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Bridging Research, Policy and Communities: The Community Areas of Research Interest Model

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Abstract

Introduction

Bradford's Health Determinants Research Collaboration (HDRC) has pioneered a novel approach to shaping its research agenda by including the voices of its residents and communities on topics around the wider determinants of health so that research carried out in Bradford District is useful, relevant and appropriate to the needs of its citizens. Areas of Research Interest (ARIs) are a policy-research interface tool gaining traction throughout all levels of UK government. To date, community priorities for research have not been integrated into ARIs systematically, despite research being intended for community benefit. Currently no previous evidence has been identified to show combining ARIs across these stakeholder groups or involvement of communities in ARI development. To address this gap, while formulating the Council's ARIs, Bradford HDRC integrated community voice into ARIs through the co-production of Community Areas of Research Interest (C-ARI).

Methods

A mixed methods participatory design was used. Ten community priority workshops were conducted across five Bradford constituencies (n = 153), using purposive selection of underrepresented communities. Participants represented a diverse cross-section of residents engaged through community, voluntary, faith, and social settings. Public Contributors from each constituency were recruited and trained to facilitate participation and leverage grassroots knowledge, supported by council neighbourhood teams. Workshops employed individual dot voting, group diamond ranking, and facilitated discussion to prioritise research area groups (RAG) linked to the wider determinants of health. Quantitative ranking data were aggregated across workshops, while qualitative field notes were subject to structured thematic analysis. Findings were triangulated to generate final C-ARI themes. A subsequent question generating session (QGS) was convened inviting representatives from all groups to co-produce actionable research questions.

Results

Fifty percent of participants ranked crime and safety as a top priority, followed by cost of living and access to education. The QGS generated thirty community-driven research questions under eight research area groups. Local authority and community priorities were amalgamated to create district level ARIs.

Conclusion

This exercise demonstrates the value in systematically embedding community priorities within ARI development and that complex and competing priorities can be successfully aligned for policy, practice and community impact.

Plain English Summary

Bradford Health Determinant's Research Collaboration (HDRC) has used a new approach to setting its research priorities by including the voices of its residents. Community and local authority priorities were combined to create district level Areas of Research Interest (ARI). ARIs were created to connect researchers and policymakers, so that research can help improve services, however this process so far has not included the voice of communities. We worked with public contributors to run 10 community-based workshops with people whose

views are not often heard, including those in voluntary, faith and community groups. Using dot voting and diamond ranking, residents ranked the issues that mattered most to them around topics on the wider determinants of health such as education, housing and transport. We then held a second session where communities coproduced research questions based on these priorities.

Fifty percent of residents ranked crime and safety as a top priority, followed by cost of living and access to education. As a result of the question generating session, we now have a list of thirty community-driven research questions under eight priority areas for Bradford District. This exercise shows the value in systematically speaking to communities to shape research agenda's so that research carried out is relevant to its communities.

This paper describes our approach of creating our community areas of research interests and combining them with council priorities for policy, practise and community impact. We share our methods and lessons learned offering recommendations for adopting and building on this work.

Background

Incorporating community perspectives into agenda-setting has become increasingly recognised as an integral component in how local governments define priorities and guide research and policy development [19, 30]. It enables policymakers to better understand how need is met or how forms of inequality can be addressed through policy. Moreover, the emergence of new approaches in governmental priority setting also needs to include community voices, especially at regional and local levels [8].

Simultaneously, the use of Areas of Research Interest (ARIs) has grown in popularity in the last decade, acting as a bridge between research and policy spheres [4]. ARIs detail some of the main research questions and areas facing UK government and creates a forum and regularly updated list of key priorities and research topics. Each government department now has a series of ARIs and there have also been significant investments in the creation of an overall national ARI database [4]. Additionally, ARI usage has been adopted across devolved government (e.g. Scotland and Wales), at regional and local levels, and by organisations and bodies alike [19].

The role of ARIs, however, at the local and regional level, is still being negotiated with significant investment and effort now placed in understanding how ARIs can shape and engage with local priorities [8, 38]. Campbell and colleagues argue the need to bring citizens and communities into research processes as genuine knowledge co-creators, rather than purely as subjects or beneficiaries in regionally framed ARIs [8]. Furthermore, community inclusion in priority-setting for research is essential to ensure outcomes are delivered that meet the needs of intended beneficiaries and this is integral to inform policy that looks to support the social and wider determinants of health [21].

Community-driven research agenda setting can move the social shaping and intervention approaches upstream, making evidence-informed research more democratic and better aligned with the moral obligation to serve the public interest [20]. However bridging community-driven agenda setting into the ARI structure, effectively adding the community in as contributing actors rather than recipients of the ARI agenda, remains underdeveloped. While ARIs have been widely adopted as tools to articulate policy relevant evidence gaps and guide research commissioning [29, 4], they have typically been formulated within government or organisational settings only. This study seeks to advance understanding of how community involvement can move beyond consultation to

actively shape research agenda setting and ARIs through the development of Community Areas of Research Interest (C-ARIs).

This study builds explicitly on existing Areas of Research Interest (ARIs) by extending their development beyond institutional and professional domains to incorporate community-generated priorities in a systematic and transparent way. While ARIs have been widely adopted as tools to articulate policy-relevant evidence gaps and guide research commissioning [29, 4], they have typically been formulated within government or organisational settings, with limited mechanisms for upstream community involvement. The Community Areas of Research Interest (C-ARI) approach developed through the Bradford Health Determinants Research Collaboration (HDRC) in Bradford, a diverse city in the North of England, complements and enhances established ARI models by introducing a participatory layer that shapes both the identification of priority areas and the framing of research questions themselves.

Rather than replacing existing programme-level ARIs, C-ARIs function as a connective framework, aligning lived experience with council-identified evidence needs and strategic objectives. In doing so, they strengthen the legitimacy, relevance and usability of ARIs as boundary objects linking community knowledge, policy priorities and academic research. This structured and replicable approach provides a mechanism through which community priorities can inform commissioned research and evidence generation within local government settings.

Although situated within a specific local authority context, the approach has international relevance. Many urban areas globally, particularly those characterised by socioeconomic deprivation, ethnic diversity and population mobility, face similar challenges in aligning research agendas with community need and policy action. The C-ARI model therefore offers a transferable framework for regions and cities seeking to embed community perspectives within place-based research agenda setting, particularly in health, social policy and urban governance contexts.

This paper first reviews the context of Bradford, England, then describes the organisation structures which produced both the general City of Bradford Metropolitan Council (CBMDC)'s ARI development and the concurrently created C-ARIs. Details of the methodology for C-ARIs is shared before reviewing both the results of the C-ARIs as well as an assessment as to the success and value of C-ARIs as a mechanism for community research agenda setting.

Context

Bradford is a large metropolitan borough in West Yorkshire, with a population of ~ 560,000 and one of the youngest populations in the UK. It is also one of the most deprived local authorities in England, ranking as 12th for deprivation, 4th for income deprivation and 5th for employment deprivation, with ~ 40% of children living below the poverty line and ~ 12% of working-age people not possessing qualifications [15]. In areas of Bradford city centre, women and men have an average of 49 and 51 years of healthy life expectancy, compared to 72 and 71 years in Wharfedale (~ 12 miles away) [33].

There have been recent, rapid developments in research regarding public health and the impact that local authorities can have on this, with an emphasis on understanding how the wider determinants of health intertwine to influence healthy life expectancy. The Dahlgren and Whitehead model developed in 1991 provides a framework for understanding how the social determinants of health, including education, employment, housing and living

conditions, play a role in compounding health outcomes in addition to a person's biological determinants (including age, sex and genetics) [39]. These wider determinants of health vary by location, with some local authorities showing higher levels of determinant-specific deprivation than others (Table 1).

Table 1
Statistics pertaining to the determinants of health comparing Bradford with the national average for England.

Bradford	England Average
135.5 fast food outlets (per 100,000 population)	115.9
15.9% of people living in fuel poverty	11.4%
28.6% economic inactivity rate	21.2%
54.2 violent offences (per 1,000 population)	31.4
5 sexual offences (per 1,000 population)	3.1

Given the influence that local authorities have over the wider determinants of health, they are well placed to lead and take part in research to understand and address these issues [28]. Previous endeavours that Bradford Council has been part of include the implementation and monitoring of a Clean Air Zone in Bradford, decreasing nitrogen dioxide (NO2) levels in specific areas of Bradford that exceeded the average air quality objective of 40µg/m3 [10]. A relatively recent initiative launched in collaboration with Bradford Council and its Living Well programme seeks to address food insecurity through the launch of a voucher scheme where families and individuals can purchase fresh fruit and vegetables from some of Bradford's markets, including the recently developed Darley Street Market [25].

Bradford HDRC - Areas of Research Interest

Health Determinants Research Collaborations (HDRC) were established in 2022 through National Institute for Health and Care Research (NIHR) funding to strengthen the Council's capacity to use high-quality research and evidence in decision-making. As part of a national programme of place-based HDRCs embedded within local authorities, it brings together Council services, communities, and academic partners to address the wider determinants of health and reduce inequalities as a core function of Council activity.

In parallel with the development of C-ARIs, work was carried out to identify Bradford Council's ARIs [6], by working with local authority staff to guide its research agenda and evidence generation. By working in this concurrent way, we demonstrate an applied model for aligning community defined priorities with institutional ARIs, addressing a recognised gap in ARI development where upstream community engagement has been limited.

The Council ARI development involved interviewing senior members of staff from each of Bradford Council's directorates of Adult Social Care, Housing, Place, Public Health, Children's Services, the Children and Families Trust, Corporate Resources, and Employment and Skills (n = 10 departments). These interviews asked officers what their evidence gaps were, their most important objectives, and what research projects they deemed to be irrelevant to their directorates. Interview notes were analysed and filtered to remove evidence gaps that were well understood in the literature and objectives that would not be met with the acquisition of further evidence. The resulting ARIs are broadly centred around the themes of economy, child poverty, young people, homelessness,

prevention and housing. These ARIs underwent a series of reviews, including by the Council senior leadership team, to understand how urgent addressing each evidence gap was, and were then listed in order of most urgent to least urgent.

The process for the C-ARIs however was developed in line with an ethos of participatory research and meeting communities 'where they are at' rather than requesting they step into a Council-based ARI development structure. Participatory methods such as citizens' juries, deliberative forums, photovoice, storytelling, and ranking techniques are widely used to surface community knowledge, foster dialogue, and redistribute power in research priority setting. Together, they underscore the value of diverse, innovative approaches to address societal challenges and enable meaningful engagement [13], informing the methodological choices in this study.

Methods

Study design

A mixed-methods, participatory design was used to prioritise community research area groups (RAG) relevant to the wider determinants of health. The design combined structured, quantitative prioritisation activities (dot voting and diamond ranking) with qualitative data capture of participants' views and lived experiences through facilitator field notes and participant post it notes.

Development of the prioritisation framework

The prioritisation framework was created by qualitative analysis of text within a series of local reports and research studies (n = 16) to derive an initial list of research area groups (≈ 12 RAG) spanning the wider determinants of health. This was done to synthesise existing evidence on what communities had already spoken about to use as a launch point for workshops. Clinical and medical factors were considered outside scope and were therefore excluded to enable focus on wider determinants, an area within the remit of local authorities and associated with upstream influence.

Documents were then thematically analysed by two different reviewers, with specific phrases and comments extracted into Microsoft Excel using the Macros function, to discern the nature of the initial themes. The group of document reviewers (n = 6) consisting of a mix of HDRC and research staff met to discuss the data extracted and additional RAGs were included to ensure no important areas were overlooked, as the reports tended to focus solely on topics under discussion. With unanimous consensus topics were narrowed down to a list of 12 RAGs to take forward; Adequate Housing, Access to Education, Community Led Services, Cost of Living, Crime & Safety, Employment & Skills Provision, Food Access, Inclusion & Belonging, Leisure and Sports Facilities, Neighbourhoods & the Environment, Parks & Green Spaces, Transport.

This list served as the starting point for community prioritisation, with flexibility for participants to add locally salient topics during sessions.

Diamond Ranking

The diamond ranking method was used to generate discussion and reach a consensus on up to nine priority areas, the maximum number possible for the diamond formation. Also known as 'Diamond 9', this method is an established collaborative ranking tool used in schools, workshops or meetings to gather opinions and ideas from a group of participants [32, 27], allowing participants to express priorities based on lived experience (Clark, 2012). This is not a linear ranking list, rather items are ranked in order of priority, whilst allowing for equal weighting of some. It is a useful tool for understanding the most important issues as well as the lower priority areas reflecting community readiness[14]. The method encourages active participation and provides insights into value positions regarding collaborative working.

We adopted an approach that extracted the top three priority RAGs from each workshop (detailed below) (n = 10), avoiding consensus-based tallying methods such as the Borda count. This ensured that the perspectives of marginalised or smaller groups remained visible and were not lost within aggregate rankings dominated by larger groups.

Participants and Sampling

A total of ten in-person workshops were undertaken within community, voluntary, faith and social settings across the five Bradford District constituencies with two workshops in each, during the summer of 2025.

We employed purposive sampling to engage a diverse cross-section of residents (n = 153), with intentional outreach to seldom-heard, under-represented and historically over-excluded groups such as minority ethnic communities, carers, the elderly and young people to support deeper inquiry[34, 31]. Recruitment was conducted via HDRC PCs, local organisations, community groups and Local Authority neighbourhood teams to ensure broad reach and contextual relevance. Organisations and resident participants were offered recognition payments to acknowledge time and expertise and to reduce participation barriers. Participants were provided with information sheets and gave informed consent.

Public Contributors and Facilitation

Five Public Contributors (PCs) living or working in each constituency were selected, trained and paid to co-facilitate workshops alongside HDRC staff, Council neighbourhood teams and VCSE development workers. Bradford HDRC created a newly formed payment process to pay PCs by BACS, rather than traditional payment via vouchers, due to the longer-term nature of the work. PCs leveraged local insider-knowledge and relationships to support inclusive participation [22]. Facilitators were briefed to remain neutral, clarify terms when needed, uphold psychological safety, and avoid introducing opinions that could bias prioritisation. Group leads for each setting were also present throughout workshops to support participants and ensure appropriate power balance within sessions.

Workshop Procedures

Each workshop followed a standardised protocol:

1. Sense-check and topic reduction (individual dot voting)

Participants received nine stickers to individually allocate across the ~ 12 RAG cards formulated in the framework development. Cards with the highest cumulative dot counts were retained, yielding nine areas to take forward, the maximum number required to formulate the diamond. If multiple cards received the same number of votes and exceeded the limit of nine, a quick re-vote was held to determine which cards to retain.

2. Prioritisation (group diamond ranking)

As a group, participants arranged the nine selected areas into a diamond formation reflecting relative importance: one card at rank 1 (highest priority, P1), two at rank 2 (P2), three at rank 3 (P3), two at rank 4 (P4), and one at rank 5 (P5). Rankings were reached through facilitated discussion and consensus building. Once the nine RAG were selected, participants were given up to three additional blank cards to add any additional areas they felt were important but not included in the initial group.

3. Constituency data check and revision opportunity

Constituency-specific contextual data on population demographics and social determinants of health (topics: relative child poverty, country of birth, crime and safety, disability, ethnicity, household composition, housing tenure, population by age, qualifications, road casualties and Universal Credit claimants) identified from the evidence synthesis were presented to participants. Data were obtained from the House of Commons Library [37] which was collated from the ONS Census [40]. A series of captioned videos and transcripts were created presenting key statistics for each constituency and shown to participants. Each video followed the same format so that participants all had the same information about relevant factors affecting the area and could change their ranking based on what was presented to them.

4. Deep dive on top three priorities

Focusing on the top three ranked positions (rank 1 and both rank 2 positions), participants identified challenges within each area. Prompts included challenges affecting (a) the community; (b) themselves or people they know; and (c) perceived root causes. Ideas were noted on flip-chart paper and post-it notes. Dot voting was then used to select the top three challenges for each priority area.

5. Ideas for addressing identified challenges

Participants proposed potential ways of addressing the selected challenges at individual, community, and district levels, and recorded them on post-it notes. Group discussion and dot voting were used to identify the top three actionable options (expectations were managed to avoid ‘over promising’).

Data Collection

PCs and Research facilitators captured: (a) field notes documenting key reasons for card placement, contested issues; (b) photographs of diamond layouts and flipcharts/post-it notes at agreed pauses; and (c) anonymised, optional participant demographics (gender, ethnicity, and age category). Outcomes for each workshop were captured of final diamond positions, voting tallies for top 3 challenges (n = 9) and solutions (n = 9) for P1 and P2 RAG.

Data Management and Governance

A Data Protection Impact Assessment (DPIA) screening revealed that a full DPIA was unnecessary as no personal identifiers were collected. Privacy notices were clearly displayed, photo consent was obtained and PCs were accompanied by Council or HDRC staff following community host organisations' safeguarding procedures. As this work was undertaken to inform policy and research agenda setting, rather than as formal academic research, formal NHS or university ethics approval was not required, in line with UK practice. Instead, a proportionate governance approach was used incorporating informed consent, safeguarding and data protection measures.

Consistent with current guidance, we adopted an 'ethical anchor' approach to support co-production, ensuring all activities adhered to ethical and safeguarding principles without relying on formal approval processes that may hinder public involvement, particularly in non-academic settings where processes are not readily available [36].

Data Analysis

An integrated analytic approach was used with both quantitative ranking positions and qualitative notes generated through workshops. Themes were inductively derived from participant-generated post-it notes, PC facilitator field notes, and photographic documentation of ranked RAG for P1 and P2 positions.

Quantitative synthesis: Diamond positions were aggregated within and across workshops to identify consistently high-ranked areas and to compare patterns across constituencies. Each ranking position was given a score; 5 for a P1, 4 for a P2 and so on.

Qualitative analysis: Field notes and photographic records were subjected to rapid, structured thematic analysis to capture rationales for prioritisation, perceived root causes, and access barriers. These data sources were organised into a tabular format (Microsoft Word) to ensure transparency in the coding process. An evidence synthesis workshop took place with the five PCs to sense check findings and ensure accuracy of the data reflecting workshop discussions.

Triangulation and consolidation: Quantitative priority patterns were triangulated with qualitative RAG to generate the final set of data to carry forward to the next phase; the academic led question generating session to coproduce C-ARI questions.

Question Generating Session

Following completion of the community workshops, an academic led question generating session (QGS) was convened to translate the priority areas into actionable research questions. Representatives from community groups who had participated in the workshop phase were invited, alongside individual residents, resulting in over 40 participants contributing to this stage. Each table was supported by a trained facilitator, assisted by HDRC PCs, to guide discussions, ensure inclusive participation, and assist in shaping participants' ideas into focused research questions.

The research team presented a synthesis of the themes and insights generated during workshops. Community members then took part in an 'evidence safari', a structured, interactive activity designed to ensure all attendees were fully immersed in the breadth of findings before co-producing research questions [9]. The evidence safari involved a series of themed stations around the room; a visual representation of the ranked priority areas, collated data for each RAG area, including anonymised participant quotes, summaries of key challenges identified and suggestions for what should be done. Small groups moved between stations at timed intervals, reviewing the evidence, discussing the implications, and annotating the materials with reflections, questions, or gaps they felt

were important. This process enabled participants to validate the themes, deepen their understanding of district-wide patterns, and bring forward additional lived-experience insights that had not been explicitly captured in earlier phases.

Reflexivity and Rigour

This study was conducted as a participatory process embedded within an ongoing partnership between the local authority, the Bradford HDRC, PCs and community groups. Researchers therefore occupied dual institutional and facilitative roles, creating potential power asymmetries that could influence participant engagement and prioritisation.

To mitigate this, workshops were co-facilitated by locally embedded PCs and Council or VCSE staff to support more equitable participation. Reflexivity was embedded in our procedures through a participant-validation step (post-data presentation) allowing participants to revisit and revise rankings, and through validation of findings by PCs during the analysis phase. Although data capture relied on facilitator field notes rather than transcripts, triangulation across notes, voting outputs and photographic records helped mitigate individual interpretive bias.

Results

A total of eight research area groups were identified as top priorities, by combining P1 and P2 scores from all 10 workshops in order of importance: Crime and Safety, Cost of Living, Access to Education, Employment and Skills Provision, Neighbourhoods and the Environment, Inclusion and Belonging, Transport, Adequate Housing (Figures 1 and 2).

The qualitative insights revealed clear community concerns with residents highlighting challenges including easy access to drugs, road safety concerns, cost of university, and the mismatch between wages and rising living costs. They described how multiple pressures “fit together like a jigsaw,” with the cost of living seen as driving a range of issues, including increased shoplifting and wider financial strain. Communities also highlighted language barriers and limited awareness of available English provision, alongside concerns about safety, identifying certain areas as “no-go” zones, particularly at night, and a lack of accessible public spaces for women. Experiences of anti-social behaviour were commonly reported, with perceptions that law enforcement responses were insufficient. Participants gave examples such as children playing in the streets causing disturbance as well as a lack of free and accessible leisure and sports facilities, particularly for young people and families.

Suggested actions included improving police visibility, implementing a living wage, introducing life-skills education in schools, and increasing fines for littering. Participants also emphasised the importance of community-led initiatives, such as intercultural events to build cohesion, reduce fear and address anti-social behaviour through positive community-driven campaigns.

The integration of ranking data and qualitative analysis, alongside the subsequent QGS process, resulted in the creation of thirty broad Community Areas of Research Interest (C-ARI) questions, with corresponding granular level sub questions reflecting the lived experience of Bradford District residents across the final eight RAG headings. These questions were then refined to the Bradford District Plan strategic outcomes; Growth and Regeneration, A Great Place to Grow Up, Happy and Healthy People, and Safe and Strong Communities, ensuring direct relevance to local policy priorities and to replicate the process taken for Council staff ARIs.

The two sets of ARIs, Council staff and communities were mapped to identify areas of overlap. Approximately nine questions showed some similarities; however, the overlap was relatively limited.

Discussions

This study set out to examine whether, and how, community priorities could be meaningfully integrated into the development of Areas of Research Interest (ARIs) via the creation of Community-ARIs; the goal being to shape a local government health determinants research agenda with clear relevance for policy and practice. Drawing on a two stage, participatory process (community-based prioritisation workshops followed by a co productive question generating session) we developed a set of Community Areas of Research Interest (C-ARIs) that now inform Bradford District's wider ARI framework. In doing so, we extend existing ARI models by trialling a structured mechanism through which community knowledge can actively shape research priorities, rather than being consulted retrospectively or symbolically. Despite the additional time and cost associated with working with paid Public Contributors and co-designing each stage of the C-ARI process, the resulting questions, along with the enhanced rigour, legitimacy, and overall quality of the outputs, demonstrate the value of this approach.

C-ARI Development Processes

Our findings demonstrate that the combination of individual dot voting and group diamond ranking functioned as an effective and inclusive prioritisation mechanism. This approach balanced individual agency with collective deliberation, helping to mitigate the risk that louder voices or larger groups would dominate decision making processes. The intentional choice to extract the top three priority research area groups (RAGs) from each workshop rather than relying on aggregate scoring methods proved important. It ensured that priorities strongly endorsed by smaller or marginalised communities were not diluted or erased during synthesis. For example, inclusion and belonging emerged as a top ranked priority within specific communities and would likely not have featured in the final eight areas had conventional consensus-based ranking been applied.

The findings reinforce wider participatory research literature that cautions against purely aggregative approaches to priority setting, particularly in contexts marked by structural inequalities [23]. By designing the process to retain difference as well as convergence, the C-ARI framework preserves minority perspectives while still identifying district wide patterns of concern.

Findings highlight the importance of treating co-production as an iterative, multi-stage process rather than a single event. The initial workshops enabled communities to articulate and prioritise issues grounded in lived experience, while the subsequent question generating session created space to collectively translate these priorities into actionable research questions. The 'evidence safari' within the question generating session was especially valuable, allowing participants to reengage with synthesised findings, validate interpretations and deepen collective understanding before generating questions.

This sequencing helped address a common tension in participatory research whereby participants tend to revisit challenges rather than move towards researchable questions. Having trained facilitators and academics supported participants to make connections between lived experience, existing evidence gaps and researchable questions, whilst avoiding steering the priorities. Our experience suggests that without this second stage, community priority setting risks stopping short of informing fundable or policy relevant research.

Relational Outcomes and Advantages of C-ARI Process

Beyond the formal outputs, the C-ARI process generated important relational outcomes. Participants consistently reported positive experiences of involvement in research, increased trust in the Council and the HDRC, and a greater willingness to engage in future research activity. These outcomes are particularly significant given longstanding evidence of mistrust and under representation of seldom heard communities in research [17]. Conducting sessions in familiar community venues, offering recognition payments, supporting participation in community languages, and involving locally embedded Public Contributors all contributed to reducing barriers and reshaping perceptions of research as extractive or inaccessible.

These relational gains should not be viewed as peripheral. Trust, legitimacy and ongoing relationships are foundational to evidence informed policymaking, particularly where research seeks to influence action on the wider determinants of health. By embedding community involvement at the agenda setting stage, the C-ARI approach helps establish research as something that is shared rather than an institutional exercise. Community groups and PCs were re engaged at multiple stages to review and shape emerging outputs, establishing a clear feedback loop that demonstrated how community input informed final decisions, supporting trust building through visible recognition of contribution.

While formal ethics approval can offer important protections in experimental or high-risk research, applying such processes to this work would likely have constrained responsiveness, limited access to trusted community spaces, and introduced delays incompatible with local policy cycles. A proportionate, governance led approach allowed the ethical principles of autonomy, beneficence, inclusion and justice to be upheld while remaining responsive to community and organisational realities.

ARI and C-ARI: Overlaps, Divergences and Value-added

Importantly, the resulting C-ARIs do not operate as a single, static list. Instead, they represent a layered framework comprising broad research areas aligned with strategic policy ambitions, alongside more granular, lived experience driven questions. This hybrid structure responds to the limitations of “one size fits all” approaches to research prioritisation and reflects the reality that local policy challenges are complex, contested and context specific. For policymakers and researchers, this offers a more nuanced and adaptable model for agenda setting that recognises multiple forms of expertise and knowledge. This exercise identified limited overlap (approximately nine questions) between the priorities of the two stakeholder groups, highlighting the importance of working with both, to develop a holistic understanding of district-wide priorities.

Limitations

Several limitations warrant reflection. First, while the sample size (n = 153) provided breadth across constituencies and communities, it cannot capture the full diversity of perspectives within Bradford District. Second, despite the use of a standardised workshop protocol, sessions necessarily varied in pace and emphasis to accommodate language needs, accessibility requirements and group dynamics. Such flexibility is a strength of inclusive practice but poses challenges for methodological uniformity.

Third, data capture relied on field notes produced by multiple facilitators, introducing variation in style and depth of qualitative recording. While triangulation and post session sense checking helped mitigate this, the resulting analysis does not constitute deep qualitative inquiry. The C-ARIs are intentionally framed as research questions rather than exhaustive accounts of community experiences.

Finally, the initial evidence synthesis revealed uneven availability of existing research across different wider determinant domains, with substantially less information available outside health and care. This reinforces the importance of ARIs, and particularly C-ARIs, as tools for surfacing under researched areas where policy need outstrips the current evidence base.

Conclusion

This study offers practical insights for local and regional governments, research organisations and funders seeking to strengthen the relevance and legitimacy of their research agendas. It demonstrates that community informed ARIs are feasible, valuable and adaptable, but require investment in facilitation, time and relational work. Co-production is neither quick nor tidy; however, the richness, credibility and usability of the resulting research priorities justify this investment. Furthermore, the adoption of these C-ARIs by the Bradford HDRC as a research agenda-setting tool (in conjunction with the other Council-developed ARIs) establishes precedence for institutional usage of C-ARIs, with this study's reporting advancing the ARI and C-ARI disciplines.

The principal contribution of this study lies in advancing ARIs as hybrid boundary objects that connect community experience, policy needs and academic research agendas. While ARIs have been widely adopted across national and devolved governments as a means of articulating policy relevant evidence gaps, they have largely been developed within institutional and professional spheres [4]. Evidence on systematic community involvement in ARI development, particularly at the local or regional level, remains limited. Our findings address this gap by showing how participatory methods can be embedded upstream in ARI formation, not only shaping topic areas but also influencing the framing of research questions themselves.

In conclusion, this study shows that systematically integrating community perspectives into ARI development can reshape research agendas in ways that are more equitable and policy relevant. By positioning communities as knowledge co-creators rather than consultees, the C-ARI approach strengthens the link between evidence, policy and lived experience. Future research could explore how C-ARIs influence subsequent commissioning decisions, research outputs and policy uptake over time, and whether similar approaches translate to other geographic or governance contexts. Comparative studies across different localities would be particularly valuable in assessing how community informed ARIs function in areas with differing demographic profiles and institutional capacities.

Abbreviations

ARI: Area of Research Interest

C-ARI: Community Area of Research Interest

HDRC: Health Determinants Research Collaboration

PPI: Patient and Public Involvement

PPIE: Patient and Public Involvement and Engagement

QGS: Question Generating Session

RAG: Research Area Group

UK: United Kingdom

Declarations

Human Ethics and consent to participate

This work was undertaken to inform policy and research agenda setting, rather than as formal academic research, consequently formal NHS or university ethics approval was not required, in line with UK practice. The activity focused on identifying and prioritising community research interests through co-production and public involvement rather than conducting research on participants. Instead, a proportionate governance approach was used incorporating informed consent, safeguarding and data protection measures.

Consent for publication

N/A

Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Competing interests

The authors declare that they have no competing interests.

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n/a

Authors' Contributions

SD led the C-ARI work, designed and planned workshops, selected and trained public contributors, synthesised existing local data to create original list of Research Area Groups (RAG), monitored and evaluated workshop findings, refined final C-ARI questions, Led the writing of the C-ARI paper and wrote methods and results section as well as notes for discussions.

CD carried out evidence synthesis of qualitative data to form original RAG list of Research Area Groups; collated statistical data from the ONS for each Bradford constituency, and created videos for use at workshops; carried out quantitative analysis of data rankings; produced data visualisations; contributed to the qualitative and qualitative methods sections of the paper; drafted and commented on other sections.

AF - Evidence synthesis of existing data to form original RAG list, workshop design, led question generating session evidence safari, supported workshop analysis themes, wrote introduction section of paper.

KK – Evidence synthesis of existing data to form original RAG list, workshop design, supported workshop analysis themes, facilitation and editing of paper.

FP – Oversaw all aspects of the C-ARI work including question generating session and analysis and wrote discussions and conclusions section of paper.

CT – Evidence synthesis of existing data to form original RAG list, supported workshop design, analysis of findings and wrote background section of paper.

NK, JS, CB – Supported workshop design and delivery including question generating session facilitation, analysed workshop findings, provided comments on paper.

All authors read and approved the final manuscript.

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Figures

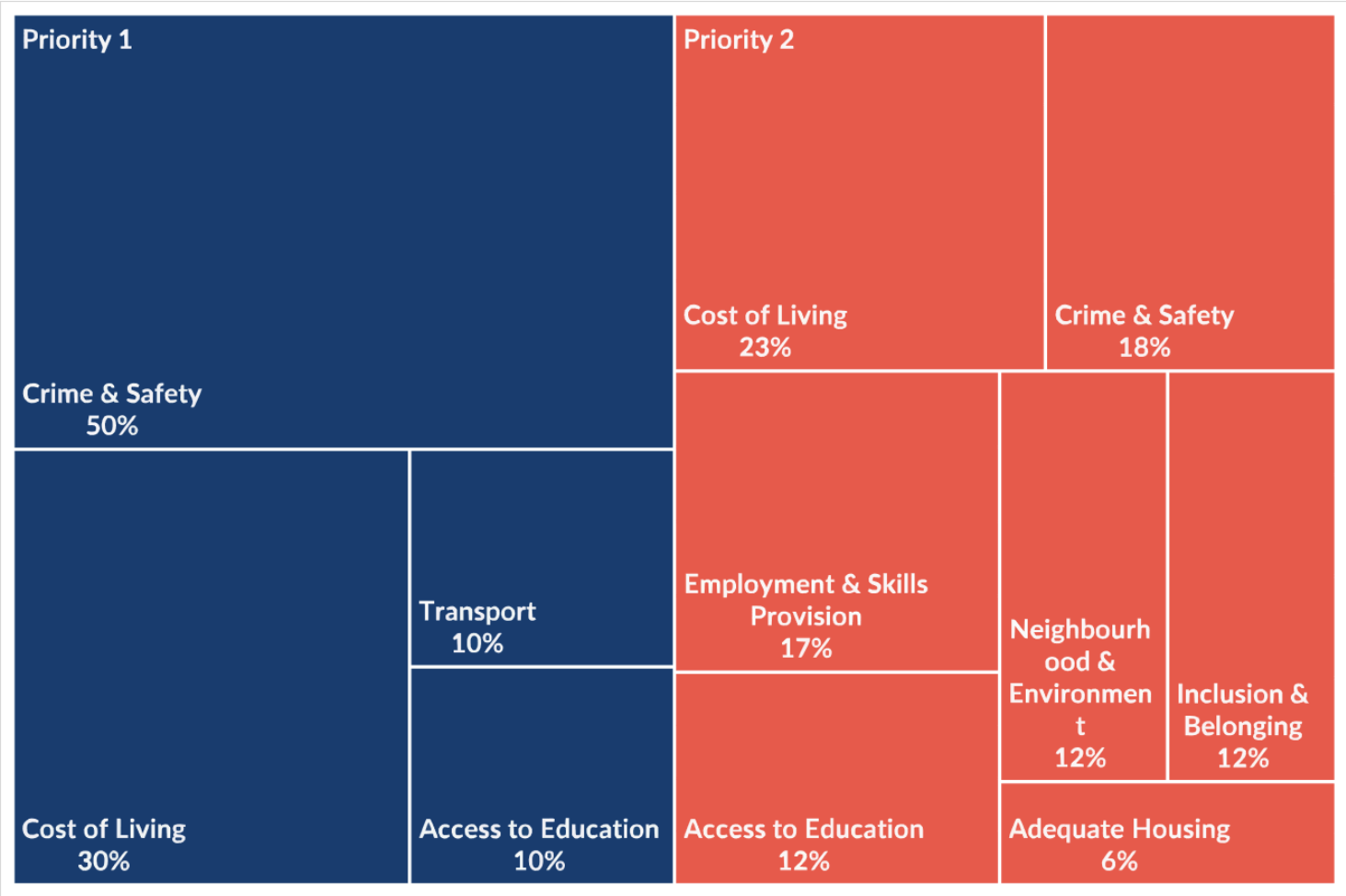


Figure 1

Separate P1 and P2 scores from community workshops

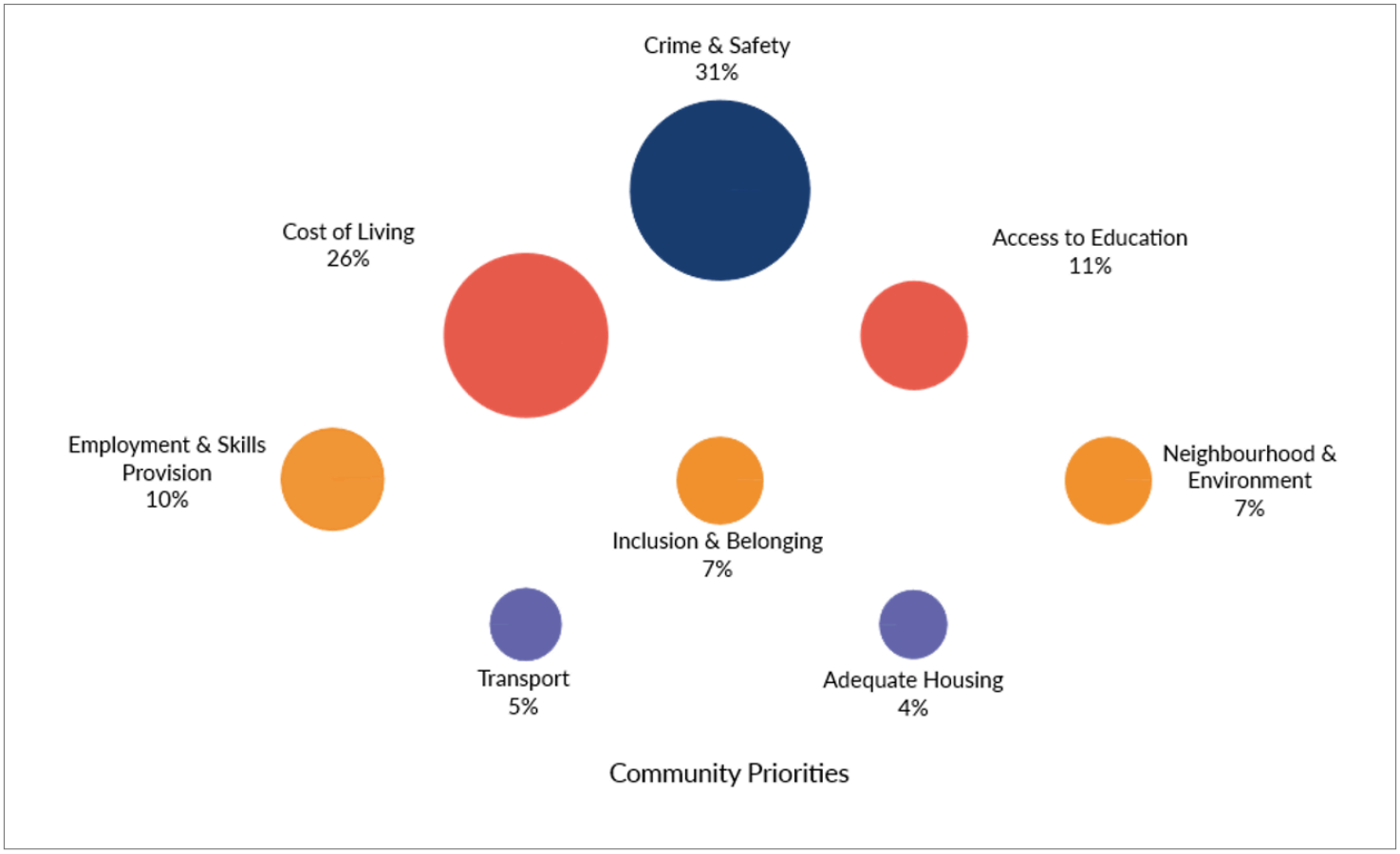


Figure 2

*Bubble diagram showing combined P1 and P2 scores * Percentages may not total 100 due to rounding.*

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