1. **Adoption of Norfolk Planning in Health Protocol 2024** (Pages 2-10)
2. **Planning in Health Protocol 2024 ICB v1.1** (Pages 11-44)

CABINET MEMBERS DELEGATED DECISION

Open/~~Exempt~~		Would any decisions proposed: Be entirely within Cabinet's powers to decide **YES**/~~NO~~ Need to be recommendations to Council ~~YES~~/**NO** Is it a Key Decision ~~YES~~/**NO**	
Any especially affected Wards	~~Mandatory/~~ ~~Discretionary /~~ **Operational**		
Lead Member: Cllr Jim Moriarty E-mail: *cllr.james.moriarty@west-norfolk.gov.uk*		Other Cabinet Members consulted: Other Members consulted:	
Lead Officer: Michael Burton (Principal Planner, Planning Policy) E-mail: *Michael.burton@west-norfolk.gov.uk*		Other Officers consulted: Alex Fradley (Planning Policy Manager)	
Financial Implications ~~YES~~/**NO**	Policy/Personnel Implications ~~YES~~/**NO**	Statutory Implications ~~YES~~/**NO**	Equal Impact Assessment **YES**/~~NO~~ If YES: **Pre-screening**/ ~~Full Assessment~~
Risk Management Implications ~~YES~~/**NO**	Environmental Considerations **YES**/~~NO~~		
If not for publication, the paragraph(s) of Schedule 12A of the 1972 Local Government Act considered to justify that is (are) paragraph(s)			
Date of publication of report: 29 November 2024		Date decision to be taken: 06 December 2024	
Deadline for Call-In: 13 December 2024			

TITLE: ADOPTION OF NORFOLK PLANNING IN HEALTH PROTOCOL 2024

This report has been prepared to secure adoption of the updated Norfolk Planning in Health Protocol ("the Protocol"/ "Health Protocol"). The Protocol is an engagement tool between Norfolk and East Suffolk Local Planning Authorities, Public Health Bodies and the Norfolk and Waveney Integrated Care System (ICS). The focus is upon delivering positive outcomes in terms of public health and wellbeing through the planning system.

The updated Health Protocol was approved by the Norfolk Strategic Planning Member Forum on 24 October 2024. This enables the partner local authorities individually to adopt the Protocol.

Recommendation

The Cabinet Member for Planning and Licensing to approve, under delegated powers, the 2024 Norfolk Planning in Health Protocol.

Reason for Decision

To approve the updated 2024 Protocol, replacing the previous (August 2019) version.

1 Background

Context

The first Norfolk Planning in Health Protocol ("the Protocol"/ "Health Protocol") was published in March 2017, with an updated version published in August 2019:

https://www.norfolk.gov.uk/media/20269/Planning-In-Health-Protocol-August-2019/pdf/3cplanning-in-health-protocol-august-2019.pdf?m=1701471987337.

The need for a further update to the Protocol has come about in recognition of a need for greater collaboration between local planning authorities, health service organisations, and public health departments in local government. This is necessary to plan for future growth and to promote health in planning/ new development.

National planning policy and guidance has also seen several updates since 2019, most recently the December 2023 update to the National Planning Policy Framework: https://www.gov.uk/government/publications/national-planning-policy-framework--2). The NPPF and Planning Practice Guidance (https://www.gov.uk/guidance/health-and-wellbeing) focus upon promoting healthy and safe communities (NPPF, section 8), including addressing identified local health and well-being needs, taking into account and supporting delivery of local strategies to improve health (NPPF paragraphs 96-97).

In addition, there is a need for health service organisations to deliver on the commitments within the NHS Long Term Plan (https://www.longtermplan.nhs.uk/) which sets out goals and actions for the future of the NHS.

The 2019 Health Protocol also precedes the Covid-19 pandemic so there is a need to review this, in terms of the long-term aspirations of the NHS around service delivery. This requires planning processes for the health sector to be reviewed, with reference current public health structures and the need to ensure continued and effective engagement between local planning authorities and health service bodies.

The updated Health Protocol was approved by the Norfolk Strategic Planning Member Forum on 24 October 2024. This enables the partner local authorities individually to adopt the Protocol.

Purpose of the Protocol

The process for updating the Protocol has been extensive, having started in early 2022. The update has been produced collaboratively between relevant public health bodies; the NHS, Norfolk and Suffolk Public Health (County Councils) and the Norfolk local planning authorities. It sets out how these partner bodies can effectively engage to ensure that health and wellbeing matters ("health considerations") are appropriately addressed in plan-making (Local Plans) and decision making (planning applications).

The Health Protocol covers two principal themes:

- Health infrastructure – planning for health service provision (e.g. provision of healthcare facilities to meet population needs – primary/ secondary healthcare and associated services such as dentistry); and
- Ensuring that health promotion is considered in the design and provision of developments (e.g. the provision of walking and cycling infrastructure, or maintenance of good air quality).

The Protocol provides information and guidance about how matters of health and wellbeing can be addressed through the planning system.

How has the Protocol been updated?

Five years have passed since the 2019 Protocol was adopted. The 2024 update includes significant changes, to:

- Ensure greater consideration of health promotion through the planning process;
- Reflect new NHS structures and changes in national planning policy; and
- Make the protocol more accessible, as well as clarifying partner roles and responsibilities.

Key changes in the 2024 Health Protocol update are as follows:

- new Section 1 ("How to use this protocol");
- additional detail on the tools and data used by NHS Norfolk and the Waveney Integrated Care Board (ICB) in calculating developer contributions, regarding the impacts of development on healthcare services;
- clarification on dental services (not included in previous versions of the Protocol) and the need to collate and publish relevant data as/ when this becomes available;
- information on Healthcare Infrastructure Development Plans; and
- recent administrative and governance changes to the health and social care system within which the Protocol operates.

Overall, the passage of five years since the 2019 Health Protocol has inevitably required an update to the Protocol, to reflect the current position, in terms of administrative requirements and current planning policies.

How should the Protocol be used?

The Health Protocol should be used by all relevant partner bodies. That is, Norfolk and East Suffolk local planning authorities, the Norfolk and Waveney Integrated Care System (ICS) Strategic Estates Group (who will liaise with relevant health and social care partners to ensure where possible, that health infrastructure is suitable for its needs and the population that it serves), and Norfolk and Suffolk County Councils' Public Health teams.

The Protocol should be used in cases where development proposals could potentially impact health services, or where there could be significant health implications. It sets out thresholds for where consultation is required on

potential health impacts and considerations associated with a development proposal. That is:

a) A housing development of 50 dwellings or more.
b) A development of less than 50 dwellings but which is still deemed to potentially impact on health services significantly.
c) A development that includes a care facility, housing for the elderly, or student accommodation.
d) A development that involves the significant loss of public open space.
e) Any other type of development that could have significant health implications.

The Protocol is intended to support all parts of the planning system; both plan-making and decision making.

For local planning, toolkits within the Protocol provide a framework for public health teams when considering health and wellbeing impacts of development plans. This also enables engagement through a documented process outlining the input and linking of relevant NHS organisations and Public Health agencies with partner local planning authorities, in planning for housing growth and the health infrastructure required to serve that growth.

For development management, Protocol guidance includes pre-planning application enquiries, where the Protocol should be used to set the scope for a Health Impact Assessments (HIA) if appropriate.

The Health Protocol is supported by a range of toolkits and data. These include:

- **"Healthy Planning Checklist" tool –** to assist developers in submitting planning applications and local planning authorities in preparing Local Plans;
- **"Healthy Urban Development Unit (HUDU) modelling tool" –** used by the ICS Strategic Estates Group to model specific impacts of new developments on healthcare infrastructure;
- **Demand and capacity modelling –** used by the ICS Strategic Estates Group to indicate existing areas of capacity or constraint across its infrastructure; and
- **Infrastructure Development Plans –** highlight specific requirements and proposed projects across health infrastructure, in response to forecast population and household growth.

Overall aims of the Protocol

The Protocol seeks to improve engagement and effective partnership working between public bodies with public health responsibilities. It is about effective planning for housing growth and the health infrastructure required to serve that growth, in terms of:

- Health;
- Well-being; and
- Long term health service and infrastructure demands.

This will enable health service providers across the Norfolk and Waveney ICS area to plan for expanding communities in areas where new housing is to be built.

2 Options Considered

No other options were considered. The 2019 Protocol was becoming outdated, particularly in terms of information regarding current healthcare policies and administrative structures. Given that 2019 Protocol is over five years old, an update/ revision has been long due.

3 Policy Implications

No direct policy implications. The Health Protocol functions as a toolkit, signposting users to relevant policies and guidance associated with health and wellbeing, and health infrastructure.

4 Financial Implications

No financial implications.

5 Personnel Implications

No personnel implications.

6 Environmental Implications

The Protocol considers best practice in promotion of health through planning, including with reference to best practice design guidance such as the National design guide (https://www.gov.uk/government/publications/national-design-guide).

The National Planning Policy Framework (NPPF) and supporting Planning Practice Guidance (PPG) recognises good design as integral to health and wellbeing. They emphasise health and wellbeing as an essential part of the planning process, including focusing on active travel, multi-functional open space, and high-quality urban environments.

Overall, the Protocol recognises the critical role of a high-quality environment for public health and wellbeing. It should therefore deliver positive outcomes in terms of environmental implications.

7 Statutory Considerations

No statutory considerations. The Health Protocol has been updated as good practice, although there is no statutory obligation to produce or maintain such a document. It should be noted that for both development management and plan-making there is a requirement to engage with relevant health bodies. NHS England and the Integrated Care Boards (in this case, Norfolk and Waveney ICB) are also statutory "Duty to Cooperate" bodies (Town and Country (Local Planning) (England) Regulations 2012, as amended; Regulation 4).

8 Equality Impact Assessment (EIA)

Pre-Screening Equality Impact Assessment undertaken, demonstrating neutral impacts. Therefore, there is no requirement to undertake a full EIA.

Borough Council of
King's Lynn &
West Norfolk

Stage 1 - Pre-Screening Equality Impact Assessment

Name of policy/service/function	Planning in Health Protocol			
Is this a new or existing policy/ service/function? *(tick as appropriate)*	New		Existing	**X**

9 Risk Management Implications

The Protocol has been updated to ensure the existing agreement between the partner bodies remains relevant and up-to-date. Given that five years have passed since the previous version was adopted, there could be a significant risk that important information and guidance relating to delivering public health and wellbeing outcomes could be missed.

No risks are identified in updating the Protocol, although there are potential risks with continued reliance upon the previous (2019) version.

10 Declarations of Interest / Dispensations Granted

None.

11 Background Papers

Planning in Health Protocol (August 2024).

Signed: Jim Moriarty

Cabinet Member for: Planning and Licensing

Date: 29.11.2024

Brief summary/description of the main aims of the policy/service/function being screened. Please state if this policy/service is rigidly constrained by statutory obligations, and identify relevant legislation.	The Protocol sets out how relevant bodies – the NHS, Norfolk and Suffolk Public Health (County Councils) and local planning authorities – can effectively engage to ensure that health and wellbeing matters ("health considerations") are appropriately addressed in plan-making and decision making (planning applications). The Protocol updates the previous (2019) version and sets out the size and scale of development when it will apply and provides information about the types of activities that can be undertaken, such as health impact assessment, to promote healthy planning and development and includes a health planning checklist. There are no direct statutory obligations associated with the Protocol, although this operates within the legal frameworks that bind the partner bodies.
Who has been consulted as part of the development of the policy/service/function? – new only *(identify stakeholders consulted with)*	Norfolk and East Suffolk Local Planning Authorities, Public Health Bodies (NHS; Norfolk and Suffolk County Councils) and the Norfolk and Waveney Integrated Care System (ICS).

Question	**Answer**				
1. Is there any reason to believe that the policy/service/function could have a specific impact on people from one or more of the following groups, for example, because they have particular needs, experiences, issues or priorities or in terms of ability to access the service? Please tick the relevant box for each group. NB. Equality neutral means no negative impact on any group. ***If potential adverse impacts are identified, then a full Equality Impact Assessment (Stage 2) will be required.***		Positive	Negative	Neutral	Unsure
	Age			**X**	
	Disability			**X**	
	Sex			**X**	
	Gender Re-assignment			**X**	
	Marriage/civil partnership			**X**	
	Pregnancy & maternity			**X**	
	Race			**X**	
	Religion or belief			**X**	
	Sexual orientation			**X**	
	Armed forces community			**X**	
	Care leavers			**X**	
	Other (eg low income, caring			**X**	

	responsibilities)					
Question	**Answer**	**Comments**				

2. Is the proposed policy/service likely to affect relations between certain equality communities or to damage relations between the equality communities and the Council, for example because it is seen as favouring a particular community or denying opportunities to another?	~~Yes~~ / **No**	Delivering good access to healthcare and wider health and wellbeing through the planning system is beneficial to all communities and groups.
3. Could this policy/service be perceived as impacting on communities differently?	~~Yes~~ / **No**	Ditto (Q2)
4. Is the policy/service specifically designed to tackle evidence of disadvantage or potential discrimination?	~~Yes~~ / **No**	Ditto (Q2)
5. Are any impacts identified above minor and if so, can these be eliminated or reduced by minor actions? If yes, please agree actions with a member of the Corporate Equalities Working Group and list agreed actions in the comments section	~~Yes~~ / **No**	**Actions:** **Actions agreed by EWG member:** ……C Dorgan…….
If 'yes' to questions 2 - 4 a full impact assessment will be required unless comments are provided to explain why this is not felt necessary: **Decision agreed by EWG member: ……..**		

Assessment completed by: **Name**			
Job title			
Date completed			
Reviewed by EWG member	**C Dorgan**	**Date**	**20/11/2024**

✓ **Please tick to confirm completed EIA Pre-screening Form has been shared with Corporate Policy (corporate.policy@west-norfolk.gov.uk)**

PLANNING IN HEALTH PROTOCOL

An engagement protocol between Norfolk and East Suffolk Local Planning Authorities, the Norfolk and Waveney Integrated Care Board, Health Partners and Public Health Norfolk and Public Health Suffolk

Revised August 2024 – Version 1.1

FOREWORD

This revision is based upon the previously published version from August 2019 and has come about in recognition of a need for greater collaboration between local planning authorities, health service organisations, and public health departments in local government to plan for future growth and to promote health in planning. It reflects changes in national planning policy and the need for health service organisations to deliver on the commitments within the NHS Long Term Plan which sets out goals and actions for the future of the NHS.

This revision recognises the emergence of the Norfolk and Waveney Integrated Care System (ICS), an umbrella body bringing together the organisations planning, buying, and providing publicly funded healthcare to the population of the area. On 1st April 2020 the five Clinical Commissioning Groups (CCGs) were merged into the Norfolk and Waveney CCG (N&WCCG). Subsequently On 1st July 2022, the N&WCCG was superseded by the Norfolk and Waveney ICS which includes an Integrated Care Partnership (ICP), and an Integrated Care Board (ICB) called NHS Norfolk and Waveney ICB (N&W ICB).

This revision recognises the latest publication of the revised National Planning Policy Framework, which sets out government's planning policies for England and how these are expected to be applied.

This revision streamlines the processes and simplifies and shortens the protocol to make it easier to use and embed into the work of all partner agencies. Updated population healthcare needs assessments as well as population and demographic change estimates will be published separately to increase the longevity of this document and facilitate timely updates. These will support plans to deliver new healthcare infrastructure formulated by NHS colleagues.

Following the Covid-19 pandemic and the long-term aspirations of the NHS to increase service delivery, planning in the health sector will need to be reviewed, which will lead to changes over the coming years. Notwithstanding this, the Protocol remains a valuable tool to ensure appropriate and continued engagement between the Norfolk and East Suffolk Local Planning Authorities and the health service communities.

ACKNOWLEDGEMENTS

This protocol was jointly prepared by staff at Norwich City Council, Broadland Council, and Norfolk County Council on behalf of all Norfolk and East Suffolk LPAs. It also built heavily upon other work across the country including The London Healthy Urban Development Unit (HUDU) which gave permission for use of their 'Planning Contribution Model'.

Amendments in 2022/23 have been made in collaboration with Public Health at Norfolk County Council, Local Planning Authorities, the Norfolk & Waveney ICS, and N&W ICB in response to requests made by the Norfolk Planning Members Forum.

Contents

1. HOW TO USE THIS PROTOCOL

1.1. WHAT IS THE PURPOSE OF THIS PROTOCOL?

The Planning in Health Protocol (hereafter the Protocol) presents a process describing how relevant NHS organisations, Norfolk & Suffolk County Councils, Public Health and the Norfolk and East Suffolk Local Planning Authorities jointly engage to ensure that health considerations are adequately accounted for in plan making and in planning applications and their subsequent developments. In this context, the term "health considerations" includes planning for health service provision (e.g. the provision of enough healthcare facilities to meet population needs) as well as ensuring that health promotion is considered in the design and provision of developments (e.g. the provision of walking and cycling infrastructure, or maintenance of good air quality).

Updates to this version of the Protocol are the addition of a new Section 1 (How to use this protocol), more detail on the tools and data used by the ICB to calculate the impacts on healthcare services, information on the Healthcare Infrastructure Development Plans, as well as revisions to the text describing changes to the health and social care system and its governance within which the Protocol operates.

1.2. WHO SHOULD USE THIS PROTOCOL?

The Protocol should be used by Norfolk and East Suffolk Local Planning Authorities (LPAs), the Norfolk and Waveney Integrated Care System (ICS) Strategic Estates Group (who will liaise with relevant health and social care partners to ensure where possible, health infrastructure is suitable for its needs and the population that it serves), and the Norfolk and Suffolk County Councils' Public Health teams. Parts of the Protocol, the 'Health Planning Checklist' at the end of the document, can also support the LPAs in any discussions they have with developers. **It is the responsibility of the planning officer in the LPA overseeing a development plan (local plan, neighbourhood plan etc.) or planning application to invoke the protocol.**

1.3. IN WHAT CIRCUMSTANCES SHOULD THE PROTOCOL BE USED?

The Protocol should be used when consultation is required on the potential health impact and considerations associated with a development. This will be for:

- A housing development of 50 dwellings or more
- A development of less than 50 dwellings but which is still deemed to potentially impact on health services significantly.
- A development that includes a care facility, housing for the elderly, or student accommodation
- A development that involves the significant loss of public open space
- Any other type of development that could have significant health implications.

Defining what is deemed to have an impact on health services or significant health implications is challenging. It could, for example, be related to likely impacts on vulnerable populations, or to do with uses for employment sites. In cases where the planning officers are unsure the protocol should be used.

Other developments, such as those related to transport, minerals, or waste, are not considered in this protocol as these are covered under existing structures, processes, and legislation.

1.4. AT WHAT POINT IN THE PLANNING PROCESS SHOULD THE PROTOCOL BE USED?

The Protocol should be used at all points in the planning process from pre-planning discussions (when the need for elements such as a Health Impact Assessment, a methodology used to judge the potential health effects of a policy, programme or project on a population, can be considered), the outline process (when the initial likely health considerations associated with any development can be scoped in or out and design implications can be flexibly considered) to the full planning application (when health considerations can be assessed in detail and any final modifications recommended).

1.5. WHAT ARE THE ACTIONS THAT THE PROTOCOL DESCRIBES?

At the *pre-planning application stage*, the ICS Strategic Estates Group and Public Health partners will be provided with information on the likely application and given the opportunity to comment. As part of their feedback, they will provide a view within 21 days (subject to negotiated extension time), on the key areas of focus of any Health Impact Assessment that is required.

At the *outline planning application stage*, the ICS Strategic Estates Group and Public Health partners will provide general comment within 21 days (subject to negotiated extension time) on health considerations in outline proposals that meet the inclusion criteria to be covered by this protocol. At this stage the ICS Strategic Estates Group will also calculate and model the specific demand and capacity impacts of the proposal and include this when responding to the consultation.

At the *full planning application stage*, the ICS Strategic Estates Group and Public Health partners will provide comments if appropriate on full planning applications that meet the inclusion criteria to be covered by this Protocol. These comments will be provided within 21 days of receipt of the request for comment, (subject to a negotiated extension time). Responses will be reported in the planning officer's report.

1.6. WHAT OTHER ACTVITIES SHOULD TAKE PLACE?

In addition to the Protocol being initiated as required, the LPAs, ICS Strategic Estates Group and Public Health teams should be in regular contact. This will include:

- The sharing of the Annual Monitoring Report (AMR) produced by each LPA at the end of the calendar year with the parties engaged in the Protocol.
- An annual meeting between all parties covered by the Protocol to consider the data within the AMRs, assess how well the Protocol is working, and discuss any other strategic and upcoming issues.
- Attendance at other meetings on an ad-hoc/as-needed basis. This might include an LPA Local Plan Meeting where a development with significant health considerations is being considered or regular 'Place' based planning and health meetings.

1.7. WHAT TOOLS AND INFORMATION ARE AVAILABLE TO SUPPORT THIS PROTOCOL?

This document contains a checklist tool, detailed background information, and data used by the ICS Strategic Estates Group in the planning process and how the Protocol integrates with it.

- The “Healthy Planning Checklist” tool is provided in Appendix 1. It provides a practical tool to assist developers and their agents when preparing development proposals as well as LPAs in policy making and in the application process. It also provides a framework for public health teams when considering health and wellbeing impacts of development plans and planning applications.

- The “Detailed background Information” section of this document (Section 2 and beyond) provides a detailed description of the current planning and health systems and structures (as of December 2023) as well as providing more information on the operation of the Protocol and how it integrates with those systems and structures. Further, it details the relevant partners to this Protocol by name. It is recommended that those not familiar with the Protocol or local planning for health process read this section before engaging.

- The “HUDU modelling tool” is used by the ICS Strategic Estates Group to model the specific impact of new developments on healthcare infrastructure. The tool is detailed in section 4.2 of this Protocol and additional technical guidance can be found at Appendix 2.

- Alongside the HUDU tool, demand and capacity modelling is used by the ICS Strategic Estates Group to indicate existing areas of capacity or constraint across its infrastructure, as well as highlight the impacts of future demand placed upon it.

- Infrastructure Development Plans will highlight the specific requirements and proposed projects across health infrastructure in response to local plans and planned population growth. The plans are covered in section 4.1. The IDPs will be shared with local planning colleagues to feed into local plans.

1.8. WHO ARE THE CONTACTS?

The local planning officer invoking and overseeing the implementation of the Protocol for a given development should use the following contact email addresses. Please make it clear that any contact is associated with the implementation of the Protocol.

NHS ICS Estates: nwicb.icsestates@nhs.net

NCC Public Health: phplanning@norfolk.gov.uk

SCC Public Health: phplanning@suffolk.gov.uk

2. DETAILED 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 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, it can adversely impact people's physical and mental health (Ross and Chang, 2012).

The National Planning Policy Framework (NPPF) 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. The revised NPPF 2023 reiterates the presumption in favour of sustainable development and now specifically includes economic, social, and environmental objectives. Government guidance on promoting healthy and safe communities also states that "the local plan promotes health, social and cultural wellbeing and supports the reduction of health inequalities".

2.1. AIM OF THE PROTOCOL

To present 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. This attempts to both better understand and consider health service needs arising from development; and also make explicit the impact that the planning process, from plan making to determining applications, can have on:

- Health,
- Well-being and
- Long term health service and infrastructure demand.

The protocol will enable health service providers across the ICS to plan for expanding communities in areas where new housing is to be built.

2.2. OBJECTIVES

Objectives for the protocol are:

- To establish a working relationship and set a protocol for engagement between Norfolk and East Suffolk[1] Local Planning Authorities (LPAs), and relevant health and social care partners within the ICS, Norfolk County Council (NCC) and Suffolk County Council (SCC) Public Health.
- To outline a standardised process for obtaining robust and consistent health and social care and public health information to inform plan making and planning decisions.
- To support appropriate health infrastructure, with technical input from appropriate public health, health, and social care information teams.

[1] East Suffolk is covered by two Integrated Care Systems (ICS), the Norfolk and Waveney ICS and the Suffolk and North East Essex ICS. This protocol only applies to the part of East Suffolk within the area of the Norfolk and Waveney ICS (which is essentially the former Waveney District Council area}

- To ensure that the principles of prevention, health and wellbeing are adequately considered in plan making and when evaluating and determining planning applications.
- To establish a collective response to planning consultations from relevant health and social care partners and commissioning organisations through the appropriate mechanism.
- To agree a defined threshold indicator for Planners to contact health and Public Health teams for input into planning applications and spatial plans.

2.3. ORGANISATIONS INVOLVED

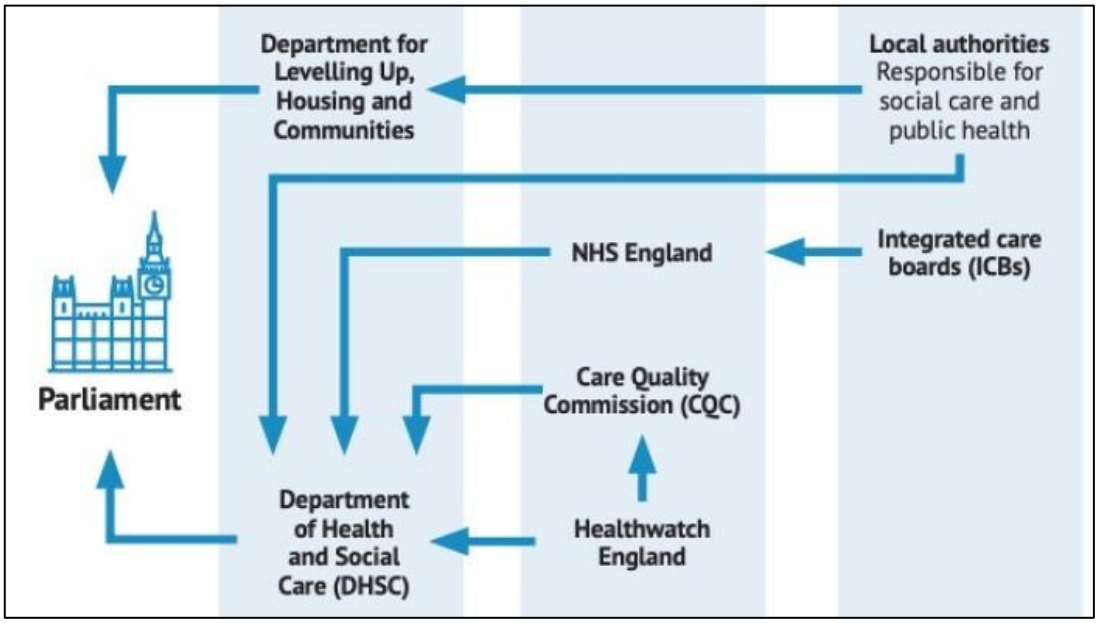
PUBLIC HEALTH FUNCTIONS IN ENGLAND

Following the Health and Social Care Act 2012, the NHS no longer has a public health function. Most of the public health workforce was transferred to Public Health England (PHE) at a national, regional, or sub-regional (in PHE Centre's) level and to local authorities at a local level, with a complementary set of roles and responsibilities. These have been further restructured in 2021 - Public health system reforms: location of Public Health England functions from 1 October - GOV.UK (www.gov.uk) when the PHE role and responsibilities were divided between the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID).

The role of the newly formed (UKHSA) 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 reform of the PHE also established (OHID). As a focus on, for example, smoking cessation and obesity, it also has an aim to "act on the wider factors that contribute to people's health, such as work, housing and education". Like UKHSA this will have a regional as well as national perspective. Figure 1 shows a schematic of how the organisations are represented at national and local level.

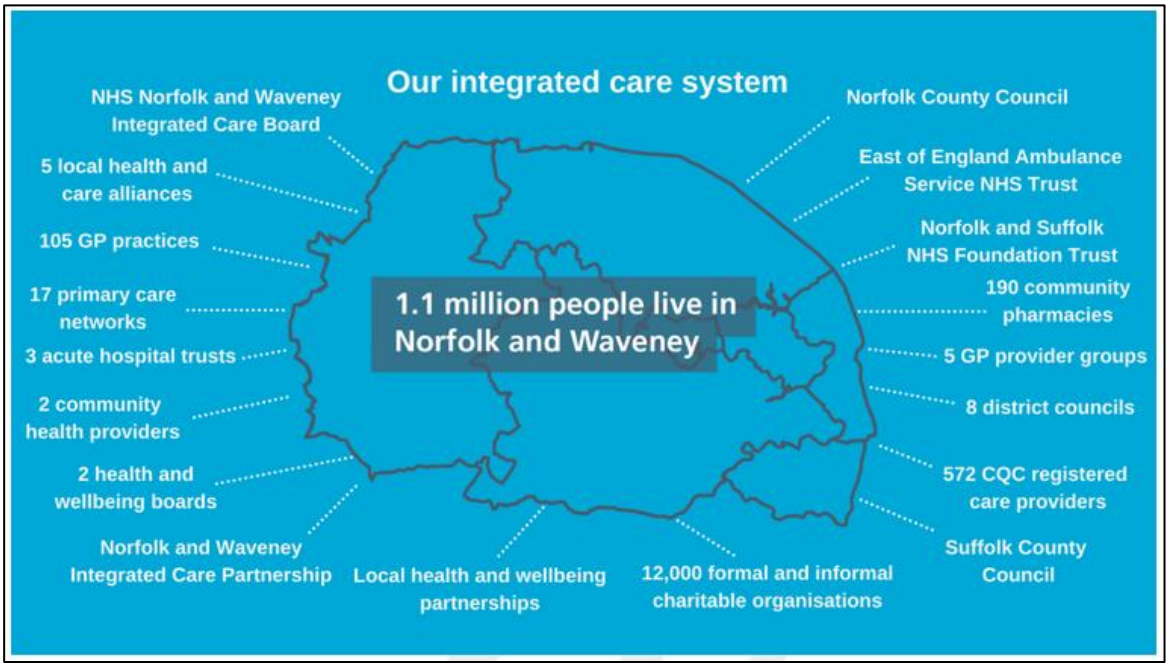
Figure 1: NHS and Local Authority Structures (National to Local)



NHS England
NHS England leads the National Health Service (NHS) in England. Services are commissioned by integrated care boards (ICBs) overseen by NHS England on a regional and national basis. Through its regional teams, NHS England support local integrated care systems (ICS) to improve the health of the population, improve the quality of care, tackle inequalities and deliver care more efficiently.

Norfolk and Waveney Integrated Care System (ICS)
The Health and Care Act 2022 put ICSs on a statutory footing from July 2022, comprising of an Integrated Care Partnership and an Integrated Care Board. Figure 2 Illustrates how the various elements including, health care providers, NHS Trusts and Councils are brought together in Norfolk under the Norfolk and Waveney ICS.

Figure 2: Infographic of Norfolk and Waveney Integrated Care System (ICS)



The Integrated Care Partnership (ICP)
A statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

NHS Norfolk and Waveney Integrated Care Board (ICB)
Is the statutory legal entity which has replaced the CCG. The ICB is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the ICS area. It will bring the local NHS together to improve population health and care.

Place-based Partnerships
Within each ICS, place-based partnerships will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.

The ICS is committed to taking a place-based approach, and the Integrated Care Board is supported by 5 Place Boards (based on old CCG boundaries), while the Integrated Care Partnership is supported by 8 Health and Wellbeing Partnerships (based on local authority footprints).

Figure 3: The 17 Primary Care Networks (PCNs), and 5 Places Boards

Local Authority Public Health, County Councils

Local authorities in the ICS area are responsible for social care and public health functions as well as other vital services for local people and businesses.

In Norfolk and Suffolk, the Director of Public Health (DPH) and public health workforce is part of Norfolk and Suffolk County Councils respectively. 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.

Health and Wellbeing Boards

Health and Wellbeing Boards are statutory bodies introduced in England under the Health and Social Care Act 2012 whose role is to promote integrated working among local providers of healthcare and social care. They bring together local authorities, the NHS, communities, and wider partners to share system leadership across the health and social care system. They 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, a document that provides local policymakers and commissioners with a profile of the health and wellbeing needs of the local population. This will be a key strategy for a local planning authority to take into account to improve health and well-being.

HEALTH AND SOCIAL CARE PARTNERS:
Many health and social care partners form part of our ICS, not all of which are specifically captured in figure 2. These include, but are not limited to:

- GP practices
- Dental practices
- Pharmacies
- Opticians
- Acute Hospital trusts
- Mental Health providers
- Community Health providers
- Social care
- 111 and out of hours care
- The Ambulance Trust and patient transport.

Local Planning Authorities
Norfolk and Waveney is covered by a number of district, borough and city councils with local planning roles and responsibilities:

- Breckland District Council
- Broadland District Council
- Great Yarmouth Borough Council
- Borough Council of King's Lynn and West Norfolk
- North Norfolk District Council
- Norwich City Council
- South Norfolk Council
- East Suffolk District Council (covers the Waveney area of the Norfolk and Waveney ICS)

The Broads Authority is a statutory body established in 1989 with a duty to manage the Norfolk and Suffolk Broads, it is also a local planning authority and is the sole planning authority in relation to land within the Broads.

Norfolk County Council and Suffolk County Council (for the East Suffolk area) are responsible for determining planning applications related to mineral extraction, waste management facilities and developments by the County Councils. Although planning applications associated with these matters fall outside the scope of this Protocol, the health and wellbeing implications of minerals and waste developments are nevertheless important considerations.

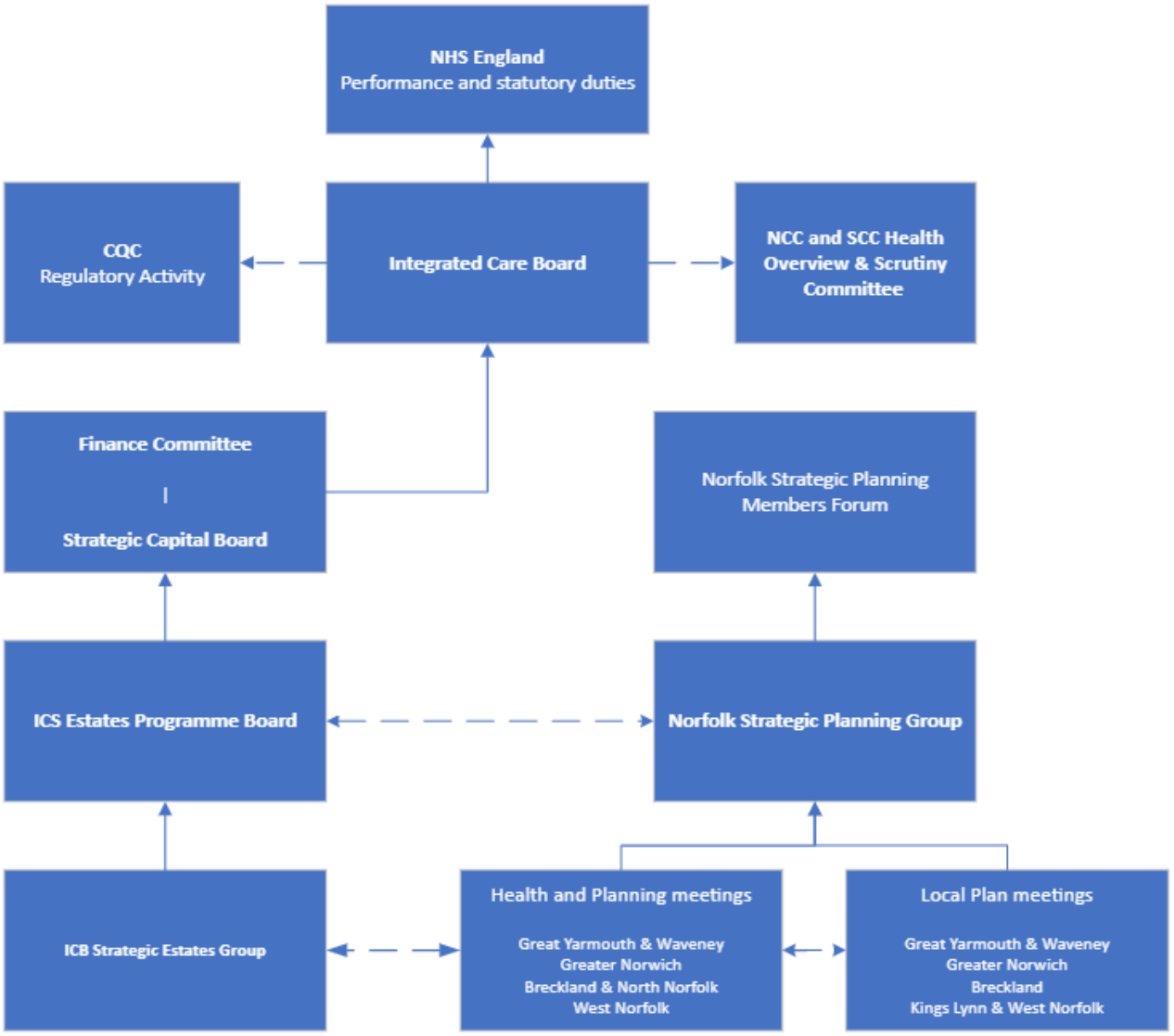
One Public Estate (OPE)
One Public Estate is an established national programme delivered in partnership by the Office of Government Property (OGP) and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious, property-focused programmes in collaboration with central government and other public sector partners. NHS and local authority colleagues will continue to work through the OPE programme to identify and deliver integrated infrastructure solutions that provide additional capacity for the growing demand on our services.

2.4. GOVERNANCE

Collaborative working must continue to underpin the relationships between the ICB and local authorities and the delivery of services to residents. The partnership we have will play a key role in making shared decisions on how to use resources, design services and improve population health.

We will continue to work with local planning authorities and ensure the impacts on health and care services are measured and managed as our population and the requirement for our services continue to grow. The governance structure below illustrates how and where the process behind the protocol is managed.

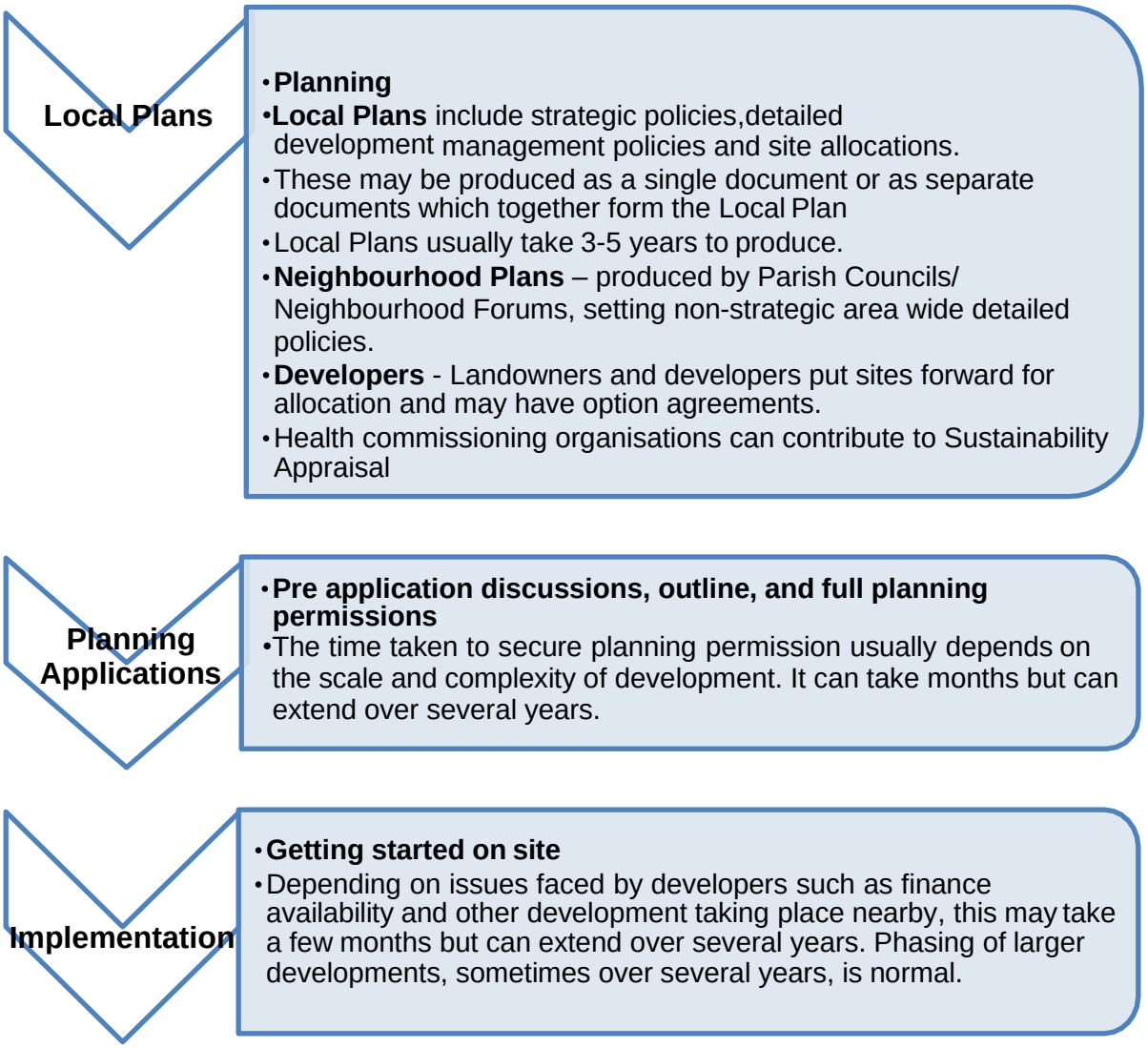
Figure 4: Structure for managing the engagement and working of this protocol.



3. THE PLANNING PROCESS – KEY STAGES

There are three key stages in the town planning process (illustrated in figure 5 below): plan making, planning applications and implementation.

Figure 5: The key planning stages for building development



3.1. PLAN MAKING

The 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 and through site allocations and detailed development management policies. These may be supported by detailed Neighbourhood Plans, with the latter combining with the Local Plan to form the development plan for the local authority area.

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 Parish and/or Town Councils), 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 and safe communities (Chapter 8) and requires Local Plans to have strategic policies which aim to achieve healthy, inclusive, and safe places (para.92)

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 healthy lifestyles and providing necessary health service infrastructure. This is an opportunity to ensure LPAs 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 Public Health and wider health commissioners 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 (HIA) to be undertaken by developers of larger scale housing developments, defined according to current guidance on HIA use in the planning process. In addition, local planning authorities have a 'duty to align and cooperate' on plan making. This advises them to work with prescribed bodies including ICSs and NHS England, as well as other local authorities, to cooperate onstrategic cross boundary matters such as health infrastructure.

3.2. 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. The revised 2023 NPPF also enables housing to be developed if there is no demonstrable supply of a five-year land supply for housing or previous three years delivery was 75% or less of the housing requirements of an area. 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 appeals 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 reserved matters 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. 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 then take place.

3.3. 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 market conditions, site costs, access to finance and the availability of construction staff or materials.

4. PROCESS FOR HEALTH COMISSIONERS ENGAGEMENT IN PLANNING

The process for health commissioners' engagement with the planning process is set out in detail below and is also summarised in Figure 6 at the end of this section.

4.1. PLAN MAKING

The extensive consultation that takes place on plan making provides the most significant opportunity for health partners including the ICS to use their expertise to ensure that Local and Neighbourhood Plans reflect national and local health priorities adequately.

During the preparation of their Local Plans the respective LPAs will need to consult all statutory and other agreed health[2] and social care consultees and at "Regulation 18 and 19" statutory consultation stages. Each of the groups of organisations will be responsible for responding on their own behalf in a manner which meets the deadlines for the planning process.

To meet 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 and East Suffolk have made available provisional figures, based on demographic modelling, for likely annual and long-term population growth in each area. This evidence assists both Local Plan making authorities and the relevant healthcare commissioning body and ICS 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 place level and is not intended to be site specific as it is the role of the relevant healthcare

[2] There will be a single point of contact for NHS / health engagement via the ICS Estates' Group –see below

commissioning body and ICS to determine how best to address the health care needs resulting directly from specific new developments. However, updated data will in the future be publicly available online which will, along with an improved understanding of the implementation of new housing schemes, provide a valuable evidence base to assist healthcare planners and commissioners in planning for health needs in the medium and long term.

The ICS Strategic Estates Infrastructure Development Plan (IDP) has been formed to provide a strategic overview exploring the health infrastructure needs arising from population growth proposed in local plans.

For the purposes of the IDP, infrastructure relates to medical facilities and other health and social care facilities as defined in the Planning Act 2008 as a type of infrastructure that can be funded by the Community Infrastructure Levy (CIL).

Investment in the county's health infrastructure is essential to cope with the proposed scale of growth identified in local plans and the Strategic Health Asset Planning and Evaluation tool (SHAPE) used by the ICB, and Community Infrastructure Levy (CIL) and Section 106 (S106) housing developer contributions can contribute towards and help fund and support the development of new and improved healthcare infrastructure.
In determining which projects CIL or S106 could help fund it is important to recognise that CIL monies can be spent on the provision, improvement, replacement, operation or maintenance of infrastructure, or anything else that is concerned with addressing demands / impacts that a proposed development places on health care in that area. Whereas S106 monies are agreements usually specific to a certain project.

The IDP informs the identification and determination of investment priorities across the Norfolk and Waveney Integrated Care Board (ICB) and its health partners. The IDP will evolve over time to reflect the changing housing landscape across the various local planning authority areas with updates being made on an annual basis.

The IDP contains various information sections covering a sites general information, its current status with regards to capacity, potential or planned development, future status once a project is realised, and the financial information to accompany the project.

In addition to this, health partners will use comprehensive health planning tools which provide detailed information on health estate, travel times to services, clinical indicators such as prevalence, GP workforce data, and mapping future housing trajectories. 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.

4.2. PLANNING APPLICATIONS

While Norfolk County Council and Suffolk County Council Public Health are informed of planning applications for larger housing developments (typically 10 or more dwellings or of an area of 1 hectare or greater) 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 and East Suffolk gaining input on housing developments not only from Public Health, but also from relevant health service planning and commissioning bodies. The ICS Strategic Estates Groups role as coordinator between local planning authorities, health partners and the ICS will assist both in ensuring that development is planned to enable healthy lifestyles and allow

service delivery to be planned effectively. Guidance is offered nationally on some considerations on who to engage.

The ICS Strategic Estates' Group[3] will be able to offer a "one stop" approach for planners to engage with the wider health system and garner views on, for example, primary and acute provision, patient needs and direct consultation requests to the ICS. This will not of course preclude individual GP surgeries or other health partners responding on an individual basis.

It is particularly important that Public Health and relevant healthcare planning and commissioning bodies, via the mechanism detailed in this protocol, are consulted on proposals for development aimed at groups in society with distinct health needs such as the elderly and students. The respective LPAs should therefore consult Public Health and health partners on planning applications submitted for housing developments of 50 dwellings or more and for all planning applications 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 any relevant pre-application discussions.
For developments below 50 dwellings which may have an impact upon health services then the ICS Strategic Estates Group should also be contacted for an initial view. Discussions and comments provided on all planning applications will make use of the criteria set out in the Health and Wellbeing Checklist (Appendix 1). Planning officers should make developers aware of this checklist and the benefits of taking account of it in working up housing proposals.

PRE-APPLICATION DISCUSSIONS
Since pre-application discussions are held for most of the larger scale proposals, Public Health and the ICS Strategic Estates Group will be engaged with and comments sought on pre-application proposals in Norfolk for all housing developments of 50 dwellings or more[4], for those including care homes, housing for the elderly, student accommodation and for proposals which would lead to significant loss of public open space. Public Health and health partners may adjust this threshold of 50 dwellings in the future in consultation with the local authority planners. However, during this review (2023) it was still felt to be a suitable threshold.

Active consideration of other developments related to, for example transport and minerals and waste, were considered to be included within the scope of the protocol. However, it was felt that there are existing structures, processes and legislation which cover these types of development.

Some LPAs within Norfolk and East Suffolk are introducing requirements for HIAs to be produced for larger developments and all partners are encouraged to consider broader use of HIAs or similar tools to understand broader health, wellbeing and prevention opportunities afforded by development and to minimise unforeseen circumstances. To this end colleagues have been approached by the Town and Country Planning Association (TCPA) with an offer to provide support to work with all signatories to the protocol about how it may best be supported to work across Norfolk and East Suffolk.

[3] This group has oversight of NHS buildings and other estate and will be able to access tools to map and plan for future growth with a specific health perspective. From 2018 it has agreement to act as a conduit for cross-county NHS service engagement

[4] See the comment above about developments below 50 dwellings which may require an initial view from the ICS Estates' Group

Pending revised tools and guidance the current Appendix 1 is to be retained to help support existing plan making and development requirements to build wider determinants of health into the planning process.

Engagement in pre-application discussions will, in many cases, be the most important stage of involvement in the planning application process as it enables Health and Social care partners and Public Health to influence the design principles of development at its earliest stage.

OUTLINE PLANNING APPLICATIONS

Consultations on outline applications provide an excellent opportunity for health partners and 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 health and Public Health to gain further knowledge of the scale and likely timescale for delivery of housing. They also provide an additional opportunity for NHS consultees and 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.

It is at this stage that the ICS Strategic Estates Group will have the detail and the opportunity to model the proposed development through the HUDU tool and provide details within the written response from the outputs of the modelling.

HUDU TOOL

The HUDU model was developed by the Healthy Urban Development Unit in London, it is a nationally recognised modelling system and is licensed by HUDU for use within the NHS. It is a comprehensive tool for assessing and forecasting the additional health service requirements and cost implications of new residential developments.

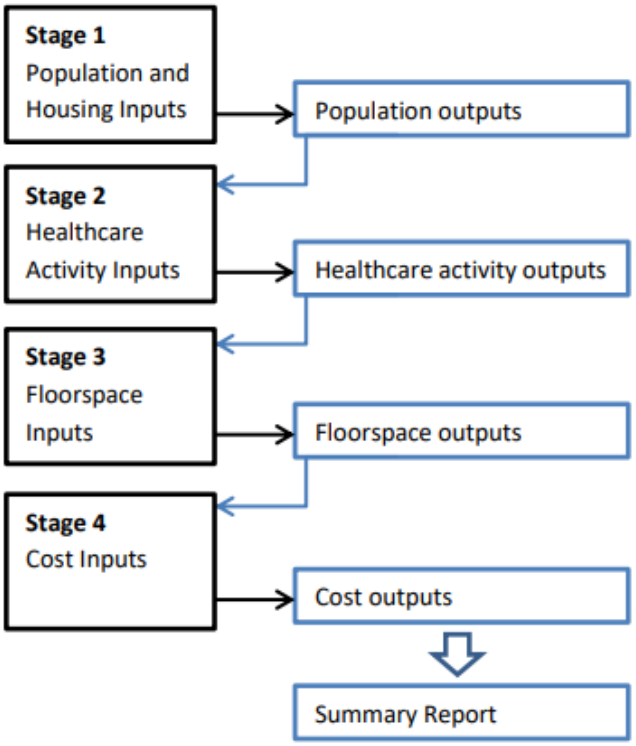
It is a transparent and standardised approach to calculate developer contributions required to mitigate the impact housing developments have on healthcare. This is in the form of capital costs for schemes such as new build facilities, extensions, reconfigurations, or refurbishments. Revenue costs are not requested as part of the modelling.

The model uses a range of assumptions based on the most up to date information available. However, users can manually adjust or input new assumptions where data exists, such as population figures for the county and health related information.

Outputs from the modelling provide information on:

- The net increase in population resulting from the specific housing development in question
- Primary healthcare needs (GP and community health facilities)
- Acute beds and floor space requirements
- Mental healthcare beds and floor space requirements
- Intermediate Healthcare beds and floorspace requirements
- Capital cost impacts (per provision type)

How HUDU works:
The HUDU model uses a step-by-step approach whereby the user progresses through the screens and calculations in sequence, with outputs generated at the end of each stage.



Data sources and metrics used within HUDU, along with an example summary report that captures the four output areas shown above and highlights the impact of population growth from a specific development can be found at Appendix 3.

FULL PLANNING APPLICATIONS
Consultation on a full planning application is the final opportunity for health partners and Public Health to influence development proposals. As this is late in the planning process, there will be limited scope for change, highlighting the importance of consultation on outline planning applications. The relevant health authorities, and Public Health will, if deemed appropriate, 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 health and social care partners, Public Health, United Kingdom Health Security Agency, NHS England Area Team and NHS Estates if required, and the ICS, on the initial results of modelled output. The criteria set out in the Health and Wellbeing checklist (see Appendix 1) will be used as the basis of detailed comments.

The written response from health and Public Health will be reported in the planning officer's report. Where health partners and 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. Legislation and national planning policy requires ongoing engagement between local planning authorities.

4.3. IMPLEMENTATION

Where developer funding is considered appropriate towards health provision associated with new residential development and is in line with the Community Infrastructure Levy Regulations (2010 as amended), this will normally be secured either through Planning Obligations; and/or Community Infrastructure Levy funds. Local Authorities will need to record any such funding arrangements in their annual Infrastructure Funding Statements (IFS).

Since the timing of the implementation of schemes granted planning permission cannot be guaranteed, it is especially important that both Public Health and health commissioners have access to the best available information on delivery that the LPA 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 appropriate mechanism should be in place for each AMR to be shared by the LPA with the ICS. It is suggested that there will be an annual meeting between partners to this protocol to consider the data within the AMR and review how well the protocol is working.

There are several existing meetings at different geographical levels which include planners, NHS colleagues and Public Health. The protocol will not prescribe the form and function of these but recommends a range of engagement processes to meet a wide range of information and consultation needs.

4.4. CONTACT DETAILS FOR PROTOCOL USE

NHS ICS Estates:	nwicb.icsestates@nhs.net
Norfolk County Council Public Health:	phplanning@norfolk.gov.uk
Suffolk County Council Public Health:	phplanning@suffolk.gov.uk

Figure 6: Summary Table – The Involvement of Health and Norfolk Public Health in the Planning Process

<table>
<tr><td colspan="2">1. Plan making
Extensive consultation over a significant period provides the opportunity for Health and Social Care partners and Public Health to ensure that Local Plans reflect national and local health strategies andpriorities and address infrastructure needs;
Health partners and Public Health to take account of Local Development Schemes and ensureevidence is available for consideration by plan makers.</td></tr>
<tr><td colspan="2">2. Planning applications
Health and Social care partners and 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.
LPAs will also consult on those sites less than 50 dwellings where there is likely to be cumulative impact (exceeding 50 dwellings) when considered with other contiguous application/s or applications close by.
Health partners and Public Health comments to focus on ensuring development will enable healthy lifestyles and allow service delivery to be planned effectively.</td></tr>
<tr><td rowspan="2">Pre-application discussions</td><td>Health partners and Public Health will attend meetings asappropriate and provide comments on all pre-application proposals consulted on, when resources allow.</td></tr>
<tr><td>Where HIAs are required, discussions should include its scope and nature.</td></tr>
<tr><td rowspan="2">Outline planning applications</td><td>Health partners and Public Health will provide comments on all pre- application proposals they are consulted on; usually only large complex proposals are included in outline phase.</td></tr>
<tr><td>Enables health partners and Public Health to enhance their intelligence on the scale and time frame for housing developments and to influence the form of development.</td></tr>
<tr><td rowspan="2">Full planning applications</td><td>Final opportunity for health partners and Public Health toinfluence development proposals.</td></tr>
<tr><td>Through the appropriate mechanism, health partners and 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 extensiontime. Response will be reported in the planning officer's report.</td></tr>
<tr><td colspan="2">3. Implementation
Health partners and Public Health provided with best available information on implementation from the LPAs through their published AMRs and attendance at bi- annual Local Plan meetings with the respective LPAs.</td></tr>
<tr><td colspan="2">4. Accountability
Public Health will report to the Health and Wellbeing Board annually, on a 'need to know basis'.</td></tr>
</table>

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 wellbeing. 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 wellbeing 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 wellbeing.

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 wellbeing through the local planning system are implemented across Norfolk.

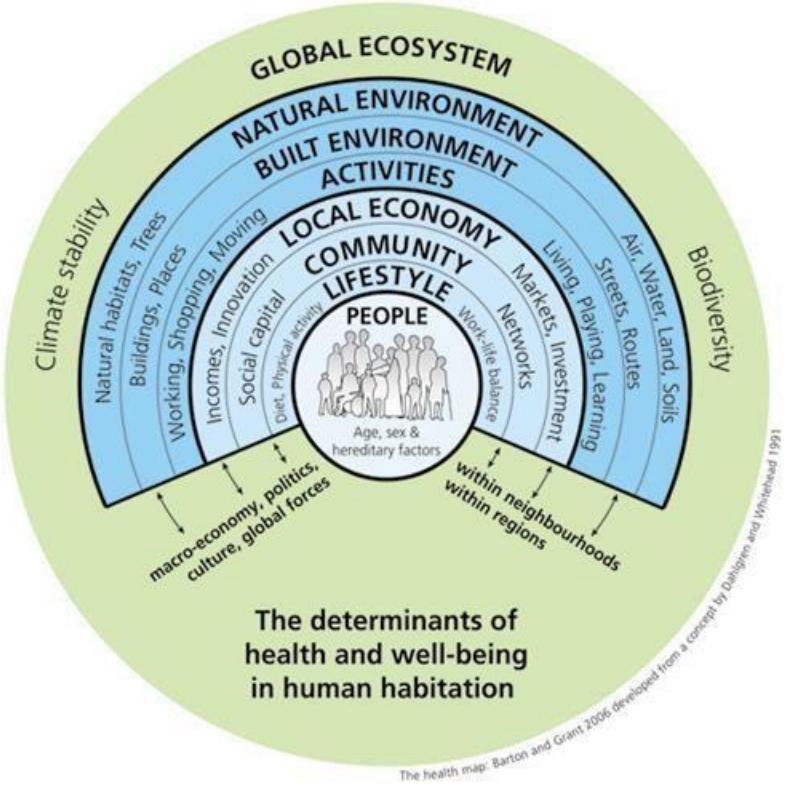
The collaboration between the Norfolk and Waveney ICS, Public Health, and local planning authorities in following this documented process provides an opportunity to share expertise between the sectors and to support the healthy growth across the communities of Norfolk and East Suffolk. Through the use of the health care requirements modelling tool, it will also assist in the long-term strategic planning of health service infrastructure.

Appendix 1 A Healthy planning checklist for Norfolk and East Suffolk

A HEALTHY PLANNING CHECKLIST FOR NORFOLK

The links between planning and health are long established. The Health Map [5] 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[1] and the Royal Town Planning Institute (RTPI) Principles for Healthy Communities[1]. 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

[5] 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 2006126: 252-253,

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.		Planning Policy Guidance, who are the main health organisations a local authority should contact and why? National Planning Policy Framework Chapter 8. National Planning Policy Framework - GOV.UK (www.gov.uk) Healthy and safe communities - GOV.UK (www.gov.uk) National Design Guide – Chapter U3 (social inclusivity)	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 Chapter 15 and e.g. paragraph 174(e) National Planning Policy Framework - GOV.UK (www.gov.uk) National Design Guide – Chapters R1, R2, R3 (Resources)	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 promotes 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.		Planning Policy Guidance. How should health and well-being and health infrastructure be considered in planning decision making? National Planning Policy Framework paragraph 20, 92c, 93 National Planning Policy Framework - GOV.UK (www.gov.uk) Healthy and safe communities - GOV.UK (www.gov.uk) Planning Policy Guidance, what is a healthy community? How can planning create a healthier food environment? Healthy and safe communities - GOV.UK (www.gov.uk) National Design Guide Chapter U1 (mix of uses)	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 (such as health, education, and cultural infrastructure) 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 good dietary behaviour

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.		National Planning Policy Framework Chapter 8 Promoting healthy and safe communities National Planning Policy Framework - GOV.UK (www.gov.uk) National Planning Policy Framework Chapter 9 Promoting sustainable transport National Planning Policy Framework - GOV.UK (www.gov.uk) Helping to create 'active environments'. Active Design Guidance Safe, sustainable development aims and guidance notes for local Highway Authority requirements in Development Management, Norfolk County Council. Highway Guidance for Development	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.		National Design Guide Chapters M1, M2 & M3 (movement)	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 Chapter 12 Achieving well-designed places National Planning Policy Framework - GOV.UK (www.gov.uk) National Design Guide Chapters H1, H2, H3, L2, & U2	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 can 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 thewhole 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 is 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.		National Planning PolicyFramework Chapter 6 Building a strong, competitive economy National Planning Policy Framework - GOV.UK (www.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.

Appendix 2 Homes England – Fact Sheet 4: New homes and healthcare facilities

This fact sheet from Home England helps highlight how new homes affect demand on GPs, what other factors influence demand for local healthcare services, the links between the quality of homes and health outcomes, and how the impact of new homes on local healthcare facilities is considered.

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homes_and_healthc

Appendix 3 HUDU Data Sources and Example Summary Report

This appendix highlights the data sources used in the HUDU modelling tool and provides an example summary report based on a 600-dwelling development.

In this example, we highlight the 600-dwelling development would result in

- a net population growth of 1,055 residents
- a need for 3.88 beds across acute, mental health and intermediate care
- a need for a further 1.11 clinical rooms in primary care
- a need for 289.62 square metres of additional floorspace across all healthcare services
- a capital investment of £2.6m to provide this additional floorspace *(note: this example is based on new build costs)*

Appendix 3 -
HUDU_Summary_Re

Appendix 4 Demand and Capacity Metrics

The HUDU tool, the stages within, and how we use the model to calculate the impacts from specific housing developments, on healthcare services, is covered within the protocol and additional detail on the data sources used can be found at Appendix 3. However, as well as understanding the future impacts from a specific development, we also need to understand the existing demand and capacity across these services. There is a number of defined metrics used in order to achieve this and highlight what appropriate levels of capacity look like; these are.

- Patients (weighted) per GP (including GPs in training) – **1,800.**
- Patients (weighted) per metres squared (GP estate) – first **6,000** patients require **500m2**, every **6,000** patients thereafter require **250m2.**
- *Patients per Dentist (as well as other primary care services) – currently being established.*
- Inpatient bed occupancy rates – **85%.** (anything over this and resilience, safety and efficiency are all at risk = additional capacity required)

To improve transparency during planning consultations, the ICB will include tables such as the below in its written responses. This will highlight the existing demand and capacity within local healthcare settings, plus the additional demand from the development being consulted upon. We will also indicate any projects planned to rectify any areas of constraint and provide the additional capacity required.

Primary Care Workforce	Registered Patients (weighted)	Patients per GP (weighted)	Additional Patients (weighted)	Future patients per GP (weighted)
General Practice 1	18,000	1,636 *(11)*	1,350	1,759
General Practice 2	12,000	2,000 *(6)*	1,255	2,209
Dental Practice 1				

Primary Care Buildings	Current NIA (m2)	NIA required for registered patients (weighted)	Current NIA Surplus/Deficit (m2)	Additional NIA required (m2)	Future NIA Surplus/Deficit (m2) (without mitigation)
General Practice 1	1,200	1,000	200	100	100
General Practice 2	500	750	-250	25	-275
Dental Practice 1					

Hospital Buildings	Latest Bed Occupancy Rate	Additional Bed Demand
Acute Hospital X	95%	2.11
Community Hospital Y	98%	0.06
Mental Health Hospital Z	86%	1.53