The Centre for Science and Policy (CSaP)

NIHR Applied Research Collaboration East of England (ARC EoE)

The Population Health Research Hub East of England (PHResH EoE)

Prevention: Strengthening Communities and Society for Collective Action

Policy Workshop Report

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Strengthening Communities and Society Action at a Glance

Reposition Health as an Asset

The COVID-19 pandemic has offered opportunities to reposition the value of health in society. Rather than treating ill health as a burden, it is important for good health to be the goal.

Workshop participants discussed the need to invest in and develop a holistic approach to health in which health is integrated into every aspect of people's lives.

Champion Meaningful Engagement with Communities

Workshop participants emphasised the importance of championing co-production and working with people in local communities to develop action which promotes health.

Sharing responsibilities with communities in delivering healthcare programmes can improve participation, build trust and foster cooperation between healthcare professionals and members of the public.

Address Challenges in Community Engagement

Practitioners should work to identify the social, cultural and other barriers to engagement, as a first step to determining how these barriers can be overcome.

It is important to understand different kinds of community experiences at a local level, seeking opportunities to build trust and explore intersectionality.

Measure Success

Workshop participants emphasised the importance of building an evidence base which is of value to the relevant community. Some participants suggested that KPI's (key performance indicators) should be more tailored and to specific target communities.

One solution could be to help communities co-design KPIs for services.

Illustration credit: Rebecca Osborne

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1. Introduction:

The COVID-19 pandemic has amplified existing inequalities, with precarity becoming a bigger part of many people's lives throughout the United Kingdom. These inequalities are expected to have a long-lasting impact upon health and well-being more broadly, with factors such as uncertainty, insecurity of income, and lack of social supports acting as multipliers with consequences for health and non-communicable disease (NCD) management. For example, multi-morbidities are more likely to occur earlier in life among more socio-economically disadvantaged populations. Consequently, this is a critical moment for planning effective disease prevention and health promotion interventions, with the goal of preventing NCDs, preventing disease, and preventing occurrences of multi-morbidities.

Those seeking to address the challenge of preventing poor health have made a case for closer collaboration between communities, community services, the welfare system, and parts of the health system. Actors in this space have expressed an interest in identifying areas of success and failure in ongoing population health interventions; finding ways to make greater use of available, effective interventions; finding ways to take a holistic partnership and working systems approach; and how we can identify and tailor interventions for use at regional, local, or hyper-local levels. The goal of this work is the development of resilient infrastructure and strategic plans which can enable communities to flourish in terms of health and wellbeing.

With this in mind, the NIHR Applied Research Collaboration East of England (ARC EoE), the Centre for Science and Policy (CSaP) and the Population Health Research Hub East of England (PHResH EoE) co-hosted a workshop and accompanying webinar in March 2021 which sought to inform the future of the prevention of poor health by exploring the challenges from a community assets perspective. While the webinar focused on empowering communities more broadly, the accompanying workshop paid special attention to two priority area case studies: dietary inequalities and accessibility of services, particularly in relation to the prevention and early detection of cancer. This was the second set of events jointly hosted between these stakeholders, following an earlier workshop in the autumn of 2020 which explored the future of disease prevention and health promotion work more broadly.

Throughout the workshop, participants explored various facets of community engagement and co-produced approaches to the prevention of poor health, while seeking to address five core questions:

1. *What does the future of prevention look like?*
2. *How can prevention be better embedded within systems for optimum impact, sustainability, and health equity within communities?*
3. *What has the impact of COVID-19 been on the current and future prevention agendas in terms of inequalities and access to services?*
4. *How, and where, do we make the case for investing in and advocating for prevention now?*
5. *Where should intervention be focused?*

2. Positioning Health

2.1 Health as an Asset

In 2018, the Annual Report of then Chief Medical Officer Professor Dame Sally Davies sought to reposition health as an asset to the nation and to communities, and the pandemic has offered a further opportunity to continue efforts to reposition the value of health in our society. Participants throughout this workshop argued that re-evaluation must involve re-examining how to measure health, how to incentivise action which promotes health, how to reduce the likelihood of poor health outcomes, how best to work with communities in promoting health, and how to invest in and develop health more broadly. Participants further emphasised the importance of building healthy environments which foster wellbeing. In doing so, public health professionals must work with each level of community and the best possible evidence to create an approach to health which is holistic, while keeping in mind that one definition of health is “not having to think about it”.

One participant noted that current approaches to health systems are designed to be (health) condition-specific, rather than exploring how each person may experience their own barriers to being healthier, or what they want from being healthy. They noted that whereas it is easy to check your bank balance, checking on your health status can be inconvenient, and that we need to make it easier for people to check in on their health. Here, one participant gave an example of one successful initiative which has made checking your health status easier for some groups – the provision of breast screening services outside of supermarkets. Throughout the workshop, participants also highlighted examples of community-led approaches which connect the idea of health as an asset to services which are asset-based. For example, one participant cited a successful co-created community initiative which mapped community assets in disadvantaged areas and shared that information with the primary care system. Others suggested that social prescribing is a natural conduit between primary care and the community, noting that relatively small amounts of additional funding could significantly expand this effectively.

2.2 Health Systems and Health in Communities

Throughout the workshop, participants identified a need for the newly formed Integrated Care Systems (ICSs) to focus on health and wellbeing in the broadest sense, rather than focusing specifically on poor health or treating illness. Too often, conversations about health focus on formal healthcare – doctors, hospitals, treatment, and ill health. Participants at this workshop emphasised that we need to change that, and increase the emphasis on ‘healthy lives, healthy living, and healthy people’. Others suggested that we need to increase the focus on community care. Alongside this, participants argued that the idea of ‘health’ should not be viewed as synonymous with the NHS, with some voicing fears that post-pandemic large hospitals will dominate health funding. Instead, we need to reposition healthcare such that it is interwoven with every part of society. We should focus more on creating environments where people feel well.

Others noted that while the numbers of people experience mental health and/or physical health conditions have started to even out, this is not presently reflected in health care systems. Moreover, while the UK has invested in acute health services, there is a need for a greater focus on health initiatives which take place outside of hospital settings – and maybe even outside of formal healthcare settings. Ultimately, participants highlighted a need to focus on enabling people to live well for longer outside of hospitals and healthcare settings, while extending approaches to public health and social care.

2.3 Social Determinants

Prior to the onset of the pandemic the UK population was living longer, but the percentage of years spent in poor health or with multi-morbidities was also increasing. This poses a significant challenge, as living in good health is key to productivity, work, education, happiness, and wellbeing. As we work together to promote health, participants noted that tackling disease prevention must be closely intertwined to wider drivers of health and will require addressing the inequalities which often come in tandem with poor health.

The two biggest drivers of multi-morbidity in the United Kingdom are age and relative deprivation, both of which have been growing in the UK over the past few decades, alongside a rise in inequality. Increasingly, health is a better predictor of prosperity than education. Consequently, health has a role to play in individual, community, and national productivity, as well as in social mobility and the exacerbation of inequalities. As we work to address these challenges, participants noted that there are lessons to be learned from local anti-poverty programmes from the 1990s, which worked by listening to community needs. Successful initiatives are likely to be those which take a whole of community approach to engagement, asking about issues facing communities beyond health directly, with one participant highlighting that "if you are worrying about how to keep a roof over your head, health can seem abstract by comparison". Here, another participant noted that to reap successes for health and wellbeing, we need to also address low self-esteem and low hope in deprived communities.

The manifestation of inequalities related to the social determinants of health can start very early in life – as seen by the higher rates of childhood obesity in deprived communities. Here, there is a need to recognize that social determinants of health are moveable, and if society were to choose to address the drivers which shape our environments, this could powerfully improve health in communities. To do so, we need to make healthy choices easier; tackle commercial drivers which negatively impact our health such as the over-consumption of unhealthy food, tobacco, and alcohol; and do more to foster total physical, mental, and social health across our society. Here, participants argued that we need to value health for in a holistic sense and make more ofthe opportunities that it can provide. Participants felt that we should invest health by making healthier choices more affordable and more accessible than their less healthy alternatives.

3. Engaging with Communities:

3.1 Building and Sustaining Meaningful Engagement

How can researchers and practitioners work to foster participation in preventative programmes and improve health outcomes?

Throughout the workshop and webinar, participants emphasised the importance of championing co-production and working with people in local communities to develop and implement health promotion initiatives. Authenticity and trust in co-production and co-design were watchwords raised throughout the events. Here, participants also emphasised the value of working with a wide range of stakeholders and relying on both lived experiences and other forms of data in informing an effective approach.

Reflecting on experiences of deep community engagement, workshop participants emphasised that there are several types of engagement and co-production, and that getting the balance right between types of engagement while maintaining strong, consistent messaging, is vital. Participants also noted that successful community engagement can be aided by embedded infrastructure, sustained commitment from civic structures, a focus on granular and fluid locality, and holistic collaboration with people embedded within the community. Here, others noted that 'a person can be part of many communities', meaning that those working to promote health in communities must think about what approaches work for the whole community, and what approaches work for specific groups within it. This must be accompanied by keeping in mind the high levels of diversity within groups, and by work to understand community priorities.

Throughout the workshop, participants also noted that there is a tendency to focus on communities having 'problems', rather than recognising that there may be interventions that are already in place which may simply need more support in being carried out more effectively. Here, others noted that we want communities to be able to define, own, and tell health practitioners what they see as being needed in their communities. This may involve linking experiences between those working in the areas of health, social justice, loneliness, social isolation, housing and neighbourhoods. Moreover, there is a risk that national level policies imposed across systems may bear little relevance to what it is needed at a household or neighbourhood level. Consequently, participants suggested that communication needs to work in both directions between the national and the local to ensure that those impacted by health systems and community services are not left behind, particularly when there is a crisis.

Through sustained collaboration with local communities, health promotion practitioners can develop understandings of how to work with the system and local partners who may already be over-extended. One workshop participant cited how their organisation has endeavoured to make it easier for partners to engage with them by preparing social media kits and flyers which simplify recruitment for interventions and patient engagement groups; and how they offer multiple ways of engaging with their organisation to suit the diverse needs of potential participants from the community. Participants emphasised the importance of keeping community engagements as dialogues, taking time to reflect on what you have heard, fostering ongoing relationships, focusing on assets and challenges, drawing on a wide range of methodologies such as ethnographies, embedding involvement, and listening well.

Throughout the event, some participants also cautioned for a need to strike a balance between increasing the involvement of beneficiaries in programme development and implementation, whilst also ensuring that initiatives remain grounded in a robust evidence base. Some members of the group shared experiences of co-designing programmes where community members held assumptions which were not borne out by the quantitative evidence. Achieving meaningful engagement whilst also ensuring that planning remains grounded in scientific and medical knowledge should therefore be a priority within programme design.

3.2 Community Leadership

What strategies can health practitioners use to effectively engage with communities?

Sharing responsibility with communities in delivering healthcare programmes can improve participation, build trust, and foster cooperation between healthcare professionals and members of the public. Throughout the discussion, several participants spoke of their experiences collaborating with the public in delivering prevention programmes, emphasising the importance of collaborating with community leaders and using social psychology, behavioural science, and ethnographies to ensure that such efforts were successful.

One participant cited the example of how a community leader getting vaccinated encouraged vaccine up-take among the broader community, while others emphasised how collaborations with community leaders from religious or minority groups could help foster trust and a sense of ownership over programme delivery. Another participant noted that ethnographic work can help highlight the ‘real influencers’ within communities, noting that they may not be those with formal roles or labels. Here, participants cited examples of hairdressers, barbers, taxi drivers, and mechanics as those within communities who have extensive networks and who have been used for community health promotion initiatives in other contexts. Ultimately, participants stressed that “the messenger is just as important as the message” and highlighted the value of community champions and connecting with a variety of local forms of civic leadership. One participant emphasised the value of faith-placed (rather than faith-based) interventions in positively influencing health behaviours, while others highlighted roles for mutual aid groups, clubs, sports teams, faith communities, and other community groups in supporting disease prevention work. In general, participants also emphasised the importance of keeping partnerships strong and having a strategic engagement plan to help manage on-the-ground connections.

3.3 Overcoming Challenges in Community Engagement

What challenges are those seeking to implement health promotion programmes likely to face?

Throughout the workshop and accompanying webinar, participants identified several types of challenges to successful health promotion programme delivery. One such challenge was bureaucracy and the chronic underfunding of community services. Here, participants raised the issue that the funding application process is time and resource intensive, and applications are often unsuccessful. Delivery of programmes can be negatively impacted by this, as can relationships with communities who participate in the funding proposal process. Everybody’s time matters, and repeated failures to make meaningful progress will dissuade continued participation even from those who were initially enthusiastic. Consequently, some participants asked whether it could be made possible to offer healthcare organisations greater self-determination and increase their independence from funding bodies. Others additionally noted that relationship building with communities and local partners “does not just happen”. It requires resourcing, sustained funding, and dedicated staff-time to determine how to best coordinate efforts, build trust and collaborations, and generate a collective impact.

Another challenge raised by workshop participants was that of capability and capacity – noting that just because individuals need help, does not mean that they have the information, tools, or connections needed to find services and support. While acknowledging that people can fall through gaps in existing systems, participants in this seminar emphasised that these groups and individuals should not simply be badged as ‘hard to reach’ or marginalised. Rather, practitioners should work to identify the social, cultural, or other barriers to engagement, as a first step to determining how they can be overcome. Here, participants noted that we can learn why people do not use services by studying examples from past programs.

In tackling other broader barriers to community engagement, participants more generally emphasised a need to be transparent about the evidence base they were working with, the importance of knowing where the data comes from, and working to build and sustain the trust of those providing that information.

3.4 Access, Equity, and Inequalities:

Heath is experienced differently by everybody, varying across population subgroups, within groups, and within individuals throughout their life course. Throughout the workshop, participants shared examples of communities and individuals – including travellers, homeless individuals, those with disabilities, those with poor mental health, those experiencing loneliness, ethnic minority groups, LGBTQ populations, those experiencing addiction, and those who have experienced incarceration – who may experience additional barriers to good health because of discrimination or inequality. Others raised examples of individuals and communities experiencing poverty or facing barriers because of social class, noting that poverty and financial precarity are significant contributing factors to ill health at a population level. For example, access to both affordable healthy foods and green spaces (for exercise and recreation) is likely to be diminished for those experiencing precarity and poverty. At the individual level, participants also noted that when facing pressing issues of rent payments, childcare support, or debt; health and wellbeing can become lower priorities than would otherwise be expected. Here, workshop participants emphasised the need to build on interventions that may not necessarily be health interventions, but which will ultimately inform health outcomes, and which link back to the prioritisation of what is important to that community. Where possible, it may then be possible to dovetail these interventions with those more directly linked to health and wellbeing.

In all cases, workshop participants emphasised the importance of understanding the different kinds of community experience at a local level, seeking opportunities to build trust, exploring ideas of intersectionality, and working to strengthen communities while generating resilience at population level.

Participants cited several examples of community initiatives which have worked to address challenges to accessibility facing specific communities, including providing cards to homeless persons without a fixed address explaining their right to register with a GP; work to overcome digital exclusion in Traveller communities, and work to develop ways to get accessible information to groups with sensory impairments or additional language requirements. Here, some participants noted that digital inequality remains a major challenge when considering participation within health promotion programmes, and there are significant intersections between issues of digital access and of financial insecurity. In addition to present challenges regarding internet and phone access to healthcare services, panellists raised the changing nature of the communities facing these issues.

Trust also remains a major factor in the success or failure of preventative healthcare programmes, and participants noted that communities which have historically faced discrimination may have reasons to be mistrustful of formalised healthcare institutions. Here, participants cited the experience of black and LGBTQ communities which have historically experienced poorer health outcomes and discrimination. One participant relayed that “historically, with black communities in particular, there has been a maltreatment of the black body whether in biomedical research or academic research, and it can be very tricky to engage with black communities” because of that legacy. In seeking to engage with groups who have experienced discrimination, workshop participants emphasised the power of long-term trust building and “compassionate leadership”. This works to acknowledge and remember the history that has influenced this lack of engagement with health institutions or programs such as vaccinations, while working to answer the question of “what happens next?” through responsive dialogue. Others suggested that it should be a priority to establish partnerships with communities to try to understand what exactly it is they feel the barriers they face are, with the goal of identifying and furthering research priorities.

Working with the system to build a picture of what people should expect from their local service, working closely with the voluntary sector and if appropriate patient participation groups, were some of the ways of addressing access issues which were raised by participants. When conducting research, workshop participants also noted the value of flexibility in methods of engagement, letting community members shape the method of interaction or allowing asynchronous methods to increase inclusiveness. Others emphasised the importance of remembering that those we engage with may not be representative of the whole community, making it important to understand diversity within groups. Thus, disaggregation and a granular approach can be valuable. Practitioners engaging with communities also need to work to understand the cultural context and to adapt around that, including, in some cases, how interactions across families and within families takes place. For example, one participant highlighted that family-based intergenerational approaches can be a powerful tool for positioning interventions when trying to reach certain minority populations.

Another participant suggested that for some families or communities, school and formal education may be an important setting for introducing health promoting concepts.

4. Measuring Success

How can we measure success within health promotion and disease prevention programs?

Some participants suggested that KPIs (Key Performance Indicators) which are more tailored and localised for specific target communities could do a much better job of assessing and recording outcomes compared to the generic and centralised metrics used today. However, others questioned how reporting and evidence synthesis would work if different communities had different metrics used for measuring success, or if NGO, private, and public sector programs were assimilated into a single evidence base. Meanwhile, others noted that questions of how funders and other stakeholders assess the performance of programmes would be complicated by having a multitude of different measurements. Participants also noted that little attention has been paid to enabling communities to co-design KPIs for services – noting that if service commissioners are not expecting communities to help define and refine these goals, then there is inequity in what we are trying to achieve.

How can citizens and communities be involved in assessing the value and success of prevention programmes? Throughout the workshop, panellists discussed the successes they had experienced when having target communities assess the value of specific preventative healthcare measures before and after an educational intervention programme and questioned whether these models could be more widely applied across the healthcare sector. Here, participants emphasised the importance of capturing 'raw experience' through both informal and formal routes, the establishment of feedback loops between research and implementation, the importance of being honest about the evidence base supporting initiatives, and the importance of knowing where your data comes from. One participant emphasised that "everyone seems to think you chuck the data in a bucket and get a beautiful rainbow out of it, but you might get a brown sludge instead if you don't understand where the data came from". Ultimately, participants emphasised the importance of building an evidence base which is of value to the community, and to be strategic in identifying where the public can contribute most and best to help design policies and interventions.

5. Case Studies

5.1 Dietary Inequalities:

<u>What are the intersections between poverty or precarity and dietary inequalities?</u>

It is often more expensive to eat healthily than to eat unhealthily. Panellists agreed that dietary inequality is inextricably linked to wider socioeconomic inequalities and it is now the case that health is a better predictor of life success than education level. Within peoples' hierarchy of priorities, dietary quality consistently ranks lower than other more pressing concerns such as employment and housing. **It is therefore crucial to contextualise dietary inequalities within wider economic inequities**.

<u>How best should researchers and public health officials interact with individuals and communities to build and maintain trust and participation in dietary programmes?</u>

Panellists stressed the importance of understanding the nature, motivations, and diversity of the communities which dietary inequality programmes target. All communities are heterogenous and previous programmes have failed due to an underappreciation for the diverse needs and challenges faced by individuals. A recent example brought up by several participants was the government's food parcel programme for 'shielding' individuals in the Coronavirus response. A centralised response which assumes that 'one size fits all' when it comes to food need and preference will never be effective: i**t is vital to provide people with as much autonomy over their food choices as possible and to appreciate the myriad cultural and personal determinants of dietary need**.

Intervention programmes should therefore be co-created with the communities they target, and researchers should do much more to listen to and understand the 'manifestos' of the groups with whom they are working. The direct involvement of people in communities may not be the best way to involve them in the design of dietary interventions, however, and consideration must be given to the factors which require additional expertise from outside of a community. **Building understanding of the complex cultural and social makeup of communities, which is critical for effective programme design, requires much more attention than has been afforded within previous dietary programmes.** Panellists discussed the possible roles of embedded ethnographers in communities on an ongoing basis, as routes to building greater appreciation of the intersectional challenges faced by marginalised peoples, who often face the highest levels of dietary inequality.

There should be a greater focus on positive reinforcement of what communities are doing right: too much attention within past dietary projects has been paid to perceived failures and shortcomings. **Behavioural science should play a far greater role within programme design and evaluation**, and time should be devoted to regular reflection and learning. All successful dietary interventions involve feedback loops between public health officials and communities, and these should be strengthened to improve the responsiveness of programmes to the changing requirements of the communities they are designed around.

Some panellists asked what role the private sector might have in ensuring the success of food inequality programmes. **Could supermarkets and other food suppliers be more actively involved with achieving public health aims?** The example of the sugar levy illustrates the relative success of policy interventions aimed at reducing obesity: could similar policies be employed more widely as one in a range of 'behavioural approaches' such as physically moving products around the shelves to make accessing healthier options easier?

How is success defined and measured within the context of dietary intervention programmes?

All panellists were quick to point out the inadequacy of current metrics for determining success: an over-emphasis on BMI reduction is characteristic of a wider inability to appreciate the diverse ways in which different communities define success and to engage with them to design more tailored aims and objectives for dietary programmes. **Panellists agreed that KPIs are too rigid and formalised to be useful for capturing the many different successes they have seen within their own programmes**. "Localised" KPIs and other more personalised metrics may improve the ability of organisations to measure success but pose their own challenges, particularly in terms of consistent reporting and centralised evaluations.

Co-creation of performance metrics with communities has not been sufficiently explored: none of the panellists had practical experience in this area but all were eager to investigate the idea in future. This raises the issue of the goals and priorities of funders taking precedence and a misalignment in motivations between practitioners and their organisations.

Though not specific to dietary inequalities, **panellists were keen to explore the reframing of public health intervention objectives by measuring success in terms of prevention of ill-health** rather than in the meeting of arbitrary metrics such as specific targets for weight loss. This point was reiterated by several participants who argued that ICSs (Integrated Care Systems) should focus on health rather than on treating illness.

What assets as well as barriers exist within communities and how can behavioural interventions work with these to improve dietary inequalities?

The coronavirus pandemic has brought to the forefront the many loosely structured and self-assembled community networks, with mutual aid groups and small charities effectively filling gaps in public sector services such as food and prescription deliveries for people who were shielding. These and similar groups could play a far larger role in dietary interventions as they have trust within the community – being organised at a grassroots level – and are stores of local knowledge and expertise.

5.2 Cancer Screening:

How does poverty or precarity influence cancer screening rates?

Panellists agreed that there are several fundamental aspects of economic deprivation that complicate or prevent individuals from attending preventative cancer screenings. **Digital inequality, while not exclusive to those living in poverty or precarity, strongly inhibits the ability of large sections of the public from accessing the information they need to make positive decisions about their health.**

Access more generally is a challenge exacerbated by financial insecurity - both in terms of having the ability to make and alter appointments using a phone, but also with respect to attending appointments. The NHS already tries to make it easy for people to attend screening appointments by ensuring that they are offered at convenient times for people who have full time work, but **those living in poverty or precarity may need extra flexibility** and this should be considered.

A significant barrier to attending or even seeing the value of cancer screening appointments is the relatively low prioritisation of health when compared to other more material needs such as paying rent and putting food on the table. Healthcare professionals should be conscious that the perceived importance of health varies greatly between individuals; and those living without financial security are likely to hold significantly different perceptions to the healthcare workers and researchers who design the programmes.

How should we engage and empower communities in cancer prevention efforts?

Panellists discussed the **importance of developing cultural and religious understanding prior to the design of any healthcare intervention programme**. Approaches such as having embedded ethnographers could be considered to better understand the population for whom a screening programme is designed to work.

Placing screening programmes within faith organisations is a promising approach to increasing the take up of cancer screening appointments in communities which are less likely to engage with services. Panellists agreed that **it is especially important that faith communities are approached and interacted with by people with whom they can relate to**.

Different groups can have very different notions about what healthy living is and looks like. A ‘one size fits all’ approach has been demonstrated to fail in previous cancer screening programmes and in future **attempts should be made to work within the conceptual frameworks of health and wellness already held by communities**. Frameworks such as Priority Setting Partnerships should be much more seriously considered at the design stage of cancer screening programmes to allow cooperation with target communities and to understand their values and goals.

What assets as well as barriers exist within communities and how can behavioural interventions work with these to improve cancer screening attendance?

The vaccination efforts for the coronavirus pandemic have demonstrated the value of 'community champions' within localities. By recognising the positive behaviour of connected individuals within communities who do not typically engage with services, a culture of positive influence can be established. Panellists did stress that these culture carriers are however not always those that the people designing healthcare interventions expect.

Panellists gave examples of their experiences of working with certain communities of faith and discussed the challenges that particular cultural differences can present. Examples were given of healthcare programmes specifically targeting women which in practice required the consent of men, **illustrating the need to understand and design programmes around the expectations and values of broad groups**.

5.3 Lessons from the COVID-19 Pandemic

What lessons can researchers and health professionals working within health promotion learn from the responses to the coronavirus pandemic?

Community engagement has increased throughout the COVID-19 pandemic, and participants emphasised that the relationships and trust built during this time can be used as a starting point for future health promotion programs. Throughout the pandemic, there has also been a high level of experimentation with different kinds of community engagement, offering valuable opportunities for learning from both programs which have – and have not – succeeded.

The COVID-19 pandemic has demonstrated the challenge of building and maintaining engagement, particularly within communities sometimes perceived as 'hard-to-reach'.

The ongoing situation has demonstrated the challenge of building and maintaining participation, particularly within communities which proved harder to engage in previous healthcare programmes. However, the immense value of community groups and the expanding role of community champions have rightly gained much positive attention. The vaccine rollout has shown the power of influential community networks, both for disseminating knowledge and encouraging positive behaviours. Similarly, access to information and services has been a priority throughout the pandemic and examples of successful approaches should be considered in programme design.

We should make greater attempts to understand the motivations and beliefs behind behaviours during the pandemic. Whether it is receiving a COVID-19 vaccine or attending a bowel cancer screening, there are a set of meanings which certain health-related practices hold for people. Some participants in this workshop argued that some of these are immutable, and great care should be taken with any attempts to change them. It is important to understand people's beliefs as part of behaviours which can be shifted, and to learn from present circumstances so that we can address inequalities in other areas of healthcare.

Engagement with communities throughout the pandemic offers a real opportunity to build trust which could later be used as the foundation for a wider health and wellbeing agenda. Moreover, council grants have supported community groups in delivering services during the pandemic while giving them a high degree of autonomy to operate as they see fit. As discussed in previous sections, giving communities self-direction and a sense of ownership improves outcomes, capitalises on existing trust, and relies upon influential community leaders. One workshop participant suggested that being in a pandemic has created new forms of community, creating opportunities for us to connect with our neighbours in new ways. This new way of thinking about community may prove valuable as we emerge from this crisis.

Participants

- **Professor Kathryn Almack**, Professor of Health, Young People and Family Lives, University of Hertfordshire
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- **Tosca Fairchild**, Delivery Director for Equality & Health Inequalities and Intensive Support with NHS England and NHS Improvement – East of England
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- **Dr Claire Thompson**, Senior Research Fellow in the NIHR ARC EoE Prevention and Early Detection in Health and Social Care theme, University of Hertfordshire
- **Dr Daksha Trivedi**, Senior Research Fellow, University of Hertfordshire
- **Dr Adam Wagner**, Health economist and statistician, UEA; Deputy lead for the ARC East of England Health Economics & Prioritisation Theme
- **Dr Salman Waqar**, GP, British Islamic Medical Association
- **Hannah Williams**, Event Coordinator, Centre for Science and Policy, University of Cambridge
- **Professor Wendy Wills**, Director, Centre for Research in Public Health and Community Care (CRIPACC), University of Hertfordshire; NIHR ARC EoE theme lead, Prevention and Early Detection in Health and Social Care

About the Organisations

NIHR Applied Research Collaborations

NIHR Applied Research Collaborations (ARCs) support applied health and care research that responds to, and meets, the needs of local populations and local health and care systems.

These 15 local partnerships between NHS providers, universities, charities, local authorities, Academic Health Science Networks and other organisations also undertake implementation research to increase the rate at which research findings are implemented into practice. The ARC aim to improve outcomes for patients and the public; improve the quality, delivery and efficiency of health and care services; and increase the sustainability of the health and care system both locally and nationally.

The ARCs undertake research on a number of areas of need highlighted by the NIHR Futures of Health report, including: the challenges of an ageing society; multimorbidity; and the increasing demands placed on our health and care system.

The £135 million five-year funding also aims to deliver national-level impact through significant collaboration between the ARCs, with individual ARCs providing national leadership within their fields of expertise.

The NIHR ARC East of England is a five-year collaboration between Cambridgeshire and Peterborough NHS Foundation Trust, and the Universities of Cambridge, East Anglia, Hertfordshire and Essex along with other NHS Trusts, Local Authorities, Regional Sustainability and Transformation Partnerships (STPs), patient-led organisations, charities, and industry partners across the region.

To learn more about ARC East of England, please visit: https://arc-eoe.nihr.ac.uk/

East of England Population Health Research Hub

The East of England Population Health Research Hub is a collaborative network which aims to inform, co-design, understand and apply responsive public health research and evaluation to address population health challenges and inequalities.

The Hub aims to provide:

A NETWORK: by bringing practitioners and researchers together for meaningful engagement and understanding of regional priorities and research approaches

A KNOWLEDGE HUB: to map and provide a greater connection between public health assets and challenges within the region

COMMUNICATION: through channels and forums to effectively share regional research, to facilitate collaboration, and to translate research into local contexts

CAPACITY BUILDING: by building bi-directional knowledge, integration and capacity of research and practice across the region, and to provide workshops to build evaluation skills within the region and demonstrate impact of local public health approaches

RESEARCH STRATEGY: to develop a regional strategic framework to inform public health research within the East of England, and identify opportunities to support co-designed research partnerships which responds to current and emerging public health issues.

For more details please visit: https://adph.org.uk/networks/eastofengland/eoephresh/

The Centre for Science and Policy

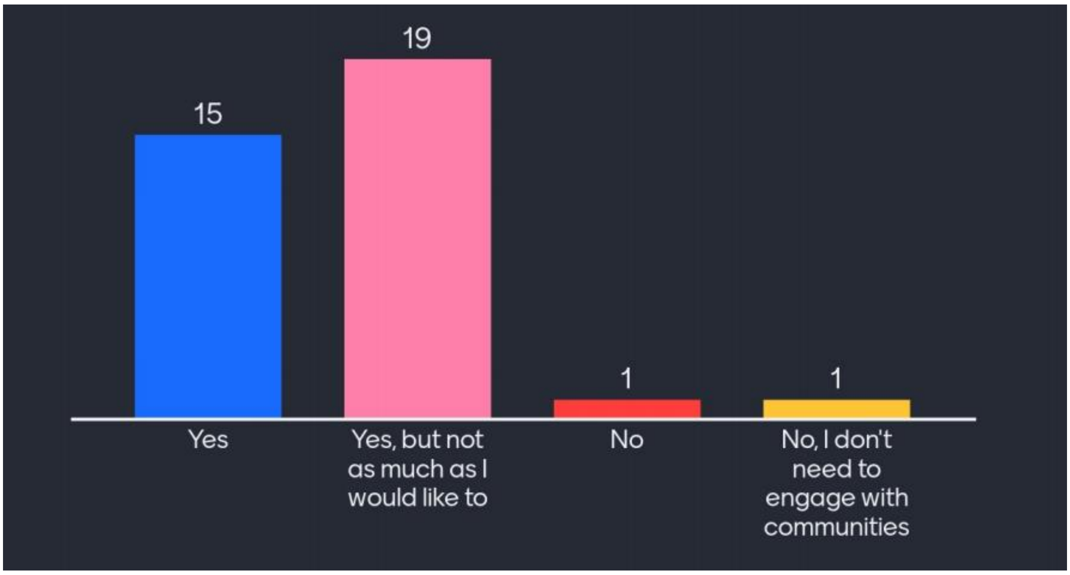
The Centre for Science and Policy is a knowledge exchange centre based at the University of Cambridge. CSaP's mission is to help improve the quality of public policy making through the more effective use of evidence and expertise. CSaP starts with the questions from policy professionals and fosters networks between policy and science based on mutual understanding, respect, and trust. The experience and diversity of CSaP's unique network provides fresh perspectives and critical challenges to conventional thinking and helps research from all disciplines contribute more effectively to society.

CSaP's brokerage work includes a flagship Policy Fellowship Programme, a flexible professional development programme which starts with five days spent at the University of Cambridge, meeting with relevant researchers from a wide range of disciplines. Over two years, CSaP Policy Fellows continue to benefit from support and involvement with the network's activities. CSaP also provides professional development training for policy professionals and early career researchers, the facilitation of curated knowledge exchange Policy Workshops for researchers and practitioners and participation in several research programs. The Centre helps facilitate a Policy Forum on climate change with Cambridge Zero, and outreach work which seeks to bring the latest information about science policy to members of the general public.

You can learn more by visiting their website at http://www.csap.cam.ac.uk.

Appendix: Mentimeter Results from Public Webinar

1. **Do you currently have opportunities to engage with communities to inform your work?**



2. **How do we ensure we are responding to local community priorities for health?**
    - Engage with local public health teams.
    - Communicating directly with communities and allowing them to lead on priorities.
    - Service evaluation, working with hostel managers and site staff to obtain feedback bespoke to each community group e.g. committee meetings.
    - Embedding data collection into our practice
    - Build relationships and dialogue with all sectors of a community.
    - Talk - and really listen to what our contacts e.g. voluntary organisations /charities are saying are the priorities.
    - Use knowledge of vulnerable or under-represented groups to engage better.
    - Needs assessment.
    - Engage directly with representative groups (i.e. go to them), often from the VCSE as well as local Councillors and social media platforms. Have representative people from the communities within decision making processes.
    - Engagement with communities.
    - Work with the communities/faith groups and leaders and even health care professionals within these communities.
    - Liaise with existing groups, regularly.
    - You need to include people with Protected Characteristics - if you only look geographically you mill miss minority groups out. Yet in minority groups are pockets of very poor health and disadvantage.
    - Interventions to address inequalities.
    - Ask those communities for their solutions and their priorities; don't impose.
    - Understand local need.
    - Create healthy places.
    - Listen to what matters to people.
    - Community/public/patient engagement in research.
    - Finding out what the priorities are.

- You have to be deliberate.
- Listening and using multiple sources of information
- Going out taking to people and working with local authority colleagues
- By creating opportunities to directly hear from individuals in the community. An example is making more digital meetings open to all.
- Engage with all age groups through community services, charities, clubs, and societies.
- Ask the service users! and speak to practitioners who work with those communities to understand the opportunities, challenges, and barriers. Also, use data to inform us.
- Use social media channels to create flow of communication both ways. Community post issues and the system responds with answers.
- Measure what we are doing. set some sensible objectives and indicators to work to. seek feedback.
- Invite more people to actively participate in statutory sector development and decision making.
- Create active community participation.
- Involve local communities.
- Involve them in the conversation and build a role for them in it.
- Ensure you identify qualified leaders, researchers and staff teams are identified to help respond and work with the said communities.
- Challenge personal assumptions. Local authorities are often very engaged with local community and have routes in to ask them about priorities.
- We need to work with local stakeholders. It takes time to build those relationships.

3. **What are your greatest challenges with regards to engaging with communities to prevent poor health?**
    - Covid
    - Language barriers
    - Not knowing where to start
    - Resources
    - People's lives are busy and there is not enough incentive for them to give up their valuable time to speak to us.
    - Lack of a coherent approach working together regionally.
    - I am working on national and subnational policies. I find it hard to engage people on these topics because the feel distant to them and they don't feel that they can make a difference.
    - Pathways into communities
    - Need to identify local groups and networks and local champions.
    - Presently, COVID reducing potential to have a physical presence.
    - Trust from the people we most want to help.
    - Trust in us and the wider system to actually do anything meaningful that will positively impact their lives.
    - History of promises to help against outcomes is not good.
    - Lack of consistent data collection methods, lack of guidance, lack of funding.
    - Lack of understanding from involved professionals about nutritional composition of feeds (usually charitable initiatives are giving food, but it is unhealthy).

- LGBT people being missed out - for example there's nothing on incidence, hospitalisations or deaths from co-19 - yet we're 1 year in to the pandemic. Why is there no data???
- Funding
- Least likely to have the chance to participate in research.
- Having the time and space to do this properly.
- Culture of the system.
- Communities can feel they are not REALLY being listened to but that it is predetermined.
- Access and opportunity
- time to engage and network with colleagues who are much closer to these communities. funding to incentivise this work.
- Ensuring we find defined time to have the conversation directly with people not just representatives.
- Access to communities
- Lack of time and reliance on virtual meetings that remove genuine social and physical connections.
- Having the mandate, time, and funding to really get into detail with them about their real lives. Building trust before asking for stuff from them.
- Hard to reach groups require tenacity and preferably engaging with them in a way that builds rapport.
- Covid

4. **What community assets do you think we could be working with to build healthier communities?**
   - Youth groups
   - Outreach centres
   - unsure
   - Charities, key members in the community or organisations.
   - Local knowledge
   - Community groups
   - Small medium VCSE groups
   - Skills, social assets, knowledge, community cohesion, beliefs, community education
   - Religious settings and faith leaders
   - Green spaces and urban spaces that could be greened.
   - Empty shops, enabling them (through LA funding) as pop ups for people to make an income and/or share support offers.
   - People who are central within their communities, often at a super local level
   - Work with minority groups and their organisations
   - Health professionals can screen for poverty (eg dietitians ask about food poverty), working with community groups to help with consistent data collection
   - Large scale research at community level
   - Schools
   - Faith groups
   - Charities
   - More scale and straightforward research

- Social media groups, e.g. community Facebook groups
- Provide more micro grants to socially active individuals
- People!
- Existing infrastructures that go beyond schools, hospitals and the historic community centres. For example, the African Caribbean Societies that were brought in by previous governments are overlook and underdeveloped and could become epicentre 1/2
- Primary and Community Care services, Local authority teams, community groups
- local charities
- of reducing health inequalities that are often disproportionate amongst black Caribbean and African communities.
- People

5. **Do you have examples where community engagement was done well? What worked well in these examples?**
    - COVID response.
    - Working with local community faith groups in their community faith based settings with health professionals who come from the same community
    - Across the UK within social prescribing - link with National Academy of Social Prescribing
    - Yes - where people worked with minority groups and their organisations that have already been set up.
    - FEAST food parcel service model has been a great success during lockdown (feastwithus.org.uk)
    - Working with vulnerable individuals and communities to hear their needs and make tailored plans accordingly.
    - Good engagement with decision makers
    - Local support of covid vaccination sites
    - covid 19 vaccine registry?
    - working stakeholder steering groups throughout.