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Caroline Lee, Gavin Parker, Stefanie Buckner, Calum Mattocks, Amy Barnes, Emily J. Oliver, Andy Cowan and Louise Lafortune

Neighbourhood planning, rural ageing and public health policy in England: a case of policy myopia?

This article draws together new research findings with recent evidence, theory and policy developments relating to place-based planning for health and well-being. It considers how neighbourhood planning (NP) can support the advancement of the ageing-well agenda and well-being goals in rural areas of England. We argue that NP can theoretically impact positively on age-friendly objectives (sensitive housing design, downsizing options, social and civic participation), but this is limited without greater incentives and political commitment to integrated policy making. Without due attention, the advancement of ageing well and rural well-being through NP, as currently constructed, will remain a largely missed opportunity.

Keywords: ageing, localism, neighbourhood, public health, planning, rural, well-being

Introduction

An emphasis on localism in English planning in recent years, coupled with an increasing concern to deliver 'age-friendly' communities, offers both an impetus and a mechanism for policy to respond to the needs of population ageing at a very local scale. However, given the broad and manifold focus of planning policy, the challenges of actually achieving this have been the subject of much discussion in the past decade (Sarkar et al., 2014; Hockey et al., 2013). This article contributes to these debates by exploring the potential role of neighbourhood planning (NP) in

Caroline Lee (corresponding author) is a Senior Research Associate at Cambridge Public Health, Interdisciplinary Research Centre, University of Cambridge, East Forvie Site, Robinson Way, Cambridge, CB2 0SR and the Cambridge Institute for Sustainability Leadership, University of Cambridge, 1 Trumpington Street, Cambridge, CB2 1QA; Gavin Parker is a Professor at the Department of Real Estate and Planning, Whiteknights Campus, Henley Business School, University of Reading, Whiteknights, Reading, RG6 6UD; Stefanie Buckner is a Senior Research Associate at Cambridge Public Health, Interdisciplinary Research Centre, University of Cambridge, East Forvie Site, Robinson Way, Cambridge, CB2 0SR; Calum Mattocks is a Research Associate, Cambridge Public Health, East Forvie Site, Robinson Way, Cambridge, CB2 0SR; Amy Barnes is Lecturer in Public Health Policy, School of Health and Related Research, University of Sheffield, 30 Regent Street, Sheffield City Centre, Sheffield, S1 4DA; Emily J. Oliver is at the Department of Sport and Exercise Sciences, Durham University, 42 Old Elvet, Durham, DH1 3HN; Andy Cowan is a Research Assistant, Cambridge Public Health, Interdisciplinary Research Centre, East Forvie Site, Robinson Way, Cambridge, CB2 0SR; Louise Lafortune is a Senior Research Associate, Cambridge Public Health, Interdisciplinary Research Centre, East Forvie Site, Robinson Way, Cambridge, CB2 0SR; email: cyl40@medschl.cam.ac.uk; g.parker@henley.reading.ac.uk; sb959@medschl.cam.ac.uk; cm726@medschl.cam.ac.uk; A.Barnes@sheffield.ac.uk; emily.oliver@durham.ac.uk; ac798@medschl.cam.ac.uk; ll394@medschl.cam.ac.uk.

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England, a participatory planning process enabled under the 2011 Localism Act (UK Government, 2011), in supporting people to age well in their community. To do so, first, we bring together key issues associated with an ageing rural population and the predominantly rural uptake of NP (Parker and Salter, 2017; Parker et al., 2020). Second, we highlight pertinent policy developments alongside recent research and theory on the implementation of NP. Lastly, we draw on findings from a recent study of how NP in rural England has embraced ageing issues. These topics have not previously been explored overtly (Wargent and Parker, 2018), suggesting that there is a disconnect, or 'policy myopia', between ageing and planning policy at this scale, and likely missed opportunities to shape neighbourhoods in ways that support the well-being of (ageing) rural communities.

Ageing and rural England

In England, the proportion of people aged 65 and over is growing faster than that of under 65s: rising from 18.2 per cent of the population in 2018 to (a predicted) 20.7 per cent in 2028, with the number of people aged 85 and over almost doubling in the next twenty years to 3 million by 2043 (ONS, 2019). In rural areas, where nearly a quarter of England's older people already live, the average age is five years higher than in urban areas (DEFRA, 2018; Rural England, 2017). By 2039 a 50 per cent growth is anticipated in the 65+ population, increasing the ratio of older to younger people (ONS, 2018; 2020). As a consequence of this demographic change, the Plunkett Foundation (2018) has estimated that by 2029 there will be around 930,000 people with social care needs living in rural areas of England. The complex shifts in population observed and predicted imply a significant mismatch in demand and supply of services. Demand for care and support services is already high, due to multi-morbidity and increasing dependency (Barnett et al., 2012; LGA and PHE, 2017), and meeting social and health needs is challenging in some rural English counties. Less than half the population is of working age in some areas, exacerbated by younger residents increasingly being priced out of the housing market, and there is significant difficulty in attracting and maintaining workforce groups, including care workers, in rural areas (LGA and PHE, 2017; Rural England, 2017; Dorling and Thomas, 2016). Unequal access to services is also a challenge, with limitations in the provision of mental health services, day care and rehabilitation, particularly affecting older adults (Rural England, 2017; LGA and PHE, 2017).

The thrust of much policy concern for rural ageing in England has been on reducing outward migration of younger adults (Satsangi and Gallent, 2010; Lowe and Speakman, 2006), rather than addressing 'wider determinants' of older adults' health and well-being. Here, the World Health Organization's (WHO) Age-Friendly Cities and Communities (AFCC) initiative provides leadership on ensuring that communities are places that enable people to live and age well (World Health Organization, 2007a; 2007b). Although

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the AFCC framework originally focused on urban areas, many recommendations apply equally to rural environments, including those addressing determinants of health and well-being that are located in the physical environment (e.g. well-maintained pavements, open space), transport (e.g. reliable and frequent public transport) and housing (e.g. affordable housing close to services) (Steels, 2015). Older adults in rural areas are especially vulnerable to living in poor-quality housing, and there is less availability of sheltered housing than in urban centres (Rural England, 2017; Doheny and Milbourne, 2014). Heating costs are often higher, and fuel poverty is proportionately more prevalent where homes are typically less energy-efficient (Rural England, 2017).

Social and civic engagement is also a key feature of the AFCC approach in process terms. This includes providing opportunities for employment and volunteering, and affordable social activities, as well as promoting involvement and engagement in decision making at a community level (Steels, 2015; Handler, 2014; Buffel et al., 2019). While the AFCC initiative has achieved high visibility globally and in urban areas of England, the promotion of living and ageing well in rural and more remote communities has received much less attention (Buffel et al., 2019; Bould et al., 2018; Menec et al., 2015; Burholt and Dobbs, 2012). However, the planning system in England is already organised to enable local community involvement through tools such as neighbourhood planning, which provides a potential point of connection with the AFCC agenda both as a process and as a generator of outcomes.

The sustainability of rural communities, and aspects once seen as strengths of rural living (such as a 'strong community'), have arguably become weakened due to sustained disinvestment in rural services and infrastructure over time as well as waves of in- and outward migration (Wilson, 2010; Gallagher et al., 2006; LGA and PHE, 2017; Shucksmith, 2018; Brown et al., 2015). This manifests in narratives of 'loss' by rural residents – of core physical and social infrastructure (i.e. libraries, post offices, churches, pubs), of community life, of interaction and of connection – and can leave limited opportunities for residents to sustain social networks (Skerrat, 2018; Allen, 2018). These impacts are worsened where there is poor or non-existent mobile-phone connectivity and broadband coverage. They are further exacerbated by loss of connectivity through reduced public transport services, and contribute to the increasing proportion of isolated, home-dwelling older adults (Rural England 2017; Moseley and Owen, 2008; Scharf et al., 2016; Skerrat, 2018; CPRE, 2020). Connectivity, both physical and virtual, is crucial to community well-being generally, and pertinent in helping to support older adults to live and age well (Marmot et al., 2010; Falk and Kilpatrick, 2000; What Works Wellbeing, 2008). It is key to the risks of social isolation and loneliness, now widely considered a major public-health issue (Mental Health Foundation, 2017), and an issue brought further into the spotlight during the COVID-19 pandemic.

As far as opportunities to address these challenges go, orthodox planning has tended to neglect smaller, rural settlements which have often been characterised as 'unsustainable'

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in terms of development and new housing allocations. Tensions exist between social and environmental priorities, lack of infrastructure and political resistance to development. This composite of issues has acted to restrict options to improve rural sustainability, risking leaving communities in a so-called 'cycle of decline' (Country Land and Business Association, 2018). Many such places have also been identified as exhibiting significant pockets of deprivation (Cloke et al., 1995; Martin et al., 2000), overlooked against more visible urban challenges. In short, a lack of attention and prioritisation of planning for ageing rural neighbourhoods over time has been further marginalised as the focus of governance on city regions and metropolitan areas has increased.

Participatory planning, ageing and well-being

Despite research evidence and demographic trends, the allied concepts of health, well-being and age equity have not been well integrated into wider policy debates. Since age was included as a dimension of equality by England's Equality Act, passed in 2010 (UK Government, 2010), limited attention has been paid to unequal opportunities for healthy and active ageing associated with the built environment (Hockey et al., 2013). Public health was a key driver for local planning in England as far back as the Victorian era (Hebbert, 1999; Cullingworth et al., 2015). Yet it has become marginalised over the past three decades, traded off against other policy concerns (e.g. environmental sustainability or development targets) and through waves of deregulation and neo-liberalisation which have shaped the priorities and outcomes of the English planning system (Lord and Tewdwr-Jones, 2014; 2018).

The age-friendly movement champions the rights of older adults to have choices about where and how they age (Wiles et al., 2012), but planning for this in a rural context has not, thus far, supported age-friendly rural communities in practice. First mooted in the 1960s, citizen engagement and participatory decision making were incorporated into planning processes in England following the 1969 Skeffington Report (Brownill and Inch, 2019) and, since the 1990s, incoming national governments have continued to discuss participatory ideas and models of decentralisation (Allmendinger and Haughton, 2013). Several initiatives to mobilise communities have been trialled, purportedly offering communities the opportunity to research and prepare action plans for their local areas, with some pilots in neighbourhood governance hailed as 'responsibilising' communities as 'citizen planners' and reducing spatial inequalities (Raco, 2007; Lord et al., 2017). Yet efforts to engage rural communities have had mixed success. Challenges have been highlighted in mobilising rural communities in England to identify issues and draw up action plans via village appraisals and parish plans (Owen and Moseley, 2003; Parker, 2015), though potential and willingness have been evidenced too (Gallent and Robinson, 2012; Parker, 2008; Parker, Wargent et al., 2020). The EU's LEADER (Links between actions for the development of the

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rural economy) programme is another effort to promote local action to revitalise rural areas, and one where local development strategies may in fact be reluctant to push an age-friendly agenda over priorities to retain young people and counter depopulation (South Ayrshire Council, 2008).

By the time of the UK's 2010 general election, the Conservative-led coalition government had signalled their intent to create neighbourhood-scale planning that would 'empower communities' to shape their own environment. This new neighbourhood planning (NP) policy, enabled through the Localism Act (2011), was presented as a different way of 'doing' planning, with residents having more control over the type, mix and location of new developments within local neighbourhoods. Involving residents in decision making is central to the NP approach and aligns with the civic engagement pillar in AFCC goals, as well as with ideas of co-production and empowerment often deemed key determinants of well-being (Parker et al., 2018; Watson, 2014; What Works Wellbeing, 2018).

Residents lead the production of formal neighbourhood development plans (NDPs) (UK Government, 2011) which carried statutory weight (Parker and Salter, 2016; Parker et al., 2015; Davoudi and Madanipour, 2013). Neighbourhood planning as a new 'community right' offered the promise of asserting local knowledge and priorities in the development cycle: as a response to a perceived need to build consensus between citizens and government on questions of growth and house building in particular (Bradley and Sparling, 2017, Stanier, 2014; Wargent and Parker, 2018). The Localism Act demarcated clear boundaries for the integration of participatory democracy within an otherwise top-down plan-making model of the local authority (Brownill and Downing, 2013). Such boundaries have regulated the relationship between representative democracy and 'bottom-up planning', distinguishing neighbourhood development plans (NPs or Plans) from previous incarnations of community engagement in development decisions (Bradley, 2015, 100). However, government also created both flexibility and confusion over what a Plan could or should cover. It directed neighbourhoods towards particular agendas while also indicating that the scope of NPs could be wide or narrow (Parker et al., 2017; Wargent and Parker, 2018): 'The new neighbourhood plans will be flexible so communities will be able to determine the issues or areas to cover and what level of detail they want to go into' (DCLG, 2010, 2); 'The specific planning topics that a neighbourhood plan covers is for the local community to determine' (MHCLG, 2019b; NPG para. 004).

Health in all policies?

Influential global initiatives such as the AFCC agenda and the United Nations Sustainable Development Goals (UN SDGs) (United Nations, 2016) could provide impetus to navigate this somewhat muddled, or 'open', backdrop and integrate

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ageing well, health, well-being and equity into all levels of governance (UK2070 Commission, 2020). There are now urgent calls to coordinate policy responses to promote the social inclusion of older people, requiring equity to be a guiding principle for both age-friendliness and meeting the UN SDGs (World Health Organization, 2015; United Nations, 2016). The WHO 'health in all policies' (HIAP) agenda (World Health Organization, 2014) also calls for policy integration that addresses health inequalities, including appropriate housing and planning which considers supportive infrastructure and the built and natural environments.

Closer to home, NHS England, together with Public Health England (PHE) and the Local Government Association, launched Sustainable, Resilient, Healthy People & Places in 2014 (NHS England and Public Health England, 2014) where the key elements underpinning the strategy were protecting natural resources and promoting healthy lifestyles and environments. The English NHS Five Year Forward View (National Health Service, 2014) reflected HIAP goals with a blueprint for the NHS to work with its many partners to address gaps in health and well-being, care and quality, finance and efficiency. Bringing partner agencies together to achieve this plan, the Sustainability and Transformation Partnerships (STPs), and later the Integrated Care Systems (ICS), (National Health Service, 2018) were introduced.

A year later, the NHS launched the Healthy New Town programme (Norman and McDonnel, 2017) in a return towards planning for population health, incorporating healthy design principles with integrated health and social care, and a focus on connected communities. Evaluations are ongoing (Watts et al., 2020; NHS, 2019) and connection to mainstream land use planning remains weak. Reflecting its service-commissioning and delivery ambitions, PHE has highlighted the potential of community-centred approaches, and specifically citizen engagement, to address inequalities and improve health and well-being (Public Health England, 2015). PHE is now actively encouraging partnership and consultation between health, public-health, and local planning authorities (LPAs) on alignment of STP/ICS. Local planners are being encouraged to engage with directors of public health, clinical commissioning groups, and health and well-being boards to assess well-being and projected needs (Public Health England, 2019). This provides the context of emerging discussions about how to mainstream this part of the health and well-being agenda through the planning system.

This renewed public-health goal was reflected in planning guidance by the 2019 revised National Planning Policy Framework (MHCLG, 2019b), which stated specifically (in Section 8) that planning should also consider health:

> Planning policies and decisions should aim to achieve healthy, inclusive and safe places which: a) promote social interaction, including opportunities for meetings between people who might not otherwise come into contact with each other – for example through mixed-use developments, strong neighbourhood centres, street layouts that

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> allow for easy pedestrian and cycle connections within and between neighbourhoods, and active street frontages; b) are safe and accessible, so that crime and disorder, and the fear of crime, do not undermine the quality of life or community cohesion – for example through the use of clear and legible pedestrian routes, and high quality public space, which encourage the active and continual use of public areas; and c) enable and support healthy lifestyles, especially where this would address identified local health and well-being needs – for example through the provision of safe and accessible green infrastructure, sports facilities, local shops, access to healthier food, allotments and layouts that encourage walking and cycling. (MHCLG, 2019b, para. 91)

This attention to spheres of both the built and social environment spans common domains of action and intersects with age-friendly goals, accessibility and community well-being. Indeed, the case for planning for healthy places is strengthened by explicit recognition that improvements to the built environment and social infrastructure benefit many different groups and sections of the population. The implementation of lifetime neighbourhoods, for example, could help realise both NPPF health-related innovations and the AFCC agenda.

Momentum thus appears to be gathering for greater integration and alignment between health and place (Chang, 2017), and the COVID-19 pandemic has acted to further propel such policy concerns. At the same time, greater devolution in decision making and 'localism', as embodied in the approach of NP, are associated with an apparent desire to empower communities and achieve a better understanding of the drivers of and mechanisms to address inequalities (Public Health England, 2015; Bailey and Pill, 2015). Thus there is potential for ageing well specifically (as well as wider health and well-being goals) to be supported first through the NP process (including the development of a Plan), and second through the outcomes of NP (directly or indirectly relating to Plan content and policies). Yet to what extent does NP realise this in rural areas and actually provide a mechanism for residents to have a voice and exert control over factors that enable people to live and age well? Thus far the actualisation of this agenda is not well researched or understood.

Research aim

To address this question, we explored how developing an NP might support ageing well, and prompt greater reflection of local need, as well as how NP could be used to influence the shape of local developments to create and sustain rural neighbourhoods as places to live and age well. This spans both process – engagement in decision making and associated community well-being benefits such as social connection and cohesion (Cramm et al., 2013), intelligence and articulation of local needs – and outputs, for example influence on housing 'type' and design, the neighbourhood environment

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and green space. To this end, we conducted a study of the current and possible future role of NP as a mechanism to foster health and well-being, and creating age-friendly environments. In this article, we reflect first on the implications of findings with regard to the process of NP – empowering citizen voice and citizens as planners, integrating local health-related concerns within place planning – and second on the outputs and outcomes of NP, and the extent to which NP is and could be seen as a vehicle for working towards integrating and meeting public-health and ageing-well goals in rural areas (see also Buckner et al., forthcoming).

Method and sample

The study reported here included four stages. First was a literature review combining a focus on age-friendly communities and planning. Second was mapping the current uptake of NP in rural local authority districts (LADs) in England. Third, we surveyed all localities that were either at or beyond the pre-submission stage of a draft NP at the time of the research, to investigate to what extent ageing and/or health and well-being goals (i) were aspects of interest to those developing NPs, (ii) made it into Plans and (iii) were anticipated outcomes of the NP process or the content of the Plan. Fourth, we conducted comparative case studies (Crowe et al., 2011) in six rural communities to explore in depth how the process of developing a Plan, and the final Plan itself, encompassed ageing-well and/or health and well-being goals. Ethical approval was obtained from the School of the Humanities and Social Sciences Research Ethics Committee at the University of Cambridge.

At the time of the study, the distribution of NP areas was sparse across the North, the South West and parts of the East of England, with little representation in LADs with higher levels of deprivation. We sent an electronic questionnaire to publicly listed NP contacts, seeking quantitative and qualitative information on the background to NP locally, and details of the NP process and its outcomes. A response rate of 13.5 per cent (n = 75) was achieved from the sample of 572 'predominantly rural' or 'significantly rural' localities, spread across 109 local authorities (LAs). No common characteristics were detected among non-responding areas, although rural LAs with higher levels of deprivation such as County Durham and Cornwall were not represented among responses (MHCLG, 2019a). Among the LAs with no respondents, a fifth (22) had only a single NP in development or adopted at the time. Descriptive statistics were produced and narrative responses were analysed thematically, informing data collection in the subsequent case studies. The six comparative case studies were purposively selected from survey responses on the basis that they had mentioned NP priorities that could support the creation of more age-friendly environments. Localities were selected from diverse regions of England representing a mix of low, middle and high deprivation, and rural and semi-rural geographies,

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including one village with an allocated growth zone and a small coastal town (see Table 1). The sites varied in population size up to 8,000 inhabitants, with between 18.5 and 42 per cent aged 65 and over, and low, middle and high index of multiple deprivation (IMD) scores (MHCLG, 2019a).

Table 1 Key features of case study sites

Case study	Region	Rurality description	Deprivation rank	Population
1	East Midlands	Growing town – rural parish with allocated growth zone	Low ranking on IMD 78% living in top 20% most deprived area	c.8,000 (18.5% aged 65+)
2	East of England	Rural village	Middle ranking on IMD 30% ranked in each of ranks 5, 6, 8	c.1,000 (26.5% aged 65+)
3	South West	Rural village	Middle ranking on IMD (average rank 5)	c.2,000 (20.7% aged 65+)
4	North West	Coastal town (classified rural on RUC)	Middle ranking IMD (50% population rank 9, 25% 6, 25% 8)	c.4,100 (41.88% aged 65+)
5	North West	Semi-rural commuter village	High ranking on IMD (Rank 2)	c.2,900 (25.5% aged 65+)
6	East of England	Semi-rural commuter village	High ranking on IMD (Rank 2)	c.2,600 (30% over 65s)

Note: Descriptions have been generalised to avoid identification

We conducted desk research analysing documentation including the adopted Plan (and earlier versions), accompanying documentation and assessments, the examiner's report on the submitted draft Plan, and records of public consultations as the Plan was developed. Researchers also visited each site and carried out face-to-face interviews or focus group discussions with those involved in developing the Plan. A further focus group was carried out in one region with representatives from six additional neighbourhoods and respective local planning officers, which were from a predominantly rural local authority area.

Research findings and discussion

Below we discuss findings from the research in relation, first, to outcomes against a context of policy myopia, and, second, to the process of NP and issues around incentives, disincentives and rational choice. We then reflect on how weaknesses observed in the roll-out of NP may interfere with processes otherwise intended to support ageing

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well and population well-being, and constrain ambitions of integrating health goals with place making.

Broad aspirations, narrow implementation

With the overall burden associated with Plan production shouldered by volunteers, the degree of innovation has tended to be limited (Parker et al., 2015; Parker et al., 2017; Parker, Dobson et al., 2020; Brownill and Bradley, 2017). From responses to our survey and case study interviews, NP reportedly offered opportunities for communities to develop as places that supported ageing well in a range of ways. Yet 40 per cent of respondents to our survey reported that the principal emphasis within Plans rested on the housing needs of localities and allocating sites for development, reflecting previous research (Bradley and Sparling, 2017). Case study respondents described curtailments on creativity, and a gap between expectations of what was achievable through NP and the reality. Disappointingly, our study found that involvement of health, public-health or social-care stakeholders in NP was not commonplace. Even in those localities where new medical and social-care facilities emerged as priorities for the community, there was little involvement reported, and little supporting evidence for needs assessments shaping Plans. An exception was one highly engaged GP in one NP case study area, highlighting both the potential and the missed opportunities to reflect health and ageing goals in development plans. This indicates to us disconnects between the promotion of wider policy agendas at national and international scales, and the facilitation of mechanisms such as NP, and highlights the critical role of effective facilitation and awareness raising in neighbourhoods.

Despite knowledge gaps that may be characterised as 'policy myopia', as below, the case study findings indicate that citizen planners had anticipated some outcomes relevant to an age-friendly agenda, once Plans had been in place for a sufficient time. Yet examples were again heavily housing-related: the construction of suitable housing for older adults, and affordable housing enabling younger adults to stay closer to ageing parents; the influence on design or inclusion of downsizing options; and upgrading of sheltered housing stock.

A third of our survey respondents anticipated that their Plan would support older adults' health and well-being, though, through better access to green spaces, walking routes, and new opportunities for independent travel. Not all of these can be directly attributable to NP, and were rather 'foreseeable' improvements, for example being adopted into local (parish council) 'objectives' or 'priorities' rather than being formalised as policies within a Plan. The case studies allowed us to explore these anticipated gains further, and we found some groups planning new facilities or attempting to secure the future of community services such as health centres, well-being 'hubs' and leisure activities. Expected improvements to infrastructure were also highlighted, to

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transport, for example, with a new community bus service offering improved accessibility to social activities. Typically, activities of these types became earmarked for Community Infrastructure Levy (CIL) or Section 106 monies.[1]

These findings suggest that there is evidence of citizen planners using the collective capacities that they have, or developed through NP, to raise the profile and priority of services in addition to housing. Although their participation was bounded within housing and development actions, the process of development and consultation creates a platform (and expectations) of a broader remit. We see this in both the age-appropriate and affordable housing reflected in Plans, and the articulation of local priorities in support of population well-being, including earmarking infrastructure levies for projects supporting such goals.

It was also clear, however, from our findings that the potential of NP and the ambition of Plans were constrained in the process of development. Several factors were highlighted as influential – from the bottom up, relating to community engagement; to the top down, relating to the interpretation of planning policy; and in the middle, individual relationships with local government (Parker et al., 2015; Parker et al., 2017), and the involvement of consultants and external advisers.

Inclusion, engagement and the influence of incentives to participate in collective action

NP case study areas overall reported a positive impact on participation in the process of developing a Plan, important as one dimension of age-friendliness. Our survey and case studies found that older adults were frequently involved in developing NPs and drafting policies, as parish councillors or members of working parties. Questionnaire responses suggested that the engagement process often resulted in well-being outcomes for older participants in NP, such as gaining new skills, building new relationships, and feeling that they had a say in shaping local decision making and local development. Community consultation exercises are an expectation in NP, and the basic conditions against which NPs are tested require adequate engagement. The case studies revealed examples of older adults' views purposely being sought alongside those of other residents, through resident surveys, focus groups and even targeted canvassing of care home residents and older adults' community groups in some cases.

Paradoxically, the voices of some older adults risked being *over*-represented in some rural areas. We also observed, in both survey and case study data, a high reliance on volunteer time and effort, favouring residents who had 'more time on their hands', typically including retired older adults. This echoes findings elsewhere that the *breadth*

1 The CIL is a set levy on types of development. Each neighbourhood with a neighbourhood plan is eligible to receive 25 per cent of the CIL receipts derived from development in their neighbourhood – if their local planning authority (LPA) has a CIL schedule in place (see Field and Layard, 2017).

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of community engagement under current implementation arrangements remains limited (Bradley and Brownill, 2017). Indeed, it is far from clear to what extent *all* voices are heard within a community during NP processes, reinforcing concerns about lack of inclusivity (Columb, 2017; Davoudi and Cowie, 2013; Wargent and Parker, 2018). Overall, our findings do not challenge the national picture of participation as dominated by more affluent and better-resourced communities, or the relatively 'advantaged' residents within them (Brookfield, 2017; Wargent and Parker, 2018; Parker and Salter, 2016; 2017): 'It was basically the same old people who organise various things [who] turned up'. This is not to say that there is deliberate limitation to deeper engagement but NP working parties may lack the collective capacities to reach seldom-heard voices or cover the gamut of possible policy concerns. 'In the end, we are all part-timers, amateurs'.

Indeed, resources on the ground – human, financial and prior experience – have been recognised as highly influential on the readiness and collective capacity to engage with decision-making processes (Stanton, 2014; Lee et al., 2018; Parker and Murray, 2012; Cowie and Davoudi, 2015; Parker et al., 2015; Parker et al., 2017; Parker, Wargent et al., 2020). Case study sites reported few people coming forward to volunteer to get involved, and little understanding of what they were aiming for at the outset. Reflecting most socio-economic inequalities, such resources are distributed unequally within and across communities (Gunn et al., 2017). Some areas invariably fare better in terms of capacities to engage in NP (Parker and Salter, 2017; Pennington and Rydin, 2000; Parker, Wargent et al., 2020), and indeed our respondents were carrying out a lot of work themselves. There is, therefore, an inherent practical (and democratic) challenge of creating collective capacity and expertise in small rural communities reliant on volunteers.

We found some areas feeling lucky that they could draw on relevant expertise within the community, including committee members with roles in higher tiers of local government. One case study area benefited from someone with a background in public health, health visiting and NHS management, who was also a district councillor with finance responsibilities. This brought clear benefits in terms of inside knowledge of local government decision making, and policies likely to receive support. While policy rhetoric champions NP as an opportunity for community involvement, or empowerment, the participation of residents is governed, at least in part, also by perceived incentives. Case study respondents confirmed that many local residents tended to get involved if they had a personal or collective cause to champion.

Where resources and capacities are limited, a strong reliance on volunteers results in Plans of limited scope in many cases (Parker et al., 2015; Parker, Wargent et al., 2020). Our interests focused equally on impacts of the process of developing a Plan, and so the rationality or otherwise for participants to embark on or pursue NP is fundamental to whether and how they proceed with such community-led planning action (and

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any associated gains). Survey and interview data both indicated that incentives (and disincentives) played a key part in residents' involvement with NP. Clear motivations for engaging in NP could be identified, including a desire to 'preserve' community characteristics (e.g. the oft-cited 'village character') in some areas and to 'regenerate' the community/area in another. In practice, these both translate into attempts to control large new housing developments, and ensure that any approved post-Plans are responsive to identified local needs, including those of the older population.

Financial incentives were clear for one case study area that had experienced substantial socio-economic decline. Here, NP was perceived as a route to attracting further investment and resources due to the opportunity to draw down Community Infrastructure Levy money raised on development. Older residents were expected to benefit equally (if not especially) from additional resources invested in improved facilities and services. The 'carrot' of obtaining CIL monies opened up the possibility of communities getting something in return for participating in NP, alongside potential improvements for health, well-being and age-friendly dimensions. Yet it may also widen the gap between those rural communities who are attractive to developers, and those where market interests and development opportunities are slim (Bailey and Pill, 2015), quashing ambitions of socially inclusive growth.

In line with previous studies our findings highlight that developing an NP represents a significant burden of time and effort on a small group of people, who can be 'exhausted and debilitated' by a drawn-out process, described as 'demoralising' (cf. Parker et al., 2020). NP was sometimes also a highly frustrating personal and collective experience, invariably affecting local social relationships and trust. Remaining involved to see it through was seen as requiring considerable 'tenacity', since inconsistent and conflicting advice from higher up the decision-making chain led to feelings of being let down. Over time, this might influence the balance of incentives and rewards for neighbourhoods to participate in future collective-governance efforts: 'lots of communities have shied away'. On the flip side, smooth liaison and support at higher tiers were influential on participants' decisions to remain in the process. The influence of strong backing at the LPA level, through both human resources and political will, was important to a positive experience of developing the Plan: 'We wouldn't have made the progress without the support and the partnership working with [District Council], that's a fact.'

If lasting, meaningful and equitable participation of communities in decision making is to be secured, questions of motive and reward need to be addressed (Parker and Murray, 2012; Mace and Tewdwr-Jones, 2019). In gauging where the balance lies for the former, there is a need to consider the incentives for individuals either in their professional capacities or as citizens. The context of the wider localism agenda is to ask, for example, under what circumstances and with what pay-offs choosing to accept housing developments in their community would be a rational choice for

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existing residents (Parker and Murray, 2012). Relatedly, under what circumstances is it rational to get involved in collectively developing a Plan? Ultimately, the trade-off of gains against input costs is about rational choice (Parker, Wargent et al., 2020; Mace and Tewdwr-Jones, 2019).

Interpretation of planning policy

Even if incentives are sufficient to engage citizens whose efforts support the integration of priorities compatible with 'ageing well', and if NP groups act with a broader agenda, there is likely to be some policy 'marginalisation', where some matters are pushed aside in favour of consideration of other issues deemed more pressing (Lodge and Wegrich, 2014). Although 'well-being' and 'ageing-well' benefits may appear to be possible outcomes of the NP process, our findings chime with previous research that little is yet known about concrete impact from Plans on communities (Wargent and Parker, 2018). An absence of specific goals (NP policies) favouring well-being or ageing well may reflect the boundaries placed around the type of decision making deemed acceptable for residents to get involved in. Case study respondents reflected these limitations in their frustrations over the quashing of creativity, having to 'jump through hoops', and constant knock-backs due to the apparent constraints in the planning regulations. There were also examples of feeling 'mucked about' through inconsistent and conflicting advice.

External advice

The perspectives and motives of external consultants or advisers may also condition the scope of a Plan, evident in the 1,000 widely varied Plans completed to late 2019 (Parker and Salter, 2016; Parker et al., 2014; Parker et al., 2016). Even if there are examples of participants attempting to use NP to exploit the spaces available to influence policy and local agendas, there is considerable evidence of outside influence in this space, including technical assistance and expert needs assessments. Case study respondents spoke about the involvement of consultants and outside experts that most communities avail themselves of (Parker et al., 2015; Parker et al., 2017). Whilst one area appeared pleased with the advice and support of their consultant, others found it challenging to find people who knew and understood the local area: 'They never understood [Place] … they hadn't got a clue.'

The role these intermediaries can play in the 'brokering' of policy outcomes and in potentially challenging what goes into Plans was highlighted by respondents who were frustrated by their narrow focus and rejection of ideas as outside the NP remit. Some planning committees are effectively 'tutored' to get through the process, rather than enabled to influence actions that could be more impactful for their community: 'We were overridden to a degree by our consultant, I think'. Similarly, a number of

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discussions highlighted the significant threat of 'the examiner' guiding the advice received, and in determining what was deemed eligible for inclusion in the final Plan. One case study site spoke of their frustration at this, feeling constrained to 'get the plan through', 'rather than encouraged to sort of be more creative'. Not only can this be seen as resulting in a 'rescripting' of ideas, policies and priorities to ensure conformity to a bounded form of collaboration (Parker et al., 2015), but it also suggests a rigidity in direct contrast to the empowerment ambitions of co-production (Cahn, 2001; SCDC, 2011).

All of the influences outlined above can negatively affect confidence in the realisation of the final content of Plans, and thus possible impact on goals such as well-being and ageing well. Of the 130 NDPs which had passed referendum by spring 2016, as examined by Parker and Salter (2016; 2017), only one escaped modification by the examiner, with 63 facing major changes (see also Parker et al., 2016).

Policy myopia

The wider policy literature indicates a long-recognised question of knowledge and information gaps cascading downwards, resulting in gaps, limited policy transfer and 'policy myopia' (Nair and Howlett, 2017; Stone, 2017). Such findings contrast with governmental claims that NP will empower communities and form part of a devolutionary 'control shift' (Conservative Party, 2009; 2010; DCLG, 2010), and difficulties that participants have faced on the ground highlight a disconnect. Whether residents engage when participation opportunities arise, and what they pursue if they do, are closely affected by considerations of rational-choice criteria, and 'bounded rationality' (Parker and Murray, 2012; Mace and Tewdwr-Jones, 2019). Our research confirms that there are still equity and inclusivity challenges for NP that reflect the issues of over-reliance on small groups of volunteers and lack of attention to incentives to collective participation such as resources, organisation and authority, outlined above (see also Lodge and Wegrich, 2014). Furthermore, where incentives to engage are insufficient to tempt residents (limited reward or guarantee of return from accepting development), or the disincentives are too great (e.g. burden of time, expectations of residents), NP is significantly constrained as a mechanism for delivering local support for development, let alone more ambitious goals in support of infrastructure for well-being and ageing well. Such limitations result in partiality or selectivity in policy adoption or application at the very local scale.

Planning involves multiple and 'wicked' problems that are both contingent and political. Groups and interests are unevenly affected, with unequally distributed resources and power to address them, privileging certain voices over others (Brown and Chin, 2013; Nasca et al., 2019). The limitations that NP actors grapple with aid policy myopia and may account for the relative lack of direct attention to the health and well-being agendas found in Plans. The 'bounded' nature of participation by

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communities in planning decisions is key, including procedural challenges that can frustrate the implementation of important agendas such as 'age-friendly' or health and well-being goals. There seems to be a case for better understanding the influence of facilitation and advice that groups are being given, and whether this is truly aligned or 'up to speed' with the stated wider aims of the emerging and known concerns generated nationally by wider policy (e.g. the integration of 'health' in 'place') or other sources (e.g. the AFCC).

These new findings should be placed in the context of the relatively short implementation history of NP. There are limitations associated with the small scale of this study and survey response rate, which might over-represent rural NP areas concerned about demographic imbalance. Nevertheless, our findings echo concerns identified elsewhere, and provoke questions over the extent to which community aspirations in general, and especially those that aim to create environments that better support older and vulnerable people, can be facilitated and met through NP as presently constituted (Bailey and Pill, 2015; Wargent and Parker, 2018; Parker et al., 2016).

Conclusions

This article has argued that neighbourhood planning could have a place in the promotion of processes and outcomes that support 'ageing well' in rural communities. At the same time, these findings chime with existing research that highlights several problems with the current roll-out of NP. Efforts to improve well-being or to make communities age-friendly are not yet integrated into processes that determine the physical and social shape of neighbourhoods in the rural communities researched. This means that despite the rhetoric around 'health in place', the strategic goal to integrate health and well-being into place-centred policy making is not currently embedded in NP practice. While some have contended that NP can form part of a progressive localism, and there is hope for such participatory spaces, our view is that innovation is currently being constrained, as is policy transfer. What may be needed is much more policy championing and ability to carry ageing-well and well-being agendas downwards for active consideration by neighbourhoods to overcome policy myopia.

We have identified contributing factors to this 'missed opportunity', and that rebalancing of innovation and enthusiasm over frustration and conservatism will be achieved as the NP policy tool is reformed. We conclude that such reform is needed in order to better enable inclusive and empowered very local planning that integrates ageing well and broader well-being ambitions across scales.

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Recommendations for reform

How we measure the success of NP should go beyond simple quantitative metrics (Wargent and Parker, 2018), such as the number of NDPs and the number of houses set out in local plans (Stanier, 2014; MHCLG, 2012; 2019b). These take no account of the quality of built environment, provision of appropriate housing, environmental safeguards, or benefits to well-being and social connectivities. There is an additional need to reflect on the balance of power between the key actors involved in delivering Plans (Vigar et al., 2017; Parker et al., 2017), for example, enhanced community control and co-production between local government and communities, reflected in measures of community participation and civic engagement (e.g. Co-op, 2019; OCSI, 2019; Centre for Thriving Places, 2019), and in different participatory spaces enabled (Ponsford et al., 2020; Powell et al., 2020); and collaboration both between public services and between statutory agencies and communities (Lent and Studdert, 2019). Similarly, there is a case for adopting or drawing on metrics developed to measure the age-friendliness of a place, acknowledging that many gaps remain in both the availability of validated metrics and the capability *in situ* to measure and draw actionable conclusions (Buckner et al., 2019).

While success measures are one important aspect of addressing the issues around bounded participation, perhaps the most impactful will be exerting pressure on 'higher' decision-making bodies to adapt and respond in planning for health in place. Evidence from earlier parish plans supports this route, citing regard to local evidence to provide the foundations for budgeting and policy directions (Parker, 2008; Parker and Murray, 2012). Significant political capital and efforts to adapt the local governance architecture have been invested in NP (Williams et al., 2014), and we support building on those positive foundations to construct a more value-added model given sufficient political will, funding and support. NP could be used both as an instrument of policy (housing, ageing, health), and as a democratic mechanism of neighbourhood governance (localism, co-production, decision making) that surpasses the constraints of land use planning and encompasses broader social and well-being goals (Chetwyn, 2018; Wargent and Parker, 2018).

On the ground, though, attention must be paid to incentives for communities to engage, and how to build the collective knowledge, skills and capacity to enable them to do so. If the remit of NP were to legitimately concern itself with matters of community well-being, perhaps the perceived benefits to involvement could be higher for local residents too. There are examples that could tip the balance in favour of engagement as a rational choice, such as a real commitment to co-development with communities, and proactive encouragement to engage in NP, through enhanced availability of support, collective facilitation and financial inducements (particularly targeting disadvantaged communities). Genuine valuing of experiential knowledge requires the removal of overly technical language, reduced bureaucracy and

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a recognition of knowledge gaps (Wargent and Parker, 2018). The question 'What's in it for me?' needs to be seen as legitimate, necessary and standard, in order to co-devise meaningful and durable participation opportunities and appropriate institutional environments. Opportunities presented by wider localist policy – such as a community 'right to buy' local facilities under threat of closure, or participatory budgeting projects, if adequately resourced and supported – may also represent the sort of concrete incentives and gains capable of tipping the balance for residents to get involved (Mace and Tewdwr-Jones, 2019).

If we raise expectations around consideration of broader health and well-being, alongside pre-existing planning priorities, then we need to ensure that groups have the right skills and collective capacities to take on these roles and question experts and authorities (Parker et al., 2015; Parker et al., 2017; MHCLG, 2018; Baxter et al., 2020). Facilitation and training are required in key areas of policy concern, whether managing the role of intermediaries in plugging residents' skills and knowledge gaps, bridging policy silos and hierarchies (Owen et al., 2007), or increasing attention to geographical inequalities and engagement and representativeness – both within communities (Davoudi and Cowie, 2013) and with other partners and stakeholders within the 'system'.

With regard to research on NP, the topics currently covered by the existing body of evidence suggest that health, well-being and ageing have so far not attracted widespread interest (Wargent and Parker, 2018). In response, future studies should address whether and how Plans and their development deliver broader social value, such as through supporting well-being and ageing well. The process and interaction of neighbourhood governance with the wider planning and 'health in all policies' system is important, as well as the content and impact of plans after adoption.

The dearth of attention in the research literature reflects the missed opportunity in policy and practice – something surely to remedy in the light of major known challenges, including ageing societies, prolonged austerity and rising inequalities. It is difficult to envisage a corresponding 'catch-up' in public health, health or social-care funding. The COVID-19 pandemic has wreaked additional damage in populations already hard hit by cuts to public services, and supporting people to age well with less demand on fully publicly provided, or funded, services is an even greater challenge. At the same time, the COVID-19 pandemic has served to reinforce the spirit of localism, highlighting a central role for volunteers, working across public, private and third sectors. After decades of cuts, collaborative, transformative approaches to supporting communities are increasingly regarded by local governments as the 'only' way forward (Lent and Studdert, 2019). Could NP overcome policy myopia to become a mechanism within this, supporting ageing-well priorities and well-being in communities? We argue that its potential is clear if neighbourhoods are able to present and deliberate these issues fully.

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