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NHS
National Institute for Health and Clinical Excellence

Quick reference guide

Community engagement

This quick reference guide summarises the recommendations made on 'Community engagement to improve health'. The guidance aims to support those working with and involving communities in decisions on health improvement that affect them. It is for people 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 will also be of interest to members of the public.

Different levels of community engagement (for example, informing, consulting, delegating power) could directly and indirectly affect health in both the intermediate and longer term. A variety of approaches can contribute to successful community engagement at these different levels. Some approaches used to inform (or consult with) communities – such as a workshop – may have a marginal impact on health. Nevertheless, these activities may have an impact on the appropriateness, accessibility and uptake of services. Approaches that help communities to work as equal partners, or delegate some power to them – or provide them with total control – may lead to more positive health outcomes.

The recommendations are based on the principles of engagement detailed in several government policies. These policies seek to ensure local authorities and the NHS consult and involve local communities in decisions related to policy, service delivery and quality of life.

These recommendations do not refer to specific populations, but it is important to identify groups that are under-represented and/or at increased risk of poor health.

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

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health. 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 and the wider public, voluntary and community sectors should take it into account when carrying out their professional, managerial or voluntary duties.

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Who should take action

The recommendations are for four groups:

- **Group A**: People involved in the planning (including coordination), design, funding and evaluation of national, regional and local policy initiatives. See recommendation 1 on page 4.
- **Group B**: **Commissioners and providers** 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.

  See recommendations 2–11 on pages 4–11.
- **Group C**: Members of community organisations and groups and community representatives involved in:
  - health promotion activities
  - activities which aim to address the wider social determinants of health
  - area-based initiatives.

  See recommendations 2–11 on pages 4–11.
- **Group D**: People who commission, plan, design, deliver and manage community engagement activities. See recommendation 12 on page 12.

It is important to note that the ordering of the groups does not imply a hierarchy of importance.

Together, the recommendations present the ideal scenario for effective community engagement. They cover four 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. Harm may be caused when elements of the prerequisites 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.

Terms printed in **bold** are explained in the key to terms on page 14

Prerequisites

These recommendations aim to put in place the essential conditions for effective community engagement. These conditions include the coordinated implementation of relevant policy initiatives, a commitment to long-term investment, an openness to organisational and cultural change, a willingness to share power, and the development of mutual trust and respect.

The following recommendation is for people in Group A[1]

Recommendation	Action
1: Policy development	• 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.

The following four recommendations are for people in Groups B and C[1]

Recommendation	Action
2: Long-term investment	• 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.

[1] For a definition of people included in each group see Who should take action on page 3

The following four recommendations are for people in Groups B and C[1] *continued*

Recommendation	Action
3: Organisation and cultural change	• 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, to 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 providing 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.
4: Levels of engagement and power	• 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.

[1] For a definition of people included in each group see Who should take action on page 3

The following four recommendations are for people in Groups B and C[1] *continued*

Recommendation	Action
4: Levels of engagement and power *continued*	• 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 includes: – 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 creche 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).

[1] For a definition of people included in each group see Who should take action on page 3

The following four recommendations are for people in Groups B and C[1] *continued*	
Recommendation	**Action**
5: Mutual trust and respect	• 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.

[1] For a definition of people included in each group see Who should take action on page 3

Infrastructure

Once the prerequisites have been met it is easier to set up the infrastructure required to implement effective practice, which includes appropriate training and development, formal mechanisms to endorse partnership working, and support for effective implementation of area-based initiatives.

The following three recommendations are for people in Group B and Group C[1]

Recommendation	Action
6: Training and resources	• 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 dealing 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.

[1] For a definition of people included in each group see Who should take action on page 3

The following three recommendations are for people in Group B and Group C[1] *continued*	
Recommendation	**Action**
7: Partnership working	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.
8: Area-based initiatives	• 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 local strategic partnerships, **local area agreements** and comprehensive area assessments).

[1] For a definition of people included in each group see Who should take action on page 3

Approaches

These are the approaches that can be used to encourage local communities to become involved in health promotion activities and area-based initiatives to address wider social determinants of health.

The following three recommendations are for people in Group B and Group C[1]

Recommendation	Action
9: Community members as agents of change	• 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).

[1] For a definition of people included in each group see Who should take action on page 3

The following three recommendations are for people in Group B and Group C[1] *continued*

Recommendation	Action
10: Community workshops	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 event(s) should be co-managed by professionals and members of the community and held at a local venue.
11: Resident consultancy	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.

[1] For a definition of people included in each group see Who should take action on page 3

Evaluation

Improving the quality of the evidence is a continuing process. Better evaluation processes are needed to increase understanding of how community engagement and the different approaches impact on health and social outcomes.

The following recommendation is for people in Group D[1]

Recommendation	Action
12: Evaluation	• 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 involved 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).

[1] For a definition of people included in each group see Who should take action on page 3

Key to terms

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.

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 people living within the same geographical location (such as a hostel, a street, a ward, town or region).

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/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.

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.

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 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.

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 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 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 antisocial 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.

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 others' opinions.

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.

Implementation tools

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

Further information

You can download the following documents from www.nice.org.uk/PH009

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

For printed copes of the quick reference guide, NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote N1477.

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

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.

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