



**INSTITUTE FOR HEALTH AND  
HUMAN DEVELOPMENT**



# **Review 5: Evidence review of barriers to, and facilitators of, community engagement approaches and practices in the UK**

**Final Report October 2015**

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## GLOSSARY

**Altogether Better** Altogether Better is based across Yorkshire and is based on an empowerment model and at the heart of this model is the concept that community health champions can be equipped with the knowledge, confidence and skills to make a difference in their communities. Altogether Better projects recruit people from a range of different communities and target groups to become community health champions.

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

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

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

**Community development** A process where community members come together to take collective action and generate solutions to common problems (United Nations 1995<sup>i</sup>)

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

**Co-production** Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours<sup>ii</sup>.

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

**Govanhill Equally Well Test Site** Equally Well – the report of the Scottish Ministerial Task Force on Health Inequalities spelt out the key determinants of health inequalities in Scotland and prioritised cross-cutting partnership activity as the vehicle for achieving measurable outcomes in reducing these. Equally Well asked Community Health Care Partnerships and Community Planning Partners to develop 'test sites' where innovative

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<sup>i</sup><http://unterm.un.org/DGAACS/unterm.nsf/8fa942046ff7601c85256983007ca4d8/526c2eaba978f007852569fd00036819?OpenDocument>

<sup>ii</sup> New Economics Foundation

approaches to service design and delivery for tackling health inequalities could be developed and tried<sup>iii</sup>.

**Health Champions** Health Champions are people who, with training and support, voluntarily bring their ability to relate to people and their own life experience to transform **health** and well-being in their communities<sup>iv</sup>. Health Champions operate in a variety of settings e.g. GP Surgeries, Area-based Health Initiatives.

**Health trainers** Health trainers help people to develop healthier behaviour and lifestyles in their own local communities. They offer practical support to change their behaviour to achieve their own choices and goals. Health Trainers are trained to engage with local people and support them in engaging with a specific Personal Health Plan (PHP) which they tailor make for the client<sup>v</sup>. Health trainers can also be called Health Trainer Champions, Health Ambassadors, Health Check Advisors etc.

**Healthy Living Centres** The Healthy Living Centre (HLC) programme was set up in 1998 to fund community level interventions to address health inequalities and improve health and wellbeing. The programme funded 351 HLCs, which generated activities, tailored to the needs of their local communities. These operated on a number of different models – some based mainly within one central building, while others functioned as partnerships or networks of activities run by different organisations at a number of different sites. Some HLCs focused on specific health-related services, but many addressed the wider determinants of health inequalities, such as social isolation, unemployment and poverty<sup>vi</sup>.

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

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

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

**National Empowerment Partnership** The National Empowerment Partnership (NEP) programme, launched by the Department for Communities and Local Government in 2007, ran until March 2011. Managed by the Community Development Foundation, the programme was delivered at a regional level through nine regional empowerment

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<sup>iii</sup> Harkins C, Egan J (2012) *Partnership approaches to address local health inequalities: final evaluation report from the Govanhill Equally Well test site*. Glasgow: Glasgow Centre for Population Health.

<sup>iv</sup> <http://www.altogetherbetter.org.uk/health-champions>

<sup>v</sup> <http://www.nhscareers.nhs.uk/explore-by-career/wider-healthcare-team/careers-in-the-wider-healthcare-team/clinical-support-staff/health-trainer/>

<sup>vi</sup> Hills et al (2007) *The Evaluation of the Big Lottery Fund Healthy Living Centres Programme*. London: Tavistock Institute and Bridge Consortium.

partnerships (REPs). A national programme of activity, along with programme management support, ran alongside the regional work commissioned, coordinated and conducted by REPs<sup>vii</sup>.

**New Deal for Communities** The New Deal for Communities (NDC) Programme was launched in 1998 and was a flagship component to the then government's National Strategy for Neighbourhood Renewal. NDC is an Area Based Initiative (ABI) in that the Programme was implemented by dedicated NDC Partnerships charged with transforming 39 deprived English localities over ten years; designed to achieve change in six key outcome areas - education, health, crime, worklessness, housing and the physical environment, and liveability; driven through strategic plans drawn up by NDC Partnerships in cooperation with existing delivery agencies; premised on the assumption that the 'community is at the heart' of neighbourhood renewal<sup>viii</sup>.

**Non-peer health advocacy** Possible roles are similar to those under "peer involvement" but involve members of the community that are not peers of the target participants.

**Participatory budgeting** Participatory budgeting (PB) is a different way to manage public money, and to engage people in government. It is a democratic process in which community members directly decide how to spend part of a public budget<sup>ix</sup>.

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

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

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

**Social Inclusion Partnerships** Scottish Social Inclusion Partnerships (SIPs) were funded to tackle local health inequalities and social exclusion using a health promotion, partnership and community-led approach<sup>x</sup>.

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<sup>vii</sup> Sender et al (2011) *National Empowerment Partnership (NEP) Programme. Final Evaluation Report*. London: Community Development Foundation. London: Community Development Foundation.

<sup>viii</sup> Lawless P, Dickinson S, Fordham G, Fuller C, Meegan R, Wells P (2007) *NDC National Evaluation Phase 2: The six case studies: an introduction*. Sheffield: Centre for Regional Economic and Social Research.

<sup>ix</sup> <http://www.participatorybudgeting.org/about-participatory-budgeting/what-is-pb/>

<sup>x</sup> Carlisle S (2010) Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a Social Inclusion Partnership in Scotland. *Critical Public Health*. 20(No. 1): 117-127.

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

**Sure Start** The core purpose of Sure Start children’s centres is to improve outcomes for young children and their families, with a particular focus on those in greatest need. They work to make sure all children are properly prepared for school, regardless of background or family circumstances. They also offer support to parents<sup>xi</sup>.

**Timebanking** Timebanking is a means of exchange used to organise people and organisations around a purpose, where time is the principal currency. For every hour participants ‘deposit’ in a timebank, perhaps by giving practical help and support to others, they are able to ‘withdraw’ equivalent support in time when they themselves are in need<sup>xii</sup>.

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

**Well London** Well London is a community development, community engagement and co-production approach and framework. Now in “Phase 3” of delivery, in Phase 1 Well London worked in 20 of the most disadvantaged neighbourhoods across 20 London boroughs, delivering a menu of core and themed projects to help residents improve their health and wellbeing<sup>xiii</sup>.

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<sup>xi</sup> <https://www.gov.uk/sure-start-childrens-centres-local-authorities-duties>

<sup>xii</sup> <http://www.timebanking.org/about/what-is-timebanking/>

<sup>xiii</sup> <http://www.welllondon.org.uk/>



# 1 EXECUTIVE SUMMARY

## 1.1 INTRODUCTION

Community engagement in public health is about people improving their health and wellbeing by helping to design, develop, deliver and evaluate local services and interventions. Community engagement can involve varying degrees of participation and control: for example, giving views on a local health issue, jointly delivering services with public service providers, or completely controlling services. Theory and emerging evidence suggest that the more a community of people is supported to take control of activities to improve their lives, the more likely their health will improve (Popay et al. 2007).

Since the publication of The National Institute for Health and Care Excellence’s guidance on community engagement in 2008 (NICE public health guidance 9) there has been considerable research activity in this topic area. A recent NIHR review (O’Mara-Eves et al. 2013) which focused on community engagement for health inequalities found 319 relevant studies, and concluded that community engagement interventions “are effective in improving health behaviours, health consequences, participant self-efficacy and perceived social support for disadvantaged groups”.

The Centre for Public Health at NICE are now updating the 2008 NICE guidance on community engagement and reducing health inequalities, and this update includes three streams of evidence: i) *Stream 1* - a report on current effectiveness including integral process evidence and an analysis of effective components; ii) *Stream 2* - a report of the UK qualitative evidence including a map (component 1a) and case studies (component 1b) and a review of barriers and facilitators (component 2); and iii) an economic analysis. This report describes the second component of the second stream focused on reviewing the evidence about barriers to, and facilitators of, community engagement.

## 1.2 AIMS AND REVIEW QUESTIONS

This review aimed to synthesise empirical evidence from qualitative and other types of studies conducted in the UK on the factors that hinder or support effective community engagement process and practice. It aimed to assess the current evidence base for UK local and national policy and practice for community engagement. For this review, we have defined community engagement as the “direct or indirect process of involving communities in decision making and/or in the planning, design, governance and delivery of services, using methods of consultation, collaboration, and/or community control’ (O’Mara-Eves et al. 2013).”

It addressed the following review questions:

- What barriers and facilitators affect the delivery of effective community engagement activities – particularly to people from disadvantaged groups?

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

Within the above we sought to explore a range of more specific issues and questions including: the factors that help or hinder communities to get involved in community engagement activities and how to build capacity and motivation; how local context, and the associated political, health and community structures and systems support or hamper community engagement; and how professionals can learn to better engage, and act on the suggestions from, communities.

### 1.3 METHODS

#### *a) Search strategy*

Our search strategy was designed in collaboration with our consortium partner, the EPPI-Centre, who carried out the effectiveness review for the first stream of evidence work commissioned to underpin the updated NICE guidance. Given the difficulties of identifying studies via traditional electronic database searches we focused our search efforts on specialised research registers and websites: the pool of included and excluded studies from the recent NIHR community engagement review (O'Mara-Eves et al. 2013); an update of these searches carried out for Stream 1 which included a search of specialist systematic review websites and databases (Database of Promoting Health Effectiveness Reviews (DoPHER); Database of Abstracts of Reviews of Effectiveness (DARE); the Cochrane Database of Systematic Reviews, the Campbell Library, the Health Technology Assessment programme website) and a search of the Trials Register of Promoting Health Interventions (TRoPHI) database of primary studies in health promotion and public health; the results of searches carried out for a recent mapping review of community based interventions for Public Health England; mining of relevant systematic reviews obtained from any of these sources; extensive website searches of relevant organisations; direct calls for evidence by NICE and by Leeds Beckett University via extensive networks of contacts with community practitioners and groups; and backward and forward citation searching.

#### *a) Screening*

Titles and abstracts identified from all searches were assessed using the following criteria:

- 1 DATE: published date in 2000 or later
- 2 COUNTRY: UK only. Reports describing non-UK studies were excluded.
- 3 INTERVENTION: only reports describing community engagement in public health related topics were included.
- 4 STUDY DESIGN: only reports describing primary research employing a qualitative, mixed methods or process evaluation design were included.

The inclusion criteria were tested and refined after piloting them on a random sample of 10% of the titles and abstracts. A team of seven reviewers independently screened these records and any differences were resolved by discussion and where necessary, informed by the advice of the NICE CPH team. Further pilot screening was conducted on an additional 10% of records until at least 80% agreement between reviewers was reached. Once this level of reliability was reached the remaining records were randomly divided between seven reviewers for single screening. All included records were marked for full text retrieval. The same process was followed for screening full text reports.

Full text reports were screened with a modified version of criteria 4 (only reports describing a piece of primary research *with discernible methods and findings* employing a qualitative, mixed methods or process evaluation design were included) and an additional fifth criteria whereby only those studies reporting findings on barriers and facilitators were included. Following discussion with the NICE team inclusion of studies in the barriers and facilitators review was further restricted to a) those reports which involved 'community partnerships/coalitions' or 'community mobilisation/action' (in line with the focus of Stream 1's work) and b) reports published in 2007 or later as a pragmatic approach which also avoids duplication of effort with a previous review commissioned by NICE which reviewed evidence on barriers and facilitators to community engagement (Popay et al., 2007). This review was undertaken to inform NICE guidance on community engagement in 2008 (NICE public health guidance 9).

#### *c) Quality assessment and data extraction*

All included studies were quality-assessed using the tool for qualitative studies detailed in Appendix H of the Methods for the development of NICE public health guidance (NICE, 2012). Each study was assigned an overall quality rating: [++], high quality; [+], medium quality; or [-], low quality. Data were extracted on the health focus, population targeted, type, level and extent of community engagement, research aims/questions, theoretical framework, funding, methods of sampling, data collection and analysis and findings on barriers and facilitators, using the format of evidence tables for qualitative studies in Appendix K of the Methods for the development of NICE public health guidance (NICE, 2012) as a guide. All reviewers undertook quality assessment and data extraction on a sample of studies independently and then met to compare assessments. Disagreements were resolved through discussion. This process was undertaken on approximately 10% of included studies until good agreement was reached (at least 80% inter-rater agreement on overall scoring for quality assessment). Once this level of agreement was reached the remaining records were randomly divided between reviewers for single quality assessment and data extraction. One reviewer (Angela Harden) oversaw the whole process and checked quality ratings and data extracted. Summaries of the characteristics, methods, quality rating and findings of each study were compiled into evidence tables.

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

#### *d) Synthesis methods*

Our approach to synthesis broadly followed methods for ‘framework synthesis’ which offers a structured but flexible approach to organising and analysing study findings. We drew on two existing community engagement frameworks (O’Mara-Eves et al., 2013; Popay et al., 2007) to analyse the barriers and facilitators found in our included studies. The framework from O’Mara-Eves et al. (2013) identifies a range of dimensions by which community engagement interventions may differ from one another, and provides a framework within which to understand how different interventions may function. The framework from Popay et al. (2007) presents categories of barriers and facilitators to community engagement. One reviewer (Kevin Sheridan) looked for common barriers and facilitators across studies and grouped these using categories from the two frameworks when possible and using modified or new categories as necessary. The results of this process were checked by a second reviewer (Angela Harden) and further revisions made to the final themes and associated barriers and facilitators.

## 1.4 FINDINGS

A total of 4889 titles and abstracts were identified for initial screening for the map. After the first screening stage, 4321 records were excluded and 568 records were marked for full text retrieval. Of these, 281 were marked as potentially relevant for the barriers and facilitators review because they were published in 2000 or later and they appeared to: have been carried out in the UK; be focused on community engagement in public health; and be a piece of primary research employing a qualitative, mixed methods or process evaluation design. Full text reports were obtained for 267 of the 281 records and these were re-screened for inclusion. From these 267 reports, 107 were eligible for inclusion. Following discussion with the NICE team, of these 107 reports we only included those which involved ‘community partnerships/coalitions’ or ‘community mobilisation/action’ (in line with the focus of Stream 1’s work) and those published in 2007 or later. A total of 35 included reports which described 34 separate studies were included in the review.

All but three of these studies included a process evaluation of a community engagement project or programme which explored barriers and facilitators to the community engagement. Methods used to explore barriers and facilitators were qualitative, consisting of in-depth interviews and/or focus groups. Two studies were mixed methods studies, one combining a survey with qualitative interviews, and one study used qualitative methods alone.

Studies aimed to examine community engagement initiatives focused on a range of health issues, although the largest number were not focused on single health topics but on broader themes such as community well-being, social capital and cohesion, or general health. There were high levels of community engagement reported in the design and delivery elements of services, interventions or programmes, but only four studies were rated as having high levels of community engagement in the evaluation of initiatives.

Findings on barriers and facilitators were organised within six broad themes ordered within three areas: ‘context’, ‘infrastructure’ and ‘process’. In this section we present a summary of the barriers and facilitators identified in the review (Table 1.1) followed by the evidence statements associated within each theme.

Table 1.1 Overview of barriers and facilitators identified in the synthesis

Area	Theme	Barriers	Facilitators
C O N T E X T	Quality of existing relationships with communities	<ul style="list-style-type: none"> <li>*History of poor relations</li> <li>*Community engagement as a threat</li> </ul>	
	Organisational culture, attitudes and practice	<ul style="list-style-type: none"> <li>*Lack of organisational commitment</li> <li>*Resistance to sharing power and control</li> <li>*Limited vision of community engagement in terms of:               <ul style="list-style-type: none"> <li>- who can be involved</li> <li>- what they can do</li> <li>- value of their experience</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>*Supportive culture, attitudes and practice embedded within the organisation from the start</li> <li>*Supportive culture, attitudes and practice triggered or reinforced during engagement</li> </ul>
I N F R A S T R U C T U R E	Investment in infrastructure and planning to support community engagement	<ul style="list-style-type: none"> <li>* Lack of clarity, lack of transparency and confused expectations</li> <li>*Competing agendas across stakeholders within partnerships</li> <li>*Lack of dedicated staff and resources</li> <li>*Limited timelines for building trust and achieving scope and depth</li> </ul>	<ul style="list-style-type: none"> <li>*Planned rather than ad-hoc community engagement strategy and methods</li> <li>*Clarity of goals and transparency of process</li> <li>*Joint decision making</li> <li>*Community engagement as a transactional and reciprocal process</li> <li>*Establishing or using existing partnerships and networks</li> <li>*Investing time, effort and resources to build relationships and trust</li> <li>*Dedicated staff</li> </ul>
	Support, training and capacity building	<ul style="list-style-type: none"> <li>*Lack of appropriate training for professionals</li> <li>*Lack of appropriate training for communities</li> </ul>	<ul style="list-style-type: none"> <li>*Mentoring and other forms of support for community members</li> <li>*Community capacity building as an important end goal</li> </ul>

IN FR A- ST RU CT UR E			
P R O C E S S	<b>Capabilitie s and the engagem ent process</b>	<ul style="list-style-type: none"> <li>*Lack of capacity within communities</li> <li>*Lack of capacity within community organisations</li> <li>*Difficulties engaging specific groups</li> </ul>	<ul style="list-style-type: none"> <li>*Gaining direct access to communities</li> <li>*Matching engagement method to community</li> <li>*Outreach and advocacy</li> </ul>
PR O C E S S	<b>Inclusive and accessible practice</b>	<ul style="list-style-type: none"> <li>*Low awareness of engagement opportunities, rights and structures</li> <li>*Failure to overcome or recognise cultural and language issues</li> <li>*Untimely events and lack of support to attend</li> <li>*Lack of appropriate venues</li> <li>*Administrative delays for volunteers</li> <li>*Unrepresentativeness and partisanship</li> <li>*Geographic boundaries</li> </ul>	<ul style="list-style-type: none"> <li>*Early advertising of engagement opportunities through multiple channels</li> <li>*Plain language and provision for non-English speakers</li> <li>*Timing of events and support to attend</li> <li>*Using familiar places and creating an informal atmosphere</li> </ul>

**a) Context**

<b>Evidence Statement 1: Quality of existing relationships with communities</b>
<p>There is evidence from eleven evaluation studies<sup>1-10,12</sup> and one qualitative study<sup>11</sup> on the quality of existing relationships with communities.</p> <p><b>ES 1.1</b> There is evidence from three [++] studies<sup>1,7,12</sup> and four [+] studies<sup>3,8,9,11</sup> that a history of poor relations between communities and engaging agencies and authorities can make it difficult to get community members to attend engagement events and to keep communities on board. Mistrust and cynicism were found to be reasons for not participating in engagement activities<sup>8,11,12</sup>. Engagement practices which were perceived to be tokenistic or not linked to decision-making reinforced pre-existing mistrust and cynicism and led to disengagement and disillusionment during and after community</p>

engagement<sup>1,3,7,9</sup>.

**ES 1.2** There is evidence from three [++] studies<sup>1,6,10</sup> and two [+] studies<sup>2,11</sup> that community engagement can be seen as a threat by communities which, as above, can make it harder to initially engage communities and keep them engaged. Experience of discrimination and exclusion by authorities<sup>11</sup>, fear of exposure to authorities (over drug use<sup>2</sup>, immigration status<sup>10</sup>, or stigmatising illness<sup>10</sup>), a lack of tradition of engagement<sup>6</sup>, and engagement seen as a means to divert existing funding into other initiatives<sup>1</sup> were all found as reasons why community engagement can be seen as a threat.

**ES 1.3** There was no evidence found within this theme regarding facilitators to community engagement.

**ES 1.4** There was evidence from two [++] studies<sup>4,6</sup> and three [+] studies<sup>2,5,8</sup> on how the difficulties of initially engaging communities and keeping them on board can be overcome. These were developing partnerships between engaging and community organisations<sup>4,5</sup>, building capacity amongst the communities to be engaged to conduct outreach and engagement activities<sup>4,5</sup>, allowing sufficient time and resources for outreach activities to build trust and acceptance, and flexibility in outreach and engagement methods<sup>2,6</sup>.

### Key

1 Carlisle (2010) ++	7 Institute for Research and Innovation in Social Services (2012) ++
2 Christie et al. (2012) +	8 Jarvis et al. (2011) +
3 Dinham (2007) +	9 Lawson et al. (2009) +
4 Fountain and Hicks (2010) ++	10 Marais (2007) ++
5 Hatzidimitriadou et al. (2012) +	11 Roma Support Group (2011) +
6 Hills et al. (2007) ++	12 Sadare (2011) ++

### Evidence Statement 2: Organisational Culture, Attitudes and Practice

There is evidence from fourteen evaluation studies<sup>1,3-11,13-16</sup> and two mixed methods studies<sup>2,12</sup> on organisational culture, attitudes and practice.

**ES 2.1** There is evidence from one [++] study<sup>12</sup> and two [+] studies<sup>5,13</sup> that a lack of organisational commitment within engaging organisations is a barrier to community engagement. This was seen within the NHS<sup>5,12</sup> and Local Authorities<sup>13</sup> and was linked to a 'slow to change' paternalistic attitude towards service users<sup>12</sup> and a lack of dedicated or shortage of staff<sup>12,13</sup>.

**ES 2.2** There is evidence from one [++] study<sup>16</sup>, one [+] study<sup>8</sup> and one [-] study<sup>2</sup> of resistance within engaging organisations to sharing power and control. This was demonstrated through practices which made it difficult for community organisations to participate in discussions such as giving too short notice for meetings<sup>2</sup> and putting the priorities of engaging organisations above those of the community<sup>8,16</sup>.



**ES 2.3** There is evidence from two [++] studies<sup>3,6</sup> and three [+] studies<sup>1,5,14</sup> that engaging organisations can hold a limited vision and set of expectations for community engagement in terms of: who or which sections of the community can be involved, what communities are capable of doing, and the value of the communities experience and expertise in comparison to that of professionals.

**ES 2.4** There is evidence from one [++] study<sup>6</sup>, four [+] studies<sup>7,9,11,15</sup> and one [-] study<sup>10</sup> that a supportive organisational culture, attitudes and practice, embedded throughout engaging organisations from the start facilitated the community engagement process. Building community engagement into funding requirements was effective in creating such a supportive environment<sup>6,9,11</sup> and the impact of this was that communities felt a true sense of ownership over projects<sup>7,15</sup>.

**ES 2.5** There is evidence from four [+] studies<sup>1,4,5,14</sup> that a committed or supportive organisational culture triggered or reinforced during the community engagement process itself, helped to motivate community workers and volunteers, and facilitated the engagement process and the delivery of subsequent projects. Community engagement in practice demonstrated more fully the benefits of harnessing local knowledge and networks<sup>4,5</sup>.

**ES 2.6** There was no direct evidence within this theme on strategies to overcome a lack of organisational commitment, a resistance to sharing power and control or a limited vision of community engagement.

### Key

1 Chau (2007) +	9 Lawless et al. (2007)+
2 Community Health Exchange (2012) –	10 Lwembe (2011) -
3 Harkins et al. (2012) ++	11 Pemberton and Mason (2008) +
4 Hatamian et al. (2012) +	12 Robinson et al. (2010) ++
5 Hatzidimitriadou et al. (2012) +	13 Sender et al. (2011)+
6 Hills et al. (2007) ++	14 White et al. (2012) +
7 Jarvis et al. (2011) +	15 Williamson et al. (2009) +
8 Kimberlee (2008) +	16 Windle et al. (2009) ++

### b) Infrastructure

#### Evidence Statement 3: Investing in infrastructure and planning

There is evidence from twenty-seven evaluation studies<sup>1-3,5-21,24-30</sup>, two mixed methods studies<sup>4,23</sup> and one qualitative study on investing in infrastructure and planning<sup>22</sup>.

**ES 3.1** There is evidence from one [++] study<sup>24</sup>, three [+] studies<sup>5,8,12</sup> and one [-] study<sup>4</sup> that a lack of clarity lack of transparency, and confused expectations around community engagement goals and process were barriers to effective community engagement.

**ES 3.2** There is evidence from four [++] studies<sup>2,24,26,29</sup>, six [+] studies<sup>3,12,15-17,21</sup>, and one [-] study<sup>19</sup> that competing agendas (e.g. targets, funding priorities, values and expectations) across the different stakeholders involved in partnerships created



tensions, and where one agenda was favoured over another especially to the perceived detriment of communities, this put a break on effective community engagement.

**ES 3.3** There is evidence from seven [++] studies<sup>10,13,20,23,,26,27,29</sup>, five [+] studies<sup>1,3,11,16,22</sup> and two [-] studies<sup>4,7</sup> that a lack of investment in dedicated staff and other resources was a barrier to effective community engagement. This posed problems for sustainability<sup>1,3,4,7,11,26,27,29</sup>, maintaining partnerships and networks<sup>13,16</sup>, and achieving representativeness and avoiding partisanship<sup>10,20</sup>.

**ES 3.4** There is evidence from six [++] studies<sup>2,10,13,20,,29,30</sup>, six [+] studies<sup>5,11,16,21,22,25</sup> and one [-] study<sup>7</sup> that a major barrier to effective community engagement was the time limited nature of community engagement projects which made it difficult to build trust and relationships between engaging agencies and communities and other stakeholders, or to achieve scope and depth in community engagement. Given the evidence of the history of poor relations and mistrust between engaging agencies and communities, the lack of time to build trust and shared understanding appears to be doubly critical.

**ES 3.5** There is evidence from two [++] studies<sup>9,24</sup>, one [+] study<sup>16</sup> and one [-] study<sup>19</sup> that the presence of a strategy or process was a key enabler to effective community engagement.

**ES 3.6** There is evidence from one [++] studies<sup>20</sup>, three [+] studies<sup>11,18,25</sup> and one [-] study<sup>19</sup> that communicating clear goals and outcomes for the community engagement from the outset and being transparent about the process aided effective community engagement.

**ES 3.7** There is evidence from five [++] studies<sup>13,20,23,24,29</sup>, five [+] studies<sup>3,15,21,22,28</sup> and one [-] study<sup>19</sup> that having in place mechanisms for joint decision-making which places communities as co-producers at the very heart of projects was a facilitator for successful community engagement.

**ES 3.8** There is evidence from two [++] studies<sup>20,27</sup> and three [+] studies<sup>11,12,15</sup> that ensuring community engagement operates as a transactional and reciprocal process aids effective community engagement. This means mutual respect and gratitude between partners, sharing learning and establishing a two-way dialogue between engaging agencies and communities as equals.

**ES 3.9** There is evidence from eight [++] studies<sup>2,9,10,13,20,26,29,31</sup>, five [+] studies<sup>11,12,14,18,25</sup> and two [-] studies<sup>4,19</sup> that having a strong partnership and network in place is an important facilitator for ensuring effective community engagement.

**ES 3.10** There is evidence from three [++] studies<sup>13,22,24</sup>, and five [+] studies<sup>6,12,16,22,25</sup> that investing time, effort and resources into building relationships and trust between engaging agencies and communities was essential to effective community engagement. This was particularly true for communities that had difficult past relationships with engaging agencies or authorities or intra-community conflicts.

**ES 3.11** There is evidence from four [++] studies<sup>2,9,13,27</sup>, three [+] studies<sup>5,14,16</sup> and one [-] study<sup>19</sup> that having dedicated staff in place is a facilitator to effective community

engagement.

### Key

1 Burgess (2014) +	16 Lawless et al (2007) +
2 Carlisle (2010) ++	17 Lawson et al (2009) +
3 Chau (2007) +	18 Liverpool JMU (2012) +
4 Community Health Exchange (2012) –	19 Lwembe (2011) –
5 Chapman (2011) +	20 Marais (2007) ++
6 Christie et al. (2012) +	21 Pemberton and Mason (2008) +
7 Craig (2010) –	22 Roma Support Group (2011) +
8 Dinham (2007) +	23 Robinson et al. (2010) ++
9 Fountain and Hicks (2010) ++	24 Sadare (2011) ++
10 Harkins et al (2012) ++	25 Sender et al. (2011) +
11 Hatamian et al. (2012) +	26 White et al. (2010) ++
12 Hatzidimitriadou et al (2012)	27 White and Woodward (2013) ++
13 Hills et al. (2007) ++	28 Williamson et al (2009)
14 Jarvis et al. (2011) +	29 Windle et al. (2009) ++
15 Kimberlee (2008) +	30 Woodall et al (2012) ++
	31 White et al. (2012) ++

### Evidence Statement 4: Support, Training and Capacity Building

There is evidence from fifteen evaluation studies<sup>1-12,15-20</sup>, one mixed methods study<sup>14</sup> and one qualitative study<sup>13</sup> on support training and capacity building.

**ES 4.1** There is evidence from three [++] studies<sup>4,7,14</sup>, and three [+] studies<sup>6,16,17</sup> that appropriate training in community engagement and co-production for professional staff of engaging agencies is needed. Lack of these general and specific skills was seen as a barrier to effective community engagement.

**ES 4.2** There is evidence from four [++] studies<sup>7,11,14,20</sup>, one [+] study<sup>9</sup> and one [-] study<sup>10</sup> that appropriate training for communities was needed. Lack of skills was seen as a barrier to effective community engagement. Two studies<sup>7,14</sup> cite the need for training for communities. Two studies<sup>10,11</sup> cite the limitations in funding for the needed training particularly in more advanced skills, and one<sup>9</sup> questions the appropriateness of the training available. One other study<sup>20</sup> cautions that not everyone, especially volunteers, necessarily wants training.

**ES 4.3** There is evidence from three [++] studies<sup>14,7,20</sup>, five [+] studies<sup>1,2,5,6,9</sup> and two [-] studies<sup>3,10</sup> that having mechanisms to ensure appropriate mentoring and other forms of support for community members are in place to build on and sustain engagement is an important facilitator to community engagement. Several studies<sup>1,3,9,10,20</sup> report that health champions, health trainers, youth ambassadors, and community activators seem to particularly benefit from support in the form of mentoring which enables these mostly local volunteer community members to better engage with their target communities.

**ES 4.4** There is evidence from six [++] studies<sup>4,7,11,14,15,20</sup>, six [+] studies<sup>2,6,8,12,13,19</sup> that training and capacity building for all sections of the community are an essential

facilitator to effective community engagement. All of these studies emphasise the need for training and/or capacity building of all sorts of types, for different constituencies, and for various reasons or outcomes.

**ES 4.5** There is evidence from one [++] study<sup>14</sup> and two [+] studies<sup>6,16</sup> that networks of shared learning of best practice, and toolkits and bespoke training opportunities are facilitators to effective community engagement.

**ES 4.6** There is evidence from one [++] study<sup>18</sup> and one [-] study<sup>19</sup> that ongoing training and support is a facilitator to effective community engagement.

### Key

1 Chapman (2011) +	11 Marais (2007) ++
2 Chau (2007) +	12 Pemberton and Mason (2008) +
3 Craig (2010) -	13 Roma Support Group (2011) +
4 Fountain and Hicks (2010) ++	14 Robinson et al. (2010) ++
5 Hatamian et al. (2012) +	15 Sadare (2011) ++
6 Hatzidimitriadou et al. (2012) +	16 Sender et al. (2011) +
7 Hills et al. (2007) ++	17 Tunariu et al. (2011) +
8 Lawless et al. (2007) +	18 White et al. (2010) ++
9 Liverpool JMU (2012) +	19 White et al. (2012) +
10 Lwembe (2011) -	20 White and Woodward (2013) ++

### c) Process

#### Evidence Statement 5: Capabilities and the engagement process

There is evidence from twenty two evaluation studies<sup>1-3,5-17,20-25</sup>, two mixed methods studies<sup>4,19</sup> and one qualitative study on capabilities and the engagement process<sup>18</sup>.

**ES 5.1** There is evidence from five [++] studies<sup>16,18,20,24,22</sup>, and two [+] studies<sup>3,9</sup> that there was a lack of capacity within communities for taking part in community engagement activities. A wide range of factors contributed to this lack of capacity: practical constraints and competing priorities such as disability or illness, work, childcare and family commitments; lack of understanding and language skills; and low self-esteem and confidence. Often this conflicted with the expectations of engaging organisations of what community members could contribute or reinforced engaging organisations existing low expectations.

**ES 5.2** There is evidence from three [++] studies<sup>2,16,22</sup>, two [+] studies<sup>9,18</sup> and one [-] study<sup>4</sup> that community organisations were restricted from fully participating in community engagement due to capacity issues such as lack of funding, staff, time and competing work priorities. Again there was a corresponding underestimation by engaging organisations of the work involved for community organisations (e.g. in becoming partners with statutory organisations to deliver services or building capacity

amongst the community).

**ES 5.3** There is evidence from four [++] studies<sup>12,16,19,24</sup>, four [+] studies<sup>1,3,5,18</sup> and one [-] study<sup>11</sup> that it was not always easy for engaging organisations and staff to reach specific groups. Specific groups covered young people, older people, ethnic minority groups, white British. The reasons for the difficulty in engaging these groups was not always evident but included groups described as stigmatised, isolated, marginalised or vulnerable.

**ES 5.4** There is evidence from six [++] studies<sup>7,10,16,19,20,24</sup>, six [+] studies<sup>5,8,9,14,15,18</sup> and two [-] studies<sup>5,6</sup> that using local organisations (both community and statutory), networks and individuals, with strong links to the target communities, is essential in reaching and engaging those communities.

**ES 5.5** There is evidence from four [++] studies<sup>10,19,20,25</sup>, four [+] studies<sup>5,13,18,21</sup> and one [-] study<sup>11</sup> that it was important to use or tailor engagement methods to particular target groups. Flexibility in approach is needed especially where a method is not reaching its intended target.

**ES 5.6** There is evidence from one [++] study<sup>10</sup> and four [+] studies<sup>8,13,17,23</sup> that outreach was a useful method for ongoing engagement and, along with advocacy, was valuable for reaching and including particularly vulnerable or marginalised groups within engagement activities.

#### Key

1 Burgess, (2014) +	14 Lawless et al. (2007) +
2 Carlisle (2010) +	15 Liverpool JMU (2012) +
3 Chau (2007) +	16 Marais (2007) ++
4 Community Health Exchange (2012) –	17 Pemberton and Mason (2008) +
5 Christie et al. (2012) +	18 Roma Support Group (2011) +
6 Craig 2010 –	19 Robinson et al. (2010) ++
7 Fountain and Hicks (2010) ++	20 Sadare (2011) ++
8 Hatamian et al. (2012) +	21 White et al. (2012) +
9 Hatzidimitriadou et al. (2012) +	22 White and Woodward (2013) ++
10 Hills et al. (2007) ++	23 Williamson et al. (2009) +
11 Lwembe (2011) -	24 Windle et al. (2009) ++
12 Institute for Research and Innovation in Social Services (2012) ++	25 Woodall et al. (2013) +
13 Kimberlee (2008) [+]	

#### Evidence Statement 6: Inclusive and accessible practice

There is evidence from eighteen evaluation studies<sup>1,3-11,13-22</sup>, two mixed methods studies<sup>2,12</sup> and one qualitative study<sup>11</sup> on inclusive and accessible practice.

**ES 6.1** There is evidence from two [++] studies<sup>12,14</sup>, three [+] studies<sup>8,10,11</sup> and one [-] study<sup>2</sup> that low levels of awareness and a lack of understanding of engagement opportunities, rights and structures were a barrier to effective community engagement.

**ES 6.2** There is evidence from three [++] studies<sup>9,14,17</sup>, two medium quality studies<sup>1,11</sup> and one low quality study<sup>2</sup> that not addressing language and cultural barriers was problematic for inclusive community engagement.

**ES 6.3** There is evidence from two [++] studies<sup>14,19</sup>, one medium quality study<sup>15</sup> and one low quality study<sup>2</sup> that the timing of community engagement events or meetings and a lack of support to help particular groups to attend were barriers to community engagement. Different timings suit different groups of people (e.g. day time preferred by older people, evening by working adults if able to feel safe) and parents, older people, those with physical disabilities and those from rural communities need additional support to attend (e.g. childcare, transport).

**ES 6.4** There is evidence from one [++] study<sup>14</sup> and one [+] study<sup>1</sup> that a lack of appropriate venues for engagement events could be a barrier to engagement. This included a lack of accessible space for informal meetings<sup>1</sup> and problems with acoustics for large group meetings<sup>14</sup>.

**ES 6.5** There is evidence from two [++] studies<sup>18,19</sup> and one [-] study<sup>3</sup> of delays or lack of planning for obtaining Criminal Records Bureau (CRB) checks, now known as Disclosure and Barring Service (DBS) checks, for community volunteers to take up volunteering roles such as becoming a 'health champion' or a 'community activator'.

**ES 6.6** There is evidence from four [++] studies<sup>9,14,20,21</sup> and one [+] studies<sup>11</sup> that conflict over the representativeness of those engaged or favoured within communities by engaging agencies appears to have weakened some community engagement processes, lead to resentment and refusal to engage by others. Often the cause of unrepresentativeness was described by studies as due to limitations on time and resources available to the engaging agencies and, therefore, the need to be pragmatic.

**ES 6.7** There is evidence from two [++] studies<sup>10,18</sup>, one [+] study<sup>3</sup> and one [-] study<sup>22</sup> that setting of geographical boundaries of engagement either too wide or too narrow could have an adverse effect on engagement.

**ES 6.8** There is evidence from one [++] study<sup>14</sup> and four [+] studies<sup>5,10,11,15</sup> that early advertising of community engagement opportunities through multiple channels was important for successful engagement. Multiple channels included a wide range of community venues (e.g. shops, fast food restaurants, launderettes), networks of community leaders, outreach and social media.

**ES 6.9** There is evidence from four [+] studies<sup>1,3,5,10</sup> that providing support for non-English speakers was crucial for enabling these groups to get involved in community

engagement activities. Plain English was also helpful for all groups<sup>10</sup>.

**ES 6.10** There is evidence from one [++] study<sup>14</sup> and three [+] studies<sup>5,10,16</sup> that suitable times for events, matched to the needs of different groups, and support to attend events (e.g. childcare, support with transport) could facilitate better engagement.

**ES 6.11** There is evidence from two [++] studies<sup>6,14</sup> and two [+] studies<sup>5,7</sup> that using familiar and informal environments or spaces was important in engaging residents and service users.

**ES 6.12** There was no evidence within this theme on strategies to overcome hard to access community engagement events and opportunities.

### Key

1 Chau (2007) +	12 Robinson et al. (2010) ++
2 Community Health Exchange (2012) –	14 Sadare (2011) ++
3 Chapman (2011) –	15 Sender et al. (2011) +
4 Christie et al. (2012) +	16 Tunariu et al. (2011) +
5 Hatamian et al. (2012) +	17 White et al. (2010) ++
6 Hills et al. (2007) ++	18 White and Woodward (2013) ++
7 Jarvis et al. (2011) +	19 Windle et al. (2009) ++
8 Lawson and Kearns (2009) +	20 Carlisle (2010) ++
9 Marais (2007) ++	21 Harkins et al. (2012) ++
10 Pemberton and Mason (2008) +	22 Craig (2010) -
11 Roma Support Group (2011) +	

## 1.5 DISCUSSION AND CONCLUSIONS

This review uncovered a relatively large body of research evidence from the UK on the barriers and facilitators to effective community engagement. Evidence came from studies of community engagement initiatives focused on a range of health topics, with the majority focused on broader outcomes such as community well-being, social capital and cohesion, or general health. A range of approaches to community engagement were studied including community representation on management boards in area-based regeneration initiatives; involving members of the community to deliver services, activities and programmes such as ‘health champions’ and ‘timebanks’; holding community engagement events to inform area-based health improvement in which local residents are invited to define and prioritise solutions; and community-led initiatives.

The review found clear and consistent evidence of at least medium quality [+] on the barriers to, and facilitators of, the delivery of community engagement across a range of contexts. Barriers and facilitators were synthesised within six emergent themes across ‘context’ (quality of existing relationships with communities; organisational culture, attitudes and practice), ‘infrastructure’ (investing in infrastructure and planning; support, training and capacity building) and ‘process’ (capabilities and the engagement process; inclusive and accessible practice). This provides the basis for key recommendations for funders and commissioners of community engagement such as local authorities and the

NHS, those who carry out community engagement such as health professionals or researchers, community organisations and members of communities. As well as offering a structure for planning and implementing community engagement in a systematic way, the synthesis also addresses the factors that help or hinder communities to get involved in community engagement activities and how to build capacity and motivation; how local context, and the associated political, health and community structures and systems support or hamper community engagement; and how professionals can learn to better engage, and act on the suggestions from, communities.

Gaps and limitations in the evidence which have implications for future research included: greater integration of process and outcome evaluation; greater use of formative evaluation to identify challenges and their solutions early on; increased attention to tracking the influence of community engagement on service design and delivery; and greater involvement of communities in the design of evaluations.

## 2 INTRODUCTION

### 2.1 REVIEW CONTEXT

‘Community engagement’ is used as an umbrella term covering community engagement and community development. It is about people improving their health and wellbeing by helping to develop, deliver and use local services, programmes and interventions. Community engagement can involve varying degrees of participation and control: for example, giving views on a local health issue, jointly delivering services with public service providers and completely controlling services.

Community engagement is thought to improve health via its impact on the development and delivery of more appropriate and accessible interventions, as well as a direct positive impact on social cohesion and individual self-esteem and self-efficacy for those who are engaged. Recent work has indicated that community engagement interventions are effective in improving health behaviours, health consequences, participant self-efficacy and perceived social support for disadvantaged groups [O’Mara-Eves et al. 2013].

While the synthesised evidence base lends strong support for the impact of community engagement improving outcomes, recent research on the views and experiences of participants, staff and others on the barriers and facilitators of community engagement practices and approaches has not been brought together and synthesised in a systematic way. This is important because if strategies to involve communities are to be successful in practice in promoting health and reducing inequalities, there needs to be evidence based strategies identified to overcome potential barriers and to strengthen facilitators.

This review is one component of one of the streams (stream 2) of evidence work commissioned by NICE to underpin the updated community engagement guidelines. The barriers and facilitators review is the second component of stream 2 (component 2). The first component consists of two parts:

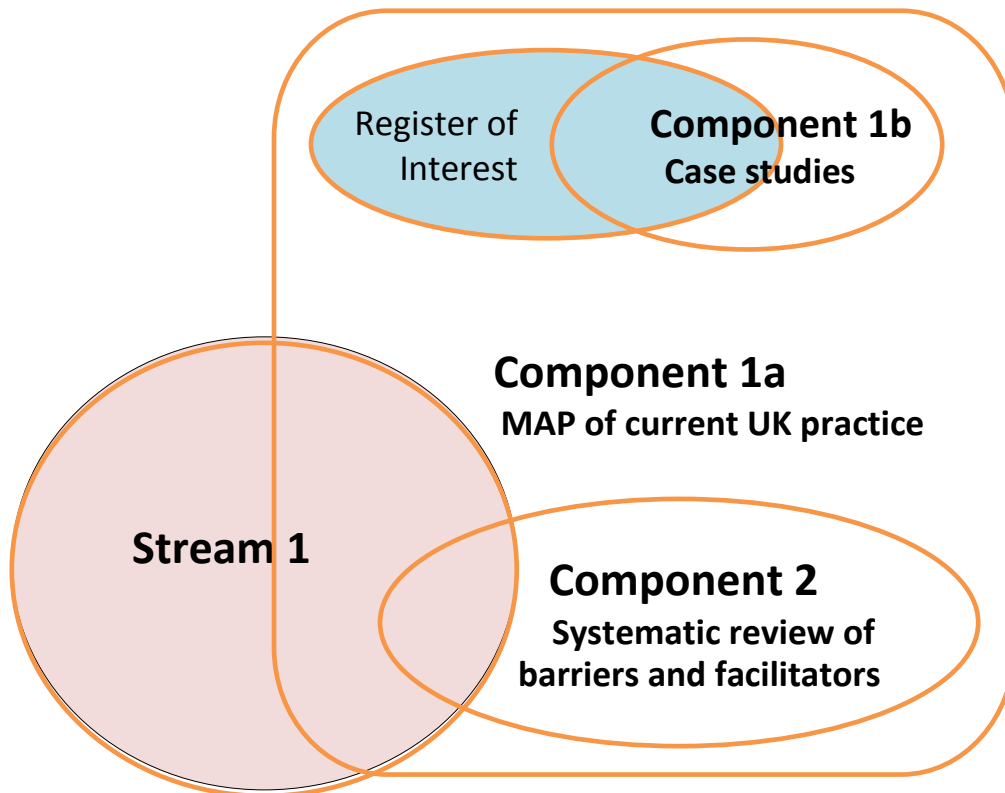
- **A map of the literature (component 1a)** which will provide a synopsis of the key characteristics and findings from documentary analysis (including grey literature and practice surveys) of the current evidence base for UK local and national policy and practice for community engagement, as well as an assessment of the extent to which relevant scope questions can be answered by the evidence base.
- **A map of current practice (component 1b)** which will consist of a series of six case studies of current or recent community engagement projects to improve health and reduce health inequalities. Case studies will be identified and selected to identify different approaches of current community engagement within the UK and will be particularly designed to fill evidence gaps identified in the literature.

Figure 1 demonstrates how components 1a, 1b and 2 are related to each other and to the evidence from Stream 1. The work was entered into as part of a consortium, with the



EPPI-Centre delivering Stream 1 and Leeds Beckett University (LBU) and the University of East London (UEL) delivering Stream 2 (LBU are leading on component 1 and UEL are leading on component 2).. We have adopted a common approach across the consortium to searching for and classifying evidence. For example, the search strategy was designed to identify evidence relevant to both component 1a and component 2 of Stream 2 and the studies included in the barriers and facilitators review (component 2) are a subset of the map (component 1a).

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



## 2.2 REVIEW AIMS AND RESEARCH QUESTIONS

This review aimed to synthesise empirical evidence from qualitative and other types of studies conducted in the UK on the factors that hinder or support effective community engagement process and practice. It aimed to assess the current evidence base for UK local and national policy and practice for community engagement.

It addressed the following review questions:

- What barriers and facilitators affect the delivery of effective community engagement activities – particularly to people from disadvantaged groups?
- To what extent do these barriers and facilitators vary according to key differences in community engagement approaches and practices, the health outcomes and

populations to which they are targeted, and the context in which they are delivered?

- How can the barriers and challenges be overcome?

Within the above we sought to explore a range of more specific issues and questions including: the factors that help or hinder communities to get involved in community engagement activities and how to build capacity and motivation; how local context, and the associated political, health and community structures and systems support or hamper community engagement; and how professionals can learn to better engage, and act on the suggestions from communities.

### **2.3 REVIEW SCOPE, OPERATIONAL DEFINITIONS AND EQUALITY & EQUITY**

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

The eligible population is communities defined by at least one of the following, especially where there is an identified need to address health inequalities (section 4.1 of guidance scope): geographical area or setting, interest, health need, disadvantage and/or shared identity.

The eligible interventions/activities are defined as (section 4.2 of guidance scope): activities to ensure that community representatives are involved in developing, delivering or managing services to promote, maintain or protect the community's health and well-being. An example of a community engagement activity is community-based participatory research. Examples of where this might take place include: care or private homes, community or faith centres, public spaces, cyberspace, health clinics or hospitals, leisure centres, schools and colleges and Sure Start centres. Examples of community engagement roles include: community (health) champions; community or neighbourhood committees or forums; and community lay or peer leaders.

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

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

The review is focused on public health in its broadest sense and includes activates targeted at the social determinants of health. It includes health protection and health improvement (both prevention of illness and promotion of health). It does not consider clinical health services, nor social care. Interventions must be delivered at the community rather than the individual level.

## 2.4 THE REVIEW TEAM

A team of researchers at the Institute for Health and Human Development (IHHD) at the University of East London (UEL) led this review on barriers and facilitators with input from the Leeds Beckett University team. IHHD is a leading public health research institute with a focus on the health and wellbeing of communities and the social, economic and cultural factors that influence them. The team at IHHD were interested in undertaking the review as we have expertise in the design, delivery and evaluation of community engagement initiatives to reduce health inequalities such as the Well London programme; a community development approach to promoting healthy eating, physical activity and mental well-being (e.g. Phillips et al., 2014). We also have considerable expertise in conducting systematic reviews of diverse study types. IHHD was a collaborator on the recently completed NIHR funded review on community engagement and health inequalities (O'Mara-Eves et al., 2013) and we have published methodological and substantive work on different types of evidence synthesis (e.g. Bonell et al., 2013; Harden and Gough, 2012; Jamal et al., 2013; Jamal et al., 2014; Shepherd et al., 2014).

Angela Harden led the review and oversaw the screening, quality assessment and data extraction, synthesis and write up. All members of the IHHD team were involved in screening, quality assessment and data extraction, and production of evidence tables. Angela Harden and Kevin Sheridan conducted the synthesis and produced the write up of the review. Members of the Leeds Beckett University team contributed to the screening of titles, abstracts and full texts (Ann-Marie Bagnall, Joanne Trigwell, Karina Kinsella) and to data extraction and quality assessment for reports related to the Well London programme (Ann-Marie Bagnall) (see below).

The Institute for Health and Human Development delivers community engagement activities and is involved in the development and evaluation of community engagement approaches to promote health and well-being. This interest has been declared to the NICE team. As indicated above, the community engagement and the overall evaluation of the Well London programme was conducted by IHHD and Well London is one of the community engagement programmes which is the subject of several research reports included in this review (Chapman, 2010; Craig, 2010; Lwembe, 2011; Sadare, 2011; Tunariu et al, 2011). None of the review team are authors on these reports although Angela Harden was a supervisor on the study conducted by Sadare (2011). There are no other conflicts of interest for any of the team.

## 3 METHODOLOGY

### 3.1 SEARCH STRATEGY

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

We used the following sources to identify studies:

1. The pool of studies (both included **and** excluded studies) that were identified within the recent NIHR funded review on community engagement (O'Mara-Eves et al., 2013). The searching for this review identified potentially relevant UK studies. An example of the search syntax used for these searches (including date of searches) is presented in Appendix A.
2. The pool of studies identified through updating the original searches that were carried out for the O'Mara-Eves et al. (2013) review. These searches were implemented from January 2011 onwards by the EPPI-Centre team conducting the evidence review for stream 1. An example of the search strategy/syntax used is presented in Appendix B. The updated searches included the following two elements:
  - a) A systematic search for existing systematic reviews which include studies of community engagement through specialist websites and databases dedicated to systematic reviews: DoPHER (the *Database of Promoting Health Effectiveness Reviews* developed and maintained by the EPPI-Centre); the *Cochrane Database of Systematic Reviews (CDSR)*; *Database of abstracts of reviews of effects (DARE)*; the *Campbell Library*; the NIHR Health Technology Assessment (HTA) programme website; and Health Technology Assessment (HTA) database hosted by CRD.
  - b) A systematic search of the EPPI-Centre database of studies in health promotion and public health that the EPPI-Centre has built up over many years as a result of carrying out systematic reviews (known as TROPHI). The studies in this database are the product of systematic searches in core NICE databases and have already been systematically classified.
3. The results of searches that were carried out in April 2014 for a Public Health England mapping review of community-based interventions (South, 2015) were rescreened for primary research (only secondary sources were included in the PHE review). The search strategy for this review is presented in Appendix C.

4. The websites of national societies, charities and funding bodies (e.g. Royal Society of Public Health, Joseph Rowntree Foundation, NESTA), local organisations (e.g. the websites of former primary care trusts with track record in community engagement), organisations with a specific focus on ethnic minority groups (e.g. Communities in Action Enterprises, Social Action for Health), relevant universities/university departments with a track record in research on community engagement and citizen or public experience websites (e.g. INVOLVE, People's Health Trust).
5. Contact was made with community practitioners and groups, and other academics, via established networks (People in Public Health database; Health Together database; Putting the Public back into Public Health database; Volunteering Fund database of projects; CHAIN; Healthwatch Leeds; CommUNITY; Locality) and local authority, academic and practice mailing lists, to request published literature, grey literature, practice surveys and details of emerging practice. An online Register of Interest was placed on the Health Together website to invite and facilitate interested parties to submit evidence.
6. Responses to the call for evidence to project stakeholders made by NICE (17 June - 15 July 2014).
7. Systematic reviews identified from any of the above sources were "mined" for relevant primary studies.
8. Backward and forward citation searches of included studies using Google Scholar.

We used EPPI-Reviewer 4 (ER4) (Thomas et al., 2010) to support the bibliographic management and screening of references and full reports and for the subsequent quality assessment and data extraction process.

### 3.2 SCREENING STUDIES

All study citations were downloaded into EPPI-Reviewer and duplicates were removed. Titles and abstracts identified from all searches were assessed using the following criteria:

- 1 DATE: published date in 2000<sup>xiv</sup> or later
- 2 COUNTRY: UK only. Reports describing non-UK studies were excluded.
- 3 INTERVENTION: only reports describing community engagement in public health related topics were included.

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<sup>xiv</sup>A search date of 2000 onwards aimed to capture relevant and appropriate records related to community engagement as conceived in the scoping document. The date range is informed by various legislation (e.g. The Health & Social Care Act, Section 11: Public Involvement & Consultation; Local Government Act) published at this time which generated research activity.

- 4 STUDY DESIGN: only reports describing primary research employing a qualitative, mixed methods or process evaluation design were included.

The inclusion criteria were tested and refined after piloting them on a random sample of 10% of the titles and abstracts. All reviewers independently screened these records and any differences were resolved by discussion and where necessary, informed by the advice of the NICE CPH team. Further pilot screening was conducted on an additional 10% of records until at least 80% agreement between reviewers was reached. Once this level of reliability was reached the remaining records were randomly divided between reviewers for single screening. All included records were marked for full text retrieval. The same process was followed for screening full text reports.

Full text reports were screened with a modified version of criteria 4 (only reports describing a piece of primary research *with discernible methods and findings* employing a qualitative, mixed methods or process evaluation design were included) and an additional fifth criteria whereby only those studies reporting findings on barriers and facilitators were included. Following discussion with the NICE team inclusion of studies in the barriers and facilitators review was further restricted to a) those reports which involved 'community partnerships/coalitions' or 'community mobilisation/action' (in line with the focus of Stream 1's work) and b) reports published in 2007 or later to avoid duplication of effort with a previous review commissioned by NICE which reviewed evidence on barriers and facilitators to community engagement (Popay et al., 2007).

### 3.3 QUALITY ASSESSMENT AND DATA EXTRACTION

All included studies were quality-assessed using the tool for qualitative studies detailed in Appendix H of the Methods for the development of NICE public health guidance (NICE, 2012). This tool contains 12 questions which can be answered 'yes', 'no', or 'can't tell / not reported'. On the basis of the answers to these questions, each study was assigned an overall quality rating: [++], high quality; [+], medium quality; or [-], low quality.

Data were extracted on the health focus, population targeted, type, level and extent of community engagement, research aims/questions, theoretical framework, funding, methods of sampling, data collection and analysis and findings on barriers and facilitators, using the format of evidence tables for qualitative studies in Appendix K of the Methods for the development of NICE public health guidance (NICE, 2012) as a guide. For type of community engagement, the typology developed in the NIHR systematic review of effectiveness (O'Mara-Eves et al. 2013) was used to ensure consistency between Stream 1 and Stream 2 (Figure 1).

Figure 1: A typology of community engagement (adapted from O'Mara-Eves et al., 2013)

Type of Community Engagement	Definition*
Community mobilization/action	A capacity building process, through which communities plan, carry out and/or evaluate activities on a participatory and sustained basis to achieve an agreed goal. Includes community development and

	asset based approaches.
Community partnerships/coalitions	Working in partnership with communities to design and/or deliver services and programmes. Partnerships/coalitions may be in the form of forums; committees; advisory groups, task forces
Peer involvement	Peers defined as people sharing similar characteristics (e.g. age group, ethnicity, health condition) who provide advice, information and support and/or organise activities around health and wellbeing in their or other communities. Can include 'bridging roles' (e.g. health trainers, navigators) or peer-based interventions (e.g. peer support, peer education and peer mentoring)
Community organisations – new and existing service development	Connecting people to community resources and information (e.g. social prescribing and other types of non-medical referral systems; community hubs, such as healthy living centres; community-based commissioning)
Non-peer health advocacy	Possible roles are similar to those under 'peer involvement' but involve members of the community that are not peers of the target participants.
Social Networks	Explicit use of the term in study reports. Community mobilization/action approaches could use social networks (e.g. timebanks)
Volunteers	Used when this term is explicitly used in study reports. Peer and non-peer roles could involve volunteers but may not be explicitly labeled as such.
Cultural adaptation	Using knowledge of a community's norms, values, preferences to make an intervention more appropriate. Note: simply translating an intervention into the relevant language is not considered cultural adaptation, as this can potentially require no community engagement.

\*Definitions expanded using South (2015) family of community-based interventions

To determine the **level of community engagement in design, delivery or evaluation** we followed the classification system from Stream 1 where community members leading or collaborating the design, delivery or evaluation was classified as 'HIGH' and community members consulted or informed was classified as 'LOW'. To determine the **extent of community engagement**, studies were classified as: a) 'HIGH' – if the level of community engagement was classified as 'HIGH' in all three categories of design, delivery, and evaluation; b) 'MODERATE' – if the level of community engagement was classified as 'HIGH' in two out of the three categories of design, delivery, and evaluation; and c) 'LOW' – if the level of community engagement was classified as 'HIGH' in none or just one out of the three categories of design, delivery, and evaluation.



All reviewers undertook quality assessment and data extraction on a sample of studies independently and then met to compare assessments. Disagreements were resolved through discussion. This process was undertaken on approximately 10% of included studies (n=4) until good agreement was reached (at least 80% inter-rater agreement on overall scoring for quality assessment). Once this level of agreement was reached the remaining records were randomly divided between reviewers for single quality assessment and data extraction. One reviewer (Angela Harden) oversaw the whole process and checked quality ratings and data extracted.

Summaries of the characteristics, methods, quality rating and findings of each study were compiled into evidence tables (Appendix I).

### 3.4 SYNTHESIS

Our synthesis methods were informed by a method of synthesis known as ‘framework synthesis’. Framework synthesis offers a more structured approach to organising and analysing study findings than other methods of synthesis such as meta-ethnography, and is especially suitable for answering policy and practice orientated questions in relatively short timescales (Barnett-Page and Thomas, 2009; Dixon-Woods, 2011). Although this aspect of the method is deductive, it also allows for new themes and categories to emerge from the ongoing analysis which can be incorporated into the original framework.

We initially mapped out two frameworks for describing barriers and facilitators against each other and against the pertinent issues in our review questions. These were subsequently organised into three levels representing ‘context’, ‘infrastructure’ and ‘process’ (Figure 3.1).

Figure 3.1: Result of mapping two frameworks for describing barriers and facilitators of community engagement against the review questions

	Popay et al. (2007)	O’Mara-Eves <i>et al.</i> (2013)	Specific review questions
CONTEXT	<ul style="list-style-type: none"> <li>*The national and policy context</li> <li>*The importance of historical context</li> <li>*Power relationships</li> <li>*Cultural and attitudinal constraints</li> </ul>	<ul style="list-style-type: none"> <li>*Sustainability</li> <li>*‘Outside world’</li> <li>*Government policy and targets</li> </ul>	<ul style="list-style-type: none"> <li>*How local context, and the associated political, health and community structures hamper or support</li> </ul>
INFRASTR-UCTURE	<ul style="list-style-type: none"> <li>*Models of engagement</li> <li>*Communicative resources and knowledge</li> </ul>	<ul style="list-style-type: none"> <li>*Communicative competence</li> <li>*Types of discourse</li> <li>*Attitudes toward expertise</li> <li>*Experienced or novice in community engagement</li> </ul>	<ul style="list-style-type: none"> <li>*How professionals can learn to better engage and respond</li> <li>*How to build capacity for community engagement</li> </ul>



		<ul style="list-style-type: none"> <li>*Levels of enthusiasm</li> <li>*Training</li> <li>*Administrative support</li> <li>*Activity and extent of CE</li> </ul>	
PROCESS	<ul style="list-style-type: none"> <li>*The practices of engagement</li> <li>*Transaction costs</li> <li>*Community resistance to engagement</li> </ul>	<ul style="list-style-type: none"> <li>*Collective decision-making</li> <li>*Communication</li> <li>*Frequency, duration and timing of events</li> <li>*Motivations for communities to engage</li> <li>*Motivations to invite communities to engage</li> <li>*Defining communities</li> <li>*Defining needs</li> </ul>	<ul style="list-style-type: none"> <li>*How to deliver effective community engagement</li> <li>*How to build motivation for community engagement</li> </ul>

Although these three levels are inter-related, we found them helpful for conceptualizing the different stages of community engagement (before it starts, during engagement and after engagement) and for making recommendations for overcoming the barriers and challenges to community engagement in terms of what needs to be considered when planning any engagement (context); the structures, resources and plans that need to be in place to support the engagement (infrastructure); and how to implement the engagement (process).

This framework was used as a starting point to interrogate the findings extracted from each study on barriers and facilitators. One reviewer (Kevin Sheridan) classified findings into 'context', 'infrastructure' and 'process' and looked for common barriers and facilitator across studies. These were grouped using categories from Popay et al. (2007) and O-Mara-Eves et al. (2013) when possible and using modified or new categories as necessary. The results of this process were checked by a second reviewer (Angela Harden) and further revisions made to the final themes and associated barriers and facilitators. The final version of this framework as modified during the synthesis is shown in figure 5.1.

## 4 SUMMARY OF INCLUDED STUDIES

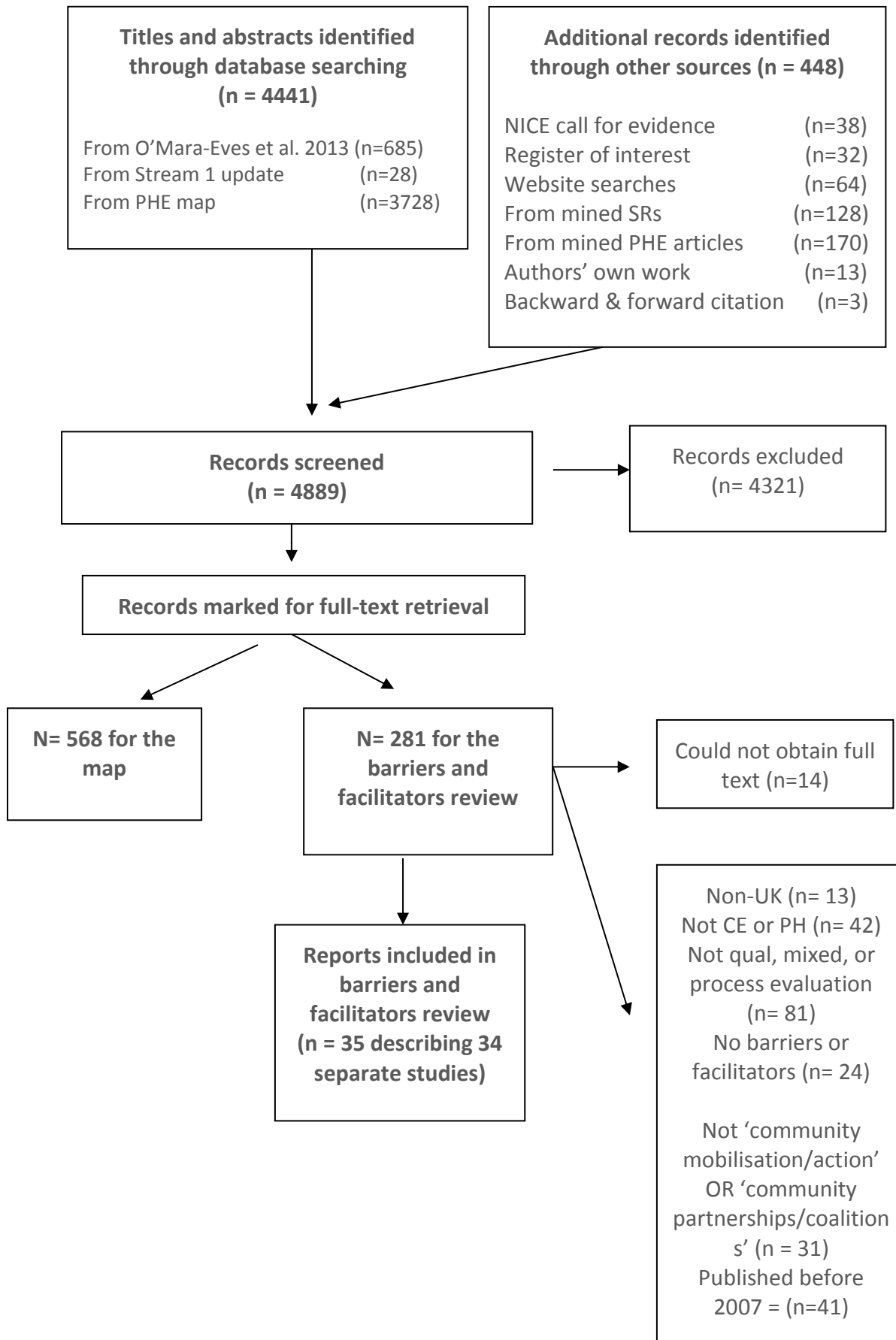
### 4.1 RESULTS OF SEARCHING AND SCREENING

A total of 4441 titles and abstracts were identified through searches of electronic databases, and 448 records were identified from additional sources, making 4889 records for initial screening for the map (Figure 4.1). After the first screening stage, 4321 records were excluded and 568 records were marked for full text retrieval. Of these, 281 were marked as potentially relevant for the barriers and facilitators review because they were published in 2000 or later and they appeared to: have been carried out in the UK; be

focused on community engagement in public health; and be a piece of primary research employing a qualitative, mixed methods or process evaluation design. Full text reports were obtained for 267 of the 281 records and these were re-screened for inclusion. From these 267 reports, 13 were excluded as they were not conducted in the UK; 42 were excluded because they did not describe a community engagement initiative and/or were not within the field of public health; 81 were excluded because they did not describe a piece of primary research (with discernible methods and findings) employing a qualitative, mixed methods or process evaluation design; and 24 were excluded because they did not describe barriers or facilitators.

This left 107 eligible reports which was too many to review within the time frame available. In discussion with the NICE team we restricted inclusion to a) those reports which involved 'community partnerships/coalitions' or 'community mobilisation/action' (in line with the focus of Stream 1's work) and b) reports published in 2007 as a pragmatic approach which also avoids duplication of effort with a previous review commissioned by NICE which reviewed evidence on barriers and facilitators to community engagement (Popay et al., 2007). This review was undertaken to inform NICE guidance on community engagement in 2008 (NICE public health guidance 9). A total of 31 reports were therefore subsequently excluded because they described a type of community engagement that did not involve 'community partnerships/coalitions' or 'community mobilisation/action', and 41 were excluded because they were published before 2007. This left a total of 35 included reports which described 34 separate studies. See Appendix F for a bibliography of included studies, and Appendix G for a bibliography of excluded studies, with reasons for exclusion.

Figure 4.1 Flow of literature through the review



## 4.2 QUALITY ASSESSMENT OF STUDIES

The results of the quality assessment are presented in table 4.2 below. The four areas in which less than half scored positively were clarity of the role of the researcher, the rigour of the data analysis of the studies, the reliability of the data analysis and the clarity and coherence of ethics. This was largely related to inadequate reporting on these issues in the study reports. In addition, assessing how well the data collection was carried out was difficult in almost half of the studies due to inadequate reporting.

A total of 13 studies were judged to be of high quality (++), 18 of medium quality (+) and three of low quality [-] as follows:

- High quality (++): Carlisle (2010); Cinderby (2014); Fountain and Hicks (2010); Harkins and Egan (2012); Hills et al. (2007); IRISS (2012); Marais (2007); Robinson and Lorenc (2010); Sadare (2011); White et al. (2010); White and Woodward (2013); Windle et al. (2009); Woodall et al. (2013).
- Medium quality (+): Burgess (2014); Chapman (2010); Chau (2007); Christie et al. (2012); Dinham (2007); Hatamian et al. (2012); Hatzidimitriadou et al. (2012); Jarvis et al. (2011); Kimberlee (2008); Lawless et al. (2007); Lawson and Kearns (2009); Liverpool JMU (2012); Pemberton and Mason (2008); Roma Support Group (2009); Sender et al. (2011); Tunariu et al. (2011); White et al. (2012); Williamson et al. (2009)
- Low quality (-): Community Health Exchange (2012); Craig (2010); Lwembe (2011)

Table 4.2: Quality of included studies

	Quality score	Is a qualitative approach appropriate?	Is the research question clear?	How defensible/rigorous is the research design?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is the data analysis sufficiently rigorous?	Are the data rich?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims?	Are the conclusions adequate?	How clear and coherent is the reporting of ethics/
<b>Burgess (2014)</b>	+	Y	Y	Y	NS	N	Y	Y	NS	Y	NS	Y	Y	Y	NS
<b>Carlisle (2010)</b>	++	Y	Y	Y	Y	N	Y	Y	Y	Y	NS	Y	Y	Y	NS
<b>Chapman (2010)</b>	+	Y	Y	Y	NS	N	Y	Y	NS	Y	NS	Y	Y	Y	NS
<b>Chau (2007)</b>	+	Y	Y	Y	NS	NS	Y	Y	NS	NS	NS	Y	P	Y	NS
<b>Christie et al. (2012)</b>	+	Y	Y	NS	Y	NS	Y	NS	NS	Y	NS	Y	Y	NS	Y
<b>Cinderby (2014)</b>	++	Y	Y	Y	Y	NS	Y	Y	Y	Y	Y	Y	Y	Y	NS
<b>Community Health Exchange (2012)</b>	-	Y	Y	Y	NS	N	NS	Y	NS	NS	NS	Y	Y	NS	NS
<b>Craig (2010)</b>	-	Y	Y	NS	NS	N	Y	Y	NS	NS	NS	NS	Y	Y	NS
<b>Dinham (2007)</b>	+	Y	Y	Y	NS	N	N	NS	NS	Y	NS	Y	Y	Y	NS
<b>Fountain and Hicks (2010)</b>	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NS

Key: Y=Yes; N=No; NS= Not sure (not reported/inadequately reported); M=Mixed; P=Partially relevant

Table 4.2: Quality of included studies (continued)

	Quality score	Is a qualitative approach appropriate?	Is the research question clear?	How defensible/rigorous is the research design?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is the data analysis sufficiently rigorous?	Are the data rich?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims?	Are the conclusions adequate?	How clear and coherent is the reporting of ethics/
<b>Harkins and Egan (2010)</b>	++	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	NS
<b>Hatamian et al. (2012)</b>	+	Y	Y	Y	NS	N	NS	Y	NS	Y	NS	Y	Y	Y	NS
<b>Hatzidimitriadou et al. (2012)</b>	+	Y	Y	NS	Y	N	NS	NS	Y	Y	NS	Y	Y	Y	Y
<b>Hills et al. (2011)</b>	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>IRISS (2012)</b>	++	Y	Y	Y	Y	Y	Y	NS	NS	Y	NS	Y	Y	Y	Y
<b>Jarvis</b>	+	NS	Y	Y	NS	N	Y	Y	Y	NS	Y	Y	Y	Y	NS
<b>Kimberlee (2008)</b>	+	Y	Y	Y	Y	N	Y	Y	NS	Y	NS	Y	Y	Y	NS
<b>Lawless et al. (2007)</b>	+	Y	Y	Y	NS	N	Y	Y	NS	Y	NS	Y	Y	Y	NS
<b>Lawson and Kearns (2009)</b>	+	Y	Y	Y	NS	Y	Y	Y	NS	Y	NS	Y	Y	Y	NS
<b>Liverpool JMU (2012)</b>	+	Y	Y	NS	NS	N	N	Y	Y	Y	NS	Y	Y	Y	NS

Key: Y=Yes; N=No; NS= Not sure (not reported/inadequately reported); M=Mixed; P=Partially relevant

Table 4.2: Quality of included studies (continued)

	Quality score	Is a qualitative approach appropriate?	Is the research question clear?	How defensible/rigorous is the research design?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is the data analysis sufficiently rigorous?	Are the data rich?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims?	Are the conclusions adequate?	How clear and coherent is the reporting of ethics/
<b>Lwembe (2011)</b>	-	Y	Y	Y	NS	N	Y	NS	NS	Y	NS	NS	Y	NS	NS
<b>Marais (2007)</b>	++	Y	Y	Y	Y	Y	NS	Y	Y	Y	Y	Y	Y	Y	Y
<b>Pemberton and Mason (2008)</b>	+	Y	Y	Y	NS	N	NS	Y	NS	Y	NS	Y	Y	Y	NS
<b>Robinson and Lorenc (2010)</b>	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	NS
<b>Roma Support Group (2009)</b>	+	Y	Y	Y	NS	NS	Y	NS	NS	NS	NS	Y	Y	Y	NS
<b>Sadare (2011)</b>	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Sender et al (2011)</b>	+	y	M	y	y	N	NS	y	NS	y	NS	y	y	y	NS
<b>Tunariu et al. (2011)</b>	+	Y	Y	Y	Y	NS	NS	Y	NS	Y	NS	Y	Y	Y	Y
<b>White et al. (2012)</b>	+	Y	Y	Y	NS	N	Y	Y	Y	Y	NS	Y	Y	Y	N
<b>White et al. (2010)</b>	++	Y	Y	Y	Y	NS	Y	Y	Y	Y	Y	Y	Y	Y	Y

Key: Y=Yes; N=No; NS= Not sure (not reported/inadequately reported); M=Mixed; P=Partially relevant

	Quality score	Is a qualitative approach appropriate?	Is the research question clear?	How defensible/rigorous is the research design?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is the data analysis sufficiently rigorous?	Are the data rich?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims?	Are the conclusions adequate?	How clear and coherent is the reporting of ethics/
<b>Lwembe (2011)</b>	-	Y	Y	Y	NS	N	Y	NS	NS	Y	NS	NS	Y	NS	NS
<b>Marais (2007)</b>	++	Y	Y	Y	Y	Y	NS	Y	Y	Y	Y	Y	Y	Y	Y
<b>Pemberton and Mason (2008)</b>	+	Y	Y	Y	NS	N	NS	Y	NS	Y	NS	Y	Y	Y	NS
<b>Robinson and Lorenc (2010)</b>	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	NS
<b>Roma Support Group (2009)</b>	+	Y	Y	Y	NS	NS	Y	NS	NS	NS	NS	Y	Y	Y	NS
<b>Sadare (2011)</b>	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Sender et al (2011)</b>	+	Y	M	Y	Y	N	NS	Y	NS	Y	NS	Y	Y	Y	NS
<b>Tunariu et al. (2011)</b>	+	Y	Y	Y	Y	NS	NS	Y	NS	Y	NS	Y	Y	Y	Y
<b>White et al. (2012)</b>	+	Y	Y	Y	NS	N	Y	Y	Y	Y	NS	Y	Y	Y	N
<b>White et al. (2010)</b>	++	Y	Y	Y	Y	NS	Y	Y	Y	Y	Y	Y	Y	Y	Y

Key: Y=Yes; N=No; NS= Not sure (not reported/inadequately reported); M=Mixed; P=Partially relevant

Table 4: Quality of included studies (continued)



	Quality score	Is a qualitative approach appropriate?	Is the research question clear?	How defensible/rigorous is the research design?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is the data analysis sufficiently rigorous?	Are the data rich?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims?	Are the conclusions adequate?	How clear and coherent is the reporting of ethics/
<b>White and Woodward (2013)</b>	++	Y	Y	Y	Y	NS	Y	Y	Y	Y	NS	Y	Y	Y	Y
<b>Williamson et al. (2009)</b>	+	Y	Y	NS	NS	N	Y	Y	NS	Y	NS	Y	Y	Y	NS
<b>Windle et al. (2009)</b>	++	Y	Y	Y	Y	NS	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Woodall et al. (2013)</b>	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Key: Y=Yes; N=No; NS= Not sure (not reported/inadequately reported); M=Mixed; P=Partially relevant

### 4.3 CHARACTERISTICS OF STUDIES

#### a) Publication details

The majority of studies were reported in the grey literature with only eight published as a journal article in the peer reviewed literature. Grey literature reports were published by universities, charities or government departments. Both categories included high and medium quality studies but only the grey literature category featured studies assessed as low quality (table 4.3)

Table 4.3 Distribution of studies between grey and peer reviewed literature

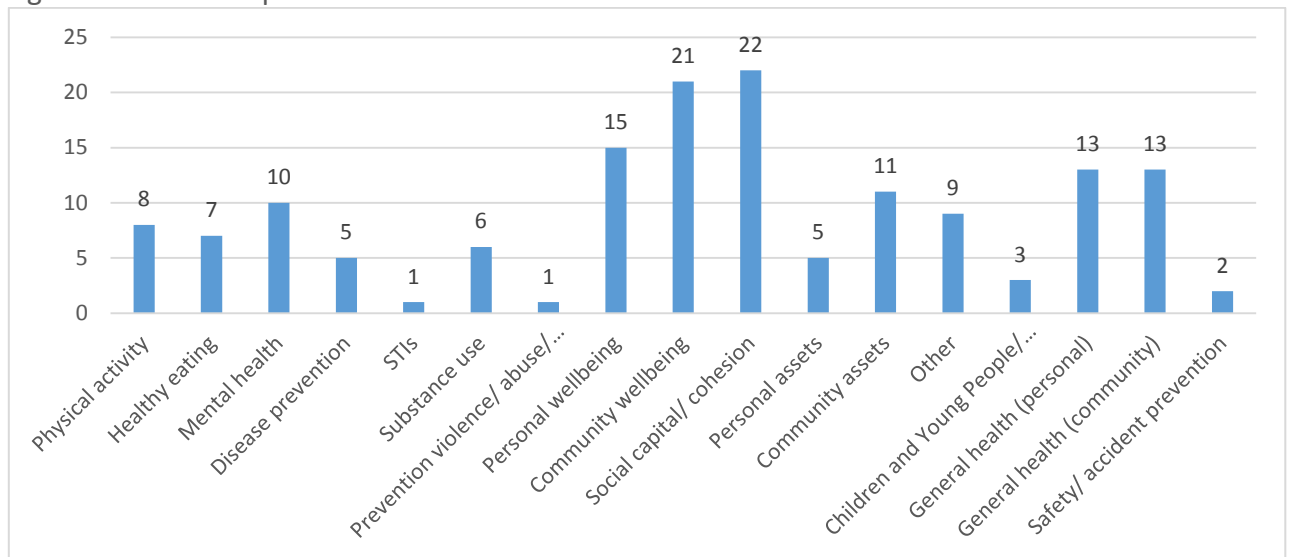
Studies published in the grey literature	Studies published in peer-reviewed journal
[+] <b>Burgess (2014)</b>	[++] Carlisle (2010)
[+] <b>Chapman (2010)</b>	[++] Christie et al. (2012)
[+] <b>Chau (2007)</b>	[+] Dinham (2007)
[+] <b>Cinderby (2014)</b>	[+] Jarvis et al. (2011)
[-] <b>Community Health Exchange (2012)</b>	[+] Kimberlee (2008)
[-] <b>Craig (2010)</b>	[+] Lawson and Kearns (2009)
[++] <b>Fountain and Hicks (2010)</b>	[+] Pemberton and Mason (2008)
[++] <b>Harkins and Egan (2012)</b>	[++] Woodall et al. (2013)
[+] <b>Hatamian et al. (2012)</b>	
[+] <b>Hatzidimitriadou et al. (2012)</b>	
[++] <b>Hills et al. (2007)</b>	
[++] <b>IRISS (2012)</b>	
[+] <b>Lawless et al. (2007)</b>	
[+] <b>Liverpool JMU (2012)</b>	
[-] <b>Lwembe (2011)</b>	
[++] <b>Marais (2007)</b>	
[++] <b>Robinson and Lorenc (2010)</b>	
[+] <b>Roma Support Group (2009)</b>	
[++] <b>Sadare (2011)</b>	
[+] <b>Sender et al (2011)</b>	
[+] <b>Tunariu et al (2011)</b>	
[++] <b>White et al (2010)</b>	
[+] <b>White et al. (2012)</b>	
[+] <b>White and Woodward (2013)</b>	
[+] <b>Williamson et al (2009)</b>	
[++] <b>Windle et al (2009)</b>	

All but three of the 34 studies included a process evaluation of a community engagement project or programme which explored barriers and facilitators to the community engagement. Methods used to explore barriers and facilitators were qualitative, consisting of in-depth interviews and/or focus groups. Two studies were mixed methods studies combining a survey with qualitative interviews, and one study used qualitative methods alone.

*b) Health and population focus*

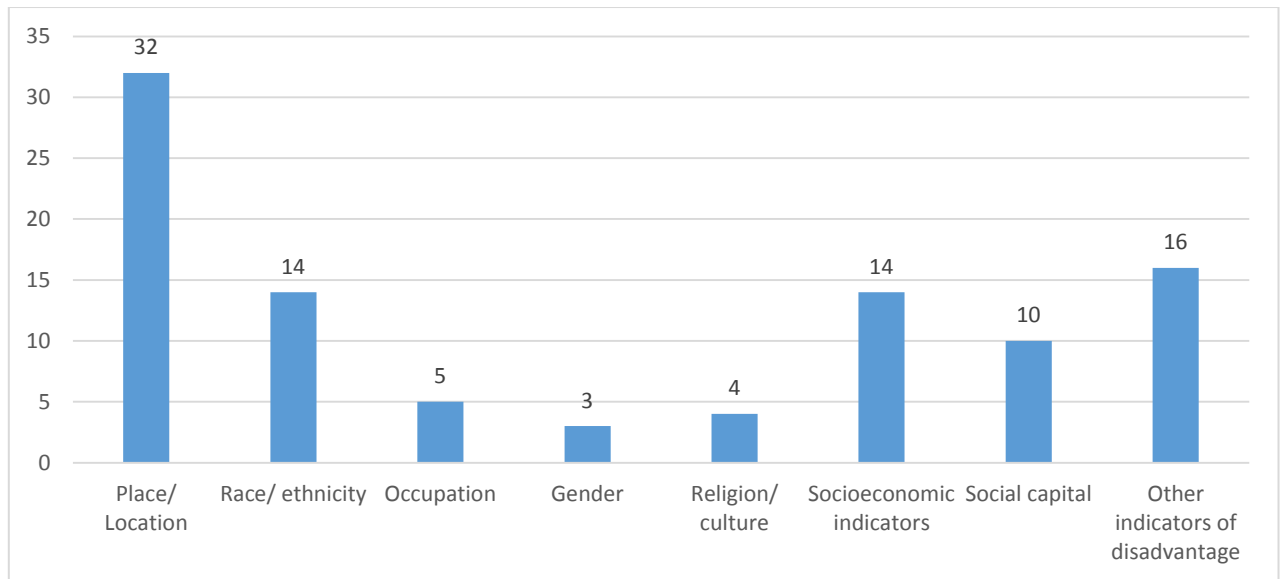
Studies focused on a range of health issues, although the largest number were not focused on single health topics but on broader themes such as community well-being, social capital and cohesion, or general health (figure 4.2).

Figure 4.2 Health topics



In terms of population focus, all studies focused on disadvantaged groups. The largest number of studies were focused on particular places/locations, typically described as deprived areas, although a significant number of studies were also focused on ethnic minority groups (n=14 groups (figure 4.3). Other specific groups targeted included older people, younger people, mental health service users, people living with long term conditions and ‘young mums’.

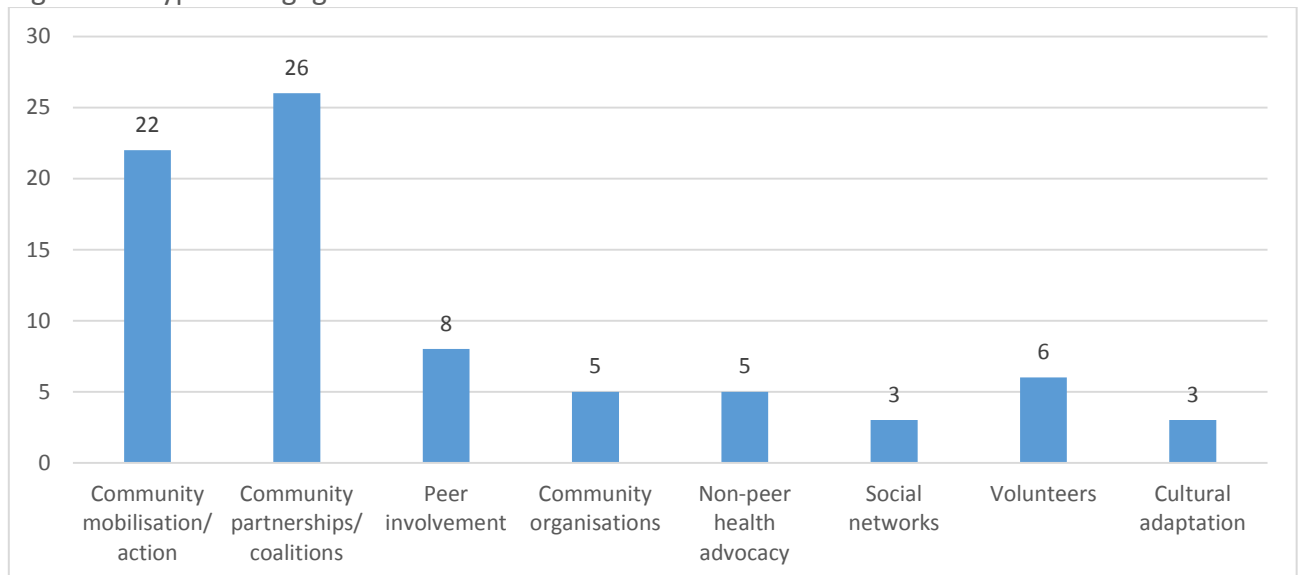
Figure 4.3 Population focus of studies



*c) Type, level and extent of community engagement*

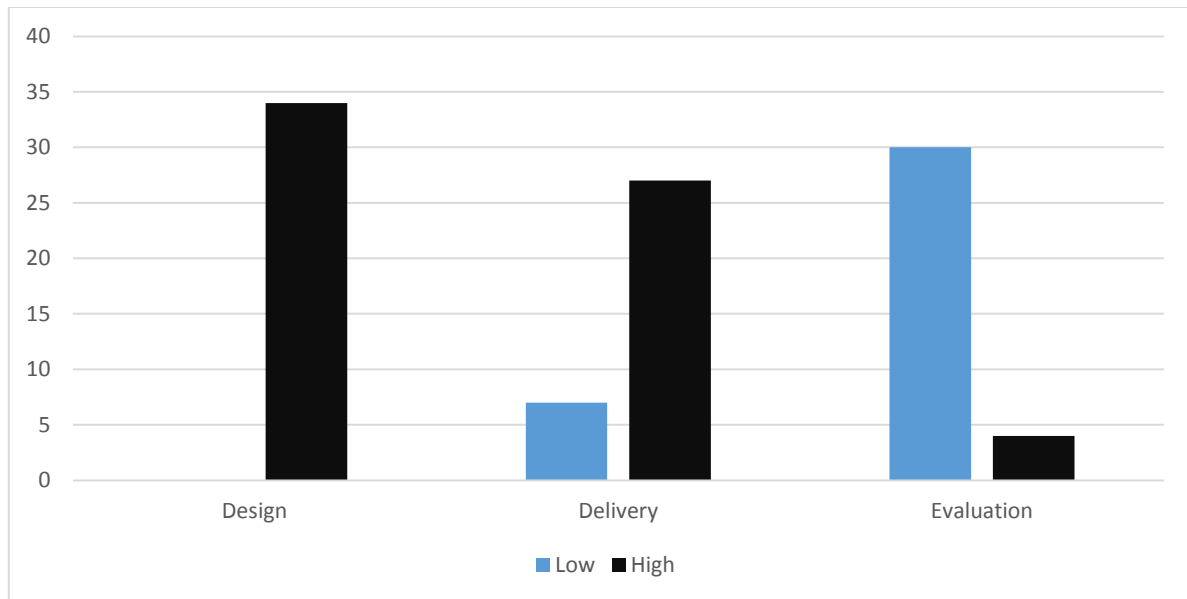
In line with the focus of this review all of the studies involved ‘community mobilisation/ action’ and /or ‘community partnerships/coalitions’. A total of 19 studies involved peers, non-peers or volunteers in the delivery of interventions (largely reflecting the studies of health champions). A smaller number (n=3) involved cultural adaptation of the intervention or social networks. A more detailed study by study presentation of the community engagement activities is presented in the next section.

Figure 4.4 Type of engagement



There were high levels of community engagement reported in the design and delivery elements of services, interventions or programmes (Figure 4.5).

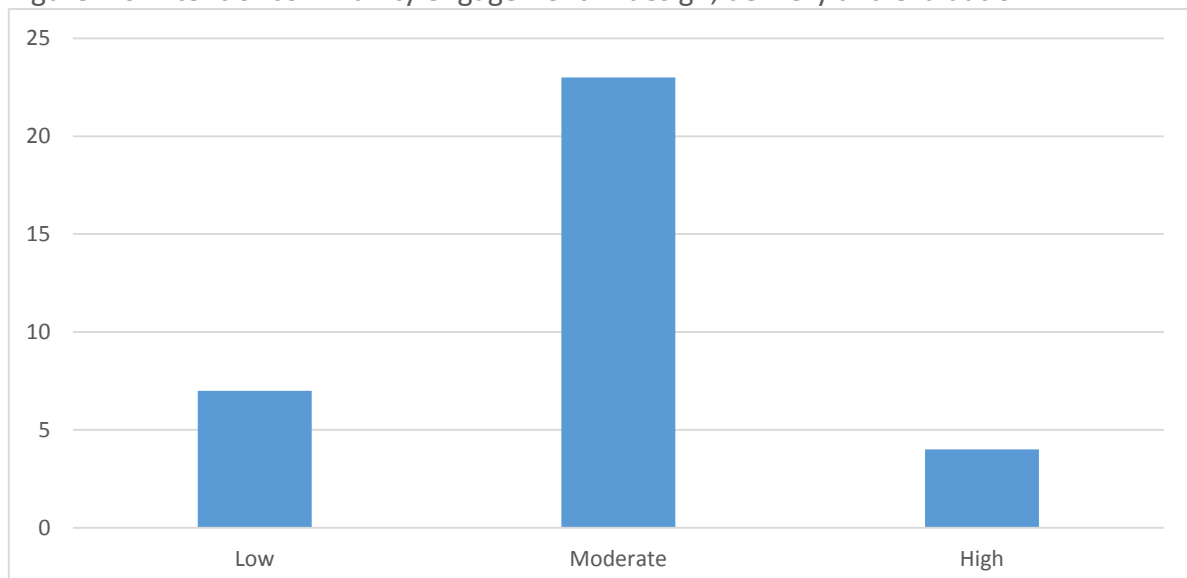
Figure 4.5 Level of community engagement in design, delivery and evaluation



Only four studies were rated as having high levels of community engagement in the evaluation of initiatives ([+] Chau (2007); [++] Marais (2007); [+] Roma Support Group (2009) and [++] Windle et al (2009)).

The above picture is reflected in the overall assessment of the extent of community engagement whereby only three studies were rated as high on overall extent of community engagement (Figure 4.6). Studies needed to have high levels of involvement across all three categories of design, delivery and evaluation to be considered as high on extent of engagement.

Figure 4.6 Extent of community engagement in design, delivery and evaluation



*d) Public health activities and further description of community engagement type*

Within the broad categories of our typology of community engagement there were a range of community engagement models or activities represented within the studies.

These tended to be mainly 'ad-hoc' with a lack of planning or grounding in a particular model of community engagement. Similarly, the community engagement was part of a range of different public health initiatives which varied in size and scope. We have described this range within six categories (Table 4.4). These categories map onto particular community engagement approaches.

Table 4.4 Studies by type of community engagement initiative

Area-based regeneration	New community services	Area-based health improvement	Health Champions/trainers	Health topic/service focused	New emerging approaches
<i>National programmes</i>	<i>National programmes</i>	<i>Well London</i> ([+] Chapman, 2010; [-] Craig, 2010; [+] Sadare, 2011; [+] Tunariu et al, 2010)	<i>Altogether Better</i> ([++] White et al., 2010)	<i>Road Safety</i> (local focus) ([++] Christie et al., 2012; [-] Kimberlee, 2008)	<i>Timebanks</i> ([+] Burgess, 2014)
<i>New Deal for Communities</i> ([+] Dinham, 2007; [+] Lawless, 2007)	<i>Sure Start</i> ([+] Pemberton and Mason, 2008)	<i>Govanhill Equally Well test site</i> ([++] Harkins et al., 2012)	<i>Ashton, Leigh and Wigan</i> ([+] Liverpool JMU, 2012)	<i>Sexual health services</i> (local focus) ([+] Robinson and Lorenc, 2014)	<i>National Empowerment Partnership</i> ([+] Sender et al., 2011)
<i>Social Inclusion Partnership Scotland</i> ([++] Carlisle, 2010)	<i>Healthy Living Centres</i> ([++] Hill et al., 2007)		<i>Kirklees</i> ([+] White et al., 2012)	<i>Mental health services</i> (national focus) ([++] Fountain and Hicks, 2009)	<i>Building community resilience</i> ([++] Cinderby et al., 2014)
<i>Local programmes</i> ([+] Jarvis, 2011; [+] Lawson and Kearns, 2009)			<i>Lincolnshire</i> ([++] White and Woodward, 2013)	<i>Tuberculosis</i> (local focus) ([++] Marais, 2007)	<i>Community-led organisations and initiatives</i> ([+] Chau, 2007; [-] Community Health Exchange, 2012; [+] Hatamian et al., 2012; [+] Roma Support Group, 2009; [++] Windle et al., 2009; [+] Williamson et al., 2009)
			<i>Yorkshire and Humber</i> ([++] Woodall et al., 2012)		<i>Asset-based approaches</i> ([++] IRISS, 2012)
			<i>Hammersmith and Fulham</i> ([-] Lwembe, 2011)		<i>Co-production of mental health services</i> ([+] Hatzidimitriadou et al., 2012)

**Area-based regeneration** – These generally used community partnerships/coalitions (see Figure 1 on p16). These generally represent early attempts to conduct community engagement. The earlier examples of community engagement and the partnerships/coalitions were often fraught with tensions (see section 5.3.1.1 in chapter 5).

**New community services** – As above, these also used community partnerships/coalitions and faced similar problems.

**Area-based health improvement** – These represent newer initiatives and involve community mobilisation/action as well as community partnerships/coalitions. The community engagement appears to be better embedded and makes use of structured and planned models of community engagement.

**Health Champions/Trainers** – These mainly use community members to deliver interventions but also involve community mobilisations as they empower community members with new skills.

**Health-topic focused** – These tended to be smaller in scale and scope (with the exception of Fountain and Hicks, 2009) but again were often explicitly community led although the choice of health topics was specified in advance.

**New emerging approaches** – This category is a mixed one, but these projects put community engagement at the centre rather than as a part of a broader initiative or a means to a particular health outcome. Of the eleven studies in this category, 6 are community-led organisations or initiatives. The other five come towards the later period of study (2012-2014) and include emerging approaches such as building resilience, timebanks, co-production and asset-based approaches.



## 5 SYNTHESIS OF FINDINGS

### 5.1 OVERVIEW

Our synthesis of study findings revealed many barriers and facilitators which we have organised under thematic headings within three areas: context; infrastructure and process (table 5.1).

These are presented in the rest of this chapter along with evidence statements. As well as our primary research question, we have also answered our sub-question on how barriers and challenges can be overcome.

Table 5.1 Overview of barriers and facilitators identified in the synthesis

Area	Theme	Barriers	Facilitators
CONTEXT	Quality of existing relationships with communities	<ul style="list-style-type: none"> <li>*History of poor relations</li> <li>*Community engagement as a threat</li> </ul>	
	Organisational culture, attitudes and practice	<ul style="list-style-type: none"> <li>*Lack of organisational commitment</li> <li>*Resistance to sharing power and control</li> <li>*Limited vision of community engagement in terms of:               <ul style="list-style-type: none"> <li>- who can be involved</li> <li>- what they can do</li> <li>- value of their experience</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>*Supportive culture, attitudes and practice embedded within the organisation <i>from the start</i></li> <li>*Supportive culture, attitudes and practice triggered or reinforced <i>during engagement</i></li> </ul>
INFRASTRUCTURE	Investment in infrastructure and planning to support community engagement	<ul style="list-style-type: none"> <li>* Lack of clarity, lack of transparency and confused expectations</li> <li>*Competing agendas across stakeholders within partnerships</li> <li>*Lack of dedicated staff and resources</li> <li>*Limited timelines for building trust and achieving scope and depth</li> </ul>	<ul style="list-style-type: none"> <li>*Planned rather than ad-hoc community engagement strategy and methods</li> <li>*Clarity of goals and transparency of process</li> <li>*Joint decision making</li> <li>*Community engagement as a transactional and reciprocal process</li> <li>*Establishing or using existing partnerships and networks</li> <li>*Investing time, effort and resources to build relationships and trust</li> <li>*Dedicated staff</li> </ul>
	Support, training and capacity building	<ul style="list-style-type: none"> <li>*Lack of appropriate training for professionals</li> <li>*Lack of appropriate training for communities</li> </ul>	<ul style="list-style-type: none"> <li>*Mentoring and other forms of support for community members</li> <li>*Community capacity building as an important end goal</li> </ul>

PROCESS	Capabilities and the engagement process	<ul style="list-style-type: none"> <li>*Lack of capacity within communities</li> <li>*Lack of capacity within community organisations</li> <li>*Difficulties engaging specific groups</li> </ul>	<ul style="list-style-type: none"> <li>*Gaining direct access to communities</li> <li>*Matching engagement method to community</li> <li>*Outreach and advocacy</li> </ul>
	Inclusive and accessible practice	<ul style="list-style-type: none"> <li>*Low awareness of engagement opportunities, rights and structures</li> <li>*Failure to overcome or recognise cultural and language issues</li> <li>*Untimely events and lack of support to attend</li> <li>*Lack of appropriate venues</li> <li>*Administrative delays for volunteers</li> <li>*Unrepresentativeness and partisanship</li> <li>*Geographic boundaries</li> </ul>	<ul style="list-style-type: none"> <li>*Early advertising of engagement opportunities through multiple channels</li> <li>*Plain language and provision for non-English speakers</li> <li>*Timing of events and support to attend</li> <li>*Using familiar places and creating an informal atmosphere</li> </ul>

## 5.2 CONTEXT

### 5.2.1 QUALITY OF EXISTING RELATIONSHIPS WITH COMMUNITIES

#### 5.2.1.1 BARRIERS

##### *a) History of poor relations*

Three high quality studies (Carlisle, 2010; Institute for Research and Innovation in Social Services, 2012; Sadare, 2011) and four medium quality studies (Dinham, 2007; Jarvis et al. 2011; Lawson and Kearns 2009; Roma Support Group, 2011) found that a history of poor relations between the community and the engaging organisations was a barrier to community engagement. The effect of this was highlighted before the engagement, characterised by the community's mistrust or cynicism, and often re-enforced during or after the engagement process due to poor engagement practices.

Sadare (2011) [++] found that unresolved local tensions with, and antagonism towards, the local authority was a reason reported by residents for not taking part in the community engagement events run within the Well London area-based health improvement programme which targeted 20 of the most deprived areas in London. Some of the residents who decided not to take part reported that they viewed the Well London programme as *"an extension of the "loathed" local authority and its agencies, and they did not want to have anything to do with it"* (p148). These residents *"believed that local authorities were "not upfront and truthful with the residents" and that "there was no*

point taking part in any consultation led by the government agencies” (p148). Similarly, Jarvis et al. (2011) [+] in an analysis of community engagement within a regeneration programme, found that residents were reluctant to get involved in neighbourhood activities in Canley – an area in the Midlands falling into the top 20 per cent of the most deprived neighbourhoods in England - due to feeling let down by local services. Jarvis et al. (2011) [+] go on to highlight how this lack of trust between residents and services, together with poor quality housing and neighbourhoods, is part of a cycle of deprivation which leads to transience and weak attachment to place, and to distrusting and disengaged residents.

The study conducted by the Roma Support Group (2011) [+] highlights another form of historical poor relations which impact negatively on community engagement. This study, described as participatory action research, aimed to identify problems (and solutions) faced by the Roma refugee and migrant community living in the UK for participating in ‘mainstream’ community engagement activities (e.g. through the ‘Duty to Involve’, Local Strategic Partnerships and Local Area Agreements). The study found that all Roma participants in the focus groups and subsequent dissemination conference agreed that:

*“long history of discrimination and social exclusion has led to the development of communities who do not know how to engage with public authorities. Frequent experiences of both overt and institutionalised racism, social and economic disadvantage and exclusion have contributed to creating inward looking and alienated Roma communities” (p26).*

Sadare (2011) [++] also found a strong cynicism towards the value of community engagement amongst the residents who did not take part in Well London engagement activities. Past experiences had taught them that community consultations had become a ‘tick-box’ exercise that did not influence decision making, and the communities expressed needs were not acted upon. For example:

*“...there have been consultations held, for example, about the park. People came out in large numbers, and what happened? They (local authority) still went ahead with their plans. There needs to be open policies where people know that what they say will be taken on board and acted on.” (p 149)*

Some residents therefore felt that taking part in Well London would be a waste of their time and efforts. This cynicism around the effectiveness of community engagement based on past negative experiences was also reported by participants in an assets-based approach to promoting positive mental health and well-being amongst mental health service users (Institute for Research and Innovation in Social Services (2012) [++]).

Furthermore, some studies found that the already shaky relationships between residents or service users may be further weakened during the engagement process if the process itself is found to be problematic (Carlisle, 2010 [++]; Dinham, 2007 [++]; Lawson and Kearns, 2009 [+]). Lawson and Kearns (2009)[+] in their evaluation of the community engagement within regeneration planning and implementation in three housing estates in Glasgow, found growing scepticism and disengagement from participants about the decision-making process. On each housing estate, ‘community consultative groups’ were

formed following more general meetings between residents and the local housing association to discuss what they liked and disliked about their homes and communities. Whilst these groups fed into the planning process through the production of a proposal with their 'preferred option' for regeneration, there was no clear remit for the groups within the next implementation stage. Few residents appeared to know what the next stage in the process was or what their role was going to be indicating a lack of clarity over decision-making and power structures within the overall process. This reinforced negative relationships between the engaging organisation and residents and undermined the enthusiasm and capacity developed within the groups during the planning stage.

These findings resonate with those of Dinham (2007) [+] in an analysis of the community engagement process within two New Deal for Communities (NDC) areas. The key finding of the analysis was that the residents' initial high expectations around community engagement and participation in the NDC (despite previous negative experiences) were diminished over time leading to 'disappointed participation'. This was a result of suspicion that the programme was concealing national policy objectives of welfare reform rather than being truly resident led; and disillusionment about levels and type of participation in which the promise of power sharing is revealed to be much more limited in reality:

*"People are definitely disappointed with how much power they have to decide things. We thought we'd really be in the lead but often we feel like we're working really hard but not really getting the rewards of making our own decisions" (p189)*

Carlisle (2010) [++] in her analysis of the community engagement process in an area-based regeneration project in Scotland (the Social Inclusion Partnership) also found that the process of engagement could inflame already tense relations between engaging authorities and the community. The community engagement process was studied in one area implementing the regeneration programme and involved community representation on the management board. Securing this participation was difficult, partly due to a lack of resources, and the management board seconded a member of staff from the local authority to manage the process. Whilst this post help to accelerate the process of achieving consensus and shared understanding around themes and goals it also served to concentrate local government influence within the regeneration project leadership, a cause of particular resentment to the community, which had a history of poor relations with the authority.

**In summary**, three high quality studies and four medium quality studies found difficulties for community engagement as a result of a history of poor relations between communities and engaging agencies or authorities. These existing poor relations can be re-enforced during and after community engagement by poor processes and lack of transparency over decisions.

#### ***b) Community engagement perceived as a threat***

Three high quality studies (Carlisle, 2010; Hills et al., 2007; Marais, 2007) and two medium quality studies (Christie et al., 2012; Roma Support Group, 2011) found that community engagement could be seen as a threat.

This was found in three studies engaging with Black and minority ethnic groups. A study examining the barriers and facilitators to participation in democratic processes faced by Roma community members in the UK (Roma Support Group, 2011 [+]) found this group to be suspicious of engaging organisations such as local authorities as a result of a long history of discrimination and social exclusion in both Eastern Europe and in the UK. Suspicion was also found in a study evaluating a specific community engagement project to inform a road safety project with the Somali Community in the London Borough of Hounslow (Christie et al., 2012 [+]). The Somali community was initially very suspicious of the project and unwelcoming. It later emerged through focus groups discussions with the community that they feared that their khat use (a legal drug used by the Somali community in the UK) may be exposed to the ‘authorities’. Similarly, Marais (2007) [++] in a study evaluating the participatory approach used to identify factors influencing the epidemiology and control of tuberculosis in migrant African communities in the London borough of Westminster, found a lack of willingness of some of the target community members to engage due to a fear of being exposed to the authorities around immigration or employment issues.

Community engagement was also seen as a threat by a rural community (Hills et al., 2007 [++]) and by residents of a deprived area targeted by a regeneration project (Carlisle, 2010 [++]). In their evaluation of the community engagement process as part of the implementation of Healthy Living Centres, Hills et al (2007) [++] found that staff undertaking outreach activities were met with considerable suspicion because residents were not used to be asked for their views and were not familiar with the concept of community engagement. In an evaluation of the community engagement process used within one area targeted by a regeneration project in Scotland (the Social Inclusion Programme), Carlisle (2010) [++] found that local community organisations regarded the programme as ‘just a new bandwagon’. Crucially, the community organisations perceived the programme to represent a shift of government funding from community development and regeneration to health promotion, with an increased emphasis on the self-sustainability of community initiatives which the community organisations had previously been funded to do. Thus, the regeneration programme and its associated community engagement were perceived as a threat to current initiatives and continued funding for community organisations.

#### 5.2.1.2 FACILITATORS

There was no evidence found within this theme regarding facilitators to community engagement.

#### 5.2.1.3 OVERCOMING THE CHALLENGES

The challenges to community engagement posed by a history of poor relations between communities and engaging organisations and community engagement being perceived as a threat could be overcome by engagers ensuring that they were fully informed and sensitive to this context when planning community engagement; allowing sufficient time and resources to build trust between engagers and engagees; and flexibility in engagement methods.

Two studies in their analysis of specific community engagement initiatives for mental health service users highlight how the strategies chosen to engage communities by engagers reflected consideration of the mistrust held by mental health services users as a result of perceived past oppressive practices by these services. The community engagement strategy evaluated by Fountain and Hicks (2010) [++] involved training Black and minority ethnic community organisations to conduct research among their own communities and then supporting them to connect with local services by setting up steering groups involving the community organisations, local mental health service planners, commissioners and providers. This was an England-wide project and a total of 547 community researchers were recruited including 48 current or previous mental health service users. The community engagement strategy evaluated by Hatzidimitriadou et al. (2012) [+] involved developing partnerships between local faith-based and other community groups and the local mental health NHS Trust to co-produce responsive mental health services. Benefits were reported by community leaders in terms of developing the capacity of community organisations (trusted by the local community) to engage with the NHS and become partners in providing services and by NHS managers in terms of improving their status, approachability and visibility in the community:

*“it gives us kudos, it gives us status, it gives us evidence of ability to work beyond the asylum, you know, beyond the gates of Springfield Hospital. We are actually out there liaising and working and trying to pick up what’s happening in the communities.” (p34).*

Jarvis et al. (2011) [+] in an analysis of community engagement within one area targeted by a regeneration programme found that a new mechanism for capturing the needs of residents (via a new neighbourhood management structure which placed individual officers within neighbourhoods) led to a renewed commitment to community engagement by the local authority and a renewed enthusiasm on the part of residents to get involved in community engagement activity. The community engagement itself was seen as crucial for re-building trust between residents and public agencies.

Fear of engagement was overcome in a project aiming to engage the Somali community in the London Borough of Hounslow in the design of a road safety project. The road safety unit within the local authority were able to overcome the initial suspicion of the Somali community toward them through being careful not to be seen as advocates for banning khat and regular visits over a period of time to gain trust and acceptance (Christie et al., 2012 [+]). Similarly, Hills et al (2007) [++] found that staff from engaging organisations were able to overcome the suspicion of rural residents unfamiliar to the idea of community engagement when carrying out engagement activities to feed into the development of a Health Living Centre. Persistent outreach activities (e.g. door knocking, identification of well-connected individuals within the community) and flexibility in approach were key to overcoming the challenges of reaching community members who were initially reluctant to take part.

#### 5.2.1.4 EVIDENCE STATEMENT

<b>Evidence Statement 1: Quality of existing relationships with communities</b>
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There is evidence from eleven evaluation studies high quality studies <sup>1-10,12</sup> and one
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qualitative study<sup>11</sup> on the quality of existing relationships with communities.

**ES 1.1** There is evidence from three [++] studies<sup>1,7,12</sup> and four [+] studies<sup>3,8,9,11</sup> that a history of poor relations between communities and engaging agencies and authorities can make it difficult to get community members to attend engagement events and to keep communities on board. Mistrust and cynicism were found to be reasons for not participating in engagement activities<sup>8,11,12</sup>. Engagement practices which were perceived to be tokenistic or not linked to decision-making reinforced pre-existing mistrust and cynicism and led to disengagement and disillusionment during and after community engagement<sup>1,3,7,9</sup>.

**ES 1.2** There is evidence from three [++] studies<sup>1,6,10</sup> and two [+] studies<sup>2,11</sup> that community engagement can be seen as a threat by communities which, as above, can make it harder to initially engage communities and keep them engaged. Experience of discrimination and exclusion by authorities<sup>11</sup>, fear of exposure to authorities (over drug use<sup>2</sup>, immigration status<sup>10</sup>, or stigmatising illness<sup>10</sup>), a lack of tradition of engagement<sup>6</sup>, and engagement seen as a means to divert existing funding into other initiatives<sup>1</sup> were all found as reasons why community engagement can be seen as a threat.

**ES 1.3** There was no evidence found within this theme regarding facilitators to community engagement.

**ES 1.4** There was evidence from two [++] studies<sup>4,6</sup> and three [+] studies<sup>2,5,8</sup> on how the difficulties of initially engaging communities and keeping them on board can be overcome. These were developing partnerships between engaging and community organisations<sup>4,5</sup>, building capacity amongst the communities to be engaged to conduct outreach and engagement activities<sup>4,5</sup>, allowing sufficient time and resources for outreach activities to build trust and acceptance, and flexibility in outreach and engagement methods<sup>2,6</sup>.

### Key

1 Carlisle (2010) ++	7 Institute for Research and Innovation in Social Services (2012) ++
2 Christie et al. (2012) +	8 Jarvis et al. (2011) +
3 Dinham (2007) +	9 Lawson et al. (2009) +
4 Fountain and Hicks (2010) ++	10 Marais (2007) ++
5 Hatzidimitriadou et al. (2012) +	11 Roma Support Group (2011) +
6 Hills et al. (2007) ++	12 Sadare (2011) ++

## 5.2.2 ORGANISATIONAL CULTURE, ATTITUDES AND PRACTICE

### 5.2.2.1 BARRIERS

#### a) Lack of organisational commitment



One high quality study (Robinson et al., 2010) and two medium quality studies (Hatzidimitriadou et al., 2012; Sender et al., 2011) reported challenges to community engagement arising due to engaging organisations not being fully committed to supporting community engagement.

Robinson et al (2010) [++] found that the most significant barrier to effective engagement identified by their survey and interview study of sexual health clinicians, commissioners, health promotion/public health specialists, service users, voluntary sector organisations and researchers across England was lack of organisational commitment, and associated lack of dedicated staff, time and money. All categories of interviewees highlighted a lack of commitment as a result of the historical absence of an “ethos of customer satisfaction” in the NHS and a paternalistic culture which undervalues the active participation of the community in designing and delivering appropriate treatment and prevention services, although they also noted that this was slowly changing:

*“Just like clinical care is shared now, it would feel very odd to split that off and say ‘you’re involved in discussions about your treatment but what we’re doing in service or commissioning wise don’t you worry your pretty little head about’. It feels that involvement should be at all levels. And it’s just, it’s funny how long it’s taken that idea to circulate through” (p10)”*

Hatzidimitriadou et al (2012) [+] in their evaluation of a co-production approach to providing community-based mental health projects in Wandsworth, found in interviews with community leaders and community development workers, a reluctance of NHS commissioners and managers to engage fully with the co-production process.

*“I feel that firstly the commissioners, those at that strategic level, need to take it seriously.” (p 40)*

*“Not all senior managers in the Trust have signed up to this – we need more ‘buy-in’ from them.” (p 40)*

Sender et al (2011) [+] in their evaluation of the ‘National Empowerment Partnership’ - which aimed to support individuals and communities to get involved in and influence local decisions and build the capacity of local authorities and other public agencies to engage and empower communities - found from interviews with those trying to implement the programme (the ‘regional empowerment leads’) that despite offering free training, some local authorities would not participate in it. This was linked to a lack of organisational commitment:

*“You’re in a double bind because the ones that really need the help are the ones that are too disorganised and too short of staff and too lacking in senior management buy-in to get it together” (p39)*

## **b) Resistance to sharing power and control**

One high quality study (Windle et al., 2009), one medium quality study (Kimberlee, 2008) and one low quality study (Community Health Exchange, 2012) found evidence of explicit or implicit resistance within engaging organisations to sharing power and control with communities or community organisations and a reluctance to change organisational or



individual practice to accommodate genuine rather than tokenistic engagement. Community Health Exchange (2012) [-] found from a survey of, and in-depth interviews with, community led health organisations in Scotland, examples of unsupportive practice by engaging organisations, such as short notice of meetings and non-reimbursement of expenses, which made building relationships towards effective joint working difficult. Similarly, Windle et al (2009) [++], in their evaluation of a national programme to involve older people in partnership with service providers and commissioners, found examples of conflict of interest between service users and professionals about what is achievable within a tight timeline, with professionals often putting the delivery of outcomes above prioritising the engagement of older people in the project. Kimberlee (2008) [+] also found tensions between the need to develop policies and programmes with public participation and professional priorities in their evaluation of the community engagement within Birmingham City Council's Streets Ahead on Safety project.

### ***c) Limited vision and expectations of community engagement***

Two high quality studies (Harkins et al., 2012; Hills et al., 2011) and three medium quality studies (Hatzidimitriadou et al. (2012); Chau, 2007; White et al., 2012) found evidence of a limited vision of community engagement within engaging organisations in terms of: who or which sections of the community can be involved, what communities are capable of doing, and the value of the communities experience and expertise in comparison to that of professionals.

This limited vision was expressed in a number of ways. Chau (2007) [+], in an evaluation of a project to build capacity and create greater opportunities for Chinese older people to get involved in policy and practice, found poor attitudes towards the volunteer Chinese older people from paid workers, one of whom described their input as 'nonsense'. White et al. (2012) [+] in their evaluation of a 'health trainer' project in Kirklees found that there was reluctance amongst some health professionals to refer patients to the health trainers. In interviews with community leaders and NHS staff in an evaluation of a co-production approach to deliver Increasing Access to Psychological Therapies in the community, Hatzidimitriadou et al (2012) [+] found different understandings between the two groups over what co-production means:

*"...there were huge disagreements, part of the disagreement were their [mainstream service providers] ...notion of co-production in the beginning was – we will just use your building and come in for two hours and provide the service and leave." (p 16)*

Harkins et al (2012)[++] in their evaluation of community engagement in an area-based health improvement project - Govanhill Equally Well Test Site - found a preference amongst public sector staff for engagement with 'professionalised' community members rather than those from a non-professional or disadvantaged background. Through interviews with project staff, the authors found that this preference is related to governance, with staff beliefs that 'professionalised' community members are more likely to be accountable within devolved decision making structures such as participatory budgeting.

Hills et al (2007) [++] in their evaluation of the Big Lottery Fund Healthy Living Centres Programme found that some centre staff and managers were more likely to attribute any difficulties encountered with community engagement (e.g. failure to recruit local people into leadership roles for community engagement) to persistent apathy or disinterest rather than looking at organisational culture or the community engagement practices employed.

#### 5.2.2.2 FACILITATORS

##### ***a) Supportive culture, attitudes and practice embedded within the organisation from the start***

One high quality study (Hills et al., 2007), four medium quality studies (Jarvis et al., 2011; Lawless et al., 2007; Pemberton and Mason, 2008; Williamson et al., 2009) and one low quality study (Lwembe, 2011) presented evidence to suggest that a supportive organisational culture, attitudes and practice, embedded throughout the organisation from the start facilitated the community engagement process.

As described in section 5.2.1.3, Jarvis et al (2011) [+] in their evaluation of the impact of community engagement in neighbourhood regeneration in Canley, Coventry, found that a new willingness on behalf of the local authority to engage comprehensively with residents and use of a bottom-up partnership approach, was crucial for the success of the community engagement process which was able to re-engaged disaffected residents.

National initiatives such as the Healthy Living Centres programme, New Deal for Communities and Sure Start required organisations to demonstrate how they would engage communities as part of their funding applications. This sets up a very strong statement of intent from organisations from the start that they are committed to involving, and developing the capacity of, the local community, in all areas of project planning, development and management (Hills et al., 2007 [++]; Lawless et al., 2007 [+]; Pemberton and Mason, 2008 [+]). Hills et al (2007) [++] in their evaluation of the Healthy Living Centre programme report that some Centre staff valued their work in developing relationships with, and capacity amongst local communities very highly and saw this work as being key to improving the health of disadvantaged and vulnerable groups. Similarly Lawless et al (2007) [+] report a strong and persistent belief across staff within the six New Deal for Communities case study sites that community engagement should be at the heart of neighbourhood renewal activities.

The impact of a supportive culture, attitudes and practice from the start from engaging organisations was that the community was able to feel true ownership of the initiative. Lwembe (2011) [-] in her evaluation of the health champion project in one London borough taking part in the overall Well London programme, found that residents felt a sense of ownership of the project from the word go. Being enabled to set the agenda for the programme from the beginning made residents feel they had a 'privileged voice', and were able to identify 'real' priorities. Similarly, Williamson et al (2009) [+] in their evaluation of the Rochdale Partnerships for Older People Project, describes how from the outset the project's aims was to enable older people to exercise greater power and control over their lives, in order to sustain independence and well-being in later years. The evaluation found that the model of community engagement used - developing four

partnerships with older people across the local borough and devolving commissioning and funding to these partnerships - conveyed a powerful commitment to community engagement.

### **b) Ongoing supportive culture, attitudes and practices during engagement**

Four medium quality studies (Chau, 2007; Hatamian et al., 2012; Hatzidimitriadou et al., 2012; White et al., 2012) found that a committed or supportive organisational culture triggered or reinforced during the community engagement process itself, helped to motivate community workers and volunteers, facilitating the engagement process and the delivery of subsequent projects.

White et al (2012) [+] in their study of a health trainer project within the Kirklees district Health Trainer Service, found commitment levels of senior managers and commissioners to be very high, demonstrated by the project integration within a broader strategic approach to improving health and encouraging self-management of long term conditions. The health trainers' project was embedded into the local authority and managerial structures were in place to provide health trainers with the support and continuity they needed to perform well. Feedback to the local authority (e.g. gaps in service provision) from community-based health trainers was taken seriously with a procedure for logging the feedback to ensure that it could be used for service improvement. This level of support was linked to the success of the health trainer project:

*"I think consistent support within the management and a clear vision of direction of travel (are key to organisational success)" (p 25)*

Support from all layers of engaging organisations beyond managers was also important. Chau (2007) [+] in an evaluation of a project to support greater involvement of Chinese older people in designing and delivering policies and services found that Chinese older people who volunteered within the project greatly valued the support they got from employed workers within the organisations they were working in partnership with.

During the process of engagement, engaging organisations became more committed to community engagement as a result of fully recognising the benefits of harnessing local knowledge and networks. Hatzidimitriadou et al (2012) [+] in their evaluation of co-production processes in a community-based mental health project in Wandsworth found that when service providers accepted that community organisations have a better understanding of their members' needs and expectations, community and NHS organisations were able to work more effectively together to deliver early intervention services in ways that are accessible and appropriate to the community. Similarly, Hatamian et al (2012) [+] in their evaluation of the 'Active at 60 Community Agent Programme', which trained older people to help other older people to become more active and positively engaged with society, found that local funders linked the knowledge that local community groups had about their neighbourhoods as a key success factor in the programme, along with their enthusiasm and passion for the work that they do and the needs that they meet.

### 5.2.2.3 OVERCOMING THE CHALLENGES

There were no studies that directly addressed how to overcome the challenges for community engagement arising from a lack of organisational commitment, a resistance to sharing power and control or a limited vision of community engagement. The facilitators described in section 5.2.1.2 provide suggestions but none of our included studies attempted to evaluate the impact of deliberate strategies to embed a supportive culture, attitudes and practice on community engagement; nor did they capture attempts to try to modify organisational culture, attitudes or practice during a community engagement process. Some of the studies did, however, make recommendations for how a positive culture, attitudes and practice could be embedded within organisations on the basis of their findings about barriers to community engagement. These were: introducing requirements for statutory organisation to report on the nature and extent of their community engagement (Community Health Exchange, 2012 [-]) and integrating community engagement into the mainstream activities of an organisation rather than as an add-on (Robinson et al., 2010 [++]; White et al., 2012 [+]).

### 5.2.2.4 EVIDENCE STATEMENTS

#### Evidence Statement 2: Organisational Culture, Attitudes and Practice

There is evidence from fourteen evaluation studies<sup>1,3-11,13-16</sup> and two mixed methods studies<sup>2,12</sup> on organisational culture, attitudes and practice.

**ES 2.1** There is evidence from one [++] study<sup>12</sup> and two [+] studies<sup>5,13</sup> that a lack of organisational commitment within engaging organisations is a barrier to community engagement. This was seen within the NHS<sup>5,12</sup> and Local Authorities<sup>13</sup> and was linked to a 'slow to change' paternalistic attitude towards service users<sup>12</sup> and a lack of dedicated or shortage of staff<sup>12,13</sup>.

**ES 2.2** There is evidence from one [++] study<sup>16</sup>, one [+] study<sup>8</sup> and one [-] study<sup>2</sup> of resistance within engaging organisations to sharing power and control. This was demonstrated through practices which made it difficult for community organisations to participate in discussions such as giving too short notice for meetings<sup>2</sup> and putting the priorities of engaging organisations above those of the community<sup>8,16</sup>.

**ES 2.3** There is evidence from two [++] studies<sup>3,6</sup> and three [+] studies<sup>1,5,14</sup> that engaging organisations can hold a limited vision and set of expectations for community engagement in terms of: who or which sections of the community can be involved, what communities are capable of doing, and the value of the communities experience and expertise in comparison to that of professionals.

**ES 2.4** There is evidence from one [++] study<sup>6</sup>, four [+] studies<sup>7,9,11,15</sup> and one [-] study<sup>10</sup> that a supportive organisational culture, attitudes and practice, embedded throughout engaging organisations from the start facilitated the community engagement process. Building community engagement into funding requirements was effective in creating such a supportive environment<sup>6,9,11</sup> and the impact of this was that communities felt a

true sense of ownership over projects<sup>7,15</sup>.

**ES 2.5** There is evidence from four [+] studies<sup>1,4,5,14</sup> that a committed or supportive organisational culture triggered or reinforced during the community engagement process itself, helped to motivate community workers and volunteers, and facilitated the engagement process and the delivery of subsequent projects. Community engagement in practice demonstrated more fully the benefits of harnessing local knowledge and networks<sup>4,5</sup>.

**ES 2.6** There was no direct evidence within this theme on strategies to overcome a lack of organisational commitment, a resistance to sharing power and control or a limited vision of community engagement.

### Key

1 Chau (2007) +	9 Lawless et al. (2007)+
2 Community Health Exchange (2012) –	10 Lwembe (2011) -
3 Harkins et al. (2012) ++	11 Pemberton and Mason (2008) +
4 Hatamian et al. (2012) +	12 Robinson et al. (2010) ++
5 Hatzidimitriadou et al. (2012) +	13 Sender et al. (2011)+
6 Hills et al. (2007) ++	14 White et al. (2012) +
7 Jarvis et al. (2011) +	15 Williamson et al. (2009) +
8 Kimberlee (2008) +	16 Windle et al. (2009) ++

## 5.3 INFRASTRUCTURE

### 5.3.1 INVESTING IN INFRASTRUCTURE AND PLANNING

#### 5.3.1.1 BARRIERS

##### **a) Lack of clarity, transparency and confused expectations**

One high quality study (Sadare, 2011), three medium quality studies (Chapman, 2010; Dinham, 2007; Hatzidimitriadou et al., 2012) and one low quality study (Community Health Exchange, 2012) found that a lack of clarity, lack of transparency, and confused expectations around community engagement goals and process were barriers to effective community engagement.

The investigation of Scottish community-led health organisations' influence in health and social planning structures by Community Health Exchange (2012) [-], found that the community-led health organisations surveyed felt there was a lack of openness and accountability from strategic planners.

*“Still too often decisions are made and then we are asked to rubber stamp them - that’s being involved but you wouldn’t call it being influential” (p 9)*

*“Service decisions are not open and transparent” (p 9)*

*“Generally we aren’t even consulted prior to decisions being made, so we’re not part of the decision making process. We are informed about decisions after the fact instead of being involved as front line staff.” (p 9)*

A lack of clarity and transparency between engaging organisations and community-based organisations was also found by Hatzidimitriadou et al (2012) [+] in their evaluation of co-production processes in a community-based mental health project in Wandsworth. Reflecting on the process, service providers felt they needed to be clearer to their co-providers, the community organisations, about what they were able to offer and the constraints within which they operate so they wouldn’t ‘raise hopes’ or disappoint community partners when they could not deliver certain expected outcomes:

*“Being professional, i.e., delivering what we say we were going to, managing expectations, staff have a passion to deliver, they really want to achieve and to make a difference, but are not always managing their expectations. (Increasing Access to Psychological Therapies (IAPT) Manager)” (p 43)*

Communities themselves were not always clear about the purpose and process of community engagement or how to get involved. Dinham (2007) [+], in a study of well-being and participation in disadvantaged areas looking at New Deal for Communities, a national strategy for neighbourhood renewal in the UK over ten years, found that messages about the purposes, implementation, outputs and outcomes of participation were very unclear to the local people whom it was intended would become participants. This in turn suggested that those messages were either unclear in the programme itself or were being poorly communicated to residents. Sadare (2011) [++], in her PhD study of the early days of the community engagement process in the Well London Programme, found that insufficient information was an apparent barrier to engagement. Several respondents said that they did not fully understand what the Well London programme was about and did not know how they could engage with it.

A lack of clarity could lead to mixed messages and confusion over what could be expected by communities. Chapman (2010) [+], in an evaluation of the Well London Community Activator Programme, found that due to a lack of clarity in the early planning stages of the Programme, mixed messages were given to the recruits prior to the training course as to the minimum length of time they would be expected to commit to the programme and, more fundamentally, whether the programme budget included allowance for any payment to the Activators themselves. Two individuals who were recruited and attended the first day of the training course, subsequently dropped out as they had been led to believe they would be paid for their time. Clearly, this was unfortunate and resulted in some confusion for a short while, which was a constraint in the early stages of the Programme.

#### **b) Competing agendas across stakeholders within partnerships**

Four high quality studies (Carlisle, 2010; Sadare, 2011; White et al, 2010; Windle et al, 2009), five medium quality studies (Hatzidimitriadou et al, 2012; Kimberlee, 2008; Lawless et al, 2007; Lawson et al, 2009; Pemberton and Mason, 2008) and one low quality study (Lwembe, 2011) found that competing agendas (e.g. targets, funding priorities, values and expectations) across the different stakeholders involved in community engagement partnerships created tensions, where one agenda was favoured over another especially to



the perceived detriment of communities, and put a break on effective community engagement.

Several studies documented the existence of competing agendas between communities and engaging organisations and the impact of these. Competing agendas could arise from a mis-match between national statutory agency priorities (e.g. reducing burglary for the police) and local priorities (e.g. reducing anti-social behaviour and drug-related crime for local communities) (Lawless et al., 2007 [+]); different definitions of health (e.g. Lwembe (2011) [-], in her evaluation report of the health champion aspect within the Well London programme in White City, found that whilst the Health Champions role was restricted to promoting general health and wellbeing, residents wanted to address wider housing and social care issues); differences in defining solutions between statutory agencies and communities (e.g. Lawson et al (2009) [+], in their study of community engagement in regeneration in the city of Glasgow, found that some of the solutions suggested by communities about the places they live went ‘against the grain’ of what was considered the ‘right option’ by engaging agencies); or differences in what can be achieved within tight timelines with engaging organisations or funders often prioritising outcomes over community engagement (White et al., 2010 [++]; Windle et al., 2009 [++]). For example, White et al (2010) [++] in their evaluation of the Altogether Better Programme, found that community project leads found it difficult to demonstrate the value of their projects against the local commissioners ‘mandate’ to “prove it, prove it, prove it!”. Similarly, Windle et al (2009) [++], in a national evaluation of the ‘Partnerships for Older People Projects’ funded by the Department of Health to develop services for older people, found that the delivery of outcomes were prioritised above the engagement of older people in the partnership areas.

Difficulties in handing over or distributing power emerged as one explanation for competing agendas between engaging organisations and communities (Carlisle, 2010 [++]; Hatzidimitriadou et al., 2012 [+]; Kimberlee, 2008 [+]; Pemberton and Mason, 2008 [+]). For example, Pemberton and Mason (2008) [+] in their evaluation of the involvement of users in Sure Start Children’s Centres in Greater Merseyside, found political difficulties of handing over power and a perceived dilution of accountability. Kimberlee (2008) [+] in an evaluation of the inclusion of children in road safety design in Birmingham, found that local councils and consultants appeared to privilege the needs of commercial stakeholders over the input of young people, because young people were seen as ‘disordering’ the urban environment.

Hatzidimitriadou et al (2012) [+] and Carlisle (2010) [++] both documented the impact of such competing agendas and difficulties in giving up or distributing power to communities. Hatzidimitriadou et al (2012) [+] in their evaluation of co-production processes in a community-based mental health project in Wandsworth, found that conflicting agendas were a major block to full engagement with the co-production process. The issue of conflicting agendas was noted for both service providers and community organisations:

*“There are different demands from different groups and it is difficult to come to a common understanding or agreement. (Increasing Access to Psychological Therapies (IAPT) Manager)” (p 44)*

*“Sometimes there are multiple organisations and I think that’s important because you cannot, you can say all this, you know, local public service, for example, and the BME community but the different communities need to, you know, they have their own priorities. (Psychological Well-being Practitioner)” (p 44)*

*“We need to think of ways in which the difference or change can be made more tangible for co-providers. The NHS wants numbers; the co-providers want to know what is making an impact. How do we know who we are reaching? (Community development worker)” (p 44)*

Carlisle (2010) [++] in her study of the community engagement process in the ‘Social Inclusion Partnership’ (SIP) in Scotland, reports at length the difficulties created throughout the SIP project in Scotland, from a lack of agreement between different partners as to purpose and outcome of the initiative. As Carlisle (p121) noted, differences became apparent at the first meeting: “The health board’s chief executive spoke of tackling lifestyle issues and specific diseases (heart disease, cancer and stroke)...The SIP manager focused on problems of poverty, unemployment and poor housing - issues central to the work of local government. Questions and concerns from community residents centred on drug and alcohol use amongst young people and mental health problems amongst long-term unemployed men”. One community member summed these differences up:

*“We’re gonnae gie ye five pieces o’ fruit [a SIP initiative] but ye can sit in yer house an’ be terrified tae go out. (Community Representative)” (P123)*

It is important to note that competing agendas existed within and between communities and community-based or focused organisations as well as between communities and engaging organisations. Sadare (2011) [++], in her evaluation of the community engagement process in the Well London Programme, found that at the beginning of the programme there were conflicts between some local community organisations and the Well London alliance partners. The local groups feared that the bigger, more established organisations, who had more resources, might take over their roles or duplicate their activities:

*“A lot of things are already happening and we have groups... facilitating these. We don’t need an external group coming in to duplicate things already happening. Rather, we need support for the local groups to continue doing what they are doing.” (p 148)*

Lawson et al (2009) [+] in their study of community engagement in regeneration in Glasgow found that all community constituencies did not feel included in the process. Lawson et al. recommend that practitioners need to avoid thinking that there will be a consensus position from the community and to acknowledge that there will be different interests. Interestingly, Lawless et al (2007) [+] in their evaluation of the community engagement in New Deal for Communities, found that there were difficulties in maintaining the interests of different constituencies, especially once the concerns of a particular interest group had been addressed.

### **c) Lack of dedicated staff and resources**

Seven high quality studies (Harkins et al., 2012; Hills et al, 2007; Marais, 2007; Robinson et al, 2010; White et al, 2010; White and Woodward, 2013; Windle et al, 2009), five medium



quality studies (Burgess, 2014; Chau, 2007; Hatamian et al, 2012; Lawless et al., 2007; Roma Support Group, 2011) and two low quality studies (Community Health Exchange, 2012; Craig, 2010) found that a lack of investment in dedicated staff and other resources was a barrier to effective community engagement.

Respondents in the survey and interview study on patient and public engagement in sexual health services in London conducted by Robinson et al (2010) [++] described difficulties in conducting meaningful engagement without dedicated staff and resources:

*"Hospitals were not told what it [patient and public engagement] looks like and they were not given any particular monies to do anything with it" (P11)*

*"I think we shouldn't just expect – 'oh it will be done', I think it does require somebody dedicated, not full time but maybe one day a week, you know, somebody who's got it in their job description, who's going to actually push the work forward". (p 36)*

A lack of, or time limited, funding for staff and other resources (e.g. running costs for volunteers) was linked to problems of sustainability of community engagement initiatives within several studies. The results of an evaluation of the Cambridgeshire timebanks, (Burgess (2014) [+]) found that timebanks would simply cease to exist if funding for co-ordinators was withdrawn. Chau (2007) [+] in their study of the involvement of Chinese older people in policy and practice found that local projects in the study all had difficulties sustaining projects once the research team left. For example, the Manchester group could not get funding to carry on the English beginners' classes for older Chinese people that the group had started. White and Woodward (2013) [++] in their study of Community Health Champions in Lincolnshire, also reported problems with funding to sustain the health champions project as funding streams were coming to an end. The project leads suggested this would be de-motivating to committed volunteers and might affect their motivation to volunteer again. White et al (2010) [++] in their study of Phase 1 of the Altogether Better Programme found that finance and resources were widely reported to be the major barriers to sustaining the projects and ensuring the momentum they had created was maintained over the long-term.

*"...you cannot empower people and take people forward in a short space of time. They have to be nurtured, it takes a long time." (p 20)*

Project leads often wanted to offer the health champions more support and assistance, but due to funding limitations this was difficult to do:

*"Well for us it's the money we are so tight on money that limits our ability to offer more support, have the champions to come in and stay more often because we can't afford room hire and we can't afford refreshments." (p 20)*

Several other studies found that under-resourcing was a problem. Craig (2010) [-] in an evaluation of the Well London 'Youth.com' and Young Ambassadors Programme found a fundamental mismatch between the aspirations for the Programme on the one hand, and the resources to support and implement it on the other. Organisationally, it led to over-stretch and a rapid turnover in young workers.

For respondents in the investigation of Scottish community-led health organisations' influence in health and social planning structures (Community Health Exchange (2012) [-]), the lack of expenses provided for their time by engaging organisations was a problem in sustaining engagement. Hatamian et al (2012) [+], in their evaluation of the 'Outcomes of the Active at 60 Community Agent Programme', found that resource constraints limited the extent to which newsletters and face-to-face opportunities to meet and share experiences for locally led groups could be provided, even though these were seen as vital. Windle et al (2009) [++], in the National Evaluation of Partnerships for Older People Projects funded by the Department of Health to develop services for older people, found that there could be a high turnover amongst older volunteers as some experienced increasing or sudden periods of ill health and as they age they could find themselves able to do less. Sufficient resources were therefore necessary to facilitate ongoing recruitment.

A lack of resources such as staff time could cause problems with maintaining the necessary partnerships for community engagement work. The findings of Hills et al (2007) [++] and Lawless et al (2007) [+] both highlighted the considerable demands on staff time in terms of maintaining functional partnerships and networks.

Problems with the representativeness of engaged communities and partisanship were also found to be a consequence of a lack of dedicated staff and other resources. Marais (2007) [++], in a participatory research study of TB in migrant African communities in the London Borough of Westminster, found that the difficulties some community partners experienced in sustaining participation due to a lack of staff capacity and associated funding meant there was a danger of some communities being excluded creating unequal representation. Similarly, Harkins et al (2012) [++] in their final evaluation report from the Govanhill Equally Well Test Site, reported that time pressures to complete their participatory budgeting pilot meant community representation was compromised. However, they also note that within diverse communities, it would be unrealistic to expect that any engagement activity (of a manageable size) will ever be truly representative of the entire community.

Engaging organisations highlighted the need to be pragmatic in the face of limited resources. For example the Roma Support Group (2011) [+], in a study of the barriers and enablers faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms, decided to rely on their existing networks and contacts. This meant that they could not ensure that all nationalities within the Roma community were represented at engagement events.

#### **d) *Limited timelines for building trust and achieving scope and depth***

Five high quality studies (Carlisle, 2010; Harkins et al, 2012; Hills et al, 2007; Marais, 2007; Woodall et al; 2012;), five medium quality studies (Chapman, 2010; Hatamian et al, 2012; Lawless et al, 2007, Pemberton and Mason, 2008; Sender et al, 2011;) and one low quality study (Craig, 2010) found that a major barrier to effective community engagement was the time limited nature of community engagement projects which made it difficult to build trust and relationships between engaging agencies and communities and other stakeholders, or to achieve scope and depth in community engagement. Given the evidence of the history of poor relations and mistrust between engaging agencies and

communities, the lack of time to build trust and shared understanding appears to be doubly critical.

Several studies found that a lack of time hindered the ability of engaging organisations to build trust with communities, especially if groups had no history of working together or were considered to be ‘hard to reach’. Carlisle (2010) [++], in her study of the community engagement process in the Social Inclusion Partnership (SIP) in Scotland, found that it is likely to “take years” for statutory organisations such as health services or local authorities and disadvantaged communities to work together because these groups are essentially “representatives of dissimilar social worlds”. Hills et al (2007) [++] in their evaluation of the community engagement in the implementation of Health Living Centres, found that it was constantly emphasised by centre staff that building trust takes time (indeed it was reported that much of the time taken up in community engagement projects was developing trust with the community), and that there needs to be a readiness to try different approaches if previous efforts have failed. Similarly, Marais (2007) [++] found that the main reason the project failed to engage some communities in which there were high rates of tuberculosis was a lack of trust which could not be established within the time and resources in hand. Pemberton and Mason (2008) [+] also found that barriers to the greater involvement of users in co-production were a lack of time to implement activities and to develop trust.

Woodall et al (2012) [++] report that time needed to engage communities in the Altogether Better programme and build trust was in short supply, especially in communities seen as ‘hard to reach’. As interviewees described it:

*‘So that’s a big barrier, getting into these communities that are quite insulated sometimes. It’s difficult to break that door down.’ (p 6)*

*“...you cannot empower people and take people forward in a short pace of time. They have to be nurtured, it takes a long time.”*

*“You can kind of imagine that if we had a lot more staff time to put into support, supervision, planning, supporting other ideas and other initiatives then a whole lot more could happen and we could get a whole lot more going on really. So it is a limitation; staff time in terms of both mine and the host staff neither are full time on this, so the amount of time that they can put into supporting people is limited. So I’m sure we could do more if we had more capacity there.”*

Limited timeframes were often associated with the pilot nature of many projects and learning from these pilots included building in more time for engagement at the beginning of projects and throughout (Chapman, 2010 [+]; Craig, 2010 [-]; Harkins et al., 2012 [++]; Hatamian et al., 2012 [+]; Lawless et al (2007) [+]; Sender et al (2011) [+]). For example, Harkins et al (2012) [++] report that the community representation within the participatory budgeting pilot they evaluated was compromised by the perceived time pressure on the entire pilot. Chapman (2010) [+] in an evaluation of the ‘Well London Community Activator Programme’, found that all but a few of the Activators reported that it took months not weeks to engage non-participants and that, once engaged, many of their participants required constant encouragement to continue participation.

Craig (2010) [-] in an evaluation of the ‘Young Ambassadors’ programme within Well London highlighted the negative effects on the time-limited nature of pilots and programmes. Because this programme took some time to establish – 15 months out of a two year time-frame, there were concerns that it was yet another ‘parachute’ intervention, which tended only to raise, and then dash, the hopes of the local community.

*"It's such a shame that it's not going to last. It's started, it's having an impact and then it stops. I've had a lot of the younger girls interested [in being a YA]. It would be nice if the tradition could be continued." (p 23)*

### 5.3.1.2 FACILITATORS

#### **a) Planned rather than ad-hoc community engagement strategy and methods**

Two high quality studies (Fountain and Hicks, 2010; Sadare, 2011), one medium quality study (Lawless et al, 2007) and one low quality study (Lwembe, 2011) found that the presence of a strategy or process was a key enabler to effective community engagement.

Lwembe (2011) [-], in her evaluation of the health champion project within one area in which the Well London programme was operating found that residents felt a sense of ownership of the project from the word go. This was linked to the nature of the community engagement process characterised as transparent, inclusive and allowing residents to set the agenda, develop priorities and a plan from which the projects emerged. Sadare (2011) [++], in her evaluation of the community engagement process in the overall Well London Programme found that the methods used in the Well London community engagement process, such as World Café and appreciative enquiry, were useful and effective approaches for engaging communities.

Fountain and Hicks (2010) [++], in their evaluation of a project to engage Black and minority ethnic communities in the improvement of mental health services, highlight what they found to be the key ingredients of the community engagement model they used: a facilitator, a host community organisation, a task, and support in the form of training, a project support worker, funding and a steering group. Similarly, Lawless et al. (2007) in their evaluation of community engagement in the national ‘New Deal for Communities’ programme, highlight the systematic nature of the community engagement process in one of the six areas studied in depth. This involved a ‘neighbourhood network’, training support, additional funding to support community engagement and a diversity and inclusion mapping exercise to inform the community engagement.

All three of the above studies (Lwembe (2011) [-], Fountain and Hicks (2010) [++], & Lawless et al (2007) [+]) suggest the enabling qualities of clear, transparent, systematic, and structured approach which includes an engagement strategy, a resourced engagement process, adequate funding, dedicated staff, information resources, capacity building, support, and management structures which include community representation.

#### **b) Clarity of community engagement goals and transparency of process**

Two high quality studies (Marais, 2007; Sadare, 2011), three medium quality studies (Hatamian et al, 2012; Liverpool JMU, 2012; Sender et al, 2011) and one low quality study

(Lwembe, 2011) found that communicating clear goals and outcomes for the community engagement from the outset and of being transparent about the process aided effective community engagement.

As noted in the previous section, Lwembe (2011) [-] in her evaluation of the health champion project within one area in which the Well London programme was operating found that residents were very satisfied with the community engagement process and this was partly related to the transparency of the process. Sadare (2011) [++], in her evaluation of the community engagement process in the overall Well London Programme found that a key lesson from the process was the need to manage the expectations of local stakeholders and residents by effectively communicating programme goals and limitations.

Transparency and clarity of community engagement goals were important for the target communities' understanding the community engagement process and their willingness to get on board with the process. Liverpool JMU (2012) [+], in their evaluation of approaches to health literacy in Ashton, Leigh and Wigan, found that by providing a clear explanation of the purpose of the community engagement ensured 'buy-in' from participants especially those who initially could not see why they were being involved. Similarly, Hatamian et al (2012) [+], in their evaluation of the 'Outcomes of the Active at 60 Community Agent Programme', found that a key role undertaken by the local funders, who distributed the money for the project to local community organisers, was to communicate the programme's aims and assist community groups in interpreting the Community Agent role. As this role was not always immediately understood, local funders provided further explanation.

Transparency in process ensured that community engagement processes were seen as fair. Marais (2007) [++], in a participatory research study of TB in migrant African communities in the London Borough of Westminster, found that community based organisations were encouraged by the transparency of budgets and their fair distribution amongst partners. Sender et al (2011) [+] in their evaluation of the 'National Empowerment Partnership' - which aimed to support individuals and communities to get involved in and influence local decisions and build the capacity of local authorities and other public agencies to engage and empower communities - found from interviews with those trying to implement the programme (the 'regional empowerment leads') that increasing the participation of communities in democratic processes, only works when processes are seen as legitimate and transparent (e.g. when decision-making options presented to communities are not limited by any initial short listing).

### ***c) Joint decision-making***

Four high quality studies (Hills et al, 2007; Marais, 2007; Sadare, 2011; Windle et al 2009), five medium quality studies (Chau, 2007; Kimberlee, 2008; Pemberton and Mason, 2008; Roma Support Group, 2011; Williamson et al, 2009) and one low quality study (Lwembe, 2011) found that having in place mechanisms for joint decision-making which places communities as co-producers at the very heart of projects was a facilitator for successful community engagement.

A range of mechanisms for facilitating joint decision-making were evaluated in studies with the following described as particularly effective: giving communities the power of veto over all decisions or community representation in management boards enshrined as a formal code of conduct (these meant that communities were “in the driving seat” in the development and management of ‘Healthy Living Centres’ and were able to strongly influence decisions (Hills et al (2007) [++]); the commitment to underlying principles for programmes such as direct involvement of communities in the design and development of programmes (Windle et al (2009) [++]); involving communities as co-designers and co-producers in projects (Lwembe (2011) [-]); providing young people with confidential voting options (Kimberlee, 2008 [+]); the production of a joint statement to reflect aspirations and priorities for communities followed by funding of a number of community-led projects to address priorities (Chau, 2008 [+]); and devolving budgetary/commissioning decisions to community partnerships (Marais (2007) [++]; Williamson et al (2009) [+])

The latter two studies cited above are worth elaborating in more detail. Williamson et al (2009) [+] evaluated the ‘Rochdale Partnerships for Older People Project (POPP)’, which aimed to enable older people to exercise greater power and control over their lives, in order to sustain independence and well-being in later years. The mechanism for joint decision making in this project consisted of four local partnerships between older people, Rochdale local authority and other local organisations for older people. The partnerships were given a budget for commissioning local activities, and promoting initiatives led or supported by older people and they were supported by a dedicated worker who helped to ensure the representativeness of older people within the partnership and supported them in their role in commissioning services. The partnerships also had a wider objective in linking with wider local democratic processes.

The participatory research evaluated by Marais (2007) [++] to engage migrant African communities in the London Borough of Westminster in developing tuberculosis services, included funding for a research partnership and insider researcher training prior to commencement of the study and adequate payment of community members undertaking research related activities. Shared power and managerial responsibility for the allocation of funds was agreed between the research team and community organisations and the evaluation of the process found that the involvement of partners in joint-decision making was ranked very high.

Some studies found that communities recommended joint decision-making as a way to ensure the effectiveness of community engagement. Sadare (2011) [++], in her evaluation of the community engagement process in the Well London Programme found that a number of participants mentioned that devolving power and influence to the residents was essential to encourage people to believe in consultations and participate in them. One respondent from the Roma Support Group (2011) [+] study to identify the barriers and enablers faced by the Roma refugee and migrant community in participating in mainstream empowerment mechanisms, put it this way:

*“Despite our gaps in education, we expect to be treated as equal partners and we need to see that they (local decision makers) care about what we think. We have come here for a better life for our families and we want to belong. They say that Gypsies (Roma)*



*are a “hard to reach” community but maybe a reason for that is that nobody has ever tried to reach us.” (Polish Roma man, age 24) (p 23)*

- d) Other studies recommended particular mechanisms as a result of observing barriers to the community engagement process in their evaluations. Pemberton and Mason (2008) [+] in their study of the engagement of users in service delivery, service planning and in monitoring and evaluation activities for Sure Start Children’s Centres (SSCC) in Greater Merseyside, recommended that parents and carers should be equally represented in the highest levels of decision making on SSCC boards and that they have equal influence over decision-making. They further suggest that this could be achieved through raising awareness of such opportunities and the provision of training and childcare, mentoring and suitable meeting times, as appropriate.

***Community engagement as a transactional and reciprocal process***

Two high quality studies (Marais, 2007; White and Woodward, 2013) and three medium quality studies (Hatamian et al, 2012; Hatzidimitriadou et al, 2012; Kimberlee, 2008) found that framing community engagement as a transactional and reciprocal process i.e. engendering mutual respect and gratitude between partners, sharing learning and expertise and establishing a two-way dialogue between engaging agencies and communities facilitates the community engagement process.

Hatzidimitriadou et al (2012) [+] in their evaluation of co-production processes in a community-based mental health project in Wandsworth, found that co-production was viewed as a transactional process, from which all participants benefited. There was a perception that there was a transfer of knowledge, skills and expertise from the communities to mental health services and vice versa:

*“And for the whole system to learn from that, it’s kind of getting both things more permeable, so that there’s a bit of public sector stuff that gets into the communities and a bit of community stuff gets into the public sector.” (Page 18)*

Learning for professionals was reported to be challenging but led to an in-depth understanding of the particular mental health issues of the Black and Minority Ethnic communities they worked with. Similarly, Marais (2007) [++], in a participatory research study of tuberculosis in migrant African communities in the London Borough of Westminster, found that the research partnership between community based organisations and the university achieved reciprocal education and capacity building through the two-way transfer and sharing of information, knowledge and skills. The trust fostered between researchers and communities also increased the quality and quantity of available data. Kimberlee (2008) [+] who evaluated the inclusion of children in road safety design in Birmingham, found that by fostering collaboration between young people, teachers, school travel plan officers and engineers in the policy-making process built two-way learning and accountability. .

The older people engaged by Hatamian et al (2012) [+], in their evaluation of the Outcomes of the Active at 60 Community Agent Programme, were very positive about what they ‘got back’ from project staff such as ongoing support including outreach and facilitating face-to-face opportunities to meet and share experiences and ideas as more appropriate for the target group. White and Woodward (2013) [++] in their study of

Community Health Champions in Lincolnshire, found that volunteers expect to be thanked and feel part of the organisation they are volunteering for with a named person whom they can readily contact.

**e) *Establishing or using existing partnerships and networks***

Six high quality studies (Carlisle, 2010; Fountain and Hicks, 2010; Harkins et al, 2012; Hills et al, 2007; White et al, 2010; Windle, 2009), five medium quality studies (Hatamian et al, 2012; Hatzidimitriadou et al, 2012; Liverpool JMU, 2012; Sender et al, 2011; White et al, 2012;) and two low quality studies (Community Health Exchange, 2012; Lwembe, 2011) provide evidence that having a strong partnership and network in place is an important facilitator for ensuring effective community engagement. The forms of partnerships described in the studies included interagency partnerships, partnerships between service providers and community organisations, partnerships between engaging organisations and residents/community members.

Several studies documented the benefits for community engagement that partnership working could bring about. White et al (2010) [++], White et al (2012) [+], Hills et al (2007) [++] and Liverpool JMU (2012) [+] all found that when partnerships were working, they promoted better community engagement. From their evaluation of health champion projects in the 'Altogether Better' programme, White et al. (2010) [++] found that in areas where community partnerships had been developed, there was a greater likelihood of sustaining the work of health champions. For example in one project, champions were "hosted" by established community groups, providing better opportunities for sustainability beyond the initial programme funding. White et al (2012) [+] in their evaluation of a health trainer scheme in Kirklees, found that the partnership developed (e.g. with GP practices, some of which hosted the health trainers) was seen by health trainers and health professionals as a crucial aspect of the success of the service. Hills et al (2007) [++] in their evaluation of the national Healthy Living Centres programme found that several centres had joined forces with partners to counter the lack of coordination or cooperation between services that had previously plagued some of the target communities. These partnerships were found to be a fruitful way to attract community members. This evaluation also found that that partnership working was particularly useful in reaching target groups; 33% of HLC managers noted that they had accessed users through their partnerships and 16% felt that working with established community and voluntary groups had enabled them to tap into specific population groups. Windle (2009) [++] in their evaluation of a national programme to involve older people in partnership with service providers and commissioners to develop services, found that better partnership working helped to strengthen the direct involvement of older in the design and implementation of services over time. Liverpool JMU (2012) [+] in their evaluation of a health champion scheme in the North West documented the wide range and large number of agencies involved in the partnership and noted that these were maintained over the long-term.

Partnerships meant that programmes had access to all the networks of partners and this enabled greater reach into communities. Hatamian et al (2012) [+] reported how their programme was promoted through local networks. Hills et al (2007) [++] also found that Healthy Living Centres developed various ways of consulting their target communities on



an ongoing basis, by establishing links, often via their partners, into existing networks of local community groups or voluntary agencies which also provided a rich source of information about local needs and issues. Sender et al (2011) [+] found that use of networks meant that the 'National Empowerment Partnership' they evaluated was able to engage more people at a local level.

Successful partnerships were characterised as those which were able to reach a common ground and a shared understanding of the goals of community engagement (Fountain and Hicks (2010) [++]; Hatzidimitriadou et al (2012) [+]; Liverpool JMU (2012) [+]). Both Hatzidimitriadou et al (2012) [+] and Fountain and Hicks (2010) [++] highlight how a co-production approach can facilitate reaching common ground across the partnership. Hatzidimitriadou et al (2012) [+] found that the co-production process adopted by NHS service providers and community-based organisations to delivering mental health services in the community, linked public services and community organisations together in a new way which opened up opportunities to initiate conversations about common purpose and solutions that could be implemented for the mutual benefit of all concerned. Carlisle (2010, p122) [++] reports that the partnership formed to drive a regeneration programmes in Scotland (the 'Social Inclusion Partnership') brought diverse agencies together, 'forcing us all to work, in a positive way, with partners'. On the basis of findings from a survey and in-depth interviews with community-led organisations to explore their influence on decision-making in statutory organisations, Community Health Exchange (2012) [-] recommend that in order to improve partnership working both community-led health organisations and statutory sector partners need to set aside previous negative experiences and recognise the contribution that each side of the partnership can make.

Studies also highlighted some of the 'ingredients' that made partnership working successful. Windle (2009) [++] in their evaluation of a national programme to involve older people in partnership with service providers and commissioners to develop services, found that although all individual projects within the programme were reasonably successful in developing good working relations with a wide range of partner organisations, there was some variation across areas and organisations. In most areas, service delivery teams comprised staff employed by more than one agency; several had multi-agency multi-disciplinary teams. Such teams facilitated easy discussion, mutual respect and, on a practical level, advice and referrals across agencies; this was particularly notable where staff worked together in the same location, in contrast to 'virtual' teams. In some areas, new posts developed expressly to overcome organisational barriers were introduced and were found to enhance good working relations. Link roles were also helpful in this respect.

Similarly, Lwembe (2011) [-] also found that the active co-ordination of the Well London partnership was a key ingredient of success in their evaluation of the health champion aspect of this programme in West London. Such active co-ordination meant that all partners had an equal voice and activities across diverse areas (physical activity, mental health, healthy eating, open spaces and culture) could be joined up. The partnership also proved to be sustainable with the original Well London steering group merging with other partners to form the White City Health and Wellbeing Board.

Co-location of partners was also identified as an important factor for successful partnership working in one study. Harkins et al. (2012)[++] in their evaluation of

community engagement in an area-based health improvement project - Govanhill Equally Well Test Site - reported that public and third sector partners shared the same workspace, 'The Hub' in Govanhill. Through the Hub, partners discussed and planned collaborative responses to local concerns on a daily basis. Often this could mean a 'same day' joint visit or response to an issue or case raised within the Hub. Evaluation evidence suggested that the Hub's success had been dependent on a group of important characteristics: a supportive, informal and honest ethos was cultivated; a learning culture whereby partners learnt from each other about what works and what does not work locally. Encouraging, flexible and intelligent facilitation within the Hub was essential; a multi-disciplinary overview and understanding was also said to be pivotal to this role.

**f) *Investing time, effort and resources to build relationships and trust***

Three high quality studies (Hills et al, 2007; Marais, 2007; Sadare, 2011) and six medium quality studies (Christie et al, 2012; Hatzidimitriadou et al, 2012; Lawless et al, 2007; Pemberton and Mason, 2008; Roma Support Group, 2011; Sender et al, 2011) found that investing time, effort and resources into building relationships and trust between engaging agencies and communities was essential to effective community engagement. This was particularly true for communities that had difficult past relationships with engaging agencies or authorities or intra-community conflicts.

Allowing enough time for relationships to develop was a strong re-occurring theme across studies. This is perhaps a reflection of the organic nature of the development of relationships in direct contrast to the time-limited and programmatic nature of community engagement projects and programmes. Hills et al (2007) [++] in their evaluation of the national Healthy Living Centres conclude that engaging with communities and developing their capacities in ways that are likely to be sustainable takes time; across centres it took two or three years for the centres to become established and trusted by users or local people, followed by a year of rolling out programmes of work, and then a year to eighteen months to develop an exit strategy. In some cases the anticipated loss of funding had negative impacts on the ability to work at a community level. Sender et al (2011) [+] in their evaluation of the 'National Empowerment Partnership' - which aimed to support individuals and communities to get involved in and influence local decisions and build the capacity of local authorities and other public agencies to engage and empower communities - echo Hills et al. in that it took into the second and third year of the programme, in the majority of regions, to see strong relationships developed with community and other partners. The evaluation also found that small amounts of resources can go a long way in communities, but sufficient time needs to be given to develop relationships with, and capabilities within, communities. Likewise, Marais (2007) [++], in a participatory research study of tuberculosis in migrant African communities in the London Borough of Westminster recommends that institutions (policy, provider, research and academic) should invest more resources (finances and time) in the sustained development of trust between themselves and migrant communities, particularly hidden sub-groups such as failed asylum seekers and undocumented migrants.

Lawless et al (2007) [+] in the six case studies in their evaluation of 'New Deal for Communities' suggest it is easy to underestimate the time and costs involved in building up robust community capacity resources, and that there is a strong sense across the six

case studies that there should have been a 'Year Zero' to provide what were then 'interim' partnerships an opportunity to establish working procedures, engage with agencies and communities, and devise plausible 10 year programmes. Similarly, the Roma Support Group (2011) [+], in a study to identify the barriers and facilitators faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms, also found that building trust with particularly vulnerable groups with a difficult history of engaging with authority can take time. Participants outlined their strategic vision for empowering the Roma community, which they envisaged as 'ten year empowerment plan'.

An illustration of the time and effort required is found in Christie et al (2012) [+]. In an evaluation of a project to engage the Somali Community in the London Borough of Hounslow in Road Safety, the authors report how the engaging agency invested time to build relationships with the target community. They explain that once the Somali road safety group was set up, the road safety team made sure that they visited the group regularly to gain trust and acceptance:

*“At first, I used to go in so they’d get to know me, maybe once a month. So they’d know me by name and [name of person] would introduce me to people and say, ‘This is [P2] and they’re helping us fund this project here’ and then the ladies were really, I suppose, thankful in a way that this opportunity was being provided so when we went and delivered the road safety training, we did the sessions, I think, 6 months later, once they had familiarised with me and who I was and where I was coming from.... We weren’t coming in and saying; ‘We’re the road safety officers and this is what...’ We got to know them and got to know who they were as a community.” (p 817)*

Hatzidimitriadou et al (2012) [+] in their evaluation of co-production processes in a community-based mental health project in Wandsworth, report at length on the importance of relationship building as pre-requisite before and during the mental health project.

Participants commented on the lengthy process required for such relationship building, stating that it was a time consuming endeavour which could not be done 'in haste':

*“I believe that it is all about relationships and it is all about building these relationships in the community and that takes time. And it takes a lot of trust and it takes a lot of effort.” (Psychological Well-being Practitioner) (p 22)*

*“Again, by virtue of a relationship, I think you can’t rush relationships.” (Psychological Well-being Practitioner) (p 22)*

In addition to dedicating sufficient time, studies also identified a number of other processes that facilitated the building of trust. Again, Hatzidimitriadou et al. (2012) [+] in their evaluation of co-production processes in a community-based mental health project in Wandsworth, found that the co-production process itself facilitated the building of trust through the development of relationships and the building of social capital. The notion of trust figured strongly in community leaders and community development workers narratives about the early negotiations with public services and developing a relationship

with them. . There were tensions in the early negotiations between public service agencies and community leaders, who were mindful of the ‘inherent risks’ of bridging relationships and establishing linkages with partners outside of the community, who might have had a different ethos. In particular, community leaders had to overcome their distrust of mental health services that had acquired a negative reputation among Black and minority ethnic communities.

*“BME have strained relationships with the statutory mental health services. IAPT is a fresh attempt really to engage with communities who have traditionally been very suspicious, for often very good reasons, of statutory services.” (Increasing Access to Psychological Therapies Manager) (p 23)*

Trust was also the outcome of social capital in the context of faith-based communities. The trustworthiness that church members placed on the church leadership engendered a ‘values ethos’ among them; this shared value created a stronger bond of trust and reciprocity thereby giving church members the confidence, they lacked, to access services:

*“And I think the trust that they (church members) would, and do have, in our leadership, gives them the confidence to access services. And I think the link I think is very important between the church and the service provisions. So I think for the service user, being able to self-refer, being able to know that if they belong to a faith group as well, that their leaders are also giving the green light to the service as well. Sometimes, you know, when an individual is instructed or guided to access a particular service, they have no other corresponding means of being able to say: ‘Well that’s an OK service’, they just trust the word of the professional.” (Community Organisation Leader) (p 23)*

The evaluation authors further found that community leaders viewed the trustworthiness inbuilt in the process of service delivery through co-production was a very effective way to open up access to ‘reluctant’ service users seeking help from mental health services.

Hills et al (2007) [++] in their evaluation of the ‘Healthy Living Centres’ Programme, found that centre managers identified the need to ensure an informal atmosphere, a welcoming atmosphere, and ensuring cultural awareness and sensitivity in order to build trust with communities. Developing trust was particularly challenging in communities scarred by sectarian violence, hostility and mistrust. In one centre operating in a rural area, described as having ‘major socio-cultural-religious differences’, the community health development workers’ approach was to link in with local people and groups and look for neutral venues to bring people together. The manager of this centre commented:

*“Local groups now trust us and believe in themselves and their ability to achieve the goals they set out for themselves. It was also reported that they now appreciate the value of working in collaboration with each other and relationships built on trust are developing.” (p 77)*

Sadare (2011) [++], in her evaluation of the community engagement process in the overall Well London Programme found that the establishment of trust was facilitated by having good knowledge of the community that is being engaged, and the local context and

peculiarities which differentiate communities. Using members of the local community could be an effective way to build trust (see also section 5.4.1.2 Gaining direct access to communities). Similarly, Pemberton and Mason (2008) [+] in their evaluation of the engagement of users in service delivery, service planning and in monitoring and evaluation activities for Sure Start Children’s Centres (SSCC) in Greater Merseyside, describes how centres used community members to engage others. For example, a number of parents had volunteered to befriend or support ‘newer’ parents or carers at activity sessions and suggested that they were acting as the ‘faces’ of certain initiatives within their local community to encourage involvement in appropriate SSCC activities. The research indicated that this appeared to be helping to generate trust by others who ‘were in the same boat’. Several interviewees highlighted that they were afraid of speaking to professionals (such as health visitors) about their concerns without such support.

### **g) Dedicated staff**

Four high quality studies (Carlisle, 2010; Fountain and Hicks, 2010; Hills et al, 2007; White and Woodward, 2013), three medium quality studies (Chapman, 2010; Jarvis et al, 2011; Lawless et al, 2007) and one low quality study (Lwembe, 2011) found that having dedicated staff in place is a facilitator to effective community engagement.

Dedicated staff or teams embedded within the communities to be engaged was a re-occurring success factor across studies. For example, Lawless et al (2007) [+] in their evaluation of ‘New Deal for Communities’ report that in the case study sites which reported the greatest increase in the proportion of residents feeling part of the community were those areas which had established a community engagement team. Similarly, Carlisle (2010) [++] in her study of the Social Inclusion Partnership (SIP) in Scotland, found that after a slow start a secondment to the post of SIP manager accelerated the community engagement process. Likewise, Jarvis et al (2011) [+] in their study of the impact of community engagement in neighbourhood regeneration in Canley, Coventry, found that new neighbourhood management structures that embedded individual officers within the neighbourhood to provide a bridge between residents and policy makers enabled the local authority to capture a clear sense of neighbourhood issues and priorities in a way that was not previously possible.

Studies also highlighted that such dedicated staff needed to have the right sort of skills and qualities. For example, Fountain and Hicks (2010) [++] in their evaluation of a project to engage Black and minority ethnic communities in the improvement of mental health services, found that dedicated community engagement staff need to adopt a facilitator rather than an authoritarian management style. This role needs to be active and ongoing from advertising, recruiting, and selecting the community organisations to participate in the project ( including advising and supporting potential applicants during this process) through to advising, guiding and supporting the relevant service agencies to engage and work with the community organisations and vice versa.

Dedicated staff were also vital for sustaining volunteering activity. Lwembe (2011) [-] and Chapman (2010) [+], in their respective evaluations on specific components within the

Well London programme found that skilled and ‘relatable’ volunteer co-ordinators were well liked and appreciated by volunteers, helping them to find their feet in the early days and sustain their activities beyond the programme timescales. Similarly, White and Woodward (2013) [++] in their study of Community Health Champions in Lincolnshire, found that support managers were essential for the volunteers as they provided a point of contact, reassurance, and motivation to keep on volunteering:

*“I think the over-riding requirement is that you get support... you know... when you get in there’s perhaps some badinage (banter?) one way or the other ‘it’s good to see you’ or ‘gosh is it Thursday already?’ And that exchange, I think, is the sort of thing you enjoy”*

*“She looks after us, she knows us all personally, if you’re poorly or something she’s very caring. She just looks after us all, she makes sure and she comes with us. I can’t imagine the group working without her support” (quotes from volunteers, p17)*

On the issue of sustainability, Hills et al (2007) [++] in their evaluation of the Big Lottery Fund Healthy Living Centres (HLC) Programme, found that the most successful HLCs in terms of sustainability were those that had at least one member of staff with entrepreneurial or fundraising skills.

### 5.3.1.3 EVIDENCE STATEMENTS

#### Evidence Statement 3: Investing in infrastructure and planning

There is evidence from twenty-seven evaluation studies<sup>1-3,5-21,24-30</sup>, two mixed methods studies<sup>4,23</sup> and one qualitative study on inclusive and accessible practice<sup>22</sup>.

**ES 3.1** There is evidence from one [++] study<sup>24</sup>, three [+] studies<sup>5,8,12</sup> and one [-] study<sup>4</sup> that a lack of clarity lack of transparency, and confused expectations around community engagement goals and process were barriers to effective community engagement.

**ES 3.2** There is evidence from four [++] studies<sup>2,24,26,29</sup>, six [+] studies<sup>3,12,15-17,21</sup>, and one [-] study<sup>19</sup> that competing agendas (e.g. targets, funding priorities, values and expectations) across the different stakeholders involved in partnerships created tensions, and where one agenda was favoured over another especially to the perceived detriment of communities, this put a break on effective community engagement.

**ES 3.3** There is evidence from seven [++] studies<sup>10,13,20,23,,26,27,29</sup>, five [+] studies<sup>1,3,11,16,22</sup> and two [-] studies<sup>4,7</sup> that a lack of investment in dedicated staff and other resources was a barrier to effective community engagement. This posed problems for sustainability<sup>1,3,4,7,11,26,27,29</sup>, maintaining partnerships and networks<sup>13,16</sup>, and achieving representativeness and avoiding partisanship<sup>10,20</sup>.

**ES 3.4** There is evidence from six [++] studies<sup>2,10,13,20,,29,30</sup>, six [+] studies<sup>5,11,16,21,22,25</sup> and one [-] study<sup>7</sup> that a major barrier to effective community engagement was the time limited nature of community engagement projects which made it difficult to build trust and relationships between engaging agencies and communities and other stakeholders, or to achieve scope and depth in community engagement. Given the evidence of the history of poor relations and mistrust between engaging agencies and communities, the



lack of time to build trust and shared understanding appears to be doubly critical.

**ES 3.5** There is evidence from two [++] studies<sup>9,24</sup>, one [+] study<sup>16</sup> and one [-] study<sup>19</sup> that the presence of a strategy or process was a key enabler to effective community engagement.

**ES 3.6** There is evidence from one [++] studies<sup>20</sup>, three [+] studies<sup>11,18,25</sup> and one [-] study<sup>19</sup> that communicating clear goals and outcomes for the community engagement from the outset and being transparent about the process aided effective community engagement.

**ES 3.7** There is evidence from five [++] studies<sup>13,20,23,24,29</sup>, five [+] studies<sup>3,15,21,22,28</sup> and one [-] study<sup>19</sup> that having in place mechanisms for joint decision-making which places communities as co-producers at the very heart of projects was a facilitator for successful community engagement.

**ES 3.8** There is evidence from two [++] studies<sup>20,27</sup> and three [+] studies<sup>11,12,15</sup> that ensuring community engagement operates as a transactional and reciprocal process aids effective community engagement. This means mutual respect and gratitude between partners, sharing learning and establishing a two-way dialogue between engaging agencies and communities as equals.

**ES 3.9** There is evidence from eight [++] studies<sup>2,9,10,13,20,26,29,31</sup>, five [+] studies<sup>11,12,14,18,25</sup> and two [-] studies<sup>4,19</sup> that having a strong partnership and network in place is an important facilitator for ensuring effective community engagement.

**ES 3.10** There is evidence from three [++] studies<sup>13,22,24</sup>, and five [+] studies<sup>6,12,16,22,25</sup> that investing time, effort and resources into building relationships and trust between engaging agencies and communities was essential to effective community engagement. This was particularly true for communities that had difficult past relationships with engaging agencies or authorities or intra-community conflicts.

**ES 3.11** There is evidence from four [++] studies<sup>2,9,13,27</sup>, three [+] studies<sup>5,14,16</sup> and one [-] study<sup>19</sup> that having dedicated staff in place as a facilitator to effective community engagement.

### Key

1 Burgess (2014) +	16 Lawless et al (2007) +
2 Carlisle (2010) ++	17 Lawson et al (2009) +
3 Chau (2007) +	18 Liverpool JMU (2012) +
4 Community Health Exchange (2012) –	19 Lwembe (2011) –
5 Chapman (2011) +	20 Marais (2007) ++
6 Christie et al. (2012) +	21 Pemberton and Mason (2008) +
7 Craig (2010) –	22 Roma Support Group (2011) +
8 Dinham (2007) +	23 Robinson et al. (2010) ++
9 Fountain and Hicks (2010) ++	24 Sadare (2011) ++
10 Harkins et al (2012) ++	25 Sender et al. (2011) +
11 Hatamian et al. (2012) +	26 White et al. (2010) ++
12 Hatzidimitriadou et al (2012)	27 White and Woodward (2013) ++
13 Hills et al. (2007) ++	28 Williamson et al (2009)

14 Jarvis et al. (2011) +  
15 Kimberlee (2008) +

29 Windle et al. (2009) ++  
30 Woodall et al (2012) ++  
31 White et al. (2012) ++

### 5.3.2 SUPPORT, TRAINING AND CAPACITY BUILDING

#### 5.3.2.1 BARRIERS

##### **a) Lack of appropriate training for professional staff**

Three high quality studies (Fountain and Hicks, 2010; Hills et al, 2007; Robinson et al, 2010) and three medium quality studies (Hatzidimitriadou et al, 2012; Sender et al, 2011; Tunariu et al, 2011) found that a lack of appropriate training in community engagement for professional staff of engaging agencies was a barrier to effective community engagement.

Studies found a lack of skills amongst professionals in engagement and especially newer techniques of engagement such as co-production. For example, Hatzidimitriadou et al (2012) [+] in their evaluation of co-production processes in a community-based mental health project in Wandsworth, identified a gap in relationship building skills:

*“Developing the skills of staff in building relationships, real listening, responsiveness and ‘being real’.” (p 43)*

Similarly, Fountain and Hicks (2010) [++], on the basis of their findings on this issue from their evaluation of a project to engage Black and minority ethnic communities in the improvement of mental health services, recommend developing a workforce with the knowledge and skills to deliver ‘equitable care’ and the ability to form external community partnerships. Likewise, Tunariu et al (2011) [+] in their evaluation report of the Well London DIY Happiness Project, emphasise the importance of facilitation skills. Other issues around a lack of training were a lack of appropriate training packages and tools and opportunities to share best practice (Robinson et al. 2010 [++]); and resistance or lack of engagement in training when it was provided due to a failure to see the value in doing community engagement (Sender et al., 2011 [+]). One participant in the in the evaluation of the Big Lottery Fund Healthy Living Centres (HLC) Programme (Hills et al. 2007 [++]) observed how many statutory organisations relied on community projects to ‘do’ their community engagement rather than developing capacity within their own organisations..

##### **b) Lack of appropriate training for communities**

Four high quality studies (Hills et al, 2007; Marais, 2007; Robinson et al, 2010; White and Woodward, 2013), one medium quality study (Liverpool JMU, 2012) and one low quality study (Lwembe, 2011) found barriers to community engagement related to appropriate training for communities.



A lack of training or toolkits for communities was found to be one of the barriers identified in a study of Patient and Public Engagement (PPE) for sexual and reproductive health and HIV/AIDS (SRHH) service users in London (Robinson et al (2010) [++]). This study also noted a need to increase motivation amongst community members to get involved with training opportunities as did Hills et al (2007) [++] in their evaluation of the Big Lottery Fund Healthy Living Centres (HLC) Programme.

There were significant amounts of training reported across studies, especially for health champion and health trainer projects. But these studies found that training was not always targeted to developing the right skills and/or there was often not enough money in training budgets to be able to fund training for more advanced or specialist skills. For example, a budget for specialist skill development in data analysis prevented community researchers providing an extra layer of interpretation in a participatory research study of TB in migrant African communities (Marais, 2007 [++]), and in their evaluation of health trainers in Ashton, Leigh and Wigan, Liverpool JMU (2012) [+] found that although the training available supported community engagement, it lacked the ability to provide the essential knowhow and interpersonal skills for community members to engage others in healthy conversations. Lwembe (2011) [-], in her evaluation report of the health champion aspect within the Well London programme in White City, found that although the health champions had access to training, the budget had strict guidelines on the nature of training and amount awarded. This did not allow for the Health Champions to undertake the necessary courses needed for their further development (e.g. to go on to secure roles within the NHS):

*“...I expected more training, I wanted to train as a facilitator but the system did not allow this...” (p 33)*

The style of training was also highlighted as an issue in the evaluation of health trainers in Ashton, Leigh and Wigan by Liverpool JMU (2012) [+] with participants not always appreciating a particular style:

*“Yes there were facts that I found out that I didn't know before, but I don't know if I could get those to the fore again. I would say that it was maybe pitched wrong in that I felt a bit like a school child. It was very basic, extremely basic and there was a lot of things like, you know playing with play dough! And it's just not really what I like. I am not interested. If I am going to go on a course I want to learn something.” (p 47)*

This suggests the need for engaging agencies, and particularly their trainers, to work with communities in devising the training that may be needed, ensuring pathways for upwards development, and that adequate funds are available to allow some to progress. On the other hand, White and Woodward (2013) [++] in their study of Community Health Champions in Lincolnshire caution that too much training, especially for volunteers, could deter people and might not be necessary:

*“Actually there may be a person who really just doesn't want to do that. They still want to volunteer, they still want to give their time, they will still do everything they need to do, but actually it's not about treating me the same way that you treat a paid member of staff and putting me through that programme” (unattributed quote, p19)*

### 5.3.2.2 FACILITATORS

#### ***a) Mentoring and other forms of support for community members***

Three high quality studies (Fountain and Hicks, 2010; Hills et al, 2007; White and Woodward, 2013), five medium quality studies (Chapman, 2010; Chau, 2007; Hatamian et al, 2012; Hatzidimitriadou et al, 2012; Liverpool JMU, 2012) and two low quality studies (Craig, 2010; Lwembe, 2011) found that having mechanisms to ensure appropriate mentoring and other forms of support for community members are in place is important to build on and sustain community engagement.

Mentoring, both initial and ongoing, was highly valued by community members acting as health or youth champions, health trainers or community agents (Craig, 2010; Chapman, 2010; Hatamian et al, 2012; Liverpool JMU, 2012; Lwembe, 2011; White and Woodward, 2013). Mentors were found to provide support in a range of ways from very practical support such as sourcing the right equipment for an event and producing publicity materials to building confidence and providing reassurance (Chapman, 2010 [+]). Mentors were provided by community organisations (e.g. Youth.com (Craig, 2010 [-])) or statutory organisations (e.g. Health Improvement Practitioners from the local authority or NHS (Liverpool JMU, 2012 [+]; Lwembe, 2013 [-]; White and Woodward, 2013 [++])). White and Woodward (2013) [++] in their study of Community Health Champions in Lincolnshire, found from focus groups with health champions, NHS staff and community organisations that a common critical factor for success was mentoring and on-going support for volunteers. The engaging organisations need to invest in recruitment, training and support structures. Volunteers who give their time, energy and commitment expect, in return, to feel part of the organisation, to be thanked and have someone they can readily contact:

*“People think volunteering is free, but there’s a lot of time, training, management costs behind it, so I think that volunteer management is the key really, and support to keep them motivated” (manager p 19)*

Lwembe (2011) [-] characterised successful mentoring for health champions as ‘handholding’, and Craig (2010) [-] describe mentors as ‘stepping back’ to let, in this case, Young Ambassadors take charge whilst still providing a safety net.

In projects which were community-led, extensive packages of support were described. The model of support used in a project to engage Black and minority ethnic communities in the improvement of mental health services was found to be crucial to develop the capacity of community members (Fountain and Hicks (2010) [++])). This consisted of training, project support workers, funding, and a steering group. In this project, and in a similar one by Chau (2007) [+] in which Chinese older people were engaged in service improvement, community members were recruited to undertake research. In the project evaluated by Fountain and Hicks (2010) [++], project teams were formed with one community member acting as a lead researcher and co-ordinator. A seven day training programme was provided for project teams in research methods and mental health policy and practice (with opportunities for participants to complete an assignment to gain a university qualification). Project support workers, who were mostly graduates with previous experience in conducting research, as well as being members of BME

communities themselves, visited projects for at least half a day once a fortnight and were in telephone and/or email contact the rest of the time. They had a number of key responsibilities, including helping community organisations to develop their methods of investigation; advising on budgetary management; making and maintaining links with local key stakeholders to ensure that projects were linked into local relevant service plans and agencies; providing academic advice to those enrolling on the university certificate courses; monitoring projects on an on-going basis; and assisting community organisations to disseminate and promote the project's final report. Chau (2007) [+] reported a similar level and range of support but also reported language support and support with ensuring equal opportunities.

In their evaluation of co-production processes in a community-based mental health project in Wandsworth, Hatzidimitriadou et al (2012) [+] highlighted the value of the mutual support that community partners provided to each other in the process as well as the practical support offered from the NHS in delivering the services.

### ***b) The importance of training and capacity building as an end goal***

Six high quality studies (Fountain and Hicks, 2010; Hills et al, 2007; Marais, 2007; Robinson et al, 2010; Sadare, 2011; White and Woodward, 2013) and six medium quality studies (Chau, 2007; Hatzidimitriadou et al, 2012; Lawless et al, 2007; Pemberton and Mason, 2008; Roma Support Group, 2011; White et al, 2012) highlighted the importance of viewing training and capacity for the community and engaging organisation as an important end goal in itself for supporting community engagement. In their evaluation of a project to engage Black and minority ethnic communities in the improvement of mental health services, Fountain and Hicks (2010) [++] found that the training and capacity building undertaken amongst community organisations, community members, and local service planners, commissioners and providers was of equal importance in ensuring services meet the needs (and build on the assets) of communities as the reports describing the findings of the community engagement. The mechanisms via which this was achieved included: raising the awareness of all stakeholders about the issues involved; reducing the community's stigma, fear, and denial of the issues; enhancing community members skills to articulate identified needs to service planners, commissioners, and providers; and increasing the trust of the community in local service planners, commissioners, and providers and vice versa.

Similar conclusions were reported by Roma Support Group (2011) [+] and Robinson et al. (2010) [++]. Hills et al (2007) [++], in their evaluation of the Big Lottery Fund Healthy Living Centres (HLC) Programme, found the process of capacity building itself is significant. In this case, they found that HLCs saw a direct impact of building the capacity and skills and local communities on their health. Likewise, White et al (2012) [+] in their study of the Kirklees Health Trainer Service report that commissioners recognised that training, reflective practice, mutual support, and supervision are a vital element of the service's success.

Another reason documented in studies for why training and capacity building is an important end goal in and of itself is to enable community members to feel confident in having an equal voice within decision-making bodies (or, in other words, to 'sit at the top

table of decision-making’) and to take an active role in matters that impact on their lives (Chau, 2007 [+]; Kimberlee, 2008 [+]; Marais, 2007 [++]; Pemberton and Mason, 2008 [+]).

This need to get people talking at all levels was echoed in reflections on the experiences captured in their six case studies of New Deal for Communities (NDC) by Lawless et al (2007) [+] who recommend a community capacity building phase which involves:

*‘a heavy investment not just of community development skills but in people with facilitation skills, mentoring skills, mediation skills, all those kind of skills, people with people skills who will knock heads together’ (p 35)*

### 5.3.2.3 EVIDENCE STATEMENTS

#### Evidence Statement 4: Support, Training and Capacity Building

There is evidence from fifteen evaluation studies<sup>1-12,15-20</sup>, one mixed methods studies<sup>14</sup> and one qualitative study<sup>13</sup> on support training and capacity building.

**ES 4.1** There is evidence from three [++] studies<sup>4,7,14</sup>, and three [+] studies<sup>6,16,17</sup> that appropriate training in community engagement and co-production for professional staff of engaging agencies is needed. Lack of these general and specific skills was seen as a barrier to effective community engagement.

**ES 4.2** There is evidence from four [++] studies<sup>7,11,14,20</sup>, one [+] study<sup>9</sup> and one [-] study<sup>10</sup> that appropriate training for communities was needed. Lack of skills was seen as a barrier to effective community engagement. Two studies<sup>7,14</sup> cite the need for training for communities. Two studies<sup>10,11</sup> cite the limitations in funding for the needed training particularly in more advanced skills, and one<sup>9</sup> questions the appropriateness of the training available. One other study<sup>20</sup> cautions that not everyone, especially volunteers, necessarily wants training.

**ES 4.3** There is evidence from three [++] studies<sup>14,7,20</sup>, five [+] studies<sup>1,2,5,6,9</sup> and two [-] studies<sup>3,10</sup> that having mechanisms to ensure appropriate mentoring and other forms of support for community members are in place to build on and sustain engagement is an important facilitator to community engagement. Several studies<sup>1,3,9,10,20</sup> report that health champions, health trainers, youth ambassadors, and community activators seem to particularly benefit from support in the form of mentoring which enables these mostly local volunteer community members to better engage with their target communities.

**ES 4.4** There is evidence from six [++] studies<sup>4,7,11,14,15,20</sup>, six [+] studies<sup>2,6,8,12,13,19</sup> that training and capacity building for both the community and the engaging organisations is an important end goal in itself which can subsequently support community engagement to feed into decision-making in the longer term..

**ES 4.5** There is evidence from one [++] study<sup>14</sup> and two [+] studies<sup>6,16</sup> that networks of shared learning of best practice, and toolkits and bespoke training opportunities are facilitators to effective community engagement.

**ES 4.6** There is evidence from one [++] study<sup>18</sup> and one [-] study<sup>19</sup> that ongoing training and support is a facilitator to effective community engagement.

### Key

1 Chapman (2011) +	11 Marais (2007) ++
2 Chau (2007) +	12 Pemberton and Mason (2008) +
3 Craig (2010) -	13 Roma Support Group (2011) +
4 Fountain and Hicks (2010) ++	14 Robinson et al. (2010) ++
5 Hatamian et al. (2012) +	15 Sadare (2011) ++
6 Hatzidimitriadou et al. (2012) +	16 Sender et al. (2011) +
7 Hills et al. (2007) ++	17 Tunariu et al. (2011) +
8 Lawless et al. (2007) +	18 White et al. (2010) ++
9 Liverpool JMU (2012) +	19 White et al. (2012) +
10 Lwembe (2011) -	20 White and Woodward (2013) ++

## 5.4 PROCESS

### 5.4.1 CAPABILITIES AND THE ENGAGEMENT PROCESS

#### 5.4.1.1 BARRIERS

##### *a) Lack of capacity within community*

Five high quality studies (Marais, 2007 [++]; Robinson et al., 2012 [++]; Sadare, 2011 [++]; Windle et al., 2009 [++]; White and Woodward, 2013 [++]) and two medium quality studies (Chau, 2007 [+]; Hatzidimitriadou et al (2012) [+]) found that there was a lack of capacity within communities for taking part in community engagement activities. A wide range of factors contributed to this lack of capacity: practical constraints and competing priorities such as disability or illness, work, childcare and family commitments; lack of understanding and language skills; and low self-esteem and confidence. Often this conflicted with the expectations of engaging organisations of what community members could contribute or reinforced engaging organisations existing low expectations.

Respondents in the survey and interview study on patient and public engagement in sexual health services in London conducted by Robinson et al. (2010) [++] found that for ethnic minorities, social, economic, political and cultural challenges can cause low self-esteem, social isolation and depression, often preventing active involvement whilst immigrants or asylum seekers may feel unable to freely express their opinions on the UK health service and feel indebted to the NHS. Other reasons for a lack of community capacity was a lack of information and other competing commitments. Hatzidimitriadou et al (2012) [+] in interviews from their evaluation of co-production processes in a community-based mental health project in Wandsworth, found that communities had few resources and little understanding of how power operates. Marais (2007) [++], in a participatory research study of TB in migrant African communities in the London Borough of Westminster cited

work pressure, lack of capacity (time, funding and staff), and competing priorities as the key factors which, at times, impeded participation by community partners in the engagement. Similarly, Sadare (2011) [++], in her evaluation of the community engagement process in the overall Well London Programme found several personal barriers to engagement for community members and these included physical health and wellbeing, childcare and family care commitments, shyness or lack of social skills, lack of time, language barriers, and socio-economic circumstances. Another barrier identified was time. This barrier was consistently reported at all the main engagement events. Many respondents were time-poor due to long working hours and other commitments.

In her study of the Involvement of Chinese Older People in Policy and Practice Chau (2007) [+] described some participants as suffering “losses” as a result of getting involved especially around time, money and energy although it was also suggested that these were not reasons in themselves to not get involved and people would persevere when they could see the value of what they were doing.

Several studies examined the barriers facing community members when taking on longer-term volunteering roles. White et al (2013) [++] in their study of Community Health Champions in Lincolnshire, found that if, for example, family issues arose, volunteers would prioritise dealing with these over volunteering. This study found that their older volunteers had limitations that came with age especially where engaging agencies were over expectant of their capacities.

*“There comes a point where we are trying or seeming to make volunteer roles so similar to paid staff roles, with the responsibilities that go with that, with health and safety (...) We are landing the same onerous expectation on volunteers and that is a huge, huge barrier” (Page 20)*

White et al (2013) [++] also found that volunteers often felt overloaded:

*“Unfortunately if you are a willing volunteer people expect you to do more and more, in some cases ... It was too much, they expected far too much and in the end I had to turn round and say ‘enough is enough.’ I think that is something you have to be wary of, expected (sic) too much from volunteers.” (Unattributed quote Page 16)*

*“This is where you have to be careful, don’t kill off the goose. From our point of view (...) the majority of volunteers are older, a lot older. And with age comes certain limitations, and you cannot expect much more from a lot of these volunteers. Because they just can’t do it.” (Page 20)*

Like White et al. (2013) [++], Windle et al (2009) [++], in the National Evaluation of Partnerships for Older People Projects funded by the Department of Health to develop services for older people, also reported on particular issues facing older volunteers. Recruitment had to be an ongoing process, because older volunteers could experience increasing or sudden periods of ill health and periods when they lacked motivation. The authors also found that while there was numerous older people willing to provide a little help towards services, it was much more difficult to recruit older volunteers to co-ordinating roles which involved greater long-term commitment and greater responsibility in the day-to-day running of services. Such roles were often perceived by older volunteers as ‘unpaid jobs’.



**b) Lack of capacity within community organisations**

Three high quality studies (Carlisle, 2010 [++]; Marais, 2007 [++]; White and Woodward, 2013 [++]), two medium quality studies (Hatzidimitriadou et al., 2012 [+]; Roma Support Group, 2011 [+]) and one low quality study (Community Health Exchange, 2012 [+]) found that community organisations were restricted from fully participating in community engagement due to capacity issues such as lack of funding, appropriate skills, staff, time and competing work priorities. Again there was a corresponding underestimation by engaging organisations of the work involved for community organisations (e.g. in becoming partners with statutory organisations to deliver services or build capacity amongst the community).

Community Health Exchange (2012) [-] investigation of Scottish community-led health organisations' influence in health and social planning structures found that three-quarters of community organisations felt that a barrier to them being involved was a lack of capacity within the organisation, particularly a lack of time, energy and money. Similarly, Roma Support Group (2011) [+], in a study commissioned by London Civic Forum to identify the barriers and enablers faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms, found that a lack of financial support to community organisations hindered work aimed at promoting the empowerment of the Roma community. Carlisle (2010) [++] in her study of the Social Inclusion Partnership (SIP) in Scotland found that partnership working added to existing workloads of all agencies including community organisations. This issue was also reported by the community organisations working on the participatory research study of TB in migrant African communities with Marais (2007) [++]. These organisations could not often attend collaboration meetings due to a clack of capacity in terms of staff time and funds. Similarly, White and Woodward (2013) [++], in their study of Community Health Champions in Lincolnshire, also found that engagement was hindered by the limited capacity of co-ordinators and managers who often worked part-time and had to cover large geographical areas.

In their evaluation of a co-production approach to providing community-based mental health projects in Wandsworth, Hatzidimitriadou et al (2012) [+] found that even if community organisations were experienced in providing support to their communities, community organisation leaders talked about the limited capacity to be co-providers and their need to build on existing skills and experience in order to be more able to deal with the demands of such approach.

**c) Difficulties engaging specific groups**

Four high quality studies (Institute for Research and Innovation in Social Services, 2012 [++]; Marais, 2007 [++]; Robinson et al., 2010 [++]; Windle et al., 2009 [++]), four medium quality studies (Burgess, 2014 [+]; Chau, 2009 [+]; Christie et al., 2012 [+]; Roma Support Group, 2011 [+]) and one low quality study (Lwembe, 2011 [-]) found that it was not always easy for engaging organisations and staff to reach specific groups. Specific groups covered young people, older people, ethnic minority groups, white British. The reasons for the difficulty in engaging these groups was not always evident but included groups described as stigmatised, isolated (socially or geographically), marginalised or vulnerable.

Whether these difficulties were overcome was not always stated, and indeed in some studies, this seems to have been an ongoing problem.

Several studies documented problems for projects with engaging older people. For example Burgess (2014) [+] in an evaluation of timebanks, found that recruiting members to the timebanks was a challenge, particularly older isolated people and it was difficult to develop strategies to overcome this. Windle et al (2009) [++], in the National Evaluation of Partnerships for Older People Projects funded by the Department of Health to develop services for older people, found that some projects found it difficult to fully involve 'older' older people. The older people that were involved tended to be newly retired (the 'young old'), healthy and well-educated. This study also found that transport was a recurring issue and projects either had to provide transport or ensure that they were easily accessible through public transport.

The stigma associated with mental and sexual health was found to be a barrier to getting involved in community engagement related to these services, with Robinson et al. (2010) [++] reporting sexual health services being reliant on the usual 'volunteer types'. Stigma related to using sexual health services was reported to be especially acute for some ethnic minority groups.

Many practitioners in the study by the Institute for Research and Innovation in Social Services (2012) [++] on mental health and wellbeing in East Dunbartonshire, commented that it had been historically quite difficult to get engagement from people using mental health services in the area due to the stigma that still surrounds mental health issues. The authors found that people were not used to being asked their views, offer their own solutions or 'give back' to others and that even those with good support and experience of speaking out could find it difficult at times. Several studies unpacked some of the barriers facing ethnic minority groups in more detail. These included language barriers, insensitivities and a lack of cultural understanding within English-speaking communities, and suspicion within ethnic minority communities towards engaging authorities (Chau, 2007 [+] ; Christie et al., 2012 [+] ; Hatzidimitriadou et al., 2012 [+] ; Lwembe, 2011 [-] ; Marais , 2007 [++] ; Roma Support Group, 2011 [+] ; Windle et al., 2009 [++] ). The study by the Roma Support Group (2011) [+] also found that Roma young people could be especially hard to reach as they reported that they had either been actively discouraged by teachers to state their Roma ethnicity at school, or had not felt safe and secure enough to do so. Consequently, many Roma children do not publicly describe themselves as Roma and try to pass as other nationals, mainly Eastern European making them harder to engage.

And Christie et al (2012) [+], in a process evaluation about engaging the Somali Community in the London Borough of Hounslow in Road Safety, found that feelings of marginalisation amongst the target Somali community made it difficult to engage them at first.

*"I think that was another learning thing in a way –how marginalised they felt. And I think because so often they didn't understand any of the council processes, they were quite, at times, quite defensive and a very strong sense, I felt, that they didn't have much control so I think doing this kind of thing was very good for the.."*



5.4.1.2 IN CONTRAST TO OTHER STUDIES, LWEMBE (2011) [-], IN HER EVALUATION REPORT OF THE HEALTH CHAMPION ASPECT WITHIN THE WELL LONDON PROGRAMME IN WHITE CITY, FOUND THAT VERY FEW RESIDENTS FROM THE WHITE ETHNIC GROUP OFFERED TO VOLUNTEER IN THE PROJECT, DESPITE WHITE BRITISH BEING THE HIGHEST ETHNIC GROUP ON THE ESTATE AT 33% ALTHOUGH NO REASONS WERE GIVEN FOR THIS.FACILITATORS

**a) Gaining direct access to communities**

Seven high quality studies (Cinderby, 2014 [++]; Fountain and Hicks, 2010 [++]; Hills et al., 2007 [++]; Marais, 2007 [++]; Robinson et al., 2010 [++]; Sadare, 2011 [++]; Windle et al., 2009 [++]), six medium quality studies (Christie et al., 2012 [+]; Hatamian et al. 2012 [+]; Hatzidimitriadou et al., 2012 [+]; Lawless et al., 2007 [+]; Liverpool JMU, 2012 [+]; Roma Support Group, 2011 [+]) and two low quality studies (Community Health Exchange, 2012 [-]; Craig, 2010 [-]) found that using local organisations (both community and statutory), networks and individuals, with strong links to the target communities, is essential in reaching and engaging those communities.

The model of community engagement used by a project to engage Black and minority ethnic communities in the improvement of mental health services, evaluated by Fountain and Hicks (2010) [++], report that the community was at the heart of the project with the essential ingredient of a host community organisation, which may be an existing organisation, or one created specifically for the project. Such a model was used successfully in a number of other projects too (e.g. Hatamian et al. 2012 [+]; Lawless et al. 2007 [+]). Characteristics of suitable and effective community organisations identified across studies included: having good links to the community that needs to be engaged; being respected and valued by the community; having the capacity to provide co-ordination and infrastructure for day-to-day activities, such as somewhere to meet, access to telephones and computers, and a financial system; having connections to wider networks and groups; and having local knowledge, enthusiasm and passion (Community Health Exchange, 2012 [-]; Fountain and Hicks, 2010 [++]; Hatamian et al. 2012 [+]; Hatzidimitriadou et al., 2012 [+]; Liverpool JMU, 2012 [+]).

Some of these characteristic are summed up by one of the community-led health organisations interviewed in the study conducted by Community Health Exchange (2012) [-]:

*“We have direct links with local families.....therefore we have accurate local knowledge plus good communication with the public. We are viewed as approachable, helpful and ‘can do’ people with ears close to the ground, so our assessments and judgements of local issues should be recognised and respected” ( p 10)*

*“A knowledge of the kinds of issues local people face. Especially those who do not engage with statutory services” (p 10)*

Other benefits reported on working with existing community organisations and networks included: greater ease in engaging people when they are already engaged in a group or activity because they see further engagement as an extension of their current involvement (Sadare, 2011 [++]); able to build on any existing links or partnerships between community

and statutory organisations (Hatzidimitriadou et al. 2012 [+]); and a useful pathway for engaging a wider cross-section of people (Cinderby, 2014 [++]; Craig, 2010 [-]; Roma Support Group, 2011 [+]);

#### **b) Matching engagement method to community**

Four high quality studies (Hills et al., 2007 [++]; Robinson et al., 2010 [++]; Sadare, 2011 [++]; Woodall et al., 2013 [++]), four medium quality studies (Christie et al., 2012 [+]; Kimberlee, 2008 [+]; Roma Support Group, 2011 [+]; White et al., 2012 [+]) and one low quality study (Lwembe, 2011 [-]) found that it was important to use or tailor engagement methods to particular target groups.

Flexibility in approach was found to be needed especially where an existing method is not reaching its intended target. For example, Hills et al (2007) [++] in their evaluation of the Big Lottery Fund Healthy Living Centres (HLC) Programme, found that centre staff tried various approaches to get people interested and involved and learnt that different things worked in different locations. In some areas leafleting individual households or providing vouchers to participate in activities worked well; in other areas it did not.

Taking time to get to know the target community well before engagement started was seen as essential in a number of studies. For example, in the Roma Support Group (2011) [+] study, the research team understood that it was important not to mistake a group as being homogenous when they were not and to acknowledge tribal affiliation and nationality, both of which produce distinct differences in cultural norms. The teams' engagement process was informed by this (e.g. separate focus groups for young Roma were held in line with the Roma community's traditional attitudes and etiquette, which does not encourage articulation of differences of opinion in the presence of one's elders). Similarly, Christie et al (2012) [+], in a process evaluation about engaging the Somali Community in the London Borough of Hounslow in Road Safety, took time to work out the best way to engage the Somali community in relation to road safety so that were able to better tailor engagement methods (e.g. engaging Somali men through khat cafes within their borough). Sadare (2011) [++] in her evaluation of the community engagement process in the first phase of the Well London Programme found that involving children was a good way of getting people engaged in community engagement events because children acted as catalysts for socialising amongst their parents and other members of the family. Robinson et al (2010) [++], in their study of Patient and Public Engagement (PPE) for Sexual and Reproductive Health and HIV/AIDS (SRHH) service users in London, used internet based methods of collecting information from service users and this method was found to encourage engagement amongst this stigmatised group as it offered anonymity and confidentiality.

Kimberlee (2008) [+] in their evaluation of the community engagement within Birmingham City Council's Streets Ahead on Safety project used interactive technology ('Quizdom') to stimulate young people's interest in engaging with road safety. 'Quizdom' used a series of multiple choice questions where young people use individual, interactive keypads. Feedback to their responses was instantaneous and it provided opportunities to discuss aspects of road safety that were of local concern to them. **c) Outreach and advocacy**

One high quality study (Hills et al., 2007 [++]) and four medium quality studies (Hatamian et al., 2012 [+]; Kimberlee, 2008; Pemberton and Mason, 2008 [+]; Williamson et al., 2009 [+]) found that outreach was a useful method for ongoing engagement and, along with advocacy, was valuable for reaching and including particularly vulnerable or marginalised groups within engagement activities.

There were two forms of outreach detailed across studies: physically locating projects and services closer to communities and deploying community members to bring other members of the community to projects and services. The evaluation of Healthy Living Centres found the use of both forms of outreach to be successful (Hills et al. 2007 [++]). Services were taken out to communities within, for example, sheltered housing, GP waiting rooms, mosques, pubs, and shopping centres. Williamson et al. (2009) [+] in their evaluation of Rochdale Partnerships for Older People Project, found that using outreach workers was not only useful for navigating, signposting and referring older people on to mainstream services, but crucial for providing the necessary intelligence on community needs to feed into commissioning decisions. Sustained engagement was achieved through outreach in the 'Active at 60 Community Agent Programme', which trained older people to help other older people to become more active and positively engaged with society (evaluated by Hatamian et al (2012) [+]). Pemberton and Mason (2008) [+] highlighted the importance of allocating sufficient funding to outreach activities in their study of the engagement of users in service delivery, service planning and in monitoring and evaluation activities for Sure Start Children's Centres (SSCC) in Greater Merseyside, especially for targeting the most excluded groups.

Kimberlee (2008) [+] in their evaluation of the community engagement within Birmingham City Council's Streets Ahead on Safety project which targeted young people found that continual advocacy was required to ensure a collaboration based on dialogue, learning and mutual reciprocity between young people and adults. Marais (2007) [++] found that advocacy around TB from within communities was enhanced through their participatory research which employed peer researchers drawn from the migrant African communities affected by TB.

#### 5.4.1.3 EVIDENCE STATEMENTS

##### Evidence Statement 5: Capabilities and the engagement process

There is evidence from twenty two evaluation studies<sup>1-3,5-17,20-25</sup>, two mixed methods studies<sup>4,19</sup> and one qualitative study on inclusive and accessible practice<sup>18</sup>.

**ES 5.1** There is evidence from five [++] studies<sup>16,18,20,24,22</sup>, and two [+] studies<sup>3,9</sup> that there was a lack of capacity within communities for taking part in community engagement activities. A wide range of factors contributed to this lack of capacity: practical constraints and competing priorities such as disability or illness, work, childcare and family commitments; lack of understanding and language skills; and low self-esteem and confidence. Often this conflicted with the expectations of engaging organisations of what community members could contribute or reinforced engaging organisations existing low expectations.

**ES 5.2** There is evidence from three [++] studies<sup>2,16,22</sup>, two [+] studies<sup>9,18</sup> and one [-] study<sup>4</sup> that community organisations were restricted from fully participating in community engagement due to capacity issues such as lack of funding, staff, time and competing work priorities. Again there was a corresponding underestimation by engaging organisations of the work involved for community organisations (e.g. in becoming partners with statutory organisations to deliver services or building capacity amongst the community).

**ES 5.3** There is evidence from four [++] studies<sup>12,16,19,24</sup>, four [+] studies<sup>1,3,5,18</sup> and one [-] study<sup>11</sup> that it was not always easy for engaging organisations and staff quality studies to reach specific groups. Specific groups covered young people, older people, ethnic minority groups, white British. The reasons for the difficulty in engaging these groups was not always evident but included groups described as stigmatised, isolated, marginalised or vulnerable.

**ES 5.4** There is evidence from six [++] studies<sup>7,10,16,19,20,24</sup>, six [+] studies<sup>5,8,9,14,15,18</sup> and two [-] studies<sup>5,6</sup> that using local organisations (both community and statutory), networks and individuals, with strong links to the target communities, is essential in reaching and engaging those communities.

**ES 5.5** There is evidence from four [++] studies<sup>10,19,20,25</sup>, four [+] studies<sup>5,13,18,21</sup> and one [-] study<sup>11</sup> that it was important to use or tailor engagement methods to particular target groups. Flexibility in approach is needed especially where a method is not reaching its intended target.

**ES 5.6** There is evidence from one [++] study<sup>10</sup> and four [+] studies<sup>8,13,17,23</sup> that outreach was a useful method for ongoing engagement and, along with advocacy, was valuable for reaching and including particularly vulnerable or marginalised groups within engagement activities.

#### Key

1 Burgess, (2014) +	14 Lawless et al. (2007) +
2 Carlisle (2010) +	15 Liverpool JMU (2012) +
3 Chau (2007) +	16 Marais (2007) ++
4 Community Health Exchange (2012) –	17 Pemberton and Mason (2008) +
5 Christie et al. (2012) +	18 Roma Support Group (2011) +
6 Craig 2010 –	19 Robinson et al. (2010) ++
7 Fountain and Hicks (2010) ++	20 Sadare (2011) ++
8 Hatamian et al. (2012) +	21 White et al. (2012) +
9 Hatzidimitriadou et al. (2012) +	22 White and Woodward (2013) ++
10 Hills et al. (2007) ++	23 Williamson et al. (2009) +
11 Lwembe (2011) -	24 Windle et al. (2009) ++
12 Institute for Research and Innovation in Social Services (2012) ++	25 Woodall et al. (2013) +
13 Kimberlee (2008) [+]	

## 5.4.2 INCLUSIVE AND ACCESSIBLE PRACTICE

### 5.4.2.1 BARRIERS

#### a) Low awareness and understanding of engagement opportunities, rights and structures

Two high quality studies (Robinson et al., 2011 [++]; Sadare, 2011 [++]), three medium quality studies (Lawson and Kearns, 2009 [+]; Pemberton and Mason, 2008 [+]; Roma Support Group, 2011 [+]) and one low quality study (Community Health Exchange, 2012 [-]) found that low levels of awareness and a lack of understanding were a barrier to effective community engagement.

Community Health Exchange (2012) [-] investigation of Scottish community-led health organisations' influence in health and social planning structures, found that 48% of community-led health organisations surveyed said lack of information was a barrier to influence. Sadare (2011) [++] in an evaluation of the community engagement process in the Well London programme found insufficient information was an apparent barrier to engagement. Several respondents said that they did not fully understand what the Well London programme was about and did not know how they could engage with it. Roma Support Group (2011) [+], in a study commissioned by London Civic Forum to identify the barriers and enablers faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms found that one of the most frequent barriers to engagement identified by participants during the focus group meetings was a lack of information regarding their rights and entitlements to have a say in public life. This was said to cause much frustration amongst the community and lead to an acute sense of vulnerability and social exclusion. Additionally, many participants felt that the information they had received was fragmentary and contradictory.

Pemberton and Mason (2008) [+] in their study of the engagement of users in service delivery, service planning and in monitoring and evaluation activities for Sure Start Children's Centres (SSCC) in Greater Merseyside, reported barriers that appeared to be of relevance to the greater involvement of users in co-production activities and included a lack of awareness of the opportunities to participate in SSCC service planning and management activities, and a lack of communication about opportunities for co-production of services by service users. It appeared from analysing interview transcripts that it was only parents or carers who had been approached specifically with regards to becoming engaged in SSCC decision-making and who had become involved beyond the level of either service user or service co-deliverer. Robinson et al (2010) [++], in their study of Patient and Public Engagement (PPE) for Sexual and Reproductive Health and HIV/AIDS (SRHH) service users in London, also found that one barrier to engagement was lack of information.

Lawson and Kearns et al (2009) [+], in their study of community engagement in regeneration in the city of Glasgow, reported that few of the participants in the community engagement appeared to know what the next stages in the process were or what their role was going to be indicating poor knowledge of power structures and what happens next in the process. This made some sceptical about their involvement and how decisions were being made.

#### **b) Failure to overcome or recognise cultural and language issues**

Three high quality studies (Marais, 2007 [++]; Sadare, 2011 [++]); two medium quality studies (Chau, 2007 [+]; Roma Support Group, 2011) and one low quality study (Community Health Exchange, 2012 [+]) found that not addressing language and cultural

barriers was problematic for inclusive community engagement. Sadare (2011) [++] in an evaluation of the community engagement process in the Well London Programme, found that language was a barrier to engagement especially for the residents whose first language was not English and who did not understand or speak the language. Although posters and leaflets had some translations into other languages, the community engagement events did not always have translators available. Chau (2007) [+] in their study of the Involvement of Chinese Older People in Policy and Practice, found that language barriers were a key hindrance to involvement in service provision in terms of getting information, communicating directly with services and applying for funding. One participant described themselves as a "'quail in a fabric bag' which could never have a clear idea about what is going on in the outside world.

Roma Support Group (2011) [+], in a study commissioned by London Civic Forum to identify the barriers and enablers faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms, found language barriers, high rates of illiteracy and ingrained discrimination made it difficult for Roma to access up-to-date information. White et al (2010) [++] in their study of Phase 1 of the Altogether Better Programme, found that cultural and language barriers were seen as key factors in the low levels of awareness of health conditions and services by champions working with black and minority ethnic communities in Sheffield. Marais (2007) [++], in a participatory research study of TB in migrant African communities in the London Borough of Westminster, found that some community research fieldworkers felt that they were not very successful in accessing and recruiting study participants from a wider range of migrant black African communities. The main reasons stated were language barriers, and little knowledge about and limited access to members from communities other than their own. Community Health Exchange (2012) [-] investigation of Scottish community-led health organisations' influence in health and social planning structures, found a lack of inclusive practice despite equalities legislation, such as provision of interpreters or translators.

### **c) Untimely events and a lack of support to attend**

Two high quality studies (Sadare, 2011 [++]; Windle et al., 2009 [++]), one medium quality study (Sender et al., 2011 [+]) and one low quality study (Community Health Exchange, 2012 [-]) found that the timing of events and a lack of support to help particular groups to attend were barriers to community engagement. Different groups within communities found different times for events to be more or less convenient. Windle et al (2009) [++] in their evaluation of the national 'Partnerships for Older People Projects' to develop services for older people found that older people were often reluctant to go out after dark, both due to safety concerns and because they may tire more easily. Sadare (2011) [++] in an evaluation of the community engagement process in the Well London programme also found safety to be a concern for evening meetings and this was especially true for older residents but was not exclusive to them. In contrast, Sadare (2011) [++] also found that day time events excluded working residents. Community Health Exchange (2012) [-] investigation of Scottish community-led health organisations' influence in health and social planning structures, found that over a quarter of community-led health organisations felt that the times at which meetings or events were held by engaging agencies meant they could not attend, and almost 20% complained of short notice of meetings.



Community Health Exchange (2012) [-] investigation of Scottish community-led health organisations' influence in health and social planning structures, found that lack of provision of childcare affected almost 15% of community-led health organisations, and 11% were affected by no provision for back up care for carers. Sadare (2011) [++] found that childcare was an issue for residents in attending community engagement events. Although crèche facilities and play areas were provided at most cafés, not everyone knew they would be available. People hesitated to bring their children with them and were unwilling to leave them at home or pay for childcare. Many respondents said they were pleasantly surprised to see the crèche facilities provided at the cafés. Getting to meetings or events, or carrying out outreach work was also a challenge for older people, those with physical disabilities and those from rural communities (Sender et al., 2011 [+]; Windle et al., 2009 [++] ).

#### ***d) Lack of appropriate venues for engagement events***

One high quality study (Sadare, 2011 [++]) and one medium quality study (Chau, 2007 [+]) found that a lack of appropriate venues for engagement events could be a barrier. Chau (2007) [+] in an evaluation of the involvement of Chinese older people in policy and practice found that there was a lack of spaces for people to get together and even chat, even in local community centres. The experience of working in groups in the project was new to many members and exciting, but existing community facilities were not set up like this for e.g. community centres might provide specific activities and classes but no space for people to hang around together afterwards more informally. Sadare (2011) reported slightly different issues related to community engagement venues in the Well London programme; acoustics problems, unfamiliarity with the venue and the association of the venue with particular community groups.

#### ***e) Administrative delays for community champions or leaders***

Two high quality studies (White and Woodward, 2013[++]; Windle et al., 2009 [++]) and one low quality study (Chapman, 2010 [+]) reported delays in obtaining Criminal Records Bureau (CRB) checks, now known as Disclosure and Barring Service (DBS) checks, for community volunteers to take up volunteering roles such as becoming a health champion or a 'community activator'. Risk assessment and CRB checks caused anxiety and were seen to be intrusive (White and Woodward, 2013 [++]). Chapman (2010) [+] in an evaluation of the Well London Community Activator Programme, found that the time it took securing enhanced CRB disclosure clearance for those who did not already have one in place contributed to the delay in starting engagement for some of the Activators. It was felt by participants that this had not been sufficiently thought through early enough as to who would action this.

#### ***f) Unrepresentativeness and partisanship***

Four high quality studies (Carlisle, 2010; Harkins et al, 2012; Marais, 2007; Sadare, 2011;), and one medium quality study (Roma Support Group, 2011) found that conflict over the representativeness of those engaged or favoured within communities by engaging agencies appears to have weakened some community engagement processes and led to resentment and refusal to engage by others. Often the cause of unrepresentativeness was

described by studies as due to limitations on time and resources available to the engaging agencies and, therefore, the need to be pragmatic.

Sadare (2011) [++], in her PhD study of the early days of the community engagement process in the Well London Programme, found that there were some barriers resulting from the conflicts between different local stakeholders, including the co-host organisations, contracted initially by the Well London Alliance to help with the community engagement. Some community groups felt that the co-host organisations selected did not adequately represent their communities, and decided to ignore the consultations. It was suggested that the external organisations needed to find out what was already happening in the communities and who was already providing services and to use local resources and providers.

Carlisle (2010) [++] in her study of the Social Inclusion Partnership (SIP) in Scotland, found that achieving community representation was a contested process as not all neighbourhoods within East Kirklands SIP were represented and this caused "vociferous objections". Further, the mechanism for electing community representatives onto the SIP board was felt by many community groups to create competition between organisations. The groups expressed worries that the 10 neighbourhoods would be in competition with each other for SIP resources and that community representatives would be partisan in respect of their own area. They foresaw problems of engagement, suggesting that it only an interested minority who would seek involvement.

#### ***g) Geographic Boundaries***

Two high quality studies (Pemberton and Mason 2008; White and Woodward, 2013), one medium quality study (Chapman, 2010) and one low quality study (Craig, 2010) found that setting of geographical boundaries of engagement either too wide or too narrow could have an adverse effect on engagement.

Both Pemberton and Mason (2008) [+] in their study of the engagement of users in service delivery, service planning and in monitoring and evaluation activities for Sure Start Children's Centres (SSCC) in Greater Merseyside, and White and Woodward (2013) [++] in their study of Community Health Champions in Lincolnshire, found that setting boundaries too wide affected the ability of staff to engage as effectively as they would have liked. Pemberton and Mason 2008) [+] found the geographical extension of SSCC boundaries impacted upon the intensity of outreach with those least likely to up-take or participate in SSCC activities (such as BME groups and males). Whilst White and Woodward (2013) [++] co-ordinators and managers who often work part-time had limited capacity to cover large geographical areas. On the other hand, both Chapman (2010) [+], in an evaluation of the Well London Community Activator Programme, and Craig (2010) [-] in an evaluation of the Well London Youth.comUnity and Young Ambassadors Programme, found that setting geographic boundaries too tight could be a constraint on success of engagement. The Phase 1 Well London model specified that interventions needed to be tightly focussed (and sometimes, apparently, delivered) in the communities living in specific areas for the purposes of its quantitative evaluation. However, in most cases, these tight geographical boundaries bore little relationship to the reality on the ground. They did not fit with the peer and friendship networks of the Young Ambassadors or Activators which were based



on family, schools and other factors. The Young Ambassadors and Activators struggled to grasp exactly where and to whom they should be engaging.

#### 5.4.2.2 FACILITATORS

##### **a) Early and consistent advertising of community engagement opportunities through multiple channels**

Two high quality studies (Cinderby, 2014 [++]; Sadare, 2011 [++]) and four medium quality studies (Hatamian et al., 2012 [+]; Pemberton and Mason (2008) [+]; Roma Support Group (2011) [+]; Sender et al (2011) [+]) found that advertising community engagement opportunities through multiple channels was important for successful engagement. Residents interviewed by Sadare (2011) [++] in an evaluation of the community engagement process in an area-based health improvement programme (Well London) suggested that early advertising of community engagement events in multiple local venues would encourage them and others to get involved. Local venues where residents visit regularly were community halls, restaurants and fast-food shops, laundrettes, pubs and convenience stores. Using community leaders and their networks, targeted outreach activities to specific groups who may not be as visible within a community, and social media were also found to be effective ways to promote events and opportunities (Hatamian et al., 2012 [+]; Pemberton and Mason (2008) [+]; Roma Support Group (2011) [+]; Sender et al (2011) [+]). Cinderby, 2014 [++] in their study of the ‘good life initiative’ within one community in York found that using a range of contact methods was important in terms of attracting a diverse group of people and that a single approach may not be successful or inclusive.

##### **b) Use of plain language and provision for non-English speakers**

Four medium quality studies found that providing support for non-English speakers was crucial for enabling these groups to get involved in community engagement activities (Chau, 2007 [+]; Christie et al., 2012 [+]; Hatamian et al., 2012 [+]; Pemberton and Mason (2008) [+]). Chau (2007) [+] found that it was essential for Chinese speakers to be accompanied by someone who could translate for them at English speaking events. Similarly Hatamian et al (2012) [+], in their evaluation of the Outcomes of the Active at 60 Community Agent Programme, found that practical and logistical support by local funders with translation of group materials into other languages where appropriate for the local area aided engagement.

Christie et al (2012) [+], a process evaluation about engaging the Somali Community in the London Borough of Hounslow in Road Safety, received funding from the Department for Transport which enabled the team to employ two bilingual Somali officers::

*“Practitioner 1: don’t know where it would have gone, how much it would have got off the ground at all without them”*

*“Practitioner 2: I don’t think we could have managed without [Somali community group], the interpreting was there, so you had to have somebody who spoke the language to make it a greater success.” (Page 818)*

Pemberton and Mason (2008) [+] in their study of the engagement of users in service delivery, service planning and in monitoring and evaluation activities for Sure Start Children's Centres in Greater Merseyside found that engagement was improved by limiting the use of practitioner jargon.

### ***c) Timing of events and support to attend***

One high quality study (Sadare, 2011 [++]) and three medium quality studies (Hatamian et al (2012) [+]; Pemberton and Mason (2008); Tunariu et al (2011) [+]) found that suitable times for events and support to attend events could facilitate better engagement. Residents in Sadare (2011) [++] evaluation of community engagement in Well London felt that events should be held in the daytime when they felt safest to go out. Pemberton and Mason (2008) [+] in their study of the engagement of users in service delivery, service planning and in monitoring and evaluation activities for Sure Start Children's Centres (SSCC) in Greater Merseyside, found that engagement was improved by holding meetings at times parents are available. In particular, to encourage the active inclusion of fathers it was suggested there needed to be a better consideration of the timing of SSCC activities, since many fathers appeared to be working during the day. Support to attend and fully participate in engagement events was in the form of crèche facilities or play areas (Sadare, 2011 [++]; Pemberton and Mason (2008); Tunariu et al (2011) [+]); provision of expenses for travel (Hatamian et al (2012) [+] and Tunariu et al (2011) [+]) and wheelchair access (Sadare, 2011 [++]).

### ***d) Using familiar places and creating an informal atmosphere***

Two high quality studies (Hills et al., 2007 [++]; Sadare, 2011 [++]) and two medium quality studies (Hatzidimitriadou et al (2012) [+]; Jarvis et al., 2011 [+]) found that using familiar and informal environments or spaces was important in engaging residents and service users. This was the case for bringing people together for meetings, workshops or 'world cafes' or when conducting outreach or promotional activities. For example, Hills et al (2007) [++] in their evaluation of the Big Lottery Fund Healthy Living Centres (HLC) Programme, report managers cited various ways that they were reaching out to the community including visits to sheltered housing, GP waiting rooms, mosques, pubs, shopping centres, talking to people on the streets and door knocking. Sadare (2011) [++], found that the conscious provision of refreshments was important at community engagement events.

## **5.4.2.3 OVERCOMING THE CHALLENGES**

There were no studies that directly addressed how to overcome the challenges for community engagement arising from hard to access events and opportunities. The facilitators described in section 5.4.2.3 provide suggestions but none of our included studies attempted to evaluate the impact of deliberate strategies to promote inclusive and accessible practice.

## **5.4.2.4 EVIDENCE STATEMENTS**

<b>Evidence Statement 6: Inclusive and accessible practice</b>
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There is evidence from eighteen evaluation studies<sup>1,3-11,13-22</sup>, two mixed methods studies<sup>2,12</sup> and one qualitative study<sup>11</sup> on inclusive and accessible practice.

**ES 6.1** There is evidence from two [++] studies<sup>12,14</sup>, three [+] studies<sup>8,10,11</sup> and one [-] study<sup>2</sup> that low levels of awareness and a lack of understanding of engagement opportunities, rights and structures were a barrier to effective community engagement.

**ES 6.2** There is evidence from three [++] studies<sup>9,14,17</sup>, two medium quality studies<sup>1,11</sup> and one low quality study<sup>2</sup> that not addressing language and cultural barriers was problematic for inclusive community engagement.

**ES 6.3** There is evidence from two [++] studies<sup>14,19</sup>, one medium quality study<sup>15</sup> and one low quality study<sup>2</sup> that the timing of community engagement events or meetings and a lack of support to help particular groups to attend were barriers to community engagement. Different timings suit different groups of people (e.g. day time preferred by older people, evening by working adults if able to feel safe) and parents, older people, those with physical disabilities and those from rural communities need additional support to attend (e.g. childcare, transport).

**ES 6.4** There is evidence from one [++] study<sup>14</sup> and one [+] study<sup>1</sup> that a lack of appropriate venues for engagement events could be a barrier to engagement. This included a lack of accessible space for informal meetings<sup>1</sup> and problems with acoustics for large group meetings<sup>14</sup>.

**ES 6.5** There is evidence from two [++] studies<sup>18,19</sup> and one [-] study<sup>3</sup> of delays or lack of planning for obtaining Criminal Records Bureau (CRB) checks, now known as Disclosure and Barring Service (DBS) checks, for community volunteers to take up volunteering roles such as becoming a 'health champion' or a 'community activator'.

**ES 6.6** There is evidence from four [++] studies<sup>9,14,20,21</sup> and one [+] studies<sup>11</sup> that conflict over the representativeness of those engaged or favoured within communities by engaging agencies appears to have weakened some community engagement processes, lead to resentment and refusal to engage by others. Often the cause of unrepresentativeness was described by studies as due to limitations on time and resources available to the engaging agencies and, therefore, the need to be pragmatic.

**ES 6.7** There is evidence from two [++] studies<sup>10,18</sup>, one [+] study<sup>3</sup> and one [-] study<sup>22</sup> that setting of geographical boundaries of engagement either too wide or too narrow could have an adverse effect on engagement.

**ES 6.8** There is evidence from one [++] study<sup>14</sup> and four [+] studies<sup>5,10,11,15</sup> that early advertising of community engagement opportunities through multiple channels was important for successful engagement. Multiple channels included a wide range of community venues (e.g. shops, fast food restaurants, launderettes), networks of community leaders, outreach and social media.

**ES 6.9** There is evidence from four [+] studies<sup>1,3,5,10</sup> that providing support for non-English speakers was crucial for enabling these groups to get involved in community

engagement activities. Plain English was also helpful for all groups<sup>10</sup>.

**ES 6.10** There is evidence from one [++] study<sup>14</sup> and three [+] studies<sup>5,10,16</sup> that suitable times for events, matched to the needs of different groups, and support to attend events (e.g. childcare, support with transport) could facilitate better engagement.

**ES 6.11** There is evidence from two [++] studies<sup>6,14</sup> and two [+] studies<sup>5,7</sup> that using familiar and informal environments or spaces was important in engaging residents and service users.

**ES 6.12** There was no evidence within this theme on strategies to overcome hard to access community engagement events and opportunities.

### Key

1 Chau (2007) +	12 Robinson et al. (2010) ++
2 Community Health Exchange (2012) –	14 Sadare (2011) ++
3 Chapman (2011) –	15 Sender et al. (2011) +
4 Christie et al. (2012) +	16 Tunariu et al. (2011) +
5 Hatamian et al. (2012) +	17 White et al. (2010) ++
6 Hills et al. (2007) ++	18 White and Woodward (2013) ++
7 Jarvis et al. (2011) +	19 Windle et al. (2009) ++
8 Lawson and Kearns (2009) +	20 Carlisle (2010) ++
9 Marais (2007) ++	21 Harkins et al. (2012) ++
10 Pemberton and Mason (2008) +	22 Craig (2010) -
11 Roma Support Group (2011) +	

## 5.5 VARIATION IN BARRIERS AND FACILITATORS

### 5.5.1 VARIATION BY CONTEXT, TYPE OF COMMUNITY ENGAGEMENT INITIATIVE, POPULATION AND HEALTH FOCUS

None of the studies directly compared community engagement initiatives across different contexts, populations or health topics. We systematically compared the barriers and facilitators identified by studies according to context, type of engagement initiative, population focus and health focus. There were very few differences suggesting that the barriers and facilitators we identified were generally associated across a whole range of contexts, health topics, populations and type of community engagement. However we did find that:

- Quality of existing relationships was a more dominant theme in ‘area-based regeneration’ initiatives compared to other types of initiatives. Barriers and facilitators within this theme were not apparent at all in ‘health champion’ studies.
- Difficulties engaging specific groups/using community organisations to reach specific groups was the barrier/facilitator most often found in community-led studies and those targeting ethnic minority groups.

- A lack of capacity within communities for taking part in community engagement activities was more frequently found in community-led initiatives. These types of initiatives are arguably more demanding on community members and require specific skills.

#### 5.5.2 VARIATION BY EXTENT OF COMMUNITY ENGAGEMENT

We also examined whether there were differences in barriers and facilitators associated with the extent of community engagement (high, medium or low). There were few clear differences except for:

- Studies classified as low on extent of community engagement were less likely to identify barriers and facilitators within the 'Support, Training and Capacity Building' theme compared with studies classified as medium or high on extent of engagement.
- Studies classified as low on extent of community engagement were also less likely to identify barriers and facilitators within the 'Capabilities and the engagement process' themes and the 'Inclusive and accessible practice' theme.

## 6 DISCUSSION AND CONCLUSIONS

### 6.1 FINDINGS INTO CONTEXT

This review uncovered a relatively large body of research evidence from the UK on the barriers and facilitators to effective community engagement. Evidence came from studies of community engagement initiatives focused on a range of health issues from healthy eating to road safety, although the majority were not focused on broader themes such as community well-being, social capital and cohesion, or general health. A range of approaches to community engagement were studied including community representation on management boards in area-based regeneration initiatives; involving members of the community to deliver services, activities and programmes such as ‘health champions’ and ‘timebanks’; holding community engagement events to inform area-based health improvement in which local residents are invited to define and prioritise solutions; and community-led initiatives.

Findings on barriers and facilitators were organised within six emergent themes which were structured across three areas: ‘context’ (quality of existing relationships with communities; organisational culture, attitudes and practice), ‘infrastructure’ (investing in infrastructure and planning; support, training and capacity building) and ‘process’ (capabilities and the engagement process; inclusive and accessible practice).

Findings on barriers and facilitators within ‘context’ reflect the pre-existing factors within communities or engaging organisations that can impact upon community engagement. With poor relations, communities can be cynical or threatened and engaging organisations are less likely to see the worth of community engagement. Where there are good relations, or efforts made to overcome a history of poor relations, engaging organisations have supportive attitudes towards community engagement throughout the organisation and from the outset.

Within ‘infrastructure’ findings highlight how planning and resources (or lack of) can impact upon community engagement and highlight what needs to be in place to support effective community engagement. Effective community engagement is hindered where there is a lack of clarity and transparency about the goals of the engagement, competing agendas across stakeholders within partnerships, a lack of dedicated staff and resources, and limited timelines for building trust or achieving the scope or depth of the community engagement. Effective community engagement is enhanced where there is planned rather than ad-hoc community engagement strategy and methods, clarity of community engagement goals and transparency of process, mechanisms for joint decision-making and a transactional and reciprocal process between communities and engaging organisations, strong partnerships and networks, and time, effort and resources invested to build relationships and trust. Further, training in methods of community engagement and co-production and other skills is essential for both community members and professionals, as well as mentoring and ongoing support for community members.

Within ‘process’ findings highlight the factors that can impact on the actual practice of community engagement as it is being done. In practice, a lack of capacity of both

community members and organisations is a limit on effective community engagement, as is the difficulty in engaging specific groups within the community. Using community organisations with good reach, being flexible in methods of engagement, and using outreach or advocacy can overcome the latter difficulty. Barriers such as poor communications, cultural or language barriers, untimely events and a lack of support to attend, or lack of appropriate venues for engagement events can adversely affect community engagement. However, early and consistent advertising of community engagement opportunities through multiple channels, use of plain language and provision for non-English speakers, appropriate timing of events and providing support to involvement (such as transport or childcare) can overcome the barriers to involvement.

Our findings build upon those of Popay et al. (2007) who reviewed the research evidence on barriers and facilitators to community engagement up until 2007 to inform NICE guidance on community engagement in 2008 (NICE public health guidance 9). The evidence at that time was largely focused on barriers rather than facilitators, although similar themes were identified. Popay et al. (2007) identified barriers including unequal power relationships between engaging organisations and communities; the importance of professionals and community members having access to training in key skills for engagement; problematic community engagement practices such as the organisation, style and timing of meetings or a lack of diversity in methods for engagement; 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; the transaction costs of community engagement such as time constraints, problems caused by poverty, low income and inflexible welfare rules and transport difficulties; poor culture and attitudes by engaging organisations and community resistance to engagement. Facilitators identified for community engagement included the inclusion of community development skills, the value of public agencies spending time building trust and relationships with communities, and enabling role of national and local NGOs or voluntary organisations.

Our review adds substantially to the evidence synthesised by Popay et al. (2007), particularly around facilitators. For example, our review identified a large number of facilitators within both “infrastructure and planning” and “process” that were not so evident in the Popay review and these included communicating clear goals and outcomes for the community engagement, having strong partnerships and networks in place, providing appropriate mentoring and other forms of support for community members as well as ongoing training and support, tailoring engagement methods to particular target groups, the early advertising of community engagement opportunities through multiple channels, support for non-English speakers, suitable times for events, matched to the needs of different groups, and support to attend engagement events.

One possible reason for a greater balance between barriers and facilitators in the current review is that the field of community engagement has advanced both in terms of policy and practice whereby policy imperatives, such as the ‘duty to involve’, have more deeply penetrated practice; and in terms of research whereby evaluation activity has begun to place a greater emphasis on teasing out how community engagement works. Our review starts where Popay’s ends and this was a period of area-based regeneration such as the



New Deal for Communities initiative, and new community services such as Sure Start and Healthy Living Centres. Certainly, in our review area-based regeneration initiatives tended to struggle more in overcoming a history of poor relationships and putting into practice their desired aim of a bottom-up community engagement. As the period covered by our review (2007-14) progresses, we see the emergence of new approaches; firstly, the area based health initiatives (such as Well London) and the Health Champion/Health Trainer models (like Altogether Better), then ideas such as timebanks, asset-based approaches, co-production and resilience models. These new approaches appear to have taken a more proactive approach in attempting to reduce the barriers to communities' involvement in community engagement. However, co-evaluation still remains one area where little progress has been made.

## 6.2 LIMITATIONS OF THE EVIDENCE AND EVIDENCE GAPS

There were a number of methodological limitations within the evidence. The majority of studies included in the review were process evaluations which examined how community engagement worked in practice. Furthermore, the predominant (and often the sole) methods used were qualitative, in particular the use of interviews, focus groups and case studies and there was a lack of mixed methods studies which integrated process and outcomes. This limits the extent to which any process information about community engagement can be linked to subsequent outcomes and suggests that process evaluations in this area are not yet following best practice recommendations (e.g. Moore et al., 2014). There was also variation amongst the studies in terms of their emphasis on identifying barriers and facilitators. Whilst some studies assessed barriers and facilitators explicitly and comprehensively, others were much more limited in the extent to which their findings addressed barriers and facilitators.

All but three studies in the review were rated at least [+] in terms of overall quality using the NICE checklist for qualitative research. There were a number of areas where methodological rigour could be improved. These were related to data analysis in terms of how well analysis methods were reported including use of and reporting on strategies to increase rigour in analysis and presentation of data in terms of richness and ensuring a clear path between data, interpretation and conclusions. In relation to the former, although studies often presented a wealth of data, this was in some cases under-analysed. In these cases analysis tended to be descriptive, sticking close to the original data. This level of analysis is, of course, useful but it lacked the interpretive power of a more conceptual level of analysis for the production of explanation. Problems with the quality of data analysis within qualitative research uncovered by systematic reviews is not unique to this particular topic, it is a common finding of reviews which include qualitative research in a range of areas (Harden and Gough, 2012).

In terms of evidence gaps, community engagement still appears to be a somewhat experimental and ad hoc process rather than a planned and purposeful activity with a rationale given for the choice of strategy or approach. Evaluations of community engagement too tend to be retrospective and occur at the end of the process rather than formative and running alongside the engagement process so that early problems can be picked up and rectified. There was very little generally in the studies about the costs of engagement, about the setting up of processes, or the investment of time or other



resources in the preparation of structures, processes or mechanisms of engagement. Further related gaps are how engaging agencies recorded, tracked, or analysed collected information/data from the community engagement activities and how this information/data was fed back into decision-making processes and the subsequent impact they had on, for example, programme design or service delivery.

Other gaps were the lack of studies which attempted to directly evaluate how to overcome identified barriers to community engagement and the absence of studies which directly compared different community engagement approaches.

### **6.3 STRENGTHS AND WEAKNESSES OF THE REVIEW**

The review took a systematic approach to reviewing evidence on barriers and facilitators which included exhaustive searches, application of explicit inclusion and exclusion criteria, quality assessment, and the use of more than one reviewer to provide quality assurance. All of these methods minimise the introduction of bias and error into the review and provides confidence in the review findings.

The scope of our review was limited to evidence generated from the UK which increases relevance, but means that learning from other countries is lost. Our searches built on those conducted for a large NIHR systematic review of the effectiveness of community engagement which relied heavily on using existing systematic reviews to identify studies (O'Mara-Eves, 2013). This had advantages because studies of community engagement can be hard to pick up via traditional bibliographic databases. However, this strategy runs the risk of not identifying the most recent evidence and missing studies not included in systematic reviews. Forward citation searching and searching specialised registers helped to protect against this.

As noted above, the review was also limited by the quality of the studies included within it. Although quality was generally good, with all but three studies achieving at least a [+] rating, the conceptual richness of study findings was very limited. This, together with the relatively short time frame of the review, meant that our synthesis was largely 'aggregative' in nature (i.e. summarising and describing the evidence) and limited the extent to which we could construct a more 'interpretive', (i.e. explanatory) phase of the synthesis of the evidence.

### **6.4 CONCLUSIONS AND IMPLICATIONS**

This review has found clear and consistent evidence of at least medium quality evidence [+] on the barriers to, and facilitators of, the delivery of community engagement. All of the evidence identified focused on disadvantaged groups. Although the studies we identified were diverse in terms of their size and scope, health and population focus and approach to community engagement, the evidence revealed few differences (across these type) in barriers and facilitators identified suggesting that the review findings are applicable across a range of contexts.

Barriers and facilitators were synthesised within six emergent themes across 'context' (quality of existing relationships with communities; organisational culture, attitudes and

practice), 'infrastructure' (investing in infrastructure and planning; support, training and capacity building) and 'process' (capabilities and the engagement process; inclusive and accessible practice). These provide the basis for key recommendations for funders and commissioners of community engagement such as local authorities and the NHS, those who carry out community engagement such as health professionals or researchers, community organisations and members of communities. As well as offering a structure for planning and implementing community engagement in a systematic way, the synthesis also addresses the factors that help or hinder communities to get involved in community engagement activities and how to build capacity and motivation; how local context, and the associated political, health and community structures and systems support or hamper community engagement; and how professionals can learn to better engage, and act on the suggestions from, communities.

There were also a number of gaps and limitations in the evidence which have implications for future research: greater integration of process and outcome evaluation; greater use of formative evaluation to identify challenges and their solutions early on; increased attention to tracking the influence of community engagement on service design and delivery; and greater involvement of communities in the design of evaluations. These recommendations should be considered by evaluators of community engagement to further strengthen the evidence base underpinning community engagement approaches to improving health and reducing health inequalities.

## 7 APPENDICES

### 7.1 A: SAMPLE SEARCH STRATEGY FROM O'MARA EVES ET AL. (2013)

#### **a) Search strategy: Database of Promoting Health Effectiveness Reviews (DoPHER)**

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

#### **b) Search strategy: Trials Register of Promoting Health Interventions (TROPHI)**

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

AND

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

AND

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

#### **c) Search strategy: Cochrane databases**

CDSR (Cochrane reviews).

DARE (other reviews).

HTA database (technology assessments).

NHS EED (economic evaluations).

“disadvantage” OR “disparities” OR “disparity” OR “equality” OR “equity” OR “gap” OR “gaps” OR “gradient” OR “gradients” OR “health determinants” OR “health education” OR

“health inequalities” OR “health promotion” OR “healthy people programs” OR  
“inequalities” OR “inequality” OR “inequities” OR  
“inequity” OR “preventive health service” OR “preventive medicine” OR “primary  
prevention” OR “public health” OR “social medicine” OR “unequal” OR “variation”  
AND  
“change agent” OR “citizen” OR “community” OR “champion” OR “collaborator” OR  
“disadvantaged” OR “lay community” OR “lay people” OR “lay person” OR “member” OR  
“minority” OR “participant” OR “patient” OR “peer” OR “public” OR “representative” OR  
“resident” OR “service user” OR “stakeholder” OR “user” OR “volunteer” OR “vulnerable”  
AND  
“capacity building” OR “coalition” OR “collaboration” OR “committee” OR “compact” OR  
“control” OR “co-production” OR “councils” OR “delegated power” OR “democratic  
renewal” OR “development” OR “empowerment” OR “engagement” OR “forum” OR  
“governance” OR “health promotion” OR “initiative” OR “integrated local development  
programme” OR “intervention guidance” OR “involvement” OR “juries” OR “local area  
agreement” OR “local governance” OR “local involvement networks” OR “local strategic  
partnership” OR “mobilisation” OR “mobilization” OR “neighbourhood committee” OR  
“neighbourhood managers” OR “neighbourhood renewal” OR “neighbourhood wardens”  
OR “networks” OR “organisation” OR “panels” OR “participation” OR “participation  
compact” OR “participatory action” OR “partnerships” OR “pathways” OR “priority  
setting” OR “public engagement” OR “public health” OR “rapid participatory assessment”  
OR “regeneration” OR “relations” OR “support”

**d) Search strategy: The Campbell Library**

“disadvantage” OR “disparities” OR “disparity” OR “equality” OR “equity” OR “gap” OR  
“gaps” OR “gradient” OR “gradients” OR “health determinants” OR “health education” OR  
“health inequalities” OR “health promotion” OR “healthy people programs” OR  
“inequalities” OR “inequality” OR “inequities” OR “inequity” OR “preventive health  
service” OR “preventive medicine” OR “primary prevention” OR “public health” OR “social  
medicine” OR “unequal” OR “variation”  
AND  
“change agent” OR “citizen” OR “community” OR “champion” OR “collaborator” OR  
“disadvantaged” OR “lay community” OR “lay people” OR “lay person” OR “member” OR  
“minority” OR “participant” OR “patient” OR “peer” OR “public” OR “representative” OR  
“resident” OR “service user” OR “stakeholder” OR “user” OR “volunteer” OR “vulnerable”  
AND  
“capacity building” OR “coalition” OR “collaboration” OR “committee” OR “compact” OR  
“control” OR “co-production” OR “councils” OR “delegated power” OR “democratic  
renewal” OR “development” OR “empowerment” OR “engagement” OR “forum” OR  
“governance” OR “health promotion” OR “initiative” OR “integrated local development  
programme” OR “intervention guidance” OR “involvement” OR “juries” OR “local area  
agreement” OR “local governance” OR “local involvement networks” OR “local strategic  
partnership” OR “mobilisation” OR “mobilization” OR “neighbourhood committee” OR  
“neighbourhood managers” OR “neighbourhood renewal” OR “neighbourhood wardens”  
OR “networks” OR “organisation” OR “panels” OR “participation” OR “participation  
compact” OR “participatory action” OR “partnerships” OR “pathways” OR “priority

setting” OR “public engagement” OR “public health” OR “rapid participatory assessment”  
OR “regeneration” OR “relations” OR “support”

## 7.2 B: SAMPLE SEARCH STRATEGY FROM UPDATED SEARCHES FOR STREAM 1

### **a) Search strategy: Database of Promoting Health Effectiveness Reviews (DoPHER)**

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

### **b) Search strategy: Trials Register of Promoting Health Interventions (TRoPHI)**

The search is based on broad terms for Population AND Intervention

Free text search of titles and abstracts, 2011 onwards:

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

AND

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

### **c) Search strategy: Cochrane/Centre for Reviews and Dissemination databases**

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

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

Search 2011 onwards. Search all fields:

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

AND

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

AND

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

***d) Search strategy: Campbell Collaboration Library***

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

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

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



### 7.3 C: SAMPLE SEARCH STRATEGY FROM PHE MAPPING REVIEW (ADD REF)

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

1. (communit\* or lay or public or citizen\* or people or empower\* or social or emancipat\* or volunt\* or "asset-based" or peer)
2. (concept\* or framework or definition\* or theory or theories or model or typolog\* or categoris\* or categoriz\* or dimension\* or domain\* or construct or review or "evidence base\*" or effective\* or outcome\*)
3. (intervention\* or prevention\* or engagement or involve\* or participat\* or action or development or mobilisation or commissioning)
4. ("health promotion" or "health improvement" or "healthy communit\*" or wellbeing or "quality of life" or "self-care" or resilience)
5. (determinant\* N2 (social or health)) or (health N2 (inequality or equity or exclu\*)) or (underserved or "hard to reach" or "seldom heard")
6. MeSH terms: (MH "Community Networks") OR (MH "Community-Based Participatory Research") OR (MH "Voluntary Health Agencies") OR (MH "Voluntary Programs") OR (MH "Volunteers") or (MH "community health worker") or (MH "public health practice")

#### Combinations

- 6 (MeSH) and 2 (TI)
- (1 N2 3) and 2 and 4
- (1 N2 3) and 2 (Title only)
- (1 N2 3) and 5
- 1 and 2 and 5 (Title only)

An additional cross-cutting search was run in MEDLINE (January 2004 to April 2014):  
((communit\* or citizen\* or empower\* or emancipat\* or "asset-based" or "co-production")  
n2 (intervention\* or engagement)) AND ( health or wellbeing or "well being" )

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

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

## 7.4 D: LIST OF SYSTEMATIC REVIEWS MINED FOR RELEVANT STUDIES

Attree P, French B, Milton B, Povall S, Whitehead M, Popay J (2011) The experience of community engagement for individuals: a rapid review of evidence. *Health & Social Care In The Community*. 19(3): 250-260.

Beth Milton (2012) The impact of community engagement on health and social outcomes: a systematic review. *Community Development Journal*. 47(3): 316-334 2012.

Bevan Gillian, Brown Michelle (2014) Interventions in exclusive breastfeeding: a systematic review. *British Journal of Nursing*. 23(2): 86-89.

Black ME, Yamada J, Mann V (2002) A systematic literature review of the effectiveness of community-based strategies to increase cervical cancer screening. . *Can J Public Health*. 93(5):386–393: .

Blank Lindsay, Baxter Susan K; Payne Nick, Guillaume Louise R; Pilgrim Hazel (2010) Systematic review and narrative synthesis of the effectiveness of contraceptive service interventions for young people, delivered in educational settings. *Journal Of Pediatric And Adolescent Gynecology*. 23(6): 341-351.

Blank Lindsay, Baxter Susan K; Payne Nick, Guillaume Louise R; Squires Hazel (2012) Systematic review and narrative synthesis of the effectiveness of contraceptive service interventions for young people, delivered in health care settings. *Health Education Research*. 27(6): 1102-1119.

Boote Jonathan, Baird Wendy, Beecroft Claire (2010) Public involvement at the design stage of primary health research: a narrative review of case examples. *Health Policy (Amsterdam, Netherlands)*. 95(1): 10-23.

Boote Jonathan, Wong Ruth, Booth Andrew (2012) 'Talking the talk or walking the walk?' A bibliometric review of the literature on public involvement in health research published between 1995 and 2009. *Health Expectations: An International Journal Of Public Participation In Health Care And Health Policy*. : .

Boote J (2012) Patient and Public Involvement in Health and Social Care Research: A Bibliography. . : .

Bouزيد Maha, Hooper Lee, Hunter Paul R; (2013) The effectiveness of public health interventions to reduce the health impact of climate change: a systematic review of systematic reviews. *Plos One*. 8(4): e62041-e62041.

Bridget Candy (2007) The health impact of policy interventions tackling the social determinants of common mental disorder: a systematic review. *Journal of Public Mental Health*. 6(2): 28-39 2007.

Burton P, Croft J, Hastings A, Slater T, Goodlad R, Abbott J, Macdonald D (2004) *What works in community involvement in area-based initiatives?: a systematic review of the literature*. London: Great Britain: Home Office.

Busch Vincent, de Leeuw , Johannes Rob Josephus; de Harder , Alinda , Schrijvers Augustinus Jacobus Petrus; (2013) Changing multiple adolescent health behaviors through school-based interventions: a review of the literature. *The Journal Of School Health*. 83(7): 514-523.

Carr S, Lhussier M, Forster N, Geddes L, Deane K, Pennington M, Visram S, White M, Michie S, Donaldson C, Hildreth A (2011) An evidence synthesis of qualitative and quantitative research on component intervention techniques, effectiveness, cost-effectiveness, equity and acceptability of different versions of health-related lifestyle advisor role in improving health. *Health Technology Assessment (Winchester, England)*. 15(9): iii.

Casiday R, Kinsman E, Fisher C, Bamba C (2008) Volunteering and health; what impact does it really have? Volunteering England.

Coles E, Themessl-Huber M, Freeman R (2012) Investigating community-based health and health promotion for homeless people: a mixed methods review. *Health Education Research*. 27(4): 624-644.

Conklin Annalijn, Morris Zoë, Nolte Ellen (2012) What is the evidence base for public involvement in health-care policy?: results of a systematic scoping review. *Health Expectations: An International Journal of Public Participation In Health Care And Health Policy*. : .

Connell P, Wolfe C, McKeivitt C (2008) Preventing stroke: a narrative review of community interventions for improving hypertension control in black adults. *Health & Social Care In The Community*. 16(2): 165-187.

Dickens Andy P; Richards Suzanne H; Greaves Colin J; Campbell John L; (2011) Interventions targeting social isolation in older people: a systematic review. *BMC Public Health*. 11: 647-647.

Van Sluijs , M F, McMinn A M; Griffin S J; (2007) Effectiveness of interventions to promote physical activity in children and adolescents: systematic review of controlled trials. *British Medical Journal*. 335(7622): 703-707.

Elliott Eva (2012) *Connected Communities. A review of theories, concepts and interventions relating to community-level strengths and their impact on health and well-being*. London: Connected Communities.

Ford P, Clifford A, Gussy K, Gartner C (2013) A systematic review of peer-support programs for smoking cessation in disadvantaged groups. *International Journal of Environmental Research and Public Health*. 10(11): 5507-5522.

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Hills D (2004) *Evaluation of community-level interventions for health improvement: a review of experience in the UK*. London: Health Development Agency.

Ingram Lucy, MacArthur Christine, Khan Khalid, Deeks Jonathan J; Jolly Kate (2010) Effect of antenatal peer support on breastfeeding initiation: a systematic review. *CMAJ: Canadian Medical Association Journal = Journal De L'Association Medicale Canadienne*. 182(16): 1739-1746.

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Lawrence W; Greenhalgh Trisha (2012) Uncovering the Benefits of Participatory Research: Implications of a Realist Review for Health Research and Practice. *Milbank Quarterly*. 90(2): 311-346.

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Brett J, Sophie Staniszewska, Carole Mockford, Kate Seers, S , y Herron-Marx, Helen Bayliss (2010) The PIRICOM Study: A systematic review of the conceptualisation, measurement, impact and outcomes of patients and public involvement in health and social care research. . . .

June Statham (2010) *Strengthening family wellbeing and community cohesion through the role of schools and extended services: research review 3*. London: Centre for Excellence and Outcomes in Children and Young Peoples Services.

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## 7.5 E: LIST OF WEBSITES SEARCHED

### a) National organisations

- Open Grey
- [healthevidence.org](http://healthevidence.org)
- UK government (gov.uk) portal
- NICE Evidence (including NICE website and former Health Development Agency documents)
- Public health observatories
- ESRC research investments: health and wellbeing (<http://www.esrc.ac.uk/research/major-investments/health-wellbeing.aspx>)
- Local government association – health (<http://www.local.gov.uk/health>)
- Local government association and Department of Health – ‘From transition to transformation in public health’ ([http://www.local.gov.uk/health/-/journal\\_content/56/10180/3374673](http://www.local.gov.uk/health/-/journal_content/56/10180/3374673))
- NICE – ‘support for local government’ (<http://www.nice.org.uk/localgovernment/localgovernment.jsp>)
- NHS Scotland (<http://www.healthscotland.com>)
- NIHR public health research programme (<http://www.nets.nihr.ac.uk/programmes/phr>)
- NIHR school for public health research (<http://www.sphr.nihr.ac.uk>)
- Policy research unit in commissioning and the healthcare system (<http://www.prucomm.ac.uk>)
- Public health agency (for Northern Ireland) - Health and social wellbeing improvement (<http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement>)
- Public health England (<http://www.gov.uk/government/organisations/public-health-england>)
- Royal Society for Public Health (<http://www.rsph.org.uk>)
- The King’s Fund – public health and inequalities (<http://www.kingsfund.org.uk/topics/public-health-and-inequalities>)
- Centre for Translational Research in Public Health (<http://www.fuse.ac.uk/shifting-the-gravity-of-spending%3f-/3131>)
- UCL Institute of Health Equity (<http://www.instituteofhealthequity.org>)
- UK Faculty of Public Health (<http://www.fph.org.uk/>)
- UK Healthy Cities Network (<http://www.healthycities.org.uk/>)
- Welsh Government – Health and social care (<http://www.wales.gov.uk/topics/health/?lang=en>)

- World Health Organisation Europe – Health 2020:the European policy for health and wellbeing (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being>)
- Altogether Better – evidence resources
- Association of public health observatories (<http://www.apho.org.uk>)
- BIG Lottery wellbeing evaluation
- Centre for Public Scrutiny (<http://www.cfps.org.uk>)
- Charities evaluation service (<http://www.ces-vol.org.uk>)
- Community development exchange (<http://www.cdx.org.uk>)
- Community development foundation (<http://www.cdf.org.uk>)
- Department of communities and local government – Community empowerment division (<http://www.togetherwecan.direct.gov.uk>)
- Community Health Exchange (<http://www.scdc.org.uk>)
- Federation of community development learning (<http://www.fcdl.org.uk>)
- Health link (<http://www.health-link.org.uk>)
- Improvement foundation – healthy community collaborative (<http://www.improvementfoundation.org>)
- Improvement and development agency for local government (<http://www.idea.gov.uk>)
- NHS Involve (<http://www.invo.org.uk/>)
- National council for voluntary organisations (<http://www.ncvo-vol.org.uk>)
- NHS Centre for involvement (<http://www.nhscentreforinvolvement.nhs.uk>)
- National social marketing centre (<http://www.nsms.org.uk>)
- National support team for health inequalities (<http://www.dh.gov.uk/en/publichealth/healthinequalities/index.htm>)
- NESTA – people powered health
- New economics foundation (<http://www.neweconomics.org>)
- Pacesetters programme (<http://www.dh.gov.uk/managingyourorganisation/equalityandhumanrights/pacesettersprogramme/index.htm>)
- Patient and public involvement specialist library (<http://www.library.nhs.uk/ppi/>)
- Picker institute Europe (<http://www.pickereurope.org>)
- Turning point (<http://www.turning-point.co.uk>)
- Joseph Rowntree Foundation
- Academy for Sustainable Communities (<http://www.ascskills.org.uk/what-we-do.html>)

*b) Local organisations*

- Bradford and Airedale PCT (<http://www.bradfordandairdale-pct.nhs.uk>)

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

c) *Organisation with a specific focus on ethnic minority communities*

- Apnee Sehat (<http://www.apneesehat.net>)
- Black and ethnic minority community care forum (<http://www.bemccf.org.uk>)
- Communities in Action Enterprises (<http://www.communitiesinaction.org>)
- Community Health Involvement and Empowerment Forum (<http://www.chiefcic.com>)
- Delivery Race Equality in mental health (<http://www.nmhdu.org.uk/our-work/promoting-equalities-in-mental-health>)
- Social Action for Health ([http://www.safh.org.uk/safh\\_php/index](http://www.safh.org.uk/safh_php/index))

d) *Universities*

- Oxford university – Department of Social policy and social work (<http://www.ox.ac.uk>)
- University of Central Lancashire – International school for communities, rights and inclusion (<http://www.uclan.ac.uk>)
- London School of Economics – Personal Social Services Research Unit (<http://www.lse.ac.uk>)
- Bath University – School for Health (<http://www.bath.ac.uk>)
- Durham University – School of Applied Social Science (<http://www.dur.ac.uk/sass>)
- Lancaster University – School of Health and Medicine (<http://www.lancs.ac.uk>)
- Liverpool University – School of population, Community and Behavioural Sciences (<http://www.liv.ac.uk>)
- York University – Social Policy Research Unit (<http://www.york.ac.uk>)
- University of Warwick
- Health Together [www.leedsmet.ac.uk/healthtogether](http://www.leedsmet.ac.uk/healthtogether)

e) *Citizens/public experiences*

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

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## 7.7 G: BIBLIOGRAPHY OF EXCLUDED STUDIES WITH REASONS FOR EXCLUSION

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## 7.9 I: EVIDENCE TABLES

<p><b>Study details</b></p> <p>Authors: <b>Burgess, G.</b>  Year: <b>2014</b>  Citation: <b>Burgess, G. (2014) Evaluation of the Cambridgeshire Timebanks. Cambridge Centre for Housing and Planning Research: Cambridge.</b>  Quality Score (++, + or -): +</p> <p><b>Source of funding:</b> Cambridgeshire County Council  <b>Type/style of community engagement:</b> Community mobilisation / action  Evidence: This is an evaluation of a time banking scheme, and these are explicitly covered by type 1 initiatives.  <b>Level of community engagement</b>  <b>Design:</b> collaborating  <b>Delivery:</b> leading  <b>Evaluation:</b> consulted  <b>Extent of community engagement:</b> moderate</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> To evaluate the outputs and outcomes of four Timebanks in Cambridgeshire. What impact do they have on individuals and communities? Can these schemes generate public cost savings?  <b>Theoretical approach:</b> None reported  <b>Data collection Method:</b> Monitoring form, interviews, follow-up survey  <b>By whom:</b> The author, although little information is provided  <b>Setting(s):</b> Not reported <b>When:</b> 2013</p>
	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Participants in time banking schemes in Cambridgeshire  <b>Report how they were recruited:</b> Through Cambridge Centre for Housing and Planning Research  <b>Number of participants recruited:</b> 166  <b>Specific inclusion/ exclusion criteria:</b> Selected according to the evaluative aims of the study, i.e. the study was commissioned to evaluate four particular time banks in Cambridgeshire, and these four are the focus of the study.</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported.  <b>Key themes relevant to this review:</b>  Member profile; Age; Gender; ethnicity; Live alone; income; employment; Highest qualification; Health Care for others; Mobility; Use of care and support service; email; internet access; Social media; Membership of community groups; Feel part of the community; no of people you know; How people heard about the timebank; Why people joined the timebank.  Perception measures.  Successes and Challenges.</p>
	<p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> There are challenges in developing and operating the timebanks. The timebanks have a long lead time to become established and begin person to person exchanges. This is</p>

	<p>reflected in the large number of hours recorded for group activities rather than for person to person exchanges. The Cambourne café is no longer part of the timebank but during the evaluation period generated a lot of the timebank hours, but was already part funded separately by CHS group which paid for the rent of the hall where the café was held, which raises the question of whether some of this activity would have happened anyway and the potential for double funding/counting the same outputs. The qualitative information from the interviews reveals that there are positive outcomes from the timebank, such as more self-confidence, greater self-worth and less isolation. But measuring such outcomes in a way that can be used in a value for money analysis of the project is very difficult. Monitoring and evaluation activities can be an additional burden on timebank coordinators, but are necessary to meet funding requirements that specify certain outputs and outcomes.</p> <p><b>Limitations identified by review team:</b> Role of the researcher not clearly described; Some doubts about analytic rigour, as there is no mention of coding, although in other respects the analysis appears sound; Also no mention of more than one researcher coding / analysing each transcript; no reporting of ethics approval procedures.</p> <p><b>Evidence gaps and/or recommendations for future research:</b> Timebanks require investment to set up, and need to run for sufficiently long period of time that they can yield results. The report suggests that it was difficult to fully assess the effectiveness of the timebanks, and indicated that this needs further research.</p>
<p><b>Study details</b></p> <p>Authors: <b>Carlisle S;</b>  Year: <b>2010</b>  Citation: <b>Carlisle S; (2010) Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a Social Inclusion Partnership in Scotland Critical Public Health, 20:1, 117-127</b>  <a href="http://dx.doi.org/10.1080/095815908">http://dx.doi.org/10.1080/095815908</a></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> This paper reports on one of the Scottish Social Inclusion Partnerships (SIPs) funded to tackle local health inequalities and social exclusion using a health promotion, partnership and community-led approach. It focuses on East Kirkland SIP. This is one of 48 SIPs which were established in the 1990s, some of which were funded for over 10 years.</p> <p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection</b></p> <p><b>Method:</b> (Based on ethnographic fieldwork) Documentary data collection (fieldnotes) at meetings and events, semi-structured discussions and interviews.</p> <p><b>By whom:</b> Researcher/author</p> <p><b>Setting(s):</b> Deprived community East Kirkland (pseudonym) industrial area</p> <p><b>When:</b> Not reported</p>

<p><b>02277341</b> Quality Score (++, + or -): ++</p> <p><b>Source of funding:</b> ESRC collaborative (CASE) studentship (which is also partly funded by the Health Education Board for Scotland (HEBS))</p> <p><b>Type/style of community engagement:</b> Community partnerships/coalitions</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> Informed</p> <p><b>Delivery:</b> Leading and collaborating</p> <p><b>Evaluation:</b> not involved</p> <p><b>Extent of community engagement:</b> Low</p>	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> East Kirklands: a former industrial area with a history of Irish immigrant labour. KirKlands is the most deprived population in its area. East Kirkland covers a population of about 20,000.</p> <p><b>Report how they were recruited:</b> SIP members from the statutory, voluntary and community sectors.</p> <p><b>Number of participants recruited:</b> 11</p> <p><b>Specific inclusion/ exclusion criteria:</b> Not specified</p> <hr/> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Documentary analysis of field notes and thematic analysis of recoded and transcribed interviews. Analysis focused on explicating the social processes of partnership work through 'rich' or 'thick' description of events and interactions, and participants' understandings of those experiences (Denzin 1994). Data were coded according to emergent themes (Thematic analysis) and checked for accuracy of interpretation in the process of ongoing refinement which an extended period of fieldwork permits (Lofland and Lofland 1995; Stake 1995).</p> <p><b>Key themes relevant to this review:</b> The SIP fund, Managing the SIP, Why no community, representation?, Launching the SIP, engaging the community, Achieving community, representation: a contested process, Rivalries and contested legitimacy, Contested priorities and conflicts of interest, Crunch point and crisis</p> <hr/> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Not reported</p> <p><b>Limitations identified by review team:</b> Authors did not report whether they considered their role or the impact of their relationship with the participants to Role to the research outcome. No reports of how many researchers were involved in choosing themes and coding transcripts/data or how differences were resolved Or if participants fed back on the transcripts/data if possible and relevant? Ethical consideration missing from report</p> <p><b>Evidence gaps and/or recommendations for future research:</b> A broader conclusion is that, whilst some success may be achieved by committed people working at the local level, inequalities in health and social exclusion remain deeply embedded within the unequal structures of society and are unlikely to be</p>
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	<p>dramatically affected. Attempts to tackle them may not be resolvable within a contemporary policy paradigm that prescribes both problem and solution. At worst, local initiatives may, unintentionally, have been set up to fail. The paper therefore presents a reality check for some key policy and practice aspirations, with potential implications not just for similar projects within the UK but also for other nations or regions tempted by the assumptions and rhetoric of partnership and community engagement.</p>
<p><b>Study details</b></p> <p>Authors: <b>Chapman J</b>  Year: <b>2010</b>  Citation: <b>Chapman J (2010) Well London – Community Activator Programme: An Independent Evaluation. Leisure Futures Report</b>  Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> The Big Lottery  <b>Type/style of community engagement:</b> community mobilisation/ action; peer involvement; non-peer health advocacy  <b>Level of community engagement</b>  <b>Design:</b> Consulted, collaborated and leading  <b>Delivery:</b> collaborated and leading  <b>Evaluation:</b> collaborated  <b>Extent of community engagement:</b> Moderate</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> The overall aim of the evaluation was to assess how successful the CYMCA Community Activator project model was at engaging people in the more deprived communities in London in physical activity and in sustaining participation. The scope of the evaluation was to cover issues of process (i.e. how the programme was delivered), as well as the outputs and outcomes achieved.</p> <ul style="list-style-type: none"> <li>• Process: The identification and recruitment of the Activators by the CYMCA Active London Team; The YMCAfit training and its component elements; Post-training support provided to the Activators – i.e. development budget, mentoring; The process for assimilating feedback from the Activators – e.g. success factors (what works), barriers and how best to overcome these.</li> <li>• Outputs: The number of Activators who went on to make use of the training to activate others; The number of Activators who continued to use the training after 3 months and after 6 months (i.e. sustainability); The number and profile of individuals recruited into activity by the Activators; The number continuing in activity after 3 months and after 6 months.</li> <li>• Outcomes: Impacts of the programme on the Activators themselves Impacts of the programme on those recruited into activity.</li> </ul> <p><b>Theoretical approach:</b> Not reported  <b>Data collection method:</b> Liaison with key stakeholders to gather information, desk and background research; mix of session observation and semi-structured interviews with a sample of Activators; quantitative surveys of a sample of participants. Semi-structured interview templates for use with the sample of Activators after three months and after six months  - Short questionnaires for use with the trainee Activators at the start and on completion of the YMCAFit training course  - Questionnaire forms for use with participants after three months and again after six months.  <b>By whom:</b> Author?</p>

	<p><b>Setting(s):</b> Communities  <b>When:</b> June-November 2010</p> <p><b>Population and sample selection</b>  <b>Population from which the sample were recruited:</b> Community Activators – established and in training, other key stakeholders and community participants. Two thirds of participants are from BME groups. The majority of participants are not in work or full time education or training and do not have further or higher educational qualifications. Nearly 3/4 of participants were female.  <b>Report how they were recruited:</b> Not reported  <b>Number of participants recruited:</b> 13 Activators gave interviews; 84 (then 78) participants returned questionnaires  <b>Specific inclusion/ exclusion criteria:</b> Not reported</p> <p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b> Not reported  <b>Key themes relevant to this review:</b> Experience of the Activators: Recruitment; Training; Retention; Functions (Planning; set-up and promotion; delivery; monitoring of outputs; sustaining the outcomes); Views of the Activators: the difficulty of the challenge -  <b>Constraints:</b> The recruitment; The programme budget; The programme length; Public Liability Insurance, CRB Checks, Budget Protocols; Paper records; Tight geographic boundaries.  <b>Impacts:</b>  The recruitment of volunteer Activators;  Training volunteer Activators; Mentoring support for Activators;  The process of assimilating feedback from the Activators; The number of Activators who go on to activate others; The number of Activators who continue to use the training; The number and profile of individuals recruited into activity;  The number continuing in activity; Impacts on the Activators; Impacts on those recruited into activity. Success factors:  The volunteers recruited to the programme;</p>
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	<p>The programme design; The programme budget; the programme mentoring; External support; The freedom to make mistakes; Replicability; Sustainability; sustaining the impacts on participants; Sustaining the impacts on the individual Activators; Sustaining similar programmes in future.</p> <p><b>Notes by review team</b> <b>Limitations identified by author:</b> Not reported <b>Limitations identified by review team:</b> Authors did not report whether they considered their role or the impact of their relationship with the participants to Role to the research outcome. No reports of how many researchers were involved in choosing themes and coding transcripts/data or how differences were resolved Or if participants fed back on the transcripts/data if possible and relevant? Ethical consideration missing from report <b>Evidence gaps and/or recommendations for future research:</b> Views of the Activators - difficulty of the challenge The main challenge, particularly for the more inexperienced among the group, was the community engagement aspect. Persuading people to act on their good intentions and actually come along having said they would, was the most cited barrier to success. As one of the volunteers said who came onto the Programme with no prior experience: “I had not realised at the outset quite how much ground work would be needed to break through the inactivity barrier – for many people it is deeply ingrained and it is easy to push too hard too soon, and to lose heart”.</p>
<p><b>Study details</b></p> <p>Authors: <b>Chau R</b> Year: <b>2007</b> Citation: <b>Chau R (2007) The Involvement of Chinese Older People in Policy and Practice: Aspirations and</b></p>	<p><b>Research parameters</b> <b>Research questions/aims:</b> The aim of the research was to understand the process of the CE involved in this initiative 'Shared expectations, shared commitment' from the perspectives of the older people that were engaged. This report provides a unique insight into the active involvement of Chinese older people in research and the promotion of their quality of life through collective actions. The primary intention of the study was to work with Chinese older people in order to act upon the outcomes of the previous work. It has aimed to support Chinese older people to develop a collective voice, to influence policy and practice and to reflect on their experiences.</p>



<p><b>Expectations. York: Joseph Rowntree Foundation.</b> Quality Score (++, + or -): +</p> <p><b>Source of funding:</b> The Joseph Rowntree Foundation</p> <p><b>Type/style of community engagement:</b> Community mobilisation &amp; Community Partnerships/coalitions: This was a Chinese older people led project, although some elements involved partnership working and peer delivery.</p> <p><b>Level of community engagement:</b> Community</p> <p><b>Design:</b> Consulted, Leading, collaborating</p> <p><b>Delivery:</b> Leading and collaborating</p> <p><b>Evaluation:</b> Leading and collaborating</p> <p><b>Extent of community engagement:</b> High; participants were involved at all level of engagement.</p>	<p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection</b></p> <p><b>Method:</b> Mixed method; A questionnaire was used to collect information about the personal characteristics and experiences of involvement from the 207 participants across eight cities. And Nine focus group meetings were organised at different stages of the project to enable participants to reflect on issues and concerns in the process of involvement.</p> <p><b>By whom:</b> The research team in collaboration with Chinese researchers from 3 working groups</p> <p><b>Setting(s):</b> South Yorkshire, Manchester and London</p> <p><b>When:</b> from 2003 to 2005</p> <hr/> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Older Chinese people in South Yorkshire, Manchester and London</p> <p><b>Number of participants recruited:</b> 207</p> <p><b>Specific inclusion/ exclusion criteria:</b> Older Chinese people</p> <hr/> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported</p> <p><b>Key themes relevant to this review:</b> Relevant findings are presented within three chapters: Chapter 3: presents findings from the three local projects in relation to working in partnership with the 'host society' to provide services (language barriers; insensitivity of the English speaking communities, relationship with key link persons, and local projects as user-led initiatives). Chapter 4: presents findings from the surveys and focus groups regarding older Chinese people's experiences of involvement (forms of involvement; knowledge of involvement; tokenism; workers insensitivity to needs; suspicion within the Chinese community; the disabling environment). Chapter 5: presents findings on why people get involved (reasons and aspirations; gains; losses; the enabling factors)</p> <hr/> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Most discussions in the project were conducted in Cantonese and occasionally in</p>
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Mandarin and Hakka. The Joint Statement and all local reports were initially written in Chinese jointly by the participants and the research team. Therefore all direct quotations in the following chapters, the Joint Statement in Appendix 1 and reports of local groups in Appendices 2 to 4 are a translated version. As Chinese and English are two very different languages both grammatically and conceptually, translation 3 Introduction from one to the other has never been easy. Moreover, most participants were not used to putting forward their views in writing or open discussion. They did not always express themselves clearly even in their own languages. To compensate for this members of the research team have repeatedly clarified and confirmed the ideas with the participants, but this has added more difficulties to the translation. In order to best capture the cultural and personal meanings, the research team has given priority to accuracy rather than style. Therefore some expressions and formats of presentation in the translated documents may be different from those in conventional English writing.

**Limitations identified by review team:** Data collection/ method of analysis were inadequately reported so cannot ascertain their defensibility or reliability. There is missing detail in order to make a full evaluation of the defensibility of the research design (e.g. data collection methods, analysis and sampling). Only other comment would be that the data comes from those who were willing to participate in the overall project and the researchers may have missed the views of those who are less likely to volunteer to get involved.

The role and relationship of the researchers was not clearly described

Ethical consideration was not reported across all projects involved in this evaluation

**Evidence gaps and/or recommendations for future research:** Recommendations for enhancing the involvement of Chinese older people:

Both the Chinese- and English-speaking communities should take this seriously.

Genuine opportunities for involvement should be offered to Chinese older people.

Both the Chinese- and English-speaking communities should remove the disabling factors which hamper the involvement of Chinese older people, such as language barriers, insensitivity to needs, and patronising and discriminatory attitudes.

Enabling factors should be in place in accordance with the abilities and preferences of Chinese older people.

These include support for personal development, support to develop skills, practice support, support for equal opportunities and support to get together and work in groups.

Members of the Chinese community should recognise the contributions of older volunteers and avoid making unnecessary criticisms.

<p><b>Study details</b></p> <p>Authors: <b>Christie N, Slaney J, Ahmed F, Knight E</b>  Year: <b>2012</b>  Citation: <b>Christie N, Slaney J, Ahmed F, Knight E (2012) Engaging the Somali Community in the Road Safety Agenda: A Process Evaluation from the London Borough of Hounslow Journal of Community Health, 37 (4) 814 - 821.</b>  Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> Transport for London and the Department for Transport</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> Engage with the Somali community in London borough of Hounslow with a key focus on 0–20 year olds;</p> <ul style="list-style-type: none"> <li>• Appoint officers from the Somali community to work alongside community groups to engage with the community members to explore road safety awareness, offer evidence based road safety training (based on the Kerbcraft model and advice on child safety seats;</li> <li>• Build capacity and ensure the sustainability of the programme after the duration of the funding.</li> </ul> <p>This aim of this paper is to describe the ways in which road safety practitioners managed to engage with the Somali community in a social marketing project with the objectives of improving the road safety of children and explore the community’s response to the intervention.</p> <p><b>Theoretical approach:</b> Kerbcraft model</p> <p><b>Data collection Method:</b> In-depth interviews with 2 Road Safety Practitioners and 6 focus groups with Somali women and parent of young children</p> <p><b>By whom:</b> University researchers</p> <p><b>Setting(s):</b> Somali community in Hounslow, London</p> <p><b>When:</b> Not reported</p>
<p><b>Type/style of community engagement:</b> Community Mobilisation/Action</p> <p><b>Level of community engagement:</b></p> <p><b>Design:</b> consulted</p> <p><b>Delivery:</b> consulted, Leading and collaborating</p>	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Somali community in London borough of Hounslow</p> <p><b>Report how they were recruited:</b> Somali participants were recruited from among individuals who attended two different community groups within Hounslow.</p> <p><b>Number of participants recruited:</b> 15 participants each in 4 different sessions</p> <p><b>Specific inclusion/ exclusion criteria:</b> People of Somali origin who live in Hounslow</p>
<p><b>Evaluation:</b> Informed A Somalian researcher was employed and trained to conduct the focus groups, another was engaged in transcribing the interview and wider Somalian community were consulted before the research began</p>	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> The evaluation involved thematic analyses of interview data from two Road Safety practitioners and translated transcripts from focus group sessions with the Somali participants who attended two different community groups within Hounslow.</p> <p><b>Key themes relevant to this review:</b></p> <p>The findings of this research are organised under two broad headings:</p> <p><b>The Practitioner’s Perspective</b></p>

<p><b>Extent of community engagement:</b> Low</p>	<p>Learning About a New Casualty Group, How to Engage with the Somali Community, Gaining Trust and Acceptance, Engaging with Local Stakeholders Who Know the Community, Addressing the Language Barrier, Understanding How the Community Felt Marginalised, Lessons for the Future, Get to know Your Community, Seek out Existing Community Groups, Focus on Smaller Groups, How Best to Evaluate</p> <p><b>The Community's Perspective</b> Lack of Understanding about the UK Road System, Fears About Road Safety, Which Impact on Mobility, Changes as a Result of Road Safety Training, Understanding how to cross safely.</p> <hr/> <p><b>Notes by review team</b> <b>Limitations identified by author:</b> A weakness of the study is that the high cost of translation was prohibitive for the borough and so the evaluation is based on two of four groups covering three sessions each. Furthermore some of the subtle nuances of the discussion may have been lost in translation. The Somali community in Hounslow may be very different from Somali communities elsewhere in London or the UK so it is not appropriate to generalise to other communities. In addition with this type of evaluation there is no injury outcome data though casualties continue to be monitored by ethnicity for London. With the drive for evidence based practice qualitative evaluation is likely to be regarded as weak evidence but a quantitative approach seems largely inappropriate given the small number of participants. <b>Limitations identified by review team:</b> The role of the researcher and their relationship with participants was unclear. Ethical consideration was not fully appropriated. <b>Evidence gaps and/or recommendations for future research:</b> However, what this study does show is that unless injury data is monitored by government in relation to ethnicity many of smaller casualty issues related to race and culture may slip underneath the epidemiological radar. It shows the importance of mapping casualties and linking with census data to understand demographic characteristics. It also shows the importance of getting to know a community initially by partnering with service providers who work with them, bolting on to existing services and employing a bottom up approach to achieve behavioural change.</p>
<p><b>Study details</b></p> <p>Authors <b>Cinderby, S., Haq, G., Cambridge, H. and Lock, K.</b> Year: <b>2014</b></p>	<p><b>Research parameters</b> <b>Research questions/aims:</b> To investigate the effect of interventions to facilitate civic engagement in order to move towards a more environmentally sustainable community in a low-income area of York <b>Theoretical approach:</b></p>

<p>Citation: <b>Cinderby, S., Haq, G., Cambridge, H. and Lock, K. (2014) Practical action to build community resilience: the good life initiative in New Earswick. York: Joseph Rowntree Foundation.</b></p> <p>Quality Score (++, + or -): +</p> <p><b>Source of funding:</b> Joseph Rowntree Foundation</p>	<p>The Good Life Initiative was framed within the broad theoretical concept of Resilience theory Tipping Point' approaches and the Capitals approach.</p> <p><b>Data collection</b></p> <p><b>Method:</b> Focus groups, door-to-door 'coldcalling', Surveys,</p> <p><b>By whom:</b> The authors</p> <p><b>Setting(s):</b> Public consultation events and one-to-one private interviews in New Earswick, York.</p> <p><b>When:</b> 2013</p>
<p><b>Type/style of community engagement:</b> type 1: community mobilisation / action</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> collaborating</p> <p><b>Delivery:</b> collaborating</p> <p><b>Evaluation:</b> consulted</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Individuals living in a low-income area on the outskirts of York</p> <p><b>Report how they were recruited:</b> Through the Good Life Initiative – part of the Joseph Rowntree Foundation's research programme on Climate Change and Social Justice</p> <p><b>Number of participants recruited:</b> 680</p> <p><b>Specific inclusion/ exclusion criteria:</b> Not reported New Earswick was selected as the case study because it was an exemplar for the investigative aims of the study, e.g: 'previous work has also demonstrated that the residents of New Earswick were likely to be mainly comprised of people with low incomes, who typically remain unconvinced about the benefits and need for pro-environmental behaviour changes'</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported</p> <p><b>Key themes relevant to this review:</b> Introduction and context for the Good Life Initiative Good Life Initiative activities and evolution Assessing the impacts of the Good Life on participants</p>

	<p>Theories of building community resilience                  The policy context surrounding the Good Life Initiative                  Good Life Initiative legacy and lessons for policy and practice</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b>                  The schemes being evaluated require investment to set up, and need to run for sufficiently long period of time that they can yield results. The report suggests that it was difficult to fully assess the effectiveness of such schemes, and indicated that this needs further research.</p> <p><b>Limitations identified by review team:</b>                  The role of the researcher was not always clearly defined; there was no reporting of observance of research ethics procedures</p> <p><b>Evidence gaps and/or recommendations for future research:</b>                  Perhaps unsurprisingly, the GLI showed that attempting to build community resilience can be characterised as a complex ('wicked') undertaking that is always 'messy' on-the-ground. To build resilience within a neighbourhood requires supporting and enhancing local leadership to encourage and enable people to take collective charge of developing community assets for the future, while also creatively addressing inevitable conflicts of direction and approach. The Good Life activities supported the notion that 'it is social relationships that are most effective in maintaining resilience in the face of adversity' (Bartley, 2006). The GLI built upon insights from other programmes that stress how the most successful communities are those which take a 'joined up' view of developing a wide and diverse range of community assets (Carnegie UK Trust, 2009). Increasing Practical action to build community resilience 64 and diversifying the skills base of the community also proved a critical development.</p>
<p><b>Study details</b></p> <p>Authors: <b>Community Health Exchange</b>                  Year: 2012                  Citation: <b>Community Health Exchange</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> This briefing highlights the levels of involvement and influence of Community-led health organisations on local planning structures related to health improvement and tackling health inequalities. Based on research with Community-led health organisations it outlines both the barriers that prevent positive engagement and the good practice that influences the delivery of holistic approaches to</p>

<p><b>(2012) Healthy influences: community-led health organisations' influence in health and social planning structures. Glasgow: Community Health Exchange</b> Quality Score (++, + or -): -</p> <p><b>Source of funding:</b> NHS Scotland</p> <p><b>Type/style of community engagement:</b> Community mobilisation/coalition</p> <p><b>Level of community engagement:</b> Community partnerships/coalitions - this is a study of the involvement and influence of Community-led health organisations on local planning structures related to health improvement and tackling health inequalities. It doesn't describe a specific project but is a more a survey of a sector (community-led health organisations in Scotland) and its self-reported experiences of influence in health and social planning structures.</p> <p><b>Design:</b> Consulted (this is how it seen by the respondents)</p> <p><b>Delivery:</b> Consulted and collaborated</p> <p><b>Evaluation:</b> Informed</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p>improving health outcomes.</p> <p><b>Theoretical approach:</b></p> <p><b>Data collection</b></p> <p><b>Method:</b> Mixed methods; Electronic survey (open and closed ended questions) and In-depth interviews with staff and board members of community led Health organisations Qualitative information was derived from open questions within the electronic survey and from in-depth semi-structured interviews with staff and board members from 7 Community-led health organisations. Participants selected for interview were chosen to represent a cross section of urban and rural organisations, geographic spread across Scotland and to include 'equalities' groups, for example BME, LGBT and mental health organisations.</p> <p><b>By whom:</b> The CHEX team</p> <p><b>Setting(s):</b> Community led Health organisations across Scotland</p> <p><b>When:</b> Not reported</p> <hr/> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Nationally across Scotland</p> <p><b>Number of participants recruited: 42 = 42 organisations responded to the whole questionnaire</b></p> <p><b>Specific inclusion/ exclusion criteria:</b> Participants from Community-led health organisations</p> <hr/> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b></p> <p>Statistical analysis of electronic survey</p> <p>Process of qualitative data analysis was not reported</p> <p><b>Key themes relevant to this review:</b></p> <p>Nature &amp; Extent of Influence; Barriers to Influence; Community-led health organisations – what they offer</p> <p>Strengthening the influence; Analysis; Conclusion</p> <hr/> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Not reported</p> <p><b>Limitations identified by review team:</b> Data collection/ method of analysis were inadequately reported so cannot ascertain its reliability.</p> <p>The role and relationship of the researchers was not reported</p> <p>Ethical consideration was not reported</p>
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	<p><b>Evidence gaps and/or recommendations for future research:</b> The findings show that both Community-led health organisations and statutory sector partners need to set aside any previous negative experiences and move forward in constructive and inclusive partnership processes, recognising the contribution that each partner can make. Proven frameworks and tools exist to help evolve these processes<sup>12</sup>. The need for greater transparency and accountability in working with Community-led health organisations and the wider third sector could be enhanced by public sector agencies having to report directly on the nature and extent of their engagement demonstrating the mechanisms whereby they engage fully in joint working and collaborative planning in an open and transparent process. It is by embracing these challenges and overcoming them that statutory sector partners should welcome Community-led health organisations into planning and decision making structures to ensure that their 'healthy influence' is secured to the benefit of all.</p>
<p><b>Study details</b></p> <p>Authors: <b>Craig S</b>  Year: <b>2010</b>  Citation: <b>Craig S (2010)</b>  <b>Youth.comUnity and the Young Ambassadors Programme: An Independent Evaluation. Leisure Futures Report.</b>  <b>Quality Score (++, + or -): -</b></p> <p><b>Source of funding:</b> NDC  <b>Type/style of community engagement:</b> not clear what mechanism was used for involving local people  <b>Level of community engagement</b>  <b>Design:</b> Some Collaboration  <b>Delivery:</b> not reported  <b>Evaluation:</b> Not reported  <b>Extent of community engagement:</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b>  The intervention aimed to reduce antisocial behaviour, violence and crime in young people by empowering them to participate in service design and delivery and improving their confidence and self-esteem.  There were four main aims for the evaluation:  To analyse the experience of the Young Ambassadors and assess the extent to which the Young Ambassadors Programme (YA Programme), and other Well London programmes, were youth led;  To review the model underpinning the YA Programme and its impact on youth participation;  To assess the impacts of the YA Programme on Well London Partners;  To look at issues of sustainability for the YA Programme, review the extent to which it is replicable and, where possible, suggest how the YA Programme may be sustained.</p> <p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection</b></p> <p><b>Method:</b> The evaluation was carried out as follows:  Initial background research into the YA Programme, Youth.com and its context within Well London;  Research and discussions with comparator programmes, in particular the Greater London Authority's Peer Outreach Workers (POW) team and the national Young Advisors initiative;  Development of research tools including semi-structured interviews for Well London Partners (WL Partners), Central YMCA (CYMCA) staff and the Young Ambassadors. The semi-structured interviews with WL Partners included some questions which asked the Partner to rate aspects of the YA Programme on a five point scale.</p>

Low	<p>For instance, Partners were asked to rate the YA Programme in terms of its achievement of each of its aims;  Selection of Young Ambassadors and their projects to track as case studies;  Observation of a group meeting of Young Ambassadors planning the forthcoming Wellnet conference;  Interviews with partners and CYMCA staff;  Interviews with Young Ambassadors including visits to their communities and observation of their projects and, where possible, other Well London projects in their communities.</p> <p><b>By whom:</b> Author  <b>Setting(s):</b> in communities  <b>When:</b> Not reported.</p> <hr/> <p><b>Population and sample selection</b>  <b>Population from which the sample were recruited:</b> Youth Ambassadors; other key stakeholders  <b>Report how they were recruited:</b> not reported  <b>Number of participants recruited:</b> not reported  <b>Specific inclusion/ exclusion criteria:</b> not reported</p> <hr/> <p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b> not reported  <b>Key themes relevant to this review:</b>  Experience of the Young Ambassadors:  Recruitment of the Young Ambassadors;  Retention;  Functions;  Views of the Young Ambassadors.  Constraints:  The Well London Alliance;  Scale of Youth.com and the Young Ambassadors Programme;  Well London Model;  Borough Coordinators;  Targets for and Duration of the Young Ambassadors Programme - 'It's such a shame that it's not going to last. It's started, it's having an impact and then it stops. I've had a lot of the younger girls interested [in being a</p>
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YA]. It would be nice if the tradition could be continued.’

Impacts (assessed against the 6 aims of the YA programme):

To allow young people to have ideas which can be implemented - ‘Some Young Ambassadors have put on projects and that’s positive. It’s allowed ideas to come through,’ commented one Partner. Another noted, ‘Yes, definitely, [the Young Ambassadors had] a key role and communicated that to partners.’ And a third stated, ‘A lot of them [the Young Ambassadors] have led on the ideas. And to make [their project] happen – that’s brilliant.’

To create a bottom up approach to planning projects which impact and/or engage young people - One partner noted, ‘They’ve done a bit of it. But I’m not sure what they can do with only two people and one Young Ambassador in each borough and over 20 boroughs.’ Another stated, ‘We have tried our best to involve them. Whether or not it has worked is by the by.’ Another noted, ‘There’s been a lot done by CYMCA to encourage young people and involve them in the programme. But it hasn’t been bottom up or influenced projects. Nobody has [influenced the projects]. The projects were already decided.’

To encourage the participation of young people - ‘Where the Young Ambassador was involved, it has definitely encouraged participation [by young people],’ one WL Partner said. Another agreed: ‘There has been the voice of someone who lives in the area and talks to the area. It’s getting someone as a link [between Well London and the LSOA].’

To train and develop skills in both the young people and Well London Partners - ‘It’s been a wonderful learning opportunity for the Young Ambassadors both through training and their exposure to a range of organisations. It’s the best thing that’s come out of the YA Programme,’ one said. ‘I’d rate it 4 for the young people and 2 for WL Partners. The WL Partners are too stressed.’

To provide opportunities for the young people to become active citizens - ‘It’s definitely encouraged young people to get involved ... It’s pushed them to be vocal and outspoken,’”;

To engage with disengaged and demotivated young people directly from the LSOA - ‘The people [Young Ambassadors] we have,’ noted one, ‘are the most active young people.’ ‘They’re not the most vulnerable,’ seconded another.

Impact on Well London Partners - ‘On a personal level [the YA Programme] has influenced the way I work,’ commented one WL Partner. ‘But not on an organisational level.’ Another, after having said that the Programme had not influenced his organisation noted, ‘But we try to recognise that all areas, including

	<p>youth, should have their voice.’</p> <p>Success Factors: Elements of Young Ambassadors Programme model; Youth.com workers; Local support.</p> <p>Sustainability: Young Ambassadors Programme; Individual Young Ambassadors; Young Ambassadors Programme as an example.</p>
	<p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Not reported</p> <p><b>Limitations identified by review team:</b> Inadequate description of data collection method (Inadequately reported - we know that 36 semi-structured interviews were carried out with 23 participants (suspect, although not quite clear that 13 were interviewed twice) but no details of how these interviews were carried out are given. Some of the questions asked can be discerned via the findings but we do not know how the data were stored etc.)</p> <p>Inadequate description of the role of the researcher (We know nothing of the role of the researcher in relation to the participants and there is not reflection within the paper. Nearly all of the sub-questions for this category I would have to answer with a 'not reported').</p> <p>The context of the research is not clearly described (The context is not clearly described. We know nothing about who the participants were (age, sex, role in NDC); participant quotes are not labelled; and we do not know the settings in which interviews were conducted).</p> <p>Not sure if methods of data collection /analysis are reliable as there was insufficient detail to make that conclusion</p> <p>Ethics not reported</p> <p><b>Evidence gaps and/or recommendations for future research:</b> How NOT to build motivation - raising expectations and not meeting them.</p> <p>The collected outcome of these characteristics appears to be a sense of disappointment that NDC is not achieving its stated aim of ‘putting local people in the driving seat’ through their participation. This is supported by many of their responses to expectations of participation on a version of Arnstein’s ladder where the overall trend is strongly in the direction of disappointment, even where there is evidence of</p>

	<p>persisting optimism for the long-term future. According to ideas of well-being, this lack of participatory power is likely to result in the diminution of levels of well-being and therefore negatively to impact upon the physical, psychological, social and 'spiritual' health of participants. This, in turn, threatens that very participation itself, because 'unwell' people are likely to engage less in activities of this kind. Nevertheless, there is a further important feature of my findings that understands many local people as personal and individual beneficiaries of their participation. Thus there are consistent positive reports of greater self-confidence, new skills and improved relationships between individuals and agencies. This suggests that the groundwork for the successful achievement of well-being, and its harnessing to the future success of participation in NDC, is in place, at least in part as a result of NDC. Yet these internal and individualized experiences of change have yet to be developed and translated into the basis of a strengthened and shared idea and experience of participation. Thus it is unlikely to sustain the interest and support of local people. The resulting disappointment is likely to impact negatively upon participants' well-being and, thus, on the well-being of the 'community', and may generate a vicious cycle in which disappointed participation leads to diminished well-being, which results in turn in less participation.</p>
<p><b>Study details</b></p> <p>Authors: <b>Dinham A</b>  Year: 2007  Citation: <b>Dinham A (2007) Raising expectations or dashing hopes? Well-being and participation in disadvantaged areas, Community Development Journal. 42: 181-193.</b>  Quality Score (++, + or -): +</p> <p><b>Source of funding:</b> NDC  <b>Type/style of community engagement:</b> not clear what mechanism was used for</p>	<p><b>Research parameters</b>  <b>Research questions/aims:</b>  The study aims to explore participant expectations and experiences of participation within the New Deal for Communities (NDC) programme. In particular it explores participation using concepts from Arnstein's ladder of participation. This article explores the relationship between well-being and participation in disadvantaged areas. Drawing on primary research in two NDC areas in the United Kingdom, it explores how local people's expectations of participation in NDC are disappointed and how that disappointment may pose a key risk to Well-being.</p> <p><b>Theoretical approach:</b> Arnstein's ladder of participation and the Third way concept</p> <p><b>Data collection</b>  <b>Method:</b> Thirty-six semi-structured in-depth Interviews with twenty-three local participants in two NDC areas</p> <p><b>By whom:</b> Author  <b>Setting(s):</b> 2 new deal communities in the UK which were pilot areas and are essentially disadvantaged.  <b>When:</b> Autumn 2002 and the second in Summer 2003</p>

<p>involving local people  <b>Level of community engagement</b>  <b>Design:</b> Some Collaboration  <b>Delivery:</b> not reported  <b>Evaluation:</b> Not reported  <b>Extent of community engagement:</b>                  Low</p>	<p><b>Population and sample selection</b>  <b>Population from which the sample were recruited from:</b> New Deal for Well-being and participation in disadvantaged areas                  NDC areas in East London and in Brighton on the south coast of England. The participants were selected in partnership with local community development workers in each area against a purposive tool that located the sample along two axes: from highly engaged to unengaged people, and from professional to non-professional people.  <b>Number of participants recruited:</b>                  Twenty-three local participants in two NDC areas.  <b>Specific inclusion/ exclusion criteria:</b> Participants were selected to ensure a distribution of age, ethnicity and gender that reflected the local demography, established using census data. The areas were selected because of their engagement as NDC pilots.</p>
	<p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b>                  'Third' way concept of analysis of the political imperatives within the NDC and an understanding of well-being as involving two key elements: participation and fulfilment of expectations was used to interpret the data.  <b>Key themes relevant to this review:</b>                  Findings are organised under the following headings:                  Wellbeing, participation and expectations in the New Deal for communities.                  Local people's expectations of participation in the New Deal for Communities.                  Three key dimensions of disappointed participation                  Implications of disappointed participation for well-being                  NB: The first section focuses on setting out the expectations around participation set out in local NDC founding documentation; the latter section includes a discussion of sorts.</p>
	<p><b>Notes by review team</b>  <b>Limitations identified by author:</b> Not reported  <b>Limitations identified by review team:</b> Inadequate description of data collection method (Inadequately reported - we know that 36 semi-structured interviews were carried out with 23 participants (suspect, although not quite clear that 13 were interviewed twice) but no details of how these interviews were carried</p>

out are given. Some of the questions asked can be discerned via the findings but we do not know how the data were stored etc.)

Inadequate description of the role of the researcher (We know nothing of the role of the researcher in relation to the participants and there is not reflection within the paper. Nearly all of the sub-questions for this category I would have to answer with a 'not reported').

The context of the research is not clearly described  
(The context is not clearly described. We know nothing about who the participants were (age, sex, role in NDC); participant quotes are not labelled; and we do not know the settings in which interviews were conducted).

Not sure if methods of data collection /analysis are reliable as there was insufficient detail to make that conclusion

Ethics not reported

**Evidence gaps and/or recommendations for future research:** How NOT to build motivation - raising expectations and not meeting them.

The collected outcome of these characteristics appears to be a sense of disappointment that NDC is not achieving its stated aim of 'putting local people in the driving seat' through their participation. This is supported by many of their responses to expectations of participation on a version of Arnstein's ladder where the overall trend is strongly in the direction of disappointment, even where there is evidence of persisting optimism for the long-term future. According to ideas of well-being, this lack of participatory power is likely to result in the diminution of levels of well-being and therefore negatively to impact upon the physical, psychological, social and 'spiritual' health of participants. This, in turn, threatens that very participation itself, because 'unwell' people are likely to engage less in activities of this kind. Nevertheless, there is a further important feature of my findings that understands many local people as personal and individual beneficiaries of their participation. Thus there are consistent positive reports of greater self-confidence, new skills and improved relationships between individuals and agencies. This suggests that the groundwork for the successful achievement of well-being, and its harnessing to the future success of participation in NDC, is in place, at least in part as a result of NDC. Yet these internal and individualized experiences of change have yet to be developed and translated into the basis of a strengthened and shared idea and experience of participation. Thus it is unlikely to sustain the interest and support of local people. The resulting disappointment is likely to impact negatively



	upon participants' well-being and, thus, on the well-being of the 'community', and may generate a vicious cycle in which disappointed participation leads to diminished well-being, which results in turn in less participation.
<p><b>Study details</b></p> <p>Authors: <b>Fountain J, Hicks J</b>  Year: <b>2010</b>  Citation: <b>Fountain J, Hicks J (2010) Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005-2008. Preston: International School for Communities, Rights and Inclusion, University of Central Lancashire.</b>  Quality Score (++, + or -): <b>++</b></p> <p><b>Source of funding:</b> NIMHE.  <b>Type of community engagement:</b> Community mobilisation/action  +Community partnerships/coalitions: National Institute for Mental Health England (NIMHE) Community Engagement Project, commissioned and conducted as part of the wider Delivering Race Equality [DRE] in Mental Health Care Programme.  <b>Level of community engagement :</b>  <b>Design:</b> Informed, &amp; Collaboration</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> This report presents an analysis of the quantitative and qualitative data from 79 studies which resulted from the work of the 75 participating community organisations. It provides a comprehensive overview of the issues that were explored by the studies in relation to Black and minority ethnic populations and mental wellbeing, mental health problems, mental health services and the vision of service characteristics for 2010 set out in DRE. The report also documents some of the project's outcomes for individuals, communities and mental health service development.</p> <p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection</b></p> <p><b>Method:</b> 77 studies used face-to-face interviews, usually conducted with two researchers in attendance, one asking the questions and the other recording the answers;</p> <ul style="list-style-type: none"> <li>– five studies used self-completion questionnaires;</li> <li>– 32 studies conducted focus groups;</li> <li>– seven studies included case studies;</li> <li>– nine community organisations organised specific events or seminars to collect data;</li> <li>– one study recorded information using a video diary;</li> </ul> <p><b>By whom:</b> 547 Community Researchers</p> <p><b>Setting(s):</b></p> <p><b>When:</b> From 2005-2008</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> BME Groups UK wide</p> <p><b>Number of participants recruited:</b> The total sample size was 6,018, comprising 5,751 community members and 267 mental health service providers.</p> <p><b>Specific inclusion/ exclusion criteria:</b> Participants in BME Mental health services</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported</p>

<p><b>Delivery:</b> Lead  <b>Evaluation:</b> not reported  <b>Extent of community engagement:</b>  Moderate</p>	<p><b>Key themes relevant to this review:</b></p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Data analysis was a complex and time-consuming process because:  – A variety of research methods were used by the community organisations (section 3.3.8) and data on a specific issue were presented both qualitatively and quantitatively. In addition, the total sample comprised a wide variety of different ethnicities and age groups (section 3.5). Their involvement with mental health services was also very varied: some had none, others had contact with services because they were caring for someone with a mental health problem, while others had used services for many years.</p> <p><b>Limitations identified by review team:</b> Ethical consideration not fully reported</p> <p><b>Evidence gaps and/or recommendations for future research:</b> Co-producing Networks  "Service systems need to incorporate into their skills base the ability to recognise, promote and play their part in co-producing networks as settings within which fear can be collectively ameliorated, new forms of reciprocity developed and discrimination addressed."</p>
<p><b>Study details</b></p> <p>Authors: <b>Harkins C, Egan J</b>  Year: <b>2012</b>  Citation: <b>Harkins C, Egan J (2012)</b>  <b>Partnership approaches to address local health inequalities: final evaluation report from the Govanhill Equally Well test site. Glasgow: Glasgow Centre for Population Health.</b></p> <p>Quality Score (++, + or -): <b>++</b></p> <p><b>Source of funding:</b> Glasgow Centre for Population Health  <b>Type/style of community engagement:</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> The purpose of this report is to conclude the evaluation of the Govanhill test site. The report will revisit the interim learning themes presented in the June 2011 report and assess their impact within local and national Equally Well networks, capturing important discussions within these networks resulting from the interim learning. The report also presents and discusses subsequent learning and describes key milestones within the test site's timeline. Some learning themes and test site milestones are presented as illustrations to aid dissemination and knowledge transfer.</p> <p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection</b></p> <p><b>Method:</b> ethnographic participant observation, interviews and focus groups.  <b>By whom:</b> 2 of the Authors  <b>Setting(s):</b> Govanhill test site in Scotland  <b>When:</b> From May 2008- November 2011</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Govanhill residents (Scotland)  <b>Number of participants recruited:</b> 17 participants from 2 focus groups</p>

<p>Community partnerships/coalitions</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> In PB design, delivery - leading. Elsewhere - informed - altho'</p> <p>"Community Anchors" Collaborated</p> <p><b>Delivery:</b> Informed &amp; Collaborated</p> <p><b>Evaluation:</b> informed</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p><b>Specific inclusion/ exclusion criteria:</b> Not reported</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Interviews and focus groups were audio-recorded using a portable digital device, with the permission of all participants. Interview and focus group data were transcribed and detailed participant observation notes were typed up after every meeting within Govanhill which the evaluator (Chris Harkins (CH)) attended. These transcribed data equate to approximately 300 hours of fieldwork. These data were combined with appropriate documentary data, meaning that all data was in textual form during analyses. These textual data were analysed using thematic analysis – one of the most common approaches to analysing qualitative data, especially within the field of health-related research. Thematic analysis involves coding the text into categories that summarise and systemise the content of the data<sup>12</sup>. The quality of the analysis was ensured through regular review meetings involving two analysts throughout the process (CH) and James Egan (JE). A qualitative data indexing package (Atlas.ti) was used to facilitate coding and retrieval of the data.</p> <p><b>Key themes relevant to this review:</b></p> <p>Defining the Govanhill test site approach</p> <p>Participatory Budgeting pilot launched (June 2010)</p> <p>Launch and mainstreaming of the Govanhill Hub (April 2010 onwards)</p> <p>Roma cardiovascular screening project launched (Nov 2011)</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> The sample size of the primary data source within the PB study (focus groups with GoCA members) was small compared to that for quantitative studies (17 participants took part in two focus groups). However, the focus group data proved sufficient for analysis to achieve saturation, with similar issues arising in both focus group discussions. The focus groups within the PB study were limited to regular GoCA attendees and did not therefore include the views of wider Govanhill residents.</p> <p><b>Limitations identified by review team:</b> The role of the researcher and their relationship with the participants was not clearly described.</p> <p>Ethical consideration not reported</p> <p><b>Evidence gaps and/or recommendations for future research:</b> Partners in Govanhill have demonstrated that within these structures and cultures there is space and enough flexibility to deliver progressive, upstream</p>
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	<p>partnership approaches which are in line with Equally Well recommendations. The Govanhill Hub is one such example. The Hub has now been firmly embedded within local service delivery in Govanhill and will continue beyond the lifetime of the test site. This is an important success. The present economic downturn and the associated policy context may represent a fertile environment from which to realise some of Equally Well's potential in terms of new models of service delivery. Amidst a national push to achieve more for less, public sector organisations are looking to become more flexible and adaptive as a matter of necessity. This is involving a very real drive for service delivery with, alongside and through community anchor organisations, community assets and communities themselves. The experience in Govanhill adds evidence in support of this thrust, indicating that such service delivery is more likely to impact on the complex local issues and conditions which are detrimental to health and wellbeing and which perpetuate health inequalities within disadvantaged Scottish communities.</p>
<p><b>Study details</b></p> <p>Authors: <b>Hatamian A, Pearmain D, Golden S.,</b>  Year: <b>2012</b>  Citation: <b>Hatamian A, Pearmain D, Golden S., (2012) Outcomes of the Active at 60 Community Agent Programme. London: DWP <a href="http://www.dwp.gov.uk">www.dwp.gov.uk</a> Research report no. 808 ISBN 978-1-908523-86-0</b>  Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> Department for Work and Pensions  <b>Type/style of community engagement:</b> Community mobilisation/peer involvement -Pre and post retirement</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> The programme aimed to: • empower individuals, at the local level, to provide leadership roles for older people in their community;  • help improve people's later life, encouraging them to play an active role in their communities;  • reduce the risk of older people becoming socially isolated and lonely; and  • achieve the sustainability of the 'Active at 60 Community Agent' role beyond the life of the programme.</p> <p><b>Theoretical approach:</b> Not specified</p> <p><b>Data collection</b></p> <p><b>Method:</b> A mixed method research design was used and this report draws on qualitative in depth interviews and quantitative data (on line and postal surveys).</p> <p><b>By whom:</b> CDF researchers</p> <p><b>Setting(s):</b> 461 community groups in 30 selected areas nationally</p> <p><b>When:</b> Fieldwork took place between August 2011 and March 2012: Between August and September 2011 (telephone interviews 10 local funders), Btw November and December 2011 (telephone interviews with 35 funded group leaders), December 2011 and February 2012 (telephone interviews with 60 Community Agents), btw February and April 2012. face-to-face (face-to-face interviews with 60 older people</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Older people who were recently retired or reaching</p>

<p>older people were recruited and trained/encouraged to take up leadership roles in their Community and to encourage their peers to lead active lives post retirement and beyond</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> consulted, leading and collaborating</p> <p><b>Delivery:</b> Leading and collaborating</p> <p><b>Evaluation:</b> Informed</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p>retirement (age group of community agent in the report include people between the age of 55 and 74) from community groups throughout the UK</p> <p><b>Report how they were recruited:</b> Through existing community groups and Nationally throughout the UK</p> <p><b>Number of participants recruited:</b> 763: 461 community organisation leaders; 252 Community agents and 60 older people</p> <p><b>Specific inclusion/ exclusion criteria:</b> older people within Pre or post retirement age</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Process of analysis not reported</p> <p><b>Key themes relevant to this review:</b> Findings for this study were obtained from quantitative (online and poster survey) and qualitative (semi-structured interviews). These are presented under the following headings: The role of Community Agents; Who became Community Agents and what type of role did they fulfil?; What support was provided for Community Agents and what was the impact of this support?; What was the impact on Community Agents including empowerment and leadership?; What were the lessons learned about fulfilling the Community Agent role?; Skills, attributes and qualities of Community Agents; Community Agents as peers; Helping other people to become Community Agents; Reaching and engaging older people; Who did the programme help to reach?; Barriers; Motivations; How did groups approach reaching and engaging older people and what was new and different about their approaches?; Using existing group members; Accessing other networks; New promotional methods; Reaching and engaging older people; Offering incentives; What were the lessons learned about the most effective ways of reaching older people?; What groups did with the funding.</p>
	<p><b>Notes by review team</b></p> <p><b>imitations identified by author:</b> Not reported</p> <p><b>Limitations identified by review team:</b> The role of the researcher was not clearly described, how the data was collected, stored</p> <p><b>Evidence gaps and/or recommendations for future research:</b></p> <ul style="list-style-type: none"> <li>• The main lessons about administering this type of fund that local funders shared included the need to communicate about the programme through a range of means, but to consider whether online or social</li> </ul>

	<p>media mechanisms are appropriate for an older target group. They emphasised the importance of using language that is easily understood and accessible to a wide range of people – such as champion rather than agent. Finally, they noted the value in building on community groups’ existing experience of delivering projects funded through small grants and of working with older people.</p> <ul style="list-style-type: none"> <li>• The use of local funders to promote the programme and reach into the community and provide support for groups to ensure high quality applications is an effective model of delivery. Through this model, the central policy message is mediated and made relevant to those implementing the aims on the ground. Local authorities seeking to ensure they make use of all the available resources in their area could usefully liaise with local funders to reach into the voluntary and community sector</li> <li>• Proactive engagement: to engage directly with older people, particularly those who are socially isolated, and consult them to ensure what is on offer is appealing to them, is resource intensive in terms of the time required to do so. However, this is the most effective means of reaching people who are not currently engaged in their community. Policy makers need to recognise that engaging people will take time and resources.</li> <li>• Build on motivation: many older people understand the value and benefit of leaving their houses, being socially engaged and mentally and physically active. Promoting opportunities to them that build on this existing motivation and emphasises how barriers such as nervousness and transport will be overcome will assist in achieving the aim of Ageing Well.</li> <li>• Use community groups: The research has shown that there can be positive outcomes for older people from participating in activities. This was achieved by having a hook to interest older people, the encouragement and support to overcome nervousness, and the forum to enable people to socialise and extend their friendships. Community groups are well placed to provide this support as they are rooted in their community, usually provide a meeting place known to the people and can use their networks to reach and engage people through word of mouth.</li> </ul>
<p><b>Study details</b></p> <p>Authors: <b>Hatzidimitriadou E, Mantovani N, Keating F</b> Year: <b>2012</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> In particular, the questions that this pilot evaluation sought to address were as follows:</p> <ol style="list-style-type: none"> <li>1. How can associations between public agencies and community groups create co-production opportunities?</li> <li>2. What are the social and economic values underpinning the Wandsworth Model of service provision?</li> </ol>

<p>Citation: <b>Hatzidimitriadou E, Mantovani N, Keating F (2012) Evaluation of co-production processes in a community-based mental health project in Wandsworth. London: Kingston University/St George's University of London. ISBN: 978-0-9558329-9-4</b></p> <p>Quality Score (++, + or -): +</p> <p><b>Source of funding:</b> South West Academic Network Interprofessional Institute (SWan IPI).</p> <p><b>Type/style of community engagement:</b> Community partnerships and coalitions: Co-production network around IAPT Services in Wandsworth</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> Collaborating and leading</p> <p><b>Delivery:</b> Collaborating and leading</p> <p><b>Evaluation:</b> Informed</p>	<p>3. How is the new learning from the co-production processes being transferred to public agencies and community groups?</p> <p>4. What are the benefits of the Wandsworth model for public agencies, community groups and the wider communities where co-produced services are delivered?</p> <p>This report presents findings from an evaluation study of the co-production processes in a community-based mental health project at the London Borough of Wandsworth. The evaluation sought to describe actions, changes, and functions that brought about a co-productive way of offering Improve Access to Psychological Therapies (IAPT) services in this locality. "The study aimed at producing transferable knowledge about a novel model of public service provision, which was developed by Wandsworth Community Empowerment Network (WCEN) in association with the South West London and St George's Mental Health Trust. The 'Wandsworth Model' entails canvassing partnerships with local faith-based and other community groups, who got engaged in co-producing responsive mental health services, in an attempt to address issues such as access and effectiveness of service delivery."</p> <p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection</b></p> <p><b>Method:</b> Our main method of gathering evidence was narrative interviews which were conducted with key informants from the three groups involved in delivering co-produced services: IAPT professionals, WCEN workers, and community/religious leaders.</p> <p><b>By whom:</b> Researchers</p> <p><b>Setting(s):</b> a community-based mental health project at the London Borough of Wandsworth.</p> <p><b>When:</b> Not reported</p>
<p><b>Extent of community engagement :</b> Moderate</p>	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Residents of Wandsworth who attended the community based mental health service of the London Borough of Wandsworth</p> <p><b>Number of participants recruited:</b> 14</p> <p><b>Specific inclusion/ exclusion criteria:</b> Not specified</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Interview data was digitally recorded and transcribed verbatim, with the exception of three interviews where notes were kept by the interviewer. The data was analysed for content.</p>



For the purpose of this analysis a coding scheme was developed, intended to capture the diversity of participant views to the evaluation questions we had posed.

**Key themes relevant to this review:**

Building relationships; Relations of trust; Shared norms; Drawing on existing local resources; Community Capacity Building; Skills building; Developing support; Benefits to service users; Trusting the services; Feeling empowered; Feeling understood; Tackling stigma of mental illness among BME communities; Building capacity of communities to deliver public health services; Benefits to service providers; Greater involvement with communities; Shift of professional attitudes; Financial gains; Learning from communities; Mutual benefits; Improved access of services for BME communities; Mutual Learning; Stronger relationships; Challenges for co-production; Reluctance to engage fully and lack of commitment; Limited capacity of organisations; Reluctance to engage fully and lack of commitment; Management of expectations; Conflicting agendas and issues of power.

**Notes by review team**

**Limitations identified by author:** Due to time and financial limitations, it was not possible to interview users of IAPT services or their carers. We acknowledge that this is an important perspective in order to understand fully the impact of co-production in mental health service provision.

**Limitations identified by review team:** Role and relationship of researcher to participants not reported

**Evidence gaps and/or recommendations for future research:** As a way forward, we would propose the following recommendations: We propose that there should be:

- A consistent way of collecting data about the use of IAPT co-produced services that should include demographic information, referral information, length of contact, type of services offered and dropout rates. It would be also important to have all this information by gender, age and ethnic group in order to have a better understanding of the diverse needs of the communities they serve.
- Mechanisms of continuing monitoring and evaluation of the effectiveness of the co-production process by collaboratively identifying meaningful outputs for both service and community co-providers. All partners should be involved in collecting and reflecting on evidence of this joint effort.
- Greater clarity, better and wider information to all co-production partners about what can be achieved through this initiative from the beginning to set common goals for all partners.
- Mechanisms and opportunities for transactional ways of knowledge and information exchange between

	<p>co-production partners; for example, practitioners holding mental health awareness days for all community members and community organisations offering cultural-specific training for practitioners.</p> <ul style="list-style-type: none"> <li>• Mechanisms to involve current service users and carers in co-production and evaluation of co-production to make their involvement more prominent in the various stages of negotiating co-produced services.</li> <li>• Strategies to maintain the existing fertile terrain that has enabled networks to develop 'relationships in action' by developing support for existing networks, but also to provide mentoring programme to enable other networks to become fully operational in delivering new services.</li> </ul>
<p><b>Study details</b></p> <p>Authors: <b>Hills D, Elliot E, Kowarzik U, Sullivan F, Stern E, Platt S, Boydell L, Popay J, et al</b>  Year: <b>2007</b>  Citation: <b>Hills D, Elliot E, Kowarzik U, Sullivan F, Stern E, Platt S, Boydell L, Popay J, et al (2007) The Evaluation of the Big Lottery Fund Healthy Living Centres Programme.. London: Tavistock Institute and Bridge Consortium.</b>  Quality Score (++, + or -): ++</p> <p><b>Source of funding:</b>  Big Lottery Fund / New Opportunities Fund</p> <p><b>Type/style of community engagement:</b>  Type 2: community partnership / coalition</p> <p><b>Level of community engagement</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b>  To evaluate the success of the Healthy Living Centre programme in terms of reducing health inequalities and improving health and wellbeing</p> <p><b>Theoretical approach:</b> Not stated</p> <p><b>Data collection</b></p> <p><b>Method:</b> : Documentary review of Field notes/reflective notes from staff and volunteers, Focus group/group Case studies, health monitoring system, surveys, workshops, interviews</p> <p><b>By whom:</b> The authors, and members of healthy living centres</p> <p><b>Setting(s):</b> Healthy Living Centres across the UK</p> <p><b>When:</b> 2001 – 2007</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b>  Regional populations in areas associated with poorest health outcomes</p> <p><b>Report how they were recruited:</b>  Via regional educational &amp; other research institutions</p> <p><b>Number of participants recruited:</b>  1361</p> <p><b>Specific inclusion/ exclusion criteria:</b>  According to aims of study, hence case studies were selected as follows:</p> <ul style="list-style-type: none"> <li>• Strong health service links and very much service/outreach oriented</li> <li>• Community development in orientation, which we believe we can identify even though there is some</li> </ul>

<p><b>Design:</b> leading  <b>Delivery:</b> leading  <b>Evaluation:</b> Informed  <b>Extent of community engagement:</b>  Moderate</p>	<p>uncertainty from available information</p> <ul style="list-style-type: none"> <li>• Single target group emphases – whether in terms of health status/illness (hypertension, mental health) or life stage/life circumstances (older persons, the homeless etc)</li> <li>• Particular approaches/strategies – even though many HLCs use more than one – such as community arts</li> <li>• Project based HLCs i.e. when an umbrella organisation has brought together 10-15 different projects – some pre-existing – to form a diversified HLC’</li> </ul> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b>  Case studies, involving repeated visits to 40 local centres; Health monitoring system, which has captured longitudinal data on over 1400 users of centres; Survey of all HLC centres undertaken in 2006; Review of external evaluations commissioned by local centres; Workshops with representatives from local centres; Utilisation of other sources of data, from the monitoring of centres, from parallel national evaluations; Analysis of the changing policy environment within which the programme has taken place</p> <p><b>Key themes relevant to this review:</b>  HLCs approach to service development, Identifying needs of their target population and gaps in existing services, Filling gaps in services, either themselves or in partnership with other local agencies; Working with other local agencies to improve the level of coordination between services; Achievements in service development; Recognition as models of good practice; Reaching target population; Difficulties in service development, Achievements in partnership and cross sector working; Difficulties in Partnership working and networking; Achievements in influencing local services; Difficulties in influencing other local agencies; Conclusions and main lessons (Building relationships based on trust, mutual understanding and collaboration, Understanding the complexity of the needs of the target population, Creating a supportive and flexible service delivery environment)</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> not reported  <b>Limitations identified by review team:</b> None reported  <b>Evidence gaps and/or recommendations for future research:</b></p>
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	Due to the difficulty of sustaining HLCs with sufficient human and financial resources, gaps remain in knowledge of their effectiveness, which require further investigation.
<p><b>Study details</b>  Authors: IRISS  Year: 2012  Citation: IRISS (2012) Using an assets based approach for positive mental health and wellbeing: An IRISS and East Dumbartonshire project. Glasgow: Institute for Research and Innovation in Social Services.</p> <p>Quality Score (++, + or -): ++</p> <p><b>Source of funding:</b> Institute for Research and Innovation in Social Science and East Dumbartonshire Council  <b>Type of community engagement:</b> Community mobilisation / action  <b>Level of community engagement</b>  <b>Design:</b> collaborating <b>Delivery:</b> leading  <b>Evaluation:</b> Informed  <b>Extent of community engagement:</b> Moderate</p>	<p><b>Research parameters</b>  <b>Research questions/aims:</b>  How can an assets based approach improve mental health and wellbeing within East Dumbartonshire?  <b>Theoretical approach:</b> Not stated  <b>Data collection</b>  <b>Method:</b> interview Interviews; engagement with staff; workshops,  <b>By whom:</b> The authors in collaboration with East Dumbartonshire Council  <b>Setting(s):</b> Kirkintilloch Health and Care Centre  <b>When:</b> June 2011 to September 2011</p> <p><b>Population and sample selection</b>  <b>Population from which the sample were recruited from:</b>  Individuals with experience of using mental health services in East Dumbartonshire, numbering approximately 1100 people  <b>Report how they were recruited:</b>  Via local health agencies, e.g. social work &amp; occupation therapy services, mental health networks and advocacy services  <b>Number of participants recruited:</b> 59  <b>Specific inclusion/ exclusion criteria:</b>  East Dumbartonshire selected because it is an area in which many NHS residential mental hospitals have been closed, with services transferred to the community. It is therefore an area well suited to investigating assets based community approaches to improving mental health</p> <p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b>  ‘Key stakeholder interviews;  Engagement activities with staff;  Three workshops bringing practitioners and people who use services together to map out the assets for mental well-being in the area; Testing different approaches;</p>

	<p>One-to-one person-centred planning discussions with people using mental health services; ‘Visual representation of mental health and universal service provision in the area; Understanding a new approach to person-centred planning for use with people experiencing mental health difficulties; Recommendations for improved service delivery in the area; Toolkit for mapping assets’</p> <p><b>Key themes relevant to this review:</b>                  Recruitment:                  Challenges in recruitment; Previous engagement experiences; Stigma; Staff engagement and access to individuals; Changing local context, Nurturing relationships; Staff Engagement; Working with groups; Workshop evaluation; Working with individuals; The assets of Kirkintilloch;                  WHAT DID WE PRODUCE? The map; The digital story, The Assets, Food; Health and well-being; Organisation; Outdoor space; Physical exercise, Religion/spiritual; Shopping, Social space; Volunteering, How could assets be used in different ways? Gaps that were identified during the project.’</p>
	<p><b>Notes by review team</b>  <b>Limitations identified by author:</b> none reported  <b>Limitations identified by review team:</b>                  Some concern over reliability of analysis, as there was little evidence for cross-checking of results by researchers, no info about coding, or discovery of discrepant results.  <b>Evidence gaps and/or recommendations for future research:</b> ‘Feedback from the project suggested that this approach could help shift the balance of delivery of <i>services</i> and would be worth developing further. It is important to recognise that the prototyping project generated and tested ideas outside the context of usual service provision – in a ‘safe space’ without financial or resources restraints, and without emphasis on achieving specific outcomes for individuals. On reflection, the recruitment and involvement of local co-facilitators could have been valuable and instructive to the project process. It is clear that, with more time for orientation and training, especially in probing for deeper information, using local facilitators would not only help develop community skills related to group process and asset mapping, but would also help transfer ownership for the initiative to the community.’</p>
<p><b>Study details</b>                   Authors: <b>Jarvis, D. Berkeley, N.</b></p>	<p><b>Research parameters</b>  <b>Research questions /aims:</b>                  To show the ‘cruciality’ of community engagement for enabling sustainable local regeneration</p>

<p><b>Broughton, K.</b> Year: <b>2012</b> Citation: <b>Jarvis, D., Berkeley, N., &amp; Broughton, K. (2011). Evidencing the impact of community engagement in neighbourhood regeneration: the case of Canley, Coventry. Community Development Journal, 47: 232-247.</b> Quality Score (++, + or -): +</p>	<p><b>Theoretical approach:</b> Not specified <b>Data collection</b> <b>Method:</b> Analysis of census data Review of secondary literature and ethnographic research Surveys Interviews <b>By whom:</b> The authors <b>Setting(s):</b> Interviews in location, i.e. Canley, and surveys remotely <b>When:</b> November 2007 and February 2008</p>
<p><b>Source of funding:</b> Coventry City Council <b>Type/style of community engagement:</b> Community mobilisation /action <b>Level of community engagement</b> <b>Design:</b> collaborating <b>Delivery:</b> consulted <b>Evaluation:</b> consulted <b>Extent of community engagement:</b> low</p>	<p><b>Population and sample selection</b> <b>Population from which the sample were recruited:</b> Households in Canley, Coventry, which has 5500 residents across 2255 households <b>Report how they were recruited:</b> Via Coventry City Council <b>Number of participants recruited:</b> 300 <b>Specific inclusion/ exclusion criteria:</b> Case study selected according to aims of study and phenomena being investigated, therefore Canley was included because of endemic deprivation, above average proportion of young and old (i.e. non-working age) residents, high proportion of lone parents, low rates of economic activity and car ownership, and high proportion of rented accommodation</p>
	<p><b>Outcomes, methods of analysis and results</b> <b>Method and process of analysis:</b> Analysis of 2001 census data; review of published ethnographic research on Canley; review of secondary literature; survey of 300 household in Canley; face-to-face interviews and workshops; review of documents about regeneration framework <b>Key themes relevant to this review:</b> ‘The cruciality of community engagement: a case study of Canley, Coventry’; ‘Context; An ‘unsustainable’ neighbourhood?’; Distrusting and disengaged residents’;</p>

	<p>'Re-engaging the community: the Canley regeneration framework'</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Not reported</p> <p><b>Limitations identified by review team:</b> Limited information about data collection process, role of the researcher was not clearly described, and data were not especially rich</p> <p><b>Evidence gaps and/or recommendations for future research:</b></p>
<p><b>Study details</b></p> <p>Authors: <b>Kimberlee, R.</b> Year: <b>2008</b> Citation: <b>Kimberlee, R. (2008). Streets ahead on safety: young people's participation in decision-making to address the European road injury 'epidemic'. Health &amp; social care in the community, 16(3), 322-328.</b> Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> Birmingham City Council</p> <p><b>Type/style of community engagement:</b> Community mobilisation / action</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> Collaborated</p> <p><b>Delivery:</b> Consulted</p> <p><b>Evaluation:</b> Consulted</p> <p><b>Extent of community engagement:</b> Low</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> To report on Birmingham City Council's 'Streets Ahead on Safety' Project, and assess its effectiveness</p> <p><b>Theoretical approach:</b> Not specified</p> <p><b>Data collection</b></p> <p><b>Method:</b> Environmental audit Road safety awareness and citizenship training</p> <p><b>By whom:</b> The authors; school travel plan officers; road safety officers; teachers; dinner ladies; teaching assistants; parents; engineers</p> <p><b>Setting(s):</b> Schools adjacent to area where roadworks were being done</p> <p><b>When:</b> 2007</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Residents of Birmingham, in particular from Asian immigrant communities</p> <p><b>Report how they were recruited:</b> Via primary schools</p> <p><b>Number of participants recruited:</b> 405</p> <p><b>Specific inclusion/ exclusion criteria:</b> Participants were selected according to proximity of school to road development area; relevance of age group and demographic to groups at greatest risk from road traffic accidents, i.e. children, particularly those</p>



	<p>from black and ethnic minorities.</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Environmental audits; interactive road safety awareness and citizenship training – both carried out by 405 young people aged 9-11</p> <p><b>Key themes relevant to this review:</b> Environmental audit; Citizenship training; Examination of engineering plans; Outcomes of participation.</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Not reported</p> <p><b>Limitations identified by review team:</b> Role of researcher not clearly described; Some concerns over rigour and reliability of data analysis; No reporting of ethics procedures.</p> <p><b>Evidence gaps and/or recommendations for future research:</b></p>
<p><b>Study details</b></p> <p>Authors: <b>Lawless P et al</b> Year: <b>2007</b> Citation: <b>Lawless P with Dickinson, S; Fordham G, Fuller C, Meegan R, Wells P (2007) NDC National Evaluation Phase 2: The six case studies: an introduction. Sheffield: Centre for Regional Economic and Social Research.</b></p> <p>Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> Office of the Deputy Prime Minister, later Communities and</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> - provide a largely factual overview of these six areas and their Partnerships - identify change in these neighbourhoods -- explore debates impacting on delivery</p> <p><b>Theoretical approach:</b> Not specified</p> <p><b>Data collection</b></p> <p><b>Method:</b> main source of evidence is from in-depth interviews with ‘key stakeholders’. survey data and explores - Case Studies</p> <p><b>By whom:</b> Evaluation team</p> <p><b>Setting(s):</b> Six out of 39 NDC (deprived) areas: Bradford, Knowsley, Lambeth, Newcastle, Newham and Walsall</p> <p><b>When:</b> autumn 2006.</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Intergenerational</p> <p>Report how they were recruited: Participants were recruited from the six case study areas to accommodate a regional spread, based on good performance of the area, type of neighbourhood and strategic approach used based on 4 indicators. Interviews were held with key NDC employees, Partnership Board Chairs, agency</p>

<p>Local Government</p> <p><b>Type/style of community engagement:</b> NDC Partnership /Community mobilisation/action NDC (phase 2) is an Area-based regeneration addressing, education, health, housing and the physical environment, crime and employment.</p> <p><b>Level of community engagement</b></p> <p><b>Design: consulted and Collaborating</b></p> <p><b>Delivery:</b> Leading and collaborating</p> <p><b>Evaluation:</b> Informed</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p>representatives, and other local actors.</p> <p><b>Number of participants recruited:</b> Typically between six and eight interviews were undertaken in each of the case study areas in autumn 2006.</p> <p><b>Specific inclusion/ exclusion criteria:</b> Not specified</p> <hr/> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported</p> <p><b>Key themes relevant to this review:</b> NDC Level Change: 2001/2 to 2005/6 Concluding observations Issues and Dilemmas in Neighbourhood Renewal Market and institutional contexts</p> <ul style="list-style-type: none"> <li>• changes in public sector budgets</li> <li>• institutional processes can prove time consuming</li> <li>• legal frameworks change:</li> <li>• the political world moves on</li> <li>• systems of governance change</li> <li>• new organisations emerge</li> </ul> <p>Relationships with agencies</p> <p>Engaging communities</p> <p>Delivering services, education, Health Crime, Worklessness, Housing and the physical environment</p> <p>Internal Processes, Sustaining change, Issues and dilemmas in neighbourhood renewal: a concluding comment</p> <p>The Six NDC Case Studies: Concluding Observations</p> <p>The 'local' matter</p> <p>Renewal is intensive, demanding and time consuming</p> <p>Successful renewal takes time, but the world moves on Limits on neighbourhood renewal</p> <p>Implications for the national evaluation.</p> <hr/> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Case study work raises a number of well-known <b>methodological issues</b>. In particular there can be problems in generalising from a relatively small number of case studies.</p>
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	<p><b>Limitations identified by review team:</b> No mention of ethical consideration in the report  inadequate report on how data was collected, stored, or transcribed  the relationship between researcher and subjects was not considered  process of data analysis was not reported</p> <p><b>Evidence gaps and/or recommendations for future research:</b>  Nevertheless it needs to be stressed that case study evidence is of particular value in helping to inform the three issues which underpin the national evaluation:  case study work can provide valuable insights into the added value of the Programme by, for instance, identifying those locally articulated benefits which arise from an ABI wedded to community engagement, longer term planning, partnership working with other agencies, and sustainability  ☑ locality work can also assist in teasing out the most effective way through which to plan renewal over ten years: undertaking longitudinal work in a small number of case study areas will allow the evaluation team, and in turn others, better to comprehend the processes inherent to, and the lessons emerging from, the planning, implementation and impact of an intensive, multi-outcome ABI in a small number of deprived localities. Pg 86/87</p>
<p><b>Study details</b></p> <p>Authors: <b>Lawson, L., Kearns, A.</b>  Year: <b>2010</b>  Citation: <b>Lawson, L., &amp; Kearns, A. (2010). Community engagement in regeneration: are we getting the point? Journal of Housing and the Built Environment, 25 (1), 19-36.</b>  Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b>  University of Glasgow, Glasgow City Council</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b>  To identify the intended benefits of community engagement in regeneration, and assess the extent to which these are being achieved through a case study of community engagement in Glasgow.</p> <p><b>Theoretical approach:</b>  Not specified</p> <p><b>Data collection</b></p> <p><b>Method:</b> Identification of case study; Initial meetings with relevant stakeholders; Discussion with residents and community actors; Focus groups with residents; Follow up meetings with consultants and housing associations; Analysis of data</p> <p><b>By whom:</b> The authors &amp; private consultants hired by the research funder</p> <p><b>Setting(s):</b> Local Housing Organisation premises where regeneration was taking place</p> <p><b>When:</b> 2006 - 2008</p> <hr/> <p><b>Population and sample selection</b></p>

<p><b>Type of community engagement:</b> Community mobilisation / action - defined as a capacity building process, through which individuals, groups and families as well as organisations, plan, carry out and evaluate activities on a participatory and sustained basis to achieve an agreed goal. Includes community development, asset based approaches</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> consulted, some collaboration</p> <p><b>Delivery:</b> consulted</p> <p><b>Evaluation:</b> informed</p> <p><b>Extent of community engagement:</b> low</p>	<p><b>Population from which the sample were recruited from:</b> Residents of three deprived areas of Glasgow</p> <p><b>Report how they were recruited:</b> Via Glasgow City Council / Glasgow Housing Association / Local Housing Organisations</p> <p><b>Number of participants recruited:</b> 30</p> <p><b>Specific inclusion/ exclusion criteria:</b> Case study areas selected according to aims of study – all three are ‘post-war mass social housing estates comprising a mixture of tower blocks and deck-access flats and each contains a significant proportion of asylum-seekers and refugees (up to 40%) in addition to longer-term predominantly Scottish residents. Large-scale demolition of tower blocks is intended as part of the renewal of each area. In each area a Local Housing Organisation (LHO), which is governed by a management committee comprised of a majority of local tenants, manages the housing stock, as part of a devolved structure within GHA (which owns the housing stock).’</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported</p> <p><b>Key themes relevant to this review:</b> Good governance; Community empowerment; Sustainable communities; Community cohesion; Effective implementation</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> ‘...there is the need to maintain continuity in community engagement between planning and implementation: community members involved in developing plans had no sense of any further involvement beyond this. If this does not happen then any gains achieved so far may be eroded.’</p> <p><b>Limitations identified by review team:</b> No reporting of ethics procedures; little reporting of analysis in terms of coding and cross-checking by researchers, so some concerns over reliability of analysis; details of data collection process are limited</p> <p><b>Evidence gaps and/or recommendations for future research:</b> ‘There is a need for clarity over the extent and limits of agency commitments to the regeneration plans. To date, there is no clearly agreed mechanism for taking the plans forward, or acknowledgement of their limitations (although things may have moved on since the study was completed).’</p>
<p><b>Study details</b></p>	<p><b>Research parameters</b></p>

<p>Authors: <b>Liverpool JMU</b>  Year: <b>2012</b>  Citation: <b>Liverpool JMU (2012)</b>  <b>Evaluation of Approaches to Health Literacy in Ashton, Leigh and Wigan.</b>  <b>Liverpool: Liverpool JMU.</b>  Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> NHS  <b>Type/style of community engagement:</b>  Community mobilisation/action - Empowerment model  <b>Level of community engagement:</b>  Health champions were a third party leading in delivery of health improvement  <b>Design:</b> consulted/ Collaborating  <b>Delivery:</b> Leading and collaborating  <b>Evaluation:</b> informed  <b>Extent of community engagement:</b>  Moderate</p>	<p><b>Research questions/aims:</b> The purpose of this evaluation is to provide evidence of the effectiveness of NHS Ashton, Leigh and Wigan’s approach to building public health capacity, developing health literacy and empowering people to manage their own health. There is a need to understand the value that is being obtained from what is being delivered and how this approach has been used to tackle poor health behaviours.</p> <ul style="list-style-type: none"> <li>• What is the delivery mechanism of the approaches, who do they reach and what is the impact</li> <li>• What is the theoretical basis that can be used to describe the approach that has been taken?</li> <li>• What impacts do delivery mechanisms have on behaviour change? Who has been reached by training? Have individuals changed their behaviour and attitude as result of training? How have trainees changed status/role in settings as a result?</li> <li>• Have there been changes among individuals and organisations as a result?</li> <li>• How can the connections between the different elements of the approach be sustained? What are the vital parts and critical factors for success in making it work?</li> <li>• What will this mean for the future given the changes taking place in the health service and other organisations?</li> </ul> <p><b>Theoretical approach:</b> Behaviour change  <b>Data collection</b>  <b>Method:</b> individual and group interviews held in Wigan  <b>Interviews By whom:</b> Not specified  <b>Setting(s):</b> Wigan Borough  <b>When:</b> The report covers the activities of the HIP team between Dec 2008 and Dec 2011. But the data collection period is not specified.</p>
	<p><b>Population and sample selection</b>  <b>Population from which the sample were recruited from:</b> Health champion and Health Improvement Practitioners employed by NHS Ashton, Leigh and Wigan at Wigan Borough  <b>Report how they were recruited:</b></p> <ol style="list-style-type: none"> <li>1. Members of the health improvement practitioner team</li> <li>2. Health champions from the community and various workplaces i.e. -Wigan borough council, borough wide community network, Electrium staff, a fire and rescue service etc but there was no description of the characteristics. Recruited out of 1007 individuals who were trained by the HIP team.</li> </ol>

	<p>3. PCT managers  <b>Number of participants recruited:</b> Not specified  <b>Specific inclusion/ exclusion criteria:</b> Not specified</p> <hr/> <p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b> Not reported  <b>Key themes relevant to this review:</b>  The findings were organised under the following thematic headings  The findings are presented in two parts - reflecting the perspectives of the HIP Team, including the managers at the PCT and the Health Champions who received the training and support. A key purpose is to understand how the health literacy approach works, who is reached and what impacts are achieved in Wigan.  HEALTH IMPROVEMENT PRACTITIONER TEAM PERSPECTIVE,  Engagement, Training, Support, Impact- Health Champions, Intelligence gathering – a two-way process,  Factors that made the team effective, concerns  HEALTH CHAMPION PERSPECTIVE,  Partnership working, The relationship with the NHS, Ensuring buy-in from staff Training, Accreditation, Being a Health Champion - Understanding the role, Approaches, support, identifying need, Difficulties encountered raising the subject, Competing priorities, Funding - less resources, more work, Ongoing support from the HIP Team, Barriers to being a Health Champion, Impact- Behaviour change, Capacity, Confidence, Reaching out</p> <hr/> <p><b>Notes by review team</b>  <b>Limitations identified by author:</b>  <b>Limitations identified by review team:</b>  No mention of ethical consideration, inadequate description of process of data collection and analysis e.g no report of how coding was done and by whom, role of researcher and relationship of researcher to participants.  <b>Evidence gaps and/or recommendations for future research:</b> Issues for consideration  Health Champion issues  It is important to:  <ul style="list-style-type: none"> <li>• Continue the provision of behaviour change training. Individuals need help to be able to ‘raise the subject’ and understand how people’s confidence and conviction can be enhanced.</li> </ul> </p>
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	<ul style="list-style-type: none"> <li>• Review the value of the accreditation process. Whilst it is an essential factor for some people, it is less so for others.</li> <li>• Learn about mental health and wellbeing. ‘Sometimes the smallest thing can boost people’s confidence. We need to focus on de-demonising mental health – so it’s not a taboo.’</li> <li>• Provide high-level support for workplace Health Champions.</li> <li>• Ensure access to ongoing support from the HIP Team. This will help maintain motivation and provide further learning opportunities among Health Champions.</li> </ul> <p>NHS issues It is important to:</p> <ul style="list-style-type: none"> <li>• Measure the impact of the programme on individual and community health. “The golden question remains – what impact is the programme having?”</li> <li>• Recognise the need to extend the reach of the programme. “We need to reach out to organisations we are not working with such as adult social care, care homes and the police.”</li> <li>• Develop the Health Champion role and infrastructure. “We need a website to share knowledge, create communities of interest and we need to produce things jointly [with other partners].”</li> <li>• Determine how partner agencies and the public perceive the ‘health offer’. Would a recognisable public-facing identity or brand alongside a wider marketing strategy help? The launch of the website will help.</li> <li>• Build resilient communities. “This should be approached in a multi-partner, asset based way, which doesn’t [just] rely on the PCT. Amateur support clubs have been brilliant at this.”</li> <li>• Embed health literacy approaches into contracts, service specifications and patient/user questionnaires.</li> </ul>
<p><b>Study details</b></p> <p>Authors: <b>Lwembe S.</b> Year: <b>2011</b> Citation: <b>Lwembe S; (2011) Health Champion Project: Evaluation report. London: Hammersmith and Fulham NHS.</b> Quality Score (++, + or -): -</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> Intervention was about tackling health inequalities- peer support tackling obesity, reducing smoking, cancer screening, improving mental health - health champions. The evaluation was undertaken to assess if the Health Champion project has been effective in supporting the NHS Hammersmith and Fulham public health objectives and if at all it has in any way made any significant inroads in contributing to the general health and wellbeing improvement to residents on White City Estate.</p> <p><b>Theoretical approach:</b> not reported</p> <p><b>Data collection Method:</b> 40 face to face and telephone interviews were conducted with key informants, 30 were reached through community café workshops</p> <p><b>By whom:</b> Not reported</p>



<p><b>Source of funding:</b> BIG Lottery wellbeing fund</p> <p><b>Type/style of community engagement:</b> community mobilisation/ action; community partnerships/ coalitions; peer involvement.</p> <p>Tackling health inequalities- peer support tackling obesity, reducing smoking, cancer screening, improving mental health - health champions</p> <p><b>Level of community engagement:</b></p> <p><b>Design:</b> consulted, leading and collaborated</p> <p><b>Delivery:</b> consulted, leading and collaborating</p> <p><b>Evaluation:</b> Informed</p> <p><b>Extent of community engagement:</b> moderate</p>	<p><b>Setting(s):</b> community cafes, workplaces, community settings</p> <p><b>When:</b> Not reported</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Efforts were made to reach those end-users who had been involved in the project activities and those who had not.</p> <p><b>Report how they were recruited:</b> not reported</p> <p><b>Number of participants recruited:</b> 70</p> <p><b>Specific inclusion/ exclusion criteria:</b> A purposeful ‘saturation’ approach was adopted: many respondents were identified and interviewed; the process was only stopped when it seemed that nothing new was emerging from the responses.</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported</p> <p><b>Key themes relevant to this review:</b> Views about the project - “...A huge benefit is the project has ensured that local residents work together and feel they have a voice to change things. In the past, people worked in isolation; we no longer see separate groups. It has promoted integration widely...”</p> <p>“...A great technique of empowering community members to work with their own people... to help deliver services.” “...residents don’t want short term. The continuation of the project is vital so that residents get full benefit and are not disappointed. They do not want to feel let down by health initiatives that are short term and short lived...”</p> <p>Motivation for getting involved in the project – Positive nature of response received at the point of enquiry.</p> <p>“...I felt all my questions were adequately answered when I enquired about the project and my involvement. This gave me confidence that the project would be great...”</p> <ul style="list-style-type: none"> <li>• Project seen as an opportunity to integrate and to ‘give back’ to the community.</li> </ul> <p>“...my knowledge and skills were both useful and wanted by residents of white city...”</p> <p>“...Since we live in a multicultural society I thought it was an easy way to get integrated with the different ethnic minorities through the project...” “...to give the best support to the residents of white city, to help those who needed help and support by giving information that would improve their life... • Locality focus of the project which meant people did not have to travel out of their estate to take part.</p> <p>“...since it was based on the Estate, I would not have to bother about changing buses or going far to take</p>
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part...”

- The design of the project was seen to be attractive

“...I felt it was different...people were seen as part of the solution, not the problem...in addressing inequalities...”;

Difference project has made to individuals - “...We all feel better, we feel wanted and more outgoing, to get involved in well London projects...”

“...I have developed many skills...I have broadened my knowledge and awareness working with a very diverse people ... has upgraded and advanced my personal development and much value to my CV...”

“...I have learnt more about my environment, met more people. I have had the opportunity to influence people’s health behaviour positively and I have the satisfaction that I am actively a part of my community...”;

Difference the project has made to the community - “...I’d say people are more galvanized into giving up smoking...increased uptake of physical activities...observed better mental wellbeing of my mates...”

“...Women feel very happy, self-confidence improved and they go on to further education, e.g. GCSE, food hygiene, ICT, etc. and some have gone to find jobs...” “...There are many problems such as loneliness and disillusionment, but the project brought a lot of people out, who have got involved...”

“...Have seen trust built up between police and residents...people feel safer on the estate”;

What has worked well = “...people feel empowered and feel their needs are being met and understood...members of the community rising to the challenge of delivering the services which they generally had not previously any expectation or experience of delivering...”;

Challenges faced - “...I expected more training, I wanted to train as a facilitator but the system did not allow this...”

Legacy - “...It has been a fantastic journey; however, people still need support in these areas even after Well London is gone. It has been a pilot with a lot of sound learning, but the community development approach to health promotion need to be sustained...”

“...the community is in a sustained and enhanced position in regards to a welfare benefits services, policing, housing, health and social care...”;

Application of the Health Champions approach - “...Don’t superimpose the model of another area even though there may be some specific traits. This approach should be tailored to recognise what people have and need; one should develop pre-knowledge accounts to identify any local differences...”

“...to feel as a community changes were wanted, and motivation to change, however slow could make

	<p>residents feel there was opportunities, and incentives to make a difference...”.</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> not reported.</p> <p><b>Limitations identified by review team:</b> Ethical issues, data collection and analysis methods not reported; role of researcher not clearly described</p> <p><b>Evidence gaps and/or recommendations for future research:</b></p> <p>A full and comprehensive evaluation of the cost-effectiveness of using volunteers (Health Champions) should be undertaken. The study should assess the costs of the individual roles performed by the Health Champions as well as the value of actual tasks undertaken by all, regardless of individual responsibility.</p>
<p><b>Study details</b></p> <p>Authors: <b>Marais F</b></p> <p>Year: <b>2007</b></p> <p>Citation: <b>Marais F (2007) Toward the improvement of tuberculosis control and participatory research. London: Department of Primary Care and Social Medicine, Imperial College.</b></p> <p>Quality Score (++, + or -): <b>++</b></p> <p><b>Source of funding:</b> UK Medical Research Council, Westminster Primary Care Trust and Imperial College London; and the publication of this report funded by the Greater London Authority, TB Alert, and Westminster Primary Care Trust, London.</p> <p><b>Type/style of community engagement:</b> Community partnerships and coalitions;</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b></p> <p>"This report presents the main findings of a 2.5-year study (conducted between November 2003 and May 2006), using a multi-method Community-based Participatory Research design to investigate the structural influences and their interplay; in terms of social, economic, legal, political and organisational (including institutional) factors; on the epidemiology and control of TB in migrant African communities in the borough of Westminster, London. The investigation focused on structural influences determined at, and operating across, community and sector level within the local context."</p> <p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection:</b></p> <p><b>Method:</b> The study used both quantitative and qualitative methods for data collection. These included: (a) questionnaire survey interviews with migrant Africans (SI), (b) semi-structured interviews with migrant Africans with no experience of TB treatment (SSINTB), (c) semi-structured interviews with migrant Africans with experience of TB treatment (SSI-TB), (d) community consultations with migrant Africans (CC), (e) semi-structured interviews with key stakeholders from multiple sectors (SSI-KS), (f) qualitative observations (minutes and notes from CAP meetings, and notes from all planned and unplanned discussions and consultations) (<b>OBS</b>), and (g) process and outcome evaluations of the participation of the CAP and CRFs.</p> <p><b>By whom:</b> Community field workers</p> <p><b>Setting(s):</b> City of Westminster</p>

<p>Community-based Participatory Research</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> consulted, leading and collaborating</p> <p><b>Delivery:</b> consulted, leading and collaborating</p> <p><b>Evaluation:</b> consulted, leading and collaborating</p> <p><b>Extent of community engagement:</b> High</p>	<p><b>When:</b> November 2003 and May 2006).</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Migrant African Communities in Westminster</p> <p><b>Number of participants recruited:</b></p> <p><b>Specific inclusion/ exclusion criteria:</b> Key stakeholders from different sectors were sampled for the study. In this study a key stakeholder was regarded as any individual, group, organisation or institution which could significantly influence public health interventions (policies, services and/or programmatic responses) for, and outcomes of, TB control. The term 'key' referred to high importance, high influence, or both. Criteria for inclusion in the study were: (a) the formal sectors (statutory and non-statutory) and CBOs representing and serving the migrant African communities, i.e. policy makers, service providers and commissioners, and (b) influential persons such as community and religious leaders.</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> The analysis of the quantitative and qualitative data sets involved a number of different steps, encompassing separate and integrated analysis. Quantitative data were analysed in SPSS 12.0 for Windows statistical software. The qualitative data were analysed manually, using a thematic approach drawing on the principles of grounded theory; clustering recurring factors into themes and sub-themes. The same procedure was followed for the integrated analysis. The CAP and CRFs participated in the data analysis process. They fulfilled a critical participatory role by shaping the interpretation of the data, and by ensuring the validity of the interpretation and that of the study conclusions and recommendations which are based on the data.</p> <p><b>Key themes relevant to this review:</b> Study evaluation results: the participatory research process  Methods and results of the process evaluation of Community Advisory Panel participation  Methods and results of the outcome evaluation of Community Advisory Panel participation  Methods and results of the outcome evaluation of Community Research Fieldworker participation  Recommendations toward improved implementation of participatory research designs</p>
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	<p>Joint-budget agreement  Maximising community representation  Community training  Promoting sustained participation  Clarifying roles and responsibilities  Facilitating socio-cultural and linguistic compatibility  Addressing Power imbalance  Preparatory work  Engaging communities in data analysis  Expanding opportunities for Community Research Fieldworkers  Organisational/institutional change</p>
	<p><b>Notes by review team</b>  <b>Limitations identified by author:</b> Not reported for the qualitative study  <b>Limitations identified by review team:</b> Not sure if context bias was considered  <b>Evidence gaps and/or recommendations for future research:</b> Joint-budget agreement</p> <ul style="list-style-type: none"> <li>• The research budget should include funding for a research partnership (CAP) and insider researcher (CRF) training prior to commencement of the study and adequate payment of research partners from CBOs for attending meetings, and of CRFs undertaking fieldwork and other research related activities.</li> <li>• A joint-budget with joint-executive (shared power and managerial responsibility) should be agreed over the allocation and distribution of funds. : The impact of participation on the workload and associated costs of all research partners should be assessed and integrated into the initial study and subsequent funding applications.</li> </ul> <p>Maximising community representation</p> <ul style="list-style-type: none"> <li>• Mechanisms should be in place to maximise community representation and ensure relative equal sex and age distributions among community CAP partners and CRFs.</li> <li>• Data collection tools should be brief and operationalised in all main community languages to reduce the duration of interviews, minimising interviewee inconvenience, and to maximise opportunities for different communities to participate, thereby increasing representation.</li> <li>• Different community organisations and members should be persuaded to participate by raising awareness</li> </ul>

	<p>of studies at CBOs prior to the main advertising and recruitment phase.</p> <ul style="list-style-type: none"> <li>• A broad range of community organisations and members should be engaged before, during and after the study to emphasise the importance of the topic, maximise ethnic diversity of participation, and to ensure positive attitudes toward the results and recommendations.</li> </ul>
<p><b>Study details</b></p> <p>Authors: <b>Pemberton, S Mason, J</b>  Year: <b>2009</b>  Citation: <b>Pemberton, S., &amp; Mason, J. (2009). Co-production and sure start children's centres: reflecting upon users', perspectives and implications for service delivery, planning and evaluation. Social Policy and Society, 8(01), 13-24.</b>  Quality Score (++, + or -): +</p> <p><b>Source of funding:</b>  Sure Start Children's Centres</p> <p><b>Type/style of community engagement:</b>  Type 2: Community partnerships / coalitions</p> <p><b>Level of community engagement</b>  Consulted on design; collaborating in service delivery; collaborating in evaluation.</p> <p><b>Design:</b> collaborating  <b>Delivery:</b> collaborating  <b>Evaluation:</b> consulted</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b>  To consider the engagement of users in service delivery, planning, monitoring and evaluation activities for Children's Centres in Greater Merseyside</p> <p><b>Theoretical approach:</b></p> <p><b>Data collection</b></p> <p><b>Method:</b> Case studies, 56 semi-structured one-to-one interviews with service users arranged and carried out  <b>By whom:</b> The authors  <b>Setting(s):</b> Sure Start children's Centres in Greater Merseyside  <b>When:</b> 2007</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b>  Communities in Greater Merseyside, an area of high deprivation and child poverty in north west England  <b>Report how they were recruited:</b> Via Sure Start Children's Centres  <b>Number of participants recruited:</b> 56  <b>Specific inclusion/ exclusion criteria:</b>  Only centres which had been operational for at least 12 months and thus established were selected. Many were still in the process of being set up.</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported  <b>Key themes relevant to this review:</b>  'Sure Start Children's Centres and co-production in service delivery'  'Sure Start Children's Centres and co-production in service planning (design, commissioning and managing services)'  'Sure Start Children's Centres and monitoring and evaluation activities – the missing element of co-</p>

<p><b>Extent of community engagement:</b> Moderate</p>	<p>production to date?’</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Difficulty of generalising from a single case study</p> <p><b>Limitations identified by review team:</b></p> <p><b>Evidence gaps and/or recommendations for future research:</b> No information about cross-checking of transcripts by researchers, so possible concerns about reliability of analysis; role of researcher not always clearly described; limited information about data collection in terms of transcribing, storage etc.</p>
<p><b>Study details</b></p> <p>Authors: <b>Robinson, N Lorenc, A</b> Year: <b>2010</b> Citation: <b>Robinson N., Lorenc, A. (2010) Strengthening the public voice in shaping sexual and reproductive health services - Changing relationships. London: London Sexual Health Programme.</b> Quality Score (++, + or -): ++</p> <p><b>Source of funding:</b> NHS London Sexual Health Programme</p> <p><b>Type/style of community engagement:</b> Type 2: Community partnerships / coalition</p> <p><b>Level of community engagement</b> <b>Design:</b> Collaborating <b>Delivery:</b> Consulted</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> ‘This project, commissioned by the London Sexual Health Programme, aimed to review current policy, guidelines and practice on PPE in SRHH and produce recommendations on how to effectively engage patients and the public in SRHH services in London in order to inform SRHH strategies.’</p> <p><b>Theoretical approach:</b> Not specified</p> <p><b>Data collection</b></p> <p><b>Method:</b> ‘Four data collection phases were used: a literature review of 59 documents/journal articles/websites; an email survey of all PCTs in England; an online survey of 72 stakeholders; and in-depth interviews with 25 stakeholders including commissioners, managers, voluntary/community organisations (VCOs) clinicians and patients.’</p> <p><b>By whom:</b> The authors</p> <p><b>Setting(s):</b> In sexual health centres across London, and online</p> <p><b>When:</b> 2009 - 2010</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Individuals in London known to sexual health services, and professional stakeholders providing these services</p> <p><b>Report how they were recruited:</b> Via NHS sexual health services</p>



<p><b>Evaluation:</b> Informed</p> <p><b>Extent of community engagement:</b> Low</p>	<p><b>Number of participants recruited:</b> 97</p> <p><b>Specific inclusion/ exclusion criteria:</b> None specified</p> <p>‘The search did not include papers on engaging patients in using services or in individual clinical decision making, only engagement in designing/planning services.’</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Framework analysis was used for analysis of interview data. Familiarisation took place during transcription of the recorded interviews. Codes were developed to label chunks of data and themes were derived from these labels arising from the data. In addition to the framework analysis, which provides anonymous data, examples of best practice were identified from interviews and survey responses.</p> <p>Analysis took place simultaneously alongside data collection, which meant interview questions could be refined to pursue emerging themes (Broom 2005). At the end of the interview phase no new themes appeared to be emerging, indicating that some level of theoretical saturation had been reached.</p> <p><b>Key themes relevant to this review:</b></p> <p>Organisational commitment to PPE; Motivating patients / public; Changing NHS philosophy; Informing patients / public about opportunities for PPE; Using public awareness / education campaigns; Overcoming the barrier of stigma; Working with voluntary sector organisations.</p>
	<p><b>Notes by review team</b></p> <p><b>imitations identified by author:</b></p> <p>Project was London-centric; Participation depended on volunteering, so some groups still not being reached; literature review was not systematic; Impact of PPE initiative outcomes and their costs were not quantified; Sustainability of the approaches was not evaluated.</p> <p><b>Limitations identified by review team:</b></p> <p>Little systematic reporting of research ethics procedures; Limited conclusions – stated only in executive summary in two sentences;</p> <p><b>Evidence gaps and/or recommendations for future research:</b></p> <p>‘- Systematic scoping of policies, guidance and practice related to these recommendations. - Exploring development of an audit tool to measure the impact of PPE in SRHH. - Training/information packages on PPE in SRHH, for both staff and patients/public. - Establishing a network for sharing of best practice in SRHH PPE. ‘</p>

<p><b>Study details</b></p> <p>Authors: <b>Roma Support Group</b>  Year: <b>2009</b>  Citation: <b>Roma Support Group (2011) Improving engagement with the Roma community: research report: London Civic Forum</b>  Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> London Civic Forum  <b>Type/style of community engagement:</b> Community mobilisation/action  <b>Level of community engagement</b>  <b>Design:</b> Consulted, collaborating, Leading  <b>Delivery:</b> Consulted, collaborating, Leading  <b>Evaluation:</b> Consulted, collaborating, Leading  <b>Extent of community engagement:</b> High</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> Action Research set to identify the barriers and enablers faced by the Roma refugee and migrant community when engaging in mainstream empowerment mechanisms  <b>Theoretical approach:</b> Not specified  <b>Data collection Method:</b> Focus group meetings, conference workshops, Q &amp; A panel and a Forum Theatre  In total, 87 Roma community members were involved in this research. This included:</p> <ul style="list-style-type: none"> <li>• 62 Roma who took part in 5 focus group meetings (47 Roma adults and 15 young Roma people (14 – 25 years old).</li> <li>• An additional 12 Roma adults and young people who took part in the final stage of the project.</li> <li>• An additional 13 Roma adults, children and young people who took part in the preparation for and performance of the forum theatre that was presented at the conference.</li> </ul> <p><b>By whom:</b> Roma Research Group  <b>Setting(s):</b> Roma refugee and migrant community in London  <b>When:</b> Between October 2009 and March 2010.</p> <hr/> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Roma refugee and migrant community in London  <b>Report how they were recruited: participants were recruited at</b>  <b>Number of participants recruited:</b> 87  <b>Specific inclusion/ exclusion criteria:</b> All Roma people living in London</p> <hr/> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported  <b>Key themes relevant to this review:</b>  A conference: the big issue for Roma: exclusion or engagement?  P. 14: Policy background  P. 15: Roma refugees and migrants in the UK  P. 19: Engaging the Roma community in action research  P. 19: a concept of Roma refugee and migrant community  P. 23: Mainstream community empowerment mechanisms and their role in the Roma community</p>
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	<p>P. 24: The barriers to participating in mainstream empowerment activity  P. 27: The enablers for Roma community empowerment  P. 29: Recommendations for the Roma community</p> <p><b>Notes by review team</b>  <b>Limitations identified by author:</b> Time and resource constraints to explore a wider range of Roma across nationalities and around London.  <b>Limitations identified by review team:</b> Method of Data collection/analysis were inadequately reported so cannot ascertain their defensibility or reliability.  The role and relationship of the researchers was not clearly described  Ethical consideration was inadequately reported.  <b>Evidence gaps and/or recommendations for future research:</b> Roma participants linked a strategy for their community empowerment to the commitment of decision makers, emphasising the need for partnership and support. One of the participants stated that in a society where it is possible “to feel proud to be Roma ... we need local governments, schools, police and others to be honest, recognise our needs and work with us to improve our situation.”</p>
<p><b>Study details</b></p> <p>Authors: <b>Sadare O.</b>  Year: <b>2011</b>  Citation: <b>Sadare O. (2011) Evaluation of Community Engagement in the Design and Delivery of Health Promotion Interventions</b>  <b>Quality Score (++, + or -): ++</b></p> <p><b>Source of funding:</b> BIG Lottery wellbeing fund  <b>Type of community engagement:</b> community mobilisation/ action;</p>	<p><b>Research parameters</b>  <b>Research questions/aims:</b>  Intervention – Well London – health promotion: physical activity, healthy eating, mental wellbeing.</p> <ol style="list-style-type: none"> <li>1. What is the current framework of best practice for community engagement in design and delivery of health promotion interventions?</li> <li>2. What are the incentives and barriers to community engagement?</li> <li>3. How can barriers to community engagement be overcome and the costs to communities met?</li> <li>4. How does the community engagement process influence the overall fitness for purpose of the intervention design (both positively and negatively)?</li> <li>5. How does the CEP vary according to the type of issue to be addressed and the type of intervention envisaged?</li> <li>6. How can community participation be delivered in a way that empowers the local communities and in a way that directly promotes their wellbeing?</li> </ol> <p><b>Theoretical approach:</b> The study and the CEP have been grounded on the theories of empowerment, which is</p>

<p>community organisations. a 5 year health promotion programme incorporating mental wellbeing, physical activity and diet</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> Consulted, collaborating, Leading</p> <p><b>Delivery:</b> Consulted, collaborating, Leading</p> <p><b>Evaluation:</b> Informed</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p>seen as an ultimate outcome of a community engagement (Christens et al., 2011).</p> <p><b>Data collection</b></p> <p><b>Method:</b> Mixed methods - literature review; questionnaire-based surveys; participant observation; qualitative interviews; and documentary analysis;</p> <p><b>By whom:</b> Author</p> <p><b>Setting(s):</b> The interviews with the residents took place in their homes (7), community Halls/centres (4), and a local café (1). The interviews with the WL partners and co-hosts took place in the offices of these organisations.</p> <p><b>When:</b> phase one and phase two</p> <hr/> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited:</b> all participants of the phase-two cafés and CAWs who participated in the surveys, plus one to two identified members of each WL organisation and each co-host organisation in phase-two CEP</p> <p><b>Report how they were recruited:</b> Participants for qualitative interviews were recruited in two ways, using the elements of purposive and convenience sampling. First, all participants of the phase-two cafés and CAWs who participated in the surveys were asked at the end of the questionnaire whether they wanted to be contacted for further in-depth research. Those who said ‘yes’ and provided their contact details were contacted six to nine months later for an interview.</p> <p><b>Number of participants recruited:</b> 33</p> <p><b>Specific inclusion/ exclusion criteria:</b> All who took part in the community cafes were eligible</p> <hr/> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> A thematic analysis was done using pre-determined themes as nodes, but some new ones were created when new themes or sub-themes emerged during analysis. All interviews were kept under the same project but each interviewee was made a case with its own attributes such as age, occupation, community, and organisation. The cases were then grouped under the three main groups - community residents, community organisations and WL partners. Nodes were created which represented the main themes of the study (perceptions, barriers and challenges, incentives, impact of CEP, community) and the relevant data were coded under each node/theme. A node tree was then created which contained a logical composition of similarly themed nodes arranged in hierarchy. The themes and ideas captured and</p>
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linked in node trees were used to create node summary reports to include node description and coding details. The reports were exported to Word® and then used for writing up results under each theme.

**Key themes relevant to this review:** Participant Observation: Target Neighbourhoods; Community Cafés; Community Action Workshops (CAWs); Project Implementation Meetings (PIMs).

CEP and its Impact – The Communities’ Perspectives: Socio-Demographic Characteristics, Health and Social Activities of Participants; Perceptions of Well London CEP; Incentives and Barriers to Participation; Impact of CEP on the Communities and Projects.

“A lot of the residents... when all this money is being spent, they think it's all just coming from the council...But when you try and tell them that it's out of a different pot, they still say, 'why can't we have that done?'” (INS- F/70/Retired) “They [Well London] should have done more research about the area before they embarked on the project and understood the extreme sensitivity of the people who are being moved around the area or moved out of the area.” (JGE- M/60/Local Councillor)

“...they only chose the Cossall Estate and we were left out...so...we haven't seen any of the benefits here... yet.” (JQS- F/61/Retired) “They decided on a name which was like 'Bollo Bridge Area' or something, which was rejected by the people who live there, who call it South Acton Estate, and don't want any changes to the name.” (JGE- M/60/Local Councillor)

**Facilitators:**

Parents who brought their children along said that the crèches helped them to relax and fully participate in the event, as one mother explained: “My daughter was with me that day; and to do something with an autistic child is very difficult...I realise that there was...a babysitter to take care of the children; that's very nice.” (SVE- F/44/Dietician, Homemaker and Carer)

Another mother said that the cafés were very engaging and interesting for both adults and children:

“My daughter came with me as well. She really enjoyed it. She was seven at the time, she's eight now. She just liked being in that environment, sitting there and talking. She actually came and spoke as well for a bit...” (LWB- F/31/Student and Mother of three children)

**Barriers:**

there were suggestions that the external agencies were coming into the community to take over things that they were already doing for themselves:

- “A lot of things are already happening and we have groups... facilitating these. We don’t need an external group coming in to duplicate things already happening. Rather, we need support for the local groups to continue doing what they are doing.”

“Most people resent the concept of Well London and similar projects, as an invasion of their privacy...they call it around here, 'the broccoli police'. It is regarded as an invasion of people's privacy; government directing them how they are going to eat, how they are going to have their entertainment. It might go down well with the middle class, but it certainly doesn't go down very well with the working class”. (JGE-M/60/Local Councillor)

“... there have been consultations held, for example, about the park. People came out in large numbers, and what happened? They (local authority) still went ahead with their plans. There needs to be open policies where people know that what they say will be taken on board and acted on.”

“...you've got a large number of people who... 'don't speak English' [and who] 'don't read English'. And that applies to people who have been educated in English schools, as well as people who've just arrived. So, giving out leaflets doesn't always encourage people...a lot of people don't speak English so they don't know what's on the leaflet anyway” (JGE-M/60/Local Councillor)

“A lot of leaflets don't get delivered; a lot of people delivering the leaflets can't get into tower blocks because they can't get through on the intercom systems.” (JGEM/60/Local Councillor)

CEP and its Impact – Local Community Organisations and Stakeholders’ Perspectives: Characteristics of Participant Organisations; Perceptions of the Well London CEP; Incentives and Challenges of CEP; Impact of Well London CEP.

CEP and its Impact – Well London Alliance Partner Organizations’ Perspectives: Characteristics of Participant Organisations; Perceptions of the Well London CEP; What was good about the CEP; What could be improved?; Lessons Learnt from the Well London CEP; Incentives for and Challenges of CEP;

“Generally... if they are well publicised, not only by leaflets but also by groups of people going round and reminding other people; and if it's a very important issue such as what is going on at the moment...they will come.” (JGE- M/60/Local Councillor)

“I would say your best bet is to just try and find out what people actually like...and advertise it over a longer period of time. Give people more notice... [be] more flexible.”

	<p>(MRB- M/27/Recycling Collector) "...the police...had a week last summer...that had much more support from the community because talking about policing issues like drugs dealing and community safety and protection from thieves and robbers; that's more appropriate. That's more a community concern than what they are going to eat." (JGE- M/60/Local Councillor)</p> <p>"...the projects... doesn't seem to be at all appropriate to an estate where there is a lot of uncertainty because the blocks are being pulled down and a lot of people are having to cope with transfers around the area or even out of the area and with possibly new people coming into the area.." (JGE- M/60/Local Councillor)</p> <p>Impact of the Well London CEP. Documentary Analysis: Opportunities of CEP; Challenges of CEP and Their Impact; Impact of CEP on the Content and Combination of the Projects Delivered in the Areas.</p>
	<p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> single researcher; findings may be applicable and relevant only to the areas and situations studied here; difficulties trying to define the boundaries of the research; study did not involve those who could not come to community events; short term impacts only; interviews after 6-9 months raises possibility of recall bias.</p> <p><b>Limitations identified by review team:</b> None</p> <p><b>Evidence gaps and/or recommendations for future research:</b> There is still a gap in literature about the barriers faced by those who do not attend community engagement events. It is essential to study the barriers faced by nonparticipants or those who disengage.</p> <p>There is a need to investigate evaluation of community events both immediately after events and over time within a reasonable follow-up period which prevents interference of a significant recall bias but which allows a certain period for people to reflect; and to examine the reasons between the differences in perception, if present.</p> <p>There is a need for further studies of the impact of community engagement on the content and delivery of health promotion activities.</p> <p>There is also a need for more robust evaluation of the medium and long-term impacts of community engagement on the communities.</p>
<p><b>Study details</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> The NEP programme aimed to empower citizens and communities, and to:</p>



<p>Authors: <b>Sender H, Khor Z, Carlisle B</b>  Year: <b>2011</b>  Citation: <b>Sender H, Khor Z, Carlisle B (2011) National Empowerment Partnership (NEP) Programme. Final Evaluation Report. London: Community Development Foundation. London: Community Development Foundation.</b>  Quality Score (++, + or -): +</p>	<p>demonstrate the difference that community empowerment can make to individuals, community groups, communities and public agencies  Develop effective methods of quality assurance for community empowerment  Promote good practice.  <b>Theoretical approach:</b> None reported  <b>Data collection</b>  <b>Method:</b> Documentary analysis of monitoring data; Focus groups, Case studies and In-depth interviews, either face to face or on the telephone, were conducted with key stakeholder representatives.  <b>By whom:</b> CDF research team  <b>Setting:</b> NEP Regions  <b>When:</b> from October 2010 to February 2011.</p>
<p><b>Source of funding:</b> Department for Communities and Local Government (DCLG)  <b>Type/style of community engagement:</b> Community mobilisation/action</p>	<p><b>Population and sample selection</b>  <b>Population from which the sample were recruited from:</b> NEP regions across England  <b>Number of participants recruited:</b>  <b>Specific inclusion/ exclusion criteria:</b> Key stakeholders of NEP programme</p>
<p><b>Level of community engagement</b>  <b>Design:</b> consulted, collaborating and leading  <b>Delivery:</b> consulted, collaborating and leading  <b>Evaluation:</b> Informed  <b>Extent of community engagement:</b> Moderate</p>	<p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b> The interviews were transcribed and analysed using the qualitative data analysis software package, Nvivo.  <b>Key themes relevant to this review:</b>  Chapter 2 considers the contribution of the work of REPs in relation to programme aims. Chapter 3 considers what has worked well and what the lessons are from the NEP programme delivery structure. Chapter 4 considers outcomes and learning in relation to a legacy for the programme, while Chapter 5 reviews programme management. The report offers conclusions and recommendations in Chapter 6.</p>
	<p><b>Notes by review team</b>  <b>Limitations identified by author:</b> Inability to contact participants who had consented to be interviewed  Inconsistency of approach across NEP regions  <b>Limitations identified by review team:</b> Method of Data collection/analysis were inadequately reported so cannot ascertain their defensibility or reliability.  The role and relationship of the researchers was not clearly described</p>

	<p>Ethical consideration was inadequately reported.</p> <p><b>Evidence gaps and/or recommendations for future research:</b></p> <p>Policy makers at local and national level should ensure that the resources, knowledge, human and relational capacity fostered through the NEP programme are not lost in the context of the end of the programme coinciding with funding cuts and policy change. There are key practice models, approaches and toolkits which have been developed through NEP programme, which lead to</p> <ul style="list-style-type: none"> <li>o fostering volunteering and social action</li> <li>o galvanising social renewal</li> <li>o encouraging youth participation</li> <li>o giving citizens more power</li> <li>o collaborative democracy.</li> </ul> <ul style="list-style-type: none"> <li>• Indeed, current government policy focus on localism and the Big Society means that the expertise accumulated through the NEP programme, and indeed other empowerment programmes such as Take Part, continues to have relevance. National and local policy makers and practitioners should make use of this rather than start to reinvent wheels.</li> <li>• As buy in from multi-sector partners at the local level is required to make empowerment work, it is necessary to continue to share evidence and work on the business case for empowerment produced through the NEP programme to support further culture change among public authorities.</li> <li>• Small amounts of resources can go a long way in communities, but sufficient time needs to be given for any future community empowerment initiatives, and they need to be underpinned by community development.</li> <li>• Empowerment work linked to increasing citizen participation and involvement, or engagement in local democratic processes, only works when it is seen as legitimate and transparent. Community-led research and planning, participatory budgeting and similar participatory approaches need to be participant-led wherever possible, rather than involving prioritisation of already shortlisted options or fails accomplis</li> </ul>
<p><b>Study details</b></p> <p>Authors: <b>Tunariu A, Boniwell I, Yusef D, Jones J</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> aim was to explore the relationship between positive mental health, a sense of competence and motivation to exercise choice and control, and adopt a healthier lifestyle. Primary research questions:</p>

<p>Year: <b>2011</b>  Citation: <b>Tunariu A, Boniwell I, Yusef D, Jones J (2011) Well London DIY Happiness Project Research Evaluation Report.</b>  Quality Score (++, + or -): <b>+</b></p> <p><b>Source of funding:</b> BIG Lottery Wellbeing fund</p> <p><b>Type/style of community engagement:</b> community mobilisation/ action.</p>	<p>Engagement and participation  Who took part? Was the DIYH project able to engage people in discussions about mental well-being?  How important, and in what ways was the £ 500 important in motivating people to come forward and participate in the project to begin with? Who came along?  <b>Theoretical approach:</b> Following a mixed method design and concepts grounded in positive psychology  <b>Data collection</b>  <b>Method:</b> one to one and focus group interviews  <b>By whom:</b> not reported  <b>Setting(s):</b> A range of boroughs  <b>When:</b> within 6 months after taking part in the project</p>
<p>Of the three Well London projects specifically designed to address the theme of mental health and well-being, DIY Happiness is the project that aims to improve individual and community health and well-being by exploring new ways to promote positive mental health from a whole population perspective by encouraging people to explore what subjective well-being and happiness means to them. The project aims to steer people away from the idea that mental health is synonymous with mental illness and begin to move people towards seeing mental health as a positive resource which can be improved and protected by making small effective changes. As a part of</p>	<p><b>Population and sample selection</b>  <b>Population from which the sample were recruited from:</b> women from a range of participating boroughs, who had taken part in the DIYH project  <b>Report how they were recruited:</b> not reported  <b>Number of participants recruited:</b> 27  <b>Specific inclusion/ exclusion criteria:</b> Not reported</p>
	<p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b> Thematic analysis  <b>Key themes relevant to this review:</b>  Being with others: establishing new, positive networks - "... with neighbours, a very serious issue and it just made me sort of be able to erm to look at it, to look at that, not in a way of forgiving the problem... to put it on a more positive level and try and get to the root of it, the problem really.",  'It's sort of given me inspiration to have a sense of community spirit",  "They wouldn't be people that I would normally see and say hello to in the street, you know...I'm always going to look at it I have something to learn from them and equally they to me. So, you know, it changed my attitudes ...";  Feeling less alienated: gaining a sense of belonging, being less isolated - "...you think that nobody else is going through and you think that erm you know feel a bit isolated and where you're sharing it within the group and you're hearing that people have got just as much</p>

this, the project's aim to enhance individual and community resilience, and so contribute to transforming the culture of engagement among the capital's residents.

**Level of community engagement**

**Design:** Collaborative

**Delivery:** Leading

**Evaluation:** informed

**Extent of community engagement:**

Moderate

problems and they're still smiling and they're still laughing and they're still.

You know, it sort of makes you put your life into more perspective and that's what it done for me.", "...I came on my own... The hole in the group was filling [by a] community spirit, I had a sense of belonging in a group",

"...meeting and mingling with the local community because a lot of those ladies I've never met before and learning about their experiences of what they, I think I've got a challenging life, what they deal with as well and I think sometimes you need to be made aware of your not on your own.";

Reaching beyond generational gaps: connectivity and community - ..."I do feel now when I see somebody on the street that's a lot older than me I wouldn't be thinking oh I've got nothing in common with them, you know, I'm always going to look at it I have something to learn from them and equally they to me. So, you know, it's changed my attitudes as well."

..."I meet, my daughter's friends, I mean there in their sort of thirties, forties, so there, to me, there never has been a generation gap";

A catalyst for gaining positive control (empowerment) - ..."What I learned here is that I can bring happiness by myself. I don't have to get it from someone, 'cause I can do it, I can create the happiness. [...] They show us how I can do it for myself. [...] And they think I can do it and, yes, eventually I will be happy and then like I said earlier if I get happiness, my kids gonna be happy."

..."Yes, to be positive and to go forward and whatever you want to achieve you can achieve it if you go forward without looking back 'cause I think the aim of it was the DIY happiness to look forward other than to look back. So that's what it has enabled me to do. To um, you know, look forward."

"... it gave me, it identified a lot of issues that I might have sort of buried deep down and I didn't really want to talk about with people I knew and it sort of gave me an opportunity to open up more."

..."I've signed up with crisis which is a charity for to do some voluntary work as well because I felt that you know I had to also give something back to my community as well.'

Doing new activities: doing things you would not do in everyday life - ..."You know don't be afraid to try things, new things and come out of your comfort zone and just go for it 'cause there's only one life we have and make the most of it."

..."I've gone away and done research and I'm actually doing a presentation at my daughter's school in a couple of weeks about this so it's just, you know, just really opened up a lot things, I've been provided with so much information, I've sort of taken it on board and I'm sharing it with other people.";

“Be the change you want to see”: increased self-determination and resilience capacity - ...”Turning my own negative into thoughts into positive thoughts and my negative thoughts because I’ve not been very well.”

...”The awareness from here made me look at erm not only myself but how I can help other people around me as I said and also made me a lot more aware of things, little things that I can do regarding my help to [inaud] a better planet. You know those sort of things.”

...”I think if you have got a family member who has got an illness and you’re their 24/7 carer, you know, life at times you can think to yourself I just gonna bash my head up against the wall, but now I know I don’t need to get myself so stressed out over situations that I have got no control of really.”;

Spreading the DYIH learning to others - ... “The five ways, he [now] has that basically [from me]. It’s like his Bible, he has that there and he refers to it on a sort of daily, bi-daily basis.”

...”I would say I’ve been on a brilliant course. [it] basically helped me to face all the challenges in my daily life, I’d try and relate it to them personally, I think it would help me cope... or I think it would help you improve”

... “I would describe it as self-healing”; Happiness in relation to self and to others - ...”It was coming here that made me think happier thoughts and how to change myself and I think also, I don’t know, it was just nice, really nice.”

...” the happiness has got to come from me. Happiness has got to come from within.”

... “I think it was the flower arranging [activity]. And I took it over and showed him. He said: I tell you what girl since you’ve been going down there you haven’t sworn at me once when you come in [she laughs].’

... “So it’s good [you later find out how deeply] it’s affected you, it’s affected your relationships with others, your husband. Absolutely positive. Brilliant!” Can money buy you happiness? - ... “Not necessarily, but it’s not helpful when you don’t have it.”

...”Not necessarily, but the challenge is finding a positive way around the pressure to have money.”

... “Not necessarily. Happiness is not always not what you’ve got, you know, materialistically, it can also be, you could have everything you want in the world but in here you’re not happy [points to chest], so it’s, you know, it’s a mixture of each. As long as you are comfortable with what you’ve got, you can still fell happy inside.”

#### **Notes by review team**

**Limitations identified by author:** not reported

**Limitations identified by review team:** Methods of analysis not reported; role of researcher and context not

	<p>clearly described</p> <p><b>Evidence gaps and/or recommendations for future research:</b> Questions needing further answers (and follow up data collection) include those related to (a) Connecting to other and building social capital – e.g., as a result of the programme did people stay in touch? Did their social networks increase? ; (b) Mental well-being – e.g.; Was there a change in people levels of mental well-being MWB 1 year later? Did the values exhibited during the investment decision-making process predict participants’ well-being 1 year later?; and (c) Economic evaluation – e.g., How cost effective is the programme compared to other mental health promotion interventions?.</p>
<p><b>Study details</b></p> <p>Authors: <b>White J ; Kinsella K ; South J</b>  Year: 2012  Citation: <b>White J, Kinsella K, South J (2012) Kirklees Health Trainer Service Evaluation. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University.</b> Quality Score (++, + or -): +</p> <p><b>Source of funding:</b> Yorkshire and Humber Health Trainer Hub  <b>Type of community engagement:</b> Community mobilisation/action - Empowerment model. In this study Health trainers served as a bridge between health professionals and community members suffering from long term conditions. They mainly participated in delivering the service</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b></p> <p>The evaluation set out to explore the following questions:</p> <ul style="list-style-type: none"> <li>• Have health trainers been successful in supporting clients to make the healthy lifestyle changes of their choice?</li> <li>• Have health trainers been successful in supporting clients to better manage their long term condition?</li> <li>• Have clients’ levels of confidence and self-efficacy improved with the support of a health trainer?</li> <li>• Do health trainers enable clients to access other services/activities which help them to make and sustain changes which benefit their health?</li> <li>• Are referral systems between health trainers and other services within Gateway to Care and beyond working well?</li> <li>• How do clients view the service?</li> <li>• Is there anything distinctive about health trainers and the way they work which enables them to successfully support clients?</li> <li>• What factors have been important to determining any achievements and ongoing challenges of the Kirklees Health Trainer Service?</li> <li>• What part has the move to the local authority played in all the above?</li> <li>• What is the future potential of the Kirklees Health Trainer Service, particularly in relation to partnership working with the Calderdale and Huddersfield Foundation Trust around co creating health; engaging volunteers as part of the service; linking in more with the work of the community care teams in localities and developing the staff well-being agenda?</li> </ul>

<p>while collaborating with other agencies to fulfil their roles.</p> <p><b>Level of community engagement:</b> Health champions led in the delivery of health improvement and collaborated with other agencies to improve the service. They were involved in the evaluation by collecting case stories and monitoring data.</p> <p><b>Design:</b> Collaborated</p> <p><b>Delivery:</b> Leading</p> <p><b>Evaluation:</b> Informed</p>	<ul style="list-style-type: none"> <li>• Do health trainers in Kirklees provide good value for money?</li> </ul> <p><b>Theoretical approach:</b> None stated</p> <p><b>Data collection</b></p> <p><b>Method:</b> Interviews with key informants (eight conducted by telephone – two GPs, two senior managers within the Council, one NHS commissioner, and 3 managers in partner organisations) A focus group with health trainers (six took part) Case stories collected by health trainers (six in total) Client telephone interviews (15 in total – nine women and six men).</p> <p><b>By whom:</b> The Evaluation team</p> <p><b>Setting(s):</b> Kirklees district</p> <p><b>When:</b> April 2011 – March 2012</p>
<p><b>Extent of community engagement:</b> Moderate</p>	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Health Trainers</p> <p><b>Report how they were recruited:</b></p> <p><b>Number of participants recruited:</b> see data collection above</p> <p><b>Specific inclusion/ exclusion criteria:</b> None specified</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Not reported</p> <p><b>Key themes relevant to this review:</b> Themes from Finding are:</p> <ol style="list-style-type: none"> <li>1. Who are the people using the Health Trainer Service?</li> <li>2. What are clients doing differently with the support of a health trainer?       <ol style="list-style-type: none"> <li>a. Accessing services and getting practical help</li> <li>b. Gaining confidence and better managing their long term conditions</li> <li>c. Reducing isolation and improving mental health</li> <li>d. Making progress on goals</li> </ol> </li> <li>3. Is there something distinctive about how health trainers work?       <ol style="list-style-type: none"> <li>a. Client centredness: ‘the personal approach.’</li> <li>b. Having time: ‘She spent time and she listened.’</li> </ol> </li> </ol>



- c. Being empathetic and friendly ‘She was like a breath of fresh air, I looked forward to her coming.’
  - d. Taking a stepped approach to behaviour change: ‘We devised a plan’
  - e. Local knowledge and acting as a ‘bridge’ to local services: I wouldn’t have known which direction to go in.’
  - f. Building confidence and motivation: ‘ I’d lost myself’
  - g. Positive mental health: ‘It’s not all about my illness.’
  - 4. What do clients think about the service?
  - 5. Organisational factors contributing to success
  - 6. Recommendations for the future
  - 7. Raising the profile of the service and embedding in the mainstream
  - 8. Extending the reach of the service
  - 9. Health trainer and client involvement
  - 10. Involving volunteers
  - 11. Data collection
  - 12. Health trainer and client involvement
- Case stories by the Health trainers were reported in Boxes under the following themes
- Box 1. A health trainer describes how she supported a client to gain confidence, independence and mobility.
  - Box 2. A health trainer describes how she has supported a carer
  - Box 3. Supporting a client to regain his life and confidence post stroke
  - Box 4. A client loses weight and takes part in a coast to coast bike ride
  - Box 5. Progressing towards getting back to work

**Notes by review team**

**Limitations identified by author:** Of 27 clients approached, three were wrong numbers and the rest either did not want to take part or it was not possible to get hold of them despite numerous attempts. Not able to interview as many GPs as planned

**Limitations identified by review team:** Evaluation team reports that Kirklees council agreed that ethical approval was not required

Inadequate reporting of data collection method. Eg how it was stored or transcribed the relationship between researcher and subjects was not considered process of data analysis was not reported. This study was mainly about the health trainers service and barriers and enablers the HTs encountered in delivering the service to the wider community. Although it presents a few barriers and facilitators that might have hindered

	<p>or helped with engaging HTs (p.25), the views of the HTs on Barriers and Enablers were not reported.</p> <p><b>Evidence gaps and/or recommendations for future research:</b> Service managers recognised that there is a need to ‘raise our profile across Kirklees’, (and) that some professionals ‘aren’t really sure of what the health trainer is and the value of the health trainer and therefore won’t make referrals into the service.....’ K18 The service needs to continue to raise its profile but it is important to recognize that some key informants noted a reluctance to refer amongst some health professionals. This may in part reflect a lack of commitment to self-care and behaviour change and possibly a lack of trust between some agencies, rather than lack of awareness of the service. These sort of attitudes can take a long time to shift but would be helped by the service being more embedded in the mainstream, for example through being built into care pathways for people with long term conditions. Being able to clearly evidence achievements is also critical to making the case for expansion and mainstreaming.</p>
<p><b>Study details</b></p> <p>Authors: <b>White J, South J, Woodall J, Kinsella K.</b></p> <p>Year: <b>2010</b></p> <p>Citation: <b>White J, South J, Woodall, J Kinsella K; (2010) Altogether Better Programme: Phase 1. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University.</b></p> <p>Quality Score (++, + or -): <b>++</b></p> <p><b>Source of funding:</b> BIG Lottery</p> <p><b>Type/style of community engagement:</b> Community mobilisation/action community development/empowerment model (1) building confidence, (2) building</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> The overarching aim of the thematic evaluation is to understand how the Altogether Better projects are contributing to health improvement in communities and to provide robust evidence to inform the development of practice. The specific objectives of the evaluation are to: Increase understanding of how the Altogether Better empowerment model is translated into practical approaches in community settings; Develop understanding of the community health champion role, linking to the existing evidence base; Explore the ways in which Altogether Better projects empower different target communities; Gather local evidence on the impact of empowerment approaches at individual and project level</p> <p><b>Theoretical approach:</b> Not specified</p> <p><b>Data collection Method:</b> 1. Interviews conducted with different stakeholder groups including: project leads, key partners from community and statutory sectors and community workers. 2. Participatory workshops to gather the views of champions.</p> <p><b>By whom:</b> Evaluation team</p> <p><b>Setting(s):</b> Yorkshire and Humber region (The regional programme is made up of a learning network and sixteen community and workplace projects)</p> <p><b>When:</b> Between March 2010 and May 2010</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Health Champions (drawn from lay people living</p>

<p>knowledge, capacity and skills and (3) system challenge.</p> <p><b>Level of community engagement:</b> Moderate - leading in delivery and collaborating in the evaluation</p> <p><b>Design:</b> Collaborated</p> <p><b>Delivery:</b> Leading</p> <p><b>Evaluation:</b> Informed</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p>across Yorkshire and Humber region) Report how they were recruited:</p> <p><b>Report how they were recruited:</b></p> <p><b>Interviews with project staff and partners</b> Initially, project leads in each of the six projects were contacted by the evaluation team and invited to participate in the evaluation. In the majority of cases, interviews were conducted face-to-face, at the convenience of the participants, using a semi-structured interview schedule designed to address the aims and objectives of the evaluation (see Appendix 2). At the end of the interview, project leads were invited to suggest other key individuals who would be able to contribute to the evaluation. Individuals were then sampled from this list based on how their background and role could contribute to meeting the evaluation's objectives. Subsequently, individuals who understood the role of champions and were familiar with how empowerment approaches work on the ground were chosen. In addition to project staff, the following partners were interviewed: Individuals involved in delivering training to champions Individuals from voluntary organisations that „host“ champions. Training and support officers, Health trainers, Community development workers.</p> <p><b>Workshops with champions</b> In terms of gaining the views of champions, two workshops were organised – one in Leeds in March 2010 and one in Hull in April 2010. Recruitment for the workshops focused on five Altogether Better projects, these projects were selected because their models for delivering empowerment approaches varied and the differing experiences of the champions would illuminate the role further. Project leads in the five projects were invited to publicise the workshops to their champions. In total, thirty champions, varying in terms of age, gender, ethnicity and disability, took part.</p> <p><b>Number of participants recruited:</b> Twenty-nine project staff and partners and 30 health champions =59 participants.</p> <p><b>Specific inclusion/ exclusion criteria:</b> those working directly within projects and in partnership and health champions</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> The analysis was conducted over a number of stages. After all data (interview and workshop recordings) had been transcribed verbatim, members of the evaluation team read and familiarised themselves with the content of the transcripts. Based on this, a coding framework was developed. This framework was derived from thematic areas of interest within the data itself. The coding</p>

framework was refined and agreed amongst the evaluation team and applied to the original transcripts to extract major themes.

**Key themes relevant to this review:** Findings were organised in 2 broad thematic heading as follows: Findings from project staff and partners Qualities required to be a champion, Motivation, Recruitment of health champions, Training and development of champions, Activities delivered by champions, Supporting champions, Outcomes and impact, Personal progression, Sustainability Findings from Community Health Champions Understanding and reaching out to communities, Motivation, Outcome for champions, The champion role, Qualities and skills, Training and Support, Outcome for individuals and communities, Sustainability and the future for community health champions

**Notes by review team**

**Limitations identified by author:** Limitations of time have meant it was not possible to hear directly from any beneficiaries, or from champions in all the projects focussed on.

**Limitations identified by review team:** The role of the researcher was not clearly described

**Evidence gaps and/or recommendations for future research:**

P 40-41 Programme evaluation highlighted difficulties in evidencing behaviour change at project/programme level. Champions did not use the term but they were recognising the value of social capital (i.e. social networks, group activities, linking people into services) to people’s health. Project staff/partners recognised that champions were promoting social cohesiveness and helping to integrate people into their community. The impact of champions on communities and social networks was identified as a research gap in the evidence review around the champion role; this evaluation would suggest that champions are making a significant contribution to form and strengthen social networks which in turn benefit health, and that this can be one of the most important aspects of their role.

P 49 Evaluation and monitoring tools need to be more sensitive to capture the wider benefits of projects. Projects should be encouraged to demonstrate not only how they have achieved targets around physical activity, healthy eating and mental health & well-being, but to also show evidence where champions have signposted individuals into other support services (e.g. GPs, leisure services, smoking cessation).

Furthermore, developing tools that capture the added value of projects, in terms of increasing levels of social capital and cohesiveness within communities and showing the „transformative“ nature of projects on individuals (in terms of progression to education, employment, training), should also be prioritised.

<p><b>Study details</b></p> <p>Authors: <b>White J, Woodward J</b>  Year: <b>2013</b>  Citation: <b>White J, Woodward J (2013) Community Health Champions in Lincolnshire. . Leeds: Health Together, Leeds Metropolitan University.</b>  Quality Score (++ , + or -): <b>+</b></p> <p><b>Source of funding:</b> Public Health; Lincolnshire  <b>Type/style of community engagement:</b> community mobilisation; peer involvement; non-peer health advocacy; volunteers  <b>Level of community engagement</b>  <b>Design:</b> Consulted, Leading, collaborating  <b>Delivery:</b> Leading  <b>Evaluation:</b> Informed  <b>Extent of community engagement:</b> Moderate</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b></p> <p>Consult with managers and volunteers in existing ‘health champion’ style schemes across Lincolnshire in order to establish what is working well and why and any potential for the future</p> <ol style="list-style-type: none"> <li>2. Assess the data collected against the existing evidence base for Community Health Champions nationally</li> <li>3. Make proposals for the commissioning of “Community Health Champion” schemes based on what is working well now and could be adapted to suit the needs of different groups and areas in Lincolnshire</li> <li>4. Identify potential areas in which future “Community Health Champions” schemes could have an impact</li> </ol> <p><b>Theoretical approach:</b> None reported</p> <p><b>Data collection</b></p> <p><b>Method:</b> Telephone interviews with service managers and focus groups with volunteers and managers  <b>By whom:</b> DevelopmentPlus, Health Together and the University of Lincoln.  <b>Setting(s):</b> Lincolnshire  <b>When:</b> November 2012.</p>
	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Health Champions and their managers in Lincolnshire</p> <p><b>Number of participants recruited:</b>  11 interviewee with Key people and four focus groups (one with managers and three with volunteers)</p> <p><b>Specific inclusion/ exclusion criteria:</b> Not reported</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Data analysis was undertaken using a thematic approach. Focus group transcriptions were read thoroughly and common themes identified. Any differences between managers and volunteer were noted. Key findings from the telephone interviews were collated into tables for comparison.</p> <p><b>Key themes relevant to this review:</b>  Results of the focus groups are organised according to the main themes to emerge:  Motivation; infrastructure support; Issues and barriers; potential role for volunteers in the area.</p>
	<p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> Not reported</p>

	<p><b>Limitations identified by review team:</b> Role of researcher unclear, details of analysis inadequately reported although there is evidence findings that show negative instances/cases/exceptions were reported</p> <p><b>Evidence gaps and/or recommendations for future research:</b></p> <p>There should be appropriate support given to all those volunteering in health programmes, which includes being allocated to a role appropriate to their skills, and provided with sufficient training and support to undertake that role safely and effectively.</p> <p>6. Organisations delivering health programmes need sufficient funding, ideally for at least three years, in order to retain and employ paid staff to manage volunteer programmes and establish the infrastructure needed to support them. Those co-ordinating volunteers need to have adequate training for the role, in order to manage risk and maximise the potential benefits of volunteer programmes.</p> <p>7. Consideration should be given to providing the infrastructure to recruit, train and allocate volunteers to roles collectively across a number of organisations, in order to make economies of scale. However, volunteers are generally motivated to work with a particular organisation, and each programme has its own training needs, so care needs to be taken in determining what can realistically be provided generically. Organisations need to recognise an individual's unique motivations for volunteering and be flexible, where possible, in offering a role that fulfils these</p>
<p><b>Study details</b></p> <p>Authors: <b>Williamson T, Prashar A, Hulme C, Warne A</b></p> <p>Year: <b>2009</b></p> <p>Citation: <b>Williamson T, Prashar A, Hulme C, Warne A (2009) Evaluation of Rochdale Partnerships for Older People Project (POPP): Building Healthy Communities for Older People. Salford: University of Salford/ University of Leeds.</b></p> <p>Quality Score (++, + or -): <b>+</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> Evaluate the impact and effectiveness of initiatives Examine the structure and governance of the project Illuminate the key systems and processes at work within the project</p> <p><b>Theoretical approach:</b> Tinetti POAM tests</p> <p><b>Data collection</b></p> <p><b>Method:</b> The research study used a mixed method approach. The methods included interrogation of the POPP database, interviews with staff, service users, commissioners and other key stakeholders and observations of various activities, such as key meetings. Interviews followed a semi structured interview schedule and all were tape recorded and transcribed verbatim. At the first class (an introductory session), the Tai Chi evaluation process was explained to the group, and information sheets were provided in order to concur with approved ethical protocols. Written consent from all participants was obtained prior to carrying out the interviews. The digitally recorded interviews were transcribed and analysed thematically.</p> <p><b>By whom:</b> POPP outreach workers</p>

<p><b>Source of funding:</b> The Department of Health</p> <p><b>Type/style of community engagement:</b> Community partnerships/coalitions</p> <p><b>Level of community engagement</b></p> <p><b>Design:</b> mixture of collaborating, consulted</p> <p><b>Delivery:</b> mixture of collaborating, consulted</p> <p><b>Evaluation:</b> Nil</p> <p><b>Extent of community engagement:</b> Moderate</p>	<p><b>Setting(s):</b> Rochdale</p> <p><b>When:</b> May 2007-March 2009</p>
	<p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Older people involved in Rochdale POPP</p> <p><b>Number of participants recruited:</b> 2500</p> <p><b>Specific inclusion/ exclusion criteria:</b> Older people within POPP</p>
	<p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> The qualitative analysis uses a thematic approach.</p> <p><b>Key themes relevant to this review:</b></p> <p>Project Background and Aims,  Overview of Rochdale PoPP  POPP members  Overview of Partnership Organisations  Devolved Decision-making:  TOPPs Commissioning  Tai Chi Case Study: Costs and Effectiveness  Challenges and Opportunities;  Costs and Effectiveness: Volunteer Driver Scheme  The Next Step  Summary and Conclusions</p>
	<p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> It should be noted that the study is limited by small sample numbers, the lack of a control group and a relatively short follow up period. It is not possible to say whether any changes are due to time rather than the Tai Chi class; or whether changes are sustained over a longer time period. Given these limitations, together with the heterogeneity of the physical ailments of the sample, the analysis points to potential benefits but further research is required.</p> <p><b>Limitations identified by review team:</b> Method of Data collection/analysis were inadequately reported so cannot ascertain their defensibility or reliability.</p>



	<p>The role and relationship of the researchers was not clearly described Ethical consideration was inadequately reported.</p> <p><b>Evidence gaps and/or recommendations for future research:</b> Whilst too early in the POPP for participants to identify much redesign of service or delivery, POPP transport was highly praised as being innovative and effective at meeting many older people's needs. Transport initiatives were also instrumental in supporting POPP work to reduce social exclusion and isolation. It was acknowledged by participants that much work needed to be done to further reach these groups and especially BME groups to reflect the diversity of the Rochdale Borough population.</p>
<p><b>Study details</b></p> <p>Authors: <b>Windle K., Wagland R., D'Amico F., Janssen D., Forder J., Wistow G.</b> Year: <b>2009</b> Citation: <b>Windle K., Wagland R., D'Amico F., Janssen D., Forder J., Wistow G., (2009)</b> National Evaluation of Partnerships for Older People Projects: Personal Social Services Research Unit, University of Kent: Final Report <i>to Department of Health, London</i> Quality Score (++, + or -): <b>++</b></p> <p><b>Source of funding:</b> Department of Health</p> <p><b>Type/style of community engagement:</b> Community partnerships/coalitions - The Partnership for Older People</p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b> •What were the opportunities and challenges to the implementation of the POPP programme? • Did the POPP programme change partnership working and practices within the pilot sites? • What was the level of older people's involvement in their local POPP programme?</p> <p><b>Theoretical approach:</b></p> <p><b>Data collection</b></p> <p><b>Method:</b> 1. 12 Focus groups with project staff &amp; volunteers (Separate ones conducted for the 2 groups); 24 Semi-structured telephone interview with Project Manager, Project Lead, Older Person's Lead (Officer) and an older person (either champion or representative); semi-structured interviews 30 POPP users and 30 with non-users; exit interviews with 39 senior members of the statutory or health authority 2. Documentary analysis of These included the second stage applications for POPP funding; Project Initiation Documents (PIDs), minutes from POPP steering groups, advisory groups and project teams; documents relating to older people's involvement within the POPP programme; Local Area Agreements and local older people strategy documents, including mental health.</p> <p><b>By whom:</b> National evaluation team</p> <p><b>Setting(s):</b> 29 pilot site across UK</p> <p><b>When:</b> May 2006 through March 2009</p> <p><b>Population and sample selection</b></p> <p><b>Population from which the sample were recruited from:</b> Older People</p> <p><b>Report how they were recruited:</b> From 29 pilot sites</p>

<p>Projects (POPP) were funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being and independence and preventing or delaying their need for higher intensity or institutional care. The evaluation team recorded broad range of organisations acting as partners to the POPP programmes. Table 6: 522 organisations across 29 (Local authorities) pilot sites, an average of 18 ‘partner’ organisations per site. The range of partners would seem to incorporate all types of organisations, with the weight of partnership being with voluntary organisations: two thirds (66%) or 347 separate organisations.</p> <p><b>Level of community engagement:</b> Older people and other members of the partnerships were involved in each of the different stages of the programme : in design, delivery and evaluation</p> <p><b>Design:</b> consulted, collaborating and Leading</p> <p><b>Delivery:</b> consulted, collaborating and Leading</p> <p><b>Evaluation:</b> consulted, collaborating and Leading</p>	<p><b>Number of participants recruited:</b> See above</p> <p><b>Specific inclusion/ exclusion criteria:</b> Not specified</p> <p><b>Outcomes, methods of analysis and results</b></p> <p><b>Method and process of analysis:</b> Each form of data collection was tape recorded, transcribed verbatim, and thematically analysed (Huberman &amp; Miles 1998) using the qualitative analysis package, NUDIST. A content analysis of the documents listed above (data collection) was then undertaken and key areas coded. For example, the involvement of older people was coded into five areas</p> <p><b>Key themes relevant to this review:</b> The Findings Summarised In The Executive Summary The main themes of the findings as summarised in the executive summary are as follows: The projects, Service users, Outcomes, Impact on older people, Impact on joint working, Expenditure and savings, Key learning points, Sustainability, Implications for Policy and Practice, Achieving desired outcomes, Improving processes and management arrangements Findings Summarised In The Discussion The national policy context, The POPP programme, The National Evaluation of POPP, National Evaluation response, Challenges to the evaluation structure and methods, Key research questions, Process issues, Barriers/facilitators to implementation, Changes to partnership working, Involvement of older people, Outcome issues, Improving quality of life – for whom? Overarching cost-effectiveness Sustainability, Recommendations for policy and practice, Lessons from the study for future policy research, Achieving desired outcomes, Improving processes and management arrangements</p> <p><b>Notes by review team</b></p> <p><b>Limitations identified by author:</b> The initiative had very ambitious aims with very limited time frame to achieve them The evaluation teams started work after the initiative was already underway</p> <p><b>Limitations identified by review team:</b> The relationship between the researcher and the participants was unclear</p> <p><b>Evidence gaps and/or recommendations for future research:</b> Improving processes and management arrangements Complex new programmes are inherently challenging to get off the ground, especially where they involve a</p>
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<p><b>Extent of community engagement:</b> High</p>	<p>range of agencies. Because it can be difficult to anticipate the particular problems likely to arise, time and resources for the implementation period should be built in from the start. It needs to be recognized – by both commissioners and programme managers alike—that recruitment, training and staff preparation are likely to take at least six months, and local project managers should be in place to ensure appropriate implementation. It should be expected that both project structures and processes will, quite rightly, evolve over time. Such changes will need to be mirrored by changes in project targets and monitoring tools. Good staff supervision should be ensured to support staff through such changes. Multi-disciplinary projects benefit from locating staff from Different agencies and professions in one place, rather than seeking to develop a ‘virtual’ team, as well as from single line management. Co-located teams enable people to work more effectively together and achieve better outcomes, although they do not function without difficulties. Where large programmes involve tendering for projects attention, should be given to the development of flexible commissioning processes appropriate to the scale of the exercise. Tendering must be arranged to ensure an equitable process, particularly where small voluntary organisations are involved. Support and assistance with capacity - building should be available early on, together with clear information concerning requirements for monitoring and targets. Where there is to be a programme evaluation, project leads should work with all stakeholders (providers, commissioners, programme clients) to think through their desired outcomes from the programme, rather than simple outputs. These outcomes should be used to develop a framework for evaluation, prior to commissioning external evaluators. Monitoring and measurement should then be embedded in any project- recording systems prior to the start of any project. Base-line measurements must be established early on. Involving consumers effectively in the design and direction of programmes is known to be difficult and may be particularly problematic in the case of older people. Time and resources to assist this process must be built into the implementation programme, including provision for appropriate training and the establishment of systems for such practical issues as payment arrangements and transport. There also needs to be a balance of understanding between the necessary ‘safe-guarding’ procedures (through Criminal Records Bureau checks) and the level of support older people are providing. Management of risk may need to be undertaken and underwritten across the authority if the contribution of volunteers and representatives is to be optimised.</p>
<p><b>Study details</b></p> <p>Authors: <b>Woodall, J White, J South, J</b></p>	<p><b>Research parameters</b></p> <p><b>Research questions/aims:</b></p> <p>To examine the role of lay workers (community health champions) involved in Altogether Better community</p>

<p>Year: <b>2012</b>  Citation: <b>Woodall J, White J, South J (2013) Improving health and well-being through community health champions: a thematic evaluation of a programme in Yorkshire and Humber. Perspectives in Public Health. 133(2): 96-103.</b>  Quality Score (++, + or -): ++</p>	<p>projects across Yorkshire &amp; Humber. Asks what are the key features of the community health champion approach, and what evidence this provides about the impact on health of this kind of intervention.  <b>Theoretical approach:</b> Not specified  <b>Data collection</b>  <b>Method:</b> Selection of projects to be evaluated, with a qualitative approach used in the evaluation. Interviews carried out with project leads, key partners, and community workers. Two workshops with groups of health champions also carried out.  <b>By whom:</b> The authors  <b>Setting(s):</b>  <b>When:</b> None reported</p>
<p><b>Source of funding:</b>  Altogether Better  <b>Type/style of community engagement:</b>  Type 3: Peer involvement  <b>Level of community engagement</b>  <b>Design:</b> Collaborated  <b>Delivery:</b> Collaborated  <b>Evaluation:</b> Consulted</p>	<p><b>Population and sample selection</b>  <b>Population from which the sample were recruited from:</b> Yorkshire and Humber  <b>Report how they were recruited:</b>  Via health agencies, e.g. NHS, and schemes run by Altogether Better in Yorkshire and Humber  <b>Number of participants recruited:</b> 59  <b>Specific inclusion/ exclusion criteria:</b>  Projects that allowed the evaluation team to explore fully the champion role and how it works as a mechanism for empowerment were included.</p>
<p><b>Extent of community engagement:</b>  Moderate</p>	<p><b>Outcomes, methods of analysis and results</b>  <b>Method and process of analysis:</b>  Results were arranged according to themes that arose in the data collection.  <b>Key themes relevant to this review:</b>  The community health champion role  Qualities required to be a champion  The process needed to support champions  Health and social benefits for community health champions  The impact of champions on communities  Altogether Better's empowerment model in progress</p>
	<p><b>Notes by review team</b></p>

	<p><b>Limitations identified by author:</b> None reported</p> <p><b>Limitations identified by review team:</b> Not reported</p> <p><b>Evidence gaps and/or recommendations for future research:</b> 'More research is needed into understanding the processes that maximise the potential of community health champions, and into capturing the full impact of their activities.'</p>
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