PLANNING IN HEALTH

AN ENGAGEMENT PROTOCOL BETWEEN LOCAL PLANNING AUTHORITIES, PUBLIC HEALTH AND HEALTH SECTOR ORGANISATIONS IN NORFOLK

MARCH 2017

FOREWORD

This engagement protocol for planning in health in Norfolk has come about in recognition of a need for greater collaboration between local planning authorities, health service organisations and public health agencies to plan for future growth and to promote health. It reflects a change in national planning policy and the need for health service organisations to deliver on the commitments within the 5 year forward view.[i]

Pressures on health services are not a new phenomenon and there is always the requirement to do more with the resources available. The Norfolk Health Overview and Scrutiny Committee has made recommendations for improvement, including producing this protocol as a means to bring closer collaboration between the district and borough councils, the clinical commissioning groups, and public health in Norfolk.

Allied to this protocol is an assessment of future health care needs based on projections for population increases and house-building rates in Norfolk to enable informed decision-making about future health services commissioning. A healthy planning checklist has also been produced. This provides a practical tool to assist health sector organisations to participate in discussions with developers and planning authorities on major new development schemes, recognising that health sector organisations can bring an added influence to designing new developments that offer people the chance to choose a healthier lifestyle.

This protocol announces a renewed commitment to influence how the places in which we live can shape our lives and contribute to better health and wellbeing for all.

[i] NHS Five Year Forward View. (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

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1 INTRODUCTION

1.1 BACKGROUND

The importance of planning decisions on the health and wellbeing of the population has been recognised since the 19th century when reforms brought about by town planners and public health practitioners resulted in improved health and life expectancy. Many of the major disease and health issues affecting the population in Britain today are impacted upon by the environment in which people live, work and play (Marmot, 2010). Spatial planning can have a major positive impact on improving the environment in which people live or, if the health impacts of developments are not adequately considered, adversely impact on people's physical and mental health (Ross and Chang, 2012).

The National Planning Policy Framework requires local planning authorities to ensure that health and wellbeing and the health infrastructure are considered in Local and Neighbourhood Plans and in planning decision making. Public health organisations, health service organisations, commissioners and providers, and local communities should work effectively with local planning authorities in order to promote healthy communities and support appropriate health infrastructure.

1.2 AIM

To formulate an engagement protocol containing a documented process outlining the input and linking of relevant NHS organisations and public health agencies with local planning authorities for planning for housing growth and the health infrastructure required to serve that growth.

1.3 OBJECTIVES

Objectives for the engagement protocol are:

- To establish a working relationship and set a protocol for engagement between Norfolk local authority planning departments and Norfolk County Council (NCC) Public Health.
- To outline a process for obtaining robust and consistent public health information to inform plan making and planning decisions to support appropriate health infrastructure, with technical input from the NCC Public Health Intelligence Team.

- To ensure that the principles of health and wellbeing are adequately considered in plan making and when evaluating and determining planning applications.
- To establish a collective input from relevant NHS healthcare planning and commissioning organisations in the public health response to planning.
- To agree a defined threshold indicator for Planners to contact the NCC Public Health team for input into planning.

1.4 ORGANISATIONS INVOLVED

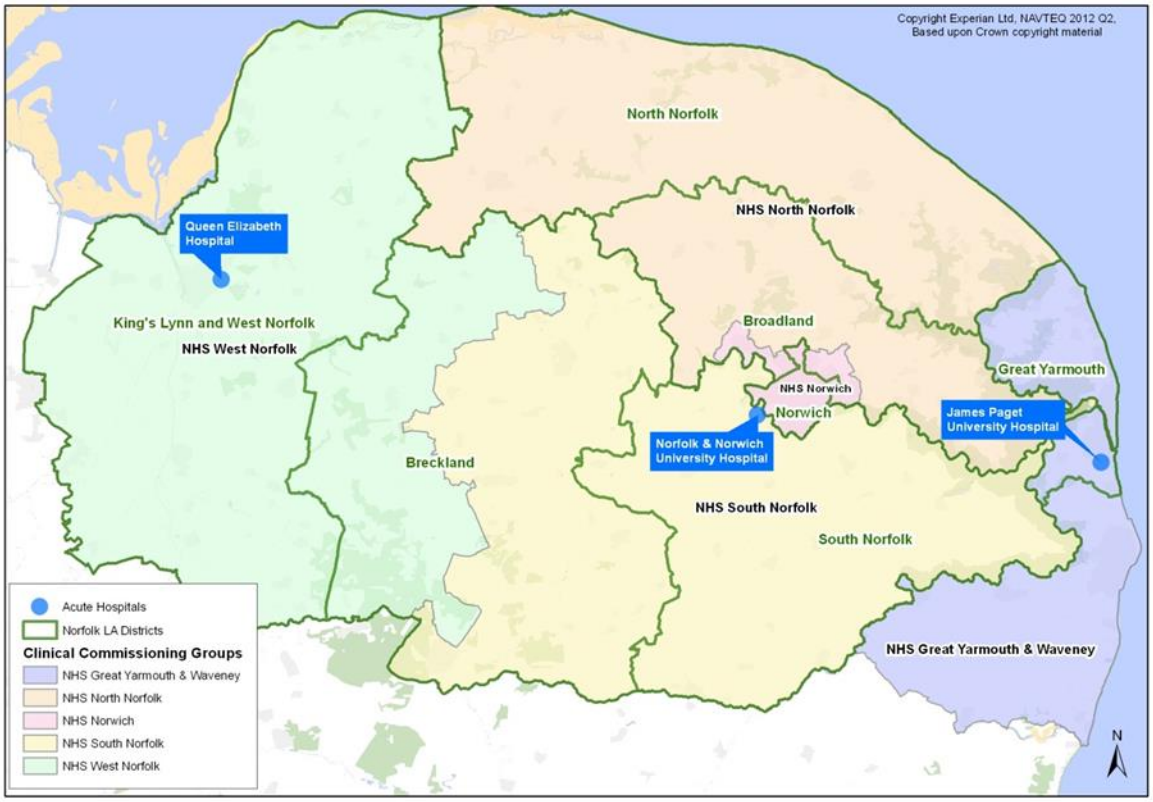
The NHS underwent a major transformation in 2013 with the implementation of the Health and Social Care Act, 2012. Planning and purchasing healthcare services for local populations which had previously been performed by the primary care trusts is now largely performed by clinical commissioning groups (CCGs), led by clinicians. CCGs now control the majority of the NHS budget, though some highly specialist services and primary care are commissioned by NHS England. The Act also provided the legislation to create Public Health England (PHE), an executive agency of the Department of Health. PHE's role is advisory, and its aim is to protect and improve the nation's health and to address health inequalities. The Act further established local public health departments, which had formally been part of the NHS primary care trusts, within upper tier and unitary local authorities.

NHS CLINICAL COMMISSIONING GROUPS:

In Norfolk there are five local CCGs each with its own commissioning budget and responsibility for commissioning the majority of health services for the population in Norfolk and Waveney, including hospital treatment and community health care. The CCGs in Norfolk (see map 1, page 3) are:

- Great Yarmouth & Waveney CCG
- North Norfolk CCG
- Norwich CCG
- South Norfolk CCG
- West Norfolk CCG

Map 1: Local Government and Health Service Infrastructure in Norfolk (including Waveney)



In conjunction with NHS England, CCGs are required to produce Local Estates Strategies looking 5 years ahead, working with a wide range of local stakeholders. The strategies are intended to allow the NHS to rationalise its estates, maximise the use of facilities, deliver value for money and enhance patients' experiences.

NHS ENGLAND

NHS England authorises the clinical commissioning groups and commissions a wide range of specialist NHS services, including prison health services, medical services for the armed forces, and primary care medical and dental services. This means that all GP practice contracts are between NHS England and the local GP provider.

There are two main types of funding associated with ownership of general practice premises:

- The practice is a tenant with a landlord (leased)
- The practice owns the premises (owner/ occupier)

NHS PROPERTY SERVICES:

Following the Health and Social Care Act 2012, NHS Property Services was established as a private limited company owned by the Secretary of State for Health. NHS Property Services manages NHS property estates across England, with

responsibility for 4,000 buildings, worth over £3 billion. The buildings are used to provide patient care such as GP surgeries and community hospitals. Norfolk is covered by NHS Property Services Midlands and East regional team.

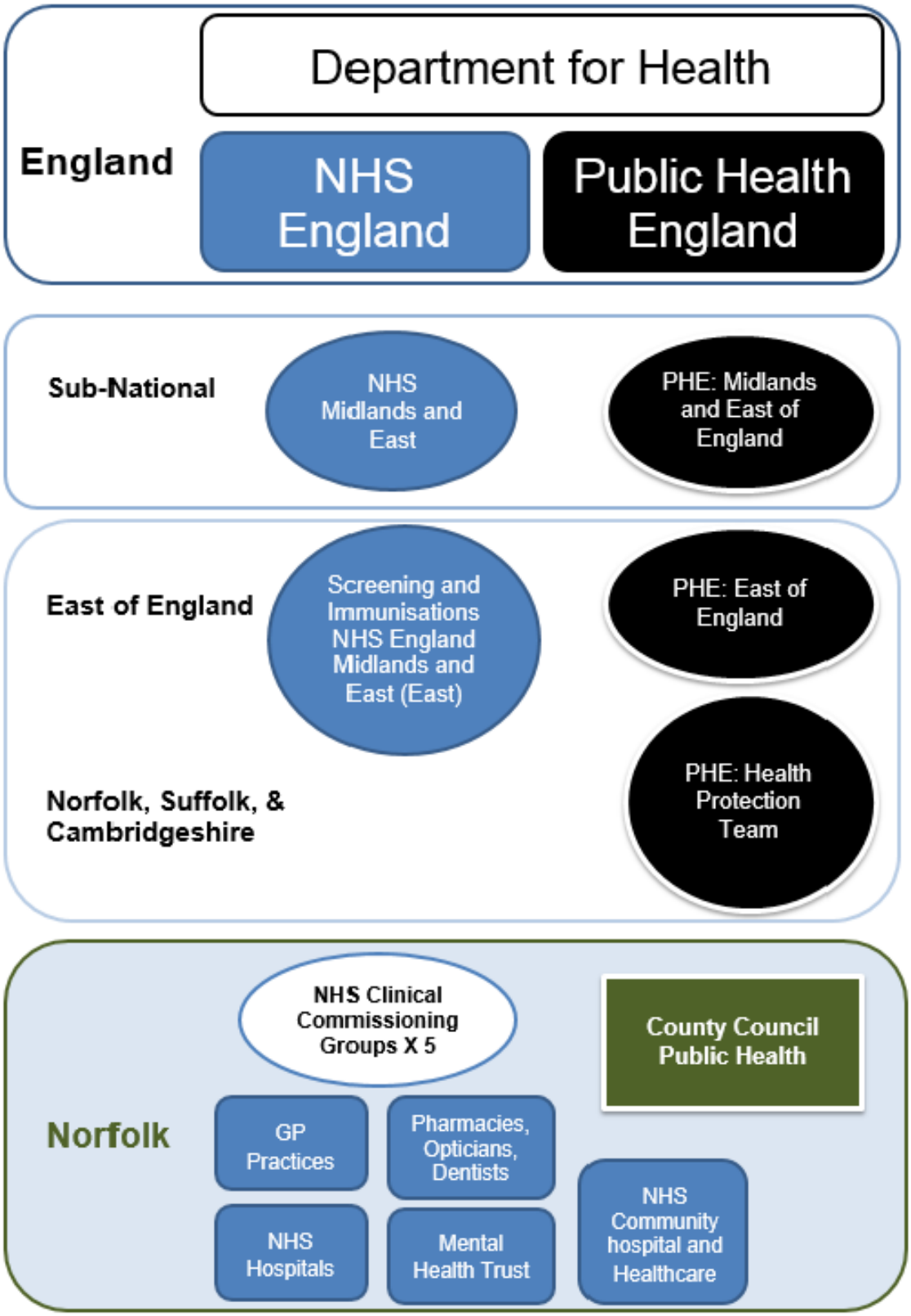
LOCAL AUTHORITY PUBLIC HEALTH, NORFOLK COUNTY COUNCIL:

Following the Health and Social Care Act 2012, the NHS no longer has a public health function. The majority of the public health workforce was transferred to Public Health England (PHE) at a national, regional or sub-regional (in PHE Centres) level, and to local authorities at a local level, with a complementary set of roles and responsibilities. In Norfolk, the Director of Public Health (DPH) and public health workforce is part of Norfolk County Council. The DPH is responsible for commissioning some mandatory and discretionary health services, for example sexual health, smoking cessation, drug and alcohol treatment, NHS Health Checks and health improvement services.

PUBLIC HEALTH ENGLAND, EAST OF ENGLAND

The role of PHE is to offer leadership and scientific and technical advice at all organisational levels. This involves working with local authorities and the NHS to reduce rates of infection and provide evidence to establish effective strategies and inform commissioning. The regional centre for PHE includes the Anglia area, with Norfolk, Suffolk and Cambridgeshire.

Figure 1: NHS and Public Health Structures from the National to Local level in Norfolk



LOCAL PLANNING AUTHORITIES

In Norfolk there are a number of district, borough and city councils with local planning roles and responsibilities:

- Breckland District Council
- Broadland District Council
- Great Yarmouth Borough Council
- King's Lynn and West Norfolk Borough Council
- North Norfolk District Council
- Norwich City Council
- South Norfolk Council

The Broads Authority, which is a statutory body established in 1989 with a duty to manage the Norfolk and Suffolk Broads, is also classified as a local planning authority. It is the sole district planning authority in relation to land within the broads which has equivalent status to a National Park (Norfolk and Suffolk Broads Act, 1988). Norfolk County Council is responsible for determining planning applications related to mineral extraction, waste management facilities and developments by the County Council.

HEALTH AND WELLBEING BOARDS:

Health and Wellbeing Boards bring together local authorities, the NHS, communities and wider partners to share system leadership across the health and social care system; and have a duty to encourage integrated working between commissioners of services, and between the functions of local government (including planning). Each Health and Wellbeing Board is responsible for producing a Health and Well-being Strategy which is underpinned by a Joint Strategic Needs Assessment. This will be a key strategy for a local planning authority to take into account to improve health and well-being.

2 THE PLANNING PROCESS – KEY STAGES

There are three key stages in the town planning process (illustrated in figure 2 below): plan making; planning applications and implementation.

2.1 PLAN MAKING

The town planning process is plan-led and local planning authorities produce Local Plans to set the planning strategy for their area, to be achieved through strategic policies (such as in the adopted Joint Core Strategy (JCS) for Broadland, Norwich and South Norfolk - see policy 7 for Health), and through site allocations and detailed development management policies. These policies are used to assess planning applications. Local Plans include housing targets. The allocation of sites establishes the principle that specific types and scales of development are appropriate in specific locations. This includes allocating sites for housing and mixed-use development to meet housing targets. It also provides healthcare planners and commissioners with the potential to take a long term strategic approach to allocating sites to meet health infrastructure needs.

Local Plans may be produced as a single document or as a suite of documents. In general, a Local Plan will take three to five years to produce. Local Plans, and Neighbourhood Plans (usually prepared by local communities), must take account of guidance in the National Planning Policy Framework (NPPF). The NPPF sets out the wide ranging ways in which planning should promote healthy communities, requiring Local Plans to:

- Involve work with other authorities and providers to assess the quality and capacity of infrastructure for health and its ability to meet forecast demands;
- Set strategic priorities for their area for the provision of health facilities, taking account of local health strategies;
- Involve work with public health leads and health organisations to understand and take account of the health status and needs of the local population (such as for sports, recreation and places of worship), including expected future changes, and any information about relevant barriers to improving health and well-being;
- Support safe, secure and healthy communities, with local services and employment accessible by active and sustainable travel modes;
- Promote good design of development and the provision of landscaping, open spaces and green links to enable people to lead healthy and active lifestyles;
- Take account of the effects of noise and pollution on health;

- Promote a diverse mix of uses, affordable housing, a mix of types of housing (including sheltered accommodation), minimum size standards and adaptable and energy efficient homes;
- Address climate change, including issues such as drainage and flood risk, water efficiency, resilience, biodiversity and trees;
- Encourage multiple benefits from the use of land, recognising that some open land can perform many functions (such as for food production).

Local Plans are subject to Sustainability Appraisal (SA) to assess the likely economic, social and environmental effects of policies. Specific questions are generally included about the built and natural environment encouraging heathy lifestyles and providing necessary health service infrastructure. This is an opportunity to ensure Councils are considering the relative merits of different sites and policies properly against public health related issues. The considerations that go into the Sustainability Appraisal are essential to what follows in the Local Plan and so early engagement in the Sustainability Appraisal process by NCC Public Health can make the biggest difference to the resultant Local Plan. Increasingly, assessment of the viability of development is important and local planning authorities must ensure that costs resulting from policy requirements would not make development unviable.

Therefore all Local Plans should contain policies to ensure health issues are considered in new development. Many more recent Local Plans set a requirement for Health Impact Assessments to be undertaken by developers of larger scale housing developments. In addition, local planning authorities have a ‘duty to cooperate’ on plan making. This requires them to work with prescribed bodies including CCGs and NHS England, as well as other local authorities, to cooperate on strategic cross boundary matters such as health infrastructure.

2.2 PLANNING APPLICATIONS

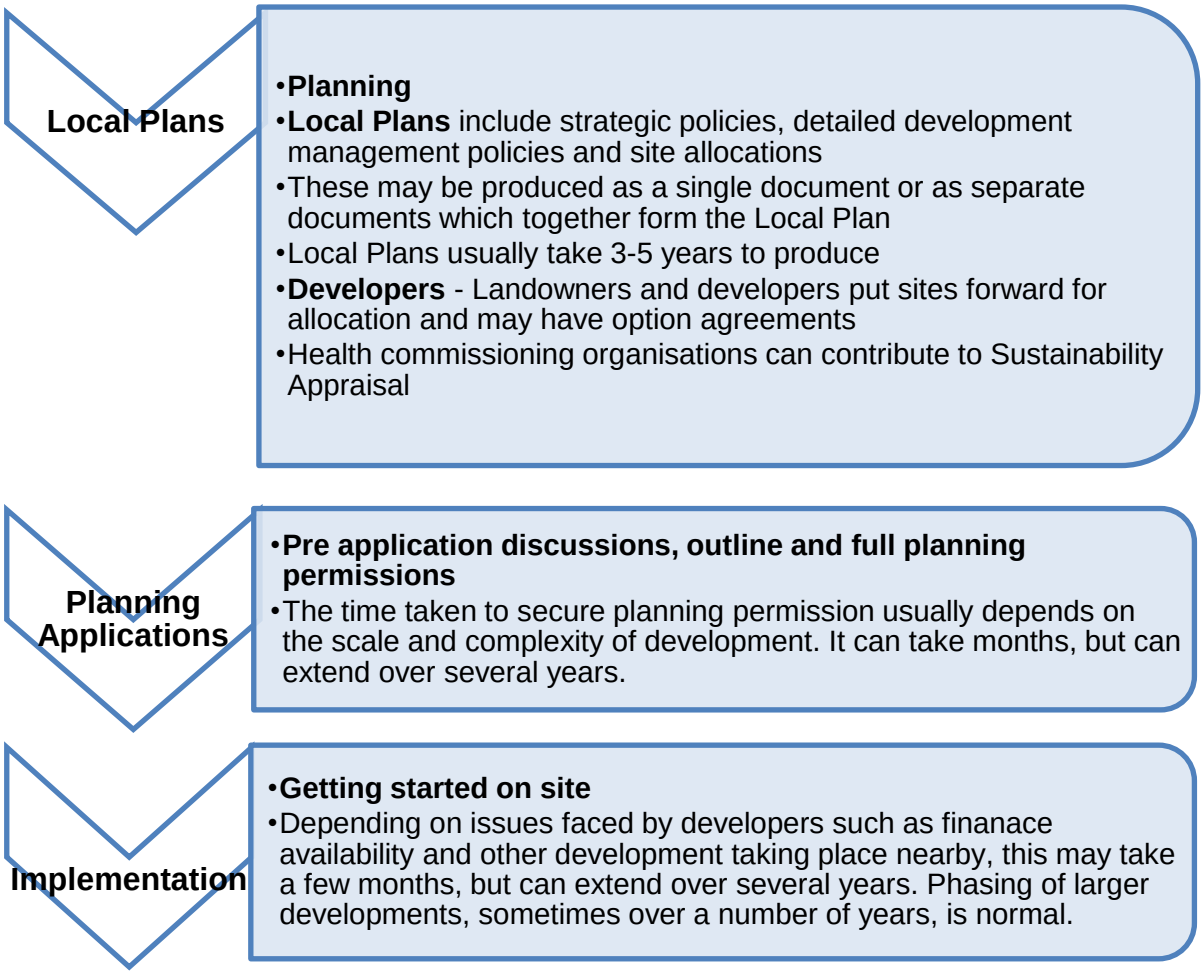
Except for limited types of permitted development such as the conversion of offices to housing, planning permission is required for housing development. An application will generally be granted permission if it is in accordance with the Local Plan, unless there are material considerations that indicate otherwise. Since there is a substantial cost to making a planning application, most promoters usually only apply if they are reasonably confident of getting consent. If an application is refused there is an appeal process via the Secretary of State, which can be costly for the promoter or developer.

- Pre application discussions: Early consultation and liaison on development proposals, although not always a formal requirement, is beneficial in enabling policy requirements to be clearly set out and in resolving potential problems or conflicts before a formal application is submitted. Following any discussions, developers submit either outline or full planning applications.
- Outline applications: An application for outline planning permission allows a decision to be made on the general principles of how a site can be developed. Outline planning permission is granted subject to conditions requiring the subsequent approval of one or more detailed 'reserved matters'. On large sites, it is common to secure an outline permission for the whole site and then to apply for full permissions for specific phases of development over time.
- Full applications: An application for full planning permission results in a decision on the detail of how a site or part of a site can be developed. This is where the local authority's planning policies are applied in detail to planning applications made by promoters and/or house builders. The planning officer dealing with an application will often negotiate, and suggest ways to improve the scheme; but the main part of the job is to make a recommendation to approve or refuse planning consent. An officer may have delegated responsibility to issue consent, but on large schemes that decision is usually taken by a council's Planning Committee. If planning permission is granted (which usually lasts for 3 years), subject to compliance with planning conditions, development can take place.

2.3 IMPLEMENTATION

The final stage is implementation of a planning permission. The timing of the implementation of schemes granted planning permission, and in some cases whether they are implemented at all, cannot be guaranteed. From the developer's perspective the planning system is only an element of the construction process. Issues may arise that delay implementation. These can be varied, and often relate to site costs, access to finance and the availability of construction staff or materials. Also, if a house-builder already has other schemes on site in the same market area, and is making healthy profits, there may be business reasons not to build out of all their development sites at once.

Figure 2: The key planning stages for building development



3 PROCESS FOR HEALTH COMMISSIONERS' ENGAGEMENT IN PLANNING

3.1 PLAN MAKING

The extensive consultation that takes place on plan making provides the most significant opportunity for healthcare planners and commissioners to use their expertise to ensure that Local and Neighbourhood Plans reflect national and local health priorities adequately. NCC public health will act as the central point of contact and co-ordinating input. NCC Public Health will, where possible, provide a collective response/input into Local Plans taking into account the views of other Healthcare planners and commissioners (e.g. CCGs and NHS England). However, the respective LPA will need to consult all statutory health consultees during the preparation of their Local Plans.

To meet National Planning Policy Framework (NPPF) requirements, it is important for relevant health planning and commissioning bodies to ensure that strategic Local Plan policies reflect their own strategic priorities and the available evidence base. Evidence on likely long term overall growth needs and the consequent strategic health needs will be key. Public Health and local planning authorities in Norfolk have made available provisional figures, based on demographic modelling, for likely annual and long term population growth in each CCG area. This evidence assists both Local Plan making authorities and the relevant healthcare commissioning bodies to assess future health facilities and workforce needs and to plan accordingly.

This evidence is intentionally "high level" to assist strategic planning. It is provided at the CCG level and is not intended to be site specific as it is the role of the relevant healthcare commissioning bodies to determine how best to address the health care needs resulting directly from specific new developments. However, updated data will be available which will, along with an improved understanding of the implementation of new housing schemes, provides a valuable evidence base to assist healthcare planners and commissioners in planning for health needs in the medium and long term. Appendix 1 contains figures by CCG area using scenario based population projections for the estimated annual and long term needs identified to 2036 for acute care (hospitals), intermediate care and general practitioners/primary service requirements. These use forecasts of hospital admissions and length of stay and take into account the increasing focus on meeting health care needs away from hospitals. The ability of the relevant healthcare planning and commissioning bodies to understand the specific locations in which housing development is to be allocated will assist in identifying health investment priorities.

It may also be possible for health care planners and commissioners to propose specific sites to be allocated for health infrastructure development to meet medium to long term needs. The engagement of NCC Public Health in Local Plans is vital for helping Local Planning Authorities justify policies that give the best chance of negotiating development that promotes the population's health and wellbeing. The requirement for Health Impact Assessments to be done by developers to assess how their proposals will create healthy communities and provide adequate health facilities can only be set through a Local Plan policy. Norfolk County Council Public Health have the opportunity to advise on appropriate policies in Local Plans. Engagement on plan making will be ongoing. Local Development Schemes for each district provide timetables for plan making, enabling NCC Public Health, together with the relevant commissioning health bodies, to ensure that the right evidence is made available for consideration by plan makers at the right time.

3.2 PLANNING APPLICATIONS

While Norfolk County Council (NCC) Public Health are informed of planning applications for significant housing developments as county councils are statutory consultees, other health planning and commissioning bodies are not listed nationally as statutory consultees on such applications. One of the aims of this document therefore is to raise awareness of the importance of local planning authorities in Norfolk gaining input not only from NCC Public Health, but also from other relevant health service planning and commissioning bodies on significant housing developments. NCC Public Health's role as co-ordinator between local planning authorities and the other health service planning and commissioning bodies will assist both in ensuring that development is planned to enable healthy lifestyles and allow service delivery to be planned effectively.

It is particularly important that NCC Public Health is consulted alongside the relevant healthcare planning and commissioning bodies, on proposals for development aimed at groups in society with distinct health needs such as the elderly and students. The respective district councils' planning services should therefore consult NCC Public Health on planning applications submitted for housing developments of 50 dwellings or more and for those including care homes, housing for the elderly, student accommodation and any proposals which would lead to significant loss of public open space. This should include informing NCC Public Health of any relevant pre-application discussions. Discussions and comments provided on all planning applications will make use of the criteria set out in the Health and Wellbeing Checklist (Appendix 2). Planning officers should make developers aware of this checklist and the benefits of taking account of it in working up housing proposals,

though unless Local Plan policies are in place to require Health Impact Assessments (HIAs) to be submitted, their completion cannot be a requirement.

PRE-APPLICATION DISCUSSIONS

Since pre-application discussions are held for most of the larger scale proposals, NCC Public Health will attend meetings and provide comments on pre-application proposals in Norfolk for all housing developments of 50 dwellings or more, for those including care homes, housing for the elderly, student accommodation and for proposals which would lead to significant loss of public open space when resources allow. NCC Public Health may adjust this threshold of 50 dwellings in the future in consultation with the local authority planners. Where HIAs are required, which currently only applies in Norfolk in Greater Norwich (only for developments of over 500 dwellings), pre-application discussions should include the HIA's scope and nature.

Engagement in pre-application discussions will, in many cases, be the most important stage of involvement in the planning application process as it enables NCC Public Health to influence the design principles of development at its earliest stage. This engagement will also assist in strengthening Development Management officers in negotiating with developers. It will also enhance NCC Public Health and the relevant healthcare planning and commissioning bodies' intelligence and understanding of health infrastructure needs arising from proposed development.

OUTLINE PLANNING APPLICATIONS

Consultations on outline applications provide an excellent opportunity for NCC Public Health to comment on emerging development proposals, influencing the eventual development form and identifying whether additional health facilities may be required to serve the community. Adding to the information gained through the Local Plan site allocation process, outline applications enable NCC Public Health to gain further knowledge of the scale and likely timescale for delivery of housing. They also provide an additional opportunity for NCC Public Health to influence the form of a development before detailed proposals are submitted. Only a proportion of major housing applications, usually the larger scale and more complex proposals, will include an outline phase.

FULL PLANNING APPLICATIONS

Consultation on a full planning application is the final opportunity for NCC Public Health to influence development proposals. NCC Public Health will provide a written response to a consultation from a planning officer within 21 days of the consultation,

subject to negotiated extension time. This period includes an opportunity for communication between NCC Public Health, Public Health England, NHS England Area Team including NHS Estates if required, and the respective CCGs, on the initial results of modelled output. The criteria set out in the Health and Wellbeing checklist (see Appendix 2) will be used as the basis of detailed comments.

The written response from NCC Public Health will be reported in the planning officer's report. NCC Public Health will provide a copy of the response to the respective CCG. Where NCC Public Health have provided a written response to a planning application case officer they should receive in writing notification of the planning decision including any relevant conditions attached to the planning decision. It is expected that the relevant local authority will maintain communications between the planning officer, NCC Public Health and the respective CCG or any other relevant health service commissioning body, as its 'duty to cooperate' as created in the Localism Act 2011 and subsequent amendment(s).

3.3 IMPLEMENTATION

Since the timing of the implementation of schemes granted planning permission cannot be guaranteed, it is very important that both NCC Public Health and Healthcare Commissioners have access to the best available information on delivery that the local planning authority can provide. In most cases, the main source of information will be the Annual Monitoring Report (AMR) produced by each local planning authority, usually at the end of the calendar year. The AMR includes details of housing completions in the last year on a site by site basis. It also includes housing delivery forecasts for each year for the next five years on a site by site basis, and a single figure for each site for the period beyond five years. Planning authorities may also provide more regular delivery updates or more detailed forecasts. The potential for providing more detail to aid NCC Public Health and the relevant healthcare commissioners should be investigated with each local planning authority. NCC Public Health attendance, subject to availability of officer resource, at bi-annual meetings held between district planning policy officers and Norfolk County Council officers will ensure that NCC Public Health and Healthcare Commissioners are informed of the best available information on implementation for each district. Separate meetings should be organised by planning policy officers from each district council with the relevant healthcare commissioners to inform them of progress on both local plan development and on site delivery.

Figure 3: Summary Table – The Involvement of Norfolk Public Health in the Planning Process

1. Plan making Extensive consultation over a significant period provides the opportunity for NCC Public Health to ensure that Local Plans reflect national and local health strategies and priorities and address infrastructure needs; NCC Public Health to take account of Local Development Schemes and ensure evidence is available for consideration by plan makers.	
2. Planning applications NCC Public Health to be consulted on all planning applications for housing developments of 50 dwellings or more, and for care homes, housing for the elderly, student accommodation and loss of open space. NCC Public Health comments to focus on ensuring development will enable healthy lifestyles and allow service delivery to be planned effectively.	
Pre-Application discussions	NCC Public Health will attend meetings as appropriate and provide comments on all pre-application proposals consulted on, when resources allow.
	Where HIAs are required discussions should include its scope and nature.
Outline Planning applications	NCC Public Health will provide comments on all pre-application proposals they are consulted on; usually only large complex proposals are included in outline phase.
	Enables NCC Public Health to enhance its intelligence on the scale and timeframe for housing developments and to influence the form of development.
Full planning applications	Final opportunity for NCC Public Health to influence development proposals.
	NCC Public Health will provide a written response within 21 days of receipt of the request, in consultation with relevant commissioning health bodies, subject to negotiated extension time. Response will be reported in the planning officer's report.
3. Implementation NCC Public Health provided with best available information on implementation from the LPAs at bi-annual meetings. Similar meetings will be held between LPAs and Health Care Commissioners annually.	
4. Accountability NCC Public Health will report to the Health and Wellbeing Board annually, on a 'need to know basis'.	

4 ACCOUNTABILITY

NCC Public Health, through the Director of Public Health, will provide an annual report to the Health and Well-being Board on its contribution to Local Plans and on responses provided to local planning authorities on planning applications. This report will be provided on 'a need to know basis'.

5 CONCLUSION

It is widely acknowledged that the environment in which we are born, grow, live, work and play (Marmot, 2010) is a major determinant of our health and well-being. Housing quality, air pollution, road infrastructure, access to green space and walk-ability of our neighbourhoods, along with many other social and environmental factors, contribute directly to our health and well-being and can impact on our ability to live healthy lifestyles. The ability to access appropriate health services when we need them is also a key requirement for our health and well-being.

This is recognised by the National Planning Policy Framework which sets out wide ranging ways in which local planning authorities together with their public health and health service colleagues can contribute to maintaining the health promoting environment.

This paper outlines a documented process that will help to ensure that local planning authorities can work effectively with their public health and health service colleagues to ensure the recommendations within the National Planning Policy Framework are carried forward and that the principles of promoting health and well-being through the local planning system are implemented across Norfolk.

The collaboration between NCC Public Health and local planning authorities in following this documented process provides an opportunity to share expertise between the sectors and to support the healthy growth across the communities of Norfolk. It will also enable NCC Public Health to facilitate engagement of Healthcare Commissioners and through the use of the healthcare requirements modelling tool will assist in the long term strategic planning of health service infrastructure.

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Introduction

This appendix provides modelling estimates, based on different housing growth scenarios, for the total and additional health care needs required in Norfolk and Waveney for 2036 to take into account projected growth. The figures are high level and contribute to understanding the potential strategic needs for CCG areas, and are not intended to set requirements for specific developments.

This is the first stage in quantifying various "health" needs locally and that further discussion and analysis will be needed as part of the Local Plan process in terms of identifying the potential for new allocations and/or policies to address these health needs.

Inputs for the healthcare requirements projections for 2036

The first assumption is that admission rates, day case rates, etc. will continue to change as they have done in the past, allowing us to build this "Do Nothing" scenario for the system. The model however, allows us to modify inputs and assumptions so that local knowledge or anticipated changes are included where necessary.
The inputs and assumptions used to calculate the healthcare requirements shown in this document are as follows:

- **Average number of houses built per year by district:** The healthcare requirements have been estimated for the projected population for a "Low", "Medium" and "High" build rate scenarios. The "High" build rate scenario corresponds to the OAN (Objectively Assessed Need for housing) figure established through the Strategic Housing Market Assessments (SHMAs) for districts, except in the case of Waveney. For Waveney, the figures have been extrapolated forward to 2036 from the current local plan housing targets to 2025 as there is not yet an OAN figure beyond 2025.

The average number of houses built for each scenario is as follows:

District	Low	Medium	High/OAN	ONS 2012 avg.
Breckland	283	424	565	550
Broadland	279	418	558	405
Great Yarmouth	210	315	420	382
King's Lynn & West Norfolk	650	680	710	557
North Norfolk	189	284	379	425
Norwich	382	573	763	566
South Norfolk	449	674	898	681
Waveney	145	218	290	332

*The houses for ONS 2012 are shown for illustration purposes only. The scenario for ONS 2012 uses the CCG population projections from ONS mid 2012 rather than the number of houses built.

- **Population projections by CCG for each scenario**: These were calculated at district level for each scenario for 10 year age bands based on the 2012 Subnational Population Projections by the ONS. The population was then allocated to the corresponding CCGs assuming the current district distribution within the CCGs for all the years in the projections. Please see page 16 for details.

- **Forecasted hospital admission rates and average length of stay**: The number of admissions for each CCG/Scenario, were calculated using projected admission rates and projected lengths of stay based on 9 years of historical data from 2005/06 to 2013/14. Any projection beyond nine years (2022 onwards) will be unreliable and should be treated with caution.

  The admission rates and length of stay, were calculated for each 10 year age band for Ordinary elective, Elective day cases and Non-elective admission rates/length of stay separately. All specialties were considered, apart from Well Babies.

  The projected admission rates were calculated using a linear projection and the number of day cases were limited to 90% of all elective admissions. The length of stay was calculated using an exponential decay function to make sure that length of stay does not become negative. These calculations can be changed if better data and/or models are available.

- **Occupancy rate:** Assumed an occupancy rate of 85%.

- **Bed-days availability:** Assumed 365 available bed days for acute health care and 447 for intermediate care.

Current Bed Availability

Overnight Beds Available | Occupied (% Occupied)					
Provider	**Total**	**General & Acute**	**Learning Disabilities**	**Maternity**	**Mental Illness**
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	438 | 386 (88%)	413 | 369 (89%)	0 | 0 (-)	25 | 17 (69%)	0 | 0 (-)
James Paget University Hospitals, NHS Foundation Trust	465 | 397 (85%)	423 | 383 (90%)	0 | 0 (-)	42 | 15 (35%)	0 | 0 (-)
Norfolk and Norwich University Hospitals, NHS Foundation Trust	1041 | 967 (93%)	994 | 935 (94%)	0 | 0 (-)	47 | 32 (68%)	0 | 0 (-)
Norfolk and Suffolk, NHS Foundation Trust	459 | 414 (90%)	0 | 0 (-)	20 | 14 (72%)	0 | 0 (-)	439 | 399 (91%)
Norfolk Community Health and Care, NHS Trust	254 | 239 (94%)	244 | 231 (95%)	10 | 8 (81%)	0 | 0 (-)	0 | 0 (-)

Table 1 Overnight bed availability (January to March 2015, http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-day-only/)

Day Beds Available | Occupied (% Occupied)					
Provider	**Total**	**General & Acute**	**Learning Disabilities**	**Maternity**	**Mental Illness**
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	111 | 111 (100%)	108 | 108 (100%)	0 | 0 (-)	3 | 3 (100%)	0 | 0 (-)
James Paget University Hospitals, NHS Foundation Trust	73 | 71 (97%)	73 | 71 (97%)	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)
Norfolk and Norwich University Hospitals, NHS Foundation Trust	241 | 241 (100%)	241 | 241 (100%)	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)
Norfolk and Suffolk, NHS Foundation Trust	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)
Norfolk Community Health and Care, NHS Trust	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)	0 | 0 (-)

Table 2 Day bed availability (January to March 2015, http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-day-only/)

The total number of beds available for the providers in Norfolk and Waveney, i.e. QEH, JPH and NNUH, is 2369 (1944 overnight and 425 day beds). Please note that Norfolk and Waveney residents could go to providers in other areas.

Current GPs, Nurses and Direct Patient Care

CCG	Registered GP Patients	All Practitioners FTE	Practitioners (excluding retainers & registrars) FTE	Number of patients per FTE GP
NHS Great Yarmouth and Waveney CCG	234,099	142	137	1,710
NHS North Norfolk CCG	165,956	117	108	1,542
NHS Norwich CCG	213,049	134	129	1,647
NHS South Norfolk CCG	229,261	155	152	1,503
NHS West Norfolk CCG	168,834	124	117	1,445

Table 3 Full Time Equivalent (FTE) GPs by CCG as at 30 September 2015, http://www.hscic.gov.uk/catalogue/PUB16934

CCG	Registered GP Patients	All Nurses FTE	Advanced Nurse FTE	Extended Nurse FTE	Practice Nurses FTE	Number of Patients per FTE nurse		Direct Patient Care FTE
NHS Great Yarmouth and Waveney CCG	234,099	79	25	8	46	2,973		34
NHS North Norfolk CCG	165,956	74	33	16	24	2,254		120
NHS Norwich CCG	213,049	60	14	15	30	3,568		29
NHS South Norfolk CCG	229,261	72	21	17	34	3,198		92
NHS West Norfolk CCG	168,834	61	13	18	31	2,745		83

Table 4Full Time Equivalent (FTE) Nurses and Direct Patient Care by CCG as at 30 September 2015, http://www.hscic.gov.uk/catalogue/PUB16934

Healthcare requirements projections for 2036

The projected Healthcare requirements for 2036 assuming that admission rates for age bands continue to change the way they have in the past are as follows:
(Please see page 17 for further details on calculations/definitions).

Healthcare requirements for Norfolk and Waveney

Norfolk & Waveney	Health Care requirements by the total CCG population					Health Care requirements due to new builds (Corresponding scenario - No Build)			
requirements for 2036	No Build	Low	Medium	High	ONS 2012[ii]	Low	Medium	High	ONS 2012
Houses built per year	0	2,587	3,586	4,583	3,900				
Projected population	900,363	1,048,117	1,106,049	1,163,880	1,125,170	147,754	205,686	263,517	224,807
Total Acute beds required	3,811	4,123	4,238	4,353	4,295	312	427	541	484
Day Cases beds required	698	770	795	821	806	71	97	122	107
Overnight beds required	3,113	3,353	3,443	3,532	3,489	240	330	419	376
Total Intermediate Care required	1,114	1,213	1,247	1,282	1,259	98	133	167	145
Intermediate beds required	557	606	624	641	629	49	66	84	72
Intermediate day spaces required	557	606	624	641	629	49	66	84	72
Number of GPs required	500	582	614	647	625	82	114	146	125

[ii] The number of houses for ONS 2012 is shown for illustration purposes only and has been calculated using linear interpolation between the Medium and High scenarios for 2036.

Healthcare requirements for Central Norfolk CCGs (NHS North Norfolk CCG, NHS Norwich CCG and NHS South Norfolk CCG)

Central Norfolk CCGs	Health Care requirements by total CCG population					Health Care requirements due to new builds (Corresponding scenario - No Build)			
requirements for 2036	No Build	Low	Medium	High	ONS 2012[ii]	Low	Medium	High	ONS 2012
Houses built per year	0	1,525	2,288	3,050	2,498				
Projected population	547,940	637,896	682,876	727,808	696,099	89,956	134,936	179,868	148,159
Total Acute beds required	2,359	2,531	2,616	2,702	2,641	171	257	342	281
Day Cases beds required	368	404	423	441	427	37	55	73	59
Overnight beds required	1,991	2,126	2,193	2,261	2,214	135	202	269	222
Total Intermediate Care required	618	668	693	718	694	50	75	100	76
Intermediate beds required	309	334	346	359	347	25	38	50	38
Intermediate day spaces required	309	334	346	359	347	25	38	50	38
Number of GPs required	304	354	379	404	387	50	75	100	82

Healthcare requirements for NHS Great Yarmouth and Waveney CCG

NHS Great Yarmouth and Waveney CCG	Health Care requirements by total CCG population					Health Care requirements due to new builds (scenario - No Build)			
requirements for 2036	No Build	Low	Medium	High	ONS 2012[ii]	Low	Medium	High	ONS 2012
Houses built per year	0	355	533	710	717				
Projected population	193,773	213,398	223,239	233,026	233,401	19,625	29,466	39,253	39,628
Total Acute beds required	752	795	817	838	840	43	65	86	88
Day Cases beds required	175	185	190	195	196	10	16	21	21
Overnight beds required	578	610	627	643	645	33	49	65	67
Total Intermediate Care required	238	251	258	264	265	13	20	27	27
Intermediate beds required	119	126	129	132	132	7	10	13	13
Intermediate day spaces required	119	126	129	132	132	7	10	13	13
Number of GPs required	108	119	124	129	130	11	16	22	22

Healthcare requirements for NHS North Norfolk CCG

NHS North Norfolk CCG requirements for 2036	Health Care requirements by total CCG population					Health Care requirements due to new builds (scenario - No Build)			
	No Build	Low	Medium	High	ONS 2012[ii]	Low	Medium	High	ONS 2012
Houses built per year	0	300	450	600	553				
Projected population	153,728	172,650	182,121	191,626	188,628	18,922	28,393	37,898	34,900
Total Acute beds required	865	916	942	968	950	51	77	102	85
Day Cases beds required	121	130	135	139	137	9	14	18	16
Overnight beds required	744	786	807	828	813	42	63	84	69
Total Intermediate Care required	191	203	208	214	210	12	17	23	19
Intermediate beds required	95	101	104	107	105	6	9	12	9
Intermediate day spaces required	95	101	104	107	105	6	9	12	9
Number of GPs required	85	96	101	106	105	11	16	21	19

Healthcare requirements for NHS Norwich CCG

NHS Norwich CCG requirements for 2036	Health Care requirements by total CCG population					Health Care requirements due to new builds (scenario - No Build)			
	No Build	Low	Medium	High	ONS 2012[ii]	Low	Medium	High	ONS 2012
Houses built per year	0	550	825	1,100	827				
Projected population	180,987	209,698	224,036	238,348	224,128	28,711	43,049	57,361	43,141
Total Acute beds required	800	852	878	903	897	51	77	103	97
Day Cases beds required	106	116	121	126	122	10	15	20	16
Overnight beds required	695	736	757	777	775	41	62	82	80
Total Intermediate Care required	124	135	141	146	142	11	16	22	18
Intermediate beds required	62	68	70	73	71	5	8	11	9
Intermediate day spaces required	62	68	70	73	71	5	8	11	9
Number of GPs required	101	116	124	132	125	16	24	32	24

Healthcare requirements for NHS South Norfolk CCG

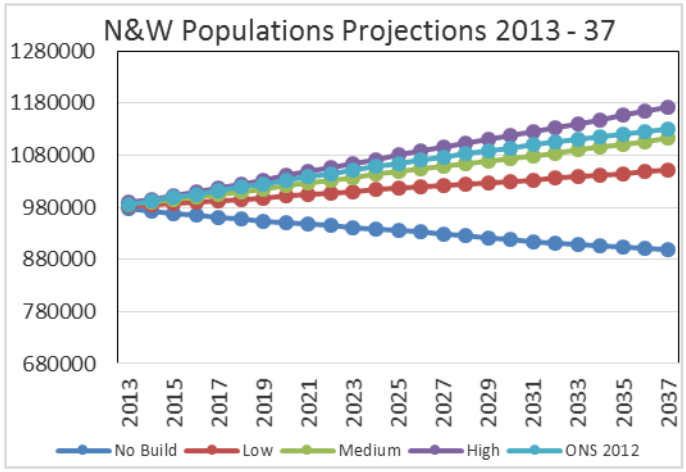
NHS South Norfolk CCG requirements for 2036	Health Care requirements by total CCG population					Health Care requirements due to new builds (scenario - No Build)			
	No Build	Low	Medium	High	ONS 2012[ii]	Low	Medium	High	ONS 2012
Houses built per year	0	675	1,013	1,350	1,119				
Projected population	213,225	255,548	276,719	297,834	283,343	42,323	63,494	84,609	70,118
Total Acute beds required	693	762	797	831	793	69	103	137	100
Day Cases beds required	141	158	167	176	168	17	26	34	26
Overnight beds required	552	604	630	655	625	52	77	103	73
Total Intermediate Care required	302	330	344	358	341	28	41	55	39
Intermediate beds required	151	165	172	179	171	14	21	28	19
Intermediate day spaces required	151	165	172	179	171	14	21	28	19
Number of GPs required	118	142	154	165	157	24	35	47	39

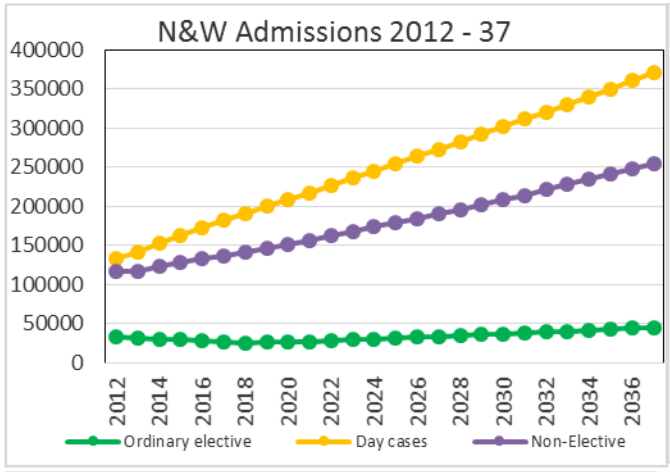
Healthcare requirements for NHS West Norfolk CCG

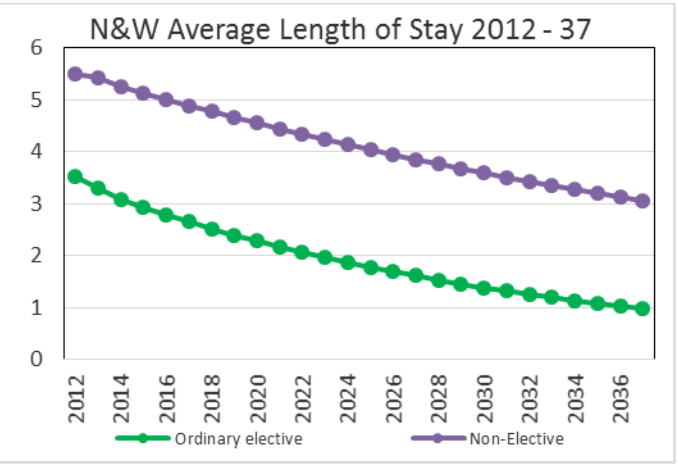
NHS West Norfolk CCG requirements for 2036	Health Care requirements by total CCG population					Health Care requirements due to new builds (scenario - No Build)			
	No Build	Low	Medium	High	ONS 2012[ii]	Low	Medium	High	ONS 2012
Houses built per year	0	707	765	823	686				
Projected population	158,650	196,823	199,934	203,046	195,670	38,173	41,284	44,396	37,020
Total Acute beds required	700	797	805	813	814	97	105	113	114
Day Cases beds required	156	180	182	184	183	24	26	28	27
Overnight beds required	544	616	622	628	631	73	79	85	87
Total Intermediate Care required	259	294	297	300	301	35	38	41	42
Intermediate beds required	129	147	148	150	150	17	19	20	21
Intermediate day spaces required	129	147	148	150	150	17	19	20	21
Number of GPs required	88	109	111	113	109	21	23	25	21

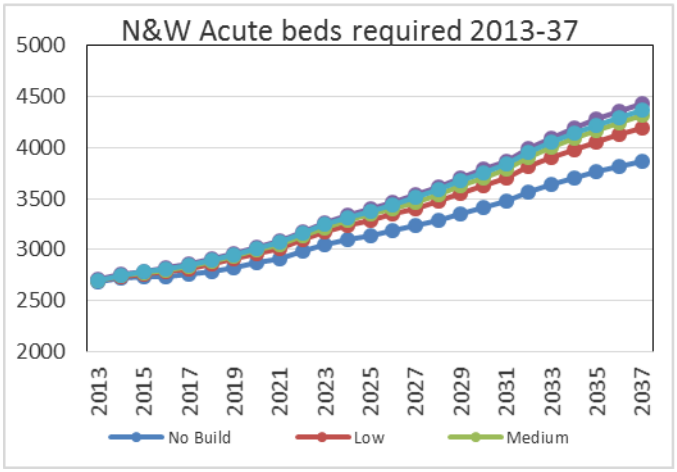
2013-37 Projections for Population, Acute beds, Overnight beds, Day Case beds, Admissions and Average Length of Stay

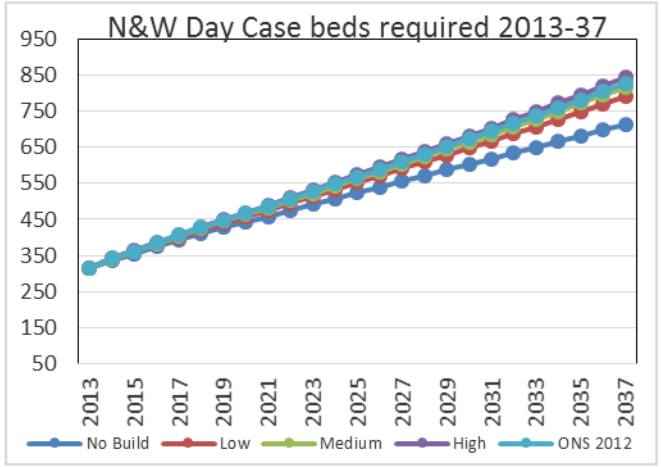
Norfolk & Waveney

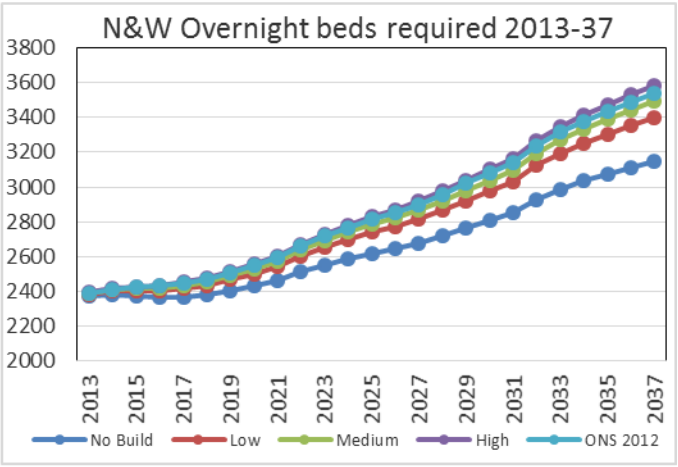




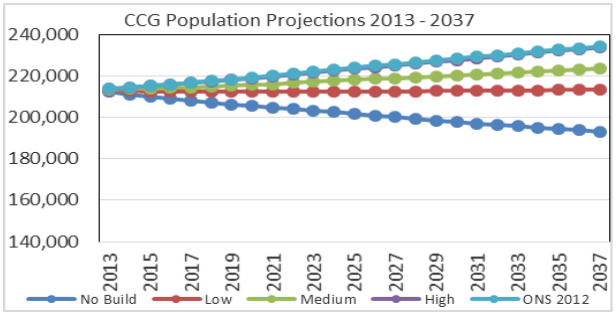


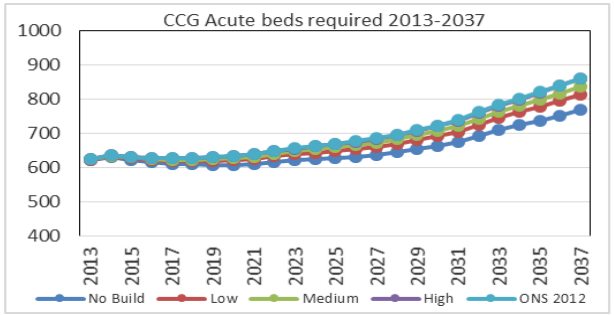


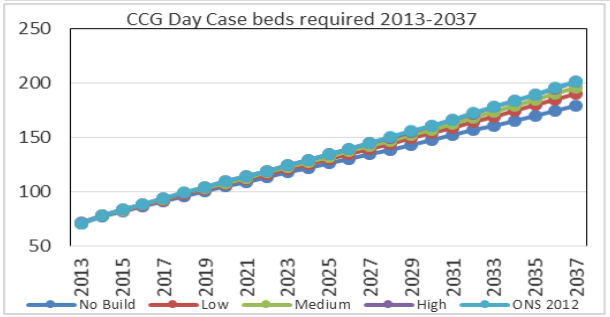


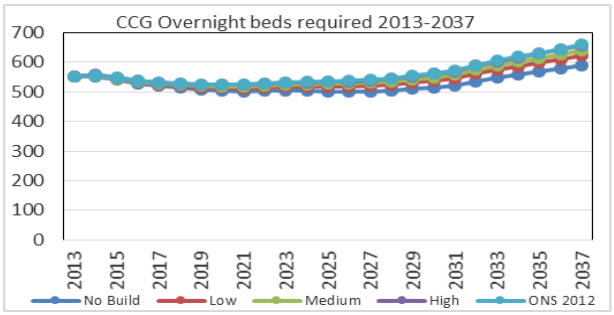


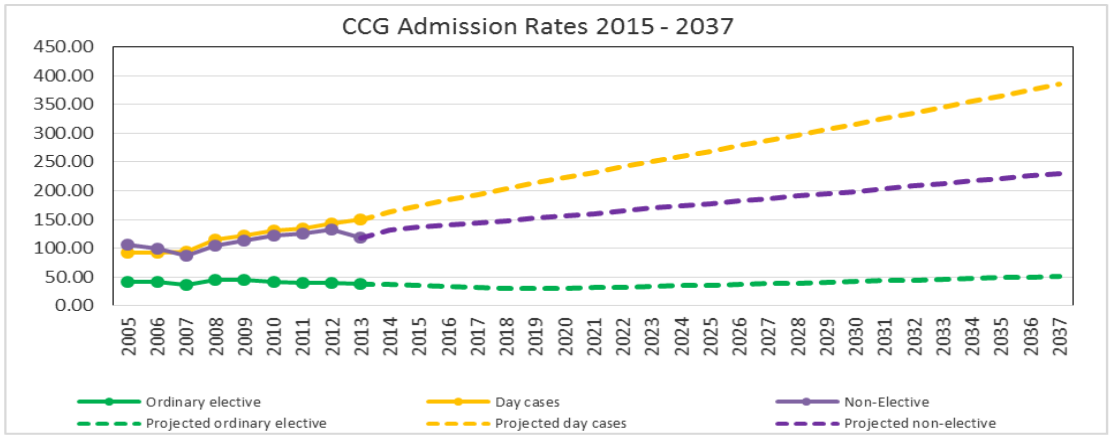
NHS Great Yarmouth and Waveney CCG

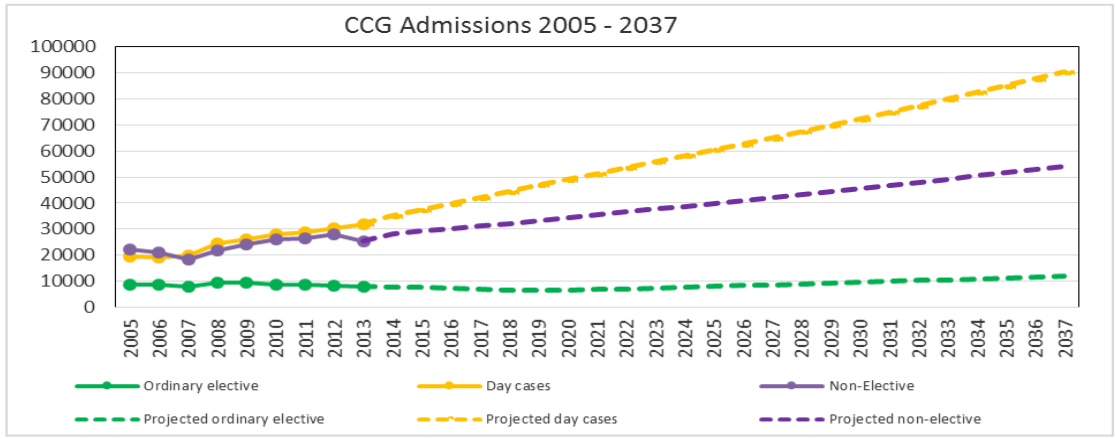


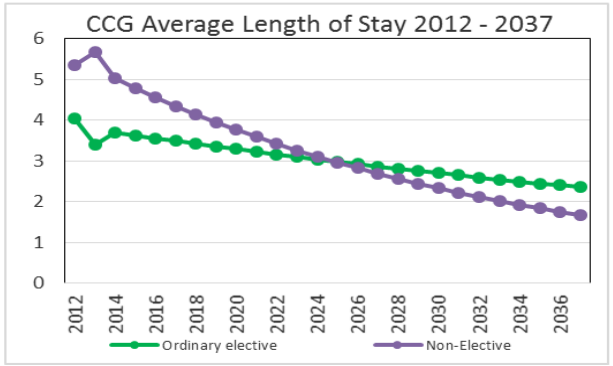




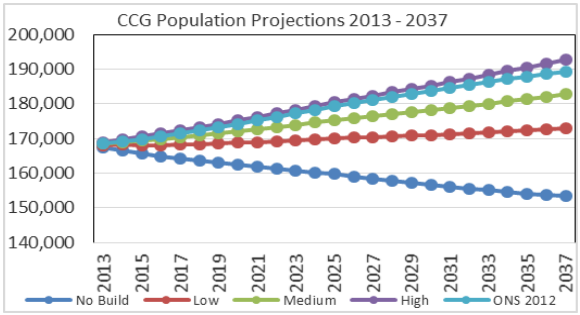


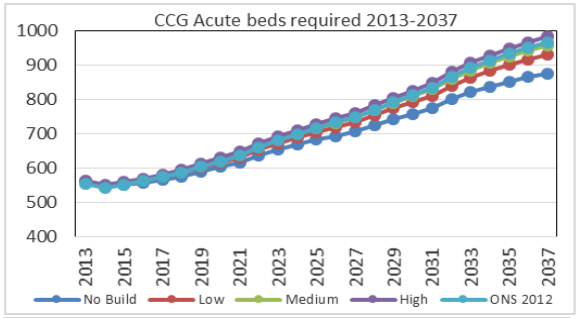


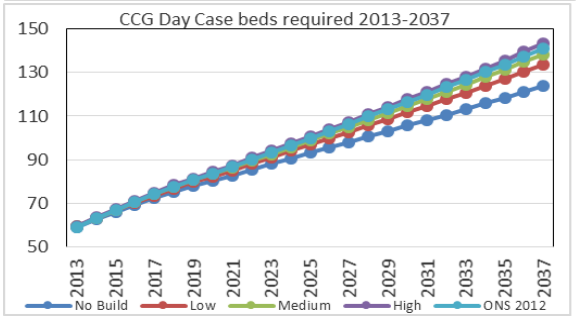


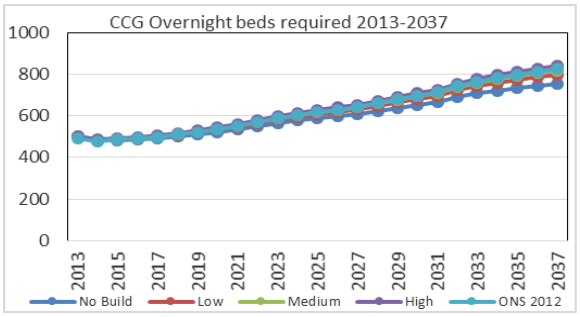


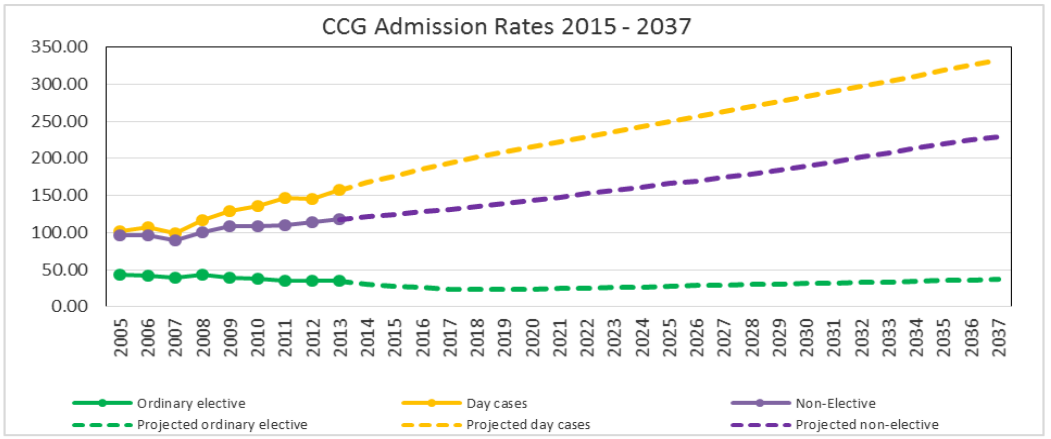
NHS North Norfolk CCG

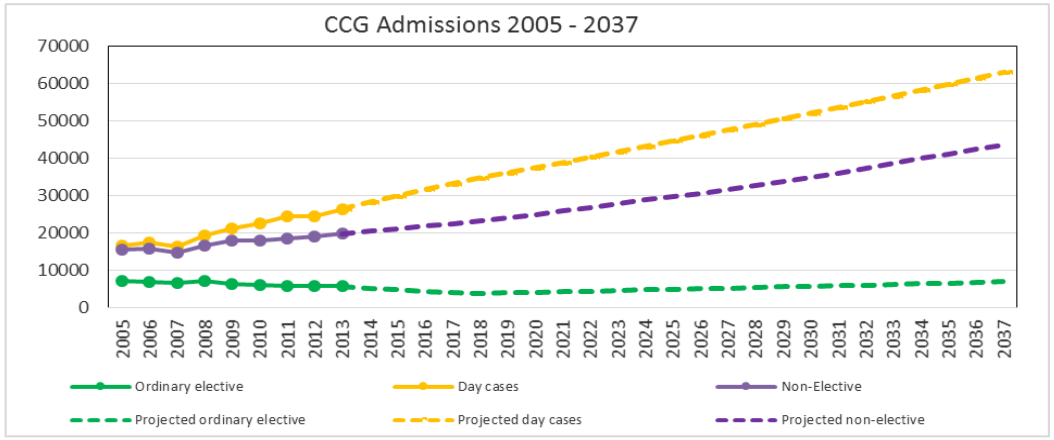


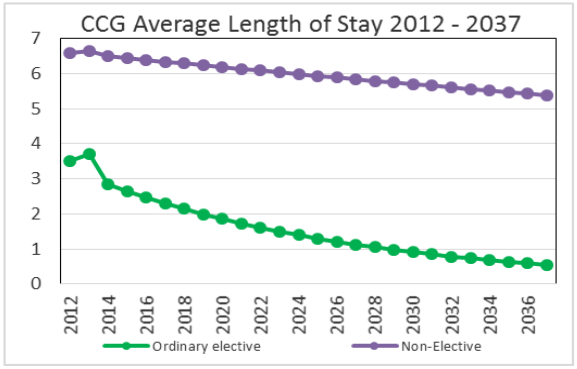




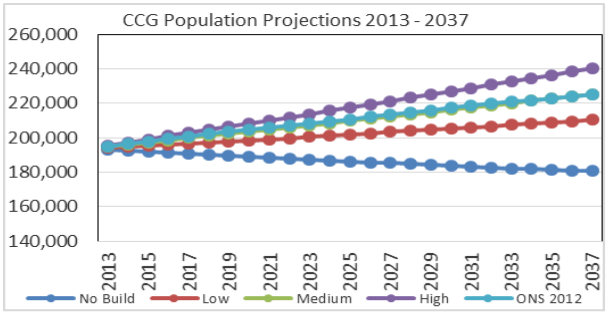


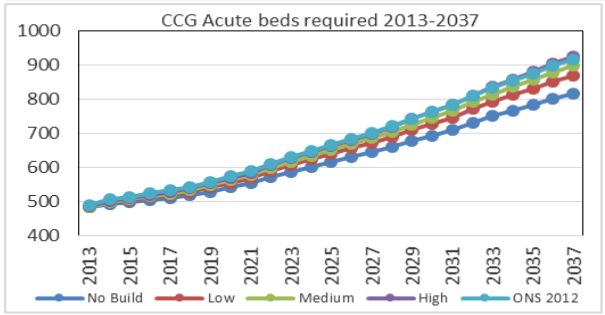


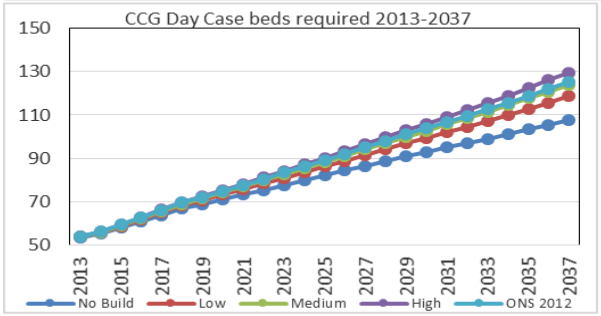


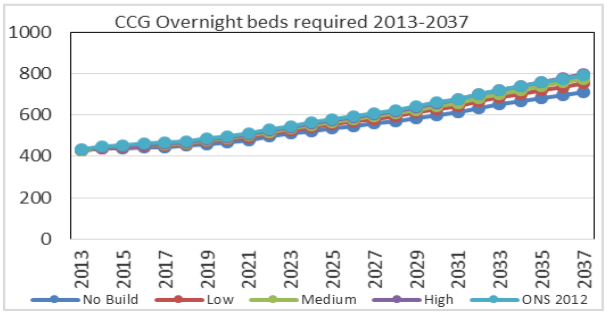


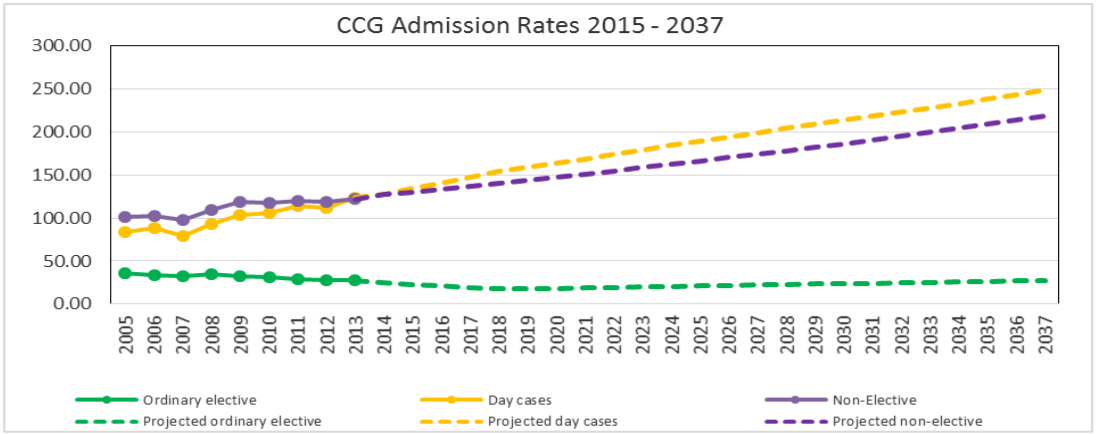
NHS Norwich CCG

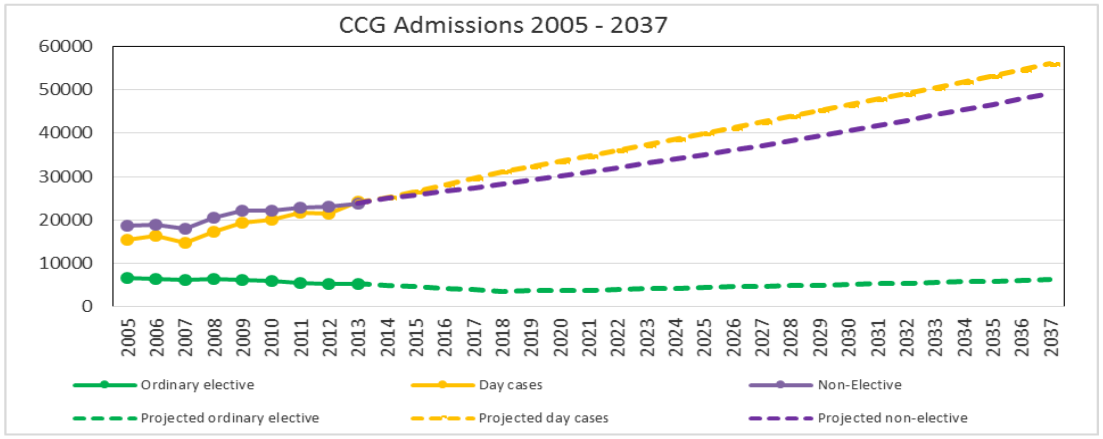


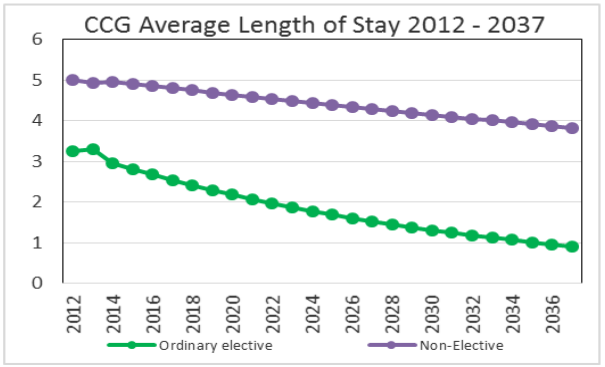




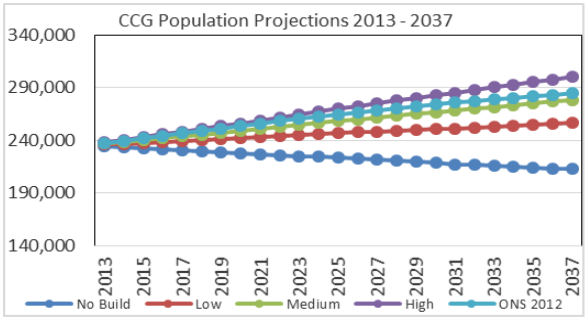


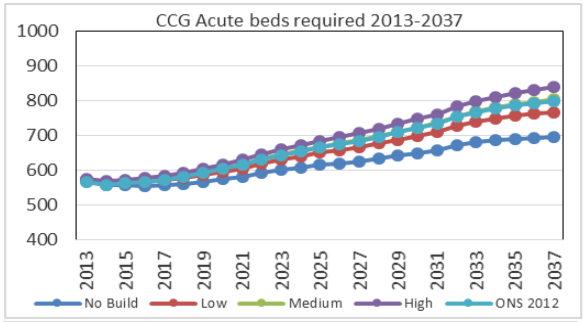


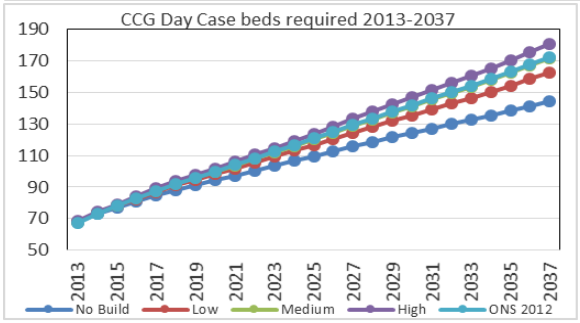


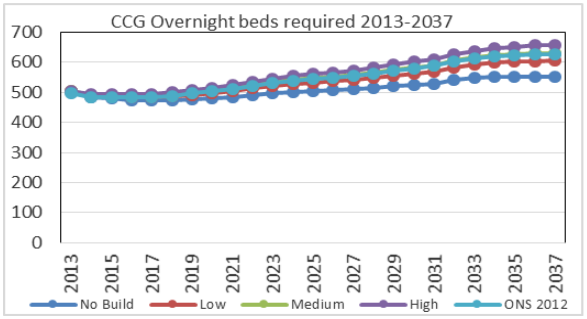


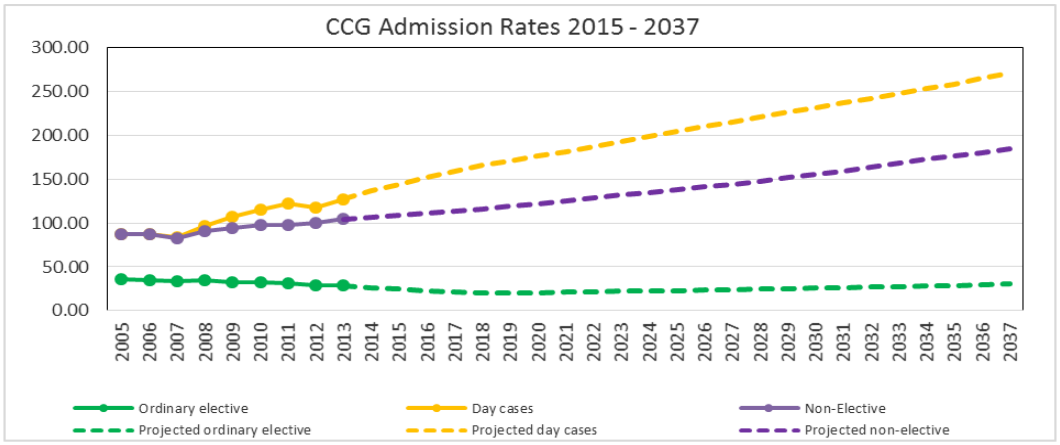
NHS South Norfolk CCG

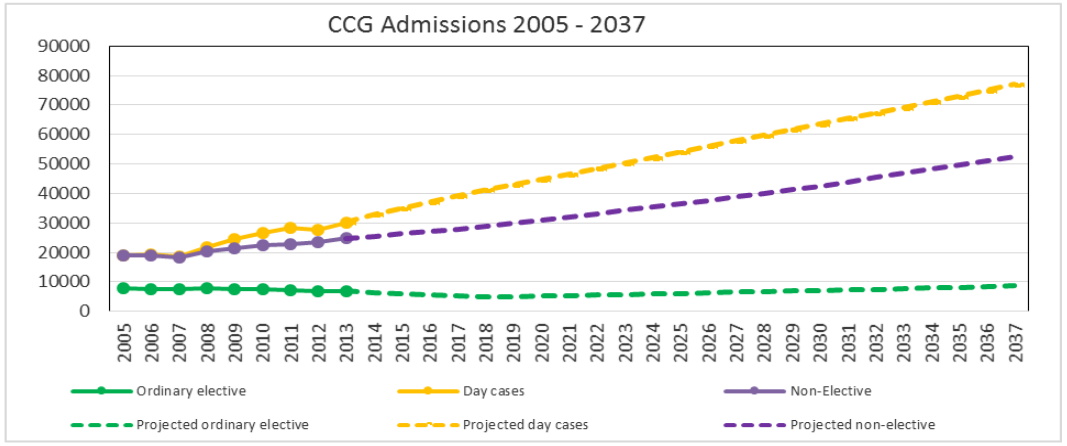


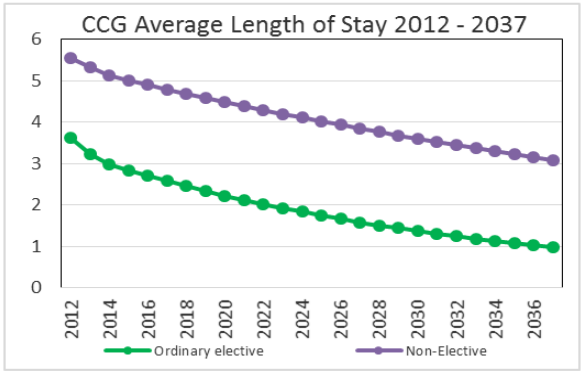




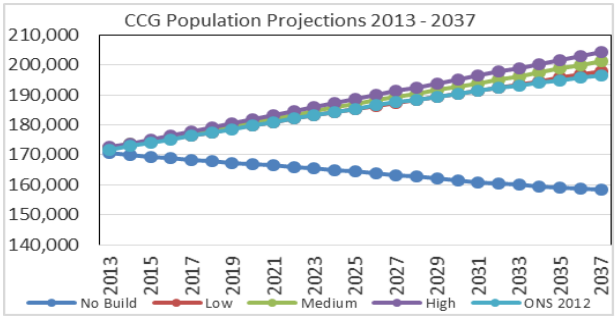


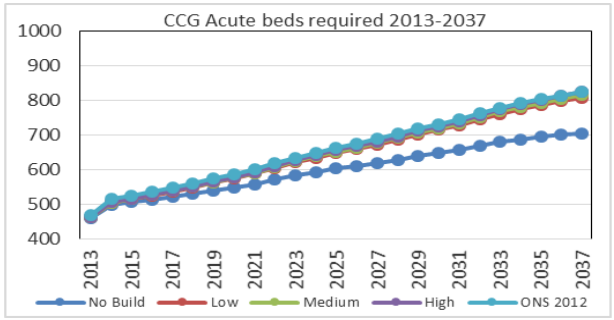


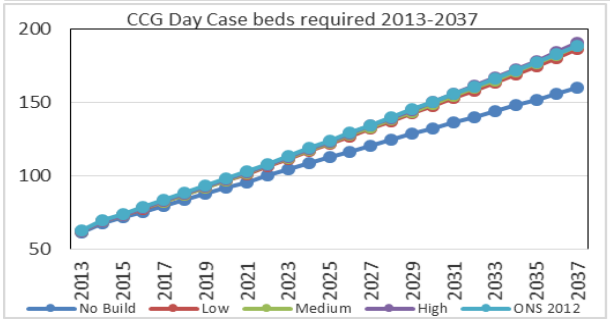


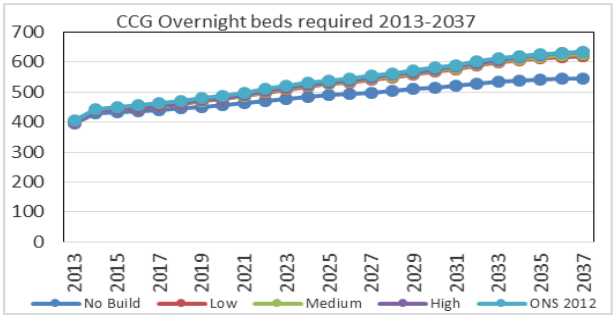


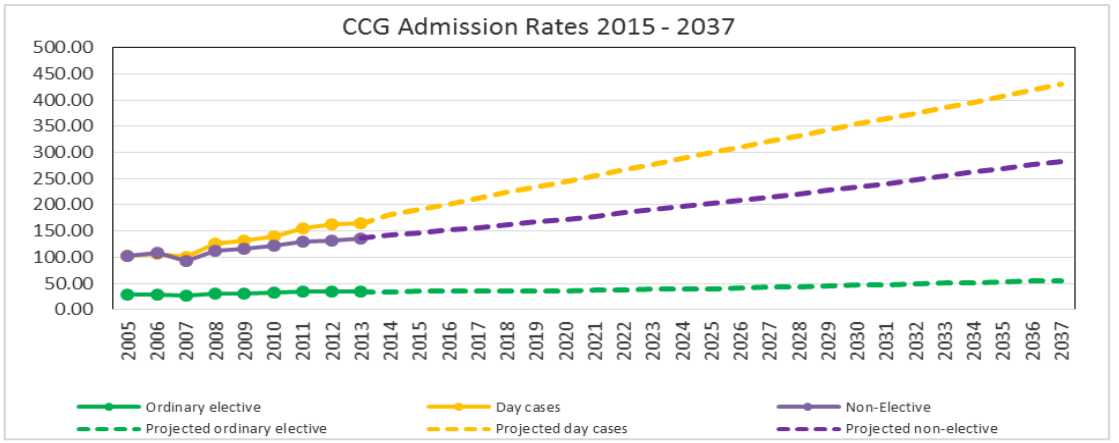
NHS West Norfolk CCG

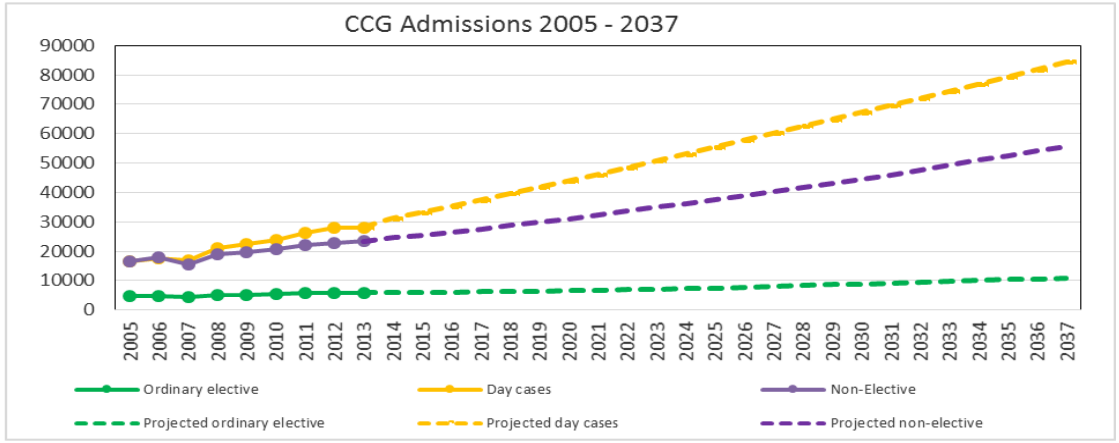


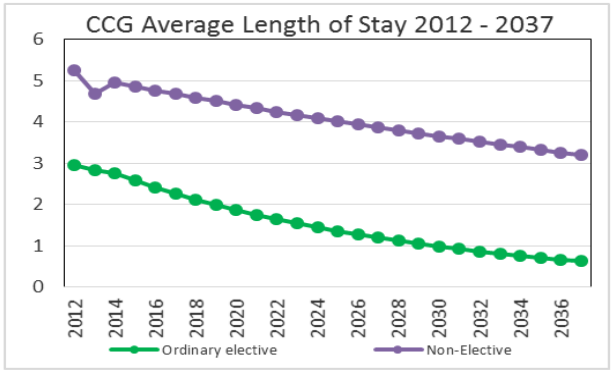












Calculations

Resident Population Projections by CCG

Using POPGROUP, the resident population projections for each district were calculated using the number of houses built per year for each scenario. (POPGROUP projections not available for CCGs). The number of houses per district per scenario is as follows:

District	Low	Medium	High
Breckland	283	424	565
Broadland	279	418	558
Great Yarmouth	210	315	420
King's Lynn & West Norfolk	650	680	710
North Norfolk	189	284	379
Norwich	382	573	763
South Norfolk	449	674	898
Waveney	145	218	290

The "High" scenario figures are based on the OAN (Objectively Assessed Need for housing). Waveney figure is based on the current local plan housing targets to 2025 extrapolated forward to 2036 as there is not yet an OAN figure beyond 2025.

POPGROUP uses births, deaths, migration rates from the mid-2012 ONS projections and the household/dwellings ratio per district in 2011 to calculate the population projections (using the same methodology as in the mid-2012 ONS projections). The CCG's population was then allocated using the proportion of the ONS mid-2013 district population estimates in the corresponding CCG. The proportions are:

CCG	District	Prop. of population in CCG
NHS Great Yarmouth and Waveney CCG	Great Yarmouth	100.00%
NHS Great Yarmouth and Waveney CCG	Waveney	100.00%
NHS North Norfolk CCG	Broadland	52.92%
NHS North Norfolk CCG	North Norfolk	100.00%
NHS Norwich CCG	Broadland	47.08%
NHS Norwich CCG	Norwich	100.00%
NHS South Norfolk CCG	Breckland	82.86%
NHS South Norfolk CCG	South Norfolk	100.00%
NHS West Norfolk CCG	Breckland	17.14%
NHS West Norfolk CCG	King's Lynn & West Norfolk	100.00%

Acute Healthcare requirements

The number of beds required were calculated based on the formulas/assumptions used by the HUDU[iii] model and are built on the assumption that admission rates and length of stay continue to change in the way that they have done in the past as follows:

Number of beds required = bed days required / Occupancy rate / Available bed days

Where:

$Beds\ required = no.of\ admissions\ by\ CCG\ \times forecasted\ average\ length\ of\ stay$

$No.of\ admissions\ by\ CCG = CCG\ Population\ Projection\ for\ scenario\ \times admission\ rate$

Admission rate = Forecasted no. of admissions / ONS 2012 Population Projection

$Occupancy\ rate = 85\%$

$Available\ bed\ days = 365$

Intermediate Healthcare requirements

25% of reduction in length of stay is assumed to be re-directed as Intermediate Care Beds and another 25% as Intermediate Day Spaces. Both are calculated the same way for each year and include Elective and Non-Elective admissions as follows:

Beds/Day Spaces required = (25 % Bed Days reduction) / Occupancy / Available Bed Days

Where:

Bed days reduction = (CCG Admissions x Length of Stay 2012) - (CCG Admissions x Length of Stay current year)

CCG admissions = (forecasted admissions / ONS Population Projection for 2012) X Population for the corresponding scenario.

Occupancy rate = 85%

Available Bed Days = 447

General Practitioners requirements

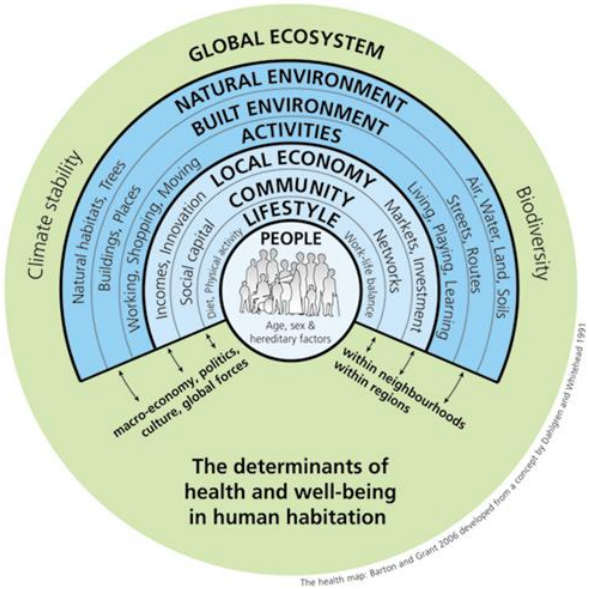
As per the HUDU model [iii], the primary healthcare assumption is set at requiring a population size of 1,800 people in order to justify one General Practitioner. This is based on guidance from the Royal College of GPs.

Number or GPs required = CCG Resident Population projection for the scenario / 1,800

[iii] HUDU model is the NHS Development Unit's online standard planning contribution model for London.

Appendix 2 A Healthy planning checklist for Norfolk

The links between planning and health are long established. The Health Map[iv] shows how lifestyle factors are nested within the wider social, economic, and environmental determinants of health which are, in turn influenced by the built and natural environments in which we live. We know that developments that are carefully planned for and managed may contribute positively to the health and well-being of a community. National Planning Policy Guidance requires local planning authorities to ensure that health and well-being, and health infrastructure are considered in local and neighbourhood plans and in planning decision making.



The Healthy Planning Checklist for Norfolk has been developed to facilitate joint working to improve health. It is based upon the London Healthy Urban Development Unit (HUDU) Rapid Health Impact Assessment Toolkit[v] and the Royal Town Planning Institute (RTPI) Principles for Healthy Communities[vi]. The Checklist is intended to provide a practical tool to assist developers and their agents when preparing development proposals and local planning authorities in policy making and in the application process. It also provides a framework for Norfolk County Council Public Health when considering health and wellbeing impacts of development plans and planning applications.

The checklist is structured around six healthy planning themes:

- Partnership and inclusion
- Healthy environment
- Vibrant neighbourhoods
- Active lifestyles
- Healthy housing and
- Economic activity

[iv] Barton H and Grant M (2006) **A health map for the local human habitat** The Journal of the Royal Society for the Promotion of Health November 2006 126: 252-253,

[v] London Healthy Urban Development Unit (2013) Rapid Health Impact Assessment Tool www.healthyurbandevelopment.nhs.uk

[vi] RTPI Principles for Healthy Communities in RTPI (2009) Good practice note 5: Delivering healthy communities.

USING THE CHECKLIST.

The checklist is designed to highlight issues and facilitate discussion and can be used flexibly, reflecting the size and significance of the development. It is best used prospectively, before a plan or proposal is submitted, but can also be used concurrently and retrospectively. Used prospectively it can help assess plans and proposals and inform the design and layout of a development and influence those factors that can impact on the health and wellbeing of residents and the wider communities of Norfolk.

Consideration should be given to each of the six healthy planning themes. It is acknowledged that there will be crossover with other assessments, including environmental impact and transport assessment, and an integrated approach is encouraged.

HEALTHY PLANNING CHECKLIST				
	Criteria to consider	Comments and recommendations	Policy requirements, standards and evidence	Why is it important?
THEME 1	PARTNERSHIP AND INCLUSION			
Engagement	Health and planning are integrated at an early stage of plan making and proposal preparation. Communities, including vulnerable and hard to reach groups have been engaged in the development of plans and policies.		National Planning Policy Framework paragraph 69, 70, 73, 74. http://planningguidance.communities.gov.uk/ Planning Policy Guidance, Who are the main health organisations a local authority should contact and why? (ID: 53-003-20140306) http://planningguidance.communities.gov.uk/	Community engagement before and during construction can help alleviate fears and concerns. Creating a sense of community is important to individual's health and wellbeing and can reduce feelings of isolation and fear of crime. Planning can support communities and improve quality of life for individuals by creating environments with opportunities for social networks and friendships to develop.
Integration	The design creates environments where people can meet and interact and connects the proposal with neighbouring communities.			

THEME 2	HEALTHY ENVIRONMENT			
Construction	The plan or proposal minimises construction impacts such as dust, noise, vibration and odours.		National Planning Policy Framework paragraph 69, 70, 73, 74. http://planningguidance.communities.gov.uk/	Construction activity can cause disturbance and stress which can have an adverse effect on physical and mental health. Mechanisms should be put in place to control hours of construction, vehicle movements and pollution.
Air quality	The plan or proposal minimises air pollution.			The long-term impact of poor air quality has been linked to life-shortening lung and heart conditions, cancer and diabetes.
Noise	The plan or proposal minimises the impact of noise caused by traffic and commercial uses through attenuation, insulation, site layout and landscaping.			Reducing noise pollution helps improve the quality of urban life.
Sustainable energy and materials	The plan or proposal maximises opportunities for renewable energy sources and promote the use of sustainable materials.			Access to nature and biodiversity can have a positive impact on mental health and wellbeing.
Biodiversity	The plan or proposal contributes to nature conservation and biodiversity.			New development can improve existing, or create new, habitats or use design solutions (green roofs, living walls) to enhance biodiversity.

Local food growing	The plan or proposal provides opportunities for food growing, for example by providing allotments, private and community gardens.			Providing space for local food growing helps promote more active lifestyles, better diets and social benefits.
Flood risk	The plan or proposal reduces surface water flood risk through sustainable urban drainage techniques, including storing rainwater, use of permeable surfaces and green roofs.			Flooding can result in risks to physical and mental health. The stress of being flooded and cleaning up can have a significant impact on mental health and wellbeing.
Overheating	The design of buildings and spaces avoids internal and external overheating, through use of passive cooling techniques and urban greening.			Climate change with higher average summer temperatures is likely to intensify the urban heat island effect and result in discomfort and excess summer deaths amongst vulnerable people. Urban greening - tree planting, green roofs and walls and soft landscaping can help prevent summer overheating.

THEME 3	VIBRANT NEIGHBOURHOODS			
Social infrastructure	The plan or proposal contributes new social infrastructure provision that is accessible, affordable and timely.		National Planning Policy Framework paragraph 69, 70, 73, 74. http://planningguidance.communities.gov.uk/ Planning Policy Guidance. How should health and well-being and health infrastructure be considered in planning decision making? (ID: 53-004-20140306) http://planningguidance.communities.gov.uk/ Planning Policy Guidance, What is a healthy community? (ID: 53-005-20140306) http://planningguidance.communities.gov.uk/	Future social infrastructure requirements are set out in the local authority infrastructure plans and developments may be expected to contribute towards additional services and facilities.
	The plan or proposal promotes access to a range of community facilities and public services that are well designed and easily accessible.			Good access to local services is a key element of a lifetime neighbourhood and additional services will be required to support new development.
Access to fresh food	The plan or proposal provides opportunities for local food shops, and avoids an over concentration or clustering of hot food takeaways.			A proliferation of hot food takeaways and other outlets selling fast food can harm the vitality and viability of local centres and undermine

THEME 4	ACTIVE LIFESTYLES			
Access	The plan or proposal protects and enhances existing and/or provides suitable new accessible green and open space, play and sports spaces, woodlands and allotments (or provides alternative facilities in the vicinity). It sets out how these new spaces will be managed and maintained for the lifetime of the development.		Healthy Environment National Planning Policy Framework paragraph 69, 70, 73, 74. http://planningguidance.communities.gov.uk/ **Safe, sustainable development:** aims and guidance notes for local Highway Authority requirements in Development Management, Norfolk County Council. http://www.norfolk.gov.uk/view/ncc099733	Access to open space and community facilities has a positive impact on health and wellbeing. Living close to areas of green space, parks, woodland and other open space can improve physical and mental health regardless of social background.

Travel and transport	The plan or proposal has a travel plan that includes adequate and appropriate cycle parking and storage and traffic management and calming measures. The layout is highly permeable and includes safe, well-lit and networked pedestrian and cycle routes and crossings. The plan or proposal minimises travel to ensure people can access facilities they need by walking cycling and public transport. The plan or proposal keeps commercial vehicles away from areas where their presence would result in danger or unacceptable disruption to the highway or cause irreparable damage.			A travel plan can promote sustainable transport and address the environmental and health impacts of a development. Cycle parking and storage in residential dwellings can encourage cycle participation. Traffic management and calming measures and safe crossings can reduce road accidents involving cyclists and pedestrians and increase active travel. Developments should prioritise the access needs of cyclists and pedestrians. Developments should be accessible by public transport.

THEME 5	HEALTHY HOUSING			
Accessible housing	The plan or proposal meets all the requirements contained in National Housing standards for daylighting, sound insulation, and private space. The plan or proposal provides accessible homes for older or disabled people.		National Planning Policy Framework paragraph 69, 70, 73, 74. http://planningguidance.communities.gov.uk/	Good daylighting can improve the quality of life and reduce the need for energy to light the home. Improved sound insulation can reduce noise disturbance and complaints from neighbours. The provision of an inclusive outdoor space which is at least partially private can improve the quality of life. Accessible and easily adaptable homes can meet the changing needs of current and future occupants.
Healthy living	The plan or proposal provides dwellings with adequate internal space, including sufficient storage space and separate kitchen and living spaces. Practical use for garden space is provided and where garden space is impractical effectively managed communal garden space will be provided. The plan or proposal encourages the use of stairs by ensuring that they are well located, attractive and welcoming.			Sufficient space is needed to allow for the preparation and consumption of food away from the living room to avoid the 'TV dinner' effect. Rather than having lifts at the front and staircases at the back of buildings hidden from view, it is preferable to have them located at the front to encourage people including those that are able to use them.

Housing mix and affordability	Neighbourhoods are designed with a mix of housing types and tenures and provide accommodation which is adaptable to cater for changing needs, including the ageing population.			The provision of affordable housing can create mixed and socially inclusive communities. The provision of affordable family sized homes can have a positive impact on the physical and mental health of those living in overcrowded, unsuitable or temporary accommodation.
	Affordable housing is integrated in the whole site and will avoid segregation.			Both affordable and private housing should be designed to a high standard ('tenure blind').

THEME 6	ECONOMIC ACTIVITY			
Local employment and healthy workspaces	A range of employment opportunities are available within the neighbourhood or accessible by sustainable travel means. The plan or proposal includes commercial uses and provides opportunities for local employment and training, including temporary construction and permanent 'end-use' jobs.		Economic Activity National Planning Policy Framework paragraph 69, 70, 73, 74. http://planningguidance.communities.gov.uk/	Unemployment generally leads to poverty, illness and a reduction in personal and social esteem. Employment can aid recovery from physical and mental illnesses. Creating healthier workplaces can reduce ill health and employee sickness absence.

ACKNOWLEDGEMENTS

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The City of Stoke-on-Trent local development framework supplementary planning document: healthy urban planning (2012);

Better health outcomes through spatial planning: a report for Cheshire West and Chester Council. Ballantyne and Blackshaw (2014);

Thetford Healthy Town, Planning and Health Checklist. Breckland Council.

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