3** indicates that expert paper 3 'NICE community engagement guidance: current context – strategies, drivers and challenges' is linked to a recommendation. **EP4** indicates that expert paper 4 'The impact of community involvement in the New Deal for Communities regeneration initiative and the Public Involvement Impact Assessment Framework' is linked to a recommendation. **PR1** indicates that primary research report 1 'Community engagement – approaches to improve health: map of current practice based on a case study approach' is linked to a recommendation.

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

**Recommendation 1.1.1**: ES1.1, ES1.2, ES1.3, ES2.1.3, ES2.3.1, ES2.4, ES2.5, ES4.5, ES5.1.1, ES5.2.3, ES5.2.5, ES5.3.1, ES5.3.2, ES5.3.4; ES5.3.11, ES5.3.12, ES5.3.13, ES5.3.14, ES5.3.15, ES5.4.1, ES5.4.1, ES5.4.3, ES5.4.4, ES5.4.5, ES5.4.6, ES5.5.4, ES5.5.5, ES5.6.1, ES5.6.2; EP1, EP2, EP3, EP4; ER1; PR1

**Recommendation 1.1.2**: ES1.1, ES1.2, ES1.3, ES2.1.3, ES2.4, ES2.5, ES2.3.1, ES5.1.1, ES5.1.2, ES5.1.4, ES5.2.1, ES5.3.3, ES5.3.4, ES5.3.6, ES5.3.14, ES5.3.16; EP4; PR1

**Recommendation 1.1.3**: ES1.1.3, ES1.4, ES1.5, ES1.6, ESS1.7, ES1.8, ES1.9, ES1.10, ES1.11, ES, 1.2, ES1.13, ES2.2.3, ES2.3.1, ES4.4, ES5.5.4; EP2, EP4; PR1

**Recommendation 1.1.4**: EP2, EP4; PR1

**Recommendation 1.1.5**: ES5.6.6; EP3; PR1

**Recommendation 1.2.1**: ES1.1, ES1.2, ES1.3, ES2.3.1, ES2.4, ES2.5, ES4.1, ES4.3, ES4.4, ES4.5, ES5.3.12, ES5.5.4, ES5.5.5; ER1; EP1, EP2, EP3, EP4; PR1

**Recommendation 1.2.2**: ES5.5.5; EP1; PR1

**Recommendation 1.3.1**: ES2.3.1, ES3.5, ES4.1, ES4.3, ES4.4, ES4.5, ES5.1.4, ES5.4.1, ES5.4.2, ES5.4.3, ES5.4.4, ES5.4.5, ES5.4.6, ES5.5.4, ES5.5.5, ES5.5.6; ER1; EP1, EP2, EP3; PR1

**Recommendation 1.3.2**: ES2.3.1, ES5.4.1, ES5.4.2, ES5.4.3, ES5.4.4, ES5.4.5, ES5.4.6; EP2; PR1

**Recommendation 1.4.1:** ES1.1, ES1.2, ES1.3, ES2.2.3, ES2.3.1, ES4.2, ES5.1.4, ES5.2.1, ES5.2.2, ES5.2.4, ES5.3.3, ES5.3.5, ES5.3.9; ES5.3.10, ES5.3.16, ES5.4, ES5.5.1, ES5.5.2, ES5.6.2, ES5.6.3, ES5.6.4, ES5.6.5, ES5.6.6, ES5.6.7, ES5.6.8, ES5.6.9E; P1, EP2, EP3, EP4; PR1

**Recommendation 1.4.2**: ES4.2, ES5.3.9; EP2, EP3, EP4; PR1

**Recommendation 1.4.3**: ES1.1, ES1.2, ES1.3, ES1.4, ES1.5, ES1.6, ES1.7, ES1.8, ES1.9, ES1.10, ES1.11, ES1.12, ES1.13, ES2.1.3, ES2.2.3, ES2.3.1, ES5.3.5, ES5.3.9; ER1; EP1, EP2, EP3, EP4; PR1

**Recommendation 1.5.1**: ES2.3.1, ES5.5.3, ES5.5.5, ES5.6.1, ES5.6.3, ES5.6.6; EP2; PR1

**Recommendation 1.5.2**: ES5.2.2, ES5.5.1, ES5.5.2, ES5.6.2, ES5.6.3, ES5.6.4, ES5.6.5, ES5.6.6, ES5.6.7, ES5.6.8, ES5.6.9; EP2; PR1

### *Implementation*

**Identifying the resources needed**: ES2.3.1, ES4.5, ES5.1.4, ES5.2.1, ES5.2.4, ES5.3.3, ES5.3.6, ES5.3.16; ES5.3.17; ER1; EP2, EP3; PR1

**Learning and training**: ES2.3.1, ES5.2.4, ES5.2.5, ES5.4.1, ES5.4.2, ES5.4.3, ES5.4.4, ES5.4.5, ES5.4.6, ES5.3.15, ES5.4; ER1; EP3; PR1

**Evaluation and feedback**: ES1.1, ES1.2, ES.13, ES2.1.3, ES2.2, ES2.3.1, ES2.5, ES4.5, ES5.3.10; ER1; EP2, EP3, EP4; PR1

## *Gaps in the evidence*

The committee's assessment of the evidence, stakeholder and expert comment on community engagement identified a number of gaps. These gaps are set out below.

1. Studies of the effectiveness of collaborations and partnerships, including those involving older people and those covering recently established communities.

(Source: evidence review 1)

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

(Source: evidence reviews 1, 2 and 3)

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

(Source: evidence reviews 1 and 7)

4. Studies on what comparators to use in a community engagement study.

(Source: evidence reviews 1 and 7)

5. Studies of community engagement in a rural environment.

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

6. Studies of community engagement addressing reproductive health, parenting or violence prevention.

(Source: evidence review 1)

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

(Source: evidence review 4)

8. Studies of community engagement approaches that have failed.

(Source: primary research report 1)

[2] Popay J (2006) Community empowerment and health improvement: the English experience. In: Morgan A, Davies M, Ziglio E (Editors) (2010) Health assets in a global context: theory, methods, action. New York: Springer, p183–195.

## Recommendations for research

The guideline committee has made the following recommendations for research. In line with the principles of best practice (section 1.1), research should be undertaken in collaboration with local communities.

### *1 Effectiveness and cost effectiveness*

Are particular components of community engagement approaches more effective and cost effective at improving health and wellbeing and reducing health inequalities than other components?

#### Why this is important

There is some evidence that community engagement improves health and wellbeing and reduces health inequalities. But studies are needed that consider both effectiveness and cost effectiveness of specific components of community engagement approaches, include a suitable comparator, and use combined impact and process evaluations. Evidence on a range of outcomes is needed, including:

- effectiveness in relation to setting local priorities
- outcomes identified by communities themselves
- health outcomes
- wider social outcomes, such as increased social capital, capacity and empowerment.

### *2 Evaluation frameworks and logic models*

Which evaluation frameworks and logic models can be used to evaluate the impact of community engagement on health and wellbeing?

#### Why this is important

Various frameworks and logic models are often cited in published interventions but they usually lack detail and their usefulness is unclear. Studies are needed to determine the key components of an 'evaluative framework' that could be used for community engagement.

Establishing a shared framework for evaluation would also aid comparison and consistency within and between approaches.

## *3 Collaborations and partnerships*

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

### Why this is important

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

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

## *4 Social media*

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

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

### Why this is important

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

## Update information

**March 2016:** This guideline updates and replaces NICE guideline PH9 (published February 2008).

**Minor changes since publication**

**May 2016:** Recommendation 1.5.2 was amended to clarify the potential use of the NHS Accessible Information Standard.

# Glossary

## *Volunteers*

Volunteers are community members in unpaid roles.

ISBN: 978-1-4731-1758-7

## *Accreditation*