Public Health England

NHS England

Protecting and improving the nation's health

A guide to community-centred approaches for health and wellbeing

Full report

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Foreword

There is extensive evidence that connected and empowered communities are healthy communities. Communities that are involved in decision-making about their area and the services within it, that are well networked and supportive and where neighbours look out for each other, all have a positive impact on people's health and wellbeing. Three million volunteers already make a critical contribution to the provision of health and social care in England. This is a huge asset to our nation's health.

The NHS Five Year Forward View sets out how our health services need to change and argues for a new relationship with patients and communities. PHE's strategy, From Evidence into Action, calls for place-based approaches that develop local solutions, drawing on all the assets and resources of an area; integrating public services and also building resilience of communities in order to improve health and wellbeing for all and to reduce health inequalities.

As part of our joint commitment to community approaches and harnessing this renewable energy, NHSE and PHE have together set out what works. Through this guide we outline a 'family of approaches' for evidence-based community-centred approaches to health and wellbeing.

Our challenge is to create the conditions for community assets to thrive, to remove any barriers and for our services to work alongside communities in ways that are empowering, engaging and meaningful.

This guide demonstrates the diversity and richness of community-centred approaches and the need to take not just one approach. We hope it will stimulate partnership working and, above all, put communities at the heart of what we do.

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Executive summary

Background

Local government and the NHS have important roles in building confident and connected communities as part of efforts to improve health and reduce inequalities. The project ‘Working with communities – empowerment evidence and learning’ was initiated jointly by PHE and NHS England to draw together and disseminate research and learning on community-centred approaches for health and wellbeing. This report presents the work undertaken in phase 1 of the project and provides a guide to the case for change, the key concepts, the varieties of approach that have been tried and tested and sources of evidence.

Why work with communities?

Communities, both place-based and where people share a common identity or affinity, have a vital contribution to make to health and wellbeing. Community life, social connections and having a voice in local decisions are all factors that underpin good health, however inequalities persist and too many people experience the effects of social exclusion or lack social support. Participatory approaches directly address the marginalisation and powerlessness caused by entrenched health inequalities.

Communities as building blocks for health

The assets within communities, such as the skills and knowledge, social networks and community organisations, are building blocks for good health. Many people in England already contribute to community life through volunteering. Participation is also about representation, community leadership and activism. There are important roles for NHS, local government and their partners in fostering community resilience and enabling individuals and communities to take more control over their health and lives.

A family of approaches that work for health and wellbeing

Community-centred approaches are not just community-based, they are about mobilising assets within communities, promoting equity and increasing people’s control over their health and lives. A new family of community-centred approaches represents some of the available options that can be used to improve health and wellbeing, grouped around four different strands:

- strengthening communities – where approaches involve building on community capacities to take action together on health and the social determinants of health
- volunteer and peer roles – where approaches focus on enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- collaborations and partnerships – where approaches involve communities and local services working together at any stage of planning cycle, from identifying needs through to implementation and evaluation
- access to community resources – where approaches connect people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation

Health outcomes and evidence

National Institute for Health and Care Excellence (NICE) guidance endorses community engagement as a strategy for health improvement. There is a substantial body of evidence on community participation and empowerment and on the health benefits of volunteering. The current evidence base does not fully reflect the rich diversity of community practice in England. Cost-effectiveness evidence is still limited; nevertheless research indicates that community capacity building and volunteering bring a positive return on investment.

Conclusion

There is a compelling case for a shift to more person and community centred ways of working in public health and healthcare. A new family of community-centred approaches maps the range of options to achieve this shift. PHE and NHS England will continue to make evidence and learning on community engagement and development more accessible as part of efforts to mainstream good practice.

Implications for local leaders, commissioners and service providers:

- consider how community-centred approaches that build on individual and community assets can become an essential part of local health plans
- recognise the scope for action as there are a diverse range of approaches that can be used to improve physical and mental health
- use the family of community-centred approaches as a tool to consider potential options for commissioning health improvement and preventive services
- involve those at risk of social exclusion in designing and delivering solutions that address inequalities in health
- celebrate, support and develop volunteering as the bedrock of community action
- apply existing evidence to the local context, but be prepared to evaluate

Introduction

The move to a new health system, including the transfer of public health to local government, has created opportunities for public health and healthcare to become more person and community centred, enabling individuals to realise their potential and to contribute to building healthier, more resilient communities.[1, 2] The shifts in commissioning and practice that are starting to occur towards a 'whole-of-society' approach to health need to be supported by a clear narrative setting out the case for working with communities, combined with good access to evidence and practical information. In England, a wealth of research and established models already exists, but that knowledge has not been brought together anywhere. The invaluable contributions and experiences of citizens actively involved in their own communities are rarely considered as part of the evidence base.

The project 'Working with communities – empowerment, evidence and learning', beginning in 2014, aims to draw together and disseminate evidence and learning on community-centred approaches to health and wellbeing. This report, which presents the work undertaken in phase 1, sets out a conceptual framework for working with communities, and summarises the different types of interventions available as well as signposting key research. Overall, the report is a guide for commissioning and practice that can be used to support delivery on the NHS Five Year Forward View[3] and PHE's seven priorities for prevention.[4] The report is set out as follows:

- the rationale for working with communities
- how community life is a major determinant of health and key concepts
- the family of community-centred approaches
- an overview of the evidence base, outcomes and economic issues
- conclusions and implications for local leaders and commissioners.

What does 'community' mean?

'Community' as a term is used as shorthand for the relationships, bonds, identities and interests that join people together or give them a shared stake in a place, service, culture or activity.[5] Distinctions are often made between communities of place/geography and communities of interest or identity, as strategies for engaging people may vary accordingly.[6] Nevertheless, communities are dynamic and complex, people's identities and allegiances may shift over time and in different social circumstances. Unless otherwise stated, this report uses the NICE definition of community as an umbrella term, to cover groups of people sharing a common characteristic or affinity, such as living in a neighbourhood, or being in a specific population group, or sharing a common faith or set of experiences.[7]

Why work with communities?

In the 21st century our health system must evolve and respond to the many demands and challenges it faces. At the same time, it must stay rooted to the values, such as equity and solidarity that have shaped and sustained it. Communities are part of that health system and have a vital contribution to make to improving health and wellbeing, along with individual-level approaches to health and care.

Community (or citizen) participation, that is the active involvement of people in 'formal or informal activities, programmes and/or discussions to bring about a planned change or improvements in community life, services and/or resources',[8] has long been a central tenet of public health and health promotion.[9] The justifications for engaging communities are well versed. A World Health Organization (WHO) Europe publication on community participation in local health and sustainable development [10:12-13] summarises the rationale to:

- increase democracy, as participation is both a basic right and an essential element of citizenship
- combat social exclusion by giving people a voice, especially marginalised populations
- empower individuals and communities and enable them to gain more control over their lives
- mobilise community resources and energy
- develop holistic approaches
- aid decision-making and design more effective services through better local intelligence
- ensure community ownership and ultimately the long-term sustainability of programmes

More recently, the idea of a 'whole-of-society' approach to achieving health goals has emerged. It is based on the idea that civil society has a vital contribution to make to an interconnected health system.[11] Health equity remains a prime concern, with calls for ending exclusionary processes that leave some groups marginalised and also greater involvement of those most affected by inequalities.[11] The chief medical officer for England has argued, with others, that we need a new wave of public health based on 'the active participation of the population as a whole' and a renewed focus on working together.[12:3]

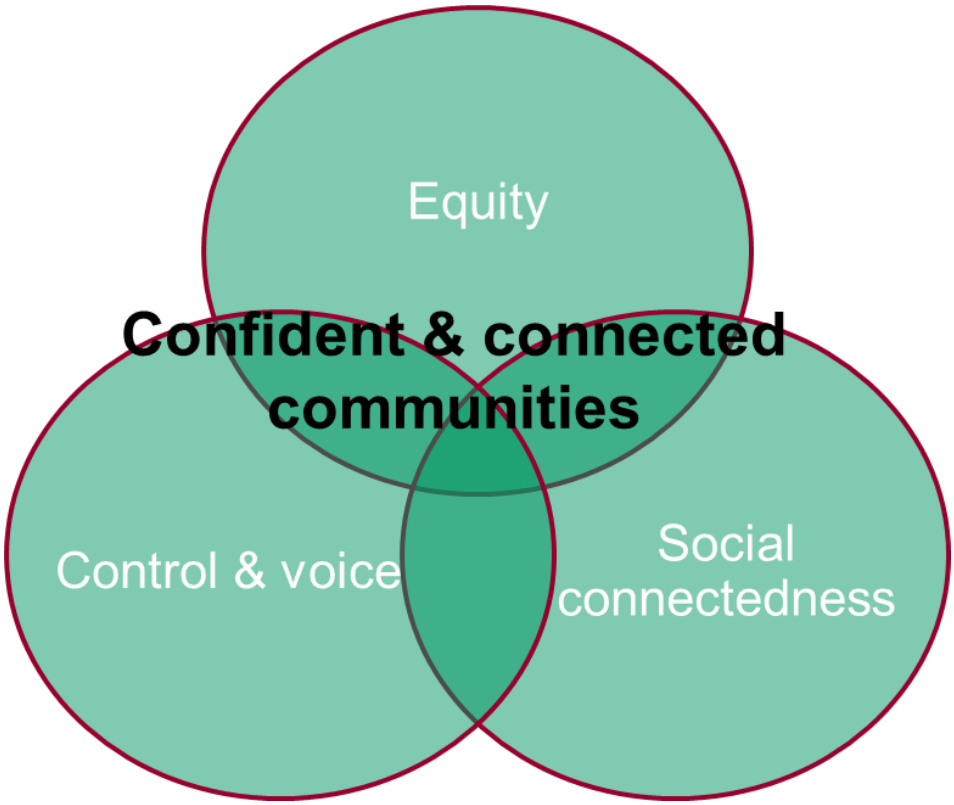
As well as new statutory duties to involve,[13, 14] government has advocated changes in the relationships between local services and citizens, so that individuals and communities can play a bigger role in improving health and wellbeing.[15, 16] While there is broad support for this,[4] the challenge has always been to translate those high-level

aspirations into sustainable action that makes a difference. Community-centred ways of working have often been poorly understood and located on the fringes of mainstream practice, which has largely been dominated by professionally-led solutions.[17] There are a number of reasons why this situation needs to change:

- we are unlikely to narrow the health gap in England without actively involving those most affected by inequalities.[18] Participatory approaches directly address the powerlessness and low self-esteem associated with structural inequalities. They also help improve access and uptake[19]
- the assets within communities, such as skills, knowledge and social networks, are the building blocks for good health and cannot continue to be ignored.[20, 21] A sole focus on community needs and deficits limits the options available, and sometimes increases stigma by labelling people with problems
- health behaviours are determined by a complex web of factors including influences from those around us.[22] Community engagement and outreach are often a vital component of behaviour change interventions[23, 24] and the support from peers who share similar life experiences can be a powerful tool for improving and maintaining health[25]
- social isolation and loneliness is a major public health issue, associated with higher risks of mortality and morbidity.[26] But people can 'recover' from loneliness,[27] meaning that there is scope for interventions to improve social connections[28]
- wellbeing is a key concept for a functioning and flourishing society[29] and community life, social connections, and active citizenship are all factors that enhance wellbeing.[30] Thinking about how to enhance the informal ways people connect with others and offer assistance opens up the possibilities for positive change[31]
- a flow of new ideas and intelligence from local communities is needed to give a full picture of what works and what is needed.[32] Local government and clinical commissioning groups now have the freedoms to involve communities in jointly developing locally tailored solutions
- in the current period of austerity, the Wanless review's conclusion that high levels of public engagement are needed in order to keep people well and manage rising demand remains highly relevant.[33] As the NHS Five Year Forward View (2014) makes clear, harnessing the 'renewable energy' of patients and communities is no longer a 'discretionary extra' but instead is key to the sustainability of health and care services[3]

There is a compelling case for a shift to more people and community centred approaches to health and wellbeing. The core concepts that underpin this shift are **voice and control**, leading to people having a greater say in their lives and health; **equity**, leading to a reduction in avoidable inequalities, and **social connectedness**, leading to healthier more cohesive communities (figure 1).

Figure 1. Confident and connected communities



Communities as building blocks for health

The quality of community life, social support and social networks are major influences on individual and population health, both physical and mental.[34, 35] The recent WHO European review on social determinants and the 'health divide' states: "How people experience social relationships influences health inequities. Critical factors include how much control people have over resources and decision-making and how much access people have to social resources, including social networks, and communal capabilities and resilience." [34:15]

Good social relationships and engagement in community life are necessary for good mental health, and may offer protection in adversity or where there is exposure to stressors.[36-38] The ability to form positive relationships is an integral part of wellbeing[29] and individuals are recommended to connect with those around them as one of the 'five ways to wellbeing'.[30] Compelling evidence from a meta-analysis of 148 studies on social relationships and mortality risk[26] shows that communities 'with strong social relationships are likely to remain alive longer than similar individuals with poor social relations', with a 50% increase in odds of survival over an average follow-up of 7.5 years when integration in social networks, supportive social interactions and perceived social support were examined.[26:9]

There is a social gradient across the social factors that support good health.[34] A WHO Europe review of mental health, resilience and inequalities[39] reports that high levels of social capital can buffer some of the effects of stress, but at the same time deprivation and inequalities 'erode' the resources needed for good mental health. The Marmot review shows how just under a fifth of people (19%) living in the most deprived areas of England have a severe lack of social support and around a quarter (26%) have some lack, compared to 12% and 23% in the least deprived areas.[18]

Health assets

All communities have local health assets as well as health needs. Assets that can support positive health and wellbeing include:

- the skills, knowledge, social competence and commitment of individual community members
- friendships, intergenerational solidarity, community cohesion and neighbourliness within a community
- local groups and community and voluntary associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles
- physical, environmental and economic resources within a community
- assets brought by external agencies – public, private and third sector[21, 40]

There is a growing interest in the UK in asset-based approaches that identify and mobilise the assets of individuals, communities and organisations to enhance individual and community capabilities and address health inequalities.[41, 42] Salutogenesis is the underpinning theory, that is understanding how positive health is created and how people stay well even when faced with stressful events or adverse circumstances.[43] Resilience is an important concept at individual and community levels[44], linked to an evidence base on social factors that protect and maintain health in adversity.[39, 45]

Empowerment

Power and participation matter to health, at an individual and a collective level. Individual empowerment is about individuals gaining a sense of control over their lives and health. This can happen through development of personal skills, self-confidence and coping mechanisms.[46] Self-efficacy, self-esteem, confidence to change and problem solving skills are all factors in the adoption of positive health behaviours and self care.[47, 48]

Community empowerment is about people working collectively to shape the decisions that influence their lives and health. Ultimately it involves changes in power relations, leading to a more equitable society.[49] There is a relationship between individual and community empowerment, but it is not a simple continuum, as participation involves dynamic processes and people's involvement can strengthen or lessen over time.

Participatory methods address some of the power imbalances that arise because of inequalities,[19, 46] enabling disadvantaged and marginalised groups to gain more control.[49] A distinction is often made between instrumental approaches to participation, where communities are engaged for a specific purpose and empowerment approaches, where the goal is determined by the community.[50] While ladders of participation usually imply citizen control is the ultimate goal[51], others argue that a pluralistic, multi-dimensional approach is required, where methods are matched to the different expectations and purposes of involvement.[52] Wilcox's ladder is often used in UK practice, because it sets out five alternative stances with differing levels of power sharing[53] (table 1).

Table 1. A ladder of participation

Level	Typical process	Stance
Supporting local initiatives	Community development	'We can help you achieve what you want, within guidelines'
Acting together	Partnership building	'We want to carry out joint decisions together'
Deciding together	Consensus building	'We want to develop options and decide together'
Consultation	Communication and feedback	'These are the options what do you think?'
Information	Presentation and promotion	'Here's what we are going to do…'

(Adapted from: Wilcox, The guide to effective participation.1994:15)

Volunteering and active citizenship

Volunteering is a form of participation and an important part of the social fabric in England, occurring across most of the wider determinants of health including: sport and exercise, education, justice, arts and culture, children and young people, older people, neighbourhood and citizens groups, conservation, environment and heritage, as well as health and care.[54] Levels of volunteering are high in England: the Citizenship Survey for 2012-13 shows that almost half of people surveyed (49%) volunteered either formally through clubs and organisations or informally assisted neighbours and friends at least once a month. Seventy-two per cent of people volunteered at least once a year.[55] In the health and social care sector in England, the King's Fund estimates that around three million people currently volunteer, compared to an NHS paid workforce of 1.4 million.[56]

Experimental and cohort studies show participation in volunteering is strongly associated with better health, lower mortality, better functioning, life satisfaction and decrease in depression.[57, 58] Whether volunteering leads to better health or healthier people are more likely to volunteer, the public health implications are that barriers to volunteering should be removed[57] and disadvantaged groups enabled to take part.[59] Finally, volunteering sits among a broader set of actions that form participation in civil society. Taking part in community life and in democratic and political processes together constitute active citizenship.[60] Community leadership and representation are part of this. There is also a long tradition of highly successful citizen activism on public health issues, from demands for access to contraception in the early 20th century to later campaigns on disability rights.[61]

The role of local services

What makes us healthy often lies outside the remit of healthcare and formal public health programmes. There are still important roles for local government and the NHS

working in partnership with communities in improving health and wellbeing and in ensuring that individuals and families receive high quality care and preventive services.[3, 4] The Marmot strategic review of health inequalities in England post-2010 recommended that public and third sectors adopt new roles to create conditions in which individuals and communities take control.[18:152]

According to the King's Fund, strong communities, wellbeing and resilience are key areas where local government can take evidence-based actions.[62] The Think Local Act Personal (TLAP) partnership, for example, brings together an emphasis on community self help with co-production of services to support the further personalisation of health and social care.[63] Local government can also use planning and regulatory powers to create safe, sustainable environments.[64] The recent O'Donnell report on wellbeing and policy argues that creating a built environment that is sociable and green is a policy priority: "Spaces that create opportunities for people to dwell and meet, be they parks, porches, or post offices, provide the soil for the seeds of friendship and connection to grow."[31:65]

Participation is part of good governance for health. Involving local communities needs to go beyond consultation in order to tackle inequalities in health effectively.[65] NHS England's guidance on transforming participation in health and care sets out the duties for commissioners involving individuals in their care and the public in commissioning.[66] People-centred health systems are a goal of WHO Europe's Health 2020 policy framework,[1] supported by new models of governance that give a greater role to citizens, patients and consumers both in policy-making and in shared decision-making in health and care relationships.[67]

In summary, this section has provided an overview of how community connections and participation influence health and wellbeing and the ways that local services can work with communities to improve community life. At the informal end are the many acts of neighbourliness and reciprocity that keep people well and engaged, with little intervention needed. At the other end of the spectrum are formal services and the ways in which patients, carers and the wider public can shape how care is provided. Local government and the NHS have a vital role in ensuring that all groups, but especially those at highest health risk, have access to the social resources that support good health. The following section identifies some of the available options for building confident and connected communities as a resource for living well.

A family of community-centred approaches

A diverse range of community interventions, models and methods can be used to improve health and wellbeing or address the social determinants of health. UK community health practice is rich and diverse, encompassing national programmes through to small local projects. This section introduces a 'family of community-centred approaches'. It illustrates some common options and identifies the mechanisms of change based on the core concepts of equity, control and social connectedness. The term 'community-centred' has been used rather than 'community-based' because these approaches draw on community assets, are non-clinical and go beyond using a community as a setting for health improvement. Community-centred approaches complement other types of interventions that focus more on individual care and behaviour change or on developing sustainable environments. The family analogy is used because there are many interconnections and relationships between the different approaches.

What are community-centred approaches to health and wellbeing?

Community-centred approaches:

– recognise and seek to mobilise assets within communities. These include the skills, knowledge and time of individuals, and the resources of community organisations and groups
– focus on promoting health and wellbeing in community settings, rather than service settings using non-clinical methods
– promote equity in health and healthcare by working in partnership with individuals and groups that face barriers to good health
– seek to increase people's control over their health and lives
– use participatory methods to facilitate the active involvement of members of the public

The family of community-centred approaches

The family of approaches represents some of the available options, grouped around four different strands (see figures 2 and 3):

- strengthening communities – where approaches involve building community capacity to take action on health and the social determinants of health
- volunteer/peer roles – where approaches focus on enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- collaborations and partnerships – where approaches involve working in partnership with communities to design and/or deliver services and programmes
- access to community resources – where approaches focus on connecting people to community resources, information and social activities

The family builds on work done in a major review of community engagement and inequalities.[68] The family provides a broader representation to reflect the breadth of UK practice, the potential contribution of civil society and public and third sectors, and the importance of equity, empowerment and social connectedness across all strands of work. Active citizenship in campaigning and lobbying, and in civic life more generally, is not represented in the family, nonetheless underpins a healthy society. The focus here is on practical, evidence-based models that local government, NHS and third sector can use to work with communities to achieve health goals. More details on how the family was developed can be found in appendix 1.

How to use the family

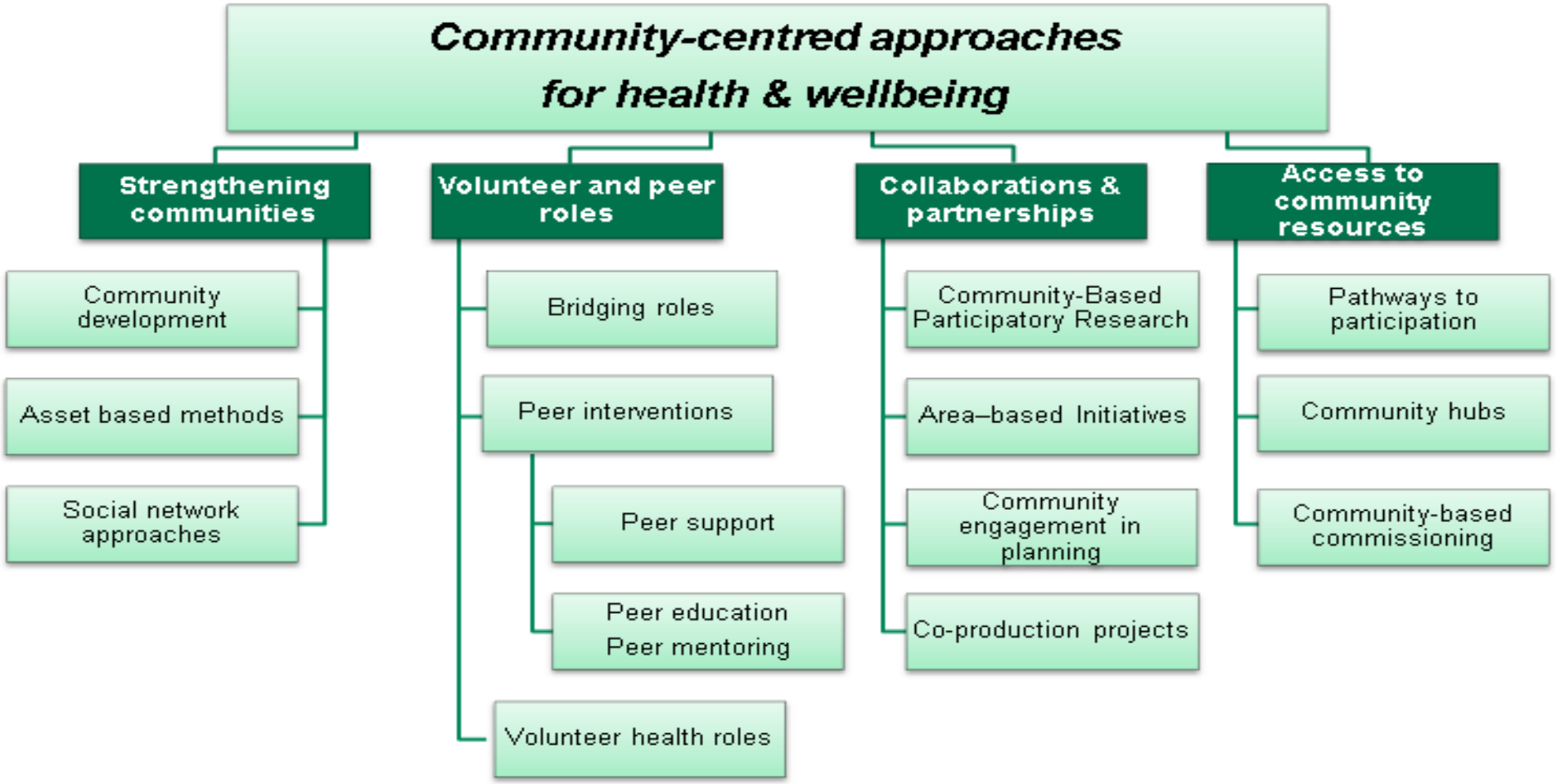
The family of approaches maps potential options, adaptable to local circumstances and priorities. The following sections describe the key features of each group, the types of interventions included and how they work (mechanisms of change), ending with a list of key reviews and resources.

The family is not a set of mutually exclusive categories as many programmes will include multiple components, for example time banking is a volunteer model that involves both community capacity building and access to community resources. Some of the differences lie in whether approaches are:

- focused on wider determinants or on individual health and/or health behaviours
- community-led or professionally-led, and whether that changes over time
- delivered as formal interventions (with some standardised components like a training package) or through developmental methods that facilitate personal learning and informal networks
- high intensity, targeted interventions that work with specific communities over time, or low intensity approaches with broader appeal that can be used across population groups

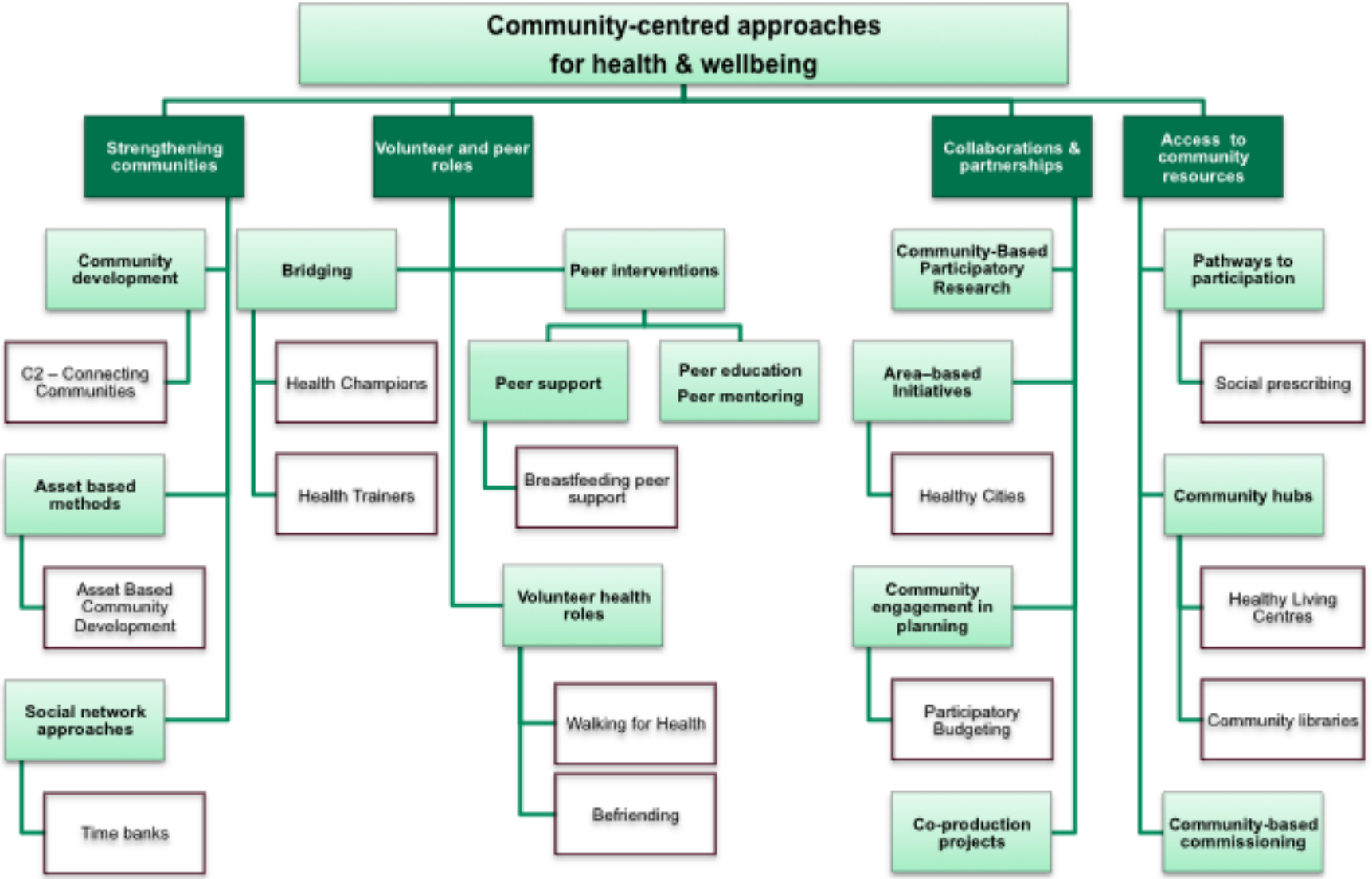
NICE guidance on community engagement[7] is that engagement principles and methods have to be considered in relation to the social context. Ultimately, what local government and the NHS do to enable and support communities needs to be proportionate for those with the greatest needs or who face the largest barriers to achieving good health.[65]

Figure 2. The family of community-centred approaches for health and wellbeing[1]



[1] The family of community-centred approaches for health and wellbeing (South, 2014)

Figure 3. The family of community-centred approaches with examples of common UK models



Strengthening communities

This group of approaches seeks to draw on and strengthen community capacity to take collective action that will in turn lead to changes in health or the social determinants of health. Approaches can be applied at a neighbourhood level to address health inequalities and also used to work with specific communities experiencing the effects of social exclusion. Approaches include: **community capacity building,**[69] **community development,**[70] **asset-based community development (ABCD),**[40] **community empowerment models,**[71] **community organising,**[72] and **mutual aid**[73] interventions. Many of these share similar principles, but traditions differ between countries. Based on common approaches in the UK, 'strengthening communities' is grouped into:

1. **Community development**. This is defined as 'a long–term value based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion'.[74] Communities identify issues and determine joint actions to build healthy, sustainable and more equitable communities.[75] There is a long tradition of **community development and health projects** in the UK;[76] these have often been locality based, and typically take a holistic approach to community health, delivering a range of community-based activities. **Community development and mental health** projects use the core principles of community development to empower people who are experiencing or are at risk of mental health problems, through raising critical awareness, offering peer support and challenging stigma.[77, 78]

C2 Connecting Communities

C2 is a specific model of neighbourhood community development that has been successfully adopted in a number of disadvantaged communities in England.[70, 79] Originally developed to tackle major health inequalities in a Falmouth community, the methodology comprises a series of seven practical steps moving from identifying issues and the community leaders who could help, through to implementing community actions and changes in service delivery. Sustained partnership working between community members and local services is a key feature of this approach.

2. **Asset-based approaches –** including **asset mapping** and **asset-based community development (ABCD)**. Asset-based approaches share an underpinning philosophy around individual and community strengths and capabilities as the foundation for improving for health and wellbeing.[21, 42] The process of identifying an inventory of assets (asset mapping) forms the basis for planning and then developing social action to improve health. The report 'What makes us healthy' describes the defining themes of asset based ways of working as 'place-based, relationship-based, citizen-led' together with promoting social justice and equality.[20:6] While asset-based values can be applied across the range of community-centred approaches, there is also a suite of specific asset-based methods including **asset**

mapping, ABCD, appreciative inquiry and world café.[40, 80] Some approaches emphasise community mobilisation and while others, like social prescribing, align to co-production approaches working in partnership with services and professionals

Asset-based community development

ABCD originated in the US and is a specific methodology that focuses on creating social change by identifying and building assets within a community. Assets include community associations, local services, informal groups and networks, and the skills, knowledge and commitment of residents.[40, 81] ABCD places emphasis on strengthening relationships within communities and on community-initiated activities, as communities are regarded as the primary building blocks for change.[81]

3. **Social network approaches.** These approaches focus on strengthening community and social support between people, via collective or community organising activities[82] (as opposed to more individually-based peer support). Interventions will typically set up structures or processes that either enhance existing networks, for example neighbourhood network models that coordinate informal support to older people[83], or create new ones, for example self help groups[73, 84] or time banking schemes. **Recovery communities** is a UK example of a mutual aid intervention that involves creating an environment where there are positive social relationships and offering peer support to people with a history of drug or alcohol misuse.[85, 86] '**Men's sheds**' is another effective mutual aid intervention, aimed at improving the wellbeing and social connectedness of men at risk of social isolation[87]

Time banking

Time banking is a specific community capacity and social networks based on the assets and time that people can share as volunteers.[88] Time banking involves reciprocity in that people exchange services with each other based on the idea of 'time credits' to meet social or health needs. This reciprocity leads to a growth of social capital and mutual learning between people.[89] There are a number of successful time banking schemes in the UK. Many of these involve disadvantaged or excluded communities in activities which improve mental and physical health.[90]

How do these approaches work?

Strengthening and empowering communities by building social cohesion, critical awareness and collective action is a strategy for tackling inequalities in health.[18, 91] The central premise is that communities can be enabled to identify health and social issues and then devise and implement appropriate solutions, with the ultimate aim of creating more supportive and healthier environments.[68] The emphasis is on community organising and capacity building, mutual aid based on strong social networks and independent community-led activities.[70, 92] This can result in sustainable social action, tackling the root causes of health and ill-health. Empowered communities may also

challenge the status quo and campaign for more equitable distribution of resources, changes in services or policy.[93]

Outcomes include more confident active communities,[46] increased social engagement and social support and more extensive social networks.[70, 87, 94] The individuals involved often find increased self-esteem and self-efficacy, sense of control and improved health literacy.[95, 96] Community mobilisation can lead to positive change in the physical and social environment, such as improved housing, and improvements in community infrastructure and increased funding.[49, 79] Outcomes cannot always be pre-determined as these approaches are developmental, with community members increasingly shaping the intervention.[97]

Key reviews and resources

- Elliott, E. et al. Connected Communities: A review of theories, concepts and interventions relating to community-level strengths and their impact on health and wellbeing. 2013. London: Connected Communities
- Fisher, B. Community development in health: a literature review. 2011. London: Health Empowerment Group
- Hothi, et al. Neighbourliness + empowerment = wellbeing: is there a formula for happy communities? 2007. London: The Young Foundation
- Knapp, M. et al. Building community capacity. Making an economic case. PSSRU Discussion Paper 2772. 2011. Canterbury: Personal Social Services Research Unit
- McLean, J. & McNeice, V. Assets in action: illustrating asset based approaches for health improvement. 2012. Glasgow: Glasgow Centre of Population Health
- Milligan, C. et al. Men's Sheds and other gendered interventions for older men: improving health and wellbeing through social activity - a systematic review and scoping of the evidence base. 2013. Lancaster: Lancaster University
- Seebohm, P. et al. "Bold but balanced: how community development contributes to mental health and inclusion". Community Development Journal. 2012, 47, 4: 473-490

Volunteer and peer roles

This group of approaches focus on enhancing individuals' capabilities to provide advice, information and support and to organise activities around health and wellbeing in their own or other communities. The key features are that people are not working in a professional capacity (lay roles). They are usually drawn from the community they work in, and receive some training and support to undertake health promotion, early intervention and sometimes care in the community.[98] The focus of interventions is usually on promoting health equity, with community members reaching out to and connecting with groups experiencing deprivation or social exclusion.[17, 99] In the UK, most of these roles are undertaken on a voluntary basis, but some lay health workers are also employed as part of the wider public health workforce.[100] This is a very broad

field of practice, with many different terms used to describe these roles.[101]Approaches are grouped into three categories:

1. **Bridging roles.** These involve community members being connectors, signposting to services and information and supporting people to improve their health and wellbeing. Volunteers are often embedded in the community and are already 'natural helpers',[102] but they are not necessarily peers. UK examples include **health trainers,**[100] **community health educators,**[103] **navigators**[104], **health champions,**[105] **community food workers**[106] and **link workers in primary care.**[107] Roles typically include outreach and communication of health messages, social support to help people develop skills or change health behaviours, signposting to services and sometimes offering practical assistance.[108, 109]

Health trainers and health champions

Health trainers and champions make up an important part of the wider public health workforce in England.[100] Health trainers support individuals to make positive changes to improve their lives and health, offering 'support from next door' rather than professional advice,[110, 111] underpinned by a common approach to behaviour change.[112] Health trainers typically work in primary health care or community settings,[110] but there are also specialised services working with groups such as ex-offenders.[113]

Community health champions are volunteers who draw on their own local knowledge and life experience to motivate and support family, friends, neighbours and work colleagues to take part in healthy social activities and also establish groups to meet local needs. [105, 114] 'Altogether Better' is an example based on empowerment principles, recruiting over 20,000 champions to date.[115] Health trainers and health champion programmes aim to address health inequalities by involving people from disadvantaged groups or those at risk of poor health.[100]

2. **Peer-based interventions**. These aim to recruit and train people on the basis of sharing the same or similar characteristics as the target community, often with the aim of reducing communication barriers, improving support mechanisms and social connections. In the UK peer methods have been applied across a range of health issues, for example community-based smoking cessation[116] and self management of long term conditions,[117] and with marginalised groups such as sex workers[118] and people experiencing homelessness.[119] Although all peer approaches aim to tap into the social influence of people who share similar experiences or characteristics, **peer education** focuses on teaching and communication of health information, values and behaviours between individuals,[120] **peer mentoring** involves one-to-one relationships that model and support positive behaviour[121] and **peer support** involves providing positive social support and helping buffer against stressors.[84] There is a clear link between peer support roles and mutual aid interventions that aim to encourage self-help and create supportive networks.

Peer support

Peer support occurs naturally between people, but can also be developed through formalised interventions where peer support workers draw on their own life experiences to provide social support, organise group activities and act as positive role models to others who face similar circumstances.[84, 101] Breastfeeding peer support is a common UK model and involves parents offering lay advice and supporting other parents to initiate and maintain breastfeeding through one-to-one support and in group settings.[122, 123] Breastfeeding peer support workers usually receive comprehensive training and work in partnership with midwives and health visitors. Other areas where peer support interventions are used include mental health,[124] smoking cessation and promoting healthy lifestyles in deprived communities.[25]

3. **Volunteer health roles.** Within an extensive range of formal volunteer health roles in the UK,[125] many of these are focused on reducing health inequalities. Common health improvement models include **walking for health,**[126] **befriending**[28] and **environment and health volunteering** projects.[127] Volunteers typically receive training and support to undertake a heath role. Some programmes encourage volunteers to independently lead health-promoting activities in their community. The Big Lottery Well-being programme, for example, supports a range of community wellbeing portfolios with volunteers involved in healthy eating, mental health and physical activity in communities.[128]

Walking for health

This is a volunteer-led physical activity programme that has been extensively adopted across England with over 600 walk schemes.[126] Walk leaders, most of whom are volunteers, receive a one-day training and then plan and lead local walks, supporting those attending as required. Opportunities for social contact through the groups helps motivate people to part in physical activity,[129, 130] with some schemes focusing on reducing inequalities in access to green space.[131] A audit in 2012 found around 10,000 volunteers and 70,000 people were regularly taking part in health walks.[129]

Befriending

Befriending is a specific type of volunteering role aiming to provide social support and companionship on a one-to-one basis to individuals who at risk of social isolation. Befrienders usually develop a relationship over time through regular visits to people in their own home, as well as helping with small practical tasks such as shopping.[28] Many befriending schemes are community-led.

How do these approaches work?

These approaches build on the skills, knowledge and commitment of individuals and then develop their capacity to become ‘agents of change’.[7] The premise is that people will use their life experience, cultural awareness and social connections to relate with other community members, to communicate in a way that people understand and to

reach those not in touch with services or who are resistant to professional messages.[99] Social support provided through health roles can be emotional (providing empathy and care), instrumental (helping with practical tasks), informational (providing advice), and appraisal (offering feedback and reflection).[82] While the focus is often on delivery of activities or services, there are many examples of community-led interventions that aim to empower community champions or advocates.[104, 105] Some US lay health advisor models have explicit 'inreach' elements to ensure community experiences are fed into planning more equitable services.[132]

Outcomes relate to individuals who undertake a public health role and the community members they work with. For volunteers, outcomes include increased knowledge and awareness, skills, self-confidence, quality of life and improved mental health.[127, 133, 134] Volunteering in a health role can also be a pathway to education, employment or other volunteer roles.[135] Outcomes for recipients depend on focus of intervention but can include health behaviour change, increased social support, improved access to services[28, 68, 100] and better management of health conditions.[136] Service outcomes can include better reach and uptake, increased workforce capacity and changes in service use.[125, 137]

Key reviews and resources

- Ford, P. et al. "A systematic review of peer-support programs for smoking cessation in disadvantaged groups." International Journal of Environmental Research & Public Health. 2013, 10, 11: 5507-5522
- Mundle, C., et al. (2012). Volunteering in health and care in England. A summary of key literature. London, The King's Fund
- O'Mara-Eves, A., et al. "Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis." Public Health Research. 2013,1,4
- Repper, J. et al. Peer support workers: theory and practice. Implementing recovery through organisational change briefing. 2013. London: Centre for Mental Health and Mental Health Network
- Royal Society for Public Health. Tackling health inequalities: the case for investment in the wider public health workforce. 2014. London: Royal Society for Public Health
- South, J., et al. People in Public Health - a study of approaches to develop and support people in public health roles. 2010. National Institute for Health Research Service Delivery and Organisation programme
- Windle, K. et.al. Preventing loneliness and social isolation: interventions and outcomes. Social Care Institute for Excellence Research Briefing 39. 2011. London: Social Care Institute for Excellence

Collaborations and partnerships

This group of approaches is characterised by partnership working with communities to improve planning and decision-making. In recent years the term 'co-production' has been used to describe engaging community members and service users as equal partners in service design and delivery.[138] However, the ideas around community-professional partnerships and community engagement are not new. There is a long tradition of participatory and collaborative approaches in health promotion and public health,[139, 140] with links to patient and public involvement in health and care services.[66, 141] Collaborative approaches involve communities and local services working together at any stage of the planning cycle: identifying needs and agreeing priorities, planning and programme design, decision-making, implementation and evaluation. These approaches are grouped into four broad categories, but this is an area where there are many variants:

1. **Community-based participatory research (CBPR)**. CBPR involves partnerships between communities, services and academic researchers, usually with the purpose of identifying community needs and then working together to develop programmes.[142] Participatory research, with its core elements of collaboration, mutual education and action,[143] fits within the broader field of public involvement in health research.[144] In CBPR, community researchers are recruited and trained to gather data in their community and then identify health issues and potential solutions. A range of research designs can be used,[145] from questionnaire-based surveys, through to creative methods such as Photovoice.[146] Established methods of participatory needs assessment, such as **rapid participatory appraisal,**[147] are now complemented by asset-based methods.[80] Participatory research can be the first stage of a collaborative planning cycle, as exemplified by the 'Connected Care' model.[148]

2. **Area-based initiatives**. ABIs tackle social or economic disadvantage at an area or neighbourhood level through partnership working and multi-faceted programmes where health is often a strand alongside economic development, urban regeneration, access to services and education.[149, 150] Community involvement, from consultation through to representation on local regeneration boards, is integral to identifying needs, shaping services and improving local areas.[149] **Health action zones** [1999-2003], for example, built intersectoral action and community involvement on health inequalities across whole districts.[151]

Healthy cities

This is an international movement focused on improving health and addressing health inequalities through local political leadership, urban planning, intersectoral action and community participation.[152, 153] Participation occurs at different levels of governance, and ranges from public consultations through to community empowerment projects.[154]

There are many European case studies of community participation leading to joint action on health[10] and from further afield. Community leadership is a strong feature of California healthy cities and communities[155] and Latin American civil society movements, such as *Nossa Sao Paulo.*[156]

3. **Community engagement in planning**. Multiple approaches exist for involving communities in planning and decision-making in local government[2] and the NHS.[66] Communities can provide insights around the wider determinants, for example, through involvement in **health impact assessment**[157] or **environmental audits**[158] or take part in priority setting and determining how health issues will be addressed.[7, 159] The **Healthy Communities Collaborative,** for example, uses an community action model to identify health topics and build joint activity between professionals and community members.[160] Community engagement methods include **area forums**, **open space** events, **planning for real**, **user panels**, **deliberative polling,**[159, 161] **residents committees** and **citizens juries,**[7] **fairness commissions**[162] and **participatory budgeting.**[163] Efforts are required to ensure engagement processes are inclusive and seldom heard communities are involved.[164]

Participatory budgeting

Participatory budgeting (community budgeting) is a devolved form of decision-making, usually place-based, where community members and community groups come together with service providers to take a fresh look at local issues and decide the allocation of resources.[163] Various UK initiatives have been piloted including **Total Place pilots,**[165] **Whole Place Community Budgets**[166] and **Neighbourhood Community Budgets.** [167] Participatory budgeting can be used to tackle the root causes of ill health and bring about a more upstream approach to health.[167] In 2014, the British Academy recommended using participatory budgeting to increase mental capital in communities.[168]

4. **Co-production projects.** Co-production approaches seek to develop equal, reciprocal partnerships between professionals and those using health and care services.[169] They share many of the features of other collaborative approaches but with more focus on people with long term conditions or needing social care. There is community input into the design process and shared delivery between professionals and communities through community-based services, volunteering and peer support networks.[170, 171] Co-production projects share a common philosophy recognising people's capabilities and assets, however there is no standardised model and projects range from personalisation and self care projects to time banks in general practice. People Powered Health is an example of a national programme based on co-production principles and leading to service redesign and community mobilisation around long term conditions.[172]

How do these approaches work?

The premise is that involving communities in assessment, design and development of solutions will result in services and health programmes that are better matched with needs.[7, 68, 159] The degree to which power is shared with the community can vary from consultation processes to long term sustainable partnerships with increasing community control. Collaborative approaches include some element of capacity building, developing skills, knowledge and community leadership,[7, 173] which can lead to long term changes in community representation and participation.[155, 174] They also require organisational change and professionals committed to power sharing with the skills to work in facilitative and empowering ways.[7, 175]

Outcomes will depend on focus of interventions, whether aimed at individual lifestyle factors[68, 160] or wider determinants such as educational attainment, housing improvements, social capital or reduced crime.[150, 176, 177] Community members who get actively involved, for example, as community researchers, may derive benefits such as increased skills, confidence and a route to employment.[148, 178] Organisations can benefit from better intelligence of needs and assets,[179] increased satisfaction with services and better relationships with communities.[163] Changes in policy or re-configuration of services can also result from public participation.[145, 180]

Key reviews and resources

- Alakeson, V. et al. Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care. 2013. London, OPM Connects
- Chadderton, C. Involving the public in HIA: An evaluation of current practise in Wales, working paper 116. 2008. Cardiff: Cardiff School of Social Sciences, Cardiff University
- Clark, A. How can local authorities with less money support better outcomes for older people? 2011. York, Joseph Rowntree Foundation
- Coulter, A. Engaging communities for health improvement. A scoping review for the Health Foundation. 2010. London: The Health Foundation
- Mackinnon, J. et al. Communities and health improvement: a review of evidence and approaches. 2006. Edinburgh: NHS Health Scotland
- National Institute for Health and Care Excellence. Community engagement to improve health. 2014. NICE local government briefings
- Social Care Institute for Excellence. Seldom heard: developing inclusive participation in social care. Position Paper 10. 2008. London: Social Care Institute for Excellence

Access to community resources

This group is about connecting individuals and families to community resources – information, services, practical help, and group activities and volunteering opportunities – in order to meet health needs and enhance wellbeing. Most areas will have a rich and

diverse third sector, with many organisations contributing to community health and wellbeing[181] as well as providing specialist services and advocacy for underserved groups.[182] Tapping into the assets of voluntary and community organisations (sometimes referred to as non-traditional providers),[183] these approaches establish referral routes, reduce barriers to accessing services and social participation, and commission and coordinate group activities. Approaches are grouped into:

1. **Pathways to participation.** This covers social prescribing[80] and other types of non-medical referral systems including **arts on prescription,**[184] **green gyms,**[185] referral systems for **food banks,**[186] **welfare advice in primary care**[187] and interventions which widen volunteering opportunities for people with specific health needs.[127] The broad aim is to connect individuals with non-clinical or social needs or those with mild to moderate mental health problems to opportunities for social interaction, support, learning and healthy living activities. Pathway approaches are often based within general practice and/or involve primary care teams, but use a social determinants rather than a clinical model of health.[188]

Social prescribing

Sometimes called **community referral**, this is a generic model that enables individuals presenting through primary health care to be signposted and connected to local organisations, groups and activities.[80, 189] Different types of social prescribing schemes exist, some of which are focused on specific health issues such as mental health or physical activity,[189] others link with a broad range of provision, including befriending and advice services.[190] Staff with knowledge of the resources available in the local community match individuals to opportunities and support them to engage in activities. In some social prescribing schemes, health trainers and health champions signpost and support clients to become involved in community activities.[191]

2. **Community hubs.** These are community centres or community anchor organisations[192] focused on health and wellbeing that can be either locality based or work as a network. Community hubs, such as **healthy living centres**, typically provide multiple activities and services that address health or the wider determinants of health, most of which are open to the wider community.[193] Some hubs layer health into an existing community resource such as faith settings[194] or libraries,[195] others build social activities and support services within a primary health care setting.[196] There are often outreach projects, social prescribing and volunteering schemes nested within a community hub, and some include co-located health services.[197, 198]

Healthy living centres

These were aimed at reducing health inequalities through an upstream approach to health.[199] Originally supported by the New Opportunities Fund (later Big Lottery), the initiative ended in 2007, but some healthy living centres remain part of the community infrastructure, for example, 'HealthWORKS' in Newcastle[198] and Bromley-by-Bow

Centre.[197] Healthy living centres typically deliver a range of services in partnership with the community and other organisations including: healthy living activities, social groups, community cafes, employment and skills training, community gyms, social support groups, volunteer-led activities, financial and housing advice and outreach.[193, 200] The healthy living centre model widens access to local services by making health and social activities easy and attractive to join, and by reducing barriers for disadvantaged groups.[193]

3. **Community-based commissioning**. Holistic models of community-based commissioning use a social determinants approach and recognise that individuals, particularly from vulnerable groups, have a range of health and social needs which cannot be met solely by health services.[188, 196] Commissioning cycles typically involve three linked elements: community engagement to understand community needs and assets, which may be linked to the joint strategic needs assessment; partnership working to tap into the knowledge and expertise of the third sector; solution-focused commissioning where non-traditional providers deliver preventive and care services,[201] which can in turn add social value through community engagement.[202] Examples of new frameworks for community-based commissioning include a commissioning model for gypsies and travellers, homeless people and sex workers,[203] and care pathways linking medical care with social support for people with long term conditions.[183]

How do these approaches work?

A large and diverse voluntary and community sector exists in most areas.[181] However, there is often a low level of awareness of what is available and people may face barriers that prevent them engaging in activities. These approaches therefore work by opening up access to advice, social support and opportunities for learning, social interaction and volunteering.[30, 204, 205] A key element is the interface with primary health care, with potential for innovative models, as proposed by the NHS Five Year Forward view.[3]

The Royal College of Physicians recommends that “in the course of all doctor-patient consultations there needs to be more scope to discuss the root causes of ill health and signpost patients towards appropriate support and services, inside and outside the health sector”. [206:8] Community hubs and commissioning models work by developing organisational and community capacity to respond to individual and community needs. In contrast pathway interventions focus more signposting and supporting individuals moving between primary health care and local voluntary and community organisations. Outcomes for community members can include reduced social isolation, increased social connectedness, increased knowledge and awareness of health issues, changes in health behaviours, and better access to services.[189, 193] Community outcomes include increased capacity through additional volunteers, funding or shared resources.

Outcomes for health services can include more appropriate use of services, increased capacity to manage non-clinical need and raised awareness of community assets.[190, 203]

Key reviews and resources

- Big Lottery Fund. Learning from Healthy Living Centres: final evaluation summary. Big Lottery Fund Research Issue 40, 2007. Big Lottery
- BMA. Social Determinants of Health – What Doctors Can Do. 2011. London, BMA
- Evans, S. & Vallerlly, S. Best practise in promoting social wellbeing in extra care housing. 2007. York: Joseph Rowntree Foundation
- O'Donnell, G. C., et al. Wellbeing and policy. 2014. London, Legatum Institute
- Gill, P. et al. Improving access to health care for gypsies and travellers, homeless people and sex workers: an evidence-based commissioning guide for Clinical Commissioning Groups and Health and Wellbeing Boards. 2013. London: RCGP
- Social Exclusion Task. Inclusion health: improving the way we meet the primary health care needs of the socially excluded. 2010. London: Social Exclusion Task Force
- Year of Care. Thanks for the Petunias - a guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions. 2011. NHS Diabetes

Health outcomes and evidence

What do we know about the effectiveness of community-centred approaches for health and wellbeing? NICE guidance endorses community engagement as a strategy for health improvement.[7] Since the guidance was issued, UK practice has continued to grow and diversify and new studies add to the evidence base. This section provides a broad overview of what is currently known about the effectiveness and cost effectiveness, signposting to major reviews. It first looks at what outcomes can be expected from involving communities as active participants in health and wellbeing.

Understanding outcomes from community-centred approaches

Working together to take action on health is a process leading to improvements in the determinants of health and an outcome in itself.[46, 68] The US Institute of Medicine has adopted a framework for community-based prevention with three interrelated domains:

- health (physical and mental) – morbidity, mortality, quality of life
- community wellbeing – physical, social and economic environments
- community process – leadership, skills, civic participation, community representation[207]

Confident and connected communities will be able to engage in other issues relating to local services and the environment in which they live, improving civic engagement.[208] Equity outcomes, such as improved living conditions and more accessible and appropriate services, may result.[7, 18] Social participation, that is our interactions and connections to others, is not separate from other types of participation but part of a spectrum of activity[209, 210] leading to improved individual and community wellbeing.[29] For example, analysis of the European Social Survey shows a weak but significant association between participation in civil society through voluntary groups and quality of life.[204:271] A study of English local authorities reports that ‘areas that enjoy vibrant community life are more likely to have high–performing public services’, as measured through the Comprehensive Performance Assessment.[211:234]

As well as promoting uptake and widening access to services, community-centred approaches may increase health literacy and give individuals the confidence to engage in their health care.[46, 68, 212] Engaged communities can provide supportive environments and positive social norms that help individuals gain motivation, confidence and skills to self care.[213]

Community-centred approaches do not tend to deliver neat, simple solutions and outcomes are often connected, for example, improved mental health and lifestyle change.[128] In interventions that work well, these links are reinforced by supportive

processes so that there is a virtuous circle of sustainable social action. Table 2 summarises the range of potential outcomes reflecting the levels at which changes occur.

Table 2. The range of outcomes from community-centred approaches

Individual	Community level	Community process	Organisational
Health literacy – increased knowledge, awareness, skills, capabilities Behaviour change – healthy lifestyles, reduction of risky behaviours Self-efficacy, self-esteem, confidence Self-management Social relationships – social support, reduction of social isolation Wellbeing – quality of life, subjective and objective wellbeing Health status physical and mental Personal development – life skills, employment, education	Social capital – social networks, community cohesion, sense of belonging, trust Community resilience Changes in physical, social and economic environment Increased community resources – including funding	Community leadership – collaborative working, community mobilisation/coalitions Representation and advocacy Civic engagement – volunteering, voting, civic associations, participation of groups at risk of exclusion	Public health intelligence Changes in policy Re-designed services Service use – reach, uptake of screening and preventive services Improved access to health and care services, appropriate use of services, culturally relevant services

Evidence of effectiveness

There is a substantial body of evidence on the benefits of community participation and empowerment in addressing the social determinants of health and removing barriers for marginalised and vulnerable groups.[18, 34] A rapid scoping review undertaken to inform this report identified 128 reviews of relevance; 32 of these were systematic reviews.

Most of these reviews report positive outcomes from working with communities, although some also report insufficient evidence to draw firm conclusions or have mixed results. Some reviews point to the importance of avoiding negative effects for those who volunteer[178] and supporting people to engage.[101]

A recent NIHR-funded systematic review and meta-analysis of effectiveness studies[68] provides a comprehensive assessment of community engagement, with 315 included studies grouped into three models: (i) empowerment (ii) peer/lay models (iii) patient/consumer involvement in service development. The conclusions were:

"Overall, community engagement interventions are effective in improving health behaviours, health consequences, participant self-efficacy and perceived social support for disadvantaged groups. There are some variations in the observed effectiveness, suggesting that community engagement in public health is more likely to require a 'fit for purpose' rather than 'one size fits all' approach."[68:xvii]

There is reasonably strong evidence on the positive impact of social participation,[26, 28, 30] taking part in volunteering[57, 125, 127, 214] and community engagement[178] with a range of benefits reported including better physical and emotional health, increased wellbeing, self-confidence, self-esteem, and social relationships.[178, 214]

There are some negative effects reported including burnout with high time spent volunteering, stress from responsibilities and consultation fatigue where ideas are not followed through.[178, 215] Groups that are already at risk of social exclusion may face barriers to taking part or experience additional stresses when involved.[178, 216] A review of volunteering, mental and social exclusion cautioned that volunteering does not 'guarantee' social inclusion.[216:169] These issues are critical in the current climate when many individuals and communities are experiencing the effects of austerity.

There are inevitably gaps in the evidence base. There are many examples of transferable and sustainable community programmes in England that have not been written up in peer reviewed journals. There is inevitably a publication bias towards professionally led interventions, as many small successful community health projects 'operate under the radar of formal evaluations'.[217:5] The dynamic nature of participatory methods is not always reflected in academic literature, often changes occur long after the evaluators have left. More evidence needs to be based on lived experiences of those most affected by health inequalities,[218] including through research controlled and led by users.[219]

Economic aspects

In a period of economic restraint, it is vital that local government and the NHS obtain economic and social value from the services they commission and deliver. Traditional ways of looking at value have tended to ignore what people and communities can bring to services.[220] It makes sense that building on the assets within communities will lead to a more equitable and sustainable use of resources.[3] Of course, community involvement and volunteering are not free. Training, volunteer coordination, project management and set-up costs, meeting out–of-pocket expenses and ongoing support are all legitimate costs.

Evidence on the cost-effectiveness of community engagement interventions is limited, although some reviews have reported cost benefits in some circumstances.[100, 221, 222] The recent review on community and engagement and inequalities concluded that there was not enough evidence to draw firm conclusions, with only 21 economic evaluations of mixed quality.[68] Evaluations may fail to capture the full span of resources used[68] and the wider benefits of involvement and unanticipated outcomes.[223] For example, many volunteer and peer health programmes will see a proportion of volunteers gain employment,[224] which generates savings to the public purse but may not be picked up in an evaluation about health behaviours. Using 2011 figures, the Cabinet Office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.[225]

Currently there is considerable interest in developing practical methods to estimate the return on investment of community and volunteer programmes. The London School of Economics undertook an economic analysis of community capacity building using three interventions: time banking, community navigators and befriending. All three were found to deliver a net economic benefit when costs and value were calculated.[88] For example, time banking had an estimated net value of £667 per person per year, extending to £1312 if improvements in quality of life were included in the analysis.

Using social return on investment (SROI) methodology, a specific methodology for assessing value, an analysis of community development in local authorities reported a return of £2.16 for each pound invested, and the value of volunteers running activities was almost £6 to a pound invested to employ a community development worker.[226] York Economics consortium carried out an SROI on individual case studies from ‘Altogether Better’ health champion projects and found that overall, and based a number of assumptions, there was a positive return on investment but with large variability from £0.78 to £111 per pound invested. Similar results about the positive return on investment have been found in other volunteer prevention programmes.[227, 228]

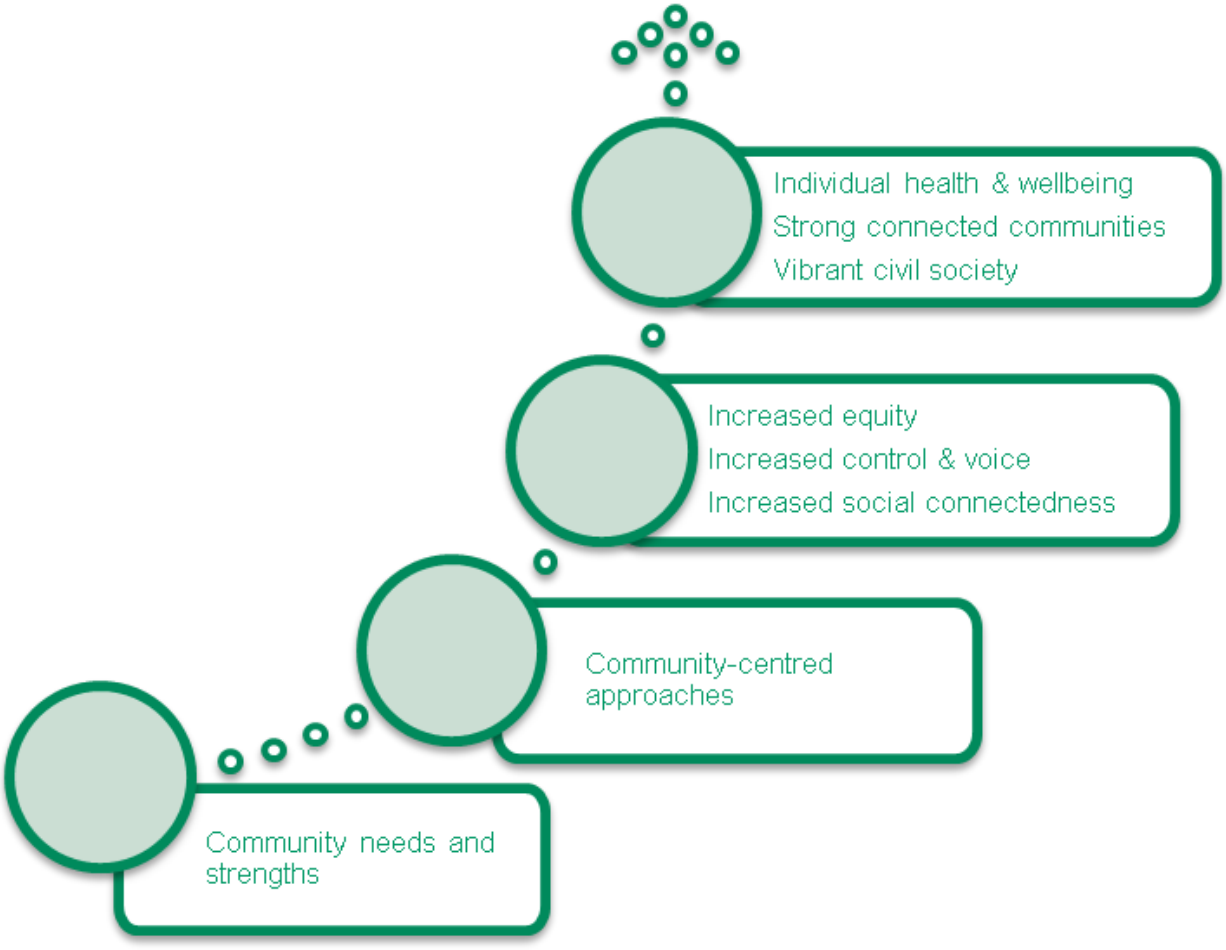
In summary, despite an incomplete picture, community-centred approaches, including community capacity building and volunteering, potentially offer a significant return on

investment. Variability in the economic value may be due to multiple factors, but poor volunteer retention, high turnover and low levels of community ownership and low uptake are likely to push costs up. Hidden costs should not be borne by the community, and consideration should be given to whether financial incentives to support engagement are needed.

Conclusion

Communities are vital building blocks for health and wellbeing (figure 4). At an individual level, joining social activities, connecting to others and taking part in local decisions help keep us healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary for people to flourish. An equitable health system involves people in determining the big questions about health and care and actively removes barriers to social inclusion. That is why individual and community empowerment have to be core to efforts to improve the population's health and reduce health inequalities.

Figure 4. Building healthier communities



This report provides a guide for working with communities as part of a whole-of-society approach to health. It has pulled together a new family of community-centred approaches that maps the range of potential interventions, how they work and where major sources of evidence and reviews of practice can be found. This is not an area that is amenable to simplistic solutions and deciding which approach to use will depend on

local context and priorities, community and organisational capabilities, and what the desired outcomes are.

Local government, the NHS and third sector have vital roles in building confident and connected communities, where all groups, but especially those at highest health risk, can tap into social support and social networks, have a voice shaping services and are able to play an active part in community life. Those leading, commissioning and providing health improvement services and programmes need to consider the implications of this report and identify practical actions that can be taken to build more confident and connected communities. PHE and NHS England will help make evidence and learning on community-centred approaches more accessible and will support knowledge exchange to mainstream good practice.

Implications for local leaders and commissioners

- consider how community-centred approaches that build on individual and community assets can become an essential part of mainstream strategies and local plans to improve health and wellbeing. There is a compelling case for a shift to more person and community centred ways of working
- recognise the scope for action. There are a diverse and broad range of community engagement and development methods that can be used to improve physical and mental health. Many models have been ‘tried and tested’ in the UK and offer alternatives for positive change
- use the family of community-centred approaches as a tool to consider potential options for commissioning health improvement and preventive services. Chose approaches based on whether the priority is to strengthen communities, build the community/volunteer workforce as agents of change, co-design services or ensure good access to healthy living activities. Whole system commissioning will use a mix of approaches and linked elements to achieve health goals
- involve those at risk of social exclusion in designing and delivering solutions that address inequalities in health. People with lived experience of deprivation bring vital knowledge and connections that can hold the key to creating pathways to good health
- celebrate, support and develop both formal and informal volunteering. Volunteering is the bedrock of community action, brings benefits to individuals and increases the capacity of services. Grants, training, marketing, organisational support and commissioning volunteer-led services are all ways to support local volunteering
- apply existing evidence to the local context, but be prepared to evaluate to check out whether approaches work and for whom. Share learning with others to support good implementation and best practice

Appendix 1. How the family was developed

The family of community-centred approaches was developed as part of the 'Working with communities: empowerment, evidence and learning' project. One of the objectives of the project was to develop a conceptual framework on community-centred approaches to health and wellbeing and identify sources of evidence and knowledge that can be used to support their application in practice.

The family of approaches was developed to make sense of the rich and diverse range of community-based prevention interventions, models and participatory methods and practices. The family analogy was used to develop a visual aid to represent the four major strands of practice. The development process involved drawing on different sources of information:

1 A scoping review was undertaken by a team at Leeds Beckett University. This involved systematic searching of conceptual and review papers on community-centred approaches. Titles and abstracts were screened and relevant publications were identified and coded. Conceptual papers with typologies were identified through this process. Most were of limited relevance to categorising interventions in practice.
2 A major review of community engagement and inequalities led by the Institute of Education had identified three distinct theories of change: (i) empowerment (ii) lay/peer involvement in delivery (iii) patient/consumer involvement in development.[68]
3 An initial 'family' was developed around four basic strands, three of these closely based on three theories of change and a fourth strand added on connections with community resources. The family was then populated and broadened to reflect the breadth of UK practice and the evidence base on social participation and social connectedness as well as the more traditional civic participation. Empowerment was not used a category, as evidence shows empowerment can occur across any of the approaches.
4 The initial family model was then tested with a number of stakeholders working at a national level and in practice. This included discussion with Nottinghamshire County and Nottingham City public health team, a workshop at the Manchester Festival of Public Health, and a presentation to the Strategic Partner Programme. Responses were overwhelmingly positive and the family was seen to have a good fit with practice.
5 The results of the scoping review were mapped back to the family. Reviews listing types of approaches/interventions[7, 68, 94, 159] were identified and checked against the family leading to additions in lists.

References

1. World Health Organization Regional Office for Europe. Health 2020: a European policy framework supporting action across government and society for health and well-being. Copenhagen: 2012.
2. National Institute for Health and Care Excellence. Community engagement to improve health. NICE local government briefings 2014. Available from: http://publications.nice.org.uk/lgb16.
3. NHS England. NHS Five Year Forward View. London: NHS England; 2014.
4. Public Health England. From evidence into action: opportunities to protect and improve the nation's health. London: Public Health England; 2014.
5. Yerbury H. Vocabularies of community. Community Development Journal. 2011;47(2):184-98.
6. Campbell F, Hughes L, Gilling T. Reaching out: community engagement and health. London: Improvement and Development Agency (IDeA), 2008.
7. National Institute for Health and Clinical Excellence. Community engagement to improve health. London: NICE, 2008.
8. Bracht N, Tsouros A. Principles and strategies of effective participation. Health Promotion International. 1990;5(3):199-208.
9. World Health Organization. Milestones in health promotion: Statements from global conferences. Geneva: 2009.
10. World Health Organization. Community participation in local health and sustainable development. Approaches and techniques. WHO regional Office for Europe, 2002 EUR/ICP/POLC 06 03 05D.
11. World Health Organization Regional Office for Europe. Health 2020 policy framework and strategy Copenhagen: 2020.
12. Davies SC, Winpenny E, Ball S, Fowler T, Rubin J, Nolte E. For debate: a new wave in public health improvement. The Lancet. 2014 vol 384, 1889-95.
13. HM Government. Health and Social Care Act. 2012.
14. HM Government. Localism Act. 2011.
15. Secretary of State for Health. Healthy Lives, Healthy People: Our strategy for public health in England. CM7985. London: HM Government, 2010.
16. Department of Health. Social action for health and well-being: building co-operative communities. Department of Health strategic vision for volunteering. Leeds: Department of Health, 2011.
17. South J, White J, Gamsu M. People-centred public health. Bristol: The Policy Press; 2013.
18. The Marmot Review. Fair Society, Healthy Lives. The Marmot Review. The Marmot Review, 2010.
19. Wallerstein N. Empowerment to reduce health disparities. Scandinavian Journal of Public Health. 2002;30(59):72-7.
20. Foot J. What makes us healthy? The asset approach in practice: evidence, action and evaluation. www.janefoot.co.uk, 2012.
21. Morgan A, Ziglio E. Revitalising the evidence base for public health: an assets model. Promotion & Education. 2007;14(Supplement 2):17-22.
22. Dolan P, Hallsworth M, Halpern D, King D, Vlaev I. MINDSPACE: Influencing behaviour through public policy. London: Institute for Government & Cabinet Office, 2010.
23. National Institute for Health and Clinical Excellence. Increasing the uptake of HIV testing among men who have sex with men. Quick reference guide. London: National Institute for Health and Clinical Excellence, 2011.
24. National Institute for Health and Care Excellence. Behaviour change: the principles for effective interventions. NICE, 2007.
25. Harris J, Springett J, Croot L, Booth A, Campbell F, Thompson G, et al. Can community-based peer support promote health literacy and reduce inequalities? A realist review. NIHR Journals, in press.
26. Holt-Lunstad J, Smith TB, Layton JB. Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Med. 2010;7(7):e1000316.
27. Victor CR, Bowling A. A Longitudinal Analysis of Loneliness Among Older People in Great Britain. Journal of Psychology. 2012;146(3):313-31.
28. Windle K, Francis J, Coomber C. Research Briefing 39: Preventing Loneliness and Social Isolation: Interventions and Outcomes. London: Social Care Institute for Excellence; 2011.
29. Foresight Mental Capital and Wellbeing Project. Mental Capital and Wellbeing: Making the most of ourselves in the 21st century. Final Project report. London: The Government Office for Science, 2008.
30. Aked J, Marks N, Cordon C, Thompson S. Five ways to wellbeing. London: New Economics Foundation, 2008.

31. O'Donnell GC, Deaton A, Durand M, Halpern D, Layard R. Wellbeing and policy. London: Legatum Institute, 2014.
32. Public Health England. Health inequalities: starting the conversation. London: PHE, 2014.
33. Wanless D. Securing good health for the whole population. Final report. London: HM Treasury, 2004.
34. UCL Institute of Equity. Review of social determinants and the health divide in the WHO European Region: executive summary. Copenhagen: World Health Organization Europe, 2013.
35. Ferlander S. The importance of different forms of social capital for health. Acta Sociologica. 2007;50(2):115-28.
36. Barry MM. Addressing the determinants of positive mental health:concepts, evidence and practice. International Journal of Mental Health Promotion. 2009;11(3):4-17.
37. Canadian Institute for Health Information. The role of social support in reducing pyschological distress. Canada: Canadian Institute for Health Information, 2012.
38. Chief Medical Officer. Our Children Deserve Better:Prevention Pays. Annual Report of the Chief Medical Officer London: Department of Health, 2012.
39. Friedli L. Mental health, resilience and inequalities. Denmark: World Health Organization Europe, 2009.
40. Foot J, Hopkins T. A glass half-full: how an asset approach can improve community health and well-being. Improvement and Development Agency Healthy Communities Team, 2010.
41. Burns H. Health in Scotland 2009. Time for Change. Edinburgh: NHS Health Scotland, 2010.
42. Morgan A. Revisiting the Asset Model: a clarification of ideas and terms. Global Health Promotion. 2014;21(3):2-6.
43. Lindström B, Eriksson M. Salutogenesis. Journal of Epidemiology and Community Health. 2005;59(6):440-2.
44. Brodsky AE, Cattaneo LB. A transconceptual model of empowerment and resilience: divergence, convergence and interactions in kindred community concepts. American Journal of Community Psychology. 2013;52:333-46.
45. Lindström B, Eriksson M. A salutogenic approach to tackling health inequalities. In: Morgan A, Davies M, Ziglio E, editors. Health assets in a global context: methods, theory, action. London: Springer; 2010. p. 17-39.
46. Wallerstein N. What is the evidence on effectiveness of empowerment to improve health? Copenhagen: WHO Regional Office for Europe (Health Evidence Network report), 2006.
47. Smith J, Gardner B, Michie S. Self efficacy guidance material for Health Trainer Service. London: UCL, 2010.
48. Hibbard J, Gilburt H. Supporting poeple to manage their health. An introduction to patient activation. London: The King's Fund, 2014.
49. Laverack G. Improving health outcomes through community empowerment: a review of the literature. Journal of Health, Population, and Nutrition. 2006;24(1):113-20.
50. Morgan LM. Community participation in health: perpetual allure, persistent challenge. Health Policy and Planning. 2001;16(3):221-30.
51. Cornwall A. Unpacking 'Participation': models, meanings and practices. Community Development Journal. 2008;43(3):269-83.
52. Tritter JQ, McCallum A. The snakes and ladders of user involvement: moving beyond Arnstein. Health Policy. 2006;76:156-68.
53. Wilcox D. The guide to effective participation. Brighton: Partnership Books; 1994.
54. Low N, Butt S, Ellis Paine A, Davis Smith J. Helping out. A national survey of volunteering and charitable giving. Cabinet Office, Office of the Third Sector, 2008.
55. Cabinet Office. Community Life Survey: August 2012-April 2013. Statistical bulletin. London: Cabinet Office, 2013.
56. Naylor C, Mundle C, Weaks L, Buck D. Volunteering in health and social care. Securing a sustainable future. London: The King's Fund, 2013.
57. Jenkinson CE, Dickens AP, Jones K, Thompson-Coon J, Rtaylor RS, TRogers M, et al. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. BMC Public Health. 2013;13:773.
58. von Bonsdorff MB, Rantanen T. Benefits of formal voluntary work among older people. Aging Clinical and Experimental Research. 2011;23(3):162-9.
59. NNVIA - The Network of National Volunteer-Involving Agencies. Overcoming barriers to volunteering. London: CSV, 2011.
60. Hoskins BL, Mascherini M. Measuring citizenship through the development of a composite indicator. Social Indicators Research. 2009;90:459-88.
61. Laverack G. Health activism. Health Promotion International. 2012;27(4):429-34.
62. Buck D, Gregory S. Improving the public's health. A resource for local authorities. London: The King's Fund, 2013.

63. Miller C. Developing the power of strong, inclusive communities. A framework for Health and Wellbeing Boards. Office for Public Management, 2014.
64. Grady M, Goldblatt P, editors. Addressing the social determinants of health: the urban dimension and the role of local government. Copenhagen: World Health Organization Regional Office for Europe; 2012.
65. Institute of Health Equity. Tackling health inequalities through action on the social determinants of health: lessons from experience. Local action on health inequalities: Health Equity Evidence Briefing 10. London PHE/IHE, 2014.
66. NHS England. Transforming participation in health and care2013. Available from: http://www.england.nhs.uk/2013/09/25/trans-part/.
67. Kickbusch I, Gleicher D. Governance for health in the 21st century. Copenhagen: World Health Organization Regional Office for Europe, 2012.
68. O'Mara-Eves A, Brunton G, McDaid D, Oliver S, Kavanagh J, Jamal F, et al. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Public Health Research. 2013;1(4).
69. Liberato S, Brimblecombe J, Ritchie J, Ferguson M, Coveney J. Measuring capacity building in communities: A review of the literature. . BMC Public Health. 2011;11(1):850.
70. Fisher B. Community development in health: a literature review2011.
71. Laverack G. Using a 'domains' approach to build community empowerment. Community Development Journal. 2006;41(1):4-12.
72. Minkler M. Introduction to community organizing and community building. In: Minkler M, editor. Community Organizing and Community Building for Health and Welfare Third ed. Newark, NJ: Rutgers University Press; 2012. p. 5-26.
73. Seebohm P, Chaudhary S, Boyce M, Elkan R, Avis M, Munn-Giddings C. The contribution of self-help/mutual aid groups to mental well-being. Health & Social Care in the Community. 2013;21(4):391-401.
74. Federation for Community Development Learning. A summary of the 2009 Community Development Occupational Standards. Sheffield: FCDL; 2009.
75. Scottish Community Development Centre. Learning, evaluation and planning (LEAP) undated. Available from: http://www.scdc.org.uk/what/LEAP/.
76. Amos M. Community development. In: Adams L, Amos M, Munro J, editors. Promoting health: politics and practice. London: Sage; 2002. p. 63-71.
77. Seebohm P, Gilchrist A. Connect and Include: An exploratory study of community development and mental health. London: National Social Inclusion Programme; 2008.
78. Seebohm P, Gilchrist A, Morris D. Bold but balanced: how community development contributes to mental health and inclusion. Community Development Journal. 2012;47(4):473-90.
79. Gillespie J, Hughes S. Positively Local. C2 a model for community change. Birmingham: University of Birmingham Health Services Management Centre, 2011.
80. Scottish Community Development Centre. Assets based approaches to health improvement - Creating a culture of thoughtfulness, briefing paper. Glasgow: SCDC; 2013.
81. Kretzmann JP, McKnight JL. Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets. Evanston, IL: Institute for Policy Research; 1993.
82. Heaney C, Israel B. Social Networks and Social Support. In: Glantz K, Rimer B, Viswanath K, editors. Health Behaviour and Health Education: Theory, Research and Practise. 4. San Francisco, CA: Jossey-Bass; 2008.
83. Leeds Age UK. Neighbourhood Network Schemes: Leeds Age UK, ; 2013 [cited 2014 20th July]. Available from: http://www.ageuk.org.uk/leeds/about-age-uk-leeds/neighbourhood-network-schemes/.
84. Dennis C-L. Peer support within a healthcare context: a concept analysis. International Journal of Nursing Studies. 2003;40(3):321-32.
85. Gilman M. People power. Druglink. 2013.
86. Public Health England. A briefing on the evidence-based drug and alcohol treatment guidance recommendations on mutual aid. London: Public Health England, 2013.
87. Milligan C, Dowrick C, Payne S, Hanratty B, Irwin P, Neary D, et al. Men's Sheds and other gendered interventions for older men: improving health and wellbeing through social activity - a systematic review and scoping of the evidence base. Lancaster: Lancaster University Centre for Ageing Research; 2013.
88. Knapp M, Bauer A, Perkins M, Snell T. Building community capital in social care: is there an economic case? Community Development Journal. 2013;48(2):313-31.
89. Seyfang G. Harnessing the potential of the social economy? Time banks and UK public policy. International Journal of Sociology and Social Policy. 2006;26(9/10):430-43.
90. Timebanking UK. Research Stroud: Timebanking UK,; 2014. Available from: http://www.timebanking.org/about/timebanking-resources/research/.

91. Whitehead M. A typology of actions to tackle social inequalities in health. Journal of Epidemiology and Community Health. 2007;61(6):473-8.
92. Minkler M, Wallerstein N, Wilson N. Improving Health through Community Organisation and Community Building. In: Glantz K, Rimmer B, Viswanath K, editors. Health Behavior and Health Education: Theory, Research and Practise. San Francisco, CA: Jossey-Bass; 2008.
93. Wallerstein N, Mendes R, Minkler M, Akerman M. Reclaiming the social in community movements: perspectives from the USA and Brazil/South America: 25 years after Ottawa. Health Promotion International. 2011;26(S2):ii226-ii36.
94. Elliott E. Connected Comunities. A review of theories, concepts and interventions relating to community-level strengths and their impact on health and well being. London: Connected Communities; 2012.
95. Woodall J, Raine G, South J, Warwick-Booth L. Empowerment and Health & Well-being: Evidence Review Leeds: Centre for Health Promotion Research, Leeds Metropolitan University, 2010.
96. Wiggins N. Popular education for health promotion and community empowerment: a review of the literature. Health Promotion International. 2012;27(3):356-71.
97. Trickett EJ, Beehler S, Deutsch C, Green LW, Hawe P, McLeroy K, et al. Advancing the science of community-level interventions. Amercian Journal of Public Health. 2011;101(8):1410-9.
98. Lewin SA, Dick J, Pond P, Zwarenstein M, Aja G, van Wyk B, et al. Lay health workers in primary and community health care. Cochrane Database of Systematic Reviews. 2005(Issue 1, Art.No.: CD0040415. DO1:10.1002/14651858.CD004015.pub2.).
99. Rhodes SD, Foley KL, Zometa CS, Bloom FR. Lay health advisor interventions among hispanics/latinos a qualitative systematic review. American Journal of Preventive Medicine. 2007;33(5):418-27.
100. Royal Society for Public Health. Tackling health inequalities: the case for investment in the wider public health workforce. London: Royal Society for Public Health; 2014.
101. South J, Meah A, Bagnall A-M, Kinsella K, Branney P, White J, et al. People in Public Health - a study of approaches to develop and support people in public health roles. Report for the National Institute for Health Research Service Delivery and Organisation programme. NIHR Service Delivery and Organisation Programme, 2010.
102. Eng E, Parker E, Harlan C. Lay health advisor intervention strategies: a continuum from natural helping to paraprofessional helping. Health Education & Behavior. 1997;24(4):413-7.
103. Chiu LF. Application and management of the Community Health Educator model. A handbook for practitioners. Leeds: Nuffield Institute for Health, 2003.
104. Turning Point. Citizen Advisors. Linking services and empowering communities. London: Turning Point, 2010.
105. NHS Confederation, Altogether Better. Community Health Champions: creating new relationships with patients and communities. London: NHS Confederation, 2012.
106. Coufopoulos A, Coffey M, Dugdill L. Working as a community food worker: voices from the inside. Perspectives in Public Health. 2010;130(4):180-5.
107. Gillam S, Levenson R. Linkworkers in Primary Care: an untapped resourse. British Medical Journal. 1999;319:1215.
108. Swider SM. Outcome effectiveness of community health workers: an integrative literature review. Public Health Nursing. 2002;19(1):11-20.
109. Kennedy L, Milton B, Bundred P. Lay food and health worker involvement in community nutrition and dietetics in England: roles, responsibilities and relationships with professionals. Journal of Human Nutrition and Dietetics. 2008;21(3):210 - 24.
110. Health Trainers England. About Health Trainers: Leeds Metropolitan University; undated. Available from: http://www.healthtrainersengland.com/about-health-trainers.
111. Department of Health. Choosing health. Making healthier choices easier. London: The Stationary Office, 2004 Cm 6732.
112. Michie S, Rumsey N, Fussell A, Hardeman W, Johnston M, Newman S, et al. Improving health: changing behaviour.NHS Health Trainer handbook. London: Department of Health, 2008.
113. Dooris M, McArt D, Hurley MA, Baybutt M. Probation as a setting for building well-being through integrated service provision: evaluating an Offender Health Trainer service. Perspectives in Public Health. 2013;133 (4):199-206.
114. Woodall J, White J, South J. Improving health and well-being through community health champions: a thematic evaluation of a programme in Yorkshire and Humber. Perspectives in Public Health 2013;133(2):96-103.
115. Altogether Better. Unlocking the power of communities to transform lives 2013 [cited 2013 20th November]. Available from: http://www.altogetherbetter.org.uk/home.aspx.

116. Springett J, Owens C, Callaghan J. The challenge of combining 'lay' knowledge with 'evidenced-based' practice in health promotion: Fag Ends Smoking Cessation Service. Critical Public Health. 2007;17(3):243-56.
117. Bakski A, Al-Mrayat M, Hogan D, Whittingstall E, Wilson P, Wex J. Peer advisers compared with specialist health professionals in delivering a training programme on self-management to people with diabetes: a randomized controlled trial. Diabetic Medicine. 2008;25:1076-82.
118. Ziersch A, Gaffney J, Tomlinson DR. STI prevention and the male sex industry in London: evaluating a pilot peer education programme. Sexually Transmitted Infections. 2000;76(6):447-53.
119. Hunter G, Power R. Involving Big Issue vendors in a peer education initiative to reduce drug-related harm: a feasibility study. Drugs: Education, Prevention & Policy. 2002;9(1):57-69.
120. Milburn K. A critical review of peer education with young people with special reference to sexual health. Health Education Research. 1995;10(4):407-20.
121. Finnegan L, Whitehurst D, Deaton S. Models of mentoring for inclusion and employment. Thematic review of existing evidence on mentoring and peer mentoring. London: Centre for Economic & Social Inclusion, 2010.
122. Britton C, McCormick FM, Renfrew MJ, Wade A, King SE. Support for breastfeeding mothers. Cochrane database of systematic reviews. 2007(1):CD001141. Epub: 2007 Jan 24.
123. Britten J, Hoddinott P, McInnes R. Breastfeeding peer support: health service programmes in Scotland [corrected] [published erratum appears in BR J MIDWIFERY 2006 Apr;14(4):232]. British Journal of Midwifery. 2006;14(1):12-9.
124. Repper J, Aldridge B, Gilfoyle S, Gillard S, Perkins R, Rennison J. Peer support workers: theory and practice. Implementing Recovery through Organisational Change briefing. London: Centre for Mental Health and Mental Health Network; 2013.
125. Mundle C, Naylor C, Buck D. Volunteering in health and care in England. A summary of key literature. London: The King's Fund, 2012.
126. Macmillan Cancer Support, Ramblers. Walking for health undated [cited 2014]. Available from: http://www.walkingforhealth.org.uk/.
127. O'Brien L, Buris A, Townsend M, Ebden M. Volunteering in nature as a way of enabling people to reintegrate into society. Perspectives in Public Health. 2010.
128. CLES Consulting, nef. Big Lottery Fund National Well-being Evaluation. Manchester: Centre for Local Economic Studies, 2013.
129. de Moor D. Walking Works. London: Ramblers, 2013.
130. South J, Giuntoli G, Kinsella K. An evaluation of the Walking for Wellness project and the befriender role. Natural England Commissioned Reports, Number 118. Natural England, 2013.
131. Institute of Health Equity. Improving access to green spaces. Local action on health inequalities: Health Equity Evidence Review 8. London: PHE/IHE; 2014.
132. Altpeter M, Earp JL, Schopler JH. Promoting breast cancer screening in rural, African American communities: The "science and art" of community health promotion. Health Soc Work. 1998;23(2):104-15.
133. South J, Raine G, White J. Community Health Champions: Evidence Review. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University, 2010.
134. Paylor J. Volunteering and health: evidence of impact and implications for policy and practice. A literature review. London: Institute of Volunteering Research, 2011.
135. Sheffield Well-being Consortium. Health Champions Case Studies Sheffield: Sheffield Well-being Consortium; undated. Available from: http://www.altogetherbetter.org.uk/Data/Sites/1/wb_chccasestorybooklet2_singles.pdf.
136. Brownstein JN, Chowdhury FM, Norris SL, Horsley T, Jack L, Zhang X, et al. Effectiveness of community health workers in the care of people with hypertension. American Journal of Preventive Medicine. 2007;32(5):435-47.
137. Kaczorowski J, Chambers LW, Dolovich L, Paterson JM, Karwalajtys T, Gierman T, et al. Improving cardiovascular health at population level: 39 community cluster randomised trial of Cardiovascular Health Awareness Program (CHAP). British Medical Journal. 2011;342:d442.
138. Boyle D, Harris H. The Challenge of Co-production: How equal partnerships between professionals and the public are crucial to improving public services. London: National Endowment for Science, Technology and the Arts, New Economics Foundation, 2009.
139. Hunter DJ, Perkins N. Partnership Working in Public Health Bristol Policy Press; 2014.
140. Rifkin SB, Lewando-Hundt G, Draper AK. Participatory approaches in health promotion and health planning. A literature review. London: Health Development Agency, 2000.
141. Baggott R. A funny thing happened on the way to the forum? Reforming patient and public involvement in the NHS in England. Public Administration. 2005;83(3):533-51.

142. Minkler M. Linking Science and Policy Through Community-Based Participatory Research to Study and Address Health Disparities. American Journal of Public Health. 2010;100(S1):S81-S7.
143. Macaulay A, Commanda L, Freeman W, Gibson N, McCabe M, Robbins C, et al. Participatory research maximises community and lay involvement. British Medical Journal. 1999;319:774-8.
144. Oliver S, Rees RW, Clarke-Jones L, Milne R, Oakley AR, Gabbay J, et al. A multidimensional conceptual framework for analysing public involvement in health services research. Health Expectations. 2008;11:72–84.
145. Andrews J, Newman S, Heath J, Williams L, Tingen M. Community-based participatory research and smoking cessation interventions: a review of the evidence. The Nursing Clinics Of North America. 2012;47(1):81-96.
146. Catalani C, Minkler M. Photovoice: A review of the literature in health and public health. Health Education & Behavior. 2010;37(3): 424-51.
147. Murray S, Tapson J, Turnbull L, McCallum J, Little A. Listening to local voices: adopting rapid appraisal to asses health and social needs in general practice. British Medical Journal. 1994;308:698-70.
148. Turning Point. Connected Care Impacts and Outcomes. London: Turning Point, 2012.
149. Burton P, Croft J, Hastings A, Slater T, Goodlad R, Abbott J, et al. What works in area-based initiatives? A systematic review of the literature. London: Home Office, 2004.
150. Muscat R. Area based initiatives: do they deliver? CLES Briefing. 2010 February 2010:1-8.
151. Perkins N, Smith KE, Hunter DJ, Bamba C. 'What counts is what works'? New Labour and partnerships in public health Policy & Politics. 2010;38(1):101-17.
152. De Leeuw E. Evidence for Healthy Cities: reflections on practice, method and theory. Health Promotion International. 2009;24(S1):19-36.
153. Tsouros A, Green G. Health promotion international: special supplement on European Healthy Cities. Health Promotion International. 2009;24:i1-3.
154. Heritage Z, Dooris M. Community participation and empowerment in Healthy Cities. Health Promotion International. 2009;24(51):45-55.
155. Kegler MC, Norton BL, Aronson RE. Strengthening community leadership: evaluation findings from the California Healthy Cities and Communities Program. Health Promotion Practice. 2008;9(2):170-9.
156. Pozzebon M, Mailhot C. Citizens engaged to improve the sustainability and quality of life of their cities: the case of *Nossa Sao Paulo*. Journal of Change Management. 2012;12(3):301-21.
157. Chadderton C, Elliott E, Williams G. Involving the public in HIA: An evaluation of current practise in Wales, working paper 116. Cardiff: Cardiff School of Social Sciences, Cardiff University; 2008.
158. Kimberlee R. Streets ahead on safety: young people's participation in decision-making to address the European road injury 'epidemic'. Health and Social Care in the Community. 2008;16(3):322-8.
159. Coulter A. Engaging communities for health improvement. A scoping review for the Health Foundation. London: The Health Foundation; 2010.
160. Slater B, Knowles J, Lyon D. Improvement Science meets Community Development: Approaching Health Inequalities through Community Engagement. Journal of Integrated Care. 2008;16(6):26-36.
161. National Council for Voluntary Organisations (NCVO). Participation: trends, facts and figures. London: NCVO, 2011.
162. Gamsu M, Abbas J. Asking the difficult questions. Making the difficult decisions. Exploring the role of Commissions in developing powerful locally owned evidence based commissioning 2013. York: Yorkshire and Humber Public Health Observatory.
163. SQW Consulting. National Evaluation of Participatory Budgeting in England: Phase 1 Main Report 2010.
164. Social Care Institute for Excellence. Seldom heard: developing inclusive participation in social care. Summary. London: Social Care Institute for Excellence; 2008.
165. HM Treasury, Communities and Local Government. Total place: a whole area approach to public services. London: HM Treasury, 2010.
166. HM Government, Local Government Association. Local Public Service Transformation: A guide to Whole Place Community Budgets. London: Local Government Association,, 2013.
167. House of Commons Communities and Local Government Committee. Community Budgets. Third Report of Session 2013–14. London: House of Commons, 2013.
168. British Academy. "If you could do one thing to reduce health inequalities". Nine local actions to reduce health inequalities. London: British Academy, 2014.
169. Realpe A, Wallace LM. What is co-production? London: The Health Foundation, 2010.
170. Boyle D, Clark S, Burns S. Hidden work. Co-production by people outside paid employment. York: Joseph Rowntree Foundation, 2006.
171. Boyle D. Turbo charging volunteering: co-production and public service reform. London: Centre Forum, 2014.

172. Hampson M, Baeck P, Langford K. For us, by us: the power of co-design and co-delivery. London: NESTA, Innovation Unit, 2014.
173. Jabbar AM, Abelson J. Development of a framework for effective community engagement in Ontario, Canada. Health Policy. 2011;101:59-69.
174. Kegler MC, Painter JE, Twiss JM, Aronson R, Norton BL. Evaluation findings on community participation in the California Healthy Cities and Communities program. Health Promotion International. 2009;24(4):300-10.
175. Pickin C, Popay J, Staley K, Bruce N, Jones C, Gowman N. Developing a model to enhance the capacity of statutory organisations to engage with lay communities. Journal of Health Services Research and Policy. 2002;7(1):34-42.
176. Milton B, Attree P, French B, Povall S, Whitehead M, Popay J. The impact of community engagement on health and social outcomes: a systematic review. Community Development Journal. 2011.
177. Mackinnon J, Reid M, Kearns A. Communities and health improvement: a review of evidence and approaches. Edinburgh: NHS Health Scotland; 2006.
178. Attree P, French B, Milton B, Povall S, Whitehead M, Popay J. The experience of community engagement for individuals: a rapid review of evidence. Health & Social Care in the Community. 2011;19(3):250-60.
179. Burton P, Goodlad R, Croft J. How would we know what works?: Context and complexity in the evaluation of community involvement. Evaluation. 2006;12(3):294-312.
180. Montini T, George A, Martin-Mollard M, Bero L. The role of public participation in public health initiatives: an analysis of the WHO Framework Convention on Tobacco Control. Global Public Health. 2010;5(1):48-61.
181. NHS Future Forum. Choice and Competition. Delivering Real Choice. A report from the NHS Future Forum. London: Department of Health, 2011.
182. Billis D, Glennerster H. Human services and the voluntary sector: towards a theory of comparative advantage. Journal of Social Policy. 1998;27(1):70-98.
183. Year of Care. Thanks for the Petunias - a guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions. NHS Diabetes, 2011.
184. Hacking S, Secker J, Spandler H, Kent L, Shenton J. Evaluating the impact of participatory arts projects for people with mental health needs. Health and Social Care in the Community. 2008;16(6):638-48.
185. Oxford Brookes University, The Conservation Volunteers. TCV Green Gym® National Evaluation Report: Summary of Findings. Donacaster: TCV, 2008.
186. The Trussell Trust. How a foodbank works 2014. Available from: http://www.trusselltrust.org/how-it-works.
187. Adams J, White M, Moffatt S, Howel D, Mackintosh J. A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings. BMC Public Health 2006;6(81).
188. BMA. Social Determinants of Health – What Doctors Can Do. London: BMA, 2011.
189. Friedli L, Jackson C, Abernethy H, Stansfield J. Social prescribing for mental health – a guide to commissioning and delivery. Lancashire: CSIP North West, 2008.
190. Dayson C, Bashir N. The social and economic impact of the Rotherham Social Prescribing Pilot: summary evaluation report. Sheffield: Centre for Regional Economic and Social Research, Sheffield Hallam University, 2014.
191. White J, Kinsella K, South J. An evaluation of social prescribing health trainers in South and West Bradford. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University, 2011.
192. Scottish Community Alliance. Community Anchor Organisations Edinburgh: Scottish Community Alliance; 2014. Available from: http://www.localpeopleleading.co.uk/on-the-ground/anchor-orgs/.
193. Big Lottery Fund. Learning from Healthy Living Centres: final evaluation summary. Big Lottery Fund Research Issue 40. Big Lottery, 2007.
194. Gul M. From hard to reach to within reach - the 'how' of community engagement in the era of the Big Society. In: Davies C, Flux R, Hales M, Walmsley J, editors. Better health in harder times Active Citizens and innvovation on the frontline. Bristol: Policy Press; 2013. p. 153-6.
195. Welsh Government. Expert Review of Public Libraries in Wales. Aberystwyth: Libraries Development Team; 2014.
196. Cabinet Office Social Exclusion Task Force. Inclusion health: improving the way we meet the primary health care needs of the socially excluded. London: HM Government, Cabinet Office, Department of Health; 2010.
197. Bromley-by-Bow Centre. Bromley-by-Bow Centre 2014. Available from: http://www.bbbc.org.uk/.
198. HealthWorks Newcastle. Welcome to HealthWORKS Newcastle 2014. Available from: http://www.healthworksnewcastle.org.uk/.
199. Hunter D. Learning from Healthy Living Centres: the changing policy context. Big Lottery Fund, 2007.
200. Hamara. Hamara celebrating 10 years of serving the community 2014. Available from: http://hamara.org.uk/.
201. Gamsu M. Tell us what the problem is and we'll try to help. Towards more effective commissioning of local voluntary sector organisations. Manchester: Voluntary Sector North West, Regional Voices, 2011.
202. Social Enterprise UK. Public Services (Social Value) Act 2012. A brief guide. London: Social Enterprise UK, 2012.

203. Gill P, MacLeod U, Lester H, Hegenbarth A. Improving access to health care for gypsies and travellers, homeless people and sex workers: an evidence-based commissioning guide for Clinical Commissioning Groups and Health and Wellbeing Boards. London: Royal College of General Practitioners; 2013.
204. Wallace C, Pichler F. More participation, happier society? A comparative study of civil society and the quality of life. Social Indicators Research. 2009;93:255-74.
205. Heaven B, Brown L, White M, Errington L, Mathers J, Moffatt S. Supporting well-being through meaningful social roles: Systematic review of intervention studies. The Milbank Quarterly. 2013;9(2):222-87.
206. Royal College of Physicians. How doctors can close the gap. Tackling the social determinants of health through culture change, advocacy and education. London: RCP, 2010.
207. Institute of Medicine. An integrated framework for assessing the value of community-based prevention. Washington DC: The National Academies Press, 2012.
208. Mittler JN, Martsolf GR, Telenko SJ, Scanlon DP. Making sense of "consumer engagement" inititaives to improve health and health care: a conceptual framework to guide practice. The Milbank Quarterly. 2013;91(1):37-77.
209. Piskur B, Daniels R, Jongmans MJ, Ketelaar M, Smeets RJEM, Norton M, et al. Participation and social participation: are they distinct concepts? Clincial Rehabilitation. 2014;28(3):211-20.
210. Levasseur M, Richard L, Gauvin L, Raymond E. Inventory and analysis of definitions of social participation found in the aging literature: proposed taxonomy of social activities. Social Science & Medicine (1982). 2010;71(12):2141-9.
211. Andrews R, Cowell R, Downe J. Support for active citizenship and public service performance: an empirical analysis of English local authorities. Policy & Politics. 2008;3(2):225-43.
212. Preston R, Waugh H, Larkins S, Taylor J. Community participation in rural primary health care: intervention or approach? Australian Journal of Primary Health. 2010;16:4-16.
213. Hibbard JH. Community-based participation approaches and individual health activation. The Journal Of Ambulatory Care Management. 2009;32(4):275-7.
214. Casiday R, Kinsman E, Fisher C, Bambra C. Volunteering and health; what impact does it really have? London: Volunteering England, 2008.
215. Warr DJ, Mann R, Kelaher M. 'A lot of things we do...people wouldn't recognise as health promotion': addressing health inequalities in settings of neighbourhood disadvantage. Critical Public Health. 2012;23(1):95-109.
216. Farrell C, Bryant W. Voluntary work for adults with mental health problems: a route to inclusion? A review of the literature. British Journal of Occupational Therapy. 2009;72(4):163-73.
217. Savage V, O'Sullivan C, Mulgan G, Ali R. Public services and civil society working together. An initial think piece. London: The Young Foundation, 2009.
218. South J, White J, Gamsu M. Putting 'the public' back into public health. A national conference on building the voice of citizens into public health evidence. Post conference briefing Leeds: Health Together, Leeds Beckett University,; 2014. Available from: http://www.leedsbeckett.ac.uk/files/Public_Health_conference_briefing.pdf.
219. Beresford P. User involvement, research and health inequalities: developing new directions. Health and Social Care in the Community. 2007;15(4):306-12.
220. Ryan-Collins J, Sanfilippo L, Spratt S. Unintended Consequences. How the efficiency agenda erodes local public services and a new public benefit model to restore them. London: New Economics Foundation, 2007.
221. Pennington M, Visram S, Donaldson C, White M, Lhussier M, Deane K, et al. Cost-effectiveness of health-related lifestyle advice delivered by peer or lay advisors: synthesis of evidence from a systematic review. Cost Effectiveness And Resource Allocation: C/E. 2013;11(1):30-.
222. NICE secretariat Cost effectiveness vignettes for community engagement. A paper prepared by the NICE secretariat for the Community Engagement Programme. NICE, 2007.
223. Mason AR, Carr Hill R, Myers LA, Street AD. Establishing the economics of engaging communities in health promotion: what is desirable, what is feasible? Critical Public Health. 2008;18(3):285-97.
224. Sheffield Well-being Consortium. Evidence to the Sheffield Fairness Commission2012. Available from: https://www.sheffield.gov.uk/your-city-council/policy--performance/fairness-commission/evidence/written-evidence.html.
225. Fujiwara D, Oroyemi P, McKinnon E. Wellbeing and civil society. Estimating the value of volunteering using subjective wellbeing data. London: Cabinet Office, DWP, 2013.
226. nef consulting. Catalysts for community action and investment: A Social Return on Investment analysis of community development work, based on a common outcomes framework. Executuive Summary. Community Development Foundation, 2010.
227. British Red Cross. Taking Stock. Assessing the value of preventative support. London: British Red Cross, 2012.

228. Natural England. An estimate of the economic and health value and cost effectiveness of the expanded WHI scheme 2009. Natural England Technical Information Note TIN055. Natural England, 2009.

About NHS England

"The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most".

NHS Constitution

The mission of NHS England is to deliver:

'High quality care for all, now and for future generations.'

The purpose of NHS England is to deliver improved health outcomes for England by:

- allocating resources to clinical commissioning groups and supporting them to commission services on behalf of their patients according to evidence-based quality standards
- directly commissioning specialised care services, primary care services, healthcare for the armed forces and their families, healthcare for those in the justice system and a range of public health services
- achieving equal access to health services designed around the needs of the patient

Working in partnership

NHS England is committed to putting patients at the heart of everything it does. NHS England works in partnership with a number of other NHS bodies including the Care Quality Commission, Monitor, the NHS Trust Development Authority, Public Health England, NICE, Health Education England and the Health & Social Care Information Centre, each of whom has distinctive responsibilities within the NHS.

For Further information on NHS England, visit www.england.nhs.uk.