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

Oxfordshire Neighbourhood Health Plan

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

Report to:
- Dr Michelle Brennan, Chair Oxfordshire GP Leadership Group.
- Matthew Tait (Chief Delivery Officer, BOB ICB)
- Dan Leveson (BOB ICB Director of Places and Communities)
- Ansaf Azhar (Director of Public Health); Lisa Lyons (Director of Children's Services)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on the ongoing development of a Neighbourhood Health Plan for Oxfordshire during its public meeting on 20 November 2025.

2. The Committee would like to thank Dr Michelle Brennan (Chair Oxfordshire GP Leadership Group); Victoria Baran (Deputy Director for Adult Social Care, Oxfordshire County Council); Ansaf Azhar (Director of Public Health, Oxfordshire County Council); Ian Bottomley (Deputy Director, Joint Commissioning); Sue Butt, Transformation Director, Oxford Health NHS Foundation Trust [OUH]); Kate Holburn (Deputy Director Public Health); Lily O'Connor (Oxfordshire Urgent Emergency Care Programme Director, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board [BOB ICB]) and Chris Wright (Associate Director of Place for Oxfordshire, BOB ICB) for attending the meeting and answering questions from the Committee.

3. The development of a Neighbourhood Health Plan for Oxfordshire is of significant importance and interest for the Committee, particularly given that national directives now require local system partners to collectively develop Neighbourhood Health Plans. This plan would also be in line with the government's NHS 10 Year Health Plan.

4. Upon commissioning the reports for this item, some of the insights the Committee sought to receive were as follows:

    - How the Neighbourhood Health Plan is being developed.
    - The national and local timescales surrounding the development of the plan.
    - The degree to which there is sufficient system partner collaboration to develop the plan.
    - The degree to which co-production is at the heart of the plan's design.

- Whether the plan will result in significant changes to how health and care is currently delivered at the neighbourhood level in Oxfordshire.

- The definition of 'neighbourhood', and how the plan will be geographically spread and consistent in its scope and delivery.

- The degree to which there is sufficient resourcing in place to deliver a Neighbourhood Health Plan.

SUMMARY

5. During the 20 November 2025 meeting, the Committee received an update on the development of Oxfordshire's Neighbourhood Health Plan; and were informed that the deadline for submitting the final version of the plan had been extended by government beyond December 2025, allowing more time for partners to refine the plan. The Committee emphasised that this extension would help avoid a rushed process and enable a more robust outcome, and that this item provided an opportunity for scrutiny of and recommendations for the plan in a timely fashion.

6. The value of community projects and lessons from co-production and voluntary sector involvement were discussed, with the Wantage Community Hospital project cited as an example of transformation from a hospital-based to a community-focused initiative. The importance of engaging the voluntary sector and leveraging local assets was highlighted, alongside the need to map community activity and integrate voluntary sector knowledge. Co-production and voluntary sector engagement were deemed essential for effective prevention and holistic neighbourhood planning.

7. The governance structure for the Neighbourhood Health Plan was examined, particularly regarding the involvement of voluntary, community, faith, and social enterprise sectors. A dedicated stakeholder event had been held to discuss engagement methods, with approaches tailored to suit different organisations' capacities. Ongoing collaboration with infrastructure organisations, regular meetings with the voluntary sector, and offers for representation on key boards were noted, aiming for both information sharing and genuine influence over decision-making.

8. The role of the Health and Wellbeing Board in the Neighbourhood Health Plan, mechanisms for public accountability, and governance sign-off were discussed. The Board would have overall accountability and leadership for the plan, with regular updates provided to the JHOSC. The plan would be developed with input from a wide range of stakeholders, including lived experience representatives and district councillors, and would be socialised with all relevant organisations for sign-off. The Board's membership might be reviewed to ensure broad stakeholder involvement.

9. Parish council involvement in the development of the Neighbourhood Health Plan was raised. Parish councils had not yet been engaged but would be included as the process moved to the individual neighbourhood level, recognising their valuable local insight. Collaboration would likely be coordinated with guidance from County

and District Councils, and it was suggested that the Oxfordshire Association of Local Councils be used as a key communication channel.

10. The criteria for determining what constituted a 'neighbourhood' within the plan, and ensuring coherence across Oxfordshire, especially with possible future changes to local government boundaries, were clarified. Four planning units: North, City, South, and West, had been established to facilitate local stakeholder engagement, not to set fixed boundaries. Neighbourhoods would likely range from 30,000 to 50,000 people, with further and continuous evaluation to ensure boundaries reflected natural community movements and local service use.

KEY POINTS OF OBSERVATION:

11. This section highlights five key observations and points that the Committee has in relation to the development of a Neighbourhood Health Plan for Oxfordshire. These five key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Clear governance arrangements: The Committee is recommending that clear governance arrangements should be developed for the Oxfordshire Neighbourhood Health Plan (ONHP), with defined roles for the Health and Wellbeing Board (HWB), the Place-Based Partnership (PBP), and the Primary and Community Care Board (PCCB), alongside openness, transparency and regular reporting to the JHOSC. This recommendation is strongly justified by: Oxfordshire's own governance trajectory and timetable; national policy and planning requirements; comparative learning from other local systems, and that the evidence says about integration at neighbourhood level.

The report submitted to the committee indicates that the objective is to set out a multi-layered model in which the HWB oversees and approves the Neighbourhood Health and Care Plan ahead of April 2026, with 2026/27 as a transition year and, a more comprehensive five-year plan from April 2027. The PBP would lead the plan's delivery via the Primary and Community Care Board (PCCB) (an established vehicle bringing partners together), and governance is to be broad, inclusive and reviewed regularly as the programme develops.

Given this context—multiple boards, evolving neighbourhood geographies, and a firm approval deadline—the case for explicit governance is not theoretical. It is a practical necessity to avoid duplication, gaps in accountability, and fragmentation across programmes and partners. The PCCB's formation and cross-sector membership (which includes district councils, social care, public health, NHS providers, pharmacy/optometry/dentistry) further underlines the scale and pluralism of delivery partners, and the need to codify who does what, where, and when.

A consistent message from some of the literature and guidance is that role clarity is a precondition for good system partner collaboration. The King's Fund analysis of the 10-Year Health Plan argues that delivering the government's "three shifts"—from hospital to community, from analogue to digital, and from sickness to prevention—requires clarity of purpose and function across system partners[1]. Additionally, NHS England's Strategic Commissioning Framework sets explicit expectations of ICBs as strategic commissioners and describes an updated commissioning cycle with responsibilities across system, place and neighbourhood levels—again, predicated on clear roles and transparent decision-making[2].

The Neighbourhood Health Guidelines 2025/26 explicitly call for integrated, locally tailored delivery with common components and transparent frameworks to track progress—an approach that benefits from regular public reporting[3]. NHS England's Medium Term Planning Framework (2026/27–2028/29) emphasises multi-year trajectories and measurable improvement, again implying cyclical reporting into formal fora[4].

The government's 10 Year Health Plan sets the direction of reform and the "three shifts", with a focus on community-based, preventative, and digitally enabled care[5]. NHS England has subsequently published the Strategic Commissioning Framework and the Medium-Term Planning Framework (both mentioned above); each of which reinforces the need for coherent governance that can join strategy (Health and Wellbeing Board), place delivery (Place-Based Partnership) and neighbourhood operationalisation (Primary and Community Care Board). For clinical and pathway development, NHS England has added targeted resources—e.g., guidance on neighbourhood Multi-disciplinary Teams (MDTs) for children and young people and the standardisation of community health services—which require local structures that can translate guidance into delivery and report progress[6].

Furthermore, one key national case is from Greater Manchester (GM); which provides a long-running example of clear, published governance backing neighbourhood models. The *GM Integrated Care Governance Handbook* sets out constitutions, schemes of delegation and terms of reference for committees and locality boards, clarifying decision-rights across system–place structures—precisely the sort of codification Oxfordshire potentially needs[7]. At neighbourhood level, Manchester Local Care Organisation (MLCO) publicly describes integrated neighbourhood teams and evolving neighbourhood leadership

[1] The King's Fund explainer
[2] NHSE Strategic Commissioning Framework
[3] NHSE Neighbourhood health guidelines 2025/26
[4] NHSE Medium Term Planning Framework
[5] DHSC policy paper
[6] NHSE MDTs for CYP; NHSE Standardising community health services
[7] NHS GM Governance Handbook (PDF)

arrangements—transparency that helps staff and residents understand how responsibilities are distributed[8].

Another example is from West Yorkshire, where the ICB operates a highly-devolved, place-based governance model, with ICB Place Committees and public documentation on roles, budgets and accountability—illustrating how transparent, delegated governance can support scale while remaining close to place and neighbourhood priorities[9].

Moreover, a 2025 systematic review on integrated neighbourhood models identified seven core domains—including integrator roles, partnership principles and core workforce—and cautions that inconsistent evaluation frameworks and funding ambiguities undermine scalability[10]. In addition, the Nuffield Trust examined/reviewed a decade of lessons for Integrated Neighbourhood Teams (INTs), starting with "be clear about definitions" and the importance of governance clarity across organisations that may each have different views of "place" and "neighbourhood"[11]. Their written evidence to Parliament likewise warns that ICS reforms can falter if responsibilities are diffuse, measures of success are unfocused, or multiple partnership structures are allowed to pile complexity without clear decision-rights and accountability[12].

Recommendation 1: *For clear governance arrangements to be developed for the Oxfordshire Neighbourhood Health Plan, including defined roles for the Health and Wellbeing Board, Place-Based Partnership, and Primary and Community Care Board. It is recommended that there is openness and transparency, as well as regular reporting to the JHOSC on the plan's development and delivery milestones.*

Alignment with strategic initiatives and avoiding duplication: Neighbourhood health planning does not exist in a vacuum. The report submitted to the Committee for this item makes clear that Oxfordshire's health and care system is already shaped by multiple long-standing programmes, each with its own governance, funding, and performance structures. The report also notes that the county is already delivering components of neighbourhood-based care—Integrated Neighbourhood Teams (INTs), multidisciplinary working, population health management, community-based initiatives—through established structures and strategies. The Committee understands that these operate within the broader context of the Oxfordshire Health and Wellbeing Strategy and the Oxfordshire Way, both of which emphasise prevention, tackling inequalities, and a whole-system approach to wellbeing. Nonetheless, without clear alignment, neighbourhood health planning could risk

[8] MLCO – INTs; Neighbourhood lead structure
[9] NHS West Yorkshire ICB; Leeds ICB committee ToR (PDF); WY devolution & productivity briefing (PDF)
[10] BMC Public Health – Integrated Neighbourhood Model
[11] Nuffield Trust – INTs: lessons from a decade
[12] Nuffield Trust evidence to Parliament (PDF)

creating overlapping responsibilities, duplicative projects, and resource inefficiency.

Without strategic alignment, a new Neighbourhood Health Plan risks:

- Re-establishing or rebadging existing programmes under a different banner.
- Creating multiple workstreams targeting the same population groups.
- Confusing partners and the public about who is responsible for what.
- Diluting the workforce by spreading clinical and managerial capacity across too many boards or initiatives.

Though there is clearly a range of existing effective health and care programmes within Oxfordshire, there is a need to coordinate and scale them rather than duplicate them.

The use of the Better Care Fund (BCF) is not optional. NHS England has stated clearly that the BCF must be aligned to neighbourhood-based models of care and community prevention[13]. This means Oxfordshire's Neighbourhood Health Plan must directly integrate with the BCF's priorities on:

- integrated discharge
- intermediate care
- support for high-need, high-risk populations
- hospital avoidance
- joint commissioning

Failure to align with these BCF priorities could jeopardise the county's ability to meet national expectations and risk future funding or performance management challenges.

Furthermore, the *Health and Wellbeing Strategy* and the *Oxfordshire Way* set out county-wide ambitions: healthier communities, earlier prevention, narrowing inequalities, and partnership between public sector, voluntary sector, and residents. These are broad, population-wide frameworks. The Neighbourhood Health Plan, by contrast, should ideally provide more local, operational detail. If the Neighbourhood Plan does not map onto these higher-level strategies, several problems could follow including:

- *Two-tier priority setting*: with neighbourhoods developing priorities that differ from county-wide objectives.
- *Unequal investment*: across geographies because planning cycles are not aligned.
- *Mixed messages:* to the voluntary sector, which already works across multiple geographic footprints.

[13] see **Revised BCF Guidance 2026/27**, awaiting publication, referenced in the Neighbourhood Health and Care JHOSC report

Moreover, NHS England's *Medium-Term Planning Framework 2026–29* stresses that local systems must streamline planning, reduce duplication, and operationalise the 10-Year Health Plan through place-level coordination[14]. Academic literature further supports the need for alignment. A 2025 systematic review of integrated neighbourhood models published in *BMC Public Health* found that common failures in neighbourhood-based care included "fragmented governance," "inconsistent evaluation models," and "multiple overlapping programmes competing for the same population groups," all of which reduce impact and sustainability. The study recommends that neighbourhood models be "explicitly tied to wider strategic structures" to create a unified system architecture[15]. The Nuffield Trust similarly observes that integrated neighbourhood teams are effective only when their work is woven into wider ambitions set at place and system level, cautioning that unaligned planning leads to "confused accountability, duplicated effort, and delivery paralysis"[16].

On a national scale, there are cases which demonstrate the effectiveness of efforts to ensure alignment between neighbourhood planning and wider strategic initiatives:

Tower Hamlets: The *Tower Hamlets Together* partnership demonstrates what effective integration looks like—neighbourhood teams operate within a borough-wide vision that aligns with the Health & Wellbeing Board strategy, reducing fragmentation and allowing the borough to deliver award-winning community prevention programmes[17].

Salford: The *Salford Together* integrated care programme evaluation found that alignment between neighbourhood teams, the locality plan, and Greater Manchester-wide priorities was a major contributor to improved outcomes. Conversely, early phases of the programme struggled where pilot projects overlapped or lacked strategic alignment[18].

Sunderland: Sunderland's *All Together Better Alliance* demonstrates how outcome-based commissioning aligned across system layers reduces fragmentation. Neighbourhood interventions feed directly into place-wide outcomes frameworks, ensuring clarity and avoiding duplication[19].

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[14] https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/

[15] https://link.springer.com/article/10.1186/s12889-025-22582-x

[16] https://www.nuffieldtrust.org.uk/news-item/integrated-neighbourhood-teams-lessons-from-a-decade-of-integration

[17] https://democracy.towerhamlets.gov.uk/documents/s263201/HASSC%20paper%20on%20Neighbourhoods%2011%20Nov%202025.pdf

[18] http://www.salfordtogether.com/wp-content/uploads/2020/09/Salford-Together-Evaluation-Report-July-2020.pdf

[19] https://outcomesbasedhealthcare.com/wp-content/uploads/2022/07/ATB-Sunderland-OBH-PHM-Outcomes-Case-Study-Full-Report-FINAL-290622.pdf

In essence, if Oxfordshire's Neighbourhood Health Plan is *not* aligned with the Better Care Fund, the Health and Wellbeing Strategy, and the Oxfordshire Way, the result could be inefficiency, duplication, contradictory priorities, and reduced impact for residents. With alignment, however, the county can create a coherent, powerful, and united vision for neighbourhood health that builds on existing strengths, reduces inequalities, and delivers better outcomes. Alignment, therefore, is not an administrative formality. It is the backbone of effective, equitable, and sustainable neighbourhood-based care.

Recommendation 2: *To ensure that the Neighbourhood Health Plan aligns with other strategic initiatives (such as the Better Care Fund and the Health & Wellbeing Strategy, and the Oxfordshire Way), and to avoid duplication and fragmentation.*

Investment in digital infrastructure: Nationally, neighbourhood health is no longer a peripheral concept but a core delivery vehicle for the NHS's shift to proactive, preventative, community-based care. NHS England's Neighbourhood Health Guidelines 2025/26 make Population Health Management the first foundational component, and require systems to develop linked, person-level datasets that join primary care, community, mental health, hospital, and local authority social care data, underpinned by interoperable systems and usable tools at neighbourhood level[20]. The guidelines also point to the *Reasonable Adjustment digital flag* (an information standard now with a full compliance deadline) as a concrete example of the data plumbing needed to identify and respond to the needs of people who are often under-represented in routine datasets[21]. NHS England's companion guidance on building an ICS intelligence function sets out what Oxfordshire must actually build: a system-wide intelligence function that integrates analytics, information governance and digital teams to provide near real-time, place and neighbourhood insights for commissioning and frontline multi-disciplinary teams[22].

There are clear indications around the country of how digital infrastructure and interoperability is being enhanced and put into effect. Greater Manchester (GM) again offers a notable model. Its *GM Care Record* federates data for 2.8 million citizens across 10 localities and is now being extended with a Secure Data Environment (SDE) to support PHM and research, under clear public communications and Section 251 approvals[23]. The GM approach shows how shared care records, when combined with robust governance and a transparent engagement campaign, can support both direct care and de-identified PHM/analytics without eroding public trust.

Another example is from London, where there is a complementary path through OneLondon and the London Care Record, under a Data Sharing Framework adopted across five ICSs, now aligned to a London Secure

[20] Reasonable Adjustment Digital Flag—NHS England Digital; Action checklist, updated Jan 2026
[21] Reasonable Adjustment Digital Flag—NHS England Digital; Action checklist, updated Jan 2026.
[22] NHSE ICS intelligence function guidance
[23] GM Care Record case study; GM Data Sharing & SDE toolkit; HRA summary of GM SDE pilot

Data Environment. This codifies controller responsibilities, access controls, and interoperability expectations to support neighbourhood information flows, while creating a platform for population-level insight[24].

In addition, Sunderland's 'All Together Better' programme provides a neighbourhood-level exemplar of PHM plus outcomes measurement. Their alliance adopted a whole-system outcomes framework, used linked longitudinal datasets to segment populations, and embedded evaluation cycles to drive improvement[25].

At policy level nationally, the case for investing in data infrastructure and usability is unambiguous. The NHSE ICS intelligence guidance argues that systems must "unlock integrated data and population analytics" to understand inequalities and target resources; it also stresses data-literate leadership and multidisciplinary intelligence teams[26]. The Neighbourhood Health Guidelines 2025/26 reiterate the need for longitudinal linked datasets and compatibility between GP, and community and social care systems[27].

Academic studies also reinforce the need for strengthening digital datasets, interoperability, and usability for PHM purposes. The *Goldacre Review* sets a blueprint for Better, Broader, Safer use of NHS data through Trusted Research Environments, open methods and improved analyst careers—precisely the scaffolding local systems need if PHM is to be safe, accepted and sustainable[28]. The *British Journal of General Practice* editorial on "Data saves lives" cautions that success requires bottom-up professional endorsement and usability at the coalface—frontline teams must see and feel the benefits[29]. Meanwhile a 2025 *BMC Public Health* systematic review on integrated neighbourhood models identifies digital exclusion and inconsistent evaluation frameworks as recurrent barriers[30].

The case for investment is therefore twofold. First, in terms of infrastructure and interoperability: Oxfordshire needs a shared, linked data layer across NHS providers and the County Council (including adult social care), with consistent Information Governance (IG) routes so that neighbourhood teams can see the same, current picture of demand, risk and capacity. National guidance on ICS intelligence functions provides a practical blueprint and a toolkit for standing this up quickly, with case studies to emulate[31]. Second, in terms of usability: neighbourhood staff—GPs, community nurses, social workers, and voluntary sector partners—need simple PHM tools that surface risk, impacts and next best actions

[24] OneLondon Data Sharing Framework; HRA—OneLondon SDE; NHSE London: information sharing for INTs
[25] ATB Sunderland PHM/outcomes case study – full report
[26] NHSE guidance
[27] NHSE neighbourhood guidelines
[28] Goldacre Review—DHSC
[29] BJGP editorial
[30] BMC Public Health systematic review
[31] NHSE ICS intelligence function; Strategy Unit toolkit

without undue complexities or barriers. The Health Economics Unit materials on risk stratification and impactibility provide off-the-shelf methods and training resources to promote consistent practice across neighbourhoods[32]

The reporting requirement recommended by the JHOSC is about prudent governance. Regular, structured updates from system partners to the JHOSC and the HWB—on data linkage coverage, IG assurance, PHM use cases, and Multi-Disciplinary Team adoption—will sustain momentum, surface barriers (such as supplier onboarding, information standards conformance), and protect public confidence. This also echoes the Oxfordshire HWB's emphasis on dashboarding of inequalities, research collaboration with universities, and building a community of practice around health equity and data use.

Recommendation 3: *To prioritise investment in digital infrastructure, interoperability, and usability to enable data sharing and Population Health Management at neighbourhood level. It is recommended that system partners report on progress in implementing Population Health Management tools and Health Evaluation Units.*

Meaningful co-production and input: The Committee believes that Neighbourhood Health planning must be built on meaningful community involvement. The plan should also embed local patient voice and voluntary sector input at its core, and opportunities should exist for Parish/Town Councils and local members to provide essential insight into community needs. Local councillors at parish-level in Oxfordshire already function as key connectors between statutory bodies and communities. Local members often do and can act as frontline representatives in their communities. Despite not yet being fully engaged, parish councillors hold "valuable local insight", which can prove pivotal for neighbourhood-level decision making[33].

The Oxfordshire Voluntary and Community Sector Strategy (2022–27) adds that Oxfordshire's 40% rural population depends heavily on voluntary groups, faith organisations, and community networks to access support and maintain wellbeing. Such groups regularly serve populations that statutory organisations struggle to reach—including older people, isolated rural residents, carers, and seldom-heard groups. It is these communities, rather than professionals, who experience the day-to-day impact of access barriers, digital exclusion, transport challenges, and service fragmentation[34].

Furthermore, voluntary sector capacity and community insights already underpin some of Oxfordshire's successful initiatives like Community Insight Profiles and the Well Together Programme. These illustrate that co-produced, community-driven interventions generate better data,

[32] HEU risk strat guide).
[33] [knowledge....hire.ac.uk], [carnallfarrar.com]
[34] OCC Voluntary and Community Sector Strategy 2022 -2027

stronger engagement, and more effective solutions than top-down planning alone[35].

As highlighted above in this report, the shift toward neighbourhood health is embedded in national policy. NHS England's *Neighbourhood Health Guidelines 2025/26* emphasise the need for *"integrated working"* at community level and call for localities to create neighbourhood systems in which *patients have increased agency over their care* and participate in shaping local service models[36].

This is reinforced by the growing emphasis on co-production in the NHS. Literature reviews commissioned by NHS England identify six core principles of co-production and conclude that co-production leads to:

- *Improved patient experience.*
- *Better clinical outcomes.*
- *More efficient services and reduced duplication*[37].

This national evidence aligns with the JHOSC's stance that co-production is not a discretionary add-on; but is a foundation of effective neighbourhood care.

Moreover, academic research strongly supports the impetus for co-production in this context. The University College London *Value of Co-Production* project (2022) found that co-produced services deliver outcomes that "actually matter to people" and promote empowerment, resource-efficient service models, and improved trust[38]. Similarly, the *Sheffield Co-production Research Review* shows that community partnership leads to better service design and more inclusive approaches to health inequalities[39].

More specific to neighbourhood health, the University of Manchester's 2025 *Rapid Evidence Synthesis* identifies community engagement as a key enabler of integrated neighbourhood team functioning—while the lack of community voices contributes to fragmentation. Additionally, a 2025 systematic review in *BMC Public Health* established that effective Integrated Neighbourhood models rely on community partnership, voluntary sector collaboration, and distributed local leadership.

[35] [england.nhs.uk]
[36] NHSE neighbourhood guidelines
[37] see: NHS England, *How co-production is used to improve care*
[38] https://www.coproductioncollective.co.uk
[39] Co-production report - Full Report.pdf

The academic study *Exploring lessons from Covid-19 for the role of the voluntary sector in ICSs* (Carpenter et al., 2022) focuses on Oxfordshire and shows that:

- VCS organisations were critical in bridging gaps between communities and statutory services.
- Hyper-local engagement was essential for reaching vulnerable groups.
- Parish Councils, especially in rural areas, acted as vital conveners connecting NHS services and community response.

This research provides powerful evidence that the voluntary sector must be a structural partner—not a peripheral participant—in Oxfordshire's neighbourhood plan.

Furthermore, Parish and Town Councils represent 92% of England's communities and act as the most local tier of democratic governance. Their statutory role in planning, community development, and neighbourhood planning is well established[40]. These councils often:

- Possess granular insight into local community needs.
- Have established communication channels with residents.
- Are trusted conveners in times of crisis.
- Manage or host community infrastructure essential for health activity (community centres, halls, volunteer transport).

Examples from research in integrated care systems shows that Parish Councils are particularly significant in rural health planning, helping address social determinants of health, coordination of transport, and digital inclusion[41]. There are three key examples of how this has played out in other regions around the country:

- *Kent & Medway:* Parish Councils have been integrated into health and wellbeing partnership boards to improve neighbourhood planning.

- *Cornwall:* Parish-led engagement has shaped local health hubs and influenced urgent care pathway redesign.

- *Leeds:* Councillors are central to the Leeds Neighbourhood Model, enabling community-led health priorities[42].

These examples show that embedding local councils improves legitimacy, accountability, and relevance of neighbourhood health interventions.

[40] National Association of Local Councils guidance, 2025
[41] [nalc.gov.uk]
[42] See LGA Healthy Places guidance: https://www.local.gov.uk

Recommendation 4: *To ensure that the local patient voice and local voluntary sector input is at the heart of the development and delivery of the neighbourhood health plan for Oxfordshire. It is recommended that the role of the local member and Parish/Town Councils is also integral to this.*

Legal Implications

12. 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.

13. 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'.

14. 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.

15. 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 Judith Edwards
    Councillor Gareth Epps
    Councillor Emma Garnett
    District Councillor Katharine Keats-Rohan
    District Councillor Elizabeth Poskitt
    City Councillor Louise Upton
    Barbara Shaw
    Sylvia Buckingham

Annex 1 – Scrutiny Response Pro Forma

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