University of Oxford 2026 Health Humanities Evaluation of Oxfordshire CHDO and WT Programmes

Summary

Purpose and Scope

- The University of Oxford's 2026 Health Humanities evaluation reviewed two community health programmes – Community Health Development Officers (CHDO) funded by Oxfordshire County Council and Well Together (WT) funded by the BOB ICB – in the ten priority wards in Oxfordshire.
- The programmes aim to reduce health inequalities by engaging with communities to support sustainable, locally-driven health initiatives.

Methodology

- The evaluation used a mixed-methods approach (qualitative and quantitative), including statistical analysis and focus groups, alongside extensive interviews, surveys, and fieldwork among user groups as well as among residents who do not usually engage with community activities
- Research was conducted from January 2024 to December 2025, focusing on implementation, community capacity building, and engagement rather than long-term statistical outcomes (as the programmes were relatively new).

Findings

- Both programmes successfully adopted a community-based approach, supporting health and wellbeing through effective communication and activities tailored to local needs.
- The programmes helped to fund over 100 community organizations, delivering more than 200 health and wellbeing activities across the ten wards.
- 73% of residents in target areas were aware of or interested in the programmes, and 34% participated in at least one funded activity.
- Success was attributed to collaboration with grassroots groups, local organizations, and the presence of skilled individuals (CHDOs and WT's Community Capacity Builders) who fostered trust and engagement.
- Residents perceive health collectively, valuing social relationships and community identity over individual health and medical models.

Recommendations

- Sustain CHDO and WT-type roles and programmes in the long term
- Treat community health as part of core health infrastructure, not as an optional add-on
- Prioritise sustainability over novelty
- Prioritise trust, relationships, and local knowledge in evaluation and commissioning of health interventions

Executive Summary

Community Health Development Officers (CHDO) and Well Together (WT) are two community health programmes aiming to reduce health inequalities in the ten Oxfordshire wards identified as priority wards in the Oxfordshire Director of Public Health Annual Report 2019/20. These are Abingdon Caldecott, Banbury Cross and Neithrop, Banbury Grimsbury and Hightown, Banbury Ruscote, Barton & Sandhills, Blackbird Leys, Littlemore, Northfield Brook, Osney & St Thomas, and Rose Hill & Iffley. Health inequalities are differences in health outcomes and access to healthcare. These can include differences in rates of illness, average life expectancy, and the availability of medical care, healthy food, and green space.

The CHDO and WT community health programmes draw on Community Insight Profiles, which are overviews of quantitative and qualitative evidence on the health and wellbeing assets that residents value. These Profiles also record what residents appreciate about their ward and which community issues they want addressed, including challenges to health and wellbeing.

Methodology

Because these two programmes were initiated in 2023, with our research conducted from January 2024 to December 2025, their quantitative impact is not yet demonstrable in routine statistical data. Instead, our evaluation uses empirical research to analyse how these programmes were implemented, whether they helped to develop and support community capacity for health and wellbeing, and the extent to which target communities engaged with the two programmes.

We used a mixed-methods approach, combining qualitative and quantitative evidence to understand the social and cultural contexts of community health. We analysed the health and social contexts of the ten priority wards, the funding activities of the two programmes, and community engagement with the two programmes. This drew on methods from the humanities and social sciences (including history, anthropology, economics, and public health): statistical analysis, focus groups, interviews, extensive fieldwork, event participation, and surveys of 1600 households to ensure we included views of residents who do not usually engage with community activities. Lead researchers were Erica Charters (PI), Sally Frampton, Urvi Khaitan, and Yuxin Peng.

Findings

Quantitative and qualitative data reveal that the two programmes (CHDO and WT) have fulfilled their objectives. They were successful in taking a community-based approach to support health and wellbeing through effective communication, activities, and practices in communities that experience health inequalities. The two programmes also demonstrated substantial reach into underserved groups. This was accomplished by implementing the recommendations of the Community Insight Profiles, coordinating with grassroots and voluntary groups, and working with local ‘anchor’ community organisations, key partners, and stakeholders.

A key factor that enabled such collaboration was each programme’s allocation of community-activity funding. Combined, this supported over 100 community organizations to help deliver over 200 health and wellbeing activities distributed across the ten wards. Our research found that two-thirds (73%) of residents in the target neighbourhoods had heard of, attended, or wished to attend these programmes’ local community health activities. Moreover, one-third (34%) of residents had participated in

at least one CHDO- or WT-funded health and wellbeing activity in their ward. Both programmes therefore had significant engagement with households in the ten priority wards.

Collaboration and coordination with communities fundamentally relied on the programmes linking residents with existing medical and health provision, as well as health and wellbeing activities in the wards. As important, they worked to make local health infrastructure not only accessible, but also trustworthy. We found that individual Community Health Development Officers and WT's Community Capacity Builders have been the key to these accomplishments. Their regular presence in community activities and excellent communication and networking skills are what allow them to engage so effectively with local communities and to effect partnerships with preexisting organisations and networks.

Our research found that residents understand health not individually (i.e. not by assessing their own health), but through social relationships: through concerns over family and household health, and the wellbeing of neighbours and other social relations. At the same time, each community is unique, requiring individuals and approaches that take account of local identity and culture, rather than simply implementing models drawn from other communities. Above all, community health and wellbeing depend on communities themselves as active and engaged networks of social and cultural relationships.

Recommendations

1. Sustain CHDO and WT-type roles and programmes in the long term. The CHDO and WT programmes provide models for effective community health and should be supported as long-term preventative health strategies. By working with existing community organizations, supporting resident-identified priorities, and making use of trusted individuals who excel at working with local communities, these programmes provide effective bottom-up and relationship-based community health infrastructure.

2. Treat community health as part of core health infrastructure, not as an optional add-on. Community health activities serve as trusted access points for health provision and information. They act as paths in and out of more formal medical and support services, and ensure that health becomes part of daily routines.

3. Prioritise sustainability over novelty. Long-term approaches and sustained initiatives and engagement are crucial to the continued effectiveness of community health programmes. Rather than one-off projects, we recommend that such community- and relationship-based approaches be categorised as key long-term strategies to achieve resilient community health, prioritising sustainability over innovation. Multi-year funding and stable programme roles enable community trust and resilience.

4. Prioritise trust, relationships, and local knowledge in evaluations and commissioning. Residents access and engage with health and wellbeing activities and with medical and health infrastructures through social relationships that require trust and familiarity, and – crucially – through longstanding social relationships that encourage aspirations for (and expectations of) improved health and wellbeing. Methodologies for evaluating the effectiveness of community health programmes should prioritise resident engagement and trust. Evaluation methodologies should be proportionate, and make use of realistic indicators of success such as participation, networks, and a programme's long-term sustainability.