

REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC):

Director of Public Health Annual Report

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:

- Ansaf Azhar- Director of Public Health, Oxfordshire County Council.
- Kate Austin- Public Health Principal, Oxfordshire County Council.
- Fiona Ruck- Health Improvement Practitioner, Oxfordshire County Council.

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered the draft Director of Public Health (DPH) annual report in its public meeting on 29 January 2026.
2. The Committee would like to thank Ansaf Azhar (Director of Public Health, Oxfordshire County Council); Kate Austin (Public Health Principal, Oxfordshire County Council); and Fiona Ruck (Health Improvement Practitioner, Oxfordshire County Council); for attending the meeting and answering questions from the Committee.
3. The DPH annual report is of significant interest and concern to the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by Oxfordshire County Council's public health team to improve public health services for residents in Oxfordshire of all ages. The DPH annual report provides a strong indications into some of the steps being taken by the public health team in this regard.
4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:
 - The nature of this year's DPH annual report and the themes/topics that will be covered within it.
 - The format of this year's annual report, and whether there have been changes in its format in line with what some other local authority Directors of public health have embarked on.
 - Whether any coproduction is involved as part of the development of this year's DPH annual report.

- The degree to which there is collaboration with key system partners in the development of (or public health commitments found within) this year's annual report.

SUMMARY

5. During the 29 January 2026 meeting, the Committee received a presentation on the Director of Public Health's Annual Report, which took the form of an interactive web-based publication designed to make health information more engaging and accessible. The Public Health Principal and Health Improvement Practitioner demonstrated the platform's features, noting its use of bold visual design, clear navigation tiles and intentionally concise text to help users explore themes such as local data, lived experience, health inequalities and community voice. It was highlighted that the new format builds on the direction set by the 2020 report, "Some Are More Equal Than Others", by showing progress in several areas of deprivation and showcasing community-led initiatives that have developed despite significant financial pressures across the system.
6. The Committee heard that the digital report incorporates videos, case studies, blogs and toolkits, including contributions from Professor Sir Michael Marmot and local community health workers. These materials aimed to demonstrate the real-life impacts of health inequalities and highlight the positive outcomes achieved by communities themselves.
7. It was discussed how the report and associated tools address the specific challenges faced by residents in rural areas, where isolation, poor transport links and hidden deprivation can hinder access to services. They emphasised the importance of integrating local insight with the NHS ten-year plan to ensure that community experience influences future commissioning. The wide geography of the Thames Valley ICB was acknowledged as a further challenge, reinforcing the need for strong partnership working and a consistent focus on inequalities.
8. The Committee explored how lived experience could be incorporated into the public health dashboard. Officers confirmed that including stories, videos and examples of community-led work was both feasible and desirable. Qualitative insight had always been central to the Community Insight Profiles, and Officers expect community-generated material to become increasingly important, particularly where quantitative data remain inconsistent. The forthcoming toolkit was intended to support community groups in collecting, structuring and sharing their insights.
9. Discussion then turned to rural access to GP services. Officers acknowledged that limited transport, dispersed populations and reliance on voluntary schemes left many residents effectively cut off from primary care. The community insight work had already highlighted these barriers, and the rural inequality framework aimed to map them more systematically. Officers emphasised the importance of using public health evidence to shape broader decisions about housing, transport and place-shaping so that access to GPs

becomes a proactive consideration rather than a reactive one. Innovation in rural areas, they said, would require stronger collaboration between councils, the NHS and local community groups.

10. Members asked how the Community Insight Profiles aligned with the NHS ten-year plan. Officers explained that the profiles were designed as a shared system resource rather than a standalone public health exercise. They already fed into neighbourhood-level planning and commissioning decisions led by the ICB, supporting a preventative approach that complemented clinical priorities. By embedding insight on wider determinants, the profiles helped to guide decisions about service locations, resource deployment and targeted interventions. Strong collaboration across the system was essential to retain this alignment.
11. Members also discussed how the community voice would continue to shape public health and wider system commissioning. Officers emphasised that community insight informed not only public health work but programmes such as school readiness and joint NHS–council evaluation projects. Stories, feedback and co-produced recommendations were expected to play a growing role in shaping prevention work and wider determinants of health across the system.

KEY POINTS OF OBSERVATION:

12. This section highlights five key observations and points that the Committee has in relation to the commitments and themes highlighted in this year's DPH annual report. (and associated services more broadly). These five key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Embedding CIPs into routine commissioning and service design:

The Director of Public Health Annual Report 2025/26 makes clear that Oxfordshire has moved beyond deficit-focused, data-only approaches towards a richer, more nuanced understanding of place, lived experience, and the wider determinants of health. However, the full value of this investment will only be realised if the insights generated through Community Insight Profiles (CIP) are systematically embedded into decision-making processes across the health and care system, rather than being treated as supplementary or optional evidence.

The DPH Annual Report explicitly recognises that traditional datasets, including statutory indicators and aggregate health outcomes, are insufficient on their own to explain why inequalities persist in specific communities or how services should respond to them. The report describes how CIPs were developed precisely to bridge this gap, combining epidemiological data with qualitative insight, asset mapping, and community-led priorities to create a more actionable understanding of local need. This aligns closely with established public health theory on the limitations of technocratic planning approaches that privilege what is

measurable over what is meaningful, particularly for marginalised populations¹.

Embedding CIPs into routine commissioning therefore represents a shift from episodic consultation towards structurally embedding community voice within the “rules of the system”. Without such embedding, there is a risk that CIP findings remain influential only where individual commissioners, clinicians or officers choose to engage with them, rather than shaping service models consistently across Oxfordshire. The Annex 1 Content Framework submitted to the committee illustrates how CIP insights have already influenced delivery decisions in areas such as community mental wellbeing support, physical activity pathways, access to food, and social connection. These examples demonstrate not only improved alignment with local priorities but also increased trust between communities and statutory partners – a critical precondition for effective preventive work².

From a commissioning perspective, embedding CIPs means more than “having regard” to local insight. It requires that business cases, service specifications, options appraisals and evaluation frameworks explicitly reference relevant CIP findings and explain how community-identified priorities have shaped proposed interventions. This approach is consistent with best practice in outcomes-based commissioning and with the NHS’s increasing emphasis on place-based and neighbourhood health models, as articulated in the NHS 10-Year Plan and national neighbourhood health guidance³. The DPH Annual Report highlights that neighbourhood working will only succeed if services are designed around people’s lived realities, including transport barriers, housing conditions, social isolation and access to trusted local services – all core components of CIP analysis.

There is strong precedent elsewhere in England for the systematic use of similar place-based insight within commissioning frameworks. In Greater Manchester, for example, locality-level intelligence drawn from community research has been embedded into Integrated Care System commissioning through “locality plans” that must demonstrate alignment with community priorities identified through qualitative insight and participatory engagement⁴. Evaluations of this approach have shown improved service take-up, better targeting of preventive resources, and greater legitimacy of commissioning decisions in communities that have historically experienced disempowerment.

Similarly, the “Neighbourhood Health” and “Thriving Places” programmes in Bradford have embedded community insight into service co-design and commissioning processes, particularly in areas of ethnic diversity and high deprivation. Independent evaluation demonstrated that services

¹ <https://www.instituteofhealthequity.org/resources-reports>

² <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

³ <https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/>

⁴ <https://www.greatermanchester-ca.gov.uk/what-we-do/health-and-social-care/>

designed using community-led intelligence were more effective at addressing trust, cultural appropriateness and access, particularly in maternal and early years services and long-term condition management⁵. These findings echo wider academic literature on co-production and participatory public health, which consistently shows that interventions designed with communities are more likely to be effective, equitable and sustainable⁶.

The Annex 1 Content Framework submitted to the Committee also highlights the role of Community Health Development Officers (CHDOs) in translating insight into action. While these roles have been instrumental in delivery, the DPH Annual Report is clear that reliance on individual posts is not sufficient to embed learning system-wide. Commissioning processes themselves must institutionalise CIP use so that learning survives changes in personnel, organisational structures, or funding cycles. This is particularly important given the risks identified in the report around funding instability, system reform, and local government reorganisation, all of which can disrupt progress if insight is not embedded structurally.

Embedding CIPs also strengthens accountability. When commissioning decisions explicitly reference CIP findings, it becomes possible for scrutiny bodies such as the JHOSC to assess not only whether engagement took place, but whether it meaningfully influenced outcomes. This responds directly to longstanding concerns nationally about “consultation fatigue” and tokenistic engagement, where communities are asked for views that do not translate into changed decisions⁷. Making CIP references a routine requirement creates a clear audit trail linking insight, decision, and impact.

Finally, this recommendation being made by the Committee is fully aligned with the Marmot principles underpinning Oxfordshire’s ambition to become a Marmot Place. Professor Sir Michael Marmot’s work consistently emphasises that reducing inequalities requires proportionate, place-sensitive action informed by the lived experiences of those most affected⁸. Embedding CIPs into commissioning operationalises these principles, ensuring that investment decisions systematically prioritise those populations and neighbourhoods facing the greatest disadvantage, rather than relying solely on county-level averages that can obscure deep local inequalities.

In summary, the recommendation to embed Community Insight Profiles into routine commissioning and service design is not an optional enhancement but a necessary step if Oxfordshire is to convert high-quality insight into sustained reductions in inequality. The DPH Annual Report and its accompanying framework demonstrate the value

⁵ <https://www.bradfordhealthpartners.org/>

⁶ <https://www.tandfonline.com/doi/full/10.1080/09581596.2020.1717511>

⁷ <https://www.health.org.uk/publications/long-reads/community-engagement-for-health>

⁸

of CIPs as an evidence base. Embedding them formally within commissioning processes ensures that this value is realised consistently, transparently, and at scale, supporting better outcomes for communities and stronger accountability for the system as a whole.

Recommendation 1: *To embed CIPs into routine commissioning and service design, ensuring decisions explicitly reference CIP findings and community led priorities.*

Ensuring neighbourhood working includes Public Health Leadership and Community Voice Structures: the case for a System-wide Roadmap on Maturity, Resourcing and Integration: The DPH Annual Report 2025/26 positions Oxfordshire’s recent progress as rooted in partnership working, hyper-local insight and engagement with the wider determinants of health. The accompanying cover report submitted to the Committee explicitly frames the Annual Report as a tool to inform future service delivery and commissioning decisions, highlighting the new interactive format of this year’s DPH Annual Report as a mechanism for improving accessibility, engagement and ongoing learning. The Annex 1 Content Framework reinforces this framing by emphasising prevention, place-based approaches and the need to consolidate progress through sustained, system-wide action, rather than discrete or time-limited initiatives. Taken together, these documents provide a strong local rationale for ensuring neighbourhood working is led by public health principles and meaningfully shaped by community voice.

Neighbourhood working requires public health leadership to succeed. Nationally, neighbourhood working has been positioned as the primary vehicle for delivering the “shift” from hospital to community, and from reactive treatment to prevention. However, experience across England demonstrates that neighbourhood models risk becoming overly clinical or narrowly focused on managing high-need cohorts unless they are explicitly grounded in population health intelligence and inequalities analysis. The Government’s Neighbourhood Health Framework is explicit that neighbourhood health can only succeed as a joint endeavour between the NHS and local government, with shared outcomes, common metrics and enabling governance structures⁹. Similarly, NHS England’s Neighbourhood Health Guidelines for 2025/26 stress the importance of system-wide population health management, partnership with local authorities and integration with voluntary and community sector partners, rather than viewing neighbourhoods solely as units for multidisciplinary clinical teams¹⁰.

The DPH Annual Report reflects this understanding locally. Annex 1 submitted to the Committee repeatedly highlights that what shapes health and wellbeing are the “building blocks of health” – income, housing, education, transport, social connection and access to resources

⁹ <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

¹⁰ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/>

– factors that sit largely outside traditional healthcare delivery. The report also includes explicit warnings about the careful interpretation of deprivation data, noting that indicators such as the Index of Multiple Deprivation must be contextualised and triangulated to avoid over-claiming progress or misdirecting resources. This analytical discipline is a core public health function and illustrates why neighbourhood working that lacks public health leadership risks being poorly targeted and potentially misleading in its assessment of impact. Academic evaluations of integrated care and community-based models reinforce this point. National evaluation work on community-based multidisciplinary teams in England found that while local integration can improve coordination, success depends on strong system enablers, including shared objectives, governance, data capability and leadership that extends beyond individual services¹¹. Public health leadership provides exactly this system-level perspective, ensuring neighbourhood priorities are aligned with inequalities intelligence and prevention objectives, rather than responding primarily to short-term service pressures.

The second pillar of the recommendation – embedding community voice structures within neighbourhood working – reflects both Oxfordshire’s own learning and a substantial national and international evidence base. Annex 1 of the DPH Annual Report describes in detail how Community Insight Profiles (CIPs) were developed to combine quantitative data with lived experience, local knowledge and asset mapping. Importantly, it also records how communities challenged partners with the question “So what?”, prompting a shift from insight-gathering towards tangible action and delivery. This experience demonstrates that engagement alone is insufficient; communities must also have a route to influence decisions, priorities and resource allocation.

The academic literature is clear that sustained community participation improves relevance, trust and equity, particularly when communities are involved throughout the full policy and commissioning cycle. A recent scoping review of co-creation in public health found that while community participation is often present in design and implementation, it is frequently weak or absent in governance and evaluation, limiting long-term impact¹². UK-focused research into commissioning and co-production similarly identifies commissioning complexity, power imbalances and organisational culture as structural barriers to meaningful co-production, unless community voice is embedded deliberately within decision-making frameworks¹³.

This evidence aligns closely with policy analysis from The King’s Fund, which cautions that neighbourhood health means different things in different places and that success depends on collaboration, leadership and investment, including genuinely community-led approaches rather

¹¹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC12423453/>

¹² <https://pmc.ncbi.nlm.nih.gov/articles/PMC10094395/>

¹³ <https://onlinelibrary.wiley.com/doi/pdf/10.1111/hex.14053>

than technocratic service redesign¹⁴. Without defined voice structures, neighbourhood working risks becoming something that is done to communities rather than with them, undermining legitimacy and long-term sustainability.

The call for a system-wide roadmap is therefore critical here. Neighbourhood working is not a single intervention but a complex capability that develops over time. Without a roadmap, neighbourhoods will mature unevenly: some benefiting from strong leadership, data and community infrastructure, while others remain under-resourced and poorly connected to wider system priorities. The DPH Annual Report's interactive format is intended to support ongoing learning and adaptability, but this flexibility increases the need for a stable implementation framework that sets out expectations for neighbourhood maturity, resourcing and accountability.

National policy increasingly reflects this logic. The Neighbourhood Health Framework explicitly refers to the need for clear archetypes, shared outcomes and enabling infrastructure to avoid a fragmented approach¹⁵. NHS England's guidance similarly emphasises progression over time and integration with wider public sector reform, including collaboration with the voluntary, community, faith and social enterprise sector¹⁶.

Evidence from other areas reinforces the importance of a structured, system-wide approach. In Bradford District and Craven, the Reducing Inequalities in Communities programme established a defined neighbourhood-scale programme supported by embedded research capability through the Bradford Inequalities Research Unit, enabling robust evaluation and learning over time¹⁷. In Wigan, the "Wigan Deal" demonstrated how an explicit, borough-wide framework for asset-based working and community partnership could reshape public services and reduce demand, but only because the approach was underpinned by leadership, culture change and sustained commitment across the system¹⁸.

Similarly, the Bromley by Bow Centre illustrates how community-anchored institutions can integrate primary care, social support and community development when supported by outcomes frameworks derived from what matters to local people¹⁹. Emerging evaluations of community health and wellbeing worker models show that these roles can be highly effective in building trust and connecting

¹⁴ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

¹⁵ <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

¹⁶ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/>

¹⁷ <https://bdcpartnership.co.uk/strategic-initiatives/ria/ric/>; https://bominbradford.nhs.uk/wp-content/uploads/2024/11/BIRU-Final-Report_v2.0_Jan24.pdf

¹⁸ <https://centreforpublicimpact.org/public-impact-fundamentals/the-wigan-deal/>; <https://www.kingsfund.org.uk/insight-and-analysis/projects/lessons-wigan-deal>

¹⁹ <https://www.health.org.uk/funding-and-fellowships/projects/practitioner-led-evidence-at-bromley-by-bow>; https://knowledge.lancashire.ac.uk/id/eprint/3386/1/Bromley_by_Bow_Centre_Report.pdf

services, but only when supported by clear infrastructure, governance and funding arrangements – again pointing to the need for a system-level roadmap rather than isolated pilots²⁰.

Therefore, the JHOSC recommendation to ensure neighbourhood working includes public health leadership, formal community voice structures and a system-wide roadmap for maturity, resourcing and integration is firmly grounded in both Oxfordshire's own learning and national and academic evidence. It recognises that neighbourhood health will only deliver on its promise if it remains anchored in prevention and inequalities intelligence, if communities have meaningful influence over priorities and design, and if progress is supported through clear expectations and sustained investment across the system.

If Oxfordshire is to protect and build on the achievements set out in the DPH Annual Report – and if neighbourhood working is to become a durable platform for reducing health inequalities rather than a transient reform narrative – then the development of such a roadmap is not an optional enhancement. It is the mechanism through which a compelling public health vision can be translated into consistent, accountable and equitable practice across all neighbourhoods in the county.

Recommendation 2: *To ensure that neighbourhood working includes public health leadership and community voice structures. It is recommended that there is a systemwide roadmap for neighbourhood maturity, resourcing, and integration with the existing voluntary and community sector and council assets.*

For the Prevention and Health Inequalities Forum to publish annual system wide progress on prevention programmes: While Oxfordshire has made tangible progress in mobilising community-led and system-wide prevention initiatives, this progress will only be sustained and scaled if it is accompanied by transparent, regular and system-level reporting. In this sense, the recommendation is not simply about producing another report; it is about embedding prevention within the governance, accountability and learning architecture of the local health and care system.

The Director of Public Health (DPH) Annual Report 2025/26 positions prevention and the reduction of health inequalities as central to Oxfordshire's strategic direction. The cover report describes how the Annual Report draws together hyper-local insight, community-led action and partnership working to inform future service delivery, and explicitly highlights the role of interactive, accessible reporting in supporting shared understanding across the system. The Annex 1 content framework reinforces this narrative by setting out the development and impact of prevention programmes such as Community Insight Profiles, Well Together, the Community Health Development Officer model, and

²⁰ <https://napc.co.uk/a-comparative-case-study-process-evaluation-of-three-community-health-and-wellbeing-worker-pilots-in-england/>; <https://arc-swp.nihr.ac.uk/research/projects/evaluation-of-the-cornwall-community-health-and-wellbeing-worker-chww-service/>

whole-system approaches to physical activity, while also underlining the fragility of progress if investment, coordination and shared ownership are not maintained. Taken together, these documents implicitly point to the need for a mechanism that can track, evidence and communicate prevention progress year-on-year beyond a single DPH Annual Report cycle.

Prevention programmes differ fundamentally from acute or treatment-focused interventions. Their impacts are often cumulative, diffuse and realised over longer timeframes, and they frequently span multiple sectors, funding streams and delivery partners. Without regular, system-wide reporting, prevention risks becoming invisible in comparison with more immediate operational pressures, despite being repeatedly recognised in national policy as essential to long-term sustainability. NHS England's Neighbourhood Health Guidelines for 2025/26 emphasise the need for integrated care systems and partners to strengthen prevention and population health management, while also acknowledging that progress requires consistent system oversight and learning²¹. Similarly, the Government's Neighbourhood Health Framework highlights the importance of shared outcomes, metrics and transparency if prevention is to be embedded rather than displaced²².

The Annex 1 (submitted to the Committee) section on the Prevention and Health Inequalities Forum makes clear that PHIF was established to provide strategic leadership across partners, particularly to secure commitment from organisations with substantial financial leverage and to align investment with prevention and equity priorities. Yet leadership without visible accountability can struggle to maintain momentum over time. Annual system-wide reporting provides a practical mechanism through which PHIF can demonstrate collective progress, identify gaps, and reinforce the shared responsibility of all partners in delivering prevention outcomes.

Academic literature strongly supports the value of transparent, regular reporting in advancing health equity and prevention. Research on prevention science and health equity consistently emphasises that system-level action requires mechanisms to track progress, make methodological choices explicit and support accountability to communities and decision-makers²³. Similarly, public health scholars argue that measuring and communicating progress on health inequalities is a necessary step in mobilising action and sustaining political and organisational commitment²⁴. Without such reporting, prevention initiatives risk being perceived as peripheral or discretionary, particularly in financially constrained environments.

²¹ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/>

²² <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

²³ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10227139/>

²⁴

The Well Together programme, described in Annex 1 as a flagship community-led prevention initiative, provides a compelling example of why annual, system-wide reporting is needed. Well Together is funded through the Thames Valley Integrated Care Board and delivered in partnership with voluntary and community sector organisations to address health inequalities in priority areas. Its design explicitly recognises that wellbeing is created collectively and that trusted, grassroots organisations are essential to engaging residents who are often least well served by traditional services²⁵.

Evaluation evidence from Oxfordshire and elsewhere demonstrates that such programmes generate value well beyond their immediate outputs, including improvements in trust, social connection and engagement with wider health services. Phase 1 evaluation of Community Health Development Officer and Well Together programmes, led by the University of Oxford, highlights the importance of continuity, embedded roles and sustained relationships for achieving impact²⁶. However, these forms of impact are unlikely to be fully appreciated or protected unless they are routinely reported at a system level, alongside more conventional activity data.

National experience reinforces this point. In Bradford District and Craven, the Reducing Inequalities in Communities programme embedded routine reporting and evaluation as part of its prevention strategy, enabling the system to understand which interventions were delivering impact and why, and to adapt accordingly²⁷. The lesson for Oxfordshire is not to replicate Bradford's model wholesale, but to recognise that annual, system-wide reporting is a key enabler of learning, credibility and sustained investment in prevention.

Moreover, the Annex 1 content framework submitted to the Committee describes Oxfordshire's whole-system approach to physical activity as a nationally recognised example of partnership working, with demonstrable outcomes for individuals, communities and the wider system. This aligns closely with a substantial academic evidence base showing that physical activity is most effectively promoted through whole-system approaches that address environmental, social and service-level factors, rather than isolated behaviour change interventions²⁸.

NHS England has repeatedly emphasised that physical activity is one of the most powerful tools available to health systems for preventing long-term conditions, supporting mental wellbeing and reducing demand on services²⁹. Yet experience shows that physical activity initiatives can

²⁵ <https://www.equalhealthoxon.org.uk/initiative/well-together-programme>;
<https://communityfirstoxon.org/community-action/community-health-wellbeing/wt/>

²⁶

²⁷ <https://bdcpartnership.co.uk/strategic-initiatives/ria/ric/>; https://borninbradford.nhs.uk/wp-content/uploads/2024/11/BIRU-Final-Report_v2.0_Jan24.pdf

²⁸ <https://pmc.ncbi.nlm.nih.gov/articles/PMC4920841>

²⁹ <https://www.england.nhs.uk/ourwork/public-health/harnessing-the-benefits-of-physical-activity>

be fragmented or short-lived unless responsibility for oversight and reporting is clearly located. Annual PHIF reporting would provide a forum through which progress on physical activity pathways can be assessed across partners, including health, local government, sport and the voluntary sector, and through which inequalities in access and outcomes can be explicitly monitored.

Whole-system reporting also aligns with the growing national emphasis on structural and accountability measures in public health and healthcare. The Health Foundation has argued persuasively that prevention will only be prioritised if systems can clearly identify, track and communicate what they are investing in and what difference it is making³⁰. Annual reporting on prevention programmes provides a practical vehicle for doing exactly that at a local system level.

The recommendation that PHIF should lead this annual reporting is also significant. PHIF is positioned, in Annex 1 submitted to the Committee, as a forum that brings together partners across sectors and uses its convening power to influence investment, align strategy and embed a prevention lens. By publishing an annual system-wide progress update, PHIF can reinforce its role not only as a strategic body but also as a steward of shared narrative and learning. This is particularly important at a time when system leaders face competing priorities and when prevention gains risk being eclipsed by short-term pressures.

International and national reporting frameworks consistently show that transparency and public accountability help sustain focus on equity and prevention. The World Health Organisation's 2025 report on social determinants of health equity underscores that progress on these complex challenges requires sustained attention, measurement and communication, not one-off initiatives³¹. Annual PHIF reporting would situate Oxfordshire's prevention work within this wider context and provide a clearer basis for scrutiny, challenge and support.

Therefore, in recommending that the Prevention and Health Inequalities Forum publish annual, system-wide progress on prevention programmes such as Well Together and physical activity pathways, the Oxfordshire JHOSC is advancing a proportionate and evidence-based response to the realities of prevention work. The recommendation recognises that prevention delivers its greatest value when it is visible, shared and accountable across the whole system. It also reflects learning from the DPH Annual Report and Annex 1 framework, which demonstrate both the achievements and the vulnerabilities of Oxfordshire's prevention agenda. Annual PHIF reporting would strengthen accountability, support learning, and help protect prevention investment at a time of significant system pressure. Critically, it would ensure that prevention and health inequalities remain firmly on the agenda not just as strategic aspirations,

³⁰ <https://www.health.org.uk/reports-and-analysis/briefings/counting-what-matters-how-to-classify-account-and-track-spending-for-prevention>

³¹ <https://www.who.int/news/item/06-05-2025-health-inequities-are-shortening-lives-by-decades>

but as measurable, reviewable and collectively owned commitments across Oxfordshire's health and care system.

Recommendation 3: *For the Prevention and Health Inequalities Forum to publish annual system wide progress on prevention programmes, including Well Together and physical activity pathways.*

Securing Prevention Gains Through Multi-Year Funding: The Case for Sustainability, Best Value and Avoiding Regression: The Committee's recommendation to move Community Health Development Officer (CHDO) roles, the Well Together programme and wider community-led initiatives onto multi-year funding cycles reflects a critical insight into how health inequalities are reduced in practice. It recognises that short-term funding, while often administratively convenient, fundamentally undermines the sustainability, effectiveness and value for money of prevention programmes. In the context of the Director of Public Health (DPH) Annual Report 2025/26, which highlights encouraging signs of improvement in some Index of Multiple Deprivation (IMD) indicators while also warning of the fragility of these gains, this recommendation addresses a central strategic risk: that progress achieved through long-term, trust-based community work may be lost through funding instability.

The DPH Annual Report cover report presents Oxfordshire's recent prevention journey as one characterised by sustained partnership working, hyper-local insight and community-led action. It explicitly notes that progress since the 2019/20 DPH report has been driven by programmes that build local capacity, relationships and trust over time, rather than by short-lived interventions. The Annex 1 content framework reinforces this message, particularly in its discussion of the Community Insight Profile (CIP) programme, CHDO roles and Well Together. These initiatives are consistently described as relational, place-based and cumulative in nature, relying on continuity and local knowledge to translate insight into meaningful and sustained change. The same framework also identifies a key risk: that without sustained investment, gains achieved in priority areas could stall or reverse, especially in a context of wider funding constraints and system reform.

Prevention and community development do not operate on the same timelines as acute service delivery. Academic and policy literature repeatedly demonstrates that short funding cycles distort behaviour, weaken partnerships and erode institutional memory. A scoping review published in the Community Development Journal found that embedding community development approaches within local systems is consistently hindered by short-term funding arrangements, which make it difficult to build trust, retain skilled staff and sustain local participation³². The review highlights that community-centred approaches are most effective when

³² <https://academic.oup.com/cdj/article/58/4/699/7332008>

they are treated as long-term system assets, rather than time-limited projects.

This evidence aligns closely with Oxfordshire's local experience. Annex 1 submitted to the Committee describes how CHDOs act as connectors, brokers and trusted local figures, supporting delivery partners, convening relationships and ensuring recommendations from CIPs are implemented in ways that make sense locally. These roles are effective precisely because they are embedded, visible and sustained over time. Short funding cycles undermine this model by creating uncertainty for staff, reducing continuity in relationships and incentivising short-term outputs over long-term outcomes. Evaluation evidence from Oxfordshire's own CHDO and Well Together programmes reinforces this point, noting that continuity and "being there over time" are essential to building trust and enabling meaningful engagement, particularly in communities that have historically experienced disengagement from public services³³.

The Well Together programme exemplifies the same dynamic. Well Together is explicitly designed around community-led, grassroots activity in priority areas, with an emphasis on trust, accessibility and building social infrastructure that supports wellbeing³⁴. Many of the organisations involved are small or emerging groups embedded in their communities, for whom short-term funding creates disproportionate administrative burden and existential risk. From a best-value perspective, repeatedly onboarding, funding and then losing such organisations due to funding uncertainty represents poor stewardship of public resources.

Furthermore, a particularly important element of the JHOSC recommendation is the explicit reference to avoiding regression in areas showing improving IMD deciles. Annex 1 of the DPH Annual Report provides a careful and nuanced discussion of Oxfordshire's IMD 2025 results, emphasising both encouraging signs of progress and the need for caution in interpretation. The report stresses that IMD is a relative, point-in-time measure, and that apparent improvements can be fragile, particularly if the underlying drivers of inequality are not addressed consistently over time.

This fragility is well documented in the wider literature. The World Health Organization's 2025 report on social determinants of health equity highlights that gains in health equity are often reversible when investment is withdrawn or when structural supports are weakened, especially in disadvantaged communities³⁵. Similarly, prevention science research shows that discontinuity in preventive interventions disproportionately

³³ <https://data.oxfordshire.gov.uk/wp-content/uploads/2025/04/ohh-chdowt-evaluation-phase1-full-report.pdf>

³⁴ <https://www.equalhealthoxon.org.uk/initiative/well-together-programme;>
<https://communityfirstoxon.org/community-action/community-health-wellbeing/wt/>

³⁵ <https://www.who.int/news/item/06-05-2025-health-inequities-are-shortening-lives-by-decades>

affects populations already experiencing disadvantage, widening inequalities rather than narrowing them³⁶.

In this context, moving to multi-year funding cycles is not merely about organisational stability; it is about safeguarding population-level gains. For areas that have begun to move up IMD deciles, often after years of targeted effort, the withdrawal or fragmentation of community-based prevention support risks undoing progress and wasting prior investment. A best-value review that explicitly considers the cost of regression – in terms of increased demand on health services, reduced community capacity and widening inequalities – would provide a more accurate assessment of value than short-term cost savings alone.

Experience from other parts of England provides strong support for this approach. In Bradford District and Craven, the Reducing Inequalities in Communities (RIC) programme was established as a multi-year initiative precisely to allow sufficient time for prevention interventions to bed in, be evaluated and refined. The programme was supported by the Bradford Inequalities Research Unit, enabling longitudinal learning and adaptation³⁷. A key lesson from Bradford has been that short-term pilots rarely deliver system-level change, whereas longer-term commitments enable both effectiveness and accountability.

Similarly, the “Wigan Deal” offers a powerful example of how sustained, multi-year investment in community-centred approaches can deliver both improved outcomes and reduced demand on public services. Wigan Council’s shift towards asset-based working and long-term partnership with the voluntary and community sector was underpinned by a deliberate move away from short-term practices³⁸. Importantly, evaluations have shown that the financial benefits of this approach were only realised over time, reinforcing the argument that prevention represents best value when funded on a multi-year basis.

The Bromley by Bow Centre in Tower Hamlets provides further evidence of the value of continuity. Over several decades, sustained investment has enabled the development of an integrated model combining primary care, social prescribing, community development and enterprise. Long-term evaluation shows that this model’s effectiveness lies in its stability, local credibility and ability to retain skilled staff and trusted relationships³⁹. These are precisely the attributes undermined by short funding cycles.

³⁶ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10227139>

³⁷ <https://bdcpartnership.co.uk/strategic-initiatives/ria/ric/>; https://bominbradford.nhs.uk/wp-content/uploads/2024/11/BIRU-Final-Report_v2.0_Jan24.pdf

³⁸ <https://centreforpublicimpact.org/public-impact-fundamentals/the-wigan-deal/>;
<https://www.kingsfund.org.uk/insight-and-analysis/projects/lessons-wigan-deal>

³⁹ https://knowledge.lancashire.ac.uk/id/eprint/3386/1/Bromley_by_Bow_Centre_Report.pdf;
<https://www.health.org.uk/funding-and-fellowships/projects/practitioner-led-evidence-at-bromley-by-bow>

Furthermore, the Committee's recommendation for a best-value review alongside multi-year funding is therefore crucial. Best value in prevention should be understood in terms of long-term outcomes, system resilience and inequality reduction, not simply annual budget containment. The Health Foundation has argued that prevention spending is often undervalued because it is poorly measured and insufficiently tracked over time, calling for more systematic approaches to classifying and reporting preventive investment⁴⁰. Applying this logic locally, a best-value review that explicitly prioritises funding continuity for high-impact community programmes would align financial decision-making with Oxfordshire's stated ambitions on prevention and health equity.

The Prevention and Health Inequalities Forum, described in Annex 1 as bringing together partners with significant financial influence, is well placed to sponsor or oversee such a review. By doing so, it could help shift the system away from reactive, short-term funding decisions and towards a more strategic, prevention-led allocation of resources that protects prior investment and maximises returns over time.

In essence, the JHOSC recommendation to move CHDO, Well Together and community-led programmes onto multi-year funding cycles, supported by a best-value review and prioritisation of funding continuity, is firmly grounded in local evidence, national experience and academic research. It reflects an understanding that prevention works through sustained relationships, trust and cumulative impact, and that short funding cycles actively undermine these mechanisms.

In the context of the DPH Annual Report's findings – particularly the warning that improving IMD indicators remain fragile – this recommendation is also a statement about risk management. Without funding continuity, Oxfordshire risks losing hard-won gains and incurring higher downstream costs as inequalities widen once again. Multi-year funding is therefore not a luxury, but a prerequisite for delivering lasting value, protecting progress and ensuring that prevention genuinely contributes to a fairer, healthier Oxfordshire over the long term.

Recommendation 4: *To move Community Health Development Officer, Well Together roles and community led programmes onto multi-year funding cycles, given that short funding cycles undermine sustainability. It is recommended that there is a best value review and prioritisation of funding continuity to avoid regression of gains in areas with improving Index of Multiple Deprivation deciles.*

Prioritising Oxfordshire-wide rural areas that are experiencing a regression on the Multiple Deprivation deciles of inequalities: The JHOSC's recommendation to prioritise rural areas experiencing regression on the Index of Multiple Deprivation (IMD) deciles represents a necessary and timely recalibration of how inequalities are/should be

⁴⁰ <https://www.health.org.uk/reports-and-analysis/briefings/counting-what-matters-how-to-classify-account-and-track-spending-for-prevention>

understood and addressed across the county. While Oxfordshire is often characterised as relatively affluent, this aggregate picture masks deep and growing inequalities within rural towns, villages and parishes. The Director of Public Health (DPH) Annual Report 2025/26 explicitly cautions against complacency, noting that improvements in deprivation indicators are uneven and, in some areas, fragile or reversing. In this context, the recommendation responds to a critical strategic risk: that rural inequalities remain under-recognised, under-resourced and structurally disadvantaged within systems primarily designed around urban or population-dense neighbourhoods.

The Annex 1 content framework submitted to the Committee is clear that health inequalities are shaped by the wider determinants of health, including transport, access to services, housing affordability, employment security and social connection. These determinants manifest differently in rural contexts. Sparse populations, limited public transport, digital exclusion and declining local infrastructure combine to create a distinct pattern of disadvantage that is not always captured by headline statistics. National evidence consistently shows that rural deprivation is more likely to be “hidden”, spatially dispersed and experienced alongside isolation, making it harder for systems to identify need and target support effectively⁴¹.

The IMD is a valuable tool, but it is a relative, place-based snapshot that can obscure emerging rural decline. As highlighted in Annex 1 of the DPH Annual Report, changes in IMD deciles must be interpreted carefully, particularly where improvements in one area may be offset by decline elsewhere or by worsening conditions in comparators. Rural areas are especially vulnerable to this methodological limitation, because small changes in income, housing costs or access to services can push communities into worse deprivation bands with little public visibility.

Academic research reinforces this point. Studies of rural health inequalities demonstrate that deprivation in rural areas is often underestimated and that service access barriers amplify the impact of poverty and disadvantage⁴². The Health Foundation has similarly noted that rural communities frequently face “double disadvantage”: poorer access to services combined with policy narratives that prioritise urban inequality⁴³.

In Oxfordshire, where housing affordability pressures, insecure work and transport dependency disproportionately affect rural residents, the risk of regression is real. The JHOSC recommendation therefore reflects an evidence-based recognition that rural inequality requires explicit

⁴¹ <https://www.gov.uk/government/publications/health-inequalities-in-rural-and-coastal-areas/health-inequalities-in-rural-and-coastal-areas>

⁴² <https://academic.oup.com/heapol/article/35/6/653/5859896>

⁴³ <https://www.health.org.uk/news-and-comment/charts-and-infographics/inequalities-in-rural-and-urban-areas>

prioritisation, rather than being assumed to improve automatically as part of county-wide progress.

A central element of this JHOSC recommendation is to explore rural community capability through the development of the Neighbourhood offer to towns and parishes. The Annex 1 content framework submitted to the Committee situates neighbourhood working as the future model for integrated, preventive and place-based delivery, aligned with national direction through neighbourhood health and the NHS 10-Year Plan. However, neighbourhood models have largely developed around urban geographies, Primary Care Networks, or densely populated estates. Without adaptation, rural towns and parishes risk being structurally excluded from the benefits of neighbourhood working.

National policy increasingly acknowledges this challenge. NHS England's neighbourhood health guidance emphasises that neighbourhood models must be locally defined and responsive to place, rather than imposed uniformly⁴⁴. The King's Fund similarly highlights that neighbourhood health must reflect how people live, travel and connect in different contexts, warning against urban-centric assumptions⁴⁵.

Extending the Neighbourhood offer to towns and parishes therefore requires a flexible, contextualised approach. In rural settings, neighbourhoods may not be contiguous estates but networks of villages, market towns and service hubs. Local assets may include parish councils, village halls, faith groups, libraries, volunteer drivers, and informal support networks. Recognising and legitimising these as part of the Neighbourhood offer is essential if rural communities are to benefit from system investment in prevention and integration.

Moreover, the recommendation's emphasis on supporting an independent voice and local members is particularly significant in rural settings. Rural communities often rely heavily on councillors, parish representatives and volunteers to advocate for local needs, yet these voices can struggle to influence system-level decision-making dominated by larger organisations and urban priorities. The DPH Annual Report and Annex 1 repeatedly stress the value of community voice in shaping effective responses to inequality, drawing on the experience of Community Insight Profiles and community-led programmes.

Academic literature on co-production and community capability underscores that meaningful participation requires infrastructure and resourcing, not just consultation. A systematic review of community co-creation in public health found that without sustained support, community voice risks being tokenistic or confined to narrow engagement exercises⁴⁶. This is particularly acute in rural contexts, where individuals

⁴⁴ <https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26>

⁴⁵ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health>

⁴⁶ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10094395>

often participate in multiple roles and where capacity can be easily overstretched.

Supporting an independent rural voice may therefore require different mechanisms than those used in urban neighbourhoods. This could include dedicated facilitation, support for parish-level collaboration, or investment in rural anchor organisations that can convene communities across dispersed geographies. The experience of rural community development programmes in counties such as North Yorkshire and Cumbria demonstrates that tailored support for parish networks and local leadership can significantly enhance community resilience and service access⁴⁷.

Examples from elsewhere reinforce the case for a differentiated rural approach. In Cornwall, where deprivation is widespread but dispersed, the development of community-led health and wellbeing models has relied on recognising parish-level identity and investing in trusted local connectors, rather than assuming neighbourhoods mirror urban patterns⁴⁸. Evaluations show that rural outreach is most effective when it builds on existing local structures and supports community capability over time.

Similarly, in Lincolnshire, place-based health inequality work has increasingly focused on rural market towns as hubs, combining local authority, voluntary sector and NHS effort around defined rural catchments⁴⁹. These models underline that rural neighbourhood working must be designed deliberately, not retrofitted from urban templates.

Furthermore, at the heart of this JHOSC recommendation is a recognition that community capability is itself a protective factor against inequality. The Marmot Review and subsequent Institute of Health Equity work emphasise that giving communities greater control and strengthening social infrastructure are essential components of reducing health inequalities⁵⁰. In rural areas, where statutory services are often distant or limited, community capability becomes even more critical.

The DPH Annual Report reflects this logic by highlighting community-led programmes as key drivers of progress since 2019/20. Extending this approach to rural areas experiencing IMD regression aligns with both evidence and equity principles. It recognises that prevention is not simply about service provision, but about enabling communities to shape solutions, access resources and sustain improvement over time.

Conclusion

⁴⁷ <https://www.localtrust.org.uk/insights/research-insights/community-power-in-rural-areas>

⁴⁸ <https://arc-swp.nihr.ac.uk/research/projects/evaluation-of-the-cornwall-community-health-and-wellbeing-worker-chww-service>

⁴⁹ <https://www.nhsconfed.org/publications/place-based-partnerships-rural-and-coastal>

⁵⁰ <https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>

Overall, the JHOSC's recommendation to prioritise rural areas experiencing regression in deprivation, to extend a contextualised Neighbourhood offer to towns and parishes, and to support independent voice and community capability is a proportionate, evidence-based response to a long-standing blind spot in inequality policy. It reflects learning from the DPH Annual Report, which shows that progress is uneven and fragile, and that rural disadvantage requires explicit attention. Without such a focus, Oxfordshire risks entrenching a two-tier approach to neighbourhood working, where urban areas benefit from system investment while rural communities could risk fall further behind. By contrast, developing a rural-appropriate Neighbourhood offer, strengthening local voice and investing in community capability would align Oxfordshire's prevention strategy with national direction, academic evidence and the lived realities of rural residents. In doing so, it would ensure that the ambition to reduce health inequalities truly extends across the whole county, not just its most visible places.

Recommendation 5: *To prioritise Oxfordshire-wide rural areas that are experiencing a regression on the Multiple Deprivation deciles of inequalities. It is recommended that the capability of rural communities is explored by the development of the Neighbourhood offer to Towns and parishes; and to give consideration for a contextualised offer to support an independent voice, local members, and to enhance community capabilities.*

Legal Implications

13. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 - Power to scrutinise health bodies and authorities in the local area
 - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 - Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.
14. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.
15. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the Committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

16. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Gareth Epps
Councillor Emma Garnett
Councillor Imade Edosomwan
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
District Councillor Val Shaw
City Councillor Louise Upton
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

Contact Officer: Dr Omid Nouri
Health Scrutiny Officer
omid.nouri@oxfordshire.gov.uk
Tel: 07729081160

June 2026