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3ni national network for neighbourhood improvement

PPL

Neighbourhood health and local government

March 2026

Local Trust

About this report

This report summarises the discussion at a consultation event organised by Local Trust, 3ni, and PPL in December 2025. The event gathered a range of experts on neighbourhood health including local authority practitioners, health sector leaders, policymakers and representatives of community and civil society organisations. The discussions centered around the implications of neighbourhood health for local government, and the role of local authorities in working with communities and the health sector to improve population health and reduce health inequalities.

Authorship

This report was authored by PPL, a leading health and social care consultancy.

Acknowledgements

With thanks to consultation participants from Bristol City Council, Capacity, Gloucester Gateway Services, Greater Manchester Combined Authority, Hackney Wick Big Local, Health Foundation, Leeds Council, Lloyds Bank Foundation for England and Wales, London Borough of Havering, Love Barrow Families, NAVCA, NHS Cheshire and Merseyside, NHS Confederation, NHS England, PPL, The King's Fund, West Midlands Combined Authority, and W12 Together.

And special thanks to our facilitator, Adam Lent.

About 3ni

3ni is a new social value partnership, bringing together policy and practice to transform neighbourhoods across the country. By creating a space for collaboration and innovation, we're working with local government and the wider public sector to drive meaningful, lasting change where it's needed most. At 3ni, we believe that real transformation starts from the ground up. Through our national network for neighbourhood improvement, we're sharing and shaping the best and next practices that help rebuild disadvantaged communities. Our research, events, and activities are designed to support local government and public sector partners in learning what works—and, more importantly, putting it into action.

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Front Cover: Community Leadership Academy learning session, Manchester, 2023
Photo: Local Trust/Tessa Harri Carrol

COMMUNITY FUND

Contents

Neighbourhood health and local government

This document aims to summarise the discussions and learning from a 2-day policy sprint organised by Local Trust, 3ni and PPL focussed on:

Understanding what neighbourhood health means, how it will impact local government and how we can engage with the agenda most effectively.

The sprint was attended by representatives from Local Government, Health, Voluntary & Community Sector and wider civil society.

Key points

- The goal of neighbourhood health is often summarised as transferring power to neighbourhoods as the only route to delivery. This is overly simplistic, as this transfer is also a huge transfer of risk, responsibility and effort to neighbourhoods, and unlikely to succeed alone given the vast assets to deliver this neighbourhood care sits within statutory services. **It is therefore vital for neighbourhood health to be "community led, but system-enabled", allowing communities to lead, but be supported by system assets and system risk sharing.**
- Neighbourhood health is a complicated and crowded delivery space, with several concurrent delivery programmes using some formulation of "Neighbourhood Working" as a title. **These programmes do not always align to shared definitions of neighbourhoods but often will interface with the same statutory and non-statutory services.** This risks confusion, fatigue and a fragmented structure for the delivery of neighbourhood health.
- Nationally, we are living in a time of great political uncertainty and division. Dividing neighbourhoods and communities is a political goal for some **and we cannot assume that all neighbourhoods will coalesce around initiatives aim to reduce inequalities and increase health and wellbeing for all.** We need to recognise that neighbourhoods are not homogenous, and are often comprised of groups and communities with different interests. This will be a challenge for working in some neighbourhoods, and often those that are most in need.

- We need to acknowledge the failure of public services as they are currently organised to deliver for our most disadvantaged neighbourhoods. Statutory services need to collectively acknowledge that a new way of working is needed and to embrace proportionate universalism as a key pillar of that change. **Proportionate universalism advocates for universal services delivered at a scale and intensity that is proportionate to need, this means an acceptance that our more deprived neighbourhoods receive enhanced support.** In doing so this will result in a flattening of the variance between the prosperous and less prosperous neighbourhoods, a reduction in inequalities and an allocation of resources towards the most in need of support.
- The attendees at the policy **sprint questioned whether statutory led delivery initiatives involving consultation with neighbourhood residents would be enough to deliver neighbourhood health.** They suggested that mobilising the full range of assets and resources in neighbourhoods may require something closer to a social movement - one that moves beyond organisational boundaries and ownership, and shifts from 'consulting' residents towards meaningfully involving them by ceding control and resources.

Background

The 10-Year Plan and neighbourhood planning guidance provide a strategic framework, intended to help systems and providers prepare for and implement neighbourhood health models. Alongside expected further guidance, this will support places to develop neighbourhood working but does not replace the need for neighbourhoods themselves to define their own activities, structures and measures of success, and share this with others on the same journey to collectively learn from this experience.

The implications of this new direction are widespread: a national transformation for our population's experience of health, care and wider services of significant scale and complexity. The distribution of power, funding and decision making is designed to change, with communities and service users increasingly part of the co-design and co-production of services that serve their neighbourhood.

The launch of the 10 Year Plan has also re-enlivened important ideological debates about how integration can be practically achieved, how partnerships at Place level can be most effective, and the relationships between Local Government, Civil Society, VCFSE Sector and the NHS. This includes how Local Government relates to Integrated Care Boards in their roles as strategic commissioners in a way that addresses wider determinants of health and ameliorates inequalities through an increased focus on integration and whole systems approaches.

Inherent in these debates is also the extent to which Local Government leads on neighbourhood working and how that leadership manifests to ensure timely and effective delivery of this national challenge. More fundamentally, the delivery of neighbourhood working raises questions around organisational identity for the partners that will be asked to work in a far more integrated way and around neighbourhood identity for our populations.

In December 2025, Local Trust, 3ni and PPL convened a policy sprint for Local Government colleagues to discuss these issues over two days at St George's House. The policy sprint intended to address the following key question through a series of panel discussions and group exercises.

"What role should local government play in improving the health and wellbeing of local communities, in the context of the shift to neighbourhood health?"

The learning

The discussions covered varied topics, and the policy sprint format contributed to an ability to achieve depth in discussions. The learning for the group centred around:

The Goal

Defining a goal for the Neighbourhood Health Service is challenging, as it is a foundational change in the delivery of services which will mean different things to different places. However, for the purposes of the discussions, the group agreed on a high-level goal of:

"Creating health and wellbeing through a hyperlocal, preventative, integrated approach that is community/ neighbourhood led."

Meeting this goal requires considerable resource at a time when additional resource is not forthcoming and cannot be the reason for inaction and further degradation of health and wellbeing. Delivering this goal requires us to use the resource already available more effectively, and mobilise the resources already existing in communities in the service of shared, long-term goals.

Systemic drivers of change

To achieve the stated goal, systemic change is required for success. Some of the systemic drivers of change discussed included:

1. **Moving beyond an institutional mindset** of scale and hierarchy to local and trust-based ways of working. This means viewing activities and goals from the perspective of whole systems, rather than the viewpoint of single organisations, and prioritising approaches that build the capacity for prevention and health creation within communities.
2. **Allowing courageous leadership and delivery to flourish**, and understanding that this means handing power and leadership from institutions to communities and neighbourhoods, giving them time and room to grow into this role, re-assessing our appetite for risk and the relinquishing of control.
3. **Giving professionals more time to deliver long-term impact**, and not defining initiatives as having "failed" when goals are not met in a matter of months. The short-termism of current funding relationships, particularly with the VCSE sector are not properly calibrated for long-term and sustainable change and are in fact contributing to a lack of consistency, collaboration and trust in these cross-organisational relationships.
4. **Make it everybody's business**, not just the NHS – the Neighbourhood Health Service is not within the power of the NHS to create, it requires broader partnership and a shared acknowledgment of shared vision and goals. If we assume that this is an "NHS problem" with an "NHS solution" it will not succeed.

Case study

Example raised at the event: Live Well (Greater Manchester)

LIVE WELL
DOING THINGS DIFFERENTLY WITH GREATER MANCHESTER'S COMMUNITIES

Live Well is Greater Manchester's community-led movement to improve health, wellbeing and social support by re-shaping how public services work with residents and local organisations. It brings together councils, the NHS, voluntary, faith and community groups in integrated neighbourhood networks of Live Well Centres, Spaces and Offers — trusted local places where people can access support, social activities or advice close to home. Example activities include community-run green hubs and bike parks that host wellbeing activities, social prescribing, and peer support, and a network of groups funded through the Live Well Communities Fund that has already supported hundreds of community projects. The approach stresses integration by connecting and partnering between health, social care and community initiatives so that people can navigate joined-up support and shape services that reflect local priorities.

5. **We need to support neighbourhoods and communities to be active leaders**, rather than passive recipients, of the change they want to see. This is involves ceding control of resources to communities and being "community led" in the interventions we seek to establish, but "system enabled" to help those communities manage risk and access the assets needed to realise change.
6. **Proportionate universalism**, and the need to be comfortable with different services, or different service intensity in different places. This will not come naturally to all who are accustomed to the concept of absolute universalism being a virtue. Some of our communities need more input and more support than others, this means different offerings in different places.

7. **The role of employers in neighbourhood change, and the role of social finance**, needs to be better understood and actively pursued. Often falling at the hurdle of being perceived as "privatisation" and therefore necessarily to be avoided, we need to acknowledge that employers, and social finance, can and do play huge roles in people's lives. Social finance models have the potential to be more permissive that state funding, potentially leading to highly innovative activity. Ignoring employers in particular ignores the context in which many people spend a vast proportion of their time and energy.

8. **We need to spend the time to listen to communities and commit to working with them in the long-term to transfer power and resource to residents,** as a precondition to achieving the upstream shift to prevention. Listening carefully and rebuilding relationships is essential if we hope to equip communities with the tools to proactively support their health needs in the long-term – but this can't be achieved in a timeline of weeks or through standard tick-box exercises. This may feel counter to the need to act fast, but is needed to foster the long-term relationships between communities and the statutory sector that this future system will revolve around.

Case study

Example raised at the event: Love Barrow Families (Barrow-in-Furness)

Love Barrow Families is a grassroots family support initiative co-designed with local families and practitioners to help those facing multiple disadvantages by combining practical, emotional and social support. It integrates services by co-locating workers from children's social care, adult social care, mental health and other agencies into one wrap-around team, so families receive holistic support rather than fragmented help. Activities include community events like regular family lunches, holiday activities and a dads' support group, which foster connection and belonging while addressing underlying issues that could lead to statutory intervention. Rooted in the community, the programme emphasises listening, co-production, shared decision-making with families, and collaboration between statutory and voluntary partners to improve outcomes and keep children safely at home.

Personal drivers of change

Individually, several suggestions were made on the drivers of change where each person in the room had the agency and ability to do things differently. These included:

1. **Focus on the real world impact outside of the institution** or on what needs to grow. This means viewing the goals of the future as whole system goals, not as goals for a particular institution, and championing this way of thinking about outcomes. This might seem intuitive and obvious, but it is not a part of our current ways of working in statutory services.
2. **Courage to ask tough questions**, to speak truth to power, to protect the pioneers and innovators, to live with ambiguity as we take on this national challenge.

3. Use **the existing levers available and focus on conditions rather than services**, support innovative and smart budgeting/ commissioning as a key role for Local Government in particular
4. **Convene, connect, broker** at a personal, not an organisational level
5. **Tell compelling stories** and allow others to imagine their own vision of change which may be different to your own vision. We do not have all of the answers, but we need to enable the neighbourhoods and communities to generate their own answers.

Challenges for neighbourhood working

The ideas behind the shift to neighbourhood health are not new, but statutory services have not organised in this way in the UK, and that is due to a number of barriers which are the same today. Some of those barriers discussed at the policy sprint include:

1. **The definition of a neighbourhood will never fully capture the diversity of how people identify themselves**. Whether a person believes they are "from" X or Y place can mean a city, an estate, a row of houses or one side or other of a river or road. The definition of a neighbourhood may not be meaningful for all people, but it is required as statutory services will need some form of "unit" to organise services around
2. **Communities are not all unified**, and are increasingly divided by groups which seek to foster divisions between them. This can lead to distrust between residents, let alone the services that are there to support them. This could make forming services around neighbourhoods and responding to communities' own suggestions of what will make their neighbourhood "better" hugely challenging. A situation where multiple diverse opinions simply cannot create a middle ground, or result in some voices retreating from their own neighbourhoods is a possibility we must acknowledge and mitigate

3. **The NHS is not good at spreading and scaling interventions** and this is exactly what is required for neighbourhood working to flourish. The current systems and processes must change to enable this spread, and we cannot rely on the current system providing this benefit. We need space to do this well, and a structure which allows people to shift from "firefighting" to "future building", however hard that may be, otherwise the fires will never resolve. We also need to ensure that 'scaling' interventions does not prioritise economies of scale over the flexibility for service providers and groups to tailor these to the needs of their areas.

4. **Measuring and reporting on progress needs to be rethought, as we are pursuing different goals, on different timelines**. If we focus on the short term goals, we will never resolve them, as the challenges of the future are demographic and fuelled by poor health behaviours today. Furthermore, communities often do not identify with the measures set by statutory services, they do not recognise these measures as "success" and we need to adopt measures that communities themselves define as success.

5. The delivery and guidance landscape is crowded, confusing and disjointed. Over 16 individual "Neighbourhood initiatives" were identified by the group, and each will have its own nuanced interpretation of what a neighbourhood is, what success looks like, and a vision for the future. We need to unite these ideals under a shared national vision

6. **You need somewhere to social prescribe to** – and some neighbourhoods will not have the infrastructure to do so, in these instances, the immediate priorities will be to rebuild the physical and social infrastructure of a neighbourhood. This is a generational challenge that will not be solved quickly and speaks to the high level of flexibility that proportionate universalism dictates. Where one area might focus on connecting people to their neighbourhood assets, another area may need to focus first on building those assets (and perhaps creating health and wellbeing in the process of creating those assets)

What next

The final substantive session of the policy sprint discussed "tactics" that link the systemic changes to personal changes and ultimately give a practical guide on what to do next

Tactics

A discussion of tactics requires a reflection on what individuals and organisations can control, what they can influence or contribute to, and what they have no control over whatsoever. Organisational change for statutory services is generally the focal point of "tactics" but does the delivery of the neighbourhood health service need a broader lens than organisational change? Does it in fact need to take the form of a grassroots "movement" in order to actually achieve the level of community participation, and system enablement that is required?

Whilst strategising at the level of individual public sector organisations is necessary, this strategising alone supports a separation of public services and citizens, something that we hope to reimagine by working in an integrated way with neighbourhoods.

If the delivery of neighbourhood health needs to be a movement, then this has implications, politics is more easily swayed by pressure than by data and evidence, so a movement could be what is needed to build the required momentum for change.

On a more practical level, statutory services cannot create a movement alone, but we can create the enabling infrastructure for this movement by:

- Opening up metrics to include measures that statutory organisations can't achieve alone and necessarily require partnership to achieve, such as population health outcomes, participation and social cohesion
- Being more flexible with spending, and spending ~20% on grassroots community groups
- Supporting the creation of Community Interest Companies within Trusts
- Creating space and funding flows for new approaches to community capacity building

Closing thoughts

Finally, acknowledging the discussions had during the sprint we would like to invite this group to reconvene in the future, reflect on what is happening and help to shape what comes next.

With major reforms ongoing, 3ni and Local Trust will continue to contribute to the neighbourhood health agenda: providing guidance on how it can interact with other neighbourhood programmes being delivered such as Pride in Place, hosting additional consultations around key issues, and building the evidence base on collaboration between communities and the health system through an action research programme delivered with the NHS Confederation.

About Local Trust

Local Trust is a place-based funder supporting communities to transform and improve their lives and the places in which they live. We believe there is a need to put more power, resources, and decision making into the hands of communities.

We do this by trusting local people. Our aims are to demonstrate the value of long term, unconditional, resident-led funding, and to draw on the learning from our work delivering the Big Local programme to promote a wider transformation in the way policy makers, funders and others engage with communities and place.

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About 3ni

The national network for neighbourhood improvement is a new learning network for local government and the wider public sector that supports policy and practice towards community-led regeneration. It was incubated and hosted by Local Trust in 2024.

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Company number 07833396

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