Healthy Communities

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

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Contents

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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 evaluations and commissioning

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.

1. Introduction

This report evaluates two innovative Oxfordshire community health programmes: Community Health Development Officers (CHDO) and Well Together (WT). These two programmes aim to reduce health inequalities in Oxfordshire's ten wards identified as priority wards in the Director of Public Health Annual Report 2019/20. Our evaluation assesses whether these programmes fulfilled their aims and examines community understandings of health and how these were applied, transformed, or reaffirmed through these programmes.

Community Health Development Officers (CHDO) and Well Together (WT) are two novel community health programmes initiated in 2023 that aim to reduce health inequalities in the ten Oxfordshire wards identified as priority wards in the Oxfordshire Director of Public Health Annual Report 2019/20: 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.[1] Health inequalities are differences in health outcomes and access to healthcare. These can include differences in rates of illness, average life expectancy, or the availability of resources such as medical care, healthy and affordable food, or green space. The CHDO and WT programmes are designed to support community health and wellbeing activities that originate within those communities, taking a bottom-up approach to developing and maintaining community health. This support is financial and administrative, but also frequently social. The WT programme gives tailored advice on applications and opportunities, for example; and the CHDO supports the implementation of Community Insight Profile recommendations.[2]

General averages portray Oxfordshire as a healthy county. For example, Oxfordshire male life expectancy is just over 80 years (compared with 79 nationally) and female life expectancy is 84 years (compared with 83 nationally). Yet, the county average conceals significant disparities between its communities. The gap in life expectancy between some Oxfordshire wards (local administrative districts) is as wide as fifteen years, with life expectancy in a number of wards significantly below the national average.[3]

Contrary to county-level data, ward-level data highlights areas where communities struggle with child poverty, substantial unemployment, social isolation, and poor health. The 2019 JSNA statistics on health, housing, and income classified ten Oxfordshire wards as falling within the 20% most deprived areas in England.[4] While all wards contain a variety of communities and a range of living conditions, categories used when calculating deprivation scores such as 'Barriers to Housing and Services' and 'Income Deprivation' classify 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 as the

[1] The CHDO programme has since expanded to Bicester, Witney, and Berinsfield. These wards did not form part of our evaluation.

[2] Community Insight Profiles (CIP) are overviews of quantitative and qualitative evidence on the health and wellbeing assets that residents value. These also record what residents appreciate about their ward and which community issues they want addressed, including challenges to health and wellbeing. More detail is provided in section 2.

[3] Oxfordshire JSNA 2023 'Population'; ONS, National life tables – life expectancy in England and Wales: 2021 to 2023; and as highlighted in the 2019/20 Oxfordshire Director of Public Health Annual Report.

[4] English indices of deprivation 2019.

'ten most deprived wards' in Oxfordshire. This led to their focus as priority wards in the 2019/20 Oxfordshire Director of Public Health Annual Report and for targeted community support through the CHDO and WT programmes.[5] This focus also produced the Community Insight Profiles for each priority ward, which provide overviews of quantitative and qualitative evidence on the health and wellbeing assets that residents value. These also record what residents appreciate about their ward and which community issues they want addressed, including challenges to health and wellbeing. (more details on priority wards and Community Insight Profiles are in Section 2)

The Community Health Development Officers (CHDO) programme is funded and managed by Oxfordshire County Council Public Health. The aim of the CHDO programme is 'to take a community-based approach to encourage health and wellbeing, communicate health messages and facilitate health-enabling activities to build social capacity and resilience in the profiled communities.' There are a total of six Oxfordshire Community Health Development Officers (CHDOs), either part-time (responsible for one ward) or full-time (responsible for two to three wards).[6] Their responsibilities include health and wellbeing network building, community engagement, and the allocation of small grants (totalling £25,000 for each of the ten wards in the first round of funding). A key objective is to work with local partners to implement health and wellbeing recommendations from Community Insight Profiles, requiring CHDOs to work flexibly and closely in response to local needs and initiatives.

Well Together (WT) is also a grant-allocation and community capacity building programme, but with a different structure and design. The WT programme is funded by the NHS Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB), and is managed by two voluntary, community, and social enterprises (VCSE): Oxfordshire Community and Voluntary Action (OCVA) and Community First Oxfordshire (CFO).[7] The management structure of the WT programme therefore integrates existing community organizations and their expertise, particularly via the CEO of Oxfordshire Community and Voluntary Action (OCVA) and the CEO of Community First Oxfordshire (CFO). The WT programme employs five staff members: a Programme Manager and four 'Community Capacity Builders'. Community Capacity Builders (CCB) are responsible for network building, community engagement, developing capacity through local 'anchor' organizations, and the advertisement and allocation of Well Together grants totalling (£100,000 for each of the ten wards).[8] Compared with the CHDO programme (where CHDOs have a specific area of focus), WT provides a more expansive, and more centrally-organized approach to supporting community health and wellbeing, managed and coordinated through two well-established Oxfordshire community voluntary organizations.

Staff for both programmes were first appointed in either 2023 or 2024. Our evaluation research was conducted from January 2024 to December 2025. Given the short timeframes of the programmes, their impact will not be demonstrable in routine population-level data – such as shifts in rates of disease or mortality ratios – for years to come. **Our evaluation therefore uses empirical research to analyse the ways in which these programmes have been implemented, to what extent the programmes helped to develop and support community**

[5] Oxfordshire JSNA 2023 Bitesize. See also full details in section 2.2.
[6] As noted, the CHDO programme has since expanded.
[7] From 2026, BOB ICB is the Thames Valley Integrated Care Board.
[8] Anchor organizations are large institutions that are civic or non-profit organizations with well-established links to its local community.

capacity for health and wellbeing, and the extent to which target communities engaged with the two programmes.

1.1 Methodology

Health is not simply a biological and scientific concept but is also deeply social and cultural. Understanding what are termed the social determinants of health – the non-medical factors such as income and living environments that can profoundly influence health and wellbeing – is necessary to make sense of health patterns across societies. The social determinants of health are also shaped by social and cultural practices, including the social and community contexts in which we are born, grow, eat, work, age, socialise, and generally live.[9]

The food we eat, for example – including how such food is prepared as well as how much and when we eat – is shaped by family, religion, culture, and social habits as much as it is by health concerns. Likewise, cholesterol testing or diabetes screening programmes are useful only when such services are accessible and when people choose to access these services. Such choices require awareness of their provision, trust in health providers, and the desire to detect and prevent potential illness. All these depend on social sensibilities and cultural behaviours. Individuals consult friends and family and absorb social norms regarding who and what to trust, before deciding whether or when to access health services and modify lifestyle habits. Indeed, research demonstrates that simply issuing more information is unlikely to produce greater engagement with public health programmes: rather than assuming a 'knowledge deficit' model, the way information is shared as well as who shares it is crucial to health communication.[10] Medical technologies and public health services – such as disease screening, hospital care, or vaccination – are part of broader social networks and cultural practices, and often only a modest part of what supports and maintains health. In a famous analogy, health and medical care have been described as an iceberg: 'only a very small part floats above the surface of public life. The visible part rests on a far larger but normally submerged basis.'[11] As Healthwatch Oxfordshire's 2021 report on community health and wellbeing recorded, only a small minority of Oxfordshire residents rely on formal medical health services for support. The majority instead turn to friends, families, and spiritual leaders for health and wellbeing guidance.[12]

Our evaluation uses a long-term and expansive approach to community health. By definition, community health takes place outside of formal medical institutions: for example, in households, schools, and neighbourhood parks and community centres. Even more so than public health, community health outlines how health and wellbeing are intertwined with social relationships and cultural practices. Our evaluation therefore examines social and cultural attitudes that shape community understandings and practices of health and wellbeing in the ten priority wards, analysing how these were applied, transformed, or reaffirmed through the CHDO and WT programmes.

To do so, the research team used a mixed-methods approach, combining qualitative and quantitative evidence. In particular, the evaluation draws on methods from the humanities and social sciences, including community and medical history, and medical anthropology's focused

[9] World Health Organization on the Social Determinants of Health; L.T. Larsen, 'Not merely the absence of disease: A genealogy of the WHO's positive health definition' *History of the Human Sciences* 35:1 (2022).
[10] British Academy, *Public Trust in Science-for-policy Making*, (2024); Vanderslott et al, 'Attributing public ignorance in vaccination narratives' *Social Science & Medicine* (2022).
[11] C. Webster, ed., *Caring for Health: History and Diversity* (2001), p. 86.
[12] Healthwatch Oxfordshire, 'Oxford's New and Emerging Communities' Views on Wellbeing' (2021).

ethnographic study. Researchers conducted participant observation and participant research, semi-structured interviews, mapping, workshops, and neighbourhood surveys.[13] The evaluation also incorporates long-term health and funding contexts in the ten priority wards in order to understand and analyse social and cultural obstacles to engagement with community health.

This evaluation was a partnership between the Oxfordshire County Council Public Health team; Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB); the University of Oxford; and Oxfordshire Voluntary, Community, and Social Enterprises. Research and evaluation were independently conducted by medical humanities researchers at the University of Oxford: Erica Charters (Principal Investigator), Yuxin Peng (Lead Researcher), Sally Frampton (Lead Researcher), Urvi Khaitan (Postdoctoral Researcher), Julia Gustavsson (Research Assistant), Theeba Krishnamoorthy (Research Assistant), Utsa Bose (Research Assistant), Joseph Foster (Research Assistant), Megan Lee (Research Assistant), Yuran Shi (Research Assistant), and Molly Wilson (Research Assistant). Ben Lacey (Population Health, University of Oxford) led a related project to integrate research and County Council health data. Members of the Oxfordshire County Council Public Health team, BOB ICB, Healthwatch Oxfordshire, Community First Oxfordshire, and Oxfordshire Community and Voluntary Action provided advice and guidance.

All participatory methods were carefully selected and tailored to research contexts, and our community engagement aligns with the objectives and goals of Oxford University's Participatory Research Programme, which emphasizes trust-building, inclusive interaction, and respect for lived experience.[14] All fieldwork researchers completed research ethics and integrity training, and the project received ethics approval from a subcommittee of the University of Oxford Central Research Ethics Committee Approval (reference R93783/RE001). Researchers ensured that all participants provided informed consent and understood how to withdraw from the study, if they so wished.

The evaluation uses three strands to evaluate the CHDO and WT programmes. The first strand (section 2) analyses the health and social context of the ten priority wards. The second strand (section 3) analyses the funding and grant activities of the CHDO and WT programmes, and the implementation of the two programmes. The third strand (section 4) examines community engagement with the two programmes. Findings and research-based recommendations are summarized in section 1.2 and described in detail in section 5.

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[13] Atkinson and Fuller, ed, *Wellbeing and Place* (2012); Twells, 'Community history' IHR Making History (2008); Deacon and Donald, 'In search of community history', *Family and Community History*, 7, 1 (2004), 13–18; D. Porter, *Health Citizenship: Essays on Social Medicine and Bio-medical Politics* (2012); D. Porter, 'The Mission of Social History of Medicine: An Historical View,' *Social History of Medicine*, (1995): 345–359; Berridge, 'History in public health: who needs it?' *The Lancet* (2000), 356, 9245: 1923 – 1925; Mold et al, ed. *Lessons from the History of British Health Policy* (2023); Howell, 'Ethnography,' *The Open Encyclopedia of Anthropology*, (2023); T. Ingold, 'That's enough about ethnography', *Journal of ethnography* 4:1 (2014); R.S. Weiss, *Learning from Strangers: The Art and Method of Qualitative Interview Studies* (1994); J.M. Murchison, *Ethnography Essentials* (2010); Ed. L. Roberts, *Mapping Cultures: Place, Practice, Performance* (2010); Pelto and Pelto, 'Studying knowledge, culture, and behavior in applied medical anthropology' *Medical Anthropology Quarterly* (1997) 11:147–163; Hahn and Inhorn, eds, *Anthropology and Public Health: Bridging Differences in Culture and Society* (2009).

[14] Researchers also incorporated Healthwatch Oxfordshire's 2023 report on Community Research in Oxfordshire.

To analyse the health and social contexts of the ten priority wards, we used the Community Insight Profiles, social histories of health in Oxfordshire, community health surveys of c. 1600 households in the ten wards, and routine statistical data.

To analyse the implementation of the two programmes, we conducted workshops with programme staff, focus groups with community organisers, and semi-structured interviews with CHDO and WT staff, as well as participant observation of funded activities. To analyse the process of grant applications and outcomes from the perspective of community group organizers, we assessed insights from 26 community groups that had secured funding from either or both programmes. These insights were gathered through one community workshop, 15 semi-structured interviews, and two sets of feedback questionnaires.

To capture community views of health and the two programmes, we conducted fieldwork visits and participant observation for 50 of the CHDO-WT funded groups and organisations alongside semi-structured interviews with resident participants. We also organized mapping activities and conducted brief structured interviews at three major community events in 2024 (Banbury People's Park, Leys Festival, Banbury Princess Diana Park Playday) and at the Rose Hill Community Cupboard for a total of 69 interviews with community event participants. The research team also conducted in-depth household interviews in the neighbourhoods categorized as among the most deprived according to the 2021 Census Map of Household Deprivation. Nearly 1600 households were visited (an average of 160 per ward), with a response rate of 14%, resulting in 223 completed household interviews (an average of 22 household interviews per ward). This provided a substantial and diverse sample of target households in the priority communities and meant that we could engage with residents who would likely not attend focus groups or respond to calls for survey respondents.

1.2 Key Findings and Recommendations

Our evaluation presents quantitative and qualitative data showing that the CHDO and WT programmes have demonstrably fulfilled their objectives. They were successful in taking a community-based approach to support health and wellbeing through effective communication, activities, and practices in the communities most likely to 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; working with 'anchor' organisations, key partners, and stakeholders; and coordinating with grassroots and voluntary sector groups.

A key factor that enabled this collaboration was each programme's allocation of community activity funding. This supported over 100 community organizations to help deliver over 200 health and wellbeing activities distributed across the ten wards. In our survey of c. 1600 households in the target neighbourhoods, we found that two-thirds (73%) of residents had heard of, attended, or wished to attend these 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. Target neighbourhoods of the ten priority wards therefore significantly engaged with both programmes.

Collaboration and coordination with communities fundamentally relied on the programmes linking residents to existing medical and health provision in the wards, as well as ensuring that local health infrastructure, including health and wellbeing activities, is accessible and trusted. To accomplish this, we found that individual Community Health Development Officers and Well

Together's Community Capacity Builders are particular strengths of each programme. They effectively engage with local communities through regular presence in community activities; excellent communication and networking skills; and active partnerships with existing organisations and networks.

The CHDO and WT programmes offer a model for long-term preventative and community health. By working with existing community organisations, 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.

Our research found that 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-based and relationship approaches be categorized as key long-term strategies to achieve resilient community health, prioritizing sustainability over innovation.

Moreover, our research found that communities understand health through social relationships: through concerns over family and household health, rather than simply through individual health. Residents also prioritize people – neighbours, family, and social ties – in what is important to them in their communities. 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. Above all, community health and wellbeing depend on communities themselves as active and engaged networks of social and cultural relationships.

Residents access and engage with medical and health infrastructures through social relationships that require trust and familiarity, and – crucially – through social relationships that encourage aspirations and expectations of improved health and wellbeing. We recommend that methodologies for evaluating the effectiveness of community health programmes prioritize resident engagement and trust to achieve meaningful reporting while ensuring proportionate demands on the responsibilities of community organizers.

2. The Programmes and the Ten Priority Wards

The aim of the CHDO and WT programmes is to work with 'local partners and residents to develop and support initiatives to improve the health and wellbeing of the communities that they are working within.' These initiatives draw in part on the Community Insight Profiles, while also linking to Oxfordshire's Joint Strategic Needs Assessment (JSNA). In particular, Oxford's 2023 JSNA highlighted that, while Oxfordshire as a whole was ranked relatively healthy when compared with other English counties, there are 'wide inequalities in health and wellbeing' within Oxfordshire. Statistical data from surveys such as the 2019 English Indices of Deprivation identified ten Oxfordshire wards that faced issues such as considerable Income Deprivation and Health Deprivation and Disability. These were: 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.

Oxfordshire County Council's Public Health team thus worked with local partners to create Community Insight Profiles, published between 2022 and 2024. These profiles use an asset-based community development model (ABCD), which recognizes that community residents themselves are best-placed to identify and mobilize existing assets – whether individuals, associations, or institutions – in developing and sustaining community connections and activity.[15] Each of the ward's Community Insight Profiles provides statistical detail on ward population, housing, health and wellbeing, employment and poverty, crime and community safety, as well as living environment. Just as crucial, each Community Insight Profile also outlines which local health and wellbeing assets residents identify as important, as well as community views on what they appreciate about their ward and which community issues they would like to see addressed, including challenges to health and wellbeing.

The CHDO and WT programmes build on these Insight Profiles and make use of them as guides in their community activities. Some CHDOs, for example, participated in the production of the Community Insight Profile for their ward(s). The Community Insight Profiles therefore provide the fundamental framework for the CHDO and WT programmes. They do so not only by providing details – qualitative and quantitative – on each of the ten priority wards, but also by outlining what local residents identify as key issues and assets regarding health and wellbeing. The CHDO and WT programmes thus build on the Community Insight Profiles and also use them in assessing grant applications, while applying the Profiles' strategy of supporting community residents to leverage existing networks and assets.

Our evaluation follows this methodology by using the criteria and issues raised in the Profiles to assess the CHDO and WT programmes. We also supplemented Community Insight Profiles through interviews and discussions with residents in target neighbourhoods. In spring and summer 2025 we visited c. 1600 households in the neighbourhoods categorized as among the most deprived according to the 2021 Census Map of Household Deprivation of the ten priority wards, resulting in 223 in-depth household interviews. As well as asking questions about health and community engagement (see section 4), we asked household members how long they had lived in their neighbourhood; what they said when asked 'where do you live', and their views on their local neighbourhood. This provided rich data on neighbourhood demographics, identity, and definitions of a good community as well as change over time.

[15] Kretzmann, J. & McKnight, J. (1999). *Leading By Stepping Back: A Guide for City Officials on Building Neighborhood Capacity*.

2.1 The Ten Priority Wards: Community Identity

Although wards serve as useful administrative units, these can be difficult to assess and portray, in part because boundaries have shifted, in part because different evaluations use different categories of assessment, and in part because wards border one another or have a variety of neighbourhoods within them.

Abingdon Caldecott, for example, had its ward boundary redefined in 2015; it is sometimes also disaggregated into Abingdon South and Vale of White Horse. While Abingdon Caldecott's statistics identify areas which struggle with issues of deprivation, in its Insight Profiles residents also note that it is an area with green spaces and a range of community organizations that help support wellbeing. Yet, in a theme that recurs in many wards, Abingdon Caldecott residents surveyed in its Community Insight Profile suggest that sustained engagement with community activities is a key problem, hindered by the perception that support is often short-lived and initiatives come from outside rather than from residents themselves.

In our community health survey of 300 households in the target neighbourhoods of Abingdon Caldecott, we completed 27 in-depth interviews. The largest group of respondents (42%) was between 35 and 69 years of age; half of households had children. The average number of years that respondents have lived in the neighbourhood was 22, with a significant proportion (25%) having lived there for more than 40 years; one respondent added that although she had only lived in her current dwelling for 13 years, she was 'born down the same street in another house'. At the same time, as an equally substantial proportion (30%) have lived in the neighbourhood for less than five years, the target neighbourhood of Abingdon Caldecott is home to those who identify as long-established members of the local community (40% living locally for 20 or more years) alongside a significant number who are recent arrivals (30% for five years or less). The majority of respondents (80%) expressed positive views of their neighbourhood. Alongside, 88% specified 'Abingdon' when asked where they live (the other 12% stating 'Oxford'), and two even specified their local neighbourhood ('Saxton Road' or 'Saccy Road'). Moreover, 55% mentioned their neighbours or a sense of community as to why they liked living in their neighbourhood; one elderly male respondent who lived alone explained, 'people care about others here, and I feel safe. …The people in this neighbourhood are amazing;' another explained 'This is home.' By contrast, 15% of respondents expressed negative views of their community, one simply stating 'it's okay'. Negative perceptions of the neighbourhood do not correlate to length of time; indeed, in a theme that reappeared in our research, long-term residents expressed concern over neighbourhood identity and recent shifts, one noting that 'it used to be' that you could rely on your neighbours for help. Location and access to green space were stated as important to at least a third of those interviewed; likewise, 40% identified 'walking' as something they did to stay healthy, and often specified walking locally.

In the Community Insight Profiles, residents of the three priority wards in Banbury -- **Banbury Ruscote, Banbury Cross and Neithrop, and Banbury Grimsbury and Hightown** – identify key community assets that they frequent, including green spaces, local community centres, and churches and mosques. With statistics that identify higher-than-average levels of unemployment, poverty, and crime, residents express concern with community safety and the cost of community events. Ruscote and Grimsbury & Hightown record significantly lower-than-average life expectancy, with high rates of mortality from respiratory diseases. Residents in all three wards recommend improved communication and networking of wellbeing activities, tailored to local residents – noting cultural and religious diversity in Banbury as a whole (Banbury Grimsbury and Hightown, for example, have an Asian, Asian British, or Asian Welsh

population of 14.5%; Banbury Cross and Neithrop of 9.6%; compared with the Oxfordshire average of 6.4%).

In our community health surveys, we visited 450 households in target neighbourhoods in Banbury (specifically in Banbury Ruscote, Banbury Cross and Neithrop, and Banbury Grimsbury and Hightown), providing a total of 59 in-depth household interviews. This consisted of visits to 180 households in the target neighbourhoods of Banbury Grimsbury and completed 18 in-depth household interviews; 120 households in the target neighbourhoods of Banbury Neithrop and completed 11 in-depth household interviews; and 150 households in the target neighbourhoods of Banbury Ruscote and completed 30 in-depth household interviews. In Grimsbury, more than 80% of respondents had lived in the neighbourhood for more than 10 years, with the average length of residence 28 years. By contrast, in Banbury Ruscote a significant proportion (40%) had lived in the neighbourhood for five years or less, with only 46% having lived there for ten years or more. Similarly, more than 65% of respondents in Banbury Neithrop had lived there for ten years or less, with the average length of residency 17 years. As a result, for the target neighbourhoods in Banbury as a whole, about 50% have lived there for less than ten years and 50% had lived there for more than ten years, with a substantial percentage (17%) who have lived in their neighbourhood for forty or more years, with 15% of respondents answering 'my entire life', 'forever,' or 'all my life' when asked.

Community identity also varied within these three target neighbourhoods. Whereas almost all respondents in Banbury Neithrop simply stated 'Banbury' when asked to name their neighbourhood, two respondents in Banbury Ruscote said they state 'Bretch Hill' and only one 'Ruscote' with the remainder stating 'Banbury.' In the target neighbourhood of Banbury Grimsbury, three (17%) answer 'Grimsbury' with the remainder stating simply 'Banbury'. The majority of respondents in Neithrop were positive about their neighbourhood; only one (10%) expressed unhappiness with the neighbourhood; three commented positively on the local community, including having family nearby. By contrast, Banbury Ruscote respondents had a larger proportion (40%) who were negative or had nothing positive to say about their neighbourhood, including two who complained about it not being a nice neighbourhood 'anymore'. However, nearly one-quarter identified the community and their neighbours as local assets, including one who noted 'It's a nice area even though people say it's not.' Respondents in Banbury Grimsbury were generally positive, with only two respondents (11%) unequivocal – either observing 'I'm used to it' or noting that it previously had a good community, suggesting that it no longer did. Interestingly, while respondents generally mention neighbours and safety when identifying important local factors, almost half (46%) mention the neighbourhood being 'quiet' as a key positive asset. What 'quiet' means seems to vary; while some answers suggest this has to do with safety or sound (e.g. 'not too busy', 'you can hear birds in the morning'), others suggest that community 'quiet' has to do with privacy (e.g. 'people keep their nose out,' 'you can just get on with your life'). Qualitative surveys thus capture conflicting community desires for privacy alongside neighbourhood connections.

In Oxford, the four wards of **Rose Hill & Iffley, Littlemore, Northfield Brook, and Blackbird Leys** are neighbouring wards, with Blackbird Leys and Northfield Brook often combined as 'the Leys'. In the Community Insight Profiles, residents of these wards note social, cultural, and ethnic diversity as a strength, with statistical data highlighting that each ward has a higher proportion of non-White residents than the Oxfordshire average. Community Insight Profiles also capture residents of all four wards identifying local community health and wellbeing activities as key community assets, as well as a strong sense of local identity. At the same time,

statistical data show Blackbird Leys and Northfield Brook to have male life expectancy rates significantly lower than the Oxfordshire average, and residents note that while there are various health and wellbeing services available in Oxford, access to these vary depending on transport links as well as issues of time or even mistrust of authorities. Residents were also aware of higher-than-average crime rates, and observed that community assets – such as parks – could become unsafe or inaccessible at night. Suggestions included ensuring that green spaces remained accessible while also improving access to health and medical provision, as well as improved information communication and networks of community resources and opportunities.

In our community health surveys, we visited 647 households in the target neighbourhoods of Rose Hill & Iffley, Littlemore, Northfield Brook, and Blackbird Leys, resulting in 93 in-depth household interviews for these four wards. In particular, we visited 51 households in the target neighbourhood of Rose Hill & Iffley, obtaining 9 in-depth household interviews; 146 households in the target neighbourhoods of Littlemore, obtaining12 in-depth household interviews; 250 households in the target neighbourhoods of Northfield Brook, obtaining 44 in-depth household interviews; and 200 households in the target neighbourhoods of Blackbird Leys, obtaining 28 in-depth household interviews. In Rose Hill & Iffley, the majority (56%) had lived in their neighbourhood for five years or less, with no respondents having lived there for forty years or more. By contrast, almost a third of Littlemore respondents had lived in their neighbourhood for upwards of forty years, with one answering 'my whole life' and two simply stating 'a long time.' Respondents in Northfield Brook varied in terms of residency: around a third (31%) had lived there for five years or less, but the same number had lived locally for twenty years or more. Blackbird Leys respondents demonstrated long residency: more than 50% had lived locally for twenty years or more; one third had lived locally for upwards of forty years; and only 15% had lived locally for less than five years.

Our interviews also captured broad divergence in terms of neighbourhood identity and community in these four wards. Almost all respondents in Rosehill and Iffley clearly stated 'Rose Hill' when asked where they say they live; those with positive (two-thirds) views of Rosehill and Iffley mentioned its convenient location – especially for access to green spaces and family. However, a third of respondents were negative about their neighbourhood, with two complaining of disruptions caused by measures designed to prevent through-traffic (LTNs). Respondents in Littlemore also generally identified as living in 'Littlemore', with only one of 12 stating 'Oxford' when asked where they lived; likewise, around a third of respondents in Littlemore either mentioned complaints about their neighbourhood or stated simply 'it's fine'. Those who shared positive reflections (50%) commented on enjoying the community and access to green spaces.

By contrast, respondents in Northfield Brook and Blackbird Leys used a variety of neighbourhoods when asked where they live: no one in the Northfield Brook ward mentioned 'Northfield Brook', instead about half either said 'Oxford' or used both 'Oxford or Greater Leys', while 8 respondents stated 'Blackbird Leys' and a third stated 'Greater Leys', one even adding, 'it's not Blackbird Leys…it's GREATER Leys.' Respondents were overwhelmingly positive about their neighbourhood: only four (10%) responded either negatively or with no opinion. Of those who responded positively, almost 70% mentioned community (friends, neighbours, or even explicitly 'a good sense of community') as to why they enjoyed living there; one of the negative respondents explained that it was because it used to have 'friendly neighbours' but this has now changed. While location (31%), access to green spaces (16%) and a quiet environment (22%)

were also frequently mentioned, it is clear that a strong social identity defines Northfield Brook, with responses such as 'The community is good; Blackbird Leys is not as dangerous as people think' or 'it has a feel of community' and 'lots of community events' capturing this view. Likewise, respondents in Blackbird Leys frequently specified 'Blackbird Leys' or 'Oxford or Blackbird Leys' (more than 75%), with only 11% stating 'Oxford', the same amount stating 'Cowley'. Respondents in Blackbird Leys were also overwhelmingly positive and emphasized strong community identity: only 3 respondents (12%) mentioned complaints, one of them again referring to the decline in community and neighbourliness as the reason, whereas 65% (or almost 75% of all positive responses) mentioned community and neighbours as the reason for liking living in Blackbird Leys, alongside it being quiet (19%), good location (19%), and access to green spaces (8%). Respondents often mentioned specific aspects of its community, such as 'closeness with neighbours,' that 'everyone helps each other,' 'my wonderful neighbours,' and that there are 'good community events.'

The Leys (Blackbird Leys and Northfield Brook) therefore demonstrate substantial and positive community identity including comments on frequent local community activities. This is in contrast with Rose Hill & Iffley and Littlemore, where although respondents demonstrate strong identity (specifying Rose Hill or Littlemore), about one third mention dissatisfaction with their local community. When interviewing attendees at a CHDO-organized event at the Rose Hill Community Centre, seniors from Littlemore were frustrated that Rose Hill and other nearby communities 'get more attention,' whereas Littlemore is forgotten because it is 'in between.' Indeed, some participants complained that activities always combined Rose Hill with Littlemore and Cowley, reminiscing that when they were growing up (in the 1960s and 1970s), Littlemore was fully of friendly neighbours and activities, whereas now 'there's nothing there.'[16]

The Oxford ward of **Barton & Sandhills** is northeast of Oxford city, and includes Barton, Barton Park, and the Sandhills estate. While statistical data classify this ward as having life expectancy lower than the Oxfordshire average, the Community Insight Profile focused on Barton and Barton Park, given that Sandhills is demographically different from Barton and Barton Park. In its Community Insight Profiles, Barton and Barton Park residents identified a number of key community assets, including green spaces, an active community association, and a central Neighbourhood Centre. At the same time, residents requested more sustained health and wellbeing services, as well as ways to ensure accessibility of community assets and organizations – including improved networking and public transportation.

In our community health surveys, we visited a total of 180 households in the target neighbourhood of **Barton**, resulting in 30 in-depth household interviews. Respondents demonstrated a majority of long residency: 70% had lived in the neighbourhood for ten years or more, with almost 50% living there for upwards of 20 years. While a majority (around 70%) state 'Barton' when asked where they live, a significant proportion (30%) state 'Oxford' or 'Headington', with two explaining 'Headington, because people are sometimes funny about Barton' and 'Headington – I don't say we're from Barton'. While only a minority shared negative or neutral views (e.g. 'it's okay' or 'no problems') of their neighbourhood, this was a substantial proportion, at 22% of respondents. Among those with positive views, a significant majority (40%) mentioned good community or neighbours, with the same number mentioning its convenient location and close to as many (25%) mentioning that it is quiet or peaceful. Some mentioned change over time; one complaining that 'there used to be a much better sense of

[16] Interview 3 Dec 2025, Winter Warmers Health Promotion Event, Rose Hill Community Centre.

community,' and another mentioning that there used to be problem teenagers but 'now they've grown up and moved on so it's calm.'

Like previous wards, the ward of **Osney & St Thomas** combines various neighbourhoods; its Community Insight Profile focused on the communities of St. Thomas, St Ebbe's, Friars Wharf, and Grandpont. This region is in central Oxford City, which includes a high student population; the Community Insight reporting focused on areas with a high proportion of social housing. Residents identified a range of community assets and organizations, ranging from activities for families and greenspaces, to skills training and housing support. At the same time, in the Insight Profiles residents identified issues with housing – with a significant homeless population in Oxford City – and recommended improved provision for free or low-cost community spaces.

In our community health surveys we visited 120 households in the target neighbourhood of Central Oxford (Osney & St Thomas), which resulted in 14 in-depth interviews. Unlike most other neighbourhoods, respondents demonstrated a high proportion of recent arrivals, with 43% having lived in Central Oxford for five years or less, and only one living there for more than 40 years. All respondents stated either 'Oxford' or 'Central Oxford' when asked where they lived. Very few (one) had negative views, with another respondent indifferent; of those who had positive views of their neighbourhood, the majority mentioned that it was quiet or peaceful (around 50%) and/or that it provided good access to green spaces (c. 50%). Only two respondents mentioned good community or neighbours, with one noting 'It took five years of me living here before people started to open up'.

Case study: What makes a healthy community?

The Oxford Central ward highlights the importance of locality and the limits of models when practicing community health, as a distinctive community in terms of location, population, and assets.

In many ways, the centre of Oxford City is recognised as a great location: close to shops, cafes, and a variety of cultural attractions. Residents also note that there are accessible and nearby green spaces. In our door-to-door neighbourhood survey of the central ward, when asked 'what do you like about living here,' 85% of respondents cited the advantages of the physical landscape, including the "countryside" feel of the area, the quietness, the river, and the green spaces. Of all the wards surveyed, residents in this area were the most engaged with the natural environment in their area. CHDO and WT funded groups have been effective in capitalising on this advantage. The Hogacre Common Eco Park, for instance, used their funding to create a series of sessions with year 3 pupils (7–8-year-olds) from the local St. Ebbe's Primary School which taught gardening and fruit/veg picking. Teachers noted that the consecutive sessions were important, as it took pupils time adjust to the activity and the surroundings. Longevity also gave pupils the opportunity to see the fruits of their labour as they grew. The sessions connected with objectives of the Children and Young People's Core20PLUS5, including the focus on tooth decay and oral health. For example, when we visited, several children came up to talk, wanting to know the difference between sugar in fruit and sugar in sweets, leading to a discussion of processed food.

Central Oxford also faces substantial challenges. High rates of homelessness are a particular challenge, with local groups providing a variety of types of support. New Life Covenant Church's monthly breakfast aims to support the homeless population and is a very well-attended initiative. Led by Pastor Memory Tapfumaneyi, the large team of volunteers provide high-quality food and work closely with Oxford Food Hub to minimize food waste. 'Good food. Nice people. Good heart,' summarized one visitor who was navigating homelessness in the Cowley Road area. Volunteers reported that they valued the experience; one explained: 'what surprised me was that they were put in that situation because something had happened…it's changed how I've seen homeless people. You want to know the story behind them.' Groups have also been responsive to regeneration of

Central Oxford, including the Oxford Local Plan 2035. For example, Well Together funding enabled Fusion Arts – one of the few community spaces in Oxford Central west – to run a community project on the history of the area, explicitly connecting heritage and memory with community health and wellbeing. An older male participant, who was also a life-long resident, used this opportunity to explore his family history and connect with others within the context of a rapidly changing neighbourhood.

Initially focused on Covid-19 vaccine uptake and coordinating the Community Insight Profile, the **Central Oxford Health and Wellbeing Committee** now has a broad remit of supporting health and wellbeing activities in Central Oxford. Along with implementing Profile recommendations and connecting community partners, it brings together a range of stakeholders (local councillors, heads of funded organisations, CHDO and WT representatives) and engages with the complexity and challenges of Central Oxford. A lack of appropriate venues for community events, for example, is often cited; others have noted that it is 'a fractured part of the city', with high prices and constant mobility from tourism and the international standing of the University of Oxford making the area 'a double-edged sword' for residents.

As Central Oxford shows, while the ten priority wards face similar challenges, they are also distinctive, with unique opportunities as well as concerns that require distinctive approaches.

Overall, this data demonstrates the variety of communities within the priority wards, and even more specifically within the target neighbourhoods. While Central Oxford appears to have a high proportion of residents who are recent to the area, neighbourhoods such as in Banbury and the Greater Leys have a significant portion who are long-term residents. Community identity also varies, with some using 'Oxford' as a catch-all for their neighbourhood, and others explicit in their local community identity. Blackbird Leys and the Greater Leys, for example, demonstrates substantial strong community identity and satisfaction, whereas residents in certain parts of Littlemore, Rose Hill, and Banbury Ruscote expressed relatively more dissatisfaction with their neighbourhood. Yet overall, community dissatisfaction was generally low, with an average of 12% of all residents negative in their views of their neighbourhood. In terms of what residents identified as positive or important in their local neighbourhood, out of all 223 in-depth household surveys, the most common factor mentioned was a form of community – either neighbours, family or social ties, or simply there being a 'nice' or 'friendly' community (c. 40%); indeed, negative views often complained of the loss of community or having unfriendly neighbours. In other words, a sense of community with other people is one of the most important factors mentioned when residents are asked about their neighbourhood. Almost as common is residents mentioning 'quiet' or 'peaceful' (c. 35%). As previously noted, 'quiet' sometimes meant a lack of noise, but 'quiet' can also mean privacy and the ability to live one's life in peace. Finally, living in a convenient location and having access to green spaces are also of importance, mentioned by around a third of respondents.

Such views echo those we found during brief structured interviews we conducted at major community events in summer 2024.[17] In discussions on the use of parks and nature reserves, people expressed desires for more bins, better arrangements of exercise equipment tailored to different age groups and, repeatedly, the desire to feel safe in such spaces. Banbury residents, for example, expressed concerns about the drug-dealing and gang activities in the local parks, and many remarked that they observed a rise of incidents after the closure of local youth clubs. Such concerns were even more in evidence at the 2024 Playday at Bretch Hill, which took place a week after a midnight stabbing in the People's Park. One 13-year-old boy expressed worries

[17] Leys Festival 28 July 2024; Banbury Playdays 31 July 2024, 14 August 2024.

that he would be a target for gangs if he walked down certain areas in the Spiceball Park. Residents also noted that while the Bridge Street Community Garden was a popular, well-designed space for local groups to meet and organise diverse health and wellbeing activities for Banbury residents, it was also occasionally used by drug dealers and users due to its convenient location. Parks and other green spaces can thus be highly valued community assets for health, while also well-known locations for anti-social behaviours.

Residents' observations suggest that identifying community assets is only the first stage in improving health and wellbeing; they also require regular and long-term maintenance, as well as awareness of their use and how such patterns can shift throughout a day as well as over years. More generally, residents note the importance of people – neighbours, family, and social ties – in maintaining communities in which people feel able to enjoy local assets. Strong community identity and resilience is therefore defined not just by infrastructure and location, but also by social relationships.

2.2 The Ten Priority Wards: Statistical Data

The Indices of Multiple Deprivation (IMD) are a weighted combination of seven domains: Income (22.5%); Employment (22.5%); Education, Skills and Training (13.5%); Health Deprivation and Disability (13.5%); Crime (9.3%); Barriers to Housing and Services (9.3%); and Living Environment (9.3%). The 2019 IMD records Oxfordshire containing 17 out of 407 Lower-layer Super Output Areas (LSOAs) in the two most deprived IMD deciles of 1 and 2. LSOAs are units used by the ONS: 'made up of groups of Output Areas (OAs), usually four or five. They comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons.'[18]

Table 1. Deprivation Scores

MSOA	Deprivation score	% of children under 16 living in poverty	% of adults over 60 living in poverty
Blackbird Leys	34.9	25.2	22.4
Littlemore and Rose Hill	29.6	28.8	18.6
Barton	28.8	23.4	20.6
Iffley Fields	15.1	14.5	16.1
East Central Oxford	18.1	13.1	18.1
Banbury Grimsbury	23.9	16	19.4
Banbury Neithrop	26.8	17.5	18.6
Banbury Ruscote	34	25.6	20.8
Abingdon South	15.6	16.2	9.6

Source: Oxfordshire Local Area Inequalities Dashboard (MSOA is middle-layer super output area, which is made up of groups of 4-5 LSOAs)

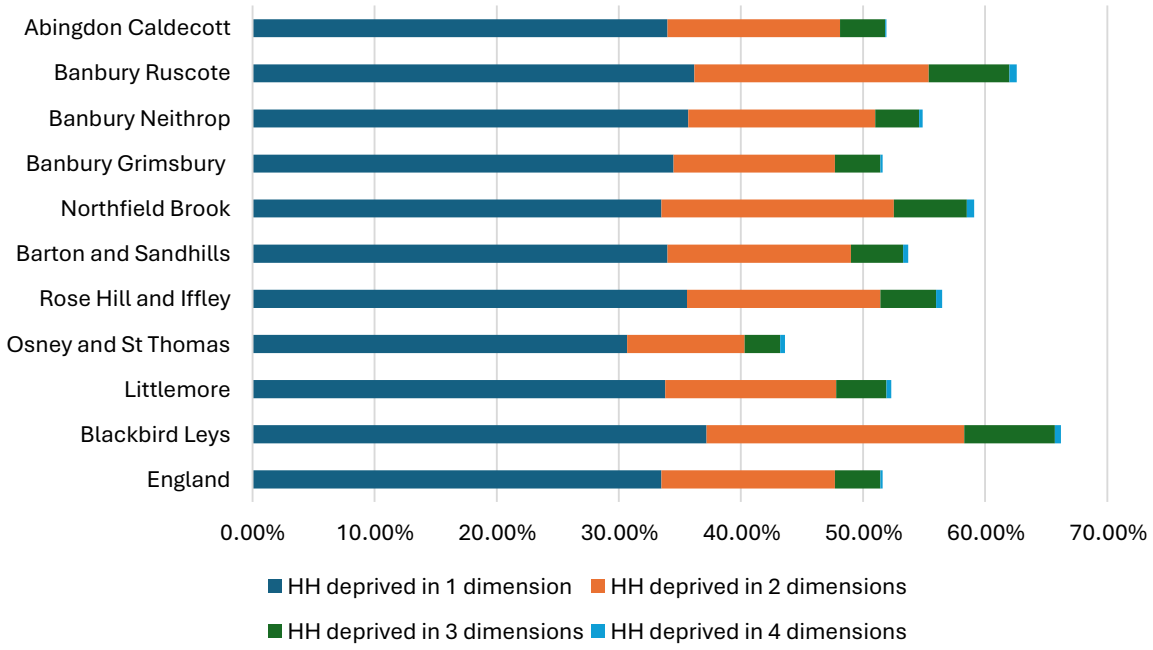
Experiences of deprivation are not uniform across the wards and there are important differences to consider, as well as the limitation of understanding communities via statistical

[18] ONS Statistical Geographies.

comparisons. The average IMD score (on a scale of 1-10, 1 being most deprived) for LSOAs in Oxfordshire is 8. However, the LSOAs in the ten wards have a score of 2 – except for Northfield Brook 18B which has the lowest score of 1. This indicates that there are wide gaps in outcomes within these wards and within the Oxfordshire average.

Figure 1 data are based on the measure of household deprivation collected for the 2021 Census, which is different from the measure of deprivation in the IMD. The Census captures granular household-level data, giving us a measure of deprivation based on four dimensions: education, employment, health and disability, and household overcrowding. While the IMD gives us data at the level of LSOA, the Census gives us data at the lowest level of the OA or Output Area, i.e., while the IMD provides data by neighbourhood, the Census gives us data by household. The IMD as an area-based measure brings together several datasets and has a much broader understanding of deprivation. More information on the differences between the two can be found here.

Figure 1. Households in deprivation according to the Census



Source: ONS, Census 2021

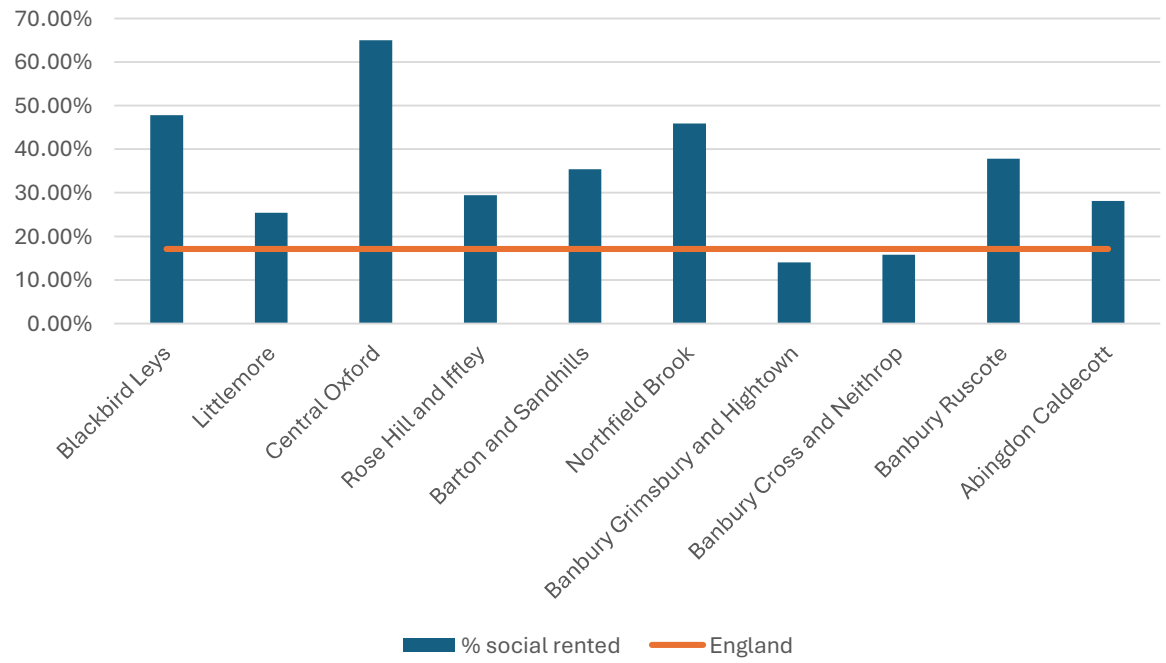
Apart from Osney and St Thomas, the rates of people engaged in routine and semi-routine occupations is high. These occupations are often manual and service occupations that are considered 'working class'.

Figure 2. Socio-economic classification of the ten wards

	Higher managerial, admin and professional occupations	Lower managerial, admin and professional occupations	Intermediate occupations	Small employers and own account workers	Lower supervisory and technical occupations	Semi-routine occupations	Routine occupations	Never worked and long-term unemployed	Full-time students
England	13.20%	19.90%	11.40%	10.60%	5.30%	11.30%	12%	8.50%	7.70%
Blackbird Leys	5%	11.50%	10.40%	6.60%	7.00%	18.30%	21.90%	11.80%	7.60%
Littlemore	14.80%	18.40%	9.60%	8.60%	5.80%	12.70%	15.10%	8.10%	6.80%
Central Oxford	9.60%	10.80%	7.70%	5.40%	5.30%	10.70%	13.10%	10.60%	26.80%
OST	23.90%	16.10%	5.80%	4.70%	2.00%	5.50%	4.60%	4.50%	33%
Rose Hill and Iffley	14.10%	16.80%	9.70%	9.00%	6.60%	12.60%	13.50%	9.90%	7.80%
Barton and Sandhills	13.20%	17.70%	10.60%	7.20%	5.20%	12.50%	17.50%	8.70%	7.50%
Northfield Brook	8.70%	16.80%	10.70%	7.20%	6.60%	16.60%	18.10%	8%	7.20%
Banbury Grimsbury	10.10%	17.30%	10%	8.90%	7.10%	14.60%	21.50%	6.10%	4.40%
Banbury Neithrop	10.10%	17.10%	10.10%	8.30%	7.00%	15.50%	19.60%	7.90%	4.40%
Banbury Ruscote	6.10%	13.60%	9.50%	9.10%	7.20%	17.40%	22.10%	9%	6%
Abingdon Caldecott	15.60%	19.90%	11.70%	8.40%	5.80%	11.90%	14.90%	7.40%	4.20%

Source: Census 2021

Figure 3. Social housing in the ten priority areas



Source: Local Insight Profiles and Census 2021

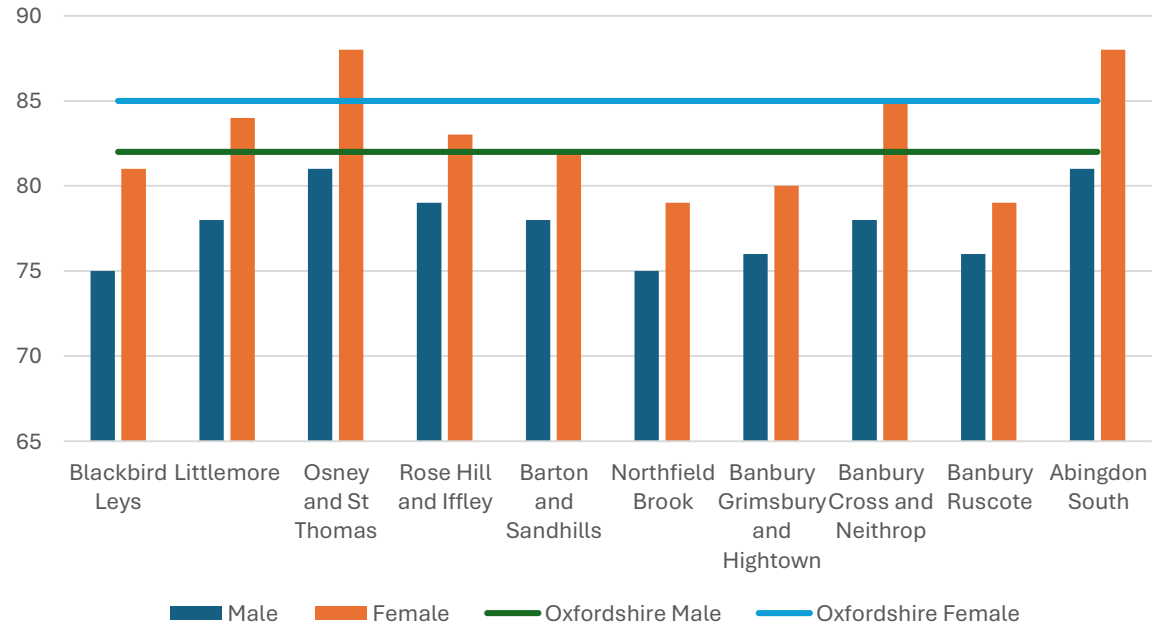
The percentage of people receiving allowances and Personal Independence Payment (PIP) tends to be higher than the national average. It is difficult to find data for Banbury and Abingdon; the table below shows the data for Oxford. The disparity between males and females is striking – especially in Blackbird Leys, Littlemore, Barton, Rose Hill and Northfield Brook.

Table 2. People receiving social care allowances in Oxford

	Attendance Allowance	PIP	Male PIP	Female PIP	Mental Health PIP	Respiratory Disease PIP	Disability Living Allowance	Universal Credit
England	*11.70%*	*7.90%*	*7.20%*	*8.60%*	*2.90%*	*0.30%*	*2.00%*	*3.70%*
Blackbird Leys	13.60%	11.60%	9.70%	14.10%	5.40%	1.00%	4.00%	6.00%
Littlemore	10.90%	9.60%	7.40%	9.90%	4.60%	0.00%	4.10%	5.90%
Osney and St Thomas	11.10%	3.60%	4.30%	3.20%	1.70%	0.20%	1.30%	3.60%
Rose Hill and Iffley	11.10%	9.20%	7.50%	10.30%	3.90%	0.40%	3.00%	4.60%
Barton and Sandhills	7.10%	9.20%	8.30%	10.50%	4.40%	0.90%	3.50%	5%
Northfield Brook	12.80%	11.30%	9.80%	13.40%	3.80%	0.60%	4.70%	6.20%

Source: Local Insight Profiles

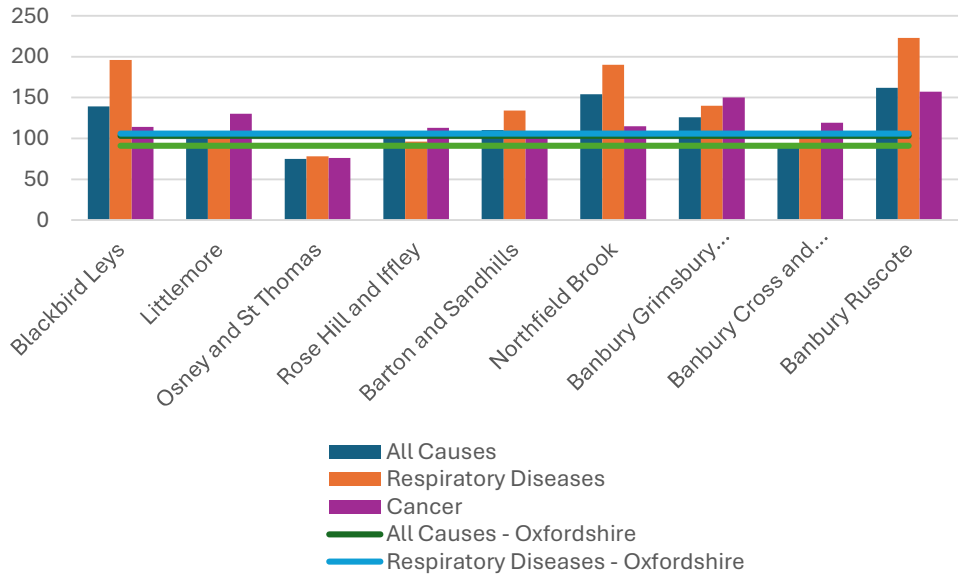
Figure 4. Life expectancy in the ten wards



Note: Data are for Abingdon South as Abingdon Caldecott data could not be located.
Source: Local Insight Profiles, Census 2021 and Oxfordshire Local Area Inequalities Dashboard

Respiratory diseases, the third biggest cause of death in England, are a leading cause of mortality in Oxfordshire. These include lung cancer, pneumonia, and chronic obstructive pulmonary disease. Indeed, mortality from such respiratory diseases is high in Blackbird Leys, Barton, Northfield Brook, Banbury Grimsbury and Ruscote.

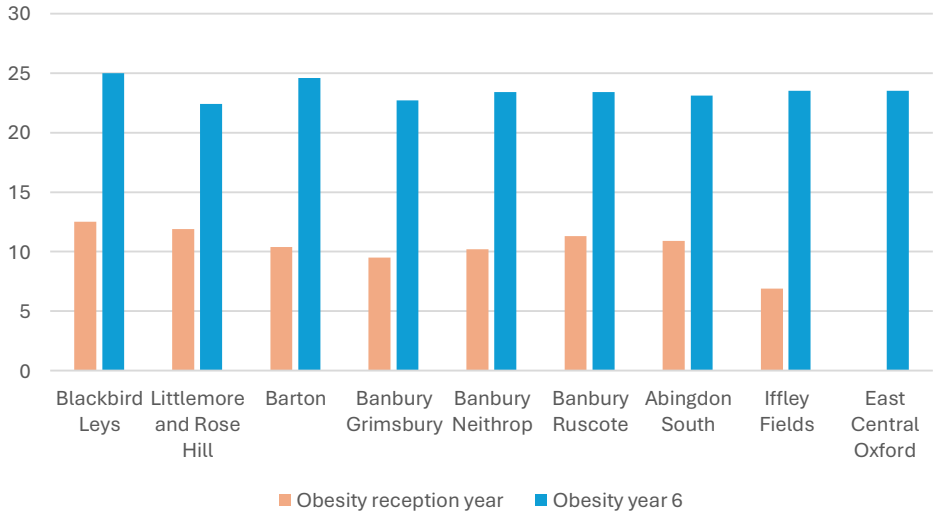
Figure 5. Mortality ratios



Source: Local Insight Profiles and Census 2021

Another focus of community health programmes in Oxfordshire is healthy eating and access to healthy food. This received greater impetus and focus recently, as reflected in the Director of Public Health Annual Report for 2022-23, titled 'Healthy Weight, Healthy Communities, Healthy Lives.' Although Oxfordshire's rates of obesity and overweight children are lower than England's averages, Barton and the Leys have higher rates.

Figure 6. Obesity among children



Source: Oxfordshire Local Area Inequalities Dashboard

More information on local food environments can be found in this interactive map that shows childhood obesity and the prevalence of fast-food outlets. It also shows how many food retailers can be accessed with a 10-minute walk. For most of Oxfordshire, especially rural

areas, this is 0. Access to healthy and affordable food is limited across Oxfordshire, not just in the deprived wards.[19]

Green Assets

While Oxfordshire contains substantial areas of green space, data show that use of and access to these regions vary. Barriers included: old age, long-term health conditions, disability, and 'being too busy at work or home'.[20]

Oxfordshire covers 2605km^2, but publicly accessible green space is only about 50-109km^2. The majority of the 700km^2 greenspace is not publicly accessible. A report by the Leverhulme Centre for Nature Recovery found 197 neighbourhoods in England which have poor public greenspace access, and 7 of these are in the 30% most deprived areas in Oxfordshire: Abingdon, Banbury, Littlemore, Blackbird Leys, and Northfield Brook. Some of these areas, particularly those in Blackbird Leys, also experience overcrowding of what green space is available.[21]

Funding

Some wards have had success at mobilizing funding, likely because of the high community needs in these areas: Blackbird Leys and Osney & St Thomas far exceed the others, although Rose Hill and Northfield Brook also perform well here. However, when looking at how funding from national organizations such as the National Lottery translates to per-person spending, Rose Hill is clearly underserved. Funding data show distinct variation by ward, as well as tangible community engagement and mobilization, and such variation is also captured by other forms of community funding.

This table shows Oxford funding from one national grant giving organizations.[22]

Table 3. Funding grants

	National Lottery Community funding per 1,000 population, 2004-21	**Total grants awarded from major funders per head, 2019**
England	*38,346*	*34*
Blackbird Leys	269,115	138
Littlemore	37,714	195
Osney and St Thomas	338,136	567
Rose Hill and Iffley	105,976	8
Barton and Sandhills	72,400	35
Northfield Brook	105,963	29

Source: Local Insight Profiles

Overall, the ten priority wards in Oxfordshire thus vary in terms of demographic, financial, and health patterns, as well as in types of assets. They also vary in terms of residents'

[19] See Oxfordshire County Council's March 2024 report on food strategy.
[20] Oxfordshire County Council, Mental Wellbeing Needs Assessment report (2021), p. 83.
[21] Leverhulme Centre for Nature Recovery Report, pp. 16-17.
[22] Data for Banbury and Abingdon could not be located.

suggestions and recommendations for improvement. At the same time, many residents of these wards share concerns regarding sustained accessibility to community assets and organisations, and often suggest improved communication and networks of opportunities.[23] Likewise, ward-level statistical data of health and wellbeing indicators – such as deprivation scores and life expectancy at birth – identify the challenges that residents face in these wards. Ward residents also note the ways in which their wards can be unfavourably characterized by those who live elsewhere and by residents themselves, which can encourage community disengagement. As the Community Insight Profiles and community health surveys demonstrate, residents are aware of these issues, but many also recognize key assets of their communities, including a strong sense of local neighbourhood identity and a strong sense of social community, with positive neighbourhood identity often defined by social relationships as well as by infrastructure and location.

[23] This builds on Healthwatch Oxfordshire research into health and wellbeing: 2021 Research Report; 2022 Research Report on Albanian and Arabic Speaking Communities; 2022 Research Report on the Sudanese Community in Oxford; 2024 Research Report on community food support in OX4.

3. The Programmes: Context, Aims, and Implementation

The initial catalyst for the CHDO and WT programmes was Oxfordshire's Director of Public Health 2019-20 Annual Report, which highlighted 'hidden inequalities in a prospering Oxfordshire'. The Covid-19 pandemic further exposed health inequalities, and tangibly reiterated the need for public health programmes (such as vaccination) to work with local communities for successful implementation.[24] In 2024, Oxfordshire County Council committed to Oxfordshire becoming a Marmot Place, partnering with the UCL's Institute of Health Equity to 'reduce inequalities in health by assessing the extent of inequalities in health and the social determinants of health locally,' drawing on the eight Marmot principles and related research. The CHDO and WT programmes are thus part of recent initiatives that aim to improve health among Oxfordshire areas that have lower-than-average life expectancy and health outcomes, through public and community health initiatives.

At the same time, the CHDO and WT programmes draw on a long history of addressing public health through preventative community-based measures. Applying methodologies of building community capacity, trust, and sustainability, the CHDO and WT programmes are designed to mobilize assets, networks, and resources from within communities. Both programmes intentionally recruit staff with experience of working for community organizations. They also share an emphasis on building community networks of trust. Yet they are also distinctive: CHDOs are managed by the OCC Public Health team, and can be considered local authority officers, while WT is managed by two Voluntary, Community, and Social Enterprises and focus particularly on collaboration and building community capacity. These two approaches to community engagement are complementary. At the same time, the two programmes are comparably small in scale (though WT has a significantly larger grant budget), and designed to work within existing infrastructure, rather than overturning or creating entirely new ways of working.

This section defines the context, aims, and implementation of the CHDO and WT programmes in order to outline how our evaluation assesses the effectiveness of the two programmes.

3.1 The long-term context and ambitions of local health interventions

Authorities – political, religious, social, and medical – have long worked to track and identify patterns of illness and mortality in general populations, and thereby intervene in order to improve overall rates of health. Some notable early practices include the recording and analysis of mortality via parish registers (begun in the Tudor period to detect plague outbreaks) and nineteenth-century civil registration (which provided statistics of types and rates of both disease and mortality). Nineteenth-century sanitarians collected and compared morbidity and mortality rates in order to distinguish between healthy and unhealthy localities as well as among different occupations in England. Such data were then leveraged to induce government intervention via local expenditure and environmental conditions to improve health. Landmark reports such as Edwin Chadwick's 1842 *Report on the Sanitary Conditions of the Labouring Population of Great Britain*, for example, marshalled extensive quantitative and qualitative evidence to argue that environmental conditions – poor living conditions such as overcrowding,

[24] Also relevant is the NHS's 2019 Long Term Plan setting out key actions to reduce healthcare inequalities; see also Healthwatch Oxfordshire's 2021 report on wellbeing.

lack of clean water, and poor drainage – caused high levels of ill-health and mortality. By comparing morbidity and mortality rates between types of workers (e.g. industrial vs agricultural labourers) as well as between localities, Chadwick's report used comparative statistics to pinpoint poor sanitation and living conditions, not just poverty alone, as the culprits behind poor health.[25]

Comparisons of health, income, and geographical statistics thus have a long history in policy discussions underpinning the practice of public health. As Chadwick's report and its reception reminds us, debates over explanations of poor health, and of what measures are most apt, are not a recent phenomenon. While many were hostile to Chadwickian intervention via central authorities that interfered with local practices, ensuing sanitary and public health regulations also effectively improved the health of England's labouring classes – particularly through the development of approaches such as the Health of Towns Association, which complemented central initiatives through local campaigns. Public health strategies have thus long highlighted the nature of such interventions, including the effectiveness, virtuousness, and sustainability of programmes that work at local levels and *with* communities.[26] Late Victorian movements like the development of first aid "ambulance" classes shifted caregiving to the wider community through modes of voluntarism largely endorsed by the political establishment of the time and which were a vital part of the public health movement. Likewise, the popularization of 'community care' from the 1960s onwards highlighted the importance of integrating primary care, social care, and households, but not always with clarity as to how this might be implemented.[27] Health reformers have thus long recognized the active role citizens need to play for improved health outcomes; however, the coordination between central and local interventions, and between governmental and community groups, can prove difficult.

Reports and initiatives have also long highlighted how different social categories relate to health outcomes – whether classified by geography, economics, type of employment, or demographic categories such as ethnicity and gender. Whether described as health inequalities, health variations, or simply excess death, such differences have long been a concern to communities and policy makers alike. The establishment of the National Health Service in 1948 was in part designed to address the problem of health inequalities in England, but as Brian Abel Smith complained in 1978, 'despite 30 years of the National Health Service, mortality rates are in general a third higher in Wales than in East Anglia…[and] the differences in mortality rates between social classes, are if anything getting wider rather than narrower.'[28]

By the 1970s, health inequalities were increasingly discussed and scrutinised, and used in calls for reform, including those leading to the reorganization of the NHS in 1974. The reorganization, also considered as shaped by the community health movement, aimed to tie health services into closer collaboration with local communities in order to address local needs and hold health services accountable. One such mechanism was the establishment of Community Health Councils, which were formed to safeguard the interests of local communities and work

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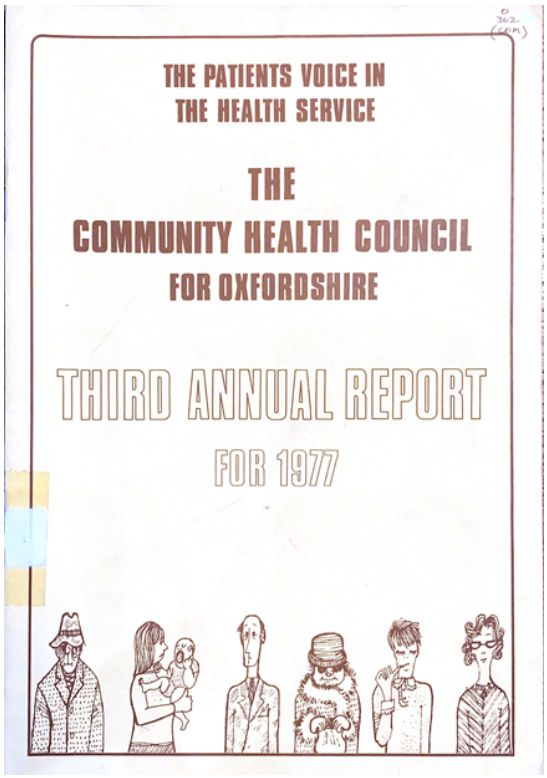
[25] Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain 1800-1854*; Crook and O'Hara (eds), *Statistics and the public sphere: numbers and the people in modern Britain, 1800-2000* (2011).
[26] Pelling, "'Progress, difficulties, suggestions and reforms': *Public Health* 1888-1974" *Public Health* (1988); Crook, *Governing Systems: Modernity and the Making of Public Health in England, c. 1830-1910* (2016); Mold et al, *Lessons from the History of British Health Policy* (2023).
[27] Lewis, "The concepts of community care and primary care in the UK" *Health and Social Care in the Community* (1999).
[28] Qtd in Webster, *The National Health Service: A Political History* (2002), p. 137.



Annual Report (1977) of the Oxfordshire Community Health Council

for increased health equity and promote the interests of overlooked groups. Attention was re-focused on the problem of health inequalities through the Black Report of 1980 (*Inequalities in Health*), and its emphasis on material and structural explanations for differential health outcomes was echoed in the 1998 Acheson Report (*Our Healthier Nation*), the 2010 'Marmot review' (*Fair Society, Healthy Lives*), and the 2020 follow-up *Health Equity in England: The Marmot Review 10 Years On*, among various publications.[29]

For local communities, the effect of these reports, commissions, and policy debates is cycles of community health funding. Given policy pressures to produce new initiatives, reports, and measures, those working in community health note the frequency with which programmes are re-named or re-defined, while administrative, financial, or political support likewise follows policy cycles of re-definition. The health economist Uwe Reinhardt accordingly observes a cyclical process of reform, attempted implementation of change, before a return to more reform, in healthcare systems such as the NHS.[30] At local levels, including Oxfordshire, such changes can be seen in the 2003 abolition of the Community Health Councils replaced by Public and Patient Involvement Forums, which were then replaced in 2008 by Local Involvement Networks (LINk). These were replaced in turn in 2011 by Healthwatch (Oxfordshire), with substantial reorganization in 2016. As we write in 2026, current restructuring and reorganisation of local health services continues. While each local organization had slightly different responsibilities and structures, these changes also capture what one individual, with 18 years of experience in the Oxfordshire community sector, described as the flawed but human urge to 'do something new' and 'constantly rebadge,' resulting in 'parachute projects' which are short-lived, well-intentioned, but ultimately problematic, interventions.[31]

While most everyone – whether residents or policy makers – agree that community is crucial to health and wellbeing, the precise meaning of 'community' in community health can often become part of policy discussions, if not political debates – and thereby less clear as to how this relates to health. The 2011 Localism Act, for example, built on a growing impulse towards localism to further decentralize power alongside a Conservative ideology of minimal state intervention to foster an active culture of volunteerism, responsible communities, and social enterprise or market-based service provision (Pattie and Johnston, 2011). This shift envisioned

[29] For overarching reviews: Powell and Exworthy, 'Improving health and tackling health inequalities: what role for the NHS?' in *The NHS at 75: The State of UK Health Policy* (2023); Dowler and Spencer, ed, *Challenging Health Inequalities: From Acheson to Choosing Health* (2007).
[30] Uwe Reinhardt, *Accountable Health Care* (1998).
[31] Well Together staff 1, interview 29 Oct 2024.

'a huge culture change…where people, in their everyday lives, in their homes, in their neighbourhoods, in their workplace don't always turn to officials, local authorities or central government for answers to the problems they face but instead feel both free and powerful enough to help themselves and their own communities.' (Cameron 2010). Likewise, in 2018 Public Health England published its 'Health matters: Community-centred approaches for health and wellbeing' resource, citing the Marmot Review among other research to outline the importance of communities for health alongside the medical and financial effectiveness of 'community engagement as a strategy for health improvement', including 'community-centred approaches.'

Across disciplinary and policy divides, community resilience and civic engagement are widely recognized as crucial to improving health. Health reformers have also long identified the importance of initiatives that work with local communities to achieve success as well as to maintain long-term trust and effectiveness. Yet, the implementation of health initiatives involves coordinating a variety of sectors and interest groups, which risks alienating local communities if initiatives are imposed from above, if they disregard community practices and identity, or if they are not sustained in the long-term. Moreover, given the diffuse nature of community resilience and civic identity, it can be difficult to find quantitative evidence for, and measure improvements in, community health. Our evaluation therefore centres the importance of 'community' as networks of social and cultural relationships in assessing these two community health programmes.

More specifically, our evaluation assesses these two programmes according to their stated aims and objectives. For the CHDO programme, this is:

- **To take a community-based approach to encourage health and wellbeing, communicate health messages, and facilitate health-enabling activities to build social capacity and resilience in the profiled communities**
- **To collaborate with others to bring collective value to community organisations and county-wide health improving services working in those areas to influence the prioritisation of service provision and address health inequalities**
- **To take forward recommendations from the completed community profiles and enable the involvement of key partners, stakeholders, and activating communities in the delivery of the action plan in each area and supporting with allocation of funding for local projects**

For the WT programme, this is:

- **To provide substantial prevention funding directly to existing and new social infrastructure organisations and groups at a neighbourhood level, in the areas most likely to experience inequality**
- **To link with existing 'anchor' programmes and to coordinate grassroots community and voluntary sector groups to develop activity that can be shown to address the Core20Plus5 principles and priorities, and the underlying drivers of inequality**

3.2 Community Programme Implementation: Funding Allocation

One of the key objectives and responsibilities of the CHDO and WT programmes, and an early form of their engagement with local community organizations and residents, is the allocation of

funding to community groups and organizations. In the first grant round of the Well Together programme, Well Together grants provided up to £100,000 for each of the ten wards. In the second phase of Community Insight Profile Grant Funding, the CHDO programme allocated up to £25,000 for each of the ten wards. The CHDO programme expected that successful applicants would receive funding between £500 and £5,000 per grant, while the WT programme anticipated that the average grant will be between £3,000 and £15,000. Both programmes aimed to award a minimum of one year of funding to successful applicants. We analysed funding allocation in early stages only to assess the implementation of the two programmes.

3.2.1 CHDO Funding Allocation: CIP Grants

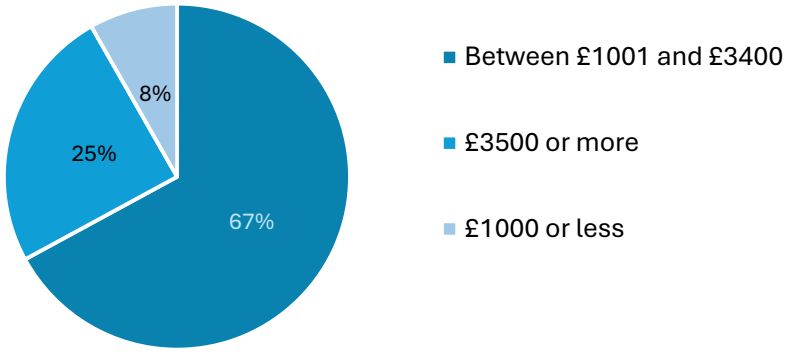
The CHDO Community Insight Profile (CIP) Grant Funding was advertised through flyers, posters, email circulations, and webpage announcements, with CHDOs available to discuss and help support applications. Applications were discussed and scored by a panel of community members and partners, taking into consideration criteria as outlined below. Most community groups received the results of their applications within three months. Given staggered starting times of each CHDO, Insight Profile Grants were allocated starting in July 2023 and final disbursement was completed in August 2024. Different approaches were used; for example, a grants-plus-approach with Community First Oxfordshire in Abingdon, and a participatory-grants-making approach in the Leys.

Information to applicants explains that most awards range between £500 and £5000, and that eligibility is focused on projects that aim to 'improve the Health and Wellbeing of local people by addressing the outcomes of the Community Insight Profiles.' Applicants were encouraged to discuss their proposals with relevant CHDOs, as well as to partner with relevant local organizations. One steering committee outlined its scoring criteria as:

1. How well the applicant addresses the outcomes of the Community Insight Profile and seeks to improve the Health and Wellbeing of the local community (60%)
2. How well the applicant demonstrates the skills and ability to deliver community projects (10%)
3. How well the applicant demonstrates an understanding of the target area (10%)
4. To what degree the applicant seeks to work in partnership with other groups/organizations and to reach and engage the residents in these groups (10%)
5. To what degree the project seeks to be sustainable once the funding period has ended (10%)

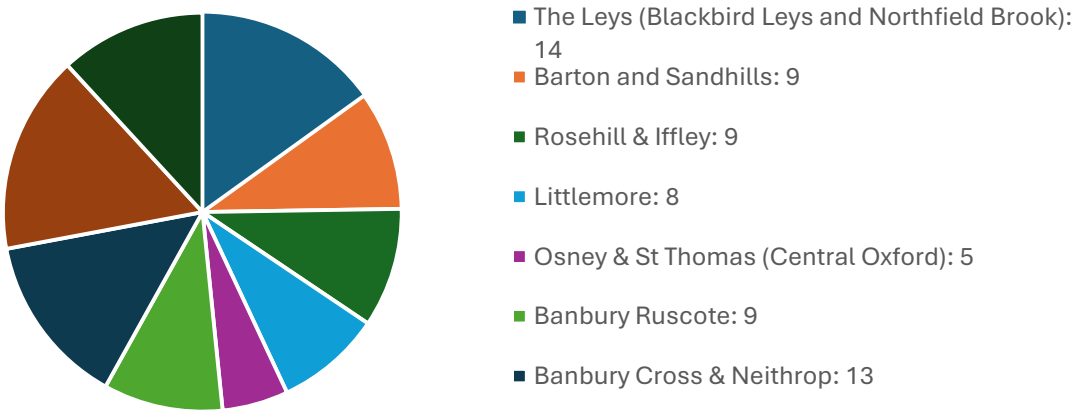
Analysing CIP grant data, we found that, overall, the allocation process was successful. It fulfilled its requirements regarding funding grants, timeline, and project criteria. A total of 85 projects were funded (with a total of 68 organizations funded), spread across the ten wards. A total of £245 061 was allocated, out of £250 000 available (£25 000 per each of the ten wards). Applicants received notification of funding decisions in less than three months. As discussed in section 4.1.4, feedback from funded organizations described the CIP application and grant process as 'straightforward' and 'quick', especially when compared with other community funding applications.

Figure 7. CIP Project Funding:
Amount of Funding Allocated across 85 projects



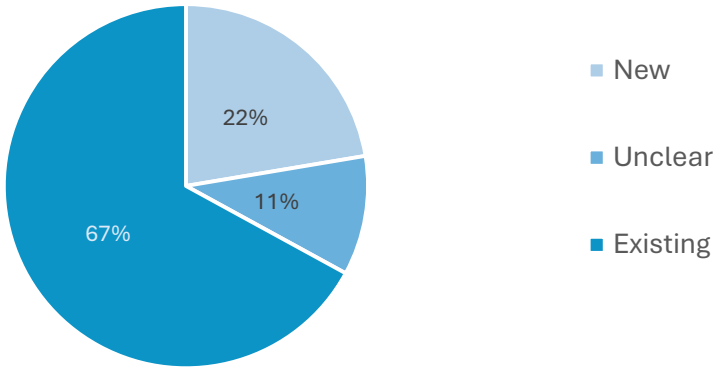
For the 85 funded projects, the average grant awarded was £2 530. Twenty-one projects (25%) received grants of £3500 or more, with the largest grant £7 000, while 7 projects (8%) received grants of £1000 or less, with the smallest grant £210. The majority (n=57, or 67%) received between £1001 and £3400 in funding. Grant data demonstrated that scoring criteria, particularly relevance to individual Community Insight Profiles, was consistently applied. Projects per ward were also evenly spread, ranging from Osney & St Thomas (5 projects) to Banbury Grimsby & Hightown (15 projects), with an average of 8.5 projects funded per ward. We also analysed whether a project was new or a 'pilot' project. Out of 85 total projects, 57 (67%) were not new projects, 19 (22%) were new or pilot projects, and for 9 (11%) we were unable to establish novelty.

Figure 8. CIP: Grants per Ward out of 85 Grants



Health and wellbeing issues addressed by each project were often in multiple categories, given that projects frequently overlapped and that some criteria are more specific and easier to define – but no more significant -- than others (e.g. early cancer diagnosis vs reducing social isolation).

Figure 9. CIP Project Funding: Sustained vs New Projects



Overall, our analysis demonstrates that the CHDO programme of CIP Grant Funding was successful in terms of timeline, amount, and geographic range. Moreover, a majority of CIP funding supports the continuation and sustainability of existing community health and wellbeing activities. CIP Grant Funding therefore enabled the CHDO programme to fulfil two of its three recommendations by enabling collaboration with existing community organisations in order to prioritise and address health inequalities, while also implementing recommendations from Community Insight Profiles through involvement with local partners and the allocation of funding for local projects.

3.2.2 WT Funding Allocation

Given the larger amount of funding available, the Well Together programme incorporated an expression of interest (EoI) stage (available from Dec 2023) which enabled case-by-case support on the application stage. This approach is designed to encourage and guide individuals and groups who are first-time applicants (see section 4.1.4) Due to the large volume of EoI for Blackbird Leys and Greater Leys (47 in total), the WT team closed the EoIs for Blackbird Leys and Greater Leys in March 2024, while the other eight wards followed the original deadline of 31 July 2024. WT funds began disbursing grants in April 2024 and completed this process in November 2024.

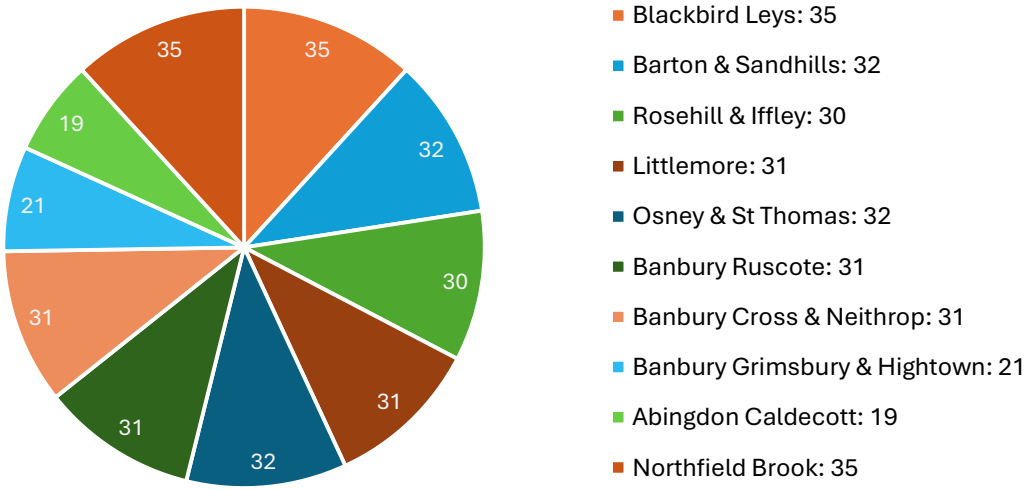
While WT grant allocation is similar to the CIP in that it invests in community health and wellbeing projects in the ten priority areas, it outlines support for people 'who might be experiencing poorer than average health access and outcomes' while also making use of categories of healthcare inequalities as identified by the NHS: hence support for parents and babies (especially for ethnic minority communities); mental health support; early cancer diagnosis; physical activity; encouraging healthy weight loss; smoking cessation; reducing harmful drinking or drug behaviours; dental care access; and encouraging longer-term health through activities such as health checks.[32] It was estimated that grants provided would range between £3 000 and £15 000.

In total, £880 624 in funding was allocated (88% of total funding available), with 107 organizations funded via 111 projects. The average project grant was £7 934, with 41 projects

[32] This draws on the NHS Core20PLUS5 approach to reducing healthcare inequalities.

receiving grants of £10 000 or more (37%) and 8 projects receiving grants of £3 000 or less (7%); the majority (n=62 or 56%) received grants above £3000 and below £10 000. The smallest grant allocated was £1 705, while the largest grant was £20 000. Funding was therefore allocated within its estimated financial range as well as within its proposed timeframe. Preliminary research found that funded organizations consider the WT application process to be

Figure 10. WT-funded activities by ward



straightforward. More details on the application process are in section 4.1.4.

While data on whether funded projects were novel or sustained was more difficult to establish, at least 73 of funded projects were confirmed as ongoing or sustaining activity (66%), with the remaining 38 projects (34%) unclear. Given the larger amount of WT funding allocated, its grants generally supported projects located in multiple wards. Only 35 projects (32%) were focused on a single ward; the remaining 76 (69%) were active in at least two wards. Funded activities were therefore spread relatively evenly across all ten areas.

Table 4. WT funded projects by category

Addressed Health Inequality	**Number of Funded Projects**
Mental health support	80
Reducing harmful drinking or drug behaviours	8
Promoting social connection and reducing isolation	81
Promoting or supporting access to healthy eating	50
Increasing physical activity	58
Early cancer diagnosis	3
Encouraging target populations to attend health checks	12
Maternity care	15
Dental care for children	4
Smoking cessation	2

WT grants were also categorized by WT staff according to which health inequality the activity addressed. The majority engaged with multiple health issues; only around 15 of the 111 funded

activities (14%) addressed a sole health issue. The table above outlines funded activities according to which Core20Plus5 principles and priorities and accompanying health inequalities they each addressed, as categorized by WT assessments.

Our analysis demonstrates that the WT Grant Funding Allocation was successful in terms of timeline, amount, and geographic range, and supported a range of activities, with mental health support, social connections, and the promotion of physical activity and healthy eating a predominant focus. Moreover, a majority of WT funding supports the continuation and thus the sustainability of existing community health and wellbeing activities. The WT Grant Funding Allocation therefore enabled the WT programme to achieve its objectives of providing substantial prevention funding directly to existing and new organisations in the areas most likely to experience inequality while connecting and coordinating with local anchor and grassroots community groups that address the Core20Plus5 principles.

More broadly, CIP and WT Grant Funding enabled the CHDO and WT programmes to achieve core aims, particularly by providing them with the infrastructure to work with and support local community groups. At the same time, while the CHDO and WT programmes draw on recent frameworks such as Marmot Principles and PHE's 2018 call for community-centred health initiatives, they also are part of continued attempts to improve health outcomes and reduce health disparities by supporting and working with, rather than imposing on, communities, and by recognizing the key role of community identity and resilience for the long-term effectiveness of health interventions.

4. The Programmes in Practice

While the allocation of grant funding enabled the CHDO and WT programmes to work with local community groups and to support local and anchor organisations in developing health-promoting activities, their objectives were also to ensure that such activities were delivered and to support local organisations in the delivery of such activities including through sharing information and helping to collect and provide evidence-based information. **This section assesses how these programmes functioned in practice by analysing: the officers' roles of these two programmes (section 4.1); the delivery of health and wellbeing activities (section 4.2); and residents' engagement with the two programmes (section 4.3).**

4.1 CHDO and WT Roles and Activities

CHDOs and WT Community Capacity Builders (CCBs) play a key role in developing and supporting community engagement, including by encouraging community residents to apply for funding as well as to participate in networks and events. Moreover, compared to the county councils' grant-allocating programmes in the past, CHDO and WT programmes are novel in their personalized approach. CHDOs are expected to take a 'community-based' approach to the health and wellbeing tasks in the wards they are responsible for. This demands them to 'wear different shoes' (Gerti, CHDO Leys) in order to understand the locally identified needs of the community members, facilitate the community groups' delivery of health and wellbeing activities, and communicate the expectations and outcomes to the management committee of the councils' public health team.

A CHDO has multiple responsibilities including but not limited to: small grant allocation, health and wellbeing network building, and community engagement. A primary responsibility of CHDOs is to work with local partners in order to implement health and wellbeing recommendations from Community Insight Profiles. Their posts are embedded in the City or District Councils; they are in regular contact with and also report to the County Council's Public Health team every quarter. CHDOs are given time and flexibility to make connections with the communities they are responsible for. The post allows hybrid and remote working, which encourages officers to spend much of their time in the communities. CHDOs report to the County Council every quarter, and the report is structured with general and open-ended questions about not only outcomes but also the challenges they are facing.

There are six Oxfordshire CHDOs.[33] There are two types of contracts for the CHDOs: part-time (0.4-0.6 FTE) for one ward, or full-time for two to three wards. The CHDOs also started in different months between January 2023 and April 2024 and their work began at different stages of the programme, tied to the development of Community Insight Profiles in each ward. The CHDO programme is therefore flexibly and locally structured, closely drawing on individual Community Insight Profiles and their recommendations.

Well Together is co-established by two community organizations: Community First Oxfordshire (CFO) and Oxfordshire Community and Voluntary Action (OCVA). It is a grant-allocation and community-capacity building programme funded by a statutory NHS body: the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB). The staff employed by the Well Together programme for community engagement are Community Capacity Builders (CCBs). Like the CHDOs, their work involves advertisement and allocation of

[33] Note that this was current as of 2025; the programme has since expanded.

the Well Together grants as well as network building and community engagement. There are four CCBs and they are on part-time contracts with Community First Oxfordshire. The CCBs are supervised by one manager employed through Community First Oxfordshire and one coordinator from Oxfordshire Community and Voluntary Action. Overseeing the WT programme are the CEO of Oxfordshire Community and Voluntary Action and the CEO of Community First Oxfordshire, providing community coordination and expertise. Compared with the CHDO programme, the Well Together programme therefore provides a larger, more geographically expansive (not tied to a single ward), and more centrally-coordinated approach to community and public health and wellbeing.

Despite differences in organizational structures and timeframes, the two programmes share similarities in their aims and approaches, as well as in their definitions of community health and wellbeing. Both support a variety of activities and networks that address key community health issues such as early health education, youth activities, support for elderly people, family activities focused on wellbeing, women's support, healthy eating support, mental health networks, and connecting with nature. Overall, both programmes fund and support groups and activities that promote public health at a local, community level; they therefore also frequently work together to share information and coordinate overlapping activities, including funding.

When the programmes started in 2024, all six CHDOs and all four WT CCBs were women. Since then, due to staff turnover, WT appointed its first male CCB in 2025. The programme staff came from a range of ethnic, social, and cultural backgrounds. None of the current CHDOs is a resident of the wards they serve. Most, however, had experience growing up, working, and living in areas or even nearby neighbourhoods that faced similar issues of health inequalities. For WT, two CCBs are residents of the priority wards they support; the other two live close to priority wards and have experience working in similar communities. What is most notable in their skillset is the ability to engage with a variety of individuals, most often through empathetic engagement and communication at multiple levels, alongside an ability to balance short- and medium-term responsibilities. All six CHDOs and four WT CCBs are outgoing and personable, able to articulate the social and cultural issues at the heart of Oxfordshire health inequalities, with practical and pragmatic views on community wellbeing.

As identified in the Community Insight Profiles (see 2.1), and as outlined in their job description, these two programmes are meant to support community engagement. This necessarily requires residents to work closely with CHDOs and CCBs, if not to trust them, seeing them as part of their social connections which can provide guidance and share opportunities, but who also in return will listen to and understand issues shared by local residents. Our evaluation identified that this is best achieved through: **regular presence in community activities; excellent communication and networking skills; and active partnerships with existing organizations and networks**. We outline examples of these types of engagement here.

4.1.1 Community Presence

An example of the crucial role of community presence is the Leys CHDO's activity at the Community Larder. At the time of writing, as the Leys CHDO was appointed only in early 2024 (as maternity cover), and therefore was not part of early community research for the Community Insight Profile, she was able to understand and identify key health issues in the ward by spending every Wednesday at the Community Larder, which also allowed her to gain the trust of community residents and organizations.

The Community Larder is a provider of low-cost surplus food to the residents. Such food services are common in many of the ten wards (including Barton, Banbury, and Rose Hill), and are often set up within existing community buildings (e.g. churches). Although food provision was initially limited to canned food, fizzy drinks, or long-life milk, the Barton CHDO noted that obtaining fridges meant that they were able to offer fresh dairy products, fruits, and vegetables. Community larders allow CHDOs to monitor the accessibility of healthy fresh food, and to get to know and be known by local residents. CHDOs, for example, help with the delivery of food in their car or carry boxes of bread to tables, making themselves visible, known, and approachable to volunteers as well as community residents. This also allows for informal conversations on the topic of local health and wellbeing issues, and builds trust between community organizations and residents and the CHDO. As the Leys CHDO explained, 'because I'm on the ground and I see these people all the time, I know which groups need a bit more support…some groups are really good at…running sessions…but they're not very good at applying for funding. I'm there nudging them and helping with the paperwork.'[34] The Leys CHDO therefore spends most of her time in the local Leisure Centre or the Blackbird Leys Oxford Hub.

The CHDOs' and CCBs' frequent presence in the community spaces makes them visible to the local groups and individuals. This in-person attendance also enables them to better understand

Figure 11. A week with Alexa, full-time CHDO for Rose Hill and Littlemore

MONDAY: home, Rose Hill Community Centre, St Mary and St Nicholas Church Littlemore.

- E-meet with programme manager, via to-do list of work; emails; attend electric blanket testing at Rose Hill Community Centre; meet with older people who participated in this event; catch-up with people who come to the coffee morning at the church

TUESDAY: Rose Hill Community Centre.

- Help at community larder; catch-up with those who come to the larder and volunteers – residents of Rose Hill, Littlemore, and nearby neighbourhoods; meet with SOFEA leader; meet with Oxford City customer service office; attend Rose Hill Network meeting (evening)

WEDNESDAY: home, Rose Hill Community Centre, St Mary and St Nicholas Church Littlemore.

- Internal team meeting or online training; meet with Littlemore Community Partnership, Littlemore Health and Wellbeing Group; catch-up with people who come to the coffee morning in the church

THURSDAY: John Henry Newman School, Littlemore

- Liaise with SOFEA on possibility of having larder held at school for Littlemore residents, explore possibility of new hub to attract more community members by holding quarterly health and wellbeing partnership meetings there

FRIDAY: home, Rose Hill Community Centre, John Henry School Littlemore

- Collect products from hygiene bank to deliver to Rose Hill Community Centre; emails; catch-up with community members and groups; help the food hub advertise for more donations

WEEKENDS:

- occasional community festivals and playdays in order to talk to community members

[34] Interview July 2024.

the place. The CHDOs who have their offices based in the local community centres or other similar venues (e.g. Town Hall, Oxford Hub) in the areas have found it convenient to access community events, especially when weekly larders are held in these community spaces.

The case study of a week with Alexa, full-time CHDO for Rose Hill and Littlemore, demonstrates the variety of locations and activities involved (figure 11). Alexa's week is multi-sited and multi-grouped. She requires flexible work hours and sometimes works in the evenings and on the weekends for network meetings and community events. This week was also prior to the start of activities and events funded by the Insight Grants, which will have her attend more community events as a result.

4.1.2 Communication and Networking

CHDOs and CCBs need to be trusted by community residents, particularly by those who may perceive 'the Council' or NHS 'officers' as problematic or intimidating individuals. CHDOs and CCBs therefore also need to be seen as members of the community, even if they do not necessarily live in that locality. Staff noted that, if they are introduced in roles akin to council or NHS officers, they are associated with issues such as council tax or policing social behaviours, resulting in social distancing or even distrust from residents who may, for example, have unpaid council bills or continuing medical issues – even though CHDOs and CCBs are in a position to offer advice and support with such issues.

Alexa, CHDO for Rose Hill and Littlemore, explained that she had first been employed in customer service for British Gas, before becoming a customer service officer at Oxford City Council for nine years. In those roles, she noted that her responsibilities were mainly 'helping people in the community,' particularly in solving problems such as late payments or repairs. By helping people identify practical solutions to their problems, Alexa gained a sense of achievement while also recognizing the social contexts of wellbeing. As she explains, 'I think it was coming from that customer service background of just generally wanting to help people, seeing the needs that are out there. It kind of led into the role within the community.' Her role as CHDO thus builds on her employment experience but also reflects her identification with residents who struggle with various day-to-day issues.

Alexa explains that although she does not live in Rose Hill or Littlemore, the two wards that she serves, she did grow up in the neighbouring ward of Blackbird Leys. This, combined with her nine years of experience working at Oxford City Council, means that she is knowledgeable about the types of services available to residents in her CHDO wards while also familiar with their neighbourhood. As she remarks, 'usually nine times out of ten you have, like, an immediate rapport of recognition. … We're from the same background, you know, even if we're not from the same background. But we've lived in the same area, we've experienced some of the same things…there's already, like, a rapport, like you recognise something in that person.'

More fundamentally, Alexa is able to understand and articulate the struggle that residents face, including how social attitudes, cultural behaviours, and financial concerns shape health and wellbeing. Having grown up in one of the ten priority wards, she was part of the System Changers programme, designed to 'support people to develop a sense of agency'. As she describes, part of what residents face are constant financial anxieties, which obscure health and wellbeing goals. From their perspective, she explains:

> I'm not thinking about, oh, I need to go for a walk or I need to go to the gym, or I need to…go to that community group because, you're thinking I've got to pay this and I'm

> not going to be able to pay for that because I don't have the money to pay for my basic needs…if you're worrying and stressing about, how am I putting food on the table, your first thought isn't always, how do I stay mobile so that I'm looking after the old version of me.

As Alexa also notes, obstacles to health and wellbeing aren't only financial. In explaining why she applied for the CHDO role, she reflected on her own changes in attitude when she was growing up. When younger, 'I wasn't caring so much about the future, I wasn't thinking about my health and wellbeing.' What helped change her outlook was discussions with others on her attitude towards her life plans, including what she hoped her children might end up doing in their lives. She notes that 'mindset' and 'attitude' are crucial, including having local role models for young people because it shows them 'you can learn from that, you can gain experience, you can prove that you have got something of value within you.' Alexa is thus able to draw on her own life experiences, including as a mother of three, alongside years of training in customer service and at Oxford City Council, to identify with local residents and help support their community interests.[35]

CCBs have roles very similar to CHDOs, and often directly support a large number of organizations, not only through funding allocation but also by providing support and connecting groups. Jane, one of the CCBs for Oxford and Abingdon, supports 35 community groups in those two areas, building on her previous employment as a schoolteacher and a Play Development Officer. Jane has lived in East Oxford for 30 years and helped to revitalize her own community (Florence Park) through the community centre, creating a community newsletter, running street parties, and being a co-founder of Flo's – The Place in the Park. Likewise, as a part-time CCB, Assia supports around 30 groups in Banbury's three priority wards. Born in Pakistan, Assia has lived in Banbury since the age of two, and draws on her long experience working with community groups in Banbury in her role as CCB.

Prior to her CCB role, Assia worked for Thames Valley Police, as well as working for over 17 years with the Sunrise Multicultural Project, a charity that supports 'ethnic minority families in Banbury.' As Assia explains, Sunrise is open to all cultures and provides support for a variety of health and wellbeing activities, including reducing social isolation, assisting victims of domestic abuse, and providing support for exercise, skill training, and healthy eating. In that role, Assia drew on her experiences as a Muslim woman who grew up in Banbury, following up requests by children and parents for activities such as sport and art scheduled at times convenient for children who attended mosque after school, or women-only swimming classes for Muslim girls. Her many years running a charity in Banbury means that Assia is familiar with the challenges that charitable organizers face, as well as knowledgeable about opportunities and networks. Most group organizers and council workers we interviewed knew Assia by name, as many had worked with her prior to her role as CCB.

This position as 'insider' for Banbury community organizations means that Assia is trusted by those in the community. Moreover, she often offers her help and guidance, particularly for groups that have no prior experience with funding applications or charity administration. She explained that, for those who had problems completing the application form, she typed up what

[35] Quotations from workshops (May 2024, July 2024); semi-structured interviews (Sept 2024, Dec 2024).

they told her and provided guidance on how to complete a budget, shepherding them through the funding process. Making use of her local networks and her experience in running a charity, Assia put three churches in touch with each other so they could benefit from the shared employment of a project coordinator, allowing them to be supported in a way that would not have been successful if they had each applied for funding individually. As she stated, 'It takes a whole village to raise a child; if you don't communicate with each other, it's not going to work. You can't be in one corner running your own stuff and hiding things. You've got to work together to be able to support the community.'[36]

4.1.3 Community Partnerships

Partnership working is a key part of CHDOs and CCBs community engagement, as it effectively advertises local health and wellbeing activities while also helping to avoid duplication and encourage networking.

In some areas, such as the three wards in Banbury, a strong network (the Brighter Futures in Banbury Partnership) already existed between the Cherwell District Council (CDC) and the local health and wellbeing partners and community groups. The partnership meets quarterly and has been joined by new local initiatives. The Banbury CHDO made effective use of this partnership, allocating CIP grants through its connections. By partnering and building on the existing network, the CHDO helped with the organization and coordination of the Banbury playdays, providing further community engagement with residents and community organizers. As a result, after only a year in post, many local organizations and residents know the Banbury CHDO by name and regard her as key contact for community issues.

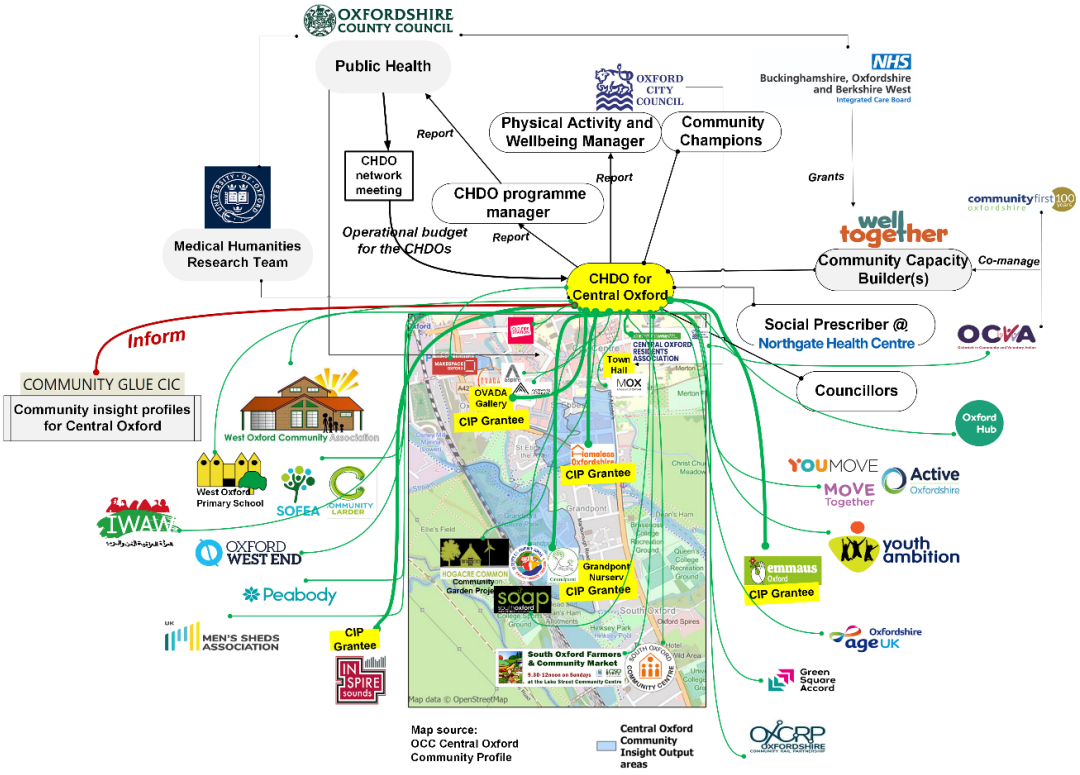
Some Oxford wards, such as Barton, the Leys, and Rose Hill, have local health and wellbeing networks that existed prior to the establishment of CHDO roles. CHDOs in these wards have inherited the role of chairing partnership meetings, as well as the challenge of gaining trust from partners who may have had more years of experience in these areas and these fields. CHDOs noted that regular outreach and updates, as well as commitment to their role, helped to gain the trust of pre-existing networks. At the same time, the financial capital that CHDOs and CCBs can access through grant allocations also helps them navigate such partnerships.

In contrast to wards with established partnerships, the areas of Central Oxford and Abingdon Caldecott are likely too small or fragmented to have had prior health and wellbeing networks. The task for CHDOs in these wards was to establish new partnerships. The CHDO for Central Oxford, for instance, has established a 'Central Oxford Steering Group Meeting' with the area's locality manager. In less than one year, the attendees have grown from four (mainly council workers) to sixteen, with 42 on the mailing list. The meeting we attended in October 2024 demonstrated a diversity of attendees: members from three local community groups (CIP grants recipients), two community researchers (part of the insights gathering for Central Oxford), two CCBs, three councillors, three officers from the City Council, and two researchers from the University of Oxford. The Oxford CHDO has also helped local residents establish a residents' association through the Oxford Town Hall.

[36] Quotation from focus groups (Aug 2024, Oct 2024) and semi-structured interviews (Nov 2024, Dec 2024).

In Figure 12, the range of partnerships of the Central Oxford CHDO (0.4 FTE) during her first six months in the role is mapped, demonstrating partnerships involved in the role.

Figure 12. Central Oxford CHDO's local connections (Oct 2024)



4.1.4 Engagement through application funding support

While both the CHDO and the WT programmes assist funding applicants, WT provides structured support through its 'Grants Plus Approach'. This builds on its use previously in OCVA and CFO's Connected Communities Fund, and thus allows WT personnel to draw on their experience with such methods in community funding applications. In general, the 'grants-plus approach' encourages those unfamiliar with or intimidated by funding applications to participate, by breaking down the application process into stages with support along the way. As Laura and Emily, joint lead organizers of Well Together, explain, 'it's about bringing people into a system' where they can access support and funding, and starting the process off by simply suggesting, 'let's have a conversation.' Such a format is designed to engage people who may not consider completing an online form or feel unable to write a summary of their plans.

At the same time, the WT programme recognizes that community organizations have likely worked alongside each other for some years and may feel that 'some people get funding and some people don't…creating winners and losers and a system of feeling it's not fair.' By contrast, the 'grants plus approach' provides feedback and revision at each stage, with WT staff encouraged to put applicants and organizations in touch with each other if it will strengthen

their projects and the potential to obtain funding. Laura and Emily therefore describe the application process as 'building relationships', rather than a competition.[37]

The first stage in WT applications is a community drop-in held in each of the ten priority wards, which were used to introduce grant opportunities to the ten priority wards in person. The community spaces for these sessions were carefully selected, usually using the assets identified in the Community Insight Profiles. Most drop-ins took place in January and February of 2024 and were one-off (for each ward) two-hour events aimed at first-time applicants and new community initiatives. CCBs used their connections to encourage attendance, along with more traditional forms of advertisement, including targeted communications to registered charities, community interest companies, and social enterprises.

Second is an online Expression of Interest form submitted on the website, which opened in December 2023. These had different deadlines according to each ward, though flexibility was provided if an applicant struggled to meet a deadline. Overall, 147 EoIs were received, with larger numbers than predicted submitted for some wards. Table 5 shows the number of EoI received per ward.

Table 5. WT EoIs received per ward

Abingdon Caldecott	24
Banbury Grimsbury	30
Banbury Ruscote and Neithrop (2 wards combined)	40
Barton	37
Blackbird Leys and Greater Leys (2 wards combined)	47
Littlemore	39
Oxford Central	33
Rose Hill	42

EoIs also varied by issue addressed, as demonstrated in table 6.

Table 6. WT EoIs received by category

Dental care for children	3
Early cancer diagnosis	5
Encouraging target populations to attend health checks	18
Healthy eating	61
Increasing physical activity	77
Maternity care	17
Mental health support	110
Promoting social connection and reducing isolation	110
Reducing harmful drinking and drug behaviours	15
Smoking cessation	6

[37] Qts from interview (Oct 2024).

CCBs reviewed the EoIs submitted in their ward, and, if needed, held further discussions with applications who might need additional support or information for their applications. These discussions could be via email, online, or in-person, and sometimes even in small groups. Such follow-up discussion took place according to applicants' time schedule, sometimes taking place outside of a CCB's usual work hours. Some activity organizers noted that a CCB visited their group to offer additional support. Overall, activity organizers suggested that this was a constructive part of the application process.

Case Study: WT application guidance session, the Leys

Dolcie (CCB, Oxford) organised a support session for Well Together applicants in Blackbird Leys and Greater Leys on a Sunday afternoon in March. This was held at the Leys leisure centre on the ground floor, which was easy to locate. In total, 13 people attended. Participants included two members from the Oxford Community Action Group (OCA), an 'anchor organization' for the Well Together programme, one local councillor, and representatives from the Sudanese and Swahili communities.

During the session, Dolcie explained the grant process as well as how applications would be assessed. She emphasised that applications needed to 'hit the criteria' as outlined. She suggested applications be specific in their activities, even narrowing their focus if necessary. She brought her computer to show the grant details via the online platform and to help participants become familiar with details of the application.

Participants expressed gratitude for this extra support; one participant explained that their community had been neglected in such funding for 'too long' and therefore wanted to submit an application.

As well as using the review of EoI to strengthen applications, CCBs also used EoIs to link individuals and community groups. This micro-scale partnership can help small groups meet grant criteria while also being cost-effective. Rachel (CCB Barton and Littlemore) explained that this required 'deep listening and reflection' to understand the project ambitions of potential applicants as well as knowledge of relevant community networks and organizations.

Case study: WT supporting local connections in grant applications

Vincent and his son Max, local to Barton, wished to start parkour training for local children and young people. Max is a parkour professional and competes internationally. He was once a school refuser; the only days he would go to school was when his father promised to take him to parkour training in the evenings. Given that his participation in the sport changed his life, Max wanted to work with children and young people who faced similar difficulties, while making use of his parkour skills. Rachel (CCB Barton and Littlemore) met with Vincent and Max and reconnected them with the Barton Community Association and Sport in Mind, a national mental health sports charity funded by Well Together. Rachel invited Oxford Parkour Activities and Sport in Mind to the Well Together drop in event for Littlemore residents and organizations held at John Henry Newman Primary School's community hub. This provided them with the opportunity to plan work together, jointly running a series of sessions with Barton Park Primary School.

Oxford Parkour Activities, for children aged 7 to 11, was granted WT funding for activities in Barton and Littlemore.

Comments from successful applicants frequently described the WT application process as 'fairly straightforward.' One noted 'we really like the EoI approach as it is helpful to know from the very beginning…whether we are eligible.' Some applicants appreciated having additional support through the application process – such as visits from WT staff, while others found that WT staff visits and feedback were unnecessary. As a result, the 'grant-plus approach' clearly helps support those who are inexperienced applicants, but for those who identify as more experienced organizers, feedback suggests that they may not want such additional stages or may prefer a different timeframe for applications. One applicant commented, 'As an experienced fundraiser I did not need too much extra support, but I could tell from the community drop-ins that there are applicants who would be benefited by the support at the EoI stage.'[38]

4.2 Community Activities

Combining CIP and WT funding, more than 200 community health and wellbeing activities were funded. Section 3 provides quantitative data on the types, locations, and health objective of funded projects; this section outlines the nature of these community health activities.

Fulfilling the definition of community health and wellbeing, these activities were located in community centres, schools, parks, and other shared public and social spaces. Key themes were: food and nutrition; physical activity and sport; mental wellbeing and social connections; and creative or skill-based practices. Many of these activities overlap, targeting more than one theme (e.g. skill-based practices and mental wellbeing). Family drop-ins, community larders, youth clubs, walking groups, and social gatherings are typical modes of delivery. Although such activities lie outside of formal medical institutions, they provide fundamental practices of health and wellbeing, most often provided through routine and place-based interactions. **Such activities make health and wellbeing part of daily life, rather than featuring as a specialised intervention.**

Food and Healthy Eating

Of most obvious and immediate benefit to health and wellbeing are groups that support food and nutrition. Yet, the range of approaches to healthy eating varied, and community organisations can provide overlaps in useful ways. Indeed, eating and cooking are often considered social activities, if not activities that need to be framed within households rather than through individuals. Moreover, while researchers often discuss a 'hierarchy of resorts' – suggesting a ladder ranging from basic to more sophisticated – our research found that food and nutrition services often work more as a patchwork, stretching to try to cover a variety of shifting needs and regions.[39]

Oxfordshire Mutual Aid, for example, provides what it defines as 'emergency food support'. It reports that it regularly supplies 180 to 200 households on a weekly basis but also deals with additional emergency request of c. 50 per week. Unlike food larders, they do not means test or require referrals. As they explain, 'If someone tells us they need food, we trust that they are in need. This approach avoids stigma and reduces administrative burden.' By delivering food to

[38] The EOI feedback was collected as part of the analysis in section 4.5.
[39] The Everyday Politics of Food Co-Ops: Care, Aid and Community in Austerity Britain (Plender 2025).

households, they avoid barriers that some face in accessing food larders, due to disability, caring responsibilities, or work schedules.

By contrast, the Rose Hill Community Cupboard provides a different type of support. Running once a week, it provides a hot meal as well as canned food (requiring a third-party referral) and fresh vegetables (requiring registration with the Cupboard) from the Food Bank to take away. The group is run by one staff member and supported by around 15 volunteers from the Rose Hill Methodist Church. The group secured a CIP grant for two weekly activities: the Community Cupboard and the Coffee Morning for elderly residents in Rose Hill and Littlemore. In one day in November 2024, 36 people visited, some of them queuing outside in the cold for 45 minutes before doors opened at 1.15 pm, to secure better food options. Although some came to collect food, many stayed for the free hot meal, chatting with each other. Four of the 20 individuals interviewed struggled with English, while all offered a variety of responses to questions of what they would change to make Rose Hill and Littlemore a healthier place. Most, however, agreed that walking and eating healthy food – particularly vegetables – was their strategy for health. This activity catered to the immediate provision of food, but it was also clear that the hot lunch encouraged social interaction and connections.

Physical and Occupational Skill-based Activities

A major theme of community health and wellbeing activities is the development of physical and practical skills, including through healthy movement such as exercise and sport. Crucial to these is communal activity along with the expertise of a group leader: whether for a football youth group, exercise training of elderly individuals, or carpentry at Oxford Wood Recycling. A key aspect to all of these groups is the development of embodied knowledge and skill through physical movement, with training and coaching by an expert leader. Gardening skills at the Bridge Street Community Garden, cooking at the Sunrise Multicultural Group, and woodwork at Restore's recovery groups were all the focus of these events. And yet, just as is the case with football at youth groups, a key component was the social aspect, not only the physical activity. Communication and other social skills, for example, are developed through team and communal coordination. Moreover, group leaders offer training and coaching, meaning that each activity provides community-led expertise in physical skill. Through communal activities, health and wellbeing are acted out together, rather than being passively absorbed.

A range of physical activities are provided, often targeted to different demographics and needs. For example, South Oxford Community Association, in collaboration with Maddy Biddulph, a professional personal trainer, provides seated exercise for older adults at the South Oxford Community Centre. As one participant explains, 'the session is well choreographed and structured. It helps keep the body moving without overexertion.' Significantly, participants recognized that the physical activity was only one outcome of the activity: 'Socialising is important. Coming here helps people stay connected and reduces isolation.'

Schoolchildren and young people

Aligning with Marmot Aims, health and wellbeing activities for children and adolescents compose a key part of funded activities and provide a route for life-long health and wellbeing practices. Over 50% the groups funded by Well Together and CIP grants offered an activity or initiative aimed at young people (0-25) or to support parents. These groups offered a wide range of activities, from pre-school stay and plays to healthy cooking for primary school-age children to community support systems for young men at risk of becoming entangled in the criminal justice system.

Groups for 4–18-year-olds are well-represented and tended to be a mix of school-integrated and external activities, providing to young people. School-based activities are particularly effective at connecting and networking disparate support structures. For example, schools select children for participation in the ARCh scheme (Assisted Reading for Children); Be Free Carers likewise work closely with schools; Oxford Parkour Activities are hosted by Barton Field Primary School and also contribute to the school's efforts to model healthy eating. However, groups noted that coordinating with school structures and timetables, as well as travelling to schools, can be challenging. Some volunteers were concerned that LTNs would affect their ability to travel and offer programmes in East Oxford schools.

Activities located outside of schools are also important for young people who may require trusted 'third' spaces. SOAP (South Oxford Adventure Playground) youth club for 11–18-year-olds, for example, is in an area without a major secondary school. As a result, children of age 11 and up can find themselves away from established networks of friends or without a healthy community centre. As one volunteer described SOAP, 'It's a safe space away from schools and families,' providing community for young people in south Oxford. An organizer explained that a troubled adolescent eventually returned to the club because 'he was safe here…people can always come back.' Participants agreed, stating that the club expanded their social networks and helps them to make and maintain friendships. Likewise, basketball sessions for older teens and young adults run by Hillsong Church in Blackbird Leys Leisure Centre are popular, but also important, in providing a community environment that is trusted by both participants and their parents.

Working with young people can create additional challenges and burdens for organisers. Many mention the requirement to provide emotional and pastoral care as well as practical guidance. At the same time, volunteers and group leaders also mention that working with young people can therefore also be particularly rewarding. As Tessa, coordinator of Oxford Contemporary Music explained in describing the creative outputs of young people: 'seeing and hearing it…its quite amazing, the doors it can open for them personally and in their imagination. As an artist it inspires me, it's inspired all the facilitators, and even their grown-ups' responses. What they [the young people] wrote made me cry…they have a say now.'

Participation and Volunteering

The benefits of volunteering in one's community are already well-evidenced, with a recent study suggesting that the health and well-being benefits continue to increase throughout one's lifetime.[40] At the same time, a majority of community activities are organized or led by volunteers, many of whom started out as participants before 'graduating' to leadership roles, and who see their volunteering as crucial to their own health and wellbeing.

Volunteers hold a variety of motivations for their involvement. One ARCh volunteer (assisted reading for children, where volunteers support in one-to-one sessions with primary school students), described their motivation from their own experience of raising children with a diagnosis of dyslexia. Similarly, peer support volunteers at Oxfordshire Breastfeeding Support have often had experience of the service themself. Some organisations created purposeful upskilling opportunities for their volunteers, which in some cases enabled participants to transition to active volunteers; for example, some visitors to the New Life Covenant Church breakfast (aimed primarily towards those experiencing homelessness) were offered training in food hygiene and a DBS check, which then enabled them to volunteer. Likewise, programme coordinators at Band of Brothers often discuss their personal experience when running

[40] Mak et al, 'Relationships between Volunteering, Neighbourhood Deprivation and Mental Wellbeing across Four British Birth Cohorts' *Int Journal of Environmental Research and Public Health* (2022).

sessions. Band of Brothers works primarily with young men at risk of becoming entangled in the criminal justice system, supporting open dialogue with men who need support, providing community, resources and a listening ear. At monthly meetings, volunteers and participants are able come together as a circle where volunteers speak openly about their own experiences (whether with specific issues such as addiction or the criminal justice system, or peer pressure and broken families), which help to connect with visitors and participants. Band of Bothers' focus on listening and storytelling – and unpacking the "stories men tell about themselves" which affect their self-worth, works as a levelling mode of dialogue in the session between volunteers, more experienced participants and newcomers.

Volunteering and leading an activity are not without its challenges. Many undertake significant voluntary work on top of various other commitments; jobs, family, caregiving responsibilities and other voluntary roles. Organization leads and volunteers often provide a variety of types of support for participants, further cementing the need to ensure evaluation demands on groups are proportional and reasonable.

Activities for Wellbeing and Health

A key component of all activities is improved and more resilient mental health and wellbeing. However, we found that this is often tackled through what we term 'social and material repair'; that is, activities that focus on crafts, gardening, or other forms of 'material repair', and yet by doing so provide social repair. This includes opportunities to learn basic as well as advanced life skills, such as financial competency (through Citizens Advice), or art and drawing. The development of such skills often takes place in structured, recovery-oriented settings, such as the recovery groups of the mental health organisation Restore, which offer hands-on, skill-based activities including gardening, catering, and craftwork. But it may also take place through shorter sessions that focus on particular problem-solving, such as home visits and community drop-ins provided by Citizens Advice in Banbury, offering people practical support to navigate everyday challenges including health, benefits, work, debt, housing, and immigration. Key to these activities is their focus on tangible activities to improve and support the more intangible nature of mental health and wellbeing.

For example, the Repair Café (co-organised by One Planet Abingdon and Abingdon Carbon Cutters) brings together residents and skilled volunteers to repair broken items. Held on the first Saturday of each month, this involves learning the practical techniques of sewing and handywork while engaging in conversation and shared problem-solving. Here, material repair – through the restoration of objects – is intertwined with social repair – through the building of connections, confidence, and a sense of community through the collaborative nature of the workshop. Participants and volunteers benefit from the process, and many volunteers are also Abingdon residents. As an Abingdon-based volunteer noted, 'Doing things for others is beneficial—you feel better yourself… mostly, it's about community: being connected, staying positive, and contributing.' In this way, wellbeing is not treated as an abstract outcome, but as something actively produced through doing, learning, and interacting with others.

Likewise, arts and crafts sessions organized by the Iraqi Women Art and War (IWAW) are advertised as an art activity. However, when we attended, the female participants explained that the sessions helped them – many of them being recent arrivals in England – get to know others with similar life experiences, learn English customs as well as the language, and receive coaching and support with IT and other life skills. As one participant explained, the women in the group 'support me for language, to speak and to talk, because [my first language is] Arabic. I need to know what's going on, how to support myself, my children, and my family, who are not

here in this country.' The participants also help each other with deliveries of fruits and vegetables from the Food Bank, and it was noted that the support provided substantially helps the participants' wellbeing, given that many of them have dealt with adverse life events and may struggle to speak openly about issues even with medical professionals.

Some participants are aware that the activity itself is what helps with their wellbeing and even their mental health. At a Sassify Zine meeting, which offers LGBTQ+ friendly self-expression workshops through zine making, the organizer explained how one of their regular attendees 'wrote to say how much the sessions had helped their mental health and creativity. That kind of feedback was the biggest impact.' Similarly, a participant explained that doing these crafts 'took the pressure off.' When asked to explain, she elaborated: 'doing crafts gives you something to focus on so you're not the centre of attention; you're doing an activity. It reduces stress about social interaction. It also helped me reconnect with creative practices and increased my confidence. … For me, it felt like a rare, welcoming space in the region.'

Case Study: The Many Uses of Community Health

Loretta's* account provides an example of the ways in which individuals engage with numerous local health and wellbeing programmes, as both provider and participant. This case study of engagement with community health through a range of roles captures a common theme we found among residents.

Loretta moved to the UK from Malaysia in her late twenties, spending several years in Wales before settling in Grimsbury, Banbury, in 2007, where she now lives with her husband and daughter. Community health and wellbeing resources intersect closely with Loretta's engagement with formal care systems. Her daughter's cerebral palsy, hearing loss, and related developmental needs require ongoing interaction with hospitals and specialist services across Oxfordshire, making healthcare a routine part of daily life. Due to her daughter's medical conditions, Loretta has had to navigate a variety of health and wellbeing demands without significant support from an extended family. She defines community as 'relationships, shared spaces, and supporting each other'.

Loretta's participation in gardening, arts, music and wellbeing activities at **Bridge Street Community Garden and the Sunrise Multicultural Project** began during Covid-19, when it enabled her and her family to build connections with friends, maintain weekly routines, and sustain a sense of belonging. Yet this was also practical; Loretta and her family made use of the gardening skills she learnt at Bridge Street by developing a garden at home, helping to provide healthy additions to their regular diet.

Loretta made use of community activities before the pandemic; she has helped with fundraising for **Banbury Young Homelessness Project (BYHP)** by co-organising a curry night, drawing on her Malaysian background to support a local issue important to her. She explains, BYHP is 'much needed to support the homeless youth in Banbury as homelessness and feeling unwanted or unsafe affects one's mental wellbeing'. Loretta has also worked as a retail manager in a charity shop for **Style Acre**, an organisation supporting people with learning disabilities and autism. She highlights the importance of such programmes in building confidence, work skills, and pathways into employment, and values both the mentoring relationships and the support provided by co-ordinators.

At **St Leonard's Primary School**, she describes a supportive environment in which staff understand and accommodate her daughter's needs, complementing specialist medical services. Alongside formal structures, Loretta makes use of local groups and facilities such as **Grimsbury Community Centre**, which offers activities like Tai Chi Chih to support physical and mental wellbeing. Acting sometimes as participant and other times as volunteer, her account frames community health and wellbeing as an interconnected landscape of services and relationships, where formal and community care operate in tandem.

**A pseudonym was used to protect identity.*

Mobility and Networks of Health

While activities are offered in particular localities and directed at residents of those neighbourhoods, many activities are run by volunteers and expert practitioners who must be mobile – working across multiple organizations, wards, and even counties. Many of the community health and wellbeing activities depend on leaders who juggle various responsibilities and contracts. Although participants recognize these practitioners by name, and consider them as trusted experts, participants are often unaware of the organisations that commission or fund them. As an example, instructor Jane Castree delivers inclusive youth dance sessions at Barton Community Centre (via Dancin' Oxford, supported by Oxford City Council), while also working with SEND students at Banbury and Bicester College as an in-house artist for The Mill Arts Centre.

Participants, too, are mobile – often taking part in multiple activities but also seeing one activity as an entry point to other health and wellbeing programmes. At a coffee morning at Barton's St Mary's Church funded by the Barton CIP grant, seven participants had tea and cake, and discussed how attending helped them with their overall health. In contrast with other funded activities we observed, this group was attended by more men than women, a demographic that community events can struggle to engage. When asked why they came to the coffee mornings, one man explained, 'I was on my own with no friends after my wife passed away, but now with the help and support from this group I am a volunteer at the food larder, meeting people, loving life.' As with the other activities, participants often described attendance at one event as a way to access other activities and services. Indeed, the coffee morning advertised a health event happening the next day at nearby Wood Farm, at which people could participate in various medical screenings, while another participant received guidance from the social prescribers from Hedena Health (in partnership with the Barton CHDO) on how to obtain a blue badge for better parking access.

The Bridge Street Community Garden (part of Banbury Community Action Group) similarly provides a range of activities under the umbrella of health and wellbeing. Run by one staff and supported by a small number of volunteers, it received WT and CIP funding. The Bridge Street Garden is in central Banbury, providing a community garden in the midst of the city centre. It frequently combines garden-based events with other health activities: in June-July 2024, for example, it hosted gardening sessions with the Orchard Recovery Group of the mental health charity Restore; a herb and flower picking and pressing workshop for refugee women with the Sunrise Multicultural Project; and free tai chi and yoga sessions in the garden. The Bridge Street Community Garden thus functions as a resource and location for health and wellbeing community groups to make use of, including via local collaborations.

Summary: Community Health in Action

Community health and wellbeing activities necessarily are varied, catering to a diverse range of needs and groups. While at first glance some of these activities may not seem directly connected to health, participants and organizers are aware of how such activities benefit them, often providing highly articulate insights into the nature of community health and wellbeing. The strength of such activities is their fluidity; what often appears to be a craft-based workshop or an exercise class is instead the opportunity to improve one's mental health or create healthy social relationships. Likewise, the boundary between participant and volunteer, or recipient and benefactor, is porous – with organizers often reporting on the health benefits that they themselves get from their role as providers, and support-recipients in one activity becoming organizers at another. More generally, these activities make health and wellbeing part of daily life, rather than featuring as a specialised intervention.

While the activity provides the main focus, often relieving any pressure of having to discuss personal health issues or create social connections explicitly, participants were also focused on the other people there. For example, participants were generally unaware of who funded the events they attend, or the official titles of organizers. Instead, most relied on first names – of other attendees and the activity leaders. The importance of interpersonal relationships was apparent throughout all activities: depending on such networks for the provision, leadership, and engagement with each activity.

The role of CHDOs and WT CCBs in supporting these activities does not end with the provision of funding; they continue to help promote such activities and – crucially – also provide expert guidance and assistance in reporting and evaluation. This support is crucial, as evaluation and reporting are what also enables these activities to be sustained, through continued funding and improved communication of their importance and what such activities accomplish.

More broadly, it is clear that one community activity – such as a coffee morning – provides direct access to other activities, such as volunteering at the community larder, accessing other social services, or going to a medical screening. Such forms of 'foundational prevention' are crucial, as these provide 'social infrastructure that generates the social capital which enables people to lead healthy lives.'[41] Summer community Playdays, for example, organized by the Oxfordshire Play Association, were funded by their local CIP grants and hosted a number of outdoor activities for families alongside stalls supporting health and medical resources such as NHS Health Checks Oxfordshire, smoking cessation, Sanctuary support housing, and local food larders. An event designed for one type of activity often serves as an access point to other health and wellbeing activities, including OCC and NHS services, showing the various networks among community health and wellbeing activities that CHDO and WT funding and collaborations support, as well as their linkages to public health and medical services.

Community health and wellbeing activities should therefore be understood as foundational preventative activities. They serve as gateways into or out of more formal medical and support services. Programmes often shepherding individuals as they make the transition out of formal medical institutions back into communities, providing routine, structure, and contacts for individuals who have completed medical treatment or hospital stays. At the same time, they also help to signpost and guide individuals to other health

[41] Demos, *Counting What Matters* (2024), p. 11.

activities, whether it be to additional community support or to more formal medical provision such as health screenings or to trust a formal medical consultation.

4.3 Community Engagement and Community Health

It can be difficult to establish how many individuals have engaged with WT and CHDO-funded health and wellbeing programmes, given that these range widely. However, by helping to support key anchor organisations and existing community activities, the two programmes have ensured that they have reached a substantial number of local residents.

For example, Well Together evaluation reporting included the number of participants at its funded activities. Of **93** activities who provided detailed reporting, this recorded at least **17 655** individuals who engaged with WT-funded health and wellbeing activities. On the one hand, large-scale organisations such as Oxford Mutual Aid reported that it reached over 2000 Oxford individuals during the period of its WT funding by delivering parcels of healthy and nutritious food to families facing poverty; likewise SOFEA, which provides training and wellbeing support to young people through work in local 'purpose projects' such as community food larders and redistribution centres, counted over 1100 individuals who had been helped through its training and food provision. On the other, more tailored and intimate programmes – often run by an individual – still made a substantial impact. Mothersong, for example, which provides mother and baby singing sessions that help support new mothers and baby-mother bonding, is run by one organiser and helped to support 38 new mothers in the Barton area. Evaluation reports explained that mothers describe how the activity 'eased feelings of isolation,' and draws on clinical evidence in helping to relieve postnatal anxiety and depression. Likewise, A Band of Brothers Oxford, which provides one-on-one mentoring and support for young men who are involved or at risk of being involved in the criminal justice system, used its WT-funds to support 48 weekly community mentoring sessions and 80 one-on-one mentoring meetings to engage with a total of 17 young men.

Reporting demonstrates that it can be difficult to quantify 'engagement'; many activities, for example, list the number of volunteers as well as participants, given that volunteers often derive substantial health and wellbeing benefits from their participation and that – as previously discussed – many participants 'graduate' to becoming volunteers. Likewise, many activities count 'families' rather than individuals, capturing the communal nature of community health. As a result, the estimate of 17 655 individuals, which includes only 93 of the c. 200 total activities, is therefore likely a substantial undercount. **The true count of individuals who have engaged with or benefitted from these activities through direct participation is likely at least 40 000**.

Our community health surveys also asked residents about their engagement with local community activities. In these, our survey of 1597 households in the underserved (target) neighbourhoods of the ten priority wards produced in-depth interviews with 223 households, which provided detailed quantitative and qualitative data on demographics, community identity, participation in local community activities, and views of health. In particular, when asked 'when was the last time you attended a community event', even when providing examples such as 'a coffee morning' or health activity, very few respondents reported community engagement. By contrast, when interviewers read out a list of WT and CHDO-funded health and wellbeing activities offered in their neighbourhood, residents demonstrated high engagement. **Three quarters (73%) of households had heard of, had attended, or wished to attend at least one**

of these activities. Moreover, **one third (34%) of all respondents in the target neighbourhoods had participated in a CHDO- or WT-funded health and wellbeing activity.**

Whether measured by activity reporting or by neighbourhood surveys, CHDO- and WT-funded activities reached a substantial proportion of Oxfordshire residents and, more specifically, of the underserved and target neighbourhoods in the ten priority wards. However, such activities are not likely to be identified as 'community' or 'health' events by residents, even though they fulfil the definition of community health and wellbeing activities.

In terms of the types of residents to participated in a CHDO- or WT-funded activity, the highest participation was for those between the ages of 26 to 49, with participation declining with age. At the same time, women were 1.5 times more likely to attend activities than men; and ethnic minorities (using census categories of 'Black, Black British, Caribbean or African' (73%); 'Asian or Asian British' (71%); and 'Mixed' (50%)) also showed higher participation rates than 'White' or 'White British' (38%) respondents. In many ways, this echoes observations from participant fieldwork: we note that women, particularly young mothers, tend to be the most engaged with both community and health activities. Our data and observations show that males, including non-minority males and elderly males, can be some of the hardest-to-reach demographic for community health activities.

Case Study: Patterns of male and female engagement with community health and wellbeing

Community groups often explicitly aim to be inclusive and welcoming, while some focus on particular social groups to help achieve key aims – whether in support for young children or ethnic minorities. As health data demonstrates, gender is also a key category and community organizers note its role in shaping activities. One volunteer at the Abingdon Caldecott repair café observed, for example, that 'having women involved makes the space feel more accessible. Workshops can sometimes feel male-dominated and intimidating.' Similarly, the organization Gal Hope provides support and resources for social groups who are under-represented in certain activities. Based in Barton and Blackbird Leys, it provides swimming lessons to female ethnic minorities; as Abbie, the programme lead explains, 'we are trying to get those people who have had no chance to swim to get that opportunity.'

As our neighbourhood surveys and review of community activities notes, male engagement and participation is often lower than that of women, reflecting lower rates of male involvement in social and informal community activities more broadly. When we listed local activities in our neighbourhood surveys, some men observed that many of the activities on offer did not target their interests. Moreover, male participants observed the disparity between high female and low male participation, pointing out that it could further add to engagement obstacles. As one explained, 'I feel a little bit, sort of shy because its [crowded] with women and no men at all;' another shared initial concerns of how he would be regarded as a male volunteer working with children.

Yet male organisers and volunteers provide significant engagement in community health and wellbeing, in a variety of activities. Many spoke openly of their aspiration to be a much needed and positive role model for young men. Get Fed, let by Tim, trains young people in barista and business skills through work in a coffee van (in which they receive a share in profits), and focuses on teens at risk of school exclusion or coercion into County Lines – both of which disproportionately affect young men. Similarly, Band of Brothers offers guidance in long-term

relationship-building with its young male participants, in part by increasing the number of trustworthy and healthy relationships young men have in their lives.

Given that men consistently have lower health outcomes than women, community health and wellbeing programmes should consider how to continue to engage with men as community health and wellbeing leaders, volunteers, and participants, and through activities and formats that are responsive to male health concerns and cultural interests.

As well as questions about community identity and demographic data, we asked residents about their views on health, including what they did to stay healthy, what would help them to remain healthy, and details of their daily health practices. Almost all residents focused on mundane and regular activities: 'eating healthy' or 'eating fresh fruits and veg' or eating in moderation were common answers, as were daily activities such as walking – often in their neighbourhoods or to work or school, capturing the importance of local green spaces and safe streets for good health. Most respondents who lived with others aimed to eat at least one daily meal together, though many noted 'we try to eat together', with added context such as 'My flatmate is a shift worker so it can be difficult but we try and eat together if we can;' 'it is difficult for us to eat as a family because I work at night.' Healthy eating is therefore often considered a social activity, navigated by families and households.

Because our household surveys also asked about views of health and health concerns, we were able to establish whether health concerns correlated with community health activity participation. We asked, 'do you have concerns about your health, or the health of your family or household'? In this, we found that a majority (c. 70%) have health concerns. This also showed that those who had health concerns were more likely to participate in health activities, with 75% of those who mentioned being concerned about their health or the health of others having taken part in a WT or CHDO-funded health activity. However, the relationship between these two factors is unclear; those who are health aware, for example, might indeed mention having health concerns and attend health and wellbeing activities; this percentage might also simply capture that many respondents (70%) reported being concerned about their health.[42]

The reason for health concerns, and their intensity, varied. For example, 29% reported that they were always or constantly concerned with health, whereas 36% stated that they had last been concerned at least a few months ago because of a specific issue or incident. A substantial number (27%) stated they were not concerned or were never concerned. In this last group, it is noticeable that many respondents shared what might be termed an 'English attitude' to health and personal concerns, with phrases such as 'you just have to get up and go,' 'I get on with it', 'you should keep it to yourself,' 'it's alright', and jokes such as 'I'm 75 and about to kick the bucket so who cares,' or 'keep it bottled up inside until you have to use the NHS app'. Yet respondents were also open that they spoke frequently with friends and family about their health concerns. When asked who they spoke to or consulted when concerned about health, half (50%) reported that they consulted with friends and family as well as with formal medical providers, outlining how health advice often combines social and medical systems. This echoes Healthwatch Oxfordshire's 2021 report that noted only a minority of Oxfordshire residents initially rely on formal medical health services for support. The majority instead turn to friends, families, and spiritual leaders for health and wellbeing guidance in the first instance.[43] In terms of why people were concerned with health, a substantial number of residents were concerned

[42] Only 215 fully answered the question on health concerns.
[43] Healthwatch Oxfordshire, 'Oxford's New and Emerging Communities' Views on Wellbeing' (2021).

not with their own health, but the health of family members or those in their household (34%). Indeed, this was larger than those who expressed health concerns because of themselves (32%).

As a result, rather than being considered as the activity of an individual or the provision of formal medical institutions alone, health and health concerns are most often understood through families, households, and social relationships. Health information and health awareness should therefore likewise be communicated and mediated through families, households, and social relationships.

5. Discussion and Recommendations

Much research has outlined methods that help to quantitatively measure the effect and impact of preventative health programmes. UK health economists Stephen Martin, James Lomas, and Karl Claxton, for example, applied quality-adjusted life year (QALY) measurements to local public health budgets, with data suggesting that every additional year of good health achieved through public health intervention costs only £3 800, whereas NHS interventions with the same outcome cost £13 500.[44] Indeed, British research on health care and cost effectiveness notes how little is spent on prevention (recently estimated at between 2.5 to 5% of the UK's National Health Service annual budget), even though it is widely recognized that preventative interventions can be more cost effective than curative treatment. Explanations for funding of curative or acute (hospitals, medical technology) rather than preventative health measures often focus on how items such as hospitals and medical technology are easily translated into the quantitative language of policy, as well how policy focuses on urgent points of health care (e.g. treatment waiting times or numbers of medical operations). By contrast, wellbeing and physical activity can remain nebulous concepts, and evaluating public health interventions remains difficult due to the complexity of attributing causation. Recent papers have thus called for identifying and classifying preventative expenditure as its own category within UK government budgets as a way to highlight and secure investment in prevention through improved accountability.[45]

Demonstrating the quantitative effectiveness of preventative health programmes is likewise the aim of methodologies such as Social Return on Investment (SROI) or Social Cost-Benefit Analysis (SCBA), which apply social value methodologies to evaluate public health interventions. SCBA, for example, assigns monetary value to categories such as 'well-being'; SROI provides a framework in which value is itself quantified. Overall, such studies often note the difference between what are often termed hard clinical outcomes – mortality, morbidity, and hospital admission rates – and soft health outcomes – such as benefits to individuals, families, communities, and their environments.[46] Similar research has focused on complexity and social-systems analysis, observing the ability of small-scale interventions to either produce change in complex systems, or to create change through what can be described as 'ripple effects'.[47]

Research and experience thus demonstrate that investment in preventative health services and community-based social infrastructure more broadly is substantially cost effective.[48] The 10 Year Health Plan for England, published in 2019, incorporates this approach, prioritizing shifts 'from hospital to community' and 'from sickness to prevention' alongside the adoption of new

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[44] Martin, Lomas, and Claxton, 'Is an ounce of prevention worth a pound of cure? A cross-sectional study of the impact of English public health grant on mortality and morbidity' *BMJ Open* Oct 10 (2020): e036411.
[45] E.g. Demos, *Counting What Matters* (2024).
[46] E.g. Ashton et al., 'The social value of investing in public health across the life course: a systematic scoping review' *BMC Public Health* 20:597 (2020); Hutchinson et al, 'Valuing the impact of health and social care programs using social return on investment analysis: how have academics advanced the methodology? A systematic review', *BMJ Open* 9:8 (2019): e029789.
[47] E.g. 'Ripple effects mapping: capturing the wider impacts of systems change efforts in public health' *BMC Medical Research Methodology* 22:72 (2022); Moore et al., 'From complex social interventions to interventions in complex social systems: Future directions and unresolved questions for intervention development and evaluation.' *Evaluation* 25:1 (2019), 23-45.
[48] E.g. Frontier Economics, *The Impacts of Social Infrastructure Investment* (2001).

health technologies. This is in part because responsive and acute medical care is more expensive than public health interventions, but also because community health interventions avoid preventable demands on public services. Social prescribing is an example of an increasingly widespread intervention that reduces demands on NHS services by connecting people to resources, but still relies on the local availability of community resources.

Research that outlines the value of what is loosely termed civic engagement, social capital, or community resilience – the degree to which individuals are part of communities and local networks – to health outcomes has long been the basis of both health and social research. While definitions and measurements of social capital can vary, it is widely acknowledged that this approach has been a crucial and useful addition to understanding population health, as it recognizes that health is not simply a condition in individuals, but needs to be understood as part of social dynamics. As a result, most health outcome data are now analysed at group level and also comparatively, by demographics, geography, economy, ethnicity, gender, and/or culture. More fundamentally, population health is understood in relation to social infrastructure and community resilience.[49]

Such community approaches have long been – and continue to be – integrated into key policy frameworks. The 2025 Pride in Place Programme, for example, 'empowers local people to shape the future of their neighbourhood' through support for community-led, flexible, and long-term initiatives in order to improve community pride, resilience, and tackle distrust in public institutions. Similar approaches were outlined in the 2019 Levelling Up agenda, which focused on local communities and made use of place-based approaches to social regeneration. Likewise, the 2026 Neighbourhood Health Framework aims to create 'a neighbourhood health service' that will make local communities a key locus for health and medical care; the Integrated Care Systems (ICSs) also aim to provide place-based health partnerships by linking NHS and local organisations with voluntary, community and social enterprise to improve health, including through a focus on prevention.

Our evaluation thus builds on longstanding research and policy frameworks that recognize the social and community aspects of health, and particularly the role of place-based social relationships in achieving and maintaining successful preventative health interventions. But as a recent UK policy analysis of public services observes, to be effective, these preventative interventions 'need to be delivered by trusted local institutions, particularly those in the hardest to reach places which have the lowest levels of trust in the state.'[50] To build and maintain trust, relationships are crucial. Communities themselves are already aware of this: as our neighbourhood surveys found, residents prioritize social relationships in their definition of strong and healthy communities. Yet, as a recent report points out, 'Too often discussions of relationships are shrugged off in policy making circles as "fluffy" or "nice to have" side issues.'

[49] Key works include Kawachi, Berman, 'Social Cohesion, Social Capital, and Health'; Rodgers et al, 'Social capital and physical health: an updated review of the literature for 2007-2018', *Social Science & Medicine* (2019); Robert Putnam et al., *Making Democracy Work: Civic Traditions in Modern Italy* (1993); Putnam, *Bowling Alone: The Collapse and Revival of American Community* (2000); Szreter and Woolcock, 'Health by association? Social capital, social theory, and the political economy of public health' *International Epidemiological Association* (2004); Wilkinson, *Unhealthy Societies* (1996).
[50] Demos, *The Preventative State* (2023), p. 17; on social prescribing: NASP, *The Impact of Social Prescribing on Health Service Use and Costs* (2024).

In reality, 'We cannot deliver more effective services, improve lives, generate better outcomes and save money through disparaging the importance of relationships.'[51]

As analyses of global and community health interventions reiterate, community health programmes work best when initiated via residents' own ambitions and wants, through collaborative partnerships, and in ways that can be maintained in the long-term. Such practices help to create trust, which is crucial in communities that consider themselves at variance with medical and political authorities, or are distrustful of wavering cycles of interventions – as found in the Community Insight Profiles of the ten priority wards. Research and experience thus emphasize the importance of avoiding so-called parachute projects by focusing on sustainable long-term relationships when designing health interventions.

As well as being ethically questionable, what defines parachute projects or parachute science (sometimes also referred to as colonial science) is not simply that it is conducted by outsiders, but also how it is conducted – in consisting of quick activities, akin to a parachute landing. Such short programmes 'fail to establish long term, equitable collaborations with local partners.'[47] The result is long-term distrust by local communities, who necessarily question the motivation of such health programmes. In response, scholars have called for intentionally collaborative research practices, described as 'rooted research' that better supports sustained global and public health – and is particularly important for communities that are already distrustful of outside or central actors.[48]

As a result, our research found that while financial, political, and administrative support was necessarily important for the CHDO and WT programmes, their long-term effectiveness depended on the nature of the social relationships established through individual CHDO and CCBs. As Szreter and Woolcock observe, 'social capital is not a magic wand for improving society.' Instead, social capital:

> is a useful concept, which focuses our attention on an important set of resources, inhering in relationships, networks, associations, and norms, which have previously been accorded insufficient priority in the social sciences and health literature. This is probably partly because they are not easy to categorize, study and measure in their effects.

Evaluating social relationships therefore focuses on the quality of such relationships, rather than only on their quantity.

More fundamentally, as the literature on social and cultural contexts of health points out, it is these relationships that allow and encourage individuals to access standard institutions of public health and medical care. Without such social relationships, residents are not aware of health and wellbeing opportunities – including health screening and medical check-ups – and will likely remain indifferent, if not hostile, to the communication about such opportunities. Social relationships are particularly key in improving health and wellbeing in the ten priority wards, given that residents identify that there is availability of health resources – but note that the difficulty is access, both material and cultural. As Szreter and Woolcock add, 'Material assistance will almost certainly be necessary in most contexts; but equally important will be attention to the quality and quantity of relationships, which carry and make interpretable any

[51] Demos, *The Preventative State* (2023), p. 20.

such material or technological transfers.'[52] The quality of social relationships provided through the CHDO and WT programmes are therefore key foundations for the success of overarching health programmes such as NHS screening and medical provision.

Alongside a focus on these 'precious resources of human relationships, effort, and care,' our research also highlights that sustainability is crucial to the effectiveness of public health interventions. As the Community Insight Profiles note, and as organizers of the health and wellbeing activities also observe, a major challenge facing community engagement is the tendency to be distracted by novelty rather than investing in continuity. Our findings outline that both programmes contribute to sustainable community health and wellbeing. There are two reasons for this. First, CHDOs and CCBs are chosen for their experience of working with local networks, meaning that they begin their roles already invested in established community organizations – which also avoids the pitfalls of 'parachute science'. Second, their roles strongly emphasize networking and collaboration, including the sharing of resources and opportunities. The outcome is seen in the fact that the majority of funding is allocated to sustaining and maintaining organizations and activities rather than to new initiatives. This stands in contrast to standard practice that suggests that only the previous five years of research or activity be taken into consideration when evaluating community health initiatives and programmes.[53] We therefore recommend that health programmes take a longer-term approach to avoid the cycles of intervention that characterize 'parachute science', which can lead to community indifference or even mistrust towards health initiatives. While policymakers may have only short-term recall, communities have long-term memory.

Our evaluation therefore recommends continued support for community health interventions that develop social relationships, as the WT and CHDO programmes do, as well as interventions that focus on sustainability in order to continue to build residents' trust as well as develop community capacity. This echoes widespread calls for investment in preventative and community health interventions that are place-based and that take account of social and cultural contexts to health. We observe that the CHDO and WT programmes reflect and build on the assets and strengths of the ten priority wards and contribute to overall health and wellbeing goals of these communities through culturally-appropriate and place-based practices. **We also recommend assessment that incorporates the quality – and not just quantity – of social relationships when outlining the effectiveness of community health programmes, and includes a long-term and contextual approach in framing interventions.** This will help to highlight the benefit of sustainability over novelty, and the importance of place-based social relationships for health.

We also encourage attention to community engagement among males, as our research suggests lower male engagement with community activity than female. Given that men have lower life expectancy than women in all priority wards, and for social and cultural reasons are known to struggle with access to health and medical services, male participation in community health and wellbeing activities would be worth analysing as an indicator of broad community involvement.[54] Likewise, **our research found strands of an 'English' cultural approach to health**: humour and self-deprecation are traits that should be considered when interpreting self-reporting on health. Similarly, **there is broad divergence in terms of neighbourhood**

[52] Szreter and Woolcock, 'Health by association' p. 663.
[53] E.g. Harris, *Evaluating Public and Community Health Programs* (2016) states that reviews should focus on publications from no more than the previous five to ten years.
[54] See also Healthwatch Oxfordshire's 'Hearing from men in Oxfordshire' 2025 research report.

identity within each ward, highlighting the need for approaches that take account of local culture, rather than simply implementing models. Approaches to community health and wellbeing should thus take account of gender norms alongside other social and cultural factors in each locality.

More generally, evaluation and assessment of community health and wellbeing is important, but also complex. Because these activities serve as paths to and from more formal public health and medical care, their impact is not easy to disentangle from official medical infrastructure. **We therefore recommend that community health be considered as part of broader health infrastructure, rather than as an optional add-on.** Community health activities make health and wellbeing part of daily life, rather than featuring as a specialised intervention.

Moreover, while the importance of civic engagement, social capital, and community resilience are widely recognized as crucial to long-term health, such factors are difficult to quantify and measure. Community focus groups are useful; at the same time, these often do not reach those who are already disengaged, thereby reifying existing patterns of activity. Broad-scale evaluation is therefore useful, but constant evaluation and assessment is an onerous demand for already-stretched community organizations and volunteers. **We therefore recommend methods of evaluation that capture the nature of community health as forms of social relationships and networks. Such methods should remain simple and straightforward, assessing impact through reach via reporting that is proportionate to the scale of activities and the responsibilities of community organisers.**

Simply providing or counting assets misses the necessary linkage between residents and infrastructure, as communities require trusted relationships with public services in order to make use of them. Our research found that a major obstacle to improving health and wellbeing in the ten priority wards is not simply a lack of health resources, but not having – or believing not to have – access to existing resources. This includes developing and maintaining confidence in health programmes to combat indifference among community members to such activities. **Residents access and engage with medical and health infrastructures through interpersonal relationships that require trust and familiarity, and – crucially – through social relationships that encourage aspirations and expectations of improved health and wellbeing.**

Our research in the target neighbourhoods of the ten wards found that health is understood primarily through social relationships: through concerns over family and household health, rather than simply through individual health. At the same time, we also found that residents note the importance of people – neighbours, family, and social ties – in maintaining communities in which people are able to enjoy local assets. Civic engagement and community resilience are therefore defined not just by infrastructure and location, but also by social relationships. Above all, community health and wellbeing depend on communities themselves as active and engaged networks of social and cultural relationships.