

The impact on health inequalities of approaches to community engagement in the New Deal for Communities regeneration initiative: a mixed-methods evaluation

Jennie Popay,^{1*} Margaret Whitehead,² Roy Carr-Hill,³ Chris Dibben,⁴ Paul Dixon,⁵ Emma Halliday,¹ James Nazroo,⁶ Edwina Peart,⁵ Sue Povall,² Mai Stafford,⁷ Jill Turner¹ and Pierre Walthery⁸

¹Division of Health Research, Lancaster University, Lancaster, UK

²Institute of Psychology, Health and Society, University of Liverpool, Liverpool, UK

³Institute for Education, University College London, London, UK

⁴School of Geosciences, University of Edinburgh, Edinburgh, UK

⁵Independent consultant, London, UK

⁶Economic & Social Research Council, Centre on Dynamics of Ethnicity, University of Manchester, Manchester, UK

⁷Medical Research Council Unit for Lifelong Health and Ageing at University College London, London, UK

⁸Cathie Marsh Institute for Social Research, University of Manchester, Manchester, UK

*Corresponding author

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Scientific summary

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Scientific summary

Background

This research has explored the social and health impacts of different approaches to community engagement (CE) in the New Deal for Communities (NDC) regeneration initiative, which was implemented between 1998/9 and 2010/11. The research has considered (1) whether or not NDC approaches to engagement had any independent impacts on a range of health and social outcomes; (2) whether or not CE contributed to the impacts of different approaches to regeneration adopted by local NDC programmes as reported in our previous study; and (3) the cost-effectiveness of NDC CE approaches.

Control, community engagement and health inequalities

Reviews of research have found evidence of potentially important relationships between CE and intermediate social determinants of health (including improved uptake and effectiveness of services, improved living conditions, including housing quality, and both 'bonding' and 'bridging' social capital), and improved self-rated health. This research suggests that initiatives aiming to give communities more control over decisions that affect their lives may have positive health and social outcomes. However, there is also some evidence of negative impacts of CE and a significant body of research highlighting the barriers to effective engagement of communities.

Additionally, much of this research is of poor quality and there are also major gaps. The research reported here has sought to address these problems and advance the evaluation of CE approaches and their impact on health inequalities.

The New Deal for Communities initiative and community engagement

The NDC initiative was a central part of the 1997–2010 Labour government's commitment to reduce social and health inequalities. The aim of the NDC was to bridge the gap over a 10-year period between some of the most deprived neighbourhoods in England and the rest of the country in six outcome domains: crime, community cohesion, housing and the physical environment, education, health and worklessness. There were 39 local NDC programmes, each with a budget of approximately £50M (nearly £2B in total), and all were required to engage residents in planning and implementation.

Study design

Our research involved collaboration between researchers at the Universities of Lancaster, Liverpool, Manchester and St Andrews, and the Medical Research Council Unit for Lifelong Health and Ageing, now at University College London. NDC residents and past workers have also been involved as public advisers.

The evaluation took place between 1 September 2011 and 31 May 2014. We have made extensive use of the rich quantitative and qualitative data collected by a team of academics commissioned by the government at the time to evaluate the impact of the NDC (the National Evaluation Team or NET). Our study has involved mixed methods and consisted of three work packages.

Work package 1: developing a typology of New Deal for Communities approaches to engagement

Initially, we used secondary data sources to develop a conceptual framework that enabled us to identify core components of different types of CE approaches. New qualitative data and additional local documents were then collected from residents and workers in a purposive sample of 11 sites. Analyses of data with reference to the original conceptual framework led to the development of a typology of CE

approaches, which was tested through telephone interviews with key informants in a further sample of NDC sites. This resulted in four different types of approach to CE being identified, ranging from NDC sites with a CE ethos driven by resident-led priorities (an empowerment approach) to NDC sites where institutional goals were prioritised over those of the community (instrumental approach):

- type A: resident led and driven by strong CE values
- type B: initially resident led with strong CE values but becoming instrumental over time
- type C: balancing instrumental and CE values and approaches
- type D: instrumental with approach to CE shaped by external priorities.

Our earlier Department of Health research categorised the 39 NDC local programmes into three theoretically derived types and these were used in some of our impact analyses alongside the fourfold CE typology described above.

Work package 2: assessing the impact of New Deal for Communities approaches to community engagement on health inequalities and their social determinants

Our impact analyses sought to answer five questions:

- (a) Which approaches to CE engage which social groups in NDC populations?
- (b) Do different approaches to CE have differential health and social outcomes for NDC populations?
- (c) Does the association between these outcomes and NDC approaches to CE vary across groups defined by age, ethnicity, gender and material circumstances?
- (d) Do different approaches to CE have any impact on the gap in health and social outcomes between NDC areas and areas from across the socioeconomic spectrum?
- (e) Does the approach to CE help to explain any of the differential outcomes of local NDC programmes identified in our previous research?

These analyses used a number of existing data sets:

- NDC Market & Opinion Research International (MORI) survey cross-sectional data consisting of data from four surveys of residents in NDC areas and comparator areas. These surveys were commissioned by NET and undertaken in 2002, 2004, 2006 and 2008.
- The NDC MORI survey panel data included data for NDC residents from the surveys who remained at the same address and who responded to the MORI surveys at two or more time points. Only respondents present at wave 1 were retained in analyses using these data.
- The Health Survey for England (HSE)/NDC MORI survey cross-sectional data set combined data from the HSE and the MORI survey data sets for 2002, 2004, 2006 and 2008 on four outcomes of interest that could be acceptably harmonised across the HSE and the MORI surveys: mental health, self-rated health, current smoker and not in paid employment.
- NDC routine/administrative area time series. The Oxford Social Disadvantage Research Group, a member of NET, constructed data sets for each NDC area and its comparator area using routine administrative data. These covered the period from 1998 to 2007 for most variables. New data, in most cases up to 2011, have been added for some of these variables for this project. Our analyses used measures of change over time in hospital admissions for selected conditions, work-limiting illness based on number of people claiming benefits, rates of low birthweight and mortality among those aged < 75 years. We computed trends on these measures for individual NDC areas and their comparators separately and then summarised these for groups of NDC areas.

Work package 3: cost-effectiveness analysis

A third strand of work explored the cost-effectiveness of different CE approaches.

Data archiving

We have produced an archive making publicly available the data and detailed information on the approach to data analysis so that the development of our typology and our analyses can be replicated to allow longer-term follow-up of the impact of the NDC.

Results

Our results present a complex, multilayered picture of the impact of different NDC approaches to CE. Although few are statistically significant, some of the findings are consistent with theories about the pathways from empowerment to health and social outcomes.

Influence of New Deal for Communities approaches to community engagement on participation, cohesion and mental health

On the whole, positive improvements in rates of social cohesion and trust outcomes between 2002 and 2008 were seen in NDC areas of all CE types whereas negative changes in these outcomes were seen in matched comparator areas. In particular, the percentage of neighbours looking out for each other increased between 2002 and 2008 in CE type A areas to a greater extent than it did in matched comparator areas. However, the percentage who thought that they could influence decisions decreased between 2002 and 2008 in CE type D areas to a greater extent than it did in matched comparator areas. (These latter results, and all results using individual rather than administrative data, take account of differences in demographic and socioeconomic characteristics of residents.) CE type A areas saw higher levels of volunteering and participation in NDC activities, trust and social cohesion in 2008 than areas with other CE types. Longitudinal data also show that individual trust in neighbours also improved between 2002 and 2008 in CE type A, C and D areas. Good mental health was more prevalent in CE type A areas and there was longitudinal evidence of improvement in mental health in CE type A, C and D areas.

Influence of community engagement type on other outcomes

The picture was a little different for self-rated health and health-related behaviours. Good self-rated health and healthy eating were more prevalent in CE type B and C areas, and smoking was less prevalent in CE type C and D areas than in CE type A areas. Disability-related and unemployment claimant counts decreased in CE type C and D areas relative to their matched comparators. However, local NDC programmes combining a type 2 incremental regeneration approach with a type B approach to CE performed relatively well overall on the outcomes based on routine administrative data, whereas those combining type 3 local programmes (which had little redevelopment and the strongest focus on developing the skills and capacity of residents) with a CE type A approach saw deterioration on most of these indicators relative to their comparators. There was a lower likelihood of gaining paid employment among those who were not working in 2002 and living in CE type B areas than among those who were not working in 2002 and living in CE type A areas.

Impact of community engagement type on the effectiveness of New Deal for Communities local programmes

There is no evidence that the approach to CE contributed to differences in any of these outcomes across local NDC programme types, as identified in our previous evaluation; instead, CE type and NDC local programme type provide complementary information about the impact of the NDC initiative on health inequalities and the social determinants of these.

Differential impact across social groups

There was some evidence of a narrowing of the gap between more and less socioeconomically disadvantaged residents in type B, C and D areas on some but by no means all outcomes. When improvements were seen, these appeared to affect residents in all socioeconomic circumstances in CE type A areas to a similar extent.

Economic analyses

Financial data show that about 19% of NDC expenditure was categorised as being on community development, varying between 22% in areas with CE type A and B approaches and 15% in areas with CE type C and D approaches, and between 23% in areas with type 2 local programmes and 18% in areas with the other two types of local programmes.

Attempts at 'bottom-up' costing focused on seven activities (e.g. voluntary work on community magazines and NDC partnership boards). Our estimate of the monetary value of participation across all 39 sites was £32M, equivalent to approximately 2% of the formal expenditure. The remainder of the analysis used official NDC expenditure information. Multivariate analysis of various regressions found few statistically significant results. There were almost as many negative as positive scores, making the calculation of cost-effectiveness an arbitrary exercise.

Conclusions

The small number of statistically significant results is not unusual in evaluations of the impact of CE. This suggests that more research is needed on the sources – theoretical and methodological – of this ubiquitous uncertainty. Overall, the findings of our economic analyses are mixed, primarily because of the difficulty of obtaining accurate cost data, and highlight the urgent need for evaluations of CE initiatives to collect systematic data on both the direct and the in-kind costs involved.

Notwithstanding the inconclusive statistical results, the patterns of impacts we found on community cohesion, community control/influence and mental health outcomes are consistent with prominent theories about the relationship between empowerment and positive health and social outcomes. The patterns in our findings point to a gradient of improvement in NDC residents' sense of control that is in line with the differing emphasis on empowerment in type A, type B and type C approaches to CE, compared with a deterioration in control in areas with type D approaches to CE, where there was little empowerment. It is plausible that the empowerment approach in type A areas would help build trust and greater cohesion because these NDC initiatives sought to bring different groups together, investing more than other areas in developing skills and processes to support residents' participation. Similarly, greater interaction with, and influence over, the NDC initiative (as in types A and C) would lead to an increased proportion of residents linking the NDC to improvements in their area. In contrast, type D areas were the only ones to see a decline in the percentage of residents feeling that they could influence decisions and our results suggest that these residents were less likely to feel that the NDC initiative had improved their area or to experience improvements in mental health, in particular compared with type A areas. These patterns are consistent with a theoretical position, which posits that if people are engaged around an agenda decided externally, rather than their own, there will be relatively little positive impact and social cohesion, and well-being may actually be undermined. The qualitative findings support these suppositions.

The results on other outcomes are more difficult to interpret theoretically and those on benefit claimants need to be interpreted with care. Changes in the claimant count are very sensitive to changes in national policy, but the patterns that we found could reflect the growing instrumental orientation of NDC partnership boards in areas with a type B approach to CE.

This study does not provide firm evidence of the effectiveness of different approaches to CE. However, it does suggest that strongly instrumental approaches, seeking to use CE as a vehicle to deliver external goals, may have unintended negative social and health outcomes, and that changes in national and local policy may lead CE approaches that are initially empowering to become less so over time. These findings point to the need for more careful application of theory to the development of community-based interventions in the public health field and for more methodological research into the evaluation of these complex interventions, particularly in relation to measures of 'control' at the population level and the measurement of in-kind costs.

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Editorial contact: nihredit@southampton.ac.uk

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