Healthy Communities:

University of Oxford Medical Humanities Phase One Evaluation of CHDO and WT Programmes

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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. 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, or the availability of resources such as medical care, healthy and affordable food, or green space.

The CHDO and WT community health programmes draw on Community Insight Profiles, detailed overviews of quantitative and qualitative evidence about which local health and wellbeing assets residents identify as important. They also record community views on what residents appreciate about their ward and which community issues they would like to see addressed, including challenges to health and wellbeing.

Methodology

Our phase one evaluation uses the criteria and issues raised in the Profiles to assess the CHDO and WT programmes. It uses empirical research to analyse the ways in which these programmes have been implemented, and how the programmes engaged with community capacity for health and wellbeing, from January to December 2024. Our evaluation applied methods from medical history, community history, economics, medical anthropology, and public health to understand the social and cultural contexts of community health. Our research team analysed the long-term health and social context of the ten wards; the funding activities of the two programmes; and the implementation of the two programmes through two workshops, four focus groups, 24 semi-structured interviews, and extensive fieldwork and event participation.

Findings

Phase one of our evaluation finds that the CHDO and WT programmes demonstrably fulfilled their goals in terms of distribution of grant funding as well as widespread and sustained engagement with community groups. Within the given period, over 100 community organizations were funded via 196 health and wellbeing activities, distributed across the ten wards.

Our research also found: **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 organizations and networks.**

Our analysis found effectiveness in health and wellbeing community activities not only through quantitative assessment of funding, events, and feedback, but also through a qualitative analysis of place-based social relationships, which serve as the building blocks of social infrastructure and healthy, resilient communities.

Portraying medical care and health by counting institutions and financial assets alone obscures the key issues of how and why people access health care, choose healthy behaviours, and maintain healthy communities. As shown in analysis of the ten priority wards, many residents share concerns about sustained accessibility to community assets and organizations, and often suggest improved sharing of information and access. Residents 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 show, residents are aware of these issues, but many also recognize key assets of their communities, including a strong sense of local neighbourhood identity and local organizations.

A major obstacle to improving health and wellbeing in the ten priority wards is not simply a lack of health resources, but improving access to existing resources. This includes developing and maintaining confidence in health programmes to combat indifference to such activities. 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.

<u>Recommendations</u>

We recommend a continued emphasis on what is called 'rooted research' that focuses on long-term and equitable collaborations with local partners, in contrast to 'parachute projects' and repetitive but unpredictable cycles of new initiatives. As the Community Insight Profiles note, and as organizers of health and wellbeing activities also report, a major challenge facing community health and wellbeing engagement is the tendency to be distracted by novelty rather than investing in continuity. In response: **We highlight the benefit of continuity and recommend a long-term approach to public health initiatives: while policy cycles are usually short, communities have long-term memory.**

A key theme of our research, methodologically as well as in terms of findings, is the nature and quality of social relationships and their role in supporting health and wellbeing. **In phase one we found that the WT and CHDO programmes are crucial in linking residents to existing medical and health provision in the wards, as well as ensuring that vital health infrastructure is accessible and trusted.** One community wellbeing event – such as a coffee morning – provides direct access to other events, whether volunteering at a community larder, accessing social services, or attending a medical screening. **The quality of social relationships provided through the CHDO and WT programmes is therefore an essential foundation for the success of overarching health programmes such as NHS screening and medical provision.**

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1. Introduction

Community Health Development Officers (CHDO) and Well Together (WT) are two novel community health programmes aiming to reduce health inequalities in the ten Oxfordshire wards identified as priority wards: 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, or the availability of resources such as medical care, healthy and affordable food, or green space.

While wards contain a variety of communities and a range of living conditions, statistics of categories such as 'Barriers to Housing and Services' and 'Income Deprivation' rank these as the 'ten most deprived wards' in Oxfordshire, as well as among the 20% most deprived in England.[1] (more details on priority wards are in sections 2.1 and 2.2) Such statistical ranking, however, does not fully capture the nature of these wards or the issues at stake in developing and sustaining healthy communities.

Statistical averages are useful, but necessarily have limitations. Oxfordshire, for example, has health outcomes that are better than the national average: with male life expectancy of just over 80 years (compared with 79 nationally) and female life expectancy of 84 years (compared with 83 nationally). These figures show Oxfordshire to be a healthy county. Yet, as detailed analysis of Oxfordshire wards shows, the overall county average conceals significant disparities between its communities. The gap in life expectancy between some Oxfordshire wards is as wide as fifteen years.[2] If one categorizes the statistical average of how long people live by ward, instead of by county, this instead demonstrates that some areas of Oxfordshire are significantly below the national average. Contrary to county-level data, ward-level data highlights regions where communities struggle with children living in poverty, substantial unemployment, social isolation, and an inability to live long and healthy lives. Statistics such as those applied to Oxfordshire as a whole can hide substantial health problems by flattening out regions into a homogeneous, quantitative average. Yet these figures can also be used to identify problems, such as the differences in health outcomes between wards, thereby highlighting significant health inequalities. Numerical data – whether statistical averages or population overviews – can be interpreted in a variety of ways. They are thus most accurate, and useful, when accompanied by detailed contextual and qualitative analysis.

[1] Oxfordshire JSNA 2023 Bitesize. See also full details in section 2.2.
[2] 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.

Likewise, characterising a ward as among the 'most deprived in England' does not capture the variety of its neighbourhoods and community resources – but it can help identify problems and suggest areas of focus. If wards are analysed only with statistical averages and numbers, their individual characteristics and strengths are lost. Similarly, **portraying medical care and health by counting institutions and financial assets alone obscures the key issues of how and why people access health care, choose healthy behaviours, and maintain healthy communities.**

This report evaluates two innovative public and community health programmes in Oxfordshire focused on the ten priority wards: Community Health Development Officers (CHDO) and Well Together (WT).

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 six Oxfordshire Community Health Development Officers (CHDOs), either part-time (responsible for one ward) or full-time (responsible for two to three wards). Their responsibilities include health and wellbeing network building, community engagement, and the allocation of small grants (£25,000 for each of the ten wards). A key objective is to work with local partners in order 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). 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 (£100,000 for each of the ten wards). Compared with the CHDO programme, WT provides a more expansive, and more centrally-organized approach to community health and wellbeing, managed and coordinated through two well-established Oxfordshire community voluntary organizations.

Both 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, including giving tailored advice on applications, opportunities, and related networks. Staff were first appointed in either 2023 or 2024, and the programmes have been initially funded until mid-2025.[3]

Given the short timeframes of the programmes, their impact will not be demonstrable in population-level data – such as shifts in rates of disease or obesity, or mortality ratios – for many years. In phase one of our evaluation, we therefore use empirical research to analyse the ways in which these programmes have been implemented, and how the programmes engage with community capacity for health and wellbeing, from January to December 2024. In doing so, this evaluation highlights the role of social relationships in developing and maintaining healthy communities. While recognizing the key role that medical and public health structures play in health and wellbeing, **this evaluation focuses on the ways that communities access and engage with such structures: through social relationships that require trust and familiarity, and – crucially – through social relationships that encourage aspirations and expectations of improved health and wellbeing.**

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. A crucial part of the social determinants of health are social and cultural practices, including the social and community contexts in which we are born, grow, eat, work, age, socialise, and generally live.[4]

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,

[3] Since the completion of phase one research in January 2024, CHDO funding has been renewed to 2027.
[4] 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).

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.[5] 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.'[6] 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.[7]

Our evaluation provides a long-term and expansive approach to public and community health. It examines social attitudes and cultural practices that shape community engagement with health and wellbeing, analysing how these were applied, transformed, or reaffirmed in the implementation of 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 ethnographic study through participant observation, semi-structured interviews, and mapping.[8] The evaluation also incorporates long-term health contexts in the ten priority wards as well as long-term cycles of community health funding in order to understand and analyse social and cultural obstacles to community health.

This evaluation was a partnership between Oxfordshire County Council Public Health, the University of Oxford Medical Humanities Research Hub, and Oxfordshire Voluntary, Community, and Social Enterprises. Research and evaluation were independently conducted by

[5] British Academy, *Public Trust in Science-for-policy Making*, (2024); Vanderslott et al, 'Attributing public ignorance in vaccination narratives' *Social Science & Medicine* (2022).
[6] C. Webster, ed., *Caring for Health: History and Diversity* (2001), p. 86.
[7] Healthwatch Oxfordshire, 'Oxford's New and Emerging Communities' Views on Wellbeing' (2021).
[8] 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).

medical humanities researchers at the University of Oxford: Erica Charters, Yuxin Peng, Urvi Khaitan, Theeba Krishnamoorthy, and Julia Gustavsson. Members of Oxfordshire County Council Public Health, 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.[9] 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 as well as these particular public health initiatives.** This strand makes use of the Community Insight Profiles and the medical and social histories of public health in Oxfordshire. **The second strand (section 3) analyses the funding and grant activities of the CHDO and WT programmes. The third strand (section 4) examines the implementation and practice of the two programmes.** This was conducted through two workshops, four focus groups, and 24 one-to-one semi-structured interviews with CHDO and WT staff. This research was accompanied by fieldwork visits to CHDOs at their workspaces in local community centres, district councils, and the town hall for formal interviews, informal catch-ups, and event participation. We also attended online and in-person events that CHDOs initiated for local health and wellbeing partners to understand the process of network-building on micro and macro levels.

While researching with the programme staff, we also analysed 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. This provided evidence to analyse the process of grant applications and outcomes from the perspective of community group organizers. Last, to capture community views of community health and the two programmes, we organized mapping activities and conducted brief structured interviews at two major community events (Banbury People's Park, Leys Festival). We also conducted brief structured interviews at the playday at Banbury Princess Diana Park and the Rose Hill Community Cupboard. This provided interviews with a total of 69 community event participants. Alongside, we participated in five community

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

activities funded by either or both programmes, analysing content, feedback, and community impact. Given that the CHDO and WT programmes began only in 2023 and 2024, most of their funded community activities were initiated later in 2024. Our phase one evaluation has had little opportunity to substantially engage with the community activities funded by the two programmes (which will be the focus of phase two); the evidence of phase one therefore focuses on the implementation and practice of these two programmes.

1.2 Key Findings

Our phase one evaluation finds that the CHDO and WT programmes demonstrably fulfilled their objectives in terms of distribution of grant funding as well as widespread and sustained engagement with community groups. Within the allocated timeframe, over 100 community organizations were funded via 196 health and wellbeing activities, distributed across the ten wards. Our research found that the individual CHDOs and CCBs are particular strengths of each programme, able to effectively engage with local communities through regular presence in community activities; excellent communication and networking skills; and active partnerships with existing organizations and networks.

Our research finds effectiveness in health and wellbeing community activities not only through quantitative assessment of funding, events, and feedback, but also through a qualitative analysis of place-based social relationships, which serve as the building blocks of social infrastructure and healthy, resilient communities. A key theme of this report, methodologically as well as in terms of findings, is the nature and quality of social relationships and their role in supporting health and wellbeing. We found that the WT and CHDO programmes are crucial in linking residents to existing medical and health provision in the wards, as well as ensuring that key health infrastructure is accessible and trusted.

We note that the context of the ten priority wards is required to understanding the nature of health and wellbeing assets, as well as obstacles to health and wellbeing. In particular, long-term context shows the regularity and frequency with which support for community health has changed, demonstrating a preference for novelty that can come at the expense of reliable and trusted community support. We therefore recommend that, alongside continued support for the two programmes, assessment takes account of long-term contexts of health initiatives and policy – including awareness of the importance of sustainability and continuity, rather than novelty.

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 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.

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.[10] 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 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's 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.**

[10] 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 Summaries[11]

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, 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, residents of Abingdon Caldecott 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.

Likewise, 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 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'. 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

[11] Data for section 2.2 and 2.3 use: Oxfordshire Community Insight reports, data, and profiles for the ten wards; ONS Census 2021; Oxfordshire Local Area Inequalities Dashboard; Local Authority Health Profiles; Joint Strategic Needs Assessments, 2019 and 2023; and Oxfordshire County Council Director of Public Health Annual Reports.

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.

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. 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.

Likewise, 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, residents identified issues with housing – with a significant homeless population in Oxford City – and recommended improved provision for free or low-cost community spaces.

To capture community views of health and wellbeing, as well as research on activities funded by CHDO-allocated grants, we organized mapping activities and conducted brief structured interviews at major community events in summer 2024.[12] This resulted in 31 interviews with 69 community event participants. The interviewees were young parents, children and teenagers, staff and volunteers of local health and wellbeing groups, church workers, retired people, NHS workers, and independent artists. Most lived locally, and had a variety of ethnic backgrounds. Some were first- or second-generation immigrants.

A few common themes emerged in views of healthy communities.[13] Half (n=30) mentioned sports and exercise as ways to keep healthy; many discussed the importance of being outdoors

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

[13] Interviews asked 5 questions: What changes do you want to see to make [community] a healthier place? Who do you think will make these changes happen? What do you do to keep healthy: What resources do you need to maintain these healthy habits? What is a healthy community?

for themselves and their children. They also expressed desires for safer and cleaner parks, more guided walks tailored for adolescents and the elderly, cycle routes separated from major roads, and lower subscription fees for the local gyms. Walking was the most popular way of exercising, followed by biking and swimming. Near one quarter (n=12) mentioned healthy eating; many noted the importance of having affordable access to fresh fruits and vegetables.

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 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.**

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%). Oxfordshire contains 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.'[14]

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 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 – with the exception of

[14] ONS Statistical Geographies.

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.

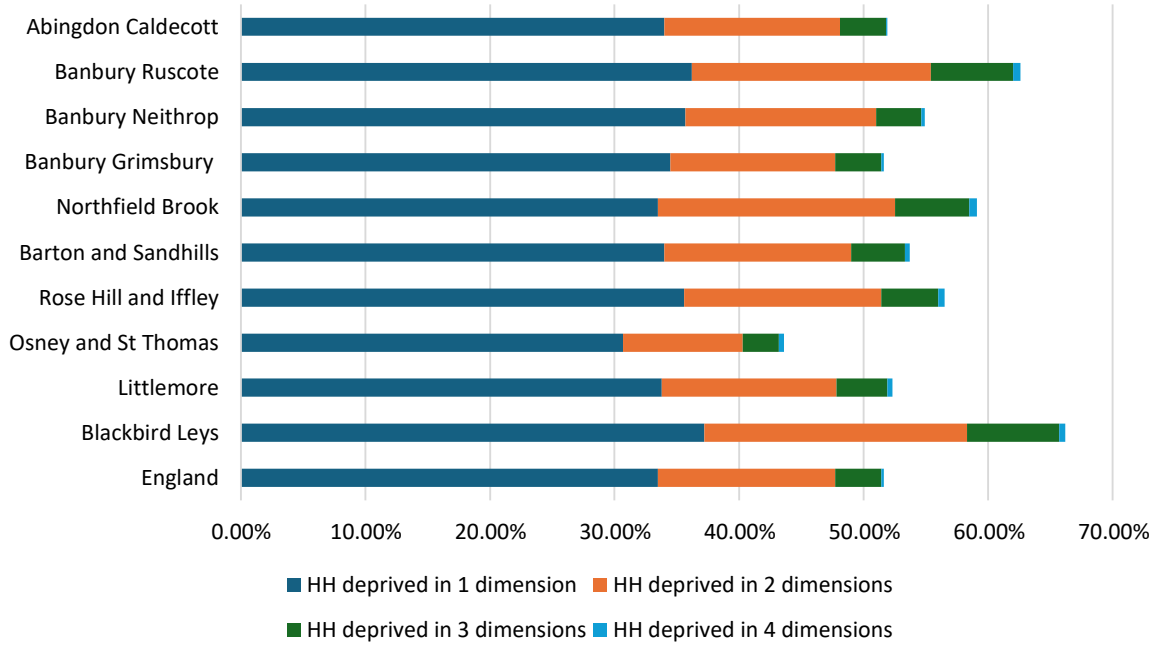
Table 1. Deprivation Scores

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)

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

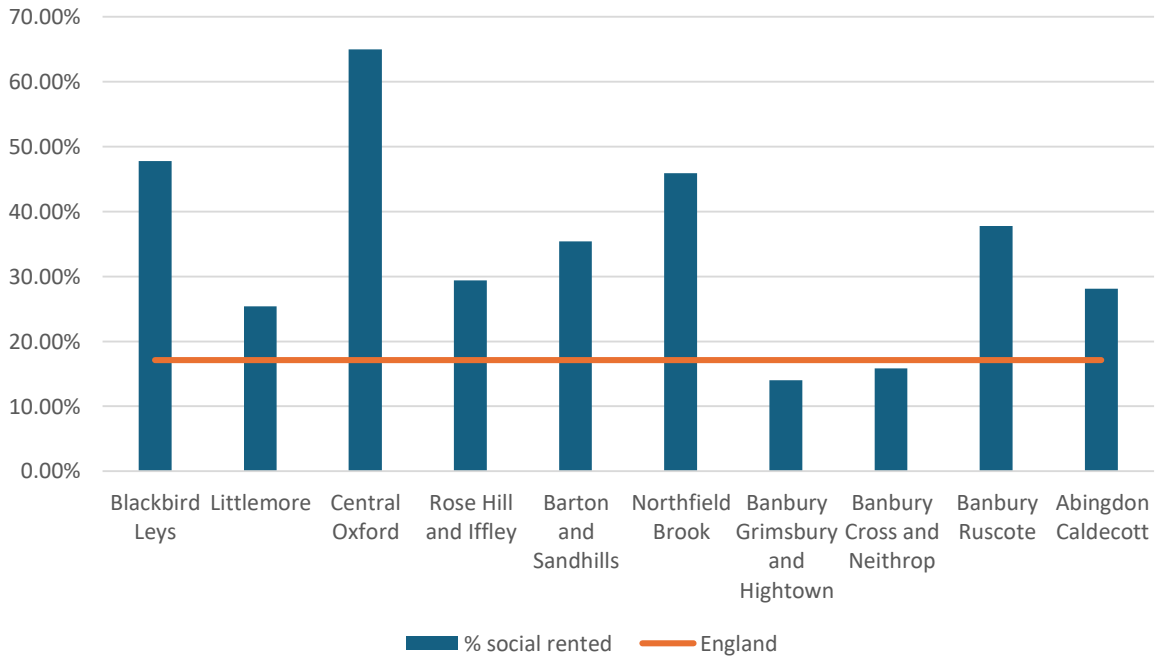
With the exception of OST, the rates of people engaged in routine and semi-routine occupations is high. These occupations are often manual and service occupations that are considered 'working class'.

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

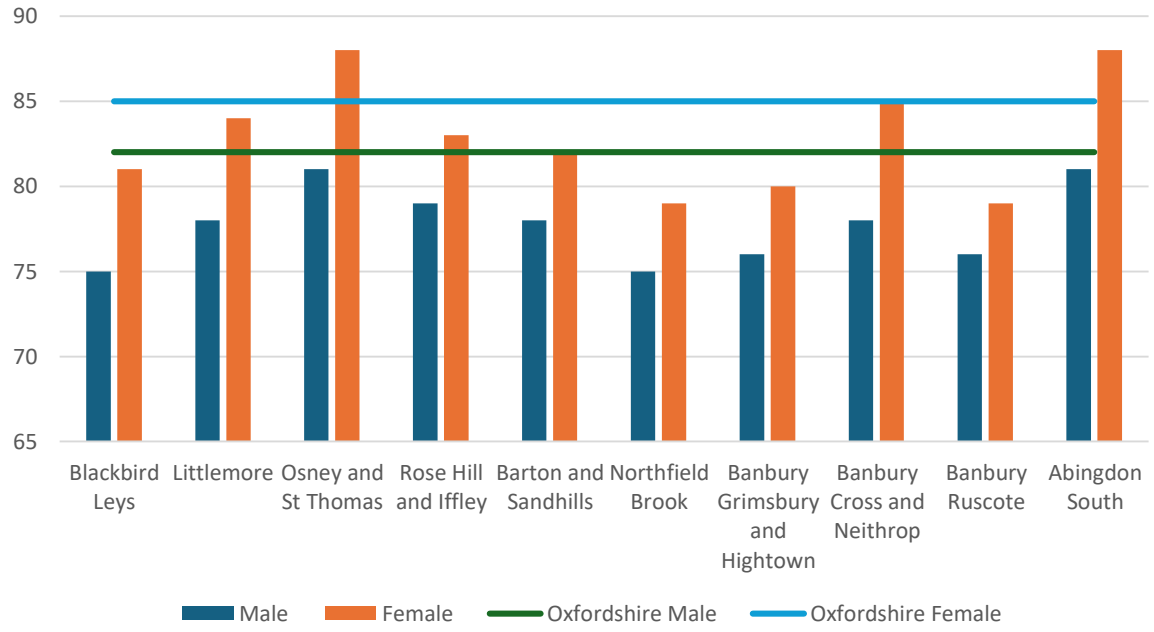
The percentage of people receiving allowances and Personal Independence Payment (PIP) tends to be higher than the national average. It is difficult to find data for Banbury and Abingdon; the table below shows the data for Oxford. The disparity between males and females is striking – especially in Blackbird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

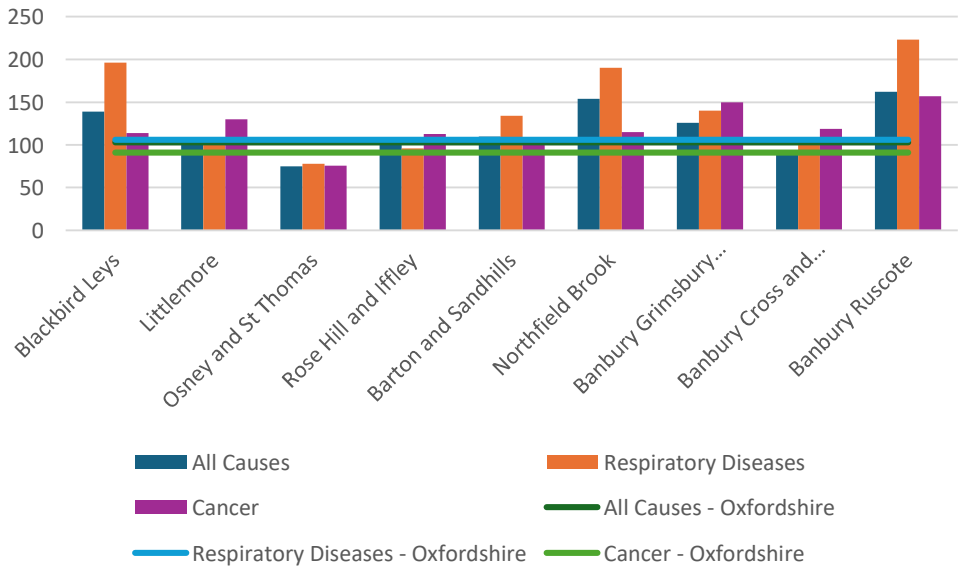


Note: Data are for Abingdon South as Abingdon Caldecott data could not be located.

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.

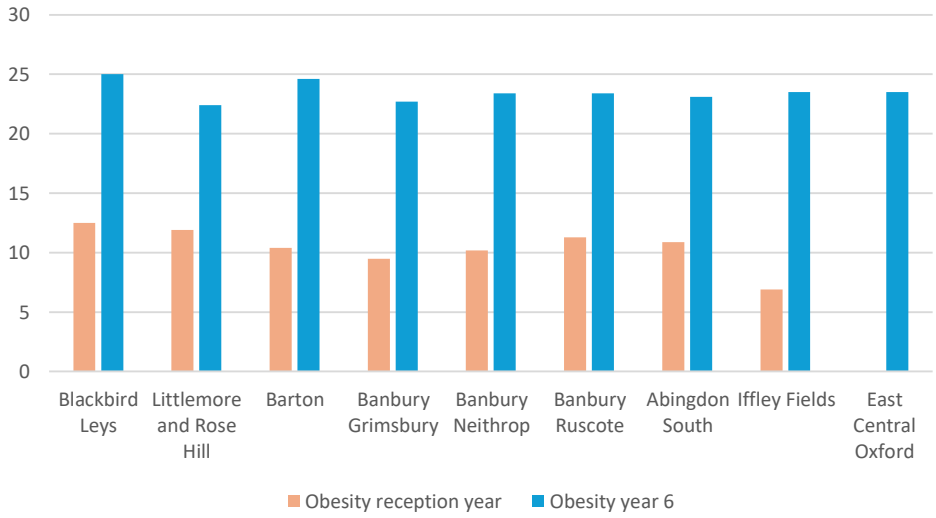
Figure 5. Mortality ratios



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.[15]

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'.[16]

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

[15] See Oxfordshire County Council's March 2024 report on food strategy.
[16] Oxfordshire County Council, Mental Wellbeing Needs Assessment report (2021), p. 83.

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, in particular those in Blackbird Leys, also experience overcrowding of what green space is available.[17]

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 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.

This table shows Oxford funding from national grant giving organizations.[18]

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' suggestions and recommendations for improvement. At the same time, many residents of these wards share concerns regarding sustained accessibility to community assets and organizations, and often suggest improved communication and networks of opportunities.[19] 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

[17] Leverhulme Centre for Nature Recovery Report, pp. 16-17.
[18] Data for Banbury and Abingdon were not able to be located.
[19] 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.

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 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 local organizations.

2.3 The Programmes in Context

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.[20] At the same time, the CHDO and WT programmes draw on a long history of addressing public health through preventative community-based measures.

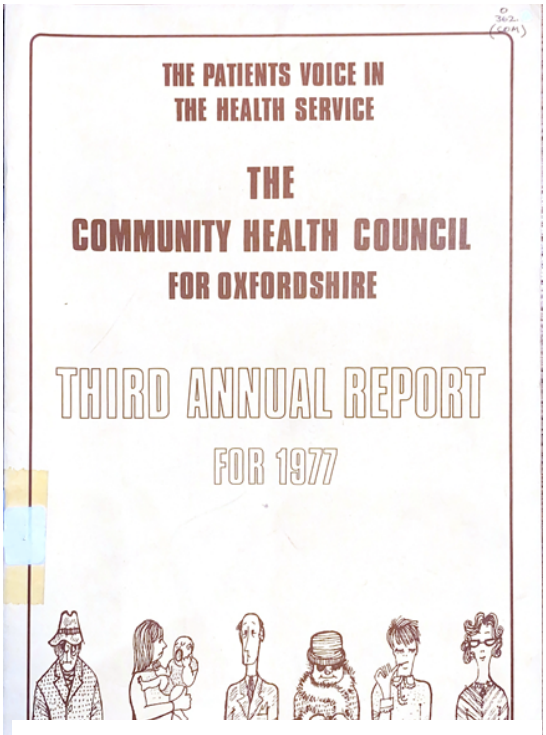
Authorities, whether political, religious, social, or medical, have long worked to track and identify patterns of illness and mortality in general populations, and thereby intervene in order to improve overall rates of health. Some notable early practices include the recording and analysis of mortality 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, 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.[21]

[20] 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.

[21] 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).

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.[22]

Likewise, reports and initiatives have long continued to highlight differences in 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.'[23]



Annual Report (1977) of the Oxfordshire CHC

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 for

[22] 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).
[23] Qtd in Webster, *The National Health Service: A Political History* (2002), p. 137.

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.[24]

For local communities, the effect of these reports, commissions, and policy debates is cycles of public 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.[25] 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. While each 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.[26]

As research in global health demonstrates, as well as being ethically questionable what defines so-called 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.'[27] 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

[24] 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).
[25] Uwe Reinhardt, *Accountable Health Care* (1998).
[26] Well Together staff 1, interview 29 Oct 2024.
[27] Odeny B, Bosurgi R (2022) Time to end parachute science. PLoS Med 19(9): e1004099; see also Heymann et al., 'Partnerships, not Parachutists, for Zika Research' *N Eng J. Med* (2016) 1504-1505.

– and is particularly important for communities that are already distrustful of outside or central actors.[28]

Although initiated by developments in 2019-2020, the CHDO and WT programmes also draw on years of public health research and practice. Applying methodologies of building community capacity, trust, and sustainability, they are designed to mobilize assets, networks, and resources from within communities – avoiding the pitfalls of parachute projects. Both programmes intentionally recruit staff with experience of working for community organizations. The two programmes also share an emphasis on building community networks of trust. At the same time, the two programmes are comparably small scale, and designed to work within existing infrastructure, rather than overturning or creating entirely new ways of working.

[28] Yzwiak et al, 'Roots, Not Parachutes: Research Collaborations combat Outbreaks' *Cell* (2016).

3. Funding Allocation

One of the key responsibilities of the CHDO and WT programmes is the allocation of funding to community groups and organizations. The Community Insight Profile Grant Funding allocated through the CHDO programme provides up to £25,000 for each of the ten wards; the Well Together grants provide up to £100,000 for each of the ten wards. The CHDO programme expected that successful applicants will 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 aim to award a minimum of one year of funding to successful applicants.

3.1 CHDO Funding Allocation: CIP Grants

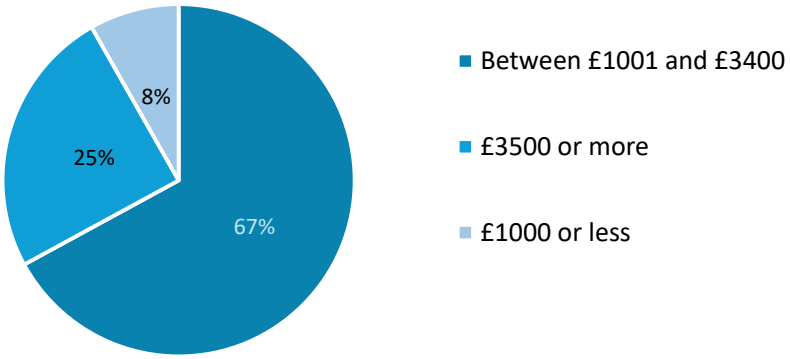
The CHDO Community Insight Profile (CIP) Grant Funding was advertised through flyers, posters, email circulations, and webpage announcements, with CHDOs available to discuss and help support applications. Applications were discussed and scored by a panel of community members and partners, taking into 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.

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. In particular, a total of 85 projects were funded (with a total of 68 organizations funded), spread across the ten

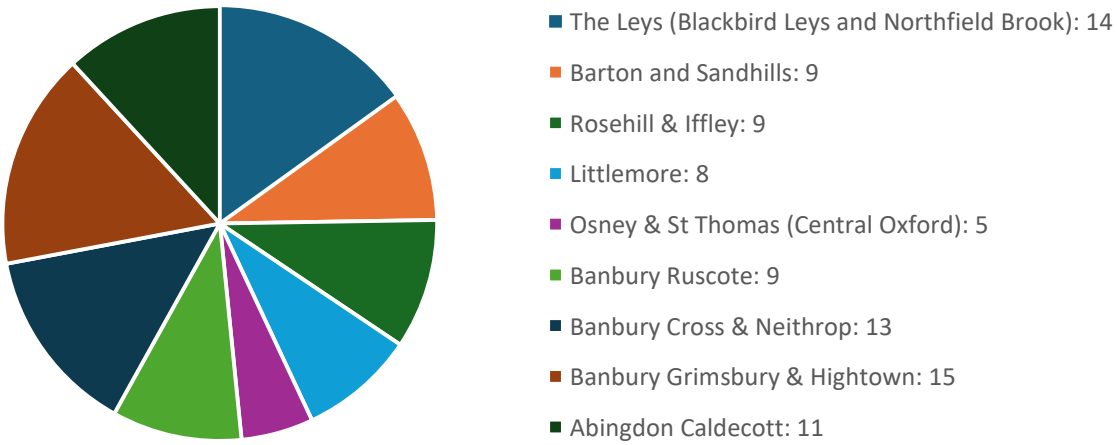
Figure 7. CIP Project Funding:
Amount of Funding Allocated across 85 projects



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 4.4, feedback from funded organizations described the CIP application and grant process as 'straightforward' and 'quick', especially when compared with other community funding applications.

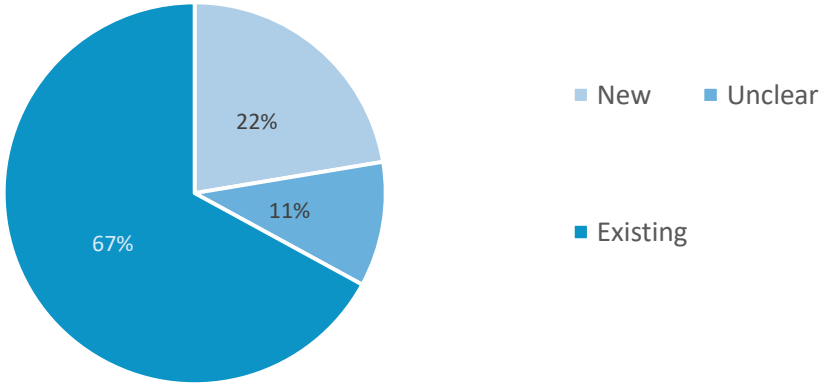
For the 85 funded projects, the average grant awarded was £2 530. Twenty-one projects (25%) received grants of £3500 or more, with the largest grant £7 000, while 7 projects (8%) received grants of £1000 or less, with the smallest grant £210. The majority (n=57, or 67%) received between £1001 and £3400 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). For this stage of the evaluation, although we were able to identify that each ward applied relevant CIP criteria to assess applications, we were not able to categorize these into coherent overarching health and wellbeing categories given the timeline and type of data submitted. We also lacked complete data from each ward in terms of duration of projects and frequency of activities, as well as estimated number of participants. With more detailed data from CIP-funded activities to be submitted in 2025, it will be possible to quantitatively analyse the impact of these projects in the second phase of evaluation.

Figure 9. CIP Project Funding: Sustained vs New Projects



The CHDO programme of CIP Grant Funding was successful in terms of timeline, amount, and geographic range. While more data and analysis are required to establish the reach and impact of funded activities, preliminary analysis demonstrates that a majority of CIP funding supports the continuation and sustainability of existing community health and wellbeing activities.

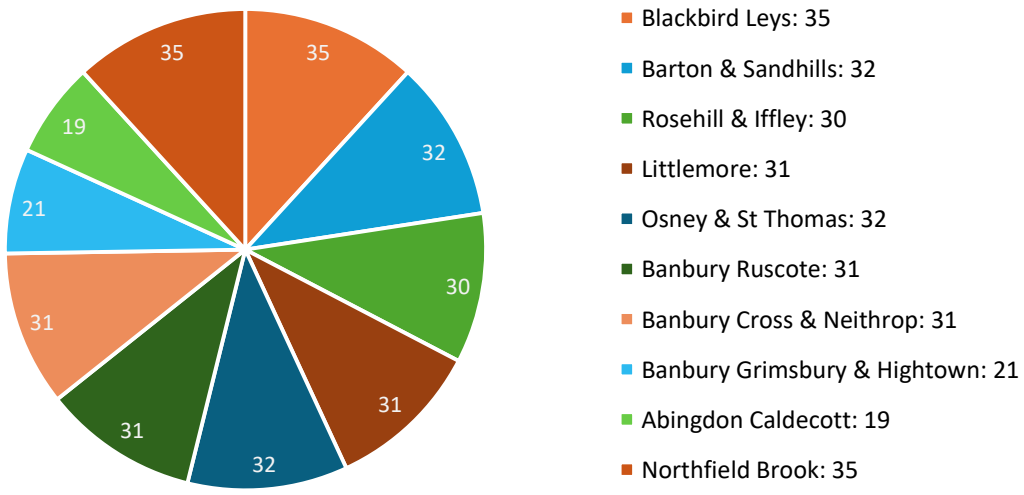
3.2 WT Funding Allocation

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 4.3) Due to the large volume of EoI for Blackbird Leys and Greater Leys (47 in total), the WT team closed the EoIs for BL 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.[29] 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 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 straightforward. More details on the application process are in section 4.3.

Figure 10. WT-funded activities by ward



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

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

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.

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 below outlines funded activities according to which health inequalities they each addressed, as categorized by WT assessments.

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

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. While more data and analysis are required to establish the reach and impact of funded activities, preliminary analysis demonstrates that a majority of WT funding supports the continuation and sustainability of existing community health and wellbeing activities.

4. The Programmes in Practice

While these programmes were initiated in 2023 and 2024, their key activities developed late in 2024. For example, WT aimed to distribute 20% of their funding by April 2024; the majority of their grants were not disbursed until late 2024, resulting in groups and networks engaging in their planned activities from late 2024 and 2025. Likewise, although CHDO grants were allocated mostly in 2024, many of the funded events and networks started in late 2024. Given this short time frame, the impact of the WT and CHDO programmes cannot be fully captured by this first phase of the evaluation, which ran from January to December 2024. More broadly, the impact of these programmes will not be demonstrable in population-level data – such as shifts in mortality rates – for some years, if not an entire generation.

Phase one of the evaluation therefore focuses on the *implementation* of the two programmes. Relying predominantly on the Focused Ethnography (FE) approach in applied anthropology, it analyses the ways in which CHDO and WT staff conducted their roles and their reflections on the role and programmes, as well as feedback from funded organizers and a small number of participants at CHDO- and WT-funded activities. It focuses on social relationships, cultural practices, and community dynamics to evaluate the effectiveness of these two health programmes.

Interviews, research workshops, focus groups, and in-person visits were conducted with CHDOs and WT staff. Specifically, two research workshops (March and July 2024) and four focus groups were held with CHDO and WT staff, allowing them to discuss first-hand insights and experiences of working in the ten wards and the process of grant application and allocation. In-person visits and one-on-one interviews were also held with all CHDOs and WT Community Capacity Builders. These semi-structured interviews and fieldwork visits allowed observation of the working methods of staff in their community locations, while fieldwork observation of events hosted by CHDOs provided insights into the process of network-building on micro and macro levels. Interviews and focus groups were also held with the CHDO programme manager, the WT programme manager, project development manager of CFO who oversaw the allocation of the Caldecott Community Grant Fund, CEOs of the two community groups (CFO, OCVA) who oversaw the WT programme, and the Oxford Hub CEO who oversaw the participatory grant making process in the Leys. Interviews encouraged reflections on the process of building and maintaining community networks, including obstacles which tested the resilience and flexibility of networks as well as the roles of the programme staff.

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 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. 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 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 expansive, 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.

All six CHDOs and all four WT CCBs are women, from a range of ethnic, social, and cultural backgrounds. None of the CHDOs is a resident of the wards they serve. Most, however, had experience growing up, working, and living in regions 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.

4.2 Community Engagement

As identified in the Community Insight Profiles (see 2.1), and as outlined in their job description, CHDOs and CCBs are meant to support community engagement. This necessarily requires residents 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.

4.2.1 Community Presence

An example of the crucial role of community presence is the Leys CHDO's activity at the Community Larder. 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.'[30] 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 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

[30] Interview July 2024.

activities and events funded by the Insight Grants, which will have her attend more community events as a result.

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

4.2.2 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.[31]

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 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,

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

‘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.’[32]

4.2.3 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 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 local 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.

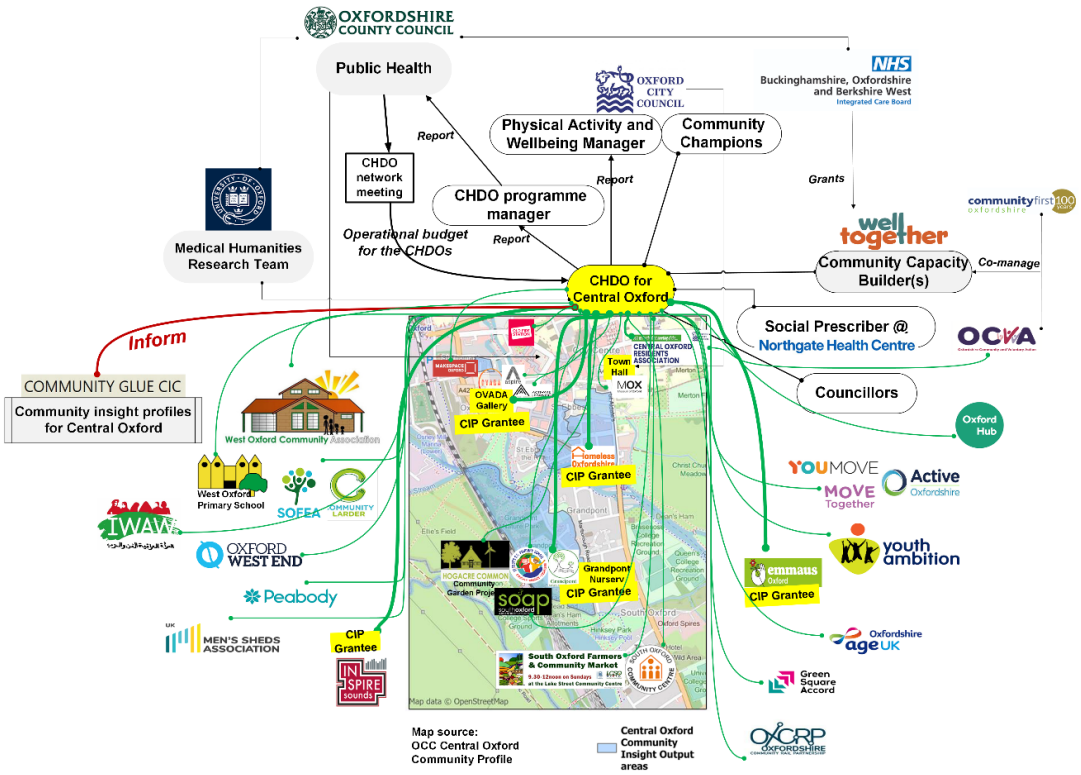
In contrast to wards with established partnerships, the areas of Central Oxford and Abingdon Caldecott are likely too small or fragmented to have had prior health and wellbeing networks. The task for CHDOs in these wards was to establish new partnerships. The CHDO for Central Oxford, for instance, has 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

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

from the University of Oxford. The Oxford CHDO has also helped local residents establish a residents' association through the Oxford Town Hall.

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, as of Oct 2024



4.3 Well Together Application 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.[33]

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 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.

[33] Qts from interview (Oct 2024).

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

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 whom we interviewed 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.'[34]

[34] The EOI feedback was collected as part of the analysis in section 4.5.

4.4 Funded Organizations

By working with CHDOs, we were able to analyse insights from 26 community groups that 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. This provided preliminary evidence to analyse the process of grant applications and outcomes from the perspective of community group organizers.

The community groups we analysed are located in a range of the priority wards (Abingdon, Banbury, Barton, Oxford, as well as in multiple wards). While the majority are based locally, two are national organizations and one is international. Only four were established in the past five years; the majority are older than ten years, with the oldest founded in 1942. They also range in size: six organizations have more than six paid employees who work full time (or equivalent in part-time), with two among these described as very large (over 40 paid full-time employees); three have between two to six paid full-time (or equivalent) employees. The majority are run either entirely by volunteers or employ one or fewer full-time paid employees. Organizations also offer a varied array of health and wellbeing activities, ranging from exercise and sports, or support for people who are homeless, to musical activities as well as more tailored education programmes that offer training in cooking or social and mental health skills.

The size and frequency of activities run by these organizations also vary, capturing the range of events supported by the WT and CHDO programmes. Less than a third cater to large groups (50 or more participants); the majority host events that support 10 to 20 participants, on either a weekly or monthly basis. Likewise, organizers vary in their account of how they officially evaluate their activities, as well as what they would consider a successful activity. For external evaluation, a handful of organizers explained detailed surveys and tracking of participation, whereas the majority noted combinations of the number of participants and qualitative reporting such as individual stories or participant feedback. By contrast, for their own measurement of success, all of them mentioned feedback or participant enjoyment, even contrasting the official need for 'data' with other forms of impact. As one organizer explained, 'I think numbers…are important. But they don't give the whole picture. … I want to hear from the people who benefit, why they benefitted.' Likewise, another remarked, 'I always think that numbers never really show the impact because you can be supporting a small number of people, but the difference you're making can be huge.'

The groups vary slightly in terms of their experience in submitting funding applications. No organizations selected 'none' in terms of their experience with community funding; the majority instead selected 'some experience' (10 groups). However, it was noted that when asked how many times they had previously applied for funding, at least five in this category

mentioned experience with applications over multiple years. As a result, according to the number of times that groups had previously applied for funding, all except two organizations had submitted more than five previous funding applications, and many noted years of experience in charitable fundraising – which also suggests that many groups do not identify as 'experts' in the application process, even if they have years of experience. Notably, the organizations were close to evenly split as to how many of them had applied to other sources to fund the particular activity that had received either WT or CHDO financial support, with 10 of the 26 having only applied to WT/CIP. Supporting the suggestive quantitative analysis of the general WT and CHDO funding allocations in section 3, the overwhelming majority of funded groups are thus experienced organizations that have been offering key community health and wellbeing services for some years.

Similarly to feedback on the WT EOI process, the funded organizers almost all agreed that the application process was straightforward, with 6 adding that these were easier to complete than many applications, and a handful also noting that the CIP grants are particularly straightforward with decisions made quickly. While a few grantees seemed unaware of the difference between the WT and CIP funding and application forms, sometimes confusing the two programmes, two were aware of the differences between these two funding programmes, and noted that they were indeed different in terms of time frame and aims, with CIP being identified as 'easy' and 'quick', and WT as longer with a longer time frame for decisions, tied to larger amounts of funding. One grantee observed that while the CIP application process meant he had to read the Community Insight Profile, 'that then benefits me when I'm writing another application…this is current findings, feedback from the residents, that I can then reference…in my applications for larger grants.'

More tangibly, when asked what would have happened to their activities if they had not received WT or CIP funding, 8 of the 26 explained that they would not have been able to offer the activity in any form, 5 of the 26 suggested they would have had to severely modify the activity or limit its reach, 10 were uncertain what they would have done, and 3 suggested they would have sourced funding from another area of their organization. This built on what organizations also report in terms of their key obstacles, not only in obtaining funding, but also simply in offering their activities: lack of sustained funding.

In terms of identifying general challenges, while some organizations noted difficulties with advertising and with recruiting trained volunteers, most frequently mentioned the value of sustained funding, that is, funding that is 'consistent'; 'security of funding'; or 'continued funding across multiple years'.

When fundraisers were asked what their biggest challenges were in terms of obtaining funding, two themes emerged. The first was increasing competition as funding sources decreased while charitable activity increased; as one fundraiser explained, 'When I started fundraising [10+ years previously], it was one in every four applications you made…was successful. Now it's 1 in 10, maybe sometimes 1 in 20…it's really competitive.'

The second challenge was sourcing funding that was described as sustained, 'regular', or continuous. This second theme, of a lack of sustained funding, is in many ways related to the challenge of a competitive funding landscape. Fundraisers observed that they needed to submit more applications, and more frequently, while also noting the drain on organizations when there was less certainty of continued funding. In particular, fundraisers noted that they were frequently challenged by demands for novelty, whereas they wished to prioritize sustainability and reliability. As one fundraiser explained:

> They [funders] often want it to do new things, while what we want is the continuity of our priority projects, to provide consistent support to our community. There is the insecurity of being able to run long term projects. One of our values as a charity is longevity. We believe that estates like [local ward] need long term support. They don't need drop-in projects that run for six weeks and never again.

Likewise, one fundraiser identified struggling with funders focusing on novelty, especially prioritizing 'new groups,' while another noted that frequent policy changes encouraged funding changes without taking account of what was already working.

Organizations funded through WT and CIP grants therefore generally agree that their funding procedures are straightforward and efficient, with small differences between CIP and WT funding in terms of time scale and process, relating to the size of grants. Organizers recognize the usefulness of quantitative data in assessing community health and wellbeing activities but also emphasize the importance of qualitative evidence in capturing and conveying effectiveness. Although the majority of fundraisers have multiple years of experience in charitable fundraising, they do not necessarily identify as 'expert' fundraisers. They agree, however, that one of their key priorities – and key challenges as charitable organizations – is obtaining sustainable and reliable funding.

4.5 Community Residents

Although CHDO and WT funded activities only started late in this evaluation, we were able to conduct pilot fieldwork in five community groups, and gather feedback from a number of participants. Given that this only provides observations on those who participate in such

activities, analysis is necessarily limited. Nonetheless, this initial survey suggests that residents engage with such activities, and rely on them for a variety of types of support.

For example, the Rose Hill Community Cupboard, which runs weekly, 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.

Likewise, arts and crafts sessions organized by the Iraqi Women Art and War (IWAW), an activity coordinated by one individual and in receipt of grants from both the CHDO and WT programmes, 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.

Bridge Street Community Garden activities (Banbury), December 2024,
from Bridge Street Community Garden Instagram

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 located 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.

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.

Barton Coffee Morning, November 2024,
from St Mary's Church Barton Facebook

Participants were, unsurprisingly, generally unaware who funded the events they attend, and also were unconcerned with official titles of organizers – such as whether someone was a CHDO or CCB. Instead, most relied on first names. At the same time, it is clear that **one community event – such as a coffee morning – provides direct access to other events, whether 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.'[35] 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.**

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

5. Discussion and Recommendations

The CHDO and WT programmes demonstrably succeed in fulfilling their stated aims and objectives, whether measured by grant allocation data or by community relationships. Individual CHDOs and CCBs show themselves to be part of local communities, with a strong presence in each neighbourhood and working in partnership with residents as well as established community organizations. In particular, our phase one research identifies that CHDOs and CCBs contribute to the building and strengthening of community health and wellbeing capacity in the ten priority wards through regular presence in community activities; excellent communication and networking skills; and active partnerships with existing organizations and networks.

The CHDO and WT programmes draw on the Community Insight Profiles in their activities, as demonstrated in the application of CIP criteria in scoring grant applications. In terms of grant allocation, the result has been the financial support of over 100 community organizations via 196 community health and wellbeing activities (WT and CIP combined), with £1 125 715 total funding allocated via an average grant of £5 743 per activity (£2 530 per CIP grant and £7 934 per WT grant). Yet, as analysis of CHDO and CCB community engagement demonstrates, financial data are only the most easily (quantitatively) measurable part of the programmes' activities, akin to the iceberg model of what is visible in public and community health.

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.[36] Indeed, British research on health care and cost effectiveness notes how little is spent on prevention (recently estimated at 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), rather than more nebulous concepts such as wellbeing or physical activity. Recent papers have thus called for identifying and classifying

[36] 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.

preventative expenditure as its own category within UK government budgets as a way to highlight and secure investment in prevention through improved accountability.[37]

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.[38] 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'.[39]

At the same time, research that outlines the value of what is loosely termed community social capital – 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 is now analysed at group level and also comparatively, whether by demographics, geography, economy, ethnicity, gender, or culture. At the same time, population health is understood in relation to social infrastructure and community resilience.[40]

[37] E.g. Demos, *Counting What Matters* (2024).

[38] 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.

[39] 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.

[40] 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).

Research and experience thus demonstrate that investment in preventative health services and social infrastructure more broadly is substantially cost effective.[41] This is in part because responsive and acute medical care is more expensive than public health interventions, but also because public health interventions avoid so-called preventable demands on public services. Social prescribing is an example of an increasingly-widespread intervention that reduces demands on NHS services. 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.'[42] To build and maintain trust, relationships are crucial. 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.' In reality, 'We cannot deliver more effective services, improve lives, generate better outcomes and save money through disparaging the importance of relationships.'[43]

Our evaluation builds on longstanding research that recognizes the social aspects of public health, and particularly the role of social relationships in achieving and maintaining successful public health interventions. 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. 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.

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

[41] E.g. Frontier Economics, *The Impacts of Social Infrastructure Investment* (2001).
[42] Demos, *The Preventative State* (2023), p. 17; on social prescribing: NASP, *The Impact of Social Prescribing on Health Service Use and Costs* (2024).
[43] Demos, *The Preventative State* (2023), p. 20.

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, as demonstrated in section 4.5. 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 such material or technological transfers.'[44] 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 (a minimum of 66%, n=130) 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.[45] We therefore recommend that health programmes take a longer-term approach to avoid the cycles of intervention that characterize 'parachute science',

[44] Szreter and Woolcock, 'Health by association' p. 663.
[45] 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.

which can lead to community indifference or even mistrust towards health initiatives. While policy-makers may have only short-term recall, communities have long-term memory.

We also encourage attention to community engagement among males, as preliminary 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. Approaches to community health and wellbeing should thus take account of gender norms, alongside other social and cultural factors.[46]

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.

[46] See also Healthwatch Oxfordshire's 'Hearing from men in Oxfordshire' 2025 research report.