

Understanding Health Inequalities Through Community Voice: A Qualitative Synthesis of Community Insight Profiles in Oxfordshire

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Additional Declarations: Competing interest reported. Kate Austin is employed by Oxfordshire County Council, which led and funded the Community Insight Profile programme and related legacy programmes described in this paper. She was involved in the development, delivery and oversight of the Community Insight Profile programme, and in commissioning the University of Oxford evaluation referenced. The evaluation was co-funded by Oxfordshire County Council along with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board. Jon Hyslop is employed by Community Glue and Katharine Howell is employed by Healthwatch Oxfordshire; both organisations were commissioned to undertake community insight work that informed specific Community Insight Profiles. To manage any potential

conflicts of interest and reduce the risk of bias, the authors used publicly available reports as the data source, maintained records of coding and theme development and discussed emerging themes with Community Health Development Officers and public contributors as part of the validation process.

Abstract

Background

Oxfordshire is often described as healthy and affluent, yet local deprivation remains concentrated in particular neighbourhoods and is associated with poorer health outcomes. The Community Insight Profile (CIP) programme was established to combine quantitative intelligence with community insight and lived experience, to support place-based action on health inequalities. This study synthesises themes across CIP reports to provide an integrated account of reported needs and community assets.

Methods

We conducted a qualitative document analysis of 12 publicly available CIP reports using reflexive thematic analysis [10]. Reports were read repeatedly, coded iteratively, and data were extracted across common domains (e.g., deprivation and poverty, mental health, access to healthcare, food insecurity, housing, safety, social exclusion, and community assets). Emerging themes were discussed with stakeholders, including public contributors, to support validation.

Results

Recurring themes included barriers to accessing GP appointments, dentistry and mental health support; social isolation (including “hidden isolation”); cost-of-living pressures and food insecurity; poor or overcrowded housing; transport and built-environment constraints; and gaps in youth provision and SEND/neurodiversity support. Reports also documented local assets (VCSE organisations, faith groups, mutual aid, ladders, warm hubs, parks and community centres) and linked these to action-oriented recommendations.

Conclusions

The CIPs provide an asset-based, place-based evidence base that integrates community voice with local data to inform equitable planning. Future profiling should strengthen inclusive engagement to ensure under-represented perspectives shape priorities and action.

Background

The issue

Despite its overall profile as a healthy and affluent county, Oxfordshire contains significant pockets of deprivation within certain communities. The Community Insight Profile (CIP) programme was initiated in 2020 as a response to the Oxfordshire Director of Public Health’s 2019/2020 Annual Report ‘Some are

more equal than others' [1]. Data from the Indices of Multiple Deprivation (IMD) for England in 2019 identified 17 Lower-level Super Output Areas (LSOAs) in Oxfordshire that were within the 20% most deprived nationally and that these were situated within 10 wards in Oxfordshire (ONS 2019). The report identified that the communities within these areas were more likely to experience poorer health outcomes and so Oxfordshire County Council worked with partners to begin a programme of work to create a deeper understanding of what the enablers and challenges to health and wellbeing were for those communities, by creating a Community Insight Profile for each of these areas.

Why it matters

Inequalities are unfair and avoidable differences in health outcomes within society [2]. Key drivers of inequalities can include low income, poor housing, unemployment and limited education opportunities [3]. These living conditions are often referred to as the 'building blocks of health', they are the resources that we all need to enable us to lead healthy and fulfilling lives [4].

Oxfordshire has a strong track record of system wide support to tackle the drivers of poor health. Community research and listening to the voices of residents is encouraged and work most recently is being collated and channelled through the Oxfordshire Community Research network (OCRN). This push has come from communities themselves. Organisations such as Healthwatch Oxfordshire [5] and Oxford Community Action [6] had already started to pave the foundations for a more scaled-up approach to listening to communities. For many years much of the evidence on health inequalities was focused on a deficit 'needs' model. This emerging approach within public health and the partners that they are working with has reframed the discourse, shifting the focus towards community assets and existing strengths rather than deficits alone.

The impact

The development of the Community Insight Profiles (CIPs) marked a fundamentally new approach within these areas. The up-front legacy plans for this programme makes it different. Funds were identified early on to put in place resources to take forward the recommendations from the profiles, ready for when they would be completed. This included small grant schemes and funding for Community Health Development Officer posts. This approach allows community members to see tangible benefits resulting from their engagement more easily, reducing 'consultation fatigue'.

Wider impacts have been observed of the profiles being used to inform and guide resource allocation. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Well Together grant Programme focussed on the initial 10 wards. In Banbury, the profiles have contributed to the evidence needed to secure investment into play zone pitches. These numerous outcomes of the profiles have been reported in the recent Oxfordshire Director of Public Health Annual Report 2025/26 which reviews progress and developments 5 years on from the original report in 2019/20 [8]. The report highlights the collective progress in addressing inequalities and brings a call to action to sustain and

scale up focus and investment. The report has this year, for the first time, been published in the format of an interactive website with videos and other media that can be navigated independently.

Impact is also being measured academically by the Oxford Research Centre in the Humanities (TORCH) programme. The initial phase of the evaluation of the Oxfordshire County Council funded Community Health Development Officer programme and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) funded Well Together programme highlights the importance of establishing trusted relationships within communities, and cautions against the implementation of externally imposed, short-term initiatives (Oxford University, 2025). Phase two findings are expected to be published later in 2026.

The Oxfordshire data hub [8] holds the latest IMD data for 2025 and highlights that there are now 11 Lower-level Super Output Areas (LSOA's) in Oxfordshire in the 20% most deprived nationally (ONS, 2025). While causality cannot be inferred, these changes provide useful context for considering how targeted, place-based investment has developed alongside wider shifts in local deprivation patterns.

Legacy

The Community Health Development Officers were appointed to support each of the 14 areas where a CIP had been produced. They bring partners together around shared priorities and lead the delivery of the recommendations from the CIPs through a locally agreed action plan. Ring fenced grant schemes have also been established for each area to ensure there is seed funding to start taking forward some of the actions identified.

Further legacy has included the development of a dashboard and a community insight profile toolkit [8]. The dashboard enables partners and communities to navigate and access the data from the profiles in a more accessible way. The toolkit will enable other organisations to learn from the profiles that have been created and produce their own profiles and subsequent action plans to scale up this approach of capturing community insight and translating it into tangible actions with collective community involvement.

Marmot

The timing fits well with Oxfordshire becoming a Marmot place in 2024. A Marmot Place is an area that formally commits to reducing health inequalities by acting on the social determinants of health. The Institute of Health Equity (IHE) works directly with each place to support them to understand their own local drivers of inequality, review what is already happening, identify gaps, and strengthen system-wide action [9]. The Community Insight Programme has largely focussed on urban areas but there is recognition that there are pockets of hidden inequalities in rural communities in Oxfordshire. Supported by district council partners, Oxfordshire County Council has commissioned a rural engagement

programme which is being delivered by Healthwatch Oxfordshire and Community First Oxfordshire to understand more about some of the inequalities face by 14 of the rural areas in Oxfordshire.

The gap our research addresses

Historically, there has been a gap between the generation of community insight and its translation into changes in practice. To date, owing to the phased approach, the community insight profiles have largely functioned as stand-alone resources for each area. Partners have therefore been required to review each profile individually to develop their own interpretation of common themes and then apply local tailored solutions aligned to the specific needs for each area. This paper synthesises the key themes from the profiles, local narratives, and brings greater visibility of the importance of community-based work viewed through an academic lens. This paper also reinforces the importance of the community voice and lived experience, placing communities at the heart of finding their own solutions.

The study aims to explore the themes and narratives presented within the Community Insight Profile reports regarding the local health needs and availability of supportive community assets across these communities in Oxfordshire

Methods

Study design

This study used a qualitative document analysis approach, drawing on thematic analysis to examine the Oxfordshire Community Insight Profile reports. Thematic analysis was selected because it provides a flexible and systematic method for identifying, analysing, and interpreting patterns of meaning across textual data. This approach was appropriate for exploring how health inequalities, community needs, and wider determinants of health were represented within the reports.

Data source

The data consisted of 12 publicly available Community Insight Profile reports produced by a range of local partners in collaboration with Oxfordshire County Council within 14 areas in Oxfordshire[7]. There were 12 reports because two of the reports each cover two areas of Oxfordshire. These reports were treated as documentary sources and analysed as secondary data. The reports were selected because they provide area-based summaries of demographic, social, economic, and health-related information across local communities in Oxfordshire. Their relevance to the study lay in their focus on factors associated with population health and wellbeing, deprivation, access to services, and local inequalities.

Sampling and selection

The 12 Community Profile Insight reports included focused on local areas of interest and contained information related to community characteristics, health outcomes, social determinants, deprivation, housing, employment, education, safety, and access to services.

Analytical approach

The analysis followed the six-phase process of thematic analysis described by Braun and Clarke (2006) [10]. First, the reports were read repeatedly to develop familiarity with the data. Second, initial codes were generated (CN) by identifying segments of text that captured important features related to the study focus. Coding was primarily inductive, allowing themes to emerge from the content of the reports, although attention was also given to concepts linked to the wider determinants of health. Third, codes were compared and grouped into broader categories based on similarity and relevance. Fourth, these categories were reviewed and refined to ensure that they accurately reflected the data across the full dataset. Fifth, themes were defined and named to capture the central organising concepts within the reports. Finally, the themes were written up with supporting examples from the documents to demonstrate how they reflected patterns across the selected areas.

Coding process

Data extraction was conducted manually and iteratively by CN, JB and KA to extract comparable information across the following domains: Deprivation & Poverty, Poor Health Outcomes, Mental Health, Access to Healthcare, Food Insecurity, Physical Activity Barriers, Housing, Crime & Safety, Social Exclusion, Community Assets

Segments of text were assigned short labels that reflected their meaning, such as housing pressures, access to services, deprivation, social isolation, employment insecurity, or community assets. As coding progressed, related codes were clustered together and revised where necessary. This constant comparison helped to distinguish between overlapping issues and to develop themes that were internally coherent and clearly differentiated from one another.

Community Involvement

Emerging themes were presented and discussed at 3 stakeholder meetings to inform validation of the themes. The first workshop involved four Community Health Development Officers within Oxfordshire, the second workshop involved one public member involved in the development of a Community Insight Profile report from one of the Oxford city areas, and the second workshop involved a member of the public who attends a community activity in one of the areas profiled in the Cherwell area.

Trustworthiness and rigour

Several steps were taken to improve the trustworthiness of the analysis. Familiarisation with the full dataset helped ensure that themes were grounded in the reports rather than based on isolated extracts. An audit trail was maintained through coding notes and theme development records, allowing the analytical process to be traced. Reflexivity was also important, as the interpretation of documentary data is shaped by the researcher's perspectives and assumptions. Throughout the analysis, attention was paid to how prior knowledge of health inequalities might influence coding decisions, and themes were reviewed against the original reports to minimise overinterpretation.

Ethical considerations

As the study used publicly available council documents, formal ethical approval was not required. No personal or identifiable data were collected, and the analysis focused on area-level information already in the public domain. However, the reports were interpreted carefully and respectfully, particularly where they described deprivation, disadvantage, or vulnerable populations, to avoid stigmatising communities. No new participant data was collected during the analysis of the profiles.

Results

Characteristics of the Community Insight Profile reports

A rich tapestry of community voices, lived experiences, and structural realities emerged across the twelve Oxfordshire Community Insight Profiles (14 areas were covered in total, two of the profiles covered 2 areas) that were produced between 2022 and 2025. The CIP reports are co-produced by Oxfordshire County Council Public Health with district/city councils, Community First Oxfordshire, Healthwatch Oxfordshire, Community Glue, Oxford Hub and local VCSE and statutory partner steering groups. This multi-agency approach is explicit across the profiles.

Common Methodologies, Distinct Local Contexts

These reports span neighbourhoods with some of the most significant social and health inequalities in the county, between them drawing on hundreds of residents of different ages, identities and backgrounds through diverse methods. As expected due to the range of partners involved in creating the CIPS, they each take a slightly different methodological approach, but overall the CIPs programme aims to take a mixed-methods, Asset-Based Community Development (ABCD) model that integrates epidemiological/statistical indicators (e.g., IMD 2019, Census, QOF, OHID) with community insight and lived experience gathered via focus groups, one-to-one interviews, surveys, participatory events (e.g., the Barton Bash), and community mapping/asset scans. The CIPs follow a structured process of scoping existing insight, convening a steering group, engaging residents, synthesising findings, and translating them into actions. Most profiles adopt, a grounding insight in community strengths rather than deficits enabling a multidimensional view of neighbourhood wellbeing.

Areas Covered: Landscapes of Inequality and Strength

Each report focuses on one of the ten areas identified as containing Lower-level Super Output Areas (LSOAs) in the 20% most deprived nationally according to the 2019 IMD or one of the 4 areas in the last phase of the profile programme which included areas that contained LSOA's in the 30–40% most deprived nationally (IMD, 2019) and where local partners identified a need for a CIP to be produced. The profiles collectively map diverse settings, from dense urban areas and estates (Central Oxford, The Leys, Barton, Rose Hill, Littlemore, Berinsfield, Wood Farm), to expanding market towns (Bicester West, Witney

Central), and mixed industrial-residential zones (Banbury). Residents in these areas disproportionately face challenges with income, education, employment, housing quality, and access to services.

Populations Reached & Representation Gaps

The profiles made notable efforts to reach across demographic groups and capture a breadth of groups e.g., older adults, parents and families, children and young people, disabled residents/families of children with Special Educational Needs and Disability (SEND) and neurodiverse communities, ethnic minorities, migrants, volunteers, and faith groups. Many profiles often disaggregated by local composition (e.g., The Leys population 13,434 with higher proportions of Black (11.8%), Asian (10.7%) and Mixed (7.3%) residents and 46.8% social rent; Central Oxford shows 27% full-time students, high social renting, and pronounced transience).

Bicester West's insight sample was 96% White British/White and 80% female, raising risks of under capturing minoritised ethnic perspectives and male views in that ward; Witney Central consulted 167 individuals (72% female; 95% White British/Other White), which similarly warrants caution when extrapolating to more diverse groups. Conversely, Barton achieved broader ethnic reach (e.g., 34% White British, 32% Other White, and smaller shares Mixed/Asian/Arab/Black), but male participation was unusually high (reported 68% male vs 31% female), which may or may not reflect community demographics and therefore needs careful interpretation. Transient and highly mobile populations are variably represented: Central Oxford explicitly integrates students (27% of residents), people in communal establishments, and those experiencing homelessness with service mapping of Housing First, St Mungo's/OxSPOT, and winter shelter provision yet comparable granularity on street connected populations is more limited in suburban/estate profiles, which tend to rely on resident panels and existing networks.

Young people were sometimes captured well (Wood Farm, Berinsfield, Barton), but often under-represented in others (Banbury wards, Central Oxford). While many reports list families/Children and Young People as priority groups, the strongest child specific evidence often comes indirectly (e.g., National Child Measurement Programme (NCMP) or school linked insights) or via area level risk signals (e.g., 44.2% Year 6 overweight/obesity in Blackbird Leys) (Oxfordshire County Council & NHS partners, 2024), with fewer direct child voices outside projects such as Healthwatch's youth art engagement[11]. LGBTQ+ residents, informal carers, and non-English-speaking newcomers appear under-represented or not explicitly disaggregated in several areas; likewise, housebound residents and people with severe mental illness may be under-captured where fieldwork relied on venue-based engagement. Many communities also highlighted gaps in the voices of Families of children with Special Educational Needs, asylum seekers, younger adults, and households experiencing severe financial stress. These gaps in representation highlight that, despite organisations using a range of engagement approaches, there remain significant challenges in reaching individuals who face the greatest barriers. Different engagement methods used to capture the community insight yielded a different reach in some areas, for example community researchers were employed for the Rose Hill insight work and door knocking was used in Wood Farm.

Finally, while intersectional vulnerabilities, such as ethnicity × poverty × disability, are discussed in depth (for example, The Leys combines high deprivation, a younger age profile, greater ethnic diversity, and higher prevalence of long-term conditions), standardised cross-area analytical tables for these intersections are not consistently presented. This reflects the original scope and time constraints of the brief, and makes systematic comparison across wards more difficult.

Thematic results

This section presents the key thematic findings that emerged from the analysis of the CIP reports. These themes detail the community assets and initiatives alongside the prominent unmet health and social needs identified by people who shared their insight for the profiles.

Across sites, recurring health and social priorities include access to primary/urgent care and dentistry, mental health and isolation, youth provision and safe spaces, cost-of-living and food insecurity, transport and the built environment, and SEND/neurodiversity support with area-specific emphases such as The Leys on emergency admissions, Chronic obstructive pulmonary disease (COPD), obesity, self-harm, and life expectancy gaps; Banbury wards on mental health, youth services, and food poverty; Bicester West on hidden isolation and VCS coordination; Rose Hill on communication gaps and activity affordability. At the same time, the CIPs document community strengths and assets from parks and outdoor gyms (The Leys), community centres, churches and green/blue spaces (Abingdon Caldecott, Central Oxford), to active local groups (Berinsfield's Warm Hub and extensive family/youth activities; Rose Hill's clubs and larder) framing recommendations that couple targeted health interventions (e.g., COPD/obesity/mental health in The Leys) with place-shaping, co-production, connector roles, communications strategies, transport/access improvements, youth and life-skills programmes, and volunteering/funding mechanisms (Witney Central, Bicester West, Berinsfield, Barton). Collectively, the reports function as action-oriented evidence bases that surface overlapping vulnerabilities (e.g., poverty + disability + ethnicity + housing insecurity) while highlighting locally owned solutions and assets to build upon, thereby informing service planning and partnerships at neighbourhood scale in line with the county's CIP programme.

Unmet needs in accessing Healthcare and the Role of Local Support Networks

Difficulties in Accessing Primary Healthcare and Specialised Support

Across numerous CIPs, people who shared their insight for the profiles consistently reported significant barriers to accessing primary healthcare services. Long waiting times for General Practitioner (GP) appointments were a common concern, as was the availability of mental health support and dentistry. Although factors like GP access, dentistry, Child and Adolescent Mental Health Services (CAMHS) waiting times are common challenges across the general population, people in these areas face

additional barriers. For instance, reports from Rose Hill, Littlemore, and Barton explicitly identified a lack of local health centres, necessitating travel to other areas for basic healthcare provision. People from the Barton community who participated in the community engagement workshop, further highlighted the significant challenges to access online services that led to appointments. In Bicester West, extensive feedback referenced difficulty in getting a GP appointment and confusion about triage processes, which community members who shared their insight for the profiles described as “intimidating”. Witney Central community members who shared their insight for the profiles echoed this, reporting that even though the area technically contains GP and dental provision, the real barrier is availability, not location: people described being “put off even trying” to obtain appointments. In Littlemore, community members who shared their insight for the profiles expressed feeling “overlooked compared to neighbouring areas,” often travelling to places like Rose Hill, Blackbird Leys, or Cowley for services. This was further validated and emphasised as a profound barrier in the community engagement workshops.

Families, especially those with additional needs, face acute challenges. In Rose Hill, parents voiced distress over the long waits for CAMHS: “It has been very hard to get my son to be on the CAMHS waiting list, it’s a joke”. Across Witney, Bicester, Littlemore, and The Leys, concerns over SEND diagnosis delays, lack of school-based support, and scarcity of specialist provision were repeatedly raised.

Central Oxford presents a distinct but equally pressing picture. While many felt technically “served” by NHS services across the city, older adults and disabled community members who shared their insight for the profiles described access being constrained by transport, mobility, parking costs, and environmental barriers rather than distance: accessing outpatient care was “limited by parking and transport costs”.

“I think having a surgery would really benefit the community” (resident)
[RoseHill_CommunityProfile_Insight.pdf, page 42]

“We need better access to health services, trying to get to see a doctor or dentist is a joke.” (online survey) [TheLeys_CommunityProfile_Insight.pdf, page 64]

The cumulative effect of these pressures creates a deep sense of inequity, reinforcing the idea that postcode determines access and, in many cases, the ability to remain well. Across the CIPs, this lack of accessibility interacts closely with deprivation. Where communities experience overcrowded housing, poverty, and poor mental health, the ability to access a GP or dentist becomes even more critical and more inequitable.

Pervasive Mental Health Concerns and Social Isolation

Mental health challenges and feelings of isolation were extensively documented. Across all fourteen areas, community members who shared their insight for the profiles described poor mental health and isolation as pervasive and often intensifying. In The Leys, survey data indicates elevated levels of depression and self-harm admissions, reflected in community narratives describing ongoing anxiety, difficulty coping, and loneliness. In Rose Hill, community members who shared their insight for the profiles described overwhelming emotional pressure: “I can often feel down and overwhelmed with life”.

Similarly, in Berinsfield, organisational stakeholders observed that “There are a lot of mental health issues – anxiety and depression.”

Bicester West and Witney Central are marked by what community members who shared their insight for the profiles called “hidden isolation” particularly among older adults, those with mobility difficulties, and people disconnected from community information networks. This experience often co-exists with bereavement, caring responsibilities, and cost-of-living stress.

“I feel like the only thing I need to practise more and find is a way to look after my mental health. I find it hard to balance a lot of things and can often feel down and overwhelmed with life.” (resident) [RoseHill_CommunityProfile_Insight.pdf, page 29]

“Loneliness, poor fitness, poor mental health, lost purpose and connection with the outside world, migraines, mobility issues” (online survey) [TheLeys_CommunityProfile_Insight.pdf, page 65]

The Banbury wards further highlighted rising mental health needs post-COVID-19, with local organisations noting deteriorating wellbeing and stretched support structures. Meanwhile, Central Oxford, with its concentration of social and supported housing, homelessness services, transient populations, and student communities, presents a unique mental-health landscape shaped by churn, instability, and high-cost urban pressures.

Mental health concerns were often linked to broader determinants: housing insecurity, financial pressure, unemployment, lack of accessible youth provision, and experiences of discrimination. The voices across areas collectively suggest that mental health inequalities are structural, not individual, and are amplified by gaps in both clinical and community-based support. The result is a pattern of place-based vulnerability, with some communities carrying a heavier burden of distress than others.

Active VCSEs and Informal Community Care

Despite these access challenges, the reports highlighted a vibrant landscape of voluntary, community, and social enterprise (VCSE) organisations and informal networks providing crucial support. In Central Oxford, services like Housing First and St. Mungo's, alongside active church groups, were instrumental in offering street outreach, winter shelters, and comprehensive support for homeless and transient populations. Rose Hill featured an active youth club, advice service, and women-only activities, contributing to mental well-being and social connection. The Berinsfield “Warm Hub” and diverse family/youth activities were noted for fostering community cohesion, while Wood Farm's 7 O’Clock Club and Bullingdon Lunch Club provided vital social interaction opportunities.

“Community membership can be an important insulator from hardship and loneliness and often provides useful connections to knowledge and resources.” (resident) [Central Oxford_CommunityProfile_Insight.pdf, page 8]

“The community larder saves and has saved me many times. I try to tell people that it is available.” (resident) [RoseHill_CommunityProfile_Insight.pdf, page 30]

“We’re quite lucky, there are good support services available locally, if you know about it.” (resident) [Abingdon Caldecott_CommunityProfile_Insight.pdf, page 39]

These networks help mitigate gaps in formal services while strengthening community belonging, collective identity and resilience. However, they face ongoing challenges such as unstable funding, limited resources and constrained capacity. This means that the same volunteers are often stretched thin, risking burnout and jeopardising the continuity of these vital informal support services. Organisations in Banbury, Witney, Bicester, and Littlemore all reported severe strain. Volunteer pipelines are shrinking; funding is short-term; demand outstrips capacity; and the burden on community groups can be heavy. Many groups expressed that they are holding together the social fabric with increasingly fewer resources.

Socioeconomic Hardship and Community-Led Resilience Initiatives

Cost of Living, Fuel Poverty, and Food Insecurity

The cost-of-living crisis is a dominant theme across all 12 reports. Rising prices for food, energy, transport, and childcare create an all-encompassing stressor that reduces people’s ability to remain healthy. The community members who shared their insight for the profiles in Abingdon Caldecott, Barton, and Berinsfield reported significant challenges related to fuel poverty and affordability barriers preventing engagement in healthy activities and access to nutritious food. In Central Oxford, community members who shared their insight for the profiles described high living costs and difficulties accessing affordable food, exacerbated by a high concentration of social rented housing (65% of households).

“Life is hard: poverty is the problem”. (resident) [CentralOxford_CommunityProfile_Insight.pdf, page 21]

“[We need] cheaper prices...[we] often have to choose between eating & heating.” [TheLeys_CommunityProfile_Insight.pdf, page 53]

“With the cost of living, even Council-led cheaper swim activities are out of reach”. (resident) [Berinsfield_CommunityProfile_Insight.pdf, slide 40]

The cumulative impact is clear: financial insecurity cascades into poor diet, inactivity, isolation, family stress, and worsening mental health, creating cycles of disadvantage that communities struggle to break.

Poor Housing Conditions and Overcrowding

Housing quality and security were also prominent concerns. Littlemore and Central Oxford identified poor housing quality and overcrowding as significant issues. The Leys reported a substantial proportion of social rented housing (46.8%), three times the Oxfordshire average, which was often linked to broader deprivation.

“I can hear everything from the upstairs flat. There’s no ventilation in the kitchen or bathroom and there’s mould growing. My chest has been awful.” (resident) [Bicester_West_CommunityProfile_Insight.pdf, page 40]

“The house type I have is concrete and asbestos and I’ve found it difficult/ impossible to find local, trustworthy, reliable tradespeople to do much needed work to my property.” (online survey respondent) [RoseHill_CommunityProfile_Insight.pdf, page 16]

“Being in unsuitable housing hasn’t helped our [SEN] child especially.” (online survey) [TheLeys_CommunityProfile_Insight.pdf, page 65]

Grassroots Food Initiatives and Mutual Aid Networks

Communities actively responded to these socioeconomic pressures through various grassroots initiatives. Community larders were reported in Barton, Rose Hill, and Berinsfield, providing direct access to food. Faith groups and mutual aid networks played a significant role, with examples from Abingdon Caldecott and Central Oxford (churches offering food support and winter shelters) illustrating practical assistance. Community members who shared their insight for the profiles in Central Oxford also expressed interest in developing local tenant associations to advocate for improved housing conditions.

“The community larder- it’s not just about getting food it’s also about meeting lots of new people. The café you can get a free cuppa and cake and that’s always nice. I’ve had amazing conversations and made new friends.” (focus group participant) [Barton_CommunityProfile_Insight.pdf, page 59]

“I am self-employed and sometimes we cannot make the ends meet and we depend on the foodbank every Friday.” (resident) [RoseHill_CommunityProfile_Insight.pdf, page 30]

“A community larder that is needs-first, food-first, not based on waste reduction” (interview) [TheLeys_CommunityProfile_Insight.pdf, page 77]

Gaps in Youth Provision and the Positive Impact of Community Spaces

Limited Youth Activities and Opportunities

A lack of suitable activities and engagement opportunities for young people was a recurring theme. Bicester West, Littlemore, and Banbury wards specifically noted insufficient youth provision. In Rose Hill and Berinsfield, barriers to training and employment for young people were also highlighted.

“They use it [the Multi-Use Games Area] to store the equipment for repairing the pipe bridge. That’s about the only use [young people in the area] get out of it.” (youth worker) [CentralOxford_CommunityProfile_Insight.pdf, page 38]

“There used to be a youth club on a Friday night – never any trouble. It was great” (young person) [Abingdon_Caldecott_CommunityProfile_Insight.pdf, page 60]

“As we hope is clear from the images there is nice places on Wood Farm which isn’t a lot but there is also a lot missing they would like on the estate. The young people described their estate as the forgotten one.” (youth group) [Wood_Farm_CommunityProfile_Insight.pdf, page 63]

Parents and community workers repeatedly called for more youth workers, safe hang-out spaces, mental health support, and accessible activities. Young people themselves often reported not being listened to by decision-makers. This set of findings reflects an intergenerational inequality: when young people lack safe, inclusive spaces to grow, participate, and belong, the impacts reverberate across community life.

Transport and Built Environment Barriers

Issues with the built environment, including transport and access to public spaces, directly impacted community well-being. In Central Oxford, community members who shared their insight for the profiles highlighted how prolonged closure of an arterial road and limited parking created mobility barriers, particularly for disabled and elderly residents. Bicester West noted that its large ward size meant longer travel distances for some residents, posing a problem for those with limited mobility.

“...the biggest inconvenience you could ever ask for.” (resident, on bridge closure) [CentralOxford_CommunityProfile_Insight.pdf, page 35]

“Why can’t half the buses go the other way, why do they all go one way? ... There are people who don’t go to the community centre because they can’t get there, or to the shops.” (resident) [Barton_CommunityProfile_Insight.pdf, page 19]

“Transport in general is the biggest challenge, for me and for the oldies like my Mum, she can’t get to the clubs and activities that are put on and she would love to.” (resident) [Berinsfield_CommunityProfile_Insight.pdf, slide 40]

In Barton, bus routes limit participation and in Berinsfield, transport barriers isolate older adults and reduce access to activities. In Littlemore, lack of safe walking routes, cul-de-sacs, and reduced bus connectivity deepened isolation and spatial health inequalities.

Green Spaces, Community Centres, and Youth-Centric Activities

Despite these limitations, communities leveraged existing assets to foster youth engagement and enhance shared spaces. Green spaces (parks, nature reserves, outdoor gyms) were highly valued, for

instance, in The Leys, where community members who shared their insight for the profiles used Gillian Park and Spindleberry Nature Reserve for physical activity. Community centres, churches, and specific youth projects also acted as vital hubs. The "Barton Bash" in Barton was cited as a successful participatory event that engaged the community, including young people. Berinsfield showcased an extensive array of family and youth activities, including a youth centre and various clubs. Recommendations from Witney Central included improving transport links and creating more inclusive venues, demonstrating a community desire to maximise the potential of their built environment.

"I like the Oval because you got all the trees in the spring, the tulips, daffodils, and it gives you the peace for your wellbeing, for your mental mind." (resident) [RoseHill_CommunityProfile_Insight.pdf, page 14]

"Lye Valley is just the most wonderful, magical place in Oxford. [...] It's like being in the middle of the countryside in the middle of a housing estate." (resident) [Wood_Farm_CommunityProfile_Insight.pdf, page 28]

"It's a shame that Eatwells has not reopened, we liked having a place to meet that was neutral. After the exercise groups we would eat together and it was always packed." (focus group participant) [Barton_CommunityProfile_Insight.pdf, page 59]

Discussion

Listening to Our Communities – How Local Strengths Can Tackle Health Inequalities

The Oxfordshire Community Insight Profiles (CIPs) are more than just reports; they are a collection of local stories and experiences, combining official data with what people in those neighbourhoods say they need and what they value. This approach helps us understand health not just through statistics, but through the everyday lives of residents, which is vital for making health efforts truly effective and fair. By bringing together detailed local information with the insight of community members, these profiles offer a powerful guide for improving health and wellbeing, especially for those who face the biggest challenges.

These findings align strongly with the extensive evidence base on health inequalities, which demonstrates that the wider determinants of health - the circumstances in which people are born, grow, live, work and age have the greatest influence on health outcomes, far beyond healthcare access alone [12, 13]. As set out in the Marmot Review, such determinants are responsible for systematic and preventable inequalities in life expectancy and healthy life expectancy across England [14]. Although Oxfordshire is broadly affluent, the Community Insight Profiles reveal stark internal disparities echoing national findings from Public Health England that people in the most deprived areas live fewer years in good health than those in the least deprived areas [15]. These results reaffirm the social gradient first

articulated in the global determinants of health evidence base, where each step down in socioeconomic status corresponds with poorer health outcomes [14].

Across all 12 profiles (covering 14 areas), people consistently described both what helps them stay well and what makes this difficult. These findings demonstrate the tangible power of community assets, reinforcing the Asset-Based Community Development (ABCD) approach underpinning the CIP programme. They highlight that interventions for health inequalities must start from and be co-created with what communities already have, value, and use. At the same time, these strengths sat alongside structural barriers that make it harder for people to live healthy and fulfilling lives. These include gaps in accessible primary care, deteriorating mental health, poverty and food insecurity, unsafe or poorly maintained environments, and insufficient youth provision. Such issues cannot be addressed by community goodwill alone, they require system-wide structural investment [14, 16].

Communities are stepping up: Bridging Gaps in Healthcare and Supporting Mental Wellbeing

A key message from the community members who shared their insight through the profiles is the widespread difficulty in getting the healthcare they need, particularly when trying to see a GP, access mental health support, or find a dentist. Areas like Rose Hill, Littlemore, and Barton, share through the CIPS that they simply don't have enough local health centres, leading to long waits and frustrating journeys to other areas for basic services. Built environment barriers are not incidental, they directly undermine access to healthcare, social participation, activity, and belonging. This creates significant health inequalities, where people in some areas struggle far more to get care than others. This mirrors national evidence that people in more deprived areas face disproportionate access barriers driven by workforce shortages, transport limitations, digital exclusion and service design [17, 18].

Mental health and feelings of loneliness are also serious concerns for many. In areas like The Leys, residents experience high rates of depression and self-harm, with data showing some of the lowest life expectancies in the county. In places like Bicester West and Witney Central, older neighbours often describe "hidden isolation," meaning they feel alone even when surrounded by others. These feelings are more common in some parts of our community than others, highlighting the unequal burden of mental health challenges. These patterns align with WHO's description of how income insecurity, discrimination and poor housing environments affect mental wellbeing across the life course [13].

Yet, even with these challenges, our communities are stepping up. The profiles show a strong network of local groups, volunteers, and faith organisations playing a crucial role. In Central Oxford, for instance, local churches and charities like St. Mungo's provide essential services for people experiencing homelessness, offering warm spaces and vital support that formal health services often can't reach. Local voluntary, community and social enterprise sector (VCSE) groups are delivering substantial emotional support despite experiencing funding pressures, volunteer shortages and rising demand. This dynamic is also observed nationally, where community organisations often fill gaps left by strained

statutory services [19]. These community efforts are critical not only for practical help but also for reducing feelings of isolation and boosting mental wellbeing, especially for those who might feel overlooked or excluded from mainstream services. Listening to these community voices helps us understand what works best on the ground. A key implication of these findings is the need for stronger strategic alignment between government bodies and Integrated Care Boards (ICBs), and the VCSE sector, to ensure that community-based provision is sustainably supported, better integrated into care pathways, and effectively leveraged to address local health inequalities.

Building Stronger Foundations: Tackling the Cost of Living and Housing Challenges

The rising cost of living is deeply affecting many residents, making it harder to afford healthy food, keep homes warm, and take part in local activities. From the insight shared in the profiles, families in Abingdon Caldecott, Barton, and Berinsfield struggle with fuel poverty, while people in Central Oxford often find it hard to access affordable food. These pressures are not felt equally; communities with higher numbers of social rented housing, like The Leys, or areas with poor quality and overcrowded homes, like Littlemore and Central Oxford, bear a disproportionate burden. These are clear examples of how social and economic conditions, directly impact people's health and create inequalities.

Despite these tough economic realities, communities are showing incredible strength and resourcefulness. Local initiatives like community larders in Barton, Rose Hill, and Berinsfield are making a real difference by providing essential food and support directly where it's needed. Faith groups and neighbour-to-neighbour networks, seen in Abingdon Caldecott and through the many churches in Central Oxford, offer crucial practical help and a sense of belonging. These community-led efforts not only provide immediate relief but also build social connections and reduce the stigma often linked with poverty. Research highlights how such local, participatory efforts are highly effective in strengthening food security and local self-reliance. The desire for tenant associations in Central Oxford also shows how the community members who shared their insight for the profile want to take control and advocate for better housing conditions, pushing for changes that can improve health for everyone in their area.

These findings reflect well-recognised pathways between the built environment, poverty, and health outcomes. Housing, income and living conditions are structural determinants of health, not merely lifestyle background factors. The CIPs show that without addressing these fundamentals, inequalities will persist regardless of downstream individual-focused interventions. Nonetheless, community-led responses such as food larders, warm hubs, and good neighbour schemes demonstrate strong local resilience. These grassroots efforts are essential but insufficient without structural investment.

Growing Together: Engaging Young People and Shaping Our Surroundings

Many of the CIPs areas, including Bicester West, Littlemore, and Banbury wards, express a clear need for more activities and opportunities for young people. Young residents in places like Rose Hill and Berinsfield also face barriers to finding training and jobs. This echoes national evidence highlighting the importance of youth involvement and early life investment as foundational for long-term health [15, 17]. Our physical surroundings, like transport links and public spaces, also play a big part in how communities feel. For example, people in Central Oxford talk about how bridge closures and limited parking make it hard for disabled and elderly residents to get around, impacting their ability to connect and stay active. The built environment profoundly influences mental health and wellbeing, with accessible green spaces and safe public transport acting as protective factors, while poorly designed or polluted areas can increase stress.

However, the CIPs also reveal the vibrant energy and assets within these communities that can address these gaps. Events like the "Barton Bash" actively involved young people in shaping their local area, showing the power of youth engagement. In The Leys, local parks and outdoor gyms are not just facilities; they are active hubs used by community groups, fostering physical activity and youth involvement. Berinsfield offers a rich variety of family and youth activities, from "Warm Hubs" to sports programs, creating safe and engaging spaces. When young people are genuinely involved in community efforts, it not only benefits their own development but also makes public health initiatives more relevant and impactful for their peers and the wider community. These examples highlight how strong community assets, from green spaces to active local groups, are essential for fostering a sense of belonging and improving quality of life for all residents. Combined, these findings emphasise that youth inequality is spatial, social, and structural. Supporting young people requires investment in local infrastructure, sustained youth work, and genuine co-production.

Learning and Improving: The Path Forward with Community Voices

The way these profiles were put together, combining quantitative data with the personal stories of residents, is a real strength. What was heard in the profiles directly shaped action via Community Health Development Officers posts, seed funding through local grant schemes and influencing the targeting of the Well Together programme grants, crucial to strengthening the assets identified in context of 15 years of austerity and cost of living crisis. Voices were not just 'heard' in the conventional sense of being put in a report but resulted in some tangible outcomes. This has also done a huge amount to build trust and partnerships between different organisations, not just the listening but the listening and taking action. This "mixed-methods" approach allows us to see how health trends and people's experiences connect, helping us understand complex issues like heart conditions and obesity in The Leys through both data and community assets. The Community Health Development Officers (CHDOs) have been introduced as the bridge between community voices and statutory partners to enable an on-going dialogue since the CIPs were produced. The CHDO's are funded by Oxfordshire County Council Public Health but hosted and employed by the relevant district or city council for their area. There are currently nine CHDO's in post, some are full time covering several areas and others are part time covering just one. The key role of the CHDO's is to work with the local community and stakeholders to take forward the recommendations

from the CIPs through a locally agreed action plan for each area. This kind of partnership, where different organisations work together with local people, helps ensure the findings are relevant and can lead to real action. The Community Insight Profiles provide a powerful, place-based public health model aligned with national recommendations for tackling inequalities through structural action, community capability building, and proportionate investment [14, 16].

However, getting everyone's voice heard can be challenging and some profiles highlighted limits to representation. For example Bicester West's, had many more White British/White residents (96%) and women (80%) contributing their views, which means the insights might not fully reflect the experiences of other ethnic groups or men. Similarly, Witney Central had a high proportion of female (72%) and White British/Other White (95%) participants. While Barton included a more diverse range of ethnic backgrounds, it had unusually high male participation (68%). These differences remind us that we need to work harder to reach all parts of our community, especially groups like LGBTQ+ residents, informal carers, and people with severe mental illness, who might often be missed. Truly involving everyone means actively overcoming barriers to participation and ensuring representative voices are amplified. This needs time to build up trust and investment in this type of listening,

Conclusions

The insights from the Oxfordshire CIPs clearly show that to improve health, we must focus on the unique needs of each place and ensure everyone has an equal chance to thrive. This means that councils, health services, and local VCSE organisations must work hand-in-hand with communities, investing in and supporting the amazing things people are already doing. The success of local groups in providing mental health support, tackling food poverty, and engaging young people proves that local solutions are powerful.

However, community assets alone cannot address the structural conditions driving unequal health outcomes. We need policies that recognise and support these community efforts, seeing them not just as helpful add-ons, but as a core part of building healthy communities, further reinforced in the new NHS Neighbourhood Health Framework [20]. To reduce these inequalities, this work points to the necessity of system-wide, sustained investment across housing, income, education, transport, local services and mental health provision consistent with national policy recommendations for tackling wider determinants [17, 18]. The Community Insight Profiles offer a practical model for place-based action, demonstrating how lived experience, local data and community partnership can shape more responsive, equitable systems.

Taken together, these findings highlight an urgent need to deepen collaboration between residents, local authorities, health systems and the voluntary and community sector. By centring community voices, strengthening local assets and addressing the structural inequalities consistently described across Oxfordshire's priority neighbourhoods, it is possible to build the fairer, healthier and more resilient communities envisioned in national frameworks for reducing health inequalities. This manuscript thus

reinforces a clear message: meaningful progress on health inequality requires both listening to communities and acting on what they say.

Declarations

Ethics approval and consent to participate:

Not applicable

Consent for publication:

Not applicable

Competing Interests

Kate Austin is employed by Oxfordshire County Council, which led and funded the Community Insight Profile programme and related legacy programmes described in this paper. She was involved in the development, delivery and oversight of the Community Insight Profile programme, and in commissioning the University of Oxford evaluation referenced. The evaluation was co-funded by Oxfordshire County Council along with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board. Jon Hyslop is employed by Community Glue and Katharine Howell is employed by Healthwatch Oxfordshire; both organisations were commissioned to undertake community insight work that informed specific Community Insight Profiles. To manage any potential conflicts of interest and reduce the risk of bias, the authors used publicly available reports as the data source, maintained records of coding and theme development and discussed emerging themes with Community Health Development Officers and public contributors as part of the validation process.

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CN, JB and KA contributed to the conceptualisation and design of the study, methodology, investigation, formal analysis, project administration, and drafted the original manuscript. KH & JH contributed to the formal analysis, and to critical review and editing of the manuscript. All authors read and approved the final manuscript.

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Data Availability

Sources (the Community Insight Profiles) used in the review Oxfordshire Data Hub – Health and Social Care – Community Insight Profiles <https://data.oxfordshire.gov.uk/health-and-social-care/community-insight-profiles/>

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