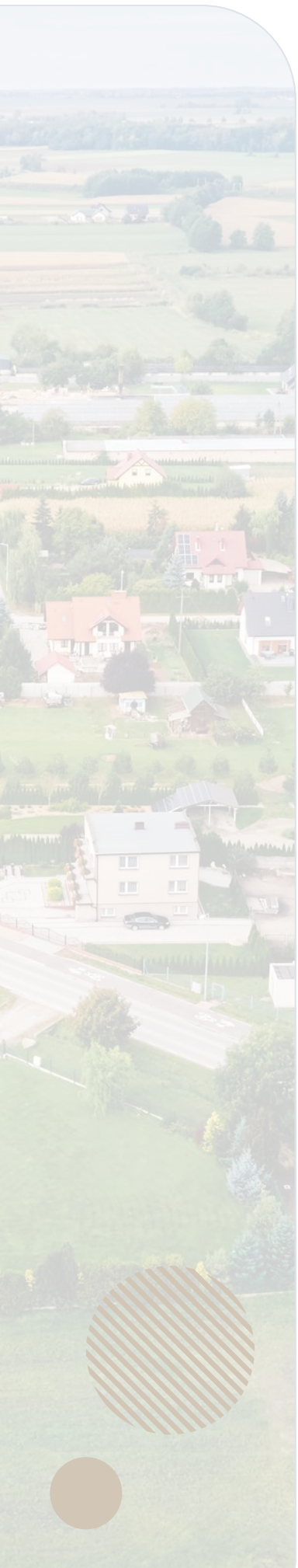
The Partner Ship

CCN
THE VOICE OF COUNTIES



Making Neighbourhood Health Planning Work in County, Rural and Coastal Areas

The Patchwork Quilt



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The Partner Ship

The Partner Ship combines partnership building with research to help organisations collaborate. We believe collaboration needs more than goodwill. It takes relationships, trust and shared purpose backed by the governance, structures and practical ways of working that help partners get things done.

Drawing on experience with over 35 partnerships, alliances and networks, we build partners' own capacity to work across organisational boundaries, sustain collaboration, and achieve more together.

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INTRODUCTION

Neighbourhood health is one of a number of government reforms seeking to create public services that work more effectively across organisational boundaries, around people and communities. The intention is to intervene earlier, prevent avoidable escalation of need and provide a more seamless experience for residents, while making better use of collective resources and supporting communities to thrive.

Within this wider reform agenda, national neighbourhood health policy gives local places the flexibility to develop arrangements that suit their populations and circumstances. While welcome, this flexibility creates ambiguity about who should lead, how responsibilities fit together, and where decisions should be made. For many County Councils Network (CCN) members, there is uncertainty about the councils' role alongside other organisations and structures in health and care, and what this means in practice at a time of constrained funding and capacity.



THIS MATTERS TO COUNCILS

The choices being made now – as neighbourhood health and care plans, delivery approaches and governance structures develop – are likely to affect how NHS services connect with social care and wider council provision, how partners work together to address inequality and support growth, and how public services invest in prevention and place-shaping more widely.

Some areas have well-established place-based partnerships to work through these questions, while others are still finding their way. This creates a risk that the opportunities to improve health and care, strengthen communities, and grow economies through neighbourhood working will be unevenly realised.

COUNTY, RURAL AND COASTAL REALITIES

County, rural and coastal areas – where almost half of England's population lives – have unique populations, geographies, infrastructure, workforces, and care markets. These nuances need to be recognised and accounted for if the opportunities of neighbourhood health are to be realised in every postcode. Urban-centric policies – such as a focus on Neighbourhood Health Centres – may not be as desirable or feasible in these areas.

A RENEWED FOCUS

'Place-based' programmes, the convening of services around people and communities, and devolution to communities are not new ideas. Over the last two decades councils have spearheaded initiatives including Local Area Agreements, Total Place, and Neighbourhood Community Budgets.

However, the National Audit Office notes 'it was generally recognised that these initiatives did not lead to widespread or fundamental changes in local public services, or in the relationship between central and local government'.[1] Evaluations have generally found pockets of success – pilot services and projects that improve people's lives and are sometimes mainstreamed – but a lack of scaled or systemic change.

CCN commissioned this research to examine how county, rural and coastal areas are responding to the opportunity and challenge of the renewed focus on neighbourhood health. Drawing on the experience of 18 areas at different stages of progress, it focuses on neighbourhood health planning rather than delivery models, projects or teams. This is an under-researched area, but we believe it to be essential to getting the architecture in place that gives neighbourhoods enough stability, authority and resource to actually improve people's lives.

A NOTE ON TERMINOLOGY

There are debates about terminology around neighbourhood health. For the purposes of this report, we mean the following for the common terms used:

Neighbourhoods are geographic areas that are defined locally and cover tens of thousands of people.

Places are geographic areas that are defined locally but often cover around 250,000 to 500,000 people, for example at borough or county level.

Neighbourhood health planning is one of the only formal mechanisms for collaboration between care and health partners.

Neighbourhood Health Plans are the delivery plans through which national neighbourhood health goals are translated into local priorities and measures.

1. NAO (2013). Case study on integration: Measuring the costs and benefits of Whole-Place Community Budgets.

EXECUTIVE SUMMARY

The neighbourhood health agenda can feel crowded and somewhat confused, but behind it lies a relatively simple idea. Help people stay well. Make care and support easier to get when it is needed. Bring services together within and around the places where people live.

None of this is new, but the agenda has been given fresh impetus by the NHS 10 Year Health Plan and its shifts from hospital to care closer to home and from sickness to prevention. However, this ambition cannot be achieved by the NHS alone.

Neighbourhood health is core business for councils, which hold statutory responsibilities for social care, children's services and public health, while also shaping many of the conditions that impact health and wellbeing. These extend far beyond NHS services, and include the economy, housing, transport, community spaces and care markets. Neighbourhood health must be shaped by councils from the outset, working alongside the VCSE sector, community-based organisations, and local citizens.

The ambition and opportunity of neighbourhood health is to:

- Connect health and social care, and wider council provision.
- Prevent, reduce and delay ill health and address the wider determinants of health.
- Work together to address inequalities.
- Shape local priorities and strengthen communities.

All councils face challenges turning the ambition of neighbourhood health into a reality.

- Reforms do not always pull in the same direction.
- The ambition can be too broad, too narrow, or too standardised.
- Organisational funding, incentives, and performance measures do not always support the shared ambition.
- Reduced place-based capacity and authority makes system change harder.
- Not all partners have an equal voice.
- Planning can struggle to keep pace with reality.

County, rural and coastal areas face additional, unique challenges. The common challenges come with a further layer of complexity. These issues may not affect every area in the same way, but geography, scale, population, access, and organisational arrangements can make neighbourhood health planning a substantially different task than in metropolitan areas.

"One size fits no one. Different places and different starting points, stitched together to create a coherent whole.

Neighbourhood health planning in county, rural and coastal areas is therefore less about laying a single blanket over the whole area and more about making a patchwork quilt."

Understanding what effective place-based planning looks like matters, particularly at a time when this layer is at risk of being squeezed.

We found four areas of additional challenge for county, rural and coastal areas that can affect what a neighbourhood looks like, how support can be organised, and what it takes to bring local plans together.

- Scale, geography and demography change the planning task.
- Governance and system architecture can be more complex.
- Access, delivery and infrastructure costs are higher.
- Need and inequality can be harder to see.

Place matters. Understanding what effective place-based planning looks like matters, particularly at a time when this layer is at risk of being squeezed.

In county, rural and coastal areas - where many different neighbourhoods must connect into a complex organisational landscape - strong place-based planning is essential to making the whole approach work.

Turning a shared ambition into coordinated action depends on three essential ingredients, though goodwill is important too.

1. Relationships and trust - the foundations for working together.
2. Governance and decisions - structures that allow partners to act.
3. Dedicated capacity - people, time and resource to turn plans into delivery.

The research identified seven common conditions for effective neighbourhood health planning.

1. **Shared purpose and narrative about the ambition.** A clear understanding of what neighbourhood health is trying to achieve locally, balancing immediate national priorities and service integration with longer-term prevention and population health.
2. **Relationships and a collaborative culture.** The bedrock of effective neighbourhood health planning and partnership.
3. **Place leadership and governance.** Spaces, structures and processes in which relationships can operate with clarity about which decisions sit in neighbourhoods, place, and system.
4. **Dedicated capacity to turn plans into action.** The "engine room". Relationships and boards are not enough - there must be the capacity, resource and accountability to turn discussions and decisions into action.
5. **Neighbourhood agency and local partnership.** Designed around real places, with communities, VCSE and other non-profit service providers involved from the outset.
6. **Flexible delivery models that fit local circumstances.** With appropriate models for different rural, coastal and small town geographies, such as hub-and-spoke, community-led, mobile, digital and dispersed provision.
7. **Shared intelligence, learning and responsive commissioning.** Mechanisms that allow learning from delivery, public health intelligence and community insight to change commissioning, investment and system decisions over time.

RECOMMENDATIONS: WHAT COUNCILS CAN DO

The following questions provide a practical agenda for assessing the starting point, identifying gaps and agreeing next steps with partners.

1. **Agree the ambition and what each partner contributes.** "What are we trying to achieve here - and for whom?"
2. **Understand the starting point.** "What already exists that we should build on or protect?"
3. **Involve the right partners from the outset.** "Have we got the right partners involved and are we building the relationships needed to work together."
4. **Clarify where decisions are made.** "Where will decisions actually be made and who has the authority to act?"
5. **Give neighbourhoods meaningful flexibility and agency.** "Do our footprints fit our communities and do neighbourhood partners have enough agency to shape what happens?"
6. **Create the engine room for action.** "Who is making the work happen between meetings?"
7. **Use local intelligence and learning to evolve decisions.** "How will neighbourhood insight change, commissioning, investment and system decisions?"
8. **Measure outcomes and system change.** "Are we measuring the things we actually care about?"
9. **Track whether commissioning and resources are actually changing.** "Are resources moving towards communities and prevention, or are pressures simply shifting elsewhere?"

RECOMMENDATIONS: WHAT NATIONAL LEADERS AND POLICYMAKERS CAN DO

Make the national framework work for different places.

1. Make local flexibility explicit in national guidance.
2. Align and sequence national policy and reform agendas.
3. Clarify accountability without prescribing one organisational model.
4. Support broader, locally appropriate outcomes frameworks.

Resource and protect the place layer.

5. Recognise the additional costs of accessible provision in county, rural and coastal areas.
6. Resource place-based planning and partnership capacity.
7. Protect planning and commissioning capacity during reform.

Enable investment in prevention and communities.

8. Test mechanisms for genuine upstream investment.

The government has allocated £50m to the first phase of its Neighbourhood Health Centres programme, with the majority of this distributed to city or urban-based provision. **A welcome starting point for action would be a parallel investment of £50m into realising the opportunities of neighbourhood health in county, rural and coastal areas.** This would enable neighbourhood health plans in these places to include delivery approaches such as hub-and-spoke arrangements, mobile units and outreach, digital infrastructure and provision, and bolstering VCSE sector infrastructure.

ABOUT THE RESEARCH

This research captures learning from evolving practice. It combined desk research with interviews involving 12 national and 30 local stakeholders, alongside input gathered from attendees at the 2026 NHS Alliance and LGA Conferences. An initial evidence review covered all 39 CCN member councils, with 18 considered in greater depth. Seven areas were explored further to understand approaches to neighbourhood health and draw out practical examples.

Throughout the research, we asked how councils and partners are translating national ambitions into local action, and what particular opportunities and challenges arise in county, rural and coastal areas. We explored what relationships, leadership, governance, capacity and ways of working are helping partners make progress, and how national policy could better support local action on neighbourhood health.

The research was developed iteratively with support from an advisory group, bringing perspectives from public health, adult social care and different regions. The group helped shape the research questions, explore and sense-check emerging findings and refine the report.

CCN member authority Leaders, Directors of Adult Social Services and Directors of Public Health also iteratively contributed to this research and report.

We thank all contributors for their time, insights and support.

Further detail on the research questions and contributors - including the advisory group members and interviewees - are provided in the Appendix.



AMBITION AND OPPORTUNITY

A CROWDED AGENDA...

Since the launch of the UK Government's Fit for the Future: 10 Year Health Plan for England, neighbourhood health has sounded like a rallying cry, with almost every ambition for health and care crowding into the agenda.

This, coupled with the flexibility in how national policy is implemented, can make it difficult for local leaders to see what they are being asked to do and to know where to start.

...BUT A RELATIVELY SIMPLE IDEA

Yet underneath all the debate about what neighbourhood health is or is not, and how to make it work, lies a relatively simple idea. Help people stay well. Make care and support easier to get when it is needed. Bring services together within and around the places where people live.

Few would disagree with that ambition or its potential. It builds on decades of work that has gone before. Across the country, many public health teams, social workers, GPs, community and mental health services, hospitals, schools, emergency services, leisure centres, charities, employers, community organisations and residents have been trying to work like this for years. There is therefore already a great deal of good neighbourhood working to build on.

A FRESH NHS PUSH...

What is different now, is that the NHS is driving forward reform of its services from the top, with a shift from hospital to community and towards more care being provided closer to home, organised around a neighbourhood model.

...THAT MUST BE SHAPED BY COUNCILS

An immediate task is to help staff and services respond together, in communities, when people need support. The longer-term opportunity is to change how places plan, invest, and work together so that people stay well for longer, communities strengthen, inequalities reduce, and needs are prevented, reduced and delayed.

This national push creates a genuine opportunity, but the wider ambition cannot be achieved by the NHS alone. Neighbourhood health is core business for councils, which hold statutory responsibilities for social care, children's services and public health, while also shaping many of the conditions that impact health and wellbeing. These extend far beyond NHS services, and include the economy, housing, transport, community spaces and care markets.

Council decisions can influence people's income, living conditions, social connections, sense of inclusion and the environments in which they live. This in turn can affect whether people stay connected, remain independent and live well.

Neighbourhood health must be shaped with councils from the outset, working alongside the VCSE sector, community-based organisations, and local citizens. If it is, then it can become more than just a way of joining up NHS services. It can become a genuinely place-based approach to improving health and wellbeing, that:

- helps communities thrive and grow;
- removes barriers that make it harder for some people to live healthy and independent lives; and
- helps to reverse the decline in healthy life expectancy.

TURNING THIS INTO REALITY

While the ambition of neighbourhood health may be easy to recognise, turning it into reality is more complicated.

> ***"It is a national ambition, but the conditions in which it must be delivered are not. The design therefore has to be local"***

NEIGHBOURHOOD HEALTH PLANNING

Place-based neighbourhood health planning is the process through which partners from across health and care can collaboratively decide and agree what that ambition should mean in their area – what they are trying to achieve, how existing strengths and services can be built on, what needs to change, who needs to contribute, and how decisions will turn into action.

HEALTH AND WELLBEING BOARDS

Health and Wellbeing Boards provide an important local forum for shared leadership. They have existing and related statutory duties for health and wellbeing needs assessments and planning, and a new and expanded role set out in the Neighbourhood Health Framework.

However, this work will take more than a plan moving through a committee. It requires partners to work through real choices together, about what matters most locally, what should happen at neighbourhood, place or system level, how resources and responsibilities fit together, and how success will be measured. Navigating those choices poses challenges for all councils and their health and care partners.



HEALTH AND WELLBEING BOARDS' STATUTORY DUTIES

Existing statutory duties include:

- Prepare and publish a Joint Strategic Needs Assessment (JSNA) of local health and wellbeing needs.
- Prepare and publish a Joint Local Health and Wellbeing Strategy setting out how assessed needs will be met.
- Involve residents (and district councils where relevant) in preparing the JSNA and strategy.
- Consider whether Section 75 arrangements could meet assessed needs more effectively.
- Prepare and publish a Pharmaceutical Needs Assessment.
- Provide advice, assistance or other support to encourage Section 75 arrangements, including pooled budgets and joint commissioning.

THE NEIGHBOURHOOD HEALTH FRAMEWORK BUILDS ON THIS ROLE

It describes Neighbourhood Health Plans as being developed under Health and Wellbeing Boards' collective leadership, with local aims and outcomes agreed alongside communities and partners. Plans should connect NHS priorities with wider local goals, clarify delivery responsibilities and governance, and align neighbourhood health with other local programmes.

During the rest of 2026 and early 2027, integrated care boards, Health and Wellbeing Boards, and partners are expected to develop and agree locally-owned Neighbourhood Health Plans for implementation from April 2027.

It should be noted that Health and Wellbeing Boards provide strategic leadership and influence decisions through shared priorities and plans. They do not hold the council's formal health scrutiny function or automatically control NHS budgets. Partners retain their statutory responsibilities unless specific functions or decisions are lawfully delegated.



ALL COUNCILS FACE CHALLENGES

Reforms do not always pull in the same direction. Neighbourhood working aims to bring activity closer to communities, while other health reforms are bringing commissioning and governance together across larger areas. Changes to integrated care boards, integrated health organisations, primary care and other provider collaboratives, alongside changes to local authority footprints and future devolution arrangements, all add uncertainty about who is responsible for planning across a place.

"Local partners are trying to build arrangements for neighbourhood working while the ground beneath them moves".

When trying to work out how to deliver multiple policy reforms at the same time, local leaders feel there can be a lack of join up across national government departments, especially between policy on health, local government and civil society, as well as across adults' and children's services.

The ambition can be too broad, too narrow, or too standardised. In some areas, almost everything is crowding into the neighbourhood health agenda. In others, the focus is narrowly on integrating NHS services to reduce demand on hospitals, with less immediate attention to prevention, communities and the wider drivers of health.

"There can be tension about the scope of neighbourhood health".

Pressure to adopt a standard model or start in a predetermined way can also leave too little room for local flexibility and partnership.



Organisational funding, incentives, and performance measures do not always support the shared ambition. Partners may share a commitment to prevention and better health, while their organisational targets keep attention on immediate priorities. Budgets can be constrained for some, and short-term priorities can crowd out longer-term change.

> ***"The benefits of working together may not be recognised by the measures against which organisations are judged."***

Reduced place-based capacity and authority makes system change harder. Collaboration takes time, people, and practical capacity, as well as goodwill.

> ***"Staff goodwill is an under-appreciated but finite resource."***

Different organisational cultures, ways of working, funding arrangements, and lines of accountability can make partnership working difficult. Recent restructures can also reduce the capacity and authority of those responsible for bringing partners together in a place, securing agreement and following decisions through at exactly the point where more cross-organisational working at a local level is required.

Not all partners have an equal voice. Councils, primary care organisations, community services, and VCSE organisations do not always have sufficient influence over priorities and investment into neighbourhood health to be an equal and active partner.

> ***"Different perspectives on local need can carry different weight."***

There is a risk that plans reflect the priorities of the most powerful organisations rather than the full range of needs and strengths in a place.

Planning can struggle to keep pace with delivery. Neighbourhood teams, service models, and delivery approaches are developing at different speeds, often ahead of wider system design. This can leave place-based planning having to try and catch up with - or build around - changes already underway, rather than agreeing together, from the outset, what should happen where, and how the different parts should fit together.

These challenges affect councils everywhere, regardless of demographics, geographies, infrastructure, workforces, and care markets. They help explain why a widely supported ambition can be difficult to translate into a coherent neighbourhood health plan.



UNIQUE CHALLENGES IN COUNTY, RURAL AND COASTAL AREAS

For county, rural and coastal councils, the common pressures come with a further layer of complexity. These issues may not affect every area in the same way, but geography, scale, population, access, and organisational arrangements can make neighbourhood health planning a substantially different task than in metropolitan areas.

Understanding these differences matters when priorities and funding are determined by national policymakers.

We found four areas of additional challenge for county, rural and coastal areas that can affect what a neighbourhood looks like, how support can be organised, and what it takes to bring local plans together.

FOUR ADDITIONAL CHALLENGES:

1. Scale, geography and demography change the planning task.
2. Governance and system architecture can be more complex.
3. Access, delivery and infrastructure costs are higher.
4. Need and inequality can be harder to see.



SCALE, GEOGRAPHY AND DEMOGRAPHY CHANGE THE PLANNING TASK

Councils in county, rural and coastal areas, work across large geographies. Individual rural neighbourhoods can also cover extensive geographical areas - similar to the size of a small city. Across these areas it is not uncommon to have a mix of geographies, with very dispersed rural or coastal communities, small towns, or, in some cases, proximity to large urban centres.

Older populations and smaller working-age populations add to the challenges in many areas. They shape both the demand for care and the availability of people to provide it.

For neighbourhood health planning this means working with considerable variation in transport, workforce, provider market, and services within one council area. In some areas there may be few large health providers but a wealth of community-based support.

"One size fits no one. Neighbourhood health planning in county, rural and coastal areas is therefore less about laying a single blanket over the whole area and more about making a patchwork quilt. "

Each piece needs to be designed locally, reflecting its communities, assets and circumstances.

The planning task is to stitch these pieces together so they form a coherent whole, connected to the services, resources and decisions that operate across a wider area. Neighbourhood boundaries may need to be pragmatic rather than based on a standard size, with some flexibility at the edges. There may also need to be flexibility over time, as neighbourhoods aren't static - they will shift and evolve.

Different functions may also need to operate at different scales. Support rooted in a village or small town, for example, may need to connect with specialist services organised across a much wider area.

Councils and Health and Wellbeing Boards overseeing multiple neighbourhoods need to:

- establish, maintain and utilise ways to understand these differences;
- identify what can be organised locally and what needs to connect across the wider place; and
- ensure neighbourhoods do not develop in isolation from one another.

WHAT THIS LOOKS LIKE IN REALITY

Many council areas involved in this research have more than 25 neighbourhoods.

Kent, the largest council area involved, has 45 neighbourhoods.

In **Hampshire**, there are 29 neighbourhood footprints varying in geographic size and population with some covering areas larger than the local cities. This means residents at opposite ends may have little connection with one another.

North Yorkshire encompasses rural, coastal, small-town, and urban communities. One neighbourhood footprint covers 500 square miles.

"Our county is a place of places."

In **Worcestershire**, there are significant contrasts within the county and pockets of both rural and urban deprivation. Over half the population live in urban areas and larger towns, while the other half of residents are spread across mostly rural areas of the county, and in small market towns.

In **Northumberland**, an area with low population density, neighbourhood footprints differ in population size due to the spectrum of rurality and natural community footprints. They cover populations ranging from 15,000 to 80,000 people. Distance is a significant factor for neighbourhood health planning, with the delivery of home-based care sometimes requiring 30 to 40 miles of travel each way.

GOVERNANCE AND SYSTEM ARCHITECTURE CAN BE MORE COMPLEX

In many places, the map of system organisations does not match the map of communities. However, in county, rural and coastal areas, the size and scale of overlapping organisational footprints can make this particularly complex and a difficult challenge to manage.

For example, one integrated care board can cover several local authority areas, each with its own priorities and political leadership. A council may work with multiple integrated care boards, NHS providers, and primary care networks whose boundaries do not align. Children's services, emergency services, and other local authority run public services may operate across different geographies. This can be strategic around schools or towns, but can also be a legacy of historical decisions.

Ongoing reforms and organisational change can make this harder. Changes to integrated care board place teams and personnel can disrupt established relationships and local capacity.

Local government reorganisation and devolution is taking place in many areas outside metropolitan areas. It can alter boundaries, leadership and responsibilities while neighbourhood plans are literally being developed. Emerging NHS integrator or integrated health organisation arrangements may add further questions about how planning, commissioning and delivery fit together.

These changes draw on many of the same people in local areas who are needed to lead neighbourhood health planning. Time spent reorganising teams, transferring responsibilities or rebuilding relationships is time that cannot be spent on developing shared plans.

The result is an exacerbation of the common coordination challenge where partners are being asked to organise more locally while some commissioning and governance functions move to larger footprints. Keeping multiple neighbourhood footprints and priorities connected to those wider decisions requires sustained attention and capacity.

WHAT THIS LOOKS LIKE IN REALITY

In **North Yorkshire**, the council spans several NHS boundaries including three ICBs in Humber and North Yorkshire, West Yorkshire, and Lancashire and South Cumbria. Local areas have different combinations of primary care networks, community services and providers.

In **Hampshire**, the county council area includes 11 district and borough councils and 29 neighbourhoods. Partners are taking an approach to connect neighbourhood health work with programmes covering employment, early years and regeneration, while simultaneously preparing for Local Government Reorganisation. This creates a substantial coordination task with a need to support development of leadership at all levels, alongside understanding about where different partners, resources and decisions come together across and within the system.

ACCESS, DELIVERY, AND INFRASTRUCTURE COSTS ARE OFTEN HIGHER

'Closer to home' is a compelling ambition. However, it can require additional time, infrastructure, and investment to make it work across a dispersed population compared with metropolitan areas.

Residents may face long journeys, limited public transport and unreliable digital connections. Staff face those distances too. Travel between home-care visits reduces the time available for direct support and increases the cost of providing it. Specialist staff may need to cover larger areas than in metropolitan places, while recruitment and retention difficulties limit what can be offered locally.

> ***"Services may need a combination of community bases, outreach, mobile provision and hub-and-spoke arrangements."***

The right balance will depend on the population, existing buildings, transport links and workforce. Digital support can form part of the offer, but its usefulness depends on connectivity and people's ability to access it.

Provider markets also vary. Some county, rural and coastal places have a major acute or community provider acting as a local anchor. Others rely more heavily on smaller providers, primary care, and a wealth of dispersed VCSE organisations. Planning must be based in reality and start with an understanding of who is available, what they can offer, and what support they need to participate in a neighbourhood model.

There are financial implications too. Supporting someone at home may require a substantial social care package, particularly where travel and workforce pressures increase costs. In a county, rural or coastal area, a reduction in hospital use may not automatically translate into a cheaper arrangement across the whole system. Neighbourhood Health Plans therefore need to account for the full cost of accessible care across the system, including the community infrastructure on which it depends.

Assumptions drawn from compact urban areas may underestimate what planning for neighbourhood health delivery actually requires in county, rural and coastal areas.

WHAT THIS LOOKS LIKE IN REALITY

Cornwall is one of England's longest counties, at around 85 miles from end-to-end, with 300 miles of coastline, and dispersed communities across its geography. This impacts on travel times for residents and staff, affecting access to services and the cost of providing care. This can mean that complex care packages delivered in rural communities can increase overall system costs, even if hospital use falls.

NEED AND INEQUALITY CAN BE HARDER TO SEE

In county, rural and coastal areas, disadvantage does not always appear as a clearly defined area on a map. Poverty may be dispersed across villages or concentrated in small pockets within otherwise affluent areas. Larger geographical averages can obscure these differences and make disadvantage harder to spot. Disadvantage may also take forms that are poorly captured by conventional measures weighted towards income and employment.

Transport poverty can limit access to care, employment and social opportunities. Poor connectivity and digital exclusion can make apparently accessible services difficult to use. Isolation and loneliness may compound these barriers, while the less visible nature of poverty can make it harder for people to seek support. The beautiful surroundings in many county, rural and coastal areas can lead to the underestimation of people's daily realities.

Neighbouring communities can appear similar if looked at from the outside, using data alone, but communities only a few miles apart can have very different strengths, relationships and patterns of service use. Reliance on conventional deprivation measures or recorded NHS activity risks overlooking people whose needs are dispersed, hidden or unmet. Low service use may reflect difficulty accessing support rather than low need.

Local intelligence about the area and the people who live there, is therefore even more essential in county, rural and coastal areas than in metropolitan areas. Neighbourhood-level public health intelligence and primary care data need to be brought together with community and VCSE insight. Information about transport, digital access and local infrastructure helps explain what the figures mean for people's everyday lives.

WHAT THIS LOOKS LIKE IN REALITY

"You can't eat the view"

The **Cornwall** Pretty Poverty Report combined statistical data with residents' experiences across six rural neighbourhoods to examine disadvantage that may be inadequately captured by national deprivation measures. It identified interconnected barriers causing deprivation in county, rural and coastal areas involving transport, housing, insecure employment and access to services.

Hampshire's joint strategic needs assessment presents all the domains of deprivation within its analysis, revealing different patterns of disadvantage when compared to the headline indicator alone. In central Test Valley, for example, rural areas outside the main towns show significant barriers to housing and services that are less apparent in the overall deprivation indicator.

In **Oxfordshire**, a rural health inequalities study commissioned through the county's Marmot Place programme, combined local data with the experiences of more than 800 people across 14 rural towns and villages. Led by Healthwatch Oxfordshire and Community First Oxfordshire, community engagement explored pockets of inequality within apparently affluent areas. This showed how financial pressures, transport and access to services shape residents' health in rural areas. It revealed hardship and barriers to support that were less apparent in the area's overall deprivation profile.

COUNTY, RURAL AND COASTAL AREAS HAVE STRENGTHS TO BUILD ON

During this research we also heard about many of the strengths in county, rural and coastal areas that can support neighbourhood health.

Upper-tier, county and unitary councils have a substantial role in shaping places across large geographies and connecting public health, social care and wider services. In some areas, partners have years of experience working together across organisational boundaries. Often locally rooted primary care can also bring longstanding knowledge of communities.

"Primary care are often the feet in the ground in these areas"

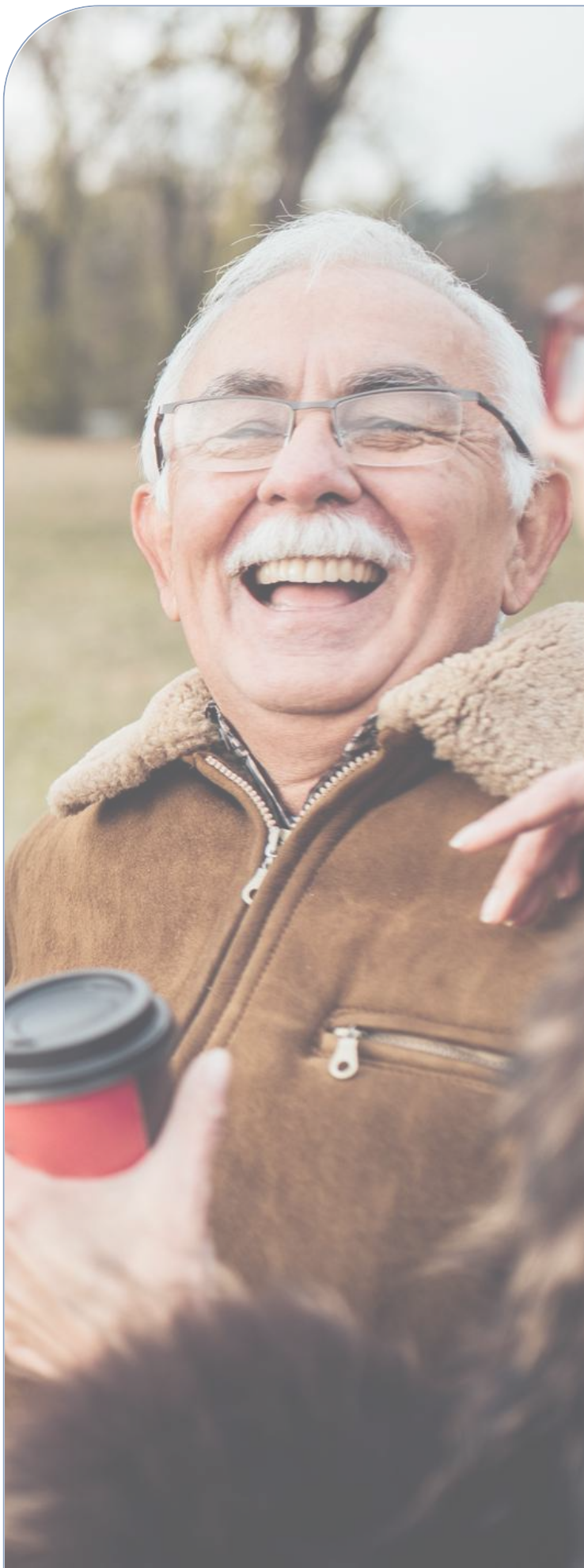
Relationships with district, town and parish councils can provide further connections to communities.

Many residents have fierce and longstanding loyalty to their local area.

Community organisations, volunteers and VCSE organisations can help partners understand local priorities, reach people and connect activity across a large area.

"The wealth of community connections and strengths offer important foundations for change"

Making the most of this community wealth takes time, relationships and resources, particularly when community organisations and public services are already stretched.



THE MISSING MIDDLE: WHY PLACE MATTERS

Taken together, the strengths and challenges in county, rural and coastal areas make the role of upper-tier councils particularly important for neighbourhood health planning. Their footprint - the county or unitary authority area, commonly referred to as 'place' - provides a crucial layer between neighbourhood working and wider system decisions. Neighbourhood health planning in these areas has to consider not only who needs support and what might prevent them getting it, but also what can realistically be put in place locally. Without this reality check, there is a risk that neighbourhood health is designed in ways that cannot be delivered, or does not work for the communities it is intended to serve.

While neighbourhoods also need enough freedom to respond to their communities, they cannot solve every problem themselves. A neighbourhood team may identify a gap in support but be unable to change a contract, secure premises, resolve a data-sharing problem or address a workforce shortage. Decisions about commissioning, funding, estates, workforce and governance often need to be made across a wider area. Teams need a route to decisions - and people with the authority to act.

"The place layer provides that connection."

It is where partners can agree what they are trying to achieve, decide what should happen at neighbourhood, place or system level, and make sure local priorities influence how resources and support are organised.



Understanding what effective place-based planning looks like matters, particularly at a time when this layer is at risk of being squeezed.

As some NHS functions and decisions move upwards to larger footprints, while delivery moves downwards to neighbourhoods, the capacity, relationships and shared decision-making between them can weaken.

In county, rural and coastal areas - where many different neighbourhoods must connect into a complex organisational landscape - strong place-based planning is therefore essential to making the whole approach work. The research suggests that, while the form this takes will vary from place to place, there are some common conditions that help it work effectively.

WHAT HELPS NEIGHBOURHOOD HEALTH PLANNING WORK WELL

The research identified seven common conditions for effective neighbourhood health planning.

Their form will vary according to local circumstances and starting points, but the underlying ingredients were consistent across many of the areas we heard from. Much of this will be familiar from previous work on collaboration, partnership, integration and system change in health and care.

Relationships are the bedrock, but they are not always enough on their own. Those relationships also need spaces and structures in which to operate and make collective decisions, especially to guard against the risk of collaboration failure if key personnel change. But even when relationships and structures are strong, partners can struggle if there is no dedicated capacity, with the trust and agency to turn those decisions and subsequent learning into practical and ongoing change suited to the local context. The seven conditions below work together to provide that foundation.

1. SHARED PURPOSE AND NARRATIVE ABOUT THE AMBITION

Effective neighbourhood health planning starts with partners agreeing what they are trying to achieve for their population. This means working through what neighbourhood health should mean locally, rather than assuming everyone understands the ambition in the same way.

SEVEN COMMON CONDITIONS

1. Shared purpose and narrative about the ambition.
2. Relationships and a collaborative culture.
3. Place leadership and governance.
4. Dedicated capacity to turn plans into action.
5. Neighbourhood agency and local partnership
6. Flexible delivery models that fit local circumstances.
7. Shared intelligence, learning and responsive commissioning

The starting point can vary. Some areas initially focus on coordinating care for people with complex needs and reducing avoidable hospital use. Others are connecting this with a longer-term ambition for prevention, stronger communities and wider system change. What matters is that partners understand the chosen focus, how their contributions fit together and how the work can develop over time.

A shared narrative can help partners explain the change to staff, elected members and communities. An agreed local outcomes framework can make that purpose practical - setting out what improvement should look like, how progress will be assessed and how it connects with partners' responsibilities. This helps keep planning focused on benefits for people and communities while

recognising the pressures individual organisations face. Different organisations may start from different priorities, and be looking to get different things from neighbourhood health, but a shared purpose should hold together the immediate task of improving care and the longer-term ambition for population health.

HOW THIS WORKS IN PRACTICE

In **North Yorkshire**, the local Health Collaborative's Ambitious for Health programme brings together three priorities of Healthy People, Integrated Neighbourhood Working and Healthy Places. Its wider programme connects work on care and prevention with employment and children's services. This gives neighbourhood health planning a broad starting point - how partners across the NHS, local government and VCSE sector can improve people's lives together, alongside how they organise care.

In **Worcestershire**, public health has clearly identified its contribution to neighbourhood development - population health data analysis, health improvement and community development. Being explicit about this offer has helped partners understand what public health can bring to shared priorities and how its contribution connects with primary care and other services.

In **Cambridgeshire**, partners are using frailty and healthy ageing as a practical starting point for neighbourhood health development. Public health leaders see this as an opportunity to connect clinical care with physical activity, social isolation, housing and family support. Working in this way, partners intend that this initial focused priority can provide a route into wider partnership working, with the purpose and delivery extending beyond medical needs.

In **Cornwall**, while there is no one form of words used by all partners, an important part of developing neighbourhood health has been to identify a shared commitment to deliver the best possible care at neighbourhood level. Aligned to this, partners continue to express priorities in ways that reflect their own context and responsibilities. Partners have also considered the benefits for adult social care, public health, communities and residents, alongside reducing hospital demand. Making these contributions and benefits explicit has helped establish the shared commitment and gives partners a clear reason to commit their time and resources.

In **Northumberland**, council health and care leaders recognise the immediate need for neighbourhood health to reduce pressure on hospitals while also looking for opportunities to improve people's lives through adult social care, public health and action on the wider determinants of health. Driven by the question 'how can we give people a better life?' the neighbourhood health planning task is to connect these ambitions of identifying practical changes that address current pressures while contributing to prevention, independence and healthier lives over time.

In **Warwickshire**, partners are exploring how to organise support in neighbourhoods so that people remain well and independent, and avoidable demand is reduced on both hospital care and adult social care. "This has led to partnership discussions about how adult social care connects with integrated neighbourhood teams, as well as questioning assumptions about whether it is feasible or appropriate for integration simply means incorporating existing social care teams into NHS neighbourhood teams."

2. RELATIONSHIPS AND A COLLABORATIVE CULTURE

Trusted relationships are a foundation for effective neighbourhood health planning. They enable partners to speak openly about pressures, work through disagreements, and explore changes that may require organisations to share influence or resources. Areas with more established neighbourhood working have often invested in these relationships over many years.

The task is to develop a collaborative culture across partners. This requires understanding of different responsibilities, professional perspectives and ways of working, rather than expecting councils to adopt NHS culture or the NHS to adopt council culture. It also means recognising the knowledge and contribution of people, communities and VCSE organisations as equal partners.

Where relationships are less developed, partners need repeated opportunities to build them through practical work. Joint development sessions, visits to each other's services, shared work on a local problem and regular conversations between meetings can help. These opportunities need to extend beyond senior leaders to the people responsible for planning and delivery. Co-location, shared roles and movement between organisations are identified as ways of building understanding and trust.

HOW THIS WORKS IN PRACTICE

In **Northumberland**, working physically alongside one another helped strengthen partnership relationships. From 2013 to 2020, the adult services and former clinical commissioning group senior management teams were co-located along one corridor in County Hall with reports that "the relationships just bloomed in that period". While not currently co-located, these relationships have provided a foundation for joint working through subsequent organisational changes. Today, senior council executives make time for informal conversations with NHS partners. They find that meeting for coffee and talking through current work and challenges helps build understanding of each other's pressures and priorities. These everyday opportunities to develop relationships underpin more formal partnership working.

In **North Yorkshire,** partners describe strong and longstanding relationships between the council, NHS and VCSE sector at every level. A fortnightly Directors' Group meeting, chaired by an NHS provider, creates a regular space to work through shared priorities and barriers. Face-to-face local care partnership meetings also help people build understanding across organisations.

In **Hampshire**, the Director of Public Health spends time with GPs and engages across and within the county's neighbourhood geographies. Joint leadership with the ICB place lead connects public health and NHS perspectives.

3. PLACE LEADERSHIP AND GOVERNANCE

Effective neighbourhood health planning needs leadership that brings partners together and governance that enables them to agree priorities, make decisions and remain accountable. Leadership and governance are connected, but they do not have to sit in the same forum. A board may endorse a plan or hold partners accountable, while the work itself is led through a smaller partnership group or several connected workstreams.

In large county, rural and coastal areas, arrangements need to be agreed about how to connect neighbourhood, place and system decisions. Partners need clarity about which decisions can be made locally in neighbourhoods, which require agreement across the place footprint and which depend on wider commissioning or investment decisions at system level. Neighbourhood partnerships also need a clear route to raise issues they cannot resolve themselves.

The research found there is no single structure that every area should adopt. Health and Wellbeing Boards can provide stewardship of the shared ambition, while other groups lead its development and implementation. Public health teams may coordinate the neighbourhood plan, and dedicated groups may bring partners together around particular priorities. The important test is whether these arrangements give collaboration a practical home, connect the relevant work and provide clear routes to decisions without requiring every issue or opportunity to pass through one large partnership meeting or single integrator function.

HOW THIS WORKS IN PRACTICE

In **Cornwall**, governance arrangements connect neighbourhood health delivery with decision-making and oversight across the wider system. Each of the 15 neighbourhoods has a multi-partner leadership team, supported by a clinical lead and change manager. Delivery is organised through integrated neighbourhood teams, with daily multidisciplinary huddles around different groups of people with identified needs. Neighbourhood leadership teams meet fortnightly, and a monthly steering group provides the formal decision-making forum. This links neighbourhood delivery with a route for raising and resolving problems and securing support. Strategic oversight and assurance processes involve the NHS chief executives' strategy group, the ICB's Neighbourhood Health and Improvement Committee and the Health and Wellbeing Board. This separates day-to-day coordination and delivery from wider oversight, while providing routes for escalating issues requiring decisions or resources beyond the neighbourhood.

In **Hampshire**, the Health and Wellbeing Board provides leadership across its 29 neighbourhoods through a combination of formal board activity and wider assemblies involving 50 to 80 people. Assemblies explore themes such as dementia and neighbourhood health, with discussions reported back to the Board. This offers a way to bring wider experience into strategic discussions without all 29 neighbourhoods needing a seat on the Board, retaining a manageable formal board.

WHAT THIS LOOKS LIKE IN REALITY

In **Northumberland**, partners use every third Health and Wellbeing Board session as a development session. These sessions bring board members and NHS colleagues together to work on different topics including neighbourhood health planning.

In **Worcestershire**, partners have invested in developing shared understanding about the strategic role of the Health and Wellbeing Board and the pressures facing health and care services. The aim has been to create informed discussion and constructive relationships in which NHS partners feel able to engage openly.

In **Cambridgeshire**, public health leaders are working with counterparts in Peterborough to use the development of the strategic neighbourhood health plan to clarify governance. The work is intended to establish how the Cambridgeshire & Peterborough Health and Wellbeing Board provides strategic oversight of the plan and partnership, and how this connects with NHS delivery arrangements. The process for developing the plan is helping partners agree responsibilities and decision-making relationships alongside their priorities.

4. DEDICATED CAPACITY TO TURN PLANS INTO ACTION

Relationships and governance need to be supported by capacity to progress the work in practice. Areas with effective neighbourhood health planning have people with the time, resources and authority to coordinate contributions, develop proposals, follow through on decisions, and resolve obstacles. This is the partnership's "engine room".

Its role is to turn shared ambition into manageable work - agreeing responsibilities, maintaining momentum between meetings, identifying where decisions or support are needed and keeping partners informed about progress. Without this capacity, even committed leaders and well-established boards can find themselves returning repeatedly to discussions about vision without achieving practical change.

The engine room can take different forms. It may be a jointly supported team, dedicated roles within partner organisations, a coordinating function hosted by one organisation or a commissioned contract. Whatever the arrangement, it needs a clear remit, sufficient resources and accountability to the partnership. It also needs the trust of partners and access to leaders who can authorise change. An integrator may fulfil some of these functions, but naming one may not itself secure the capacity, resources, trust and authority needed, especially if there is not buy-in of wider partners.

HOW THIS WORKS IN PRACTICE

Partners in **North Yorkshire** identified the loss of dedicated ICB place capacity as a challenge to neighbourhood health development. Established relationships, shared ambition and governance remained, but the partnership recognised the need for people able to convene the system and turn decisions into practical delivery. In response, a small Ambitious for Health Delivery Team is being established, with contributions and ownership shared across organisations. Partners are contributing funding and/or named resources, with work overseen by the Health Collaborative Directors' Group. The Delivery Team is being led by the Council's Head of Health Improvement, until the partnership-funded Council-hosted Head of Neighbourhood Health begins in role.

In **Northumberland**, the council's public health team is leading on the coordination of the neighbourhood health plan in response to reduced ICB capacity. Public health and primary care are working closely together, alongside the ICB place director, integrated health organisation and other partners.

In **Cambridgeshire**, NHS hospital trusts are hosting and funding neighbourhood health director roles and supporting teams where ICB capacity is limited. Place-based directors from the trusts also chair the North and South Partnerships. The leadership and capacity from NHS providers for neighbourhood health development is welcomed and accompanied with clear arrangements to ensure it supports the shared partnership ambition.

In **Warwickshire**, the ICB commissioned South Warwickshire University NHS Foundation Trust as lead provider for a Community Integrator contract, with explicit responsibility to convene, co-design and implement integrated neighbourhood teams. Partners identify this contractual arrangement as helpful in moving neighbourhood development forward and giving the work a named organisational home. The trust also hosts a £3 million Neighbourhood Health Fund and works with the Warwickshire Care Collaborative to shape and agree its use. This supports integrated neighbourhood team development, a place-based single point of access to wider services, and investment in VCFSE provision. The community investment is being commissioned through the Warwickshire VCFSE Collaborative to support independence, reduce loneliness and address wider determinants of health.

In **Cornwall**, neighbourhood change managers are supported by development capacity across three Integrated Care Areas and a weekly neighbourhood innovation delivery team meeting. Enabling workstreams cover areas including people and culture, information, estates and digital.

In **Hampshire**, neighbourhood health development is drawing heavily on public health capacity and senior leaders' time. Partners have identified the challenge of developing leadership across 29 neighbourhoods. This highlights the need to resource both countywide coordination and local leadership, with practical support that enables senior staff to concentrate on strategic relationships, decisions and delivery.

5. NEIGHBOURHOOD AGENCY AND LOCAL PARTNERSHIPS

Neighbourhood planning works best when it recognises natural communities and gives local partners meaningful influence over what happens there. Agreeing footprints therefore requires more than dividing a county into populations of a standard size or just assuming the existing footprints of one partner. Partners need to consider how people identify with places, where they access support, existing relationships, and the practical geography of services.

Residents, communities, VCSE organisations and other non-profit service providers like leisure centres can contribute different knowledge to these decisions. Involving them from the outset helps establish neighbourhood partnerships around local strengths and needs, across the population and life course. Boundaries may need to be pragmatic, with flexibility where communities or services cross them, and scope to adapt as wider arrangements change, including from future reforms like devolution and changes to council boundaries through local government reform.

Agency also means being clear about what neighbourhood partners can shape or decide. They need room to identify priorities and develop responses, alongside support from place and system partners where action requires changes to contracts, workforce or investment.

HOW THIS WORKS IN PRACTICE

In **Cambridgeshire**, neighbourhood teams are developing around primary care, with work under way to connect them with adult social care, VCSE organisations and wider council services. A public health-led group is exploring connections around frailty, falls prevention, housing, fuel poverty and family support, including opportunities involving libraries and family hubs. The planning task is to turn these connections into practical support around residents.

In **Warwickshire**, multi-agency workshops have helped partners explore what integrated neighbourhood teams will and will not do. Partners have found that making the scope explicit provides a practical basis for agreeing contributions, identifying gaps and understanding how neighbourhood teams connect with existing services.

In **Cornwall**, neighbourhood health planning takes place alongside an established network of 55 VCSE community hubs. Mapping this infrastructure within 16 neighbourhoods alongside NHS and council provision creates an opportunity to build on trusted community connections, local knowledge and existing support. The planning question is how neighbourhood teams will work with these assets and involve them in shaping delivery.

"Expectations should be matched by influence, resources and routes to decisions."

6. FLEXIBLE DELIVERY MODELS THAT FIT LOCAL CIRCUMSTANCES

Effective neighbourhood health planning considers how care, support and prevention can be organised around the geography, population and assets of communities. Across a large county, different communities may need different arrangements.

"A single physical hub will rarely meet every need."

The research identified a range of delivery approaches in county, rural and coastal areas, including small community bases and dispersed provision, community and VCSE-led support, hub-and-spoke arrangements, mobile outreach and digital provision. Neighbourhood health planning needs to determine the appropriate combination by considering travel distances, public transport, connectivity, workforce, existing buildings and the organisations already supporting residents.

This also requires clarity about which functions can be sustained locally and which need to connect with provision across a wider area. Digital access may extend the offer, but plans must account for people who cannot use it. Different models across a county, rural or coastal area can be a necessary response to different circumstances, provided they support shared outcomes and accessible care.

"This can benefit from what partners in North Yorkshire call a 'team of teams' approach."

HOW THIS WORKS IN PRACTICE

In **North Yorkshire**, digital support connects care across dispersed communities and services. Care homes access remote clinical advice through Airedale Hospital's digital hub, bringing shared expertise into residents' usual place of care through a hub-and-spoke model delivered across multiple local settings, combining face-to-face provision with access to expertise from further afield.

Hampshire has a range of existing public service delivery models within one county. In the New Forest, drug and alcohol support is organised through four small hubs to provide support across a dispersed population. In Andover, several health services come together in a town-centre shopping complex. Countywide planning accommodates these different approaches, reflecting settlement patterns, travel distances, and local assets and needs.

In **Warwickshire**, domiciliary care commissioning is divided into geographical zones, with different fees for rural and urban provision. This recognises that delivering care across dispersed communities involves different costs and demonstrates why neighbourhood health planning needs to translate an understanding of rural delivery into commissioning arrangements and funding.

In **Worcestershire**, partners are supplementing family hubs in urban areas with commissioned outreach to village halls and community centres. This combines established service locations with support taken into other communities through a hub-and-spoke model, illustrating how provision can adapt to local geography and access needs within one county.

7. SHARED INTELLIGENCE, LEARNING, AND RESPONSIVE COMMISSIONING

Neighbourhood development and strategic planning do not always move at the same speed, and slowing delivery whilst planning catches up is rarely realistic or welcomed. Effective neighbourhood health planning therefore needs ways for experience - of people, professionals and community-based organisations - and learning from delivery to influence priorities, commissioning and investment. Neighbourhood health plans need to develop and flex as partners learn what works, where gaps remain and what communities need.

This requires bringing together different forms of intelligence. Public health analysis and primary care activity data can be combined with the experience of frontline staff, residents and VCSE organisations to understand population needs and assets. Data from recorded service use alone may overlook unmet need, barriers to access or opportunities to prevent problems earlier.

"Learning needs a route to action."

Neighbourhood partners should be able to raise issues, test responses and seek changes that sit beyond their authority. Place and system partners then need mechanisms to review that learning and adapt contracts, investment or working arrangements. This virtuous circle of learning, or feedback loop, means partners can use what they learn to change services and investment flows. Over time, this can then help shift resources and practice towards prevention and community support, while maintaining a clear view of outcomes for residents.

HOW THIS WORKS IN PRACTICE

In **Hampshire**, the joint strategic needs assessment has recently been published with health and wellbeing profiles presented for each of the 29 neighbourhoods covering population characteristics, levels of deprivation, life expectancy, risk factors and long-term conditions. The profiles provide a shared starting point for discussions about need across the county's varied communities. Combining this analysis with primary care data, and VCSE and resident insight, can help partners develop shared community intelligence, agree priorities and identify changes needed to provision.

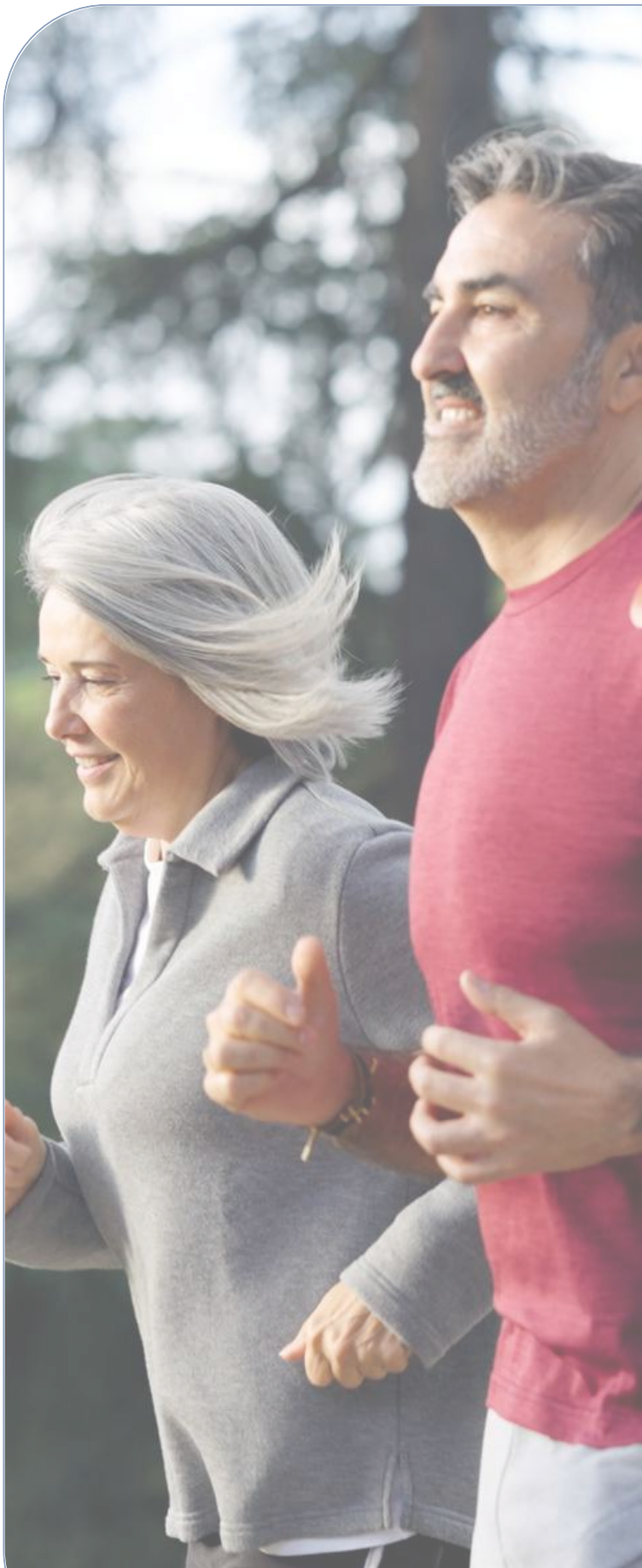
In **Worcestershire**, public health analysed data at Lower Super Output Area level to identify small communities with unusually poor health outcomes and greater social challenges that wider averages could obscure. Priority Neighbourhood Profiles bring together information on population, health, housing, deprivation and public services. This analysis informs the Priority Neighbourhood Development programme, through which residents and local partners shape how funding is used to address community priorities.

In **Cornwall**, neighbourhood leadership teams meet fortnightly to review local data, identify actions and track proposals, escalating issues requiring decisions or resources to a monthly steering group. This creates a regular route through which neighbourhood intelligence informs wider decisions.

WHAT COUNCILS CAN DO

Councils and Health and Wellbeing Boards have an important role in enabling effective neighbourhood health planning. Their role extends beyond individual delivery models - they need to be leading partners in the place-based planning that shapes them, drawing on councils' responsibilities, local knowledge, place-shaping capability and democratic leadership.

The following questions provide a practical agenda for assessing the starting point, identifying gaps and agreeing next steps with partners.



1. AGREE THE AMBITION AND WHAT EACH PARTNER CONTRIBUTES

Ask yourself:

"What are we trying to achieve here - and for whom?"

- Are NHS, council commissioners, public health, adult social care, primary care, VCSE and community partners clear about what neighbourhood health should achieve for residents?
- Do partners understand what neighbourhood health helps them achieve and what they can each offer?
- Have we thought through how we can progress the longer-term prevention and population health ambition while addressing short-term NHS priorities?
- Are we clear which partners needs to work together, and on what?

2. UNDERSTAND THE STARTING POINT

Ask yourself:

"What already exists that we should build on or protect?"

- What plans, decision-making arrangements, neighbourhood partnerships and forums already exist across neighbourhood, place and system levels?
- Where are relationships, teams, community infrastructure, local partnerships and provider collaboratives already working?
- What needs to be strengthened or developed, and where should we start?

3. INVOLVE THE RIGHT PARTNERS FROM THE OUTSET

Ask yourself:

"Have we got the right partners involved and are we building the relationships needed to work together?"

- Are we talking to NHS community, mental health and secondary care providers alongside public health, GPs, pharmacy, optometry and dentistry, adult social care, children's services, VCSE, wider council functions such as housing, transport, leisure centres and employment support, residents and user-led organisations?
- Are the people and organisations with knowledge of communities and local need involved early enough to shape the approach, rather than being asked to respond once decisions have largely been made?

4. CLARIFY WHERE DECISIONS ARE MADE

Ask yourself:

"Where will decisions actually be made, and who has the authority to act?"

- Which decisions sit at neighbourhood, place and system levels?
- How are councils involved in strategic planning alongside NHS and VCSE partners?
- What is the Health and Wellbeing Board's role? Is it equipped to provide stewardship of neighbourhood health?
- Where is the work led, what sits elsewhere, and how do these arrangements connect?
- If a neighbourhood team identifies a problem, who can change something?

5. GIVE NEIGHBOURHOODS MEANINGFUL FLEXIBILITY AND AGENCY

Ask yourself:

"Do our footprints fit our communities, and do neighbourhood partners have enough agency to shape what happens?"

- Are neighbourhood footprints meaningful to residents and practical for partners?
- Can people access the proposed support, including in sparsely populated areas?
- Do we need distributed provision rather than a single centre?
- Can footprints and models adapt as circumstances change?
- What can partners influence or decide themselves, and what resources and support can they draw on?
- How can partners escalate issues they cannot resolve?

6. CREATE THE ENGINE ROOM FOR ACTION

Ask yourself:

"Who is making the work happen between meetings?"

- Is there named leadership, dedicated capacity and sufficient resource to turn plans and decisions into action, or are we relying on goodwill?
- Who coordinates partners' contributions, progresses agreed work and brings obstacles to people who can resolve them?
- Are responsibilities and accountability clear?
- Does this engine room for action have the trust of partners and access to people with the authority to act?

7. USE LOCAL INTELLIGENCE AND LEARNING TO EVOLVE DECISIONS

Ask yourself:

"How will neighbourhood insight change commissioning, investment and system decisions?"

- Are we bringing together partners' intelligence, data and insight about neighbourhoods, along with learning from delivery?
- Who reviews this intelligence, and how does it inform decisions at place and system levels?
- What will be commissioned or organised differently as a result?
- Can partners adapt provision and flex resources as they learn what works, including stopping activity that is not improving outcomes?
- How are decisions communicated across neighbourhood partners?

8. MEASURE OUTCOMES AND SYSTEM CHANGE

Ask yourself:

"Are we measuring the things we actually care about?"

- Are hospital and service measures balanced with population health, inequalities, access, residents' experience and community outcomes?
- Do the measures reflect the shared ambition and show whether people's lives are actually improving?
- Are we also tracking whether the system is changing and organisations are working differently - for example, whether neighbourhood priorities influence wider decisions and whether support is becoming easier to access?

9. TRACK WHETHER COMMISSIONING AND RESOURCES ARE ACTUALLY CHANGING

Ask yourself:

"Are resources moving towards communities and prevention, or are pressures simply shifting elsewhere?"

- Are commissioning decisions and budgets supporting the agreed ambition?
- Are the full costs of rural and dispersed provision recognised and covered?
- Are changes reducing pressures across the whole system, or shifting them from the NHS to adult social care, VCSE organisations or families?
- What evidence do we have that investment is reaching the community infrastructure and support on which neighbourhood health depends?

A NEIGHBOURHOOD HEALTH PLANNING LIBRARY

The following resources - while not an exhaustive list - offer further background information, evidence and ideas.

A starting point for councils
The LGA's Neighbourhood Health Hub combines guidance, practical tools and case studies for councils and their partners. It includes resources on local leadership, as well as approaches to prevention and joined-up working. It also includes a Health and Wellbeing Board Maturity Matrix.

Understanding national expectations
The Department of Health and Social Care and NHS England's Neighbourhood Health Framework sets out national ambitions and expectations for neighbourhood health. It describes the roles of councils, Health and Wellbeing Boards, ICBs and wider partners in developing locally owned plans and bringing services together around people and communities.

Connecting plans with commissioning
NHS England's Strategic Commissioning Framework sets out how ICBs should understand population needs, agree priorities, and allocate resources to improve health and reduce inequalities. It provides context for connecting neighbourhood health planning with commissioning decisions at neighbourhood, place and system levels.

Working with communities and VCSE organisations
The VCSE Handbook on Neighbourhood Health by NAVCA, The Partner Ship and Alliance42, offers practical guidance on building neighbourhood health around communities through VCSE partnership.



The resources explore community insight, relationships, shared leadership, participation in decisions and aligning funding around local priorities.

Building on community strengths
Putting the Neighbourhood Back into Neighbourhood Health, by Lisa McNally and Cormac Russell for New Local, explores the contribution of communities to creating health.

Understanding county, rural and coastal realities
The Chief Medical Officer's 2026, 2023 and 2021 reports on Health in rural areas and small towns, Health in an ageing society and Health in coastal communities explore how geography, demography and inequality shape health needs and access to services.

WHAT NATIONAL LEADERS AND POLICYMAKERS CAN DO

National leaders can help local partners turn the neighbourhood health ambition into practical change by ensuring policy, funding and expectations are designed around the realities of county, rural and coastal areas.

The research points to eight priorities across three themes.

MAKE THE NATIONAL FRAMEWORK WORK FOR DIFFERENT PLACES

1. Make local flexibility explicit in national guidance

- Clarify that neighbourhood footprints and delivery models can vary to reflect geography, populations, community assets and access.
- Ensure indicative population sizes do not become default requirements that local partners must negotiate their way out of or accept to the detriment of neighbourhoods.
- Guidance could explicitly support locally justified footprints and different models within the same county.

2. Align and sequence national policy and reform agendas

- Ensure alignment and logical sequencing of neighbourhood health policy, NHS reform, local government reorganisation, Rewiring the State, SEND reform, and other elements of the civil society agenda. This requires coordination between Government Departments, so that local partners can develop coherent approaches across local services.



"National expectations should help local partners work toward a shared ambition."

3. Clarify accountability without prescribing one organisational model

- Set out the functions required at neighbourhood, place and system levels, and clarify expectations of Health and Wellbeing Boards, ICBs, NHS providers and emerging Integrated Health Organisations, primary care and place partnerships.
- Allow local partners to agree who is best placed to lead particular functions, with clear responsibility for decisions, action and outcomes.
- As devolution and the Rewiring the State agenda develop, national policy should also recognise councils' place-shaping responsibilities, expertise and democratic role, and clarify how these connect with the roles of strategic authorities and mayors, building on the capacity and relationships already held within councils.

4. Support broader, locally appropriate outcomes frameworks

- Make explicit the expectation for locally agreed outcomes frameworks.
- Support partners to address immediate NHS priorities alongside prevention, population health, inequalities, access and community outcomes. National assurance and performance arrangements should reinforce, rather than narrow, these broader outcomes, giving local partners scope to reflect their populations and circumstances.

"Places will have numerous local priorities. Some - like managing waiting lists and hospital discharge - will hold immediate urgency, but neighbourhood health planning should look to the longer-term too. It's an opportunity to work towards the shifts described in the 10 Year Health Plan, including more preventative approaches and care closer to home".

RESOURCE AND PROTECT THE PLACE LAYER

5. Recognise the additional costs of accessible provision in county, rural and coastal areas

- Ensure funding settlements and allocation arrangements fairly reflect the costs associated with distance, sparsity, workforce pressures, outreach and dispersed provision.
- Assess costs across health, social care and community support, so that reductions in hospital use do not simply transfer unfunded pressures elsewhere, including to councils and VCSE organisations.

6. Resource place-based planning and partnership capacity

- Provide for the capacity needed to coordinate partners, develop plans and turn decisions into action across multiple neighbourhoods.
- Recognise the additional demands on public health teams, including aligning Joint Strategic Needs Assessment analyses with neighbourhood footprints, developing neighbourhood health plans, and building relationships with neighbourhood teams and primary care.
- Resource the wider commissioning and partnership coordination capacity needed to sustain this work.

7. Protect planning and commissioning capacity during reform

- Assess the impact of NHS and local government reorganisations on place-based planning and commissioning capacity.
- Support continuity by being clear about where responsibility for functions sits as they move between organisations or geographical footprints.

ENABLE INVESTMENT IN PREVENTION AND COMMUNITIES

8. Test mechanisms for genuine upstream investment

- Test approaches that enable sustained investment in prevention and community support, including how transition costs are funded and benefits shared between partners.
- Build on areas already using the Better Care Fund and other arrangements effectively. The aim should be to increase the resources available for prevention, not simply to redistribute already stretched Better Care Fund, community health or social care budgets.
- Look again at implementing the Hewitt Review recommendation that "the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years." Other mechanisms may be desirable and feasible, but this offers a tangible starting point for testing.

"Effective neighbourhood health planning depends on local partners having the relationships, decision-making arrangements and capacity to act together."

Councils have a central contribution to make, but national policy must create the conditions in which their contribution can be realised. If national leaders provide flexibility where places need it, protect and resource the place layer, and enable genuine investment in prevention, then neighbourhood health has a much better chance of delivering on its promises of better care, stronger communities and healthier lives.



APPENDIX: METHODOLOGY AND ACKNOWLEDGEMENTS

The County Councils Network commissioned The Partner Ship to explore effective neighbourhood health planning in county, rural and coastal areas.

The research was conducted in four phases, between June and October 2026, in close collaboration with Chloe Reeves, CCN's Senior Policy Advisor for Adult Social Care and Health.

The research took a qualitative, practice-informed approach, combining desk research with semi-structured interviews.

The objectives were to identify practical learning for councils and Health and Wellbeing Boards, and to explain what national policymakers need to understand about county, rural and coastal contexts.

The research project was launched at the CCN County Adult Social Care and Health Forum in June 2026.

A seven-member **Advisory Group** brought perspectives from public health, adult social care, and across regions.

- **Neil Bradley** - Executive Director of Adults, Ageing and Wellbeing, Northumberland
- **Simon Bryant** - Director of Public Health, Hampshire
- **Sally Cartwright** - Director of Public Health, Cambridgeshire and Peterborough
- **Helen Coombes** - Executive Director of Adults, Health and Wellbeing, Lancashire
- **Trudi Grant** - Director of Public Health, Lincolnshire (and formerly DPH, Somerset)
- **Lisa McNally** - Director of Public Health, Worcestershire
- **David Watts** - Executive Director of Adults, Health Partnerships and Housing, North Northamptonshire

Scoping: Desk research considered national policy and guidance, existing research and local material relating to neighbourhood health, partnership working, governance and the particular circumstances of county, rural and coastal areas. An initial evidence and practice review covered all 39 CCN member council areas, with 18 identified for further exploration. Early discussions with the Advisory Group, and input gathered through the NHS Alliance and LGA Conferences, helped identify interviewees, refine the detailed research questions and explore the issues that mattered most to local leaders.

Interviews: Interviews involved 42 contributors from national bodies, councils (including public health and adult social care), primary care, NHS organisations and VCSE organisations. Interviewees came from 18 areas. A common set of topics supported comparison across interviews, while allowing contributors to explain local circumstances and raise issues arising from experience.

Questions explored:

- How are councils and partners translating national ambitions for neighbourhood health into local action?
- What opportunities and challenges arise in county, rural and coastal areas?
- What roles, relationships, governance, capacity and ways of working support progress?
- How could national policy, funding, expectations and support better enable local progress?

Analysis and refinement: Interview findings and supporting documentary evidence were analysed and synthesised to identify recurring themes, differences and practical learning. Advisory Group and CCN Leaders' Forum discussions helped test and refine findings and recommendations. The analysis distinguished between challenges common to neighbourhood health planning across England and additional considerations arising in county, rural and coastal areas. It also explored the conditions supporting progress and the connections needed between neighbourhood delivery, place leadership and wider system decisions.

Practical examples: Findings from all 18 areas informed the research report's common conditions for effective neighbourhood health planning, practical actions for councils and partners, and recommendations for national policymakers. Seven areas informed the detailed examples used throughout the report: Cambridgeshire, Cornwall, Hampshire, Northumberland, North Yorkshire, Warwickshire and Worcestershire.

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CCN COUNTY COUNCILS NETWORK

THE VOICE OF COUNTIES

CCN is the voice of England's counties. Representing the local authorities in county areas, the network is a cross-party organisation which develops policy, commissions research, and presents evidence-based solutions to issues on behalf of the largest grouping of councils in England.

In total, the 21 county councils and 18 unitary councils that make up the CCN represent 26 million residents, account for 39% of England's GVA, and deliver high-quality services that matter the most to local communities.

The Partner Ship

The Partner Ship combines partnership building with research to help organisations collaborate. We believe collaboration needs more than goodwill. It takes relationships, trust and shared purpose backed by the governance, structures and practical ways of working that help partners get things done.

Drawing on experience with over 35 partnerships, alliances and networks, we build partners' own capacity to work across organisational boundaries, sustain collaboration, and achieve more together.

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