OXFORDSHIRE HEALTH AND WELLBEING BOARD
24 SEPTEMBER 2026

Oxfordshire Marmot Place - Rural Inequalities report

Report by Ansaf Azhar– Director of Public Health and Communities, Oxfordshire County Council

RECOMMENDATION

1. **The Oxfordshire Health and Wellbeing Board is RECOMMENDED to**

   1.1 **NOTE** the findings of the Oxfordshire Rural Areas Data Pack and the "Health and wellbeing in rural towns and villages in Oxfordshire" report, and their alignment with the Board's prevention and inequalities priorities.

   1.2 **SUPPORT** dissemination of both reports and encourage partners to work with rural communities to develop locally-led responses, building on existing community assets.

   1.3 **USE** the quantitative data and community insight to inform system-wide place-based planning, including the development of neighbourhood approaches, with particular attention to transport and connectivity, access to health and care, young people, housing and infrastructure, and the sustainability of community and voluntary action.

Executive Summary

2. This paper presents two complementary reports developed through Oxfordshire's Marmot Place programme: the Oxfordshire Rural Areas Data Pack and Healthwatch Oxfordshire's "Health and wellbeing in rural towns and villages in Oxfordshire" report, produced with Community First Oxfordshire (CFO) and funded by Oxfordshire County Council Public Health. Together they combine analysis of population demographics, health and wider determinants with the experiences of residents and organisations in 14 rural towns and villages.

3. Rural areas are performing better than urban centres across multiple indicators, including life expectancy and overall deprivation. However, these averages mask marked variation between places and smaller pockets of disadvantage. Rural disadvantage is also shaped by distance and connectivity: geographical access to services, limited public transport and poor walking and cycling infrastructure can amplify the effects of low income, disability, poor housing or ill health.

4. Community engagement heard from 850 people through surveys, outreach, and focus groups. Residents valued community spirit, local groups, green space and access to the countryside. However, they also described barriers relating to the cost of living, transport, access to health and care, affordable and energy-efficient housing, opportunities for young people, local employment and skills, the public realm, and feeling insufficiently involved in decisions. Financial hardship was consistently associated with poorer self-reported health and greater difficulty looking after health and wellbeing.

5. The actions deriving from the report recommendations should be both strategic and place-specific, following an Asset-Based Community Development (ABCD) approach. These should build on local assets and sustained community relationships, empowering residents to take ownership of their health and wellbeing priorities without transferring responsibility for structural problems to volunteers and community groups.

Background

6. Oxfordshire became a Marmot county in November 2024, partnering with the UCL Institute of Health Equity to develop a coordinated approach to reducing health inequalities. One of the main programme priorities was to understand how rural health inequalities manifest in Oxfordshire, where they are concentrated, and how they can be addressed. Oversight has been provided by a rural inequalities working group with representation from local authorities, voluntary and community organisations, academic partners, and the Institute of Health Equity.

7. The Office for National Statistics (ONS) 2021 Rural Urban Classification (RUC) was used to determine which area were rural. The RUC classifies settlements with a population of 10,000 or more as urban, and all other settlements as rural, alongside measures of address density, physical settlement form, and relative access to major towns and cities.

8. Rural settlements cover 89% of Oxfordshire's land area and contain 35% of its population. Population and services are concentrated within urban centres, creating distinctive challenges for rural communities in relation to transport, access to services and social connectivity.

9. Fourteen areas were selected to focus further work on, based on their diverse populations, deprivation markers, and distance from urban centres. These areas are the following:
   (a) Cropredy, Deddington, Heyford, and Yarnton in Cherwell;
   (b) Charlbury, Chipping Norton, Freeland, and Long Hanborough in West Oxfordshire;
   (c) Chalgrove and Sonning Common in South Oxfordshire;
   (d) Faringdon, Standford in the Vale, Watchfield, and Shrivenham in the Vale of White Horse.

10. The approach followed was modelled on the successful Community Insight Profiles, which included mapping the assets in each area, capturing community insight around enablers and challenges to health and wellbeing and detailing a dataset of indicators for each area to help inform high level recommendations.

11. The data pack provides a summary of facts and figures about rural Oxfordshire overall, as well as the selected rural areas, using the smallest available statistical geographies to provide granularity and uncover pockets of deprivation. Comparisons are made with urban areas and Oxfordshire as a whole.

12. Healthwatch Oxfordshire in partnership with Community First Oxfordshire undertook community engagement work in the selected areas between January and June 2026, commissioned by Oxfordshire County Council Public Health, with oversight by the Marmot rural inequalities working group. Resident and organisational surveys, focus groups, in-person outreach and one-to-one conversations were used to:

    (a) explore the experiences of the residents living and working in these areas in relation to their health and wellbeing and the factors that influence them;
    (b) map the supply of available services;
    (c) assess the gaps and make recommendations to improve the health and wellbeing of the residents in rural Oxfordshire, taking into account local needs.

Main findings from the data pack

13. **Population:** Oxfordshire's rural population was 268,542 in 2024. The 14 rural areas described in this report have a combined population of 52,921, equivalent to 20% of Oxfordshire's rural population and 7% of the county population. Rural areas have a higher proportion of people aged 65 and over than urban areas, 24% compared with 16%, but age profiles vary substantially. Watchfield and Heyford are comparatively young, while Freeland and Cropredy have older profiles. Six of the 14 selected areas have at least a quarter of their population aged 65 and over.

14. **Growth**: Oxfordshire has experienced sustained population growth over the last decade, but growth has been disproportionately concentrated in rural communities where engagement activity has taken place. These grew by 23% between 2014 and 2024, compared with 15% across rural areas overall and 12% across the urban areas. The observed rapid growth has not been matched by health, transport, education, social and physical infrastructure.

15. **Health outcomes:** Life expectancy in 2019 to 2023 was higher in most rural areas compared to urban for women and men, apart from Chipping Norton, which had significantly lower life expectancy than Oxfordshire for both and was an outlier across mortality and emergency admission indicators. Faringdon and Stanford was also one of four Oxfordshire Middle Layer Super Output Areas

where Reception-year overweight and obesity prevalence (29%) was significantly higher than the Oxfordshire average of 20%.

16. **Deprivation**: Overall Index of Multiple Deprivation scores are low in rural Oxfordshire, with no areas in the 20% most deprived nationally and only two LSOAs in the 40% most deprived. However, rural communities face substantial challenges relating to access to services. All rural areas were within the 40% most deprived nationally on the geographical barriers to services measure, and 87% of the rural population lived in neighbourhoods within the 20% most deprived for that indicator. Chipping Norton, Cropredy, and Faringdon were the most deprived of the selected rural areas.

17. **Housing and fuel poverty:** Rural housing is more likely to be detached and owner-occupied, but it is also less energy-efficient, with 20% of rural properties having a low Energy Performance Certificate rating (E to G), compared with 8% in urban areas. The proportion of households in fuel poverty in rural areas (10.2%) was significantly higher than the Oxfordshire average of 8.7% and the urban area average of 7.9%. This is related to the low energy efficiency of rural housing stock but reveals additional challenges related to income. Cropredy was prominent for poor energy efficiency and housing deprivation.

18. **Income and children:** Rural averages for child poverty and free school meal eligibility were below the Oxfordshire average, but local variation was marked. Watchfield had 21% of children aged 0 to 15 in relative low-income families compared to 10% in Oxfordshire, while Watchfield, Chalgrove, Shrivenham, and Chipping Norton had significantly higher free school meal eligibility than Oxfordshire. Watchfield, Chipping Norton, and Faringdon also had higher proportions of older residents claiming Pension Credit than the county average.

Main findings from the community engagement

19. **Health and wellbeing:** Most respondents reported good physical and mental health, but this varied by financial circumstances and other characteristics. People who described their financial situation as not comfortable were three times as likely to report poor physical health as comfortable respondents (27% compared with 9%), and four times as likely to report poor mental health (24% compared with 6%). Cost of living, access to health and care, existing health conditions and transport were the most commonly reported barriers to looking after health and wellbeing.

20. **Community assets:** Across all 14 places, residents valued friendliness, local identity, countryside and green spaces, community groups, village halls, pharmacies, cafes, and other local services. These assets support physical activity and social connection. However, lack of affordable activities, safe spaces, transport, employment and training opportunities for teenagers was a recurring gap.

21. **Community connection:** Community groups were central to wellbeing, but many faced funding and volunteer recruitment challenges. Loneliness and weak

integration between established and new developments were concerns. Only 19% of online survey respondents felt involved in neighbourhood decisions and 14% felt listened to by decision-makers.

22. **Transport and connectivity:** Residents described infrequent or indirect public transport, limited evening and weekend services, high costs, weak links between nearby villages and essential services, and reliance on cars or lifts. Poor pavements, crossings, cycle routes, lighting, and road maintenance compounded barriers and prevented active travel options such as walking and cycling, especially for disabled and older residents.

23. **Cost of living and food provision:** Half of online survey participants identified the cost of living as a challenge. Financial pressure affected healthy food, heating, transport and participation in social or physical activity. Community larders and welfare support were valued but depended on awareness, volunteers and sustainable funding.

24. **Housing and development:** Residents raised the limited supply of genuinely affordable or suitable homes, poor insulation, damp, and heating costs. Many felt that housing growth had outpaced health services, schools, transport, and community infrastructure.

25. **Health and care:** People often valued the quality of local practitioners and pharmacies when accessible, but reported difficulty obtaining GP, NHS dental, physiotherapy, and mental health support. Distance, unsuitable appointment locations, digital systems and cross-border fragmentation created additional barriers.

Report recommendations

26. The recommendations from this work include integrated transport and connectivity; access to health and care closer to home and across borders; support for young people; affordable, suitable and energy-efficient housing; infrastructure alongside housing growth; accessible public realm and flood resilience; and sustainable community and voluntary sector capacity.

27. The recommendations also support a rural-proofing approach during strategy development; assessing whether prevention, neighbourhood health, family support, youth provision, employment and skills, transport, housing and planning proposals are accessible and beneficial for rural residents, including those without a car and those living near administrative borders.

28. The findings and recommendations also support an asset-based approach. Existing local organisations, volunteers, parish and town councils, community spaces, social prescribers, and transport schemes are important foundations. However, long-term improvement also requires system action on structural barriers and sustainable support for community infrastructure; it should not rely on volunteers replacing statutory provision.

Next steps

29. Subject to the Board's endorsement, the reports will be published on the Oxfordshire Data Hub and disseminated through the Marmot Place partnership and relevant strategic and neighbourhood forums.

30. The Marmot rural inequalities working group is currently developing an action plan to carry the recommendations forward and identify opportunities for coordinated action.

31. Further engagement should focus on groups underrepresented in this research and on households most likely to experience inequalities. Progress should be informed by local data and continued community dialogue, recognising that the 14 places are not representative of every rural village and hamlet in Oxfordshire.

Corporate Policies and Priorities

32. The creation of the rural reports links to the strategic priorities in the Oxfordshire County Council Corporate Plan of tackling inequalities in Oxfordshire and prioritising the health and wellbeing of residents.

33. This work also aligns with the Oxfordshire Health and Wellbeing Strategy 2024-2030, including its ambition to understand the strengths and challenges of living in rural areas, and to reduce loneliness and social isolation in rural areas.

Financial Implications

34. There are no direct financial implications from this paper. The report draws on work funded through the Public Health grant.

    Comments checked by:

    Lucy Moore Finance Business Partner

Legal Implications

35. There are no specific legal implications arising from this report. The collation and use of the data pack and report will help inform decision making regarding the targeting of resources to address inequalities in accordance with the Marmot Principles.

    Comments checked by:

    Janice White, Principal Solicitor – ASC, SEND and Education

Staff Implications

36. There are no additional staffing implications arising from noting and disseminating these reports. Development and delivery of any subsequent actions will utilise existing capacity within the Public Health Directorate and any additional capacity will be covered by the Public Health grant subject to approval.

Equality & Inclusion Implications

37. The Oxford Marmot place programme and the rural inequalities workstream in particular seeks to identify and address inequalities by providing insight into communities experiencing inequality, to help inform service planning and to act as evidence for funding applications for activities in those areas.

Local Government Reorganisation Implications

38. The evidence provides an opportunity to maintain focus on inequalities and rural challenges during transition to the new unitary arrangements from April 2028. The findings could be used to support place-based planning across future boundaries.

Sustainability Implications

39. There are no specific environmental impacts from adoption of the recommendations in the report. Place-based actions that emerge, such as improved public and community transport, active travel, energy-efficient housing, accessible green space and flood resilience, could deliver health and climate co-benefits. These would need to be considered at a project level.

Risk Management

40. The report does not propose a strategy or major change associated with risk to the Council.

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Annex 1: Oxfordshire Rural Areas Data Pack
Annex 2: Health and wellbeing in rural towns and villages in Oxfordshire report

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September 2026