NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Cambridgeshire
County Council

New Housing Developments and the Built Environment JSNA

2015/16

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EXECUTIVE SUMMARY

DEMOGRAPHY

Cambridgeshire was the fastest growing county authority between 2001 and 2011 and isexpected to continue to grow. The number of people living in the county is expected to increase from 627,000 in 2012 to 769,000 in 2031.

This forecasted 25% increase in the size of Cambridgeshire's population (to just over 800 thousand) over the next 20 years linked to the expected changing demographic shape of the county are key considerations for health and social care service providers, local authorities, developers, the voluntary and community sector.

A common emerging development across the districts is the rapid growth of the older population, and its increasing share of the total population over the next 20 years. The over 65s are forecast to grow by almost 80% between 2013 and 2036, within this the over 90s to grow by more than 250%, from 5,600 to 19,700.

Summary – key demographic and health data

- It is estimated that there are 627,000 people living in Cambridgeshire, with a bulge seen in 40-49 year olds, which is due to high births in the 1960, and a higher number of 60-69 year olds are the post war baby boomers.
- Forecasts suggest that the population of Cambridgeshire is set to increase by 25% over the next 20 years, with the majority of the increase seen in Cambridge City and South Cambridgeshire. This is associated with a forecast increase in the number of new dwellings between up to 2036 of 73,000.
- Population trends in the GP Practice populations serving new developments show a steady increase each year from 2006 to 2015, except the Bar Hill Practice, which has remained constant indicating that the population in Bar Hill has matured and is settled.
- The age profile breakdown for GP Practice populations serving new developments show the that majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.
- The average household size in new developments ranges from 2.6 to 2.8.

THE BUILT ENVIRONMENT

Place and space have an impact on health and wellbeing and individual actions to improve lifestyle or health and wellbeing status are likely to be influenced by the environmental and socioeconomic context in which they take place. The term "built environment" includes open space, networks and connectivity between areas as well as the physical structures. This includes the places where people work, live, play and socialise. The connections between these spaces, both manmade and natural features are also important. The built environment includes several material determinants of health, including housing, neighbourhood conditions and transport routes, all of which shape the social, economic and environmental conditions for which good health and wellbeing is dependent.

There is strong evidence that the following aspects of the environment affect heath and wellbeing:

- Generic evidence supporting the built impact on health
- Green space
- Developing sustainable communities
- Community design (to prevent injuries, crime, and to accommodate people with disabilities)
- Connectivity and land use mix
- Communities that support healthy ageing
- House design and space
- Access to unhealthy/“Fast Food”
- Health inequality and the built environment

The planning system involves making decisions about the future of cities, towns and the countryside. This is vital to balance the desire to develop the areas where we live and work with ensuring the surrounding environment isn't negatively affected. It includes considering the sustainable needs of future communities.

In order to ensure health impacts are assessed and successful outcomes are achieved, the opportunities to include health related policies in local planning policy documents and local planning guidance should be sought.

The main findings from both the evidence and the review of the five local plans within Cambridgeshire show that:

- There is a lack of consistency across the Local Authority Local Plans with regard to the inclusion of policies to improve health. The main policies to include in future local plans need to focus on green infrastructure, active travel, suicide prevention, Health Impact Assessment requirements.

- There is a lack of consistency and understanding on the funding of Primary Care facilities and securing Community Infrastructure Levy/Section 106 funding.

- Importance of accessible green space and parks, which need to be designed to maximise potential use. There is a need for an open spaces specific design code to complement the policies on open space within Local Plans, design code should cover provision of paths, cycleways and unstructured routes through and to the green space, provision of toilets and other facilities.

- The importance of providing infrastructure to enable people to make more active travel choices.

- Securing what can be perceived as “nice to have” infrastructure as part of the overall design of new development to support healthy ageing, e.g. street furniture, public toilets.

- The need to consider suicide prevention and public mental health as part of the design of high rise private and public buildings to limit their access and opportunities for suicide.

- The NHS Local Estates Plan should be reflected in the District/City Councils local plans and Infrastructure Delivery Plans.

SOCIAL COHESION/COMMUNITY DEVELOPMENT

There is a marked difference between those occupying private rented market homes and other tenures in the amount of time those occupiers intend to stay in those properties, with the majority intending to stay less than three years.

The occupiers in new developments show a difference in occupations compared to the working population as a whole with more residents employed in the: managers and senior officials, associate professional and technical occupation sectors and less in the skilled trade, sales and customer service, process, plant and machine, and elementary occupationsectors.

The main findings from the evidence show that the evidence on the need for community development in the early stages of new developments is strong, however, more research is needed locally into the measures of and approaches taken to improve social cohesion and community resilience in new developments, and the funding opportunities available to secure this. In addition, community development work needs to continue to focus on building resilient empowered communities rather than dependent communities. This should be carried out with other key agencies. Responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

ASSETS AND SERVICES

Of the larger new communities in Cambridgeshire, feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. Using data from some of the new communities in Cambridgeshire we have analysed whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services.

From data available, in three of the four new communities there are higher referral rates to higher tier children's services, expected/average referrals to lower tier children's services and very low use of adult social care. For children's services, Orchard Park has very low usage of any children's services at all tiers (data was not available to assess adult social care).

The main findings from the evidence show that a joint strategy is needed to develop a way to engage and attract the leisure market into new communities early in the development. This could be through ensuring the units are built early, opening units at discounted/nil business rate, allowing locals to use the units as pop up shops etc.

Further research to understand the length that referral to Social Services cases are open, and what was the primary reason for referral to better conclude if there are particular social reasons for referrals that can help establish whether new communities are prone to certain social needs.

During the pre-application stage of the planning process, services and the community should be engaged and a working group of people centred support established so that there is a clear co-ordinated effort and communication channels between services and the planning of the new community. This will enable co-ordinate response to planning applications through to service/support delivery. Where possible these groups should be led by the community

whether this is parish council, residents association etc. with support from the local authority. Where the community is not willing or able to lead, the local authority will lead but with a clear hand over strategy for when the community is able to lead. These groups will have engagement from the widest group of services (but not necessarily attending physically) and agree, achievable action and communication plans

Additional support to be provided to schools to enable them to deal with the additional challenges that new community schools can expect to face. Ensure that during the selection process these challenges are clearly detailed and ask how the prospective sponsor of the school would face these challenges and work with the community to help secure positive outcomes for all new community schools.

Provide incentives to attract full day care/early years providers to developments, such as free plots of serviced land etc.

Further research into categories of crime committed and to look into other new communities and compare them to the rest of the county.

NHS COMMISSIONING

The NHS Commissioning landscape is complex with commissioners at different levels (from local to regional to national) commissioning different services which make up the NHS.

The main findings from the evidence show that the current engagement between Planning Authorities, CCG and NHS England need to be strengthened, with NHS England and the CCG needing robust cases when seeking Section 106/CIL contributions with a defined need and costed solution. In addition all health partners including Primary Care Practices are consulted on planning applications. and health partners should come together at the earliest opportunity to discuss needs at strategic sites.

1. INTRODUCTION

1.1. CONTEXT – WHAT IS THE BACKGROUND TO THIS JSNA?

1.1.1 What is the scale of growth across Cambridgeshire?

Table 1: Cambridgeshire and Districts population estimates mid-2013 (Totals may not add due to rounding))

Local Authority Area	2011 census	2012 Mid-year estimate	2013 Mid-year estimate	% Change 2011-2013	% Change 2012-2013
Cambridge City	123,900	126,500	128,000	3.3%	1.2%
East Cambridgeshire	83,800	84,700	85,600	2.1%	1.1%
Fenland	95,300	95,600	95,600	0.3%	0.0%
Huntingdonshire	169,500	171,100	175,700	3.7%	2.7%
South Cambridgeshire	148,800	149,300	150,200	0.9%	0.6%
Cambridgeshire	**621,200**	**627,200**	**635,100**	**2.2%**	**1.3%**

Source: CCC R&P 2013 mid-year estimates & ONS 2011 Census figures

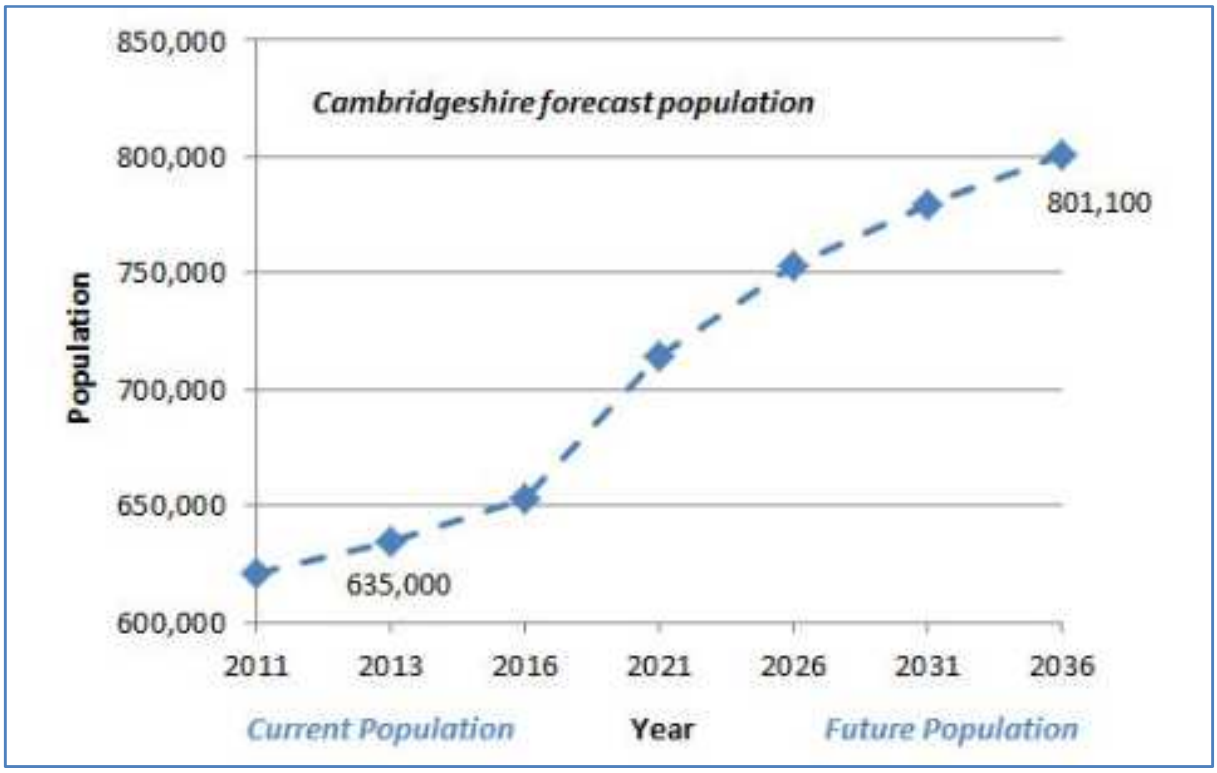
Cambridgeshire was the fastest growing county authority between 2001 and 2011 and isexpected to continue to grow. The number of people living in the county is expected to increase from 627,000 in 2012 to 769,000 in 2031.

This forecasted 25% increase in the size of Cambridgeshire's population (to just over 800 thousand) over the next 20 years linked to the expected changing demographic shape of the county are key considerations for health and social care service providers, local authorities, developers, the voluntary and community sector to name but a few.

Cambridgeshire's settlement pattern is dominated by Cambridge City, which accounts for 20% of the county's population. Most settlements are small, with only 19 of Cambridgeshire's 238 parishes (including Cambridge) having populations larger than 5,000 residents, and only 10 cities/parishes with more than 10,000. Three fifths (60%) of Cambridgeshire's population live in those 19 parishes

The 2013 mid-year estimates show that the development in the new parish of Cambourne now places it above Littleport in order of ranked population size compared to 2012.

Figure 1: The Cambridgeshire Research Group's 2013 mid-year population estimates, along with CRG's forecasts for 2016, 2021, 2026, 2031 and 2036



Source: Cambridgeshire County Council Research Group

The population pyramids for each of the five districts, Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire, show some variations across the districts, notably a higher population in their 20s in Cambridge City (due to the high numbers of students and young professionals). A common emerging development across the districts is the rapid growth of the older population, and its increasing share of the total population over the next 20 years. The over 65s are forecast to grow by almost 80% between 2013 and 2036, within this the over 90s to grow by more than 250%, from 5,600 to 19,700.

The growth in the working age and children sectors is forecast to be less dramatic. This means the dependent population's share of the total population is growing whilst the working age population's proportion of the total is shrinking.

- The rise in the number of births in recent years is reflected in the higher numbers of under 5s.
- The bulge seen in 40-49 year olds is due to high births in the 1960's.
- The higher number of 60-69 year olds are the post war baby boomers.
- The county is seeing a significantly ageing population (the extent of this varies by district).
- The pyramid for Cambridge City is different to other districts. This is predominantly due to a high student and young professional population (20-24 years).

Population pyramids for the five districts within Cambridgeshire are available at http://www.cambridgeshireinsight.org.uk/poppyramids

1.1.2 Where is the growth happening?

Table 2: Number of New Houses from the District Council's Local Plans

Local Authority	Number of new dwellings	Local Plan Period	SMHA Requirement	Comments
Cambridge City	14,000	2011-2031	14,000	Greater Cambridge Area (City and South Cambs) total is 33,500
South Cambridgeshire	19,500	2011-2031	19,000	500 added following consultant's study
East Cambridgeshire	11,500	2011-2036	13,000	Shortfall addressed by Peterborough area
Huntingdonshire	17,000	N/A	17,000	Local Plan not yet submitted
Fenland	11,000	2011-2031	12,000	Shortfall addressed by Peterborough area
Cambridgeshire	73,000			

This growth is happening across the county, most of which is happening in the south of the county.

Table 3: Major Growth Sites across the county

District	Site Name	Number of Dwellings	Status
Cambridge City and South Cambridgeshire	Cambridge North West	up to 3,000	Primary school opened September 2015.
	Darwin Green 1 & 2	• DG1 - 1593 • DG2 - 1100	Darwin Green 1 granted outline permission and s.106 signed
	Southern Fringe	4,100	Building work started, and occupation started for Trumpington Meadows site Due for completion 2028
	WING	Up to 1,300	Awaiting viability assessment prior to Planning Committee
South Cambridgeshire	Northstowe	up to 10,000 (phase 1 - 1,500)	Phase 1 granted outline planning permission Work on infrastructure has started Phase two outline permission granted (subject to signing of s.106 agreement).
	Cambourne West	2,350	Application has been submitted
	Bourn Airfield	3,500	Site in proposed Local Plan Planning Application expected2016
	Waterbeach	Up to 9,000	Site in proposed Local Plan Early consultations started

Huntingdonshire	Alconbury Weald	Up to 5,000	First occupations due summer 2016
	Wintringham Park and Loves Farm 2	up to 2,800 and 1,020 at Loves Farm 2	Application approved subject to signing Sec 106 No timescales for Loves Farm 2
	Wyton	4,500	Application expected2016
	Bearscroft	753	
East Cambridgeshire	Ely North	up to 3,000 across two sites	First phase of 800 homes approved
Fenland	Hatchwood Park, March	1,450	
	Hallam Land, Chatteris	1,000	

1.1.3 House Prices and Affordability in Cambridgeshire

Affordability of housing is a key issue for Cambridgeshire, those people on lower incomes find it particularly hard to access the private housing market. This is due to a number of factors including changes to benefits, availability of homes that are in the right location and of the right type. This includes many households that form key staff for organisations providing health, social care and service industries.

The highest average house price in Cambridge of £483,000(1) is up by £50,629 compared to September 2014. South Cambridgeshire saw a slightly bigger increase, up by £50,790, and the average rise across England in the past year was more than £20,000, the East of England was more than £26K.

There is a pattern of higher prices in the south and the west of the Cambridge sub-Regional Housing Board (CRHB) and lower to the north and east.

The Cambridge sub-Regional Housing Board (CRHB) area consists of: Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire, South Cambridgeshire, Forest Heath and St Edmundsbury.

The average prices used are based on sales and valuation data using prices averaged over the previous six months.

Average prices over time inCambridge and South Cambridgeshire are noticeably higherthan in other districts, and rising more quickly. The trendsfor England and the region are very similar.

Ratio of House Price to Income
This data is based on Hometrack's house price data (both salesand valuations) and CACI data on household incomes.

The ratios show, on average, how many "times" income the localhouse prices represent. One common rule of thumb is that houseprices of 3 to 3.5 times income are considered affordable. In general, homes are less affordable in thesouth and the north-west of the area. There is a wide variationacross the districts. This points out that district-wide figuresmask the

local variations at ward level. Allratios are well above the “rule of thumb” 3 to 3.5 times income,and in general are worsening.

Cambridge sees the highest ratios, where the median house price was 11.5 times the median income, there is not a linear relationship between income and house prices with the lower quartile house price was 17.1 times the lower quartile income, meaning that lower a households income the greater the ratio. Lowest ratios were seen in Fenland with median house price 6.0 times median income.

Table 4: Median house price to income ratio at September 2015

District	Number of times higher
Cambridge City	11.9
East Cambridgeshire	7.3
Fenland	6.2
Huntingdonshire	6.4
South Cambridgeshire	8.2

Source: Cambridge Sub-Region's Housing Market Bulletin, Issue 26 (Hometrack)

Affordable Housing Need

The overall net need for affordable homes per year

District	Affordable housing need 2011 to 2031 (based on 2011/12 data)
Cambridge City	14,418
East Cambridgeshire	3,517
Fenland	3,527
Huntingdonshire	7,212
South Cambridgeshire	9,011

Map 1: Average House Price by Ward

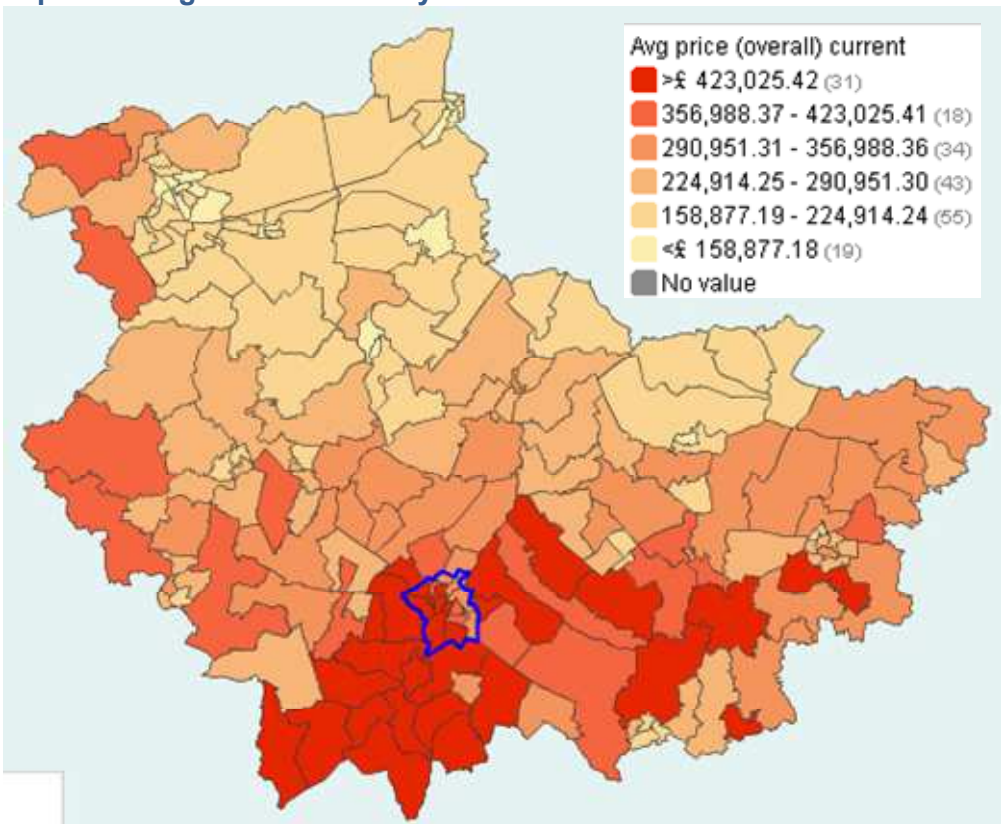
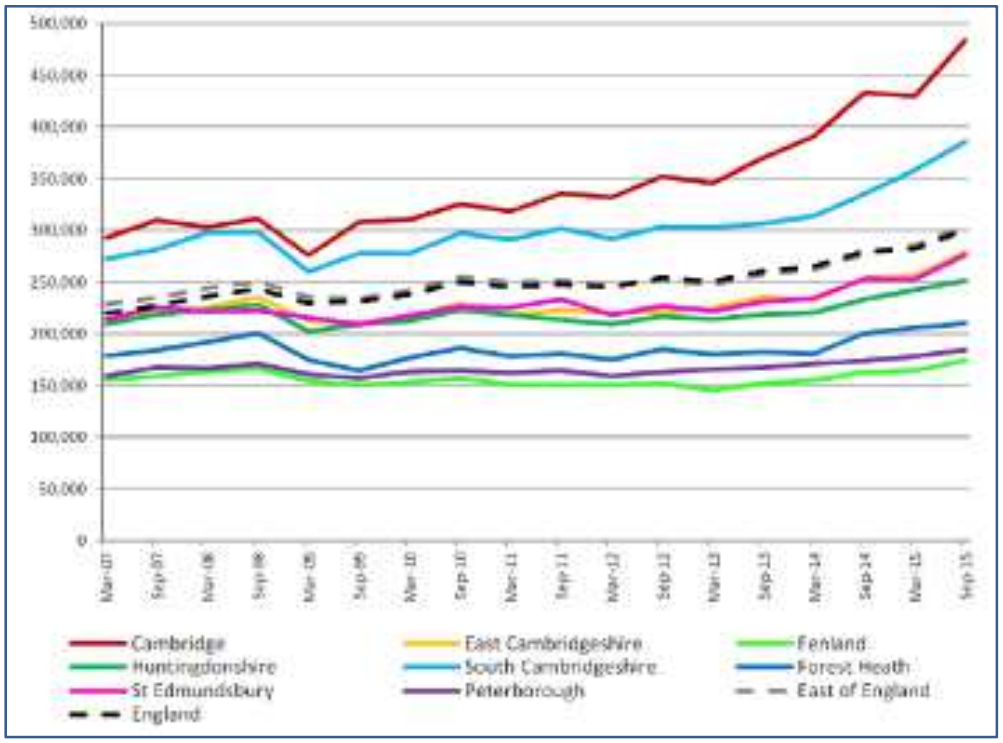


Figure 2: Trends in average house prices



The Cambridge housing sub-region is an area of economic success with a continued record of housing delivery and even during the recession homes continued to be delivered. Although this delivery tells a positive story, there are consequences when housing pressure in an area leads to problems with access and affordability, in urban, market town and rural communities.

More housing information can be found in the Housing & Health JSNA and on the Housing Pages on Cambridgeshire Insight:

http://www.cambridgeshireinsight.org.uk/housing-jsna-2013

http://www.cambridgeshireinsight.org.uk/housing

Some parts of the area feel other kinds of pressure, where land values are lower and new development is harder to get off the ground. The strategic housing market assessment and regular housing market bulletins track changes in the market and compare local areas to the regional and national picture.

The Cambridge functional economic area (which covers the housing sub-region) continues to thrive, both nationally and internationally. The labour market is fairly self-contained, with Cambridge acting as a regional centre of employment. It is a diverse economy with some significant strengths, but some weaknesses too. Housing is both a positive and a negative force within the local economy.

1.1.4 Do housing developments and the environment have an effect on the local health system?

There are two main effects on the local health system which could be attributed to new developments. The first being the pressures the increase in the population has on the Health system, typically new developments see an increased birth rate and demand for maternity services. The second is how the design of the build of a new development can affect the preventative health agenda by encouraging healthy lifestyles and enabling people to remain independent and remain in their own homes for longer.

Cambridgeshire and Peterborough health system was identified as one of the 11 most challenged health economies in England. NHS England, Monitor and NHS Trust Development Authority identified 11 health systems that are particularly challenged as a whole, and were most likely to benefit from intensive support in order to develop plans which would improve outcomes for patients, whilst developing a financially sustainable future for the local health economy.

A healthy well-designed environment can add to the prevention of ill health and aid in improving health and wellbeing, reduce demand on services through enabling healthier lifestyle choices.

1.1.5 What do we mean by “health and the built environment”?

The World Health Organisation (2) defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.” Implicit in the definition is the notion that there are both positive and negative elements of health.

Defra(3)also mentions the connection between positive and negative elements of health and wellbeing. Wellbeing is defined as “a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity.”

Health and wellbeing are therefore related concepts. It has been observed (4) that “health” is generally used in a medical context where the presence or absence of physical and psychological symptoms is used to categorise an individual. “Wellbeing” tends to be used to describe a broader and more encompassing concept that takes into consideration the “whole person”. It aims to capture how a person is flourishing. The social rather than the medical context is relevant in defining “wellbeing”. Indicators that attempt to quantify “quality of life” generally attempt to measure wellbeing.

A “healthy community” would be one that prevented ill-health and promoted wellbeing. Building structures and transport systems that reduce or minimise air and noise pollution have demonstrable health benefits in terms of respiratory illness and stress related conditions. Providing adequate green space can promote physical activity with the subsequent benefits of reducing overweight and promoting mental health. The evidence base for ensuring healthy communities through design and planning is summarised in reports(5)such as “Future Health: sustainable places for health and wellbeing” by the Commission for Architecture and the Built Environment (CABE), and is explored further in Chapter 2 (Built Environment) of this JSNA.

Alongside the physical built environment, another aspect of a new community that is vital to its health is the social environment that has important benefits to physical and mental health, and is the context in which people can flourish. The social environment can be facilitated by the social amenities that are included in a new community such as community buildings but relies heavily on how people work together to achieve good governance and build cohesive and inclusive communities, social cohesion and community assets & services are explored further in Chapters 3 and 4 respectively.

1.2 AIM AND SCOPE – WHY A JSNA ON NEW HOUSING DEVELOPMENTS AND THE BUILT ENVIRONMENT?

The Cambridgeshire Health and Wellbeing Board selected New Communities as a topic for the JSNA programme of work for 2015-16 following feedback from district councils and other colleagues who emphasised the importance of assessing the health needs of new communities, given the scale of housing development in Cambridgeshire. Following a stakeholder event and discussions held at the JSNA steering group the topic was refined to focus on new housing developments and the built environment.

1.2.1 What are the aims of a JSNA for new housing developments and the built environment communities?

The first aim of the JSNA is to gather data and information on the health and wellbeing needs of populations in new developments with a view to informing service provision and commissioning for existing and future development sites within Cambridgeshire.

The second aim of the JSNA is to review the evidence on “designing and building in” opportunities for improving and maintaining health and wellbeing as part of the design of the new developments.

Unlike other JSNAs this JSNA focuses on communities and population groups that do not yet exist, although it does draw on the experience and evidence from existing new communities. While all JSNAs must rely on assumptions about the changes in size and needs of population groups to plan future health and wellbeing needs, these extrapolations are generally based on fairly stable estimates in existing populations.

Every new community is different and while lessons learnt from experiences in one community can inform planning for another there must necessarily be caution in transferring these lessons from one setting to another.

A particular challenge of this JSNA is that each new development poses very different challenges. The largest and most complex such as Northstowe will be built over relatively long periods of time (15+ years). This prolonged period will likely have unpredictable impacts on community identity and cohesion, and in turn on mental health and wellbeing, the "needs" of a new community in year one of occupation are likely to be different from the "needs" at the end of the construction many years later.

Smaller developments also have cumulative impacts on existing communities and infrastructure. It is not always possible to ensure that the relevant infrastructure and services will be available when needed. Health services and facilities must be commissioned at the optimal point. Too early and the facilities are underused and uneconomical; too late and health needs are not adequately met and waiting times increase. In addition, with the pressures on public sector finances there is a need to plan and provide services differently, the model of service provision now may not be "fit for purpose" in 20 years' time.

1.2.2 What is the focus of this JSNA?

Due to the complexity of the various impacts of new housing developments and the built environment on health this, Cambridgeshire New Housing Developments and The Built Environment, JSNA has restricted its focus to the following themes:

- Demography
- Environment
- Social Cohesion and Social connectivity
- Assets and services
- NHS Commissioning

The JSNA is relevant to all priorities of the Health and Wellbeing Strategy 2012-17 although Priority 5: Create a sustainable environment in which communities can flourish is the most relevant.

A scoping paper was submitted and approved by the Health and Wellbeing Board on Thursday 17 September 2015, agreeing the focus on the five priority themes.

A stakeholder workshop was held on 28 July 2015 and was wellattended with approximately 40 representatives from Cambridgeshire County Council, District Councils, NHS organisations, academic groups, Third Sector organisations and Healthwatch. The aims of this workshop were to:

- Capture stakeholders' perspectives on the scope of this JSNA – priorities, questions to be answered and how to approach these.
- Increase awareness and understanding of the purpose of the JSNA.

- Identify stakeholder priorities and “place making” intentions (including commissioning and service delivery.

The workshop was organised into three sessions focusing on:

- Identifying the perceived and actual health and wellbeing needs of a new community in Cambridgeshire.
- Identifying what a successful and resilient community looks like, specifically:
    - What are the local assets – both physical and social
    - Are there any good examples we should be drawing from?
- What should the JSNA contain, specifically:
    - What evidence/intelligence do the stakeholders need in order to plan services in new communities
    - What evidence do stakeholders need to enable healthy design of new communities
    - What evidence do stakeholders need in order to support bids for money in new communities (including Section 106 and Community Infrastructure Levy (CIL) negotiations)

Feedback from this event significantly shaped the specific focus for each theme, and working groups were subsequently created for The Built Environment, Social Cohesion, Assets and Services, and NHS Commissioning. These working groups had significant input from Cambridgeshire County Council (Public Health and Children Families and Adults), District Councils, NHS, Third Sector organisations.

The JSNA, therefore, tries to address the following questions within these themes:

Demography and Health & Wellbeing Needs

- What are the demographic profiles and health and wellbeing needs of existing new developments and can they be applied to proposed new communities, and are these health and wellbeing needs likely to be different depending on the development?
- Where do people who move into new communities move from and how long do they stay?

Built Environment

- What factors contribute to “health and wellbeing” in new communities?
- What can we learn from other new developments in terms of communities that are healthy and resilient?
- How do we “design and build in” opportunities for improved health and wellbeing as part of the design of the new developments, e.g. access and active travel, mental wellbeing, nutrition, opportunities to be physically active etc.?

Social Cohesion and Social Connectivity

- What are the most effective models of community development for building healthy and resilient communities and when should they be deployed?
- How can a community development approach be sustained through the long periods required for communities to mature?
- What do existing new community residents value? – learning from other developments
- What type of Health and Social Care services (including non “health and social care services” which contribute to health and wellbeing e.g. Community Development) need to be provided in New Communities and what models of finance are available?

Assets and services

- What do we know about Health & Social Care utilisation in new communities, and can an analysis of the data show any patterns?
- What assets are currently available in new communities (a Needs and Assets Assessment), and how can we replicate good practice in new and developing communities?

Implications for NHS Commissioning

- What is the current NHS commissioning landscape, and how does this "fit in" with the Local Authority Planning system? To include but not limited to:
    - Pharmacy provision
    - Primary Care
    - Secondary care
    - Dentistry
    - Ophthalmology

The JSNA also contains case studies of new communities locally as illustrations.
Links are made to other relevant JSNAs e.g. Housing and Health, Transport and Health.

1.2.3 Ways of accessing information from this JSNA

This JSNA provides evidence and information on New Developments and the Built Environment and Health in Cambridgeshire and is available as a full report and in separate section reports on the CambridgeshireInsight website (www.cambridgeshireinsight.org.uk/jsna).

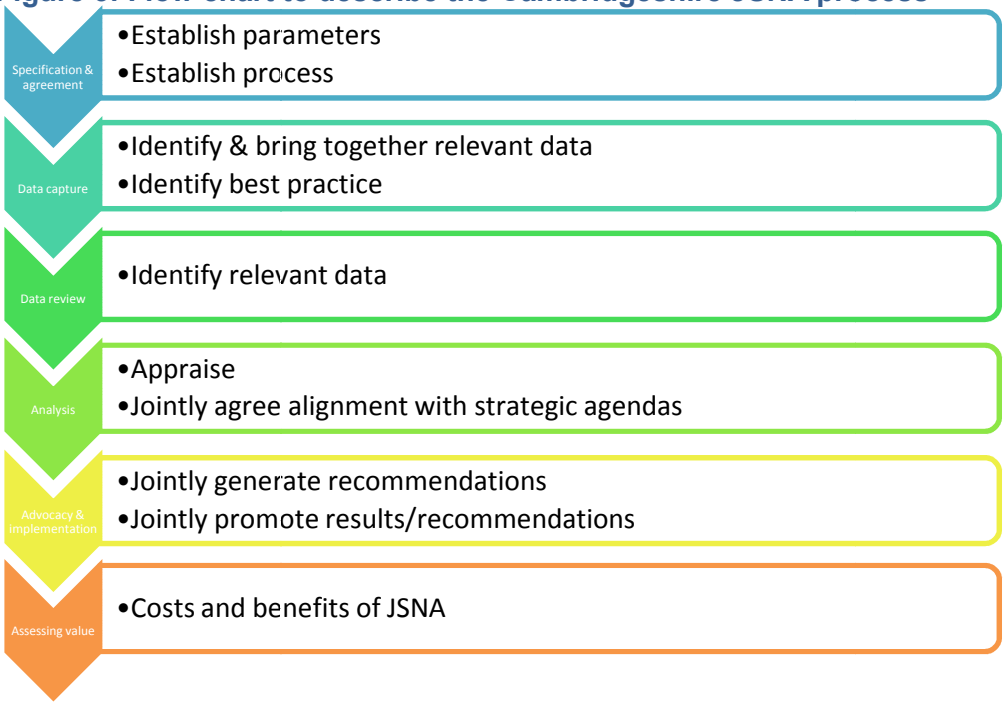
1.2.4 Who should use this JSNA?

This JSNA is intended as a resource of evidence to help developers design and build healthy developments, commissioners of NHS services understand how the "Planning System" operates, Local Authority planning officers in understanding how the NHS Commissioning system works, and how the built impacts health and wellbeing, and by all others with an interest in the built environment, community cohesion and health and wellbeing.

1.3. PROCESS – HOW HAS THIS JSNA BEEN PRODUCED?

There have been several stages in the development of this JSNA (Figure3).

Figure 3: Flow chart to describe the Cambridgeshire JSNA process



1.4. STRUCTURE – HOW IS THIS JSNA REPORT ORGANISED?

Following the agreed scope outlined in 1.2.2 above the JSNA consists of five chapters with case studies. The chapters can be read as standalone documents but are better taken in the context of the complete JSNA.

Chapter 1: **Demography** - provides an overview and context of the new growth in Cambridgeshire; it describes the policies that determine the pattern of housing development, for example, the housing need for the county contained in the Local Planning Authorities Local Plans. This chapter summarises the key demographics for the main growth areas that are being built now along with population forecasts for the new areas of development. The chapter also summarises the main demographics for each primary care practice(s)within these new housing developments.

Chapter 2: The Built Environment - provides a summary review of the evidence of the health implications of the built environment. The chapter outlines the national planning system and reviews the local plans of each planning authority within Cambridgeshire exploring where health related planning policies are contained in the local plans and identifying where they are not.

Chapter 3: Social Cohesion/Community Development - provides a review of the evidence on what the health implication of the social environment are on health, it emphasises some of the 'softer' outcomes for health and wellbeing such as community development and social cohesion. New communities do not develop in isolation from existing communities. The character of new communities is also determined by much more than their

physical infrastructure. Communities continue to develop for decades after building has stopped.

Chapter 4: Assets and Services – reviews the evidence on what are “assets & services” and what is the utilisation of services in New Developments? The chapter examines local referral rates of children and adults to social services in these new developments, and contains examples of good practice.

Chapter 5: NHS Commissioning–provides an overview of the commissioning landscape for the NHS, who are the main players and who commissions what services. The chapter also explores the links between contributions from developers and provision of primary care buildings in new communities, an explanation of which is the detail required under planning law in order to help secure developer contributions.

Chapter 6: Orchard Park Case Study – provides a case study of Orchard Park, on the outskirts of Cambridge, in the form of the results of the South Cambridgeshire District Council Scrutiny Task and Finish Group. This group reviewed the lessons learned from Orchard Park.

DEMOGRAPHY

1. KEY FINDINGS

Summary – key demographic and health data

- It is estimated that there are 627,000 people living in Cambridgeshire, with a bulge seen in 40-49 year olds which is due to high births in the 1960's and a higher number of 60-69 year olds are the post war baby boomers.

- Forecasts suggest that the population of Cambridgeshire is set to increase by 25% over the next 20 years, with the majority of the increase seen in Cambridge City and South Cambridgeshire. This is associated with a forecast increase in the number of new dwellings between up to 2036 of 73,000.

- Population trends in the GP Practice populations serving new developments show a steady increase each year from 2006 to 2015, except the Bar Hill Practice which has remained constant indicating that the population in Bar Hill has matured and is settled.

- The age profile breakdown for GP Practice populations serving new developments show the that majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.

- The average household size in new developments ranges from 2.6 to 2.8.

2. INTRODUCTION

This JSNA seeks to compare Health and Social Care Data from new developments to the Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG) area as a whole to explore any differences with a view to service delivery in new developments.

Six new developments, of different scales,have been compared to the C&PCCG area one of which, Bar Hill, is a settled new community and is a useful comparator to see how the development has matured and changed over time now having a profile similar to the C&PCCG profile.

The new developments are:

- Southern Fringe/Trumpington Meadows (Straddles Cambridge City and South Cambridgeshire).
- Loves Farm (St Neots, Huntingdonshire).
- Orchard Park (Straddles Cambridge City and South Cambridgeshire)
- Cambourne (South Cambridgeshire)
- Bar Hill (South Cambridgeshire)
- Hampton Heath (Peterborough City)

3. MAIN DATA

3.1 PRACTICE PROFILES

This section provides a snap shot of the demographic profiles of the Primary Care practices that serve the new developments of:Trumpington Meadows, Loves Farm, Orchard Park, Cambourne, Bar Hill and Hampton Heath. Where possible the practice profiles have been compared to the Cambridgeshire and Peterborough CCG profile.

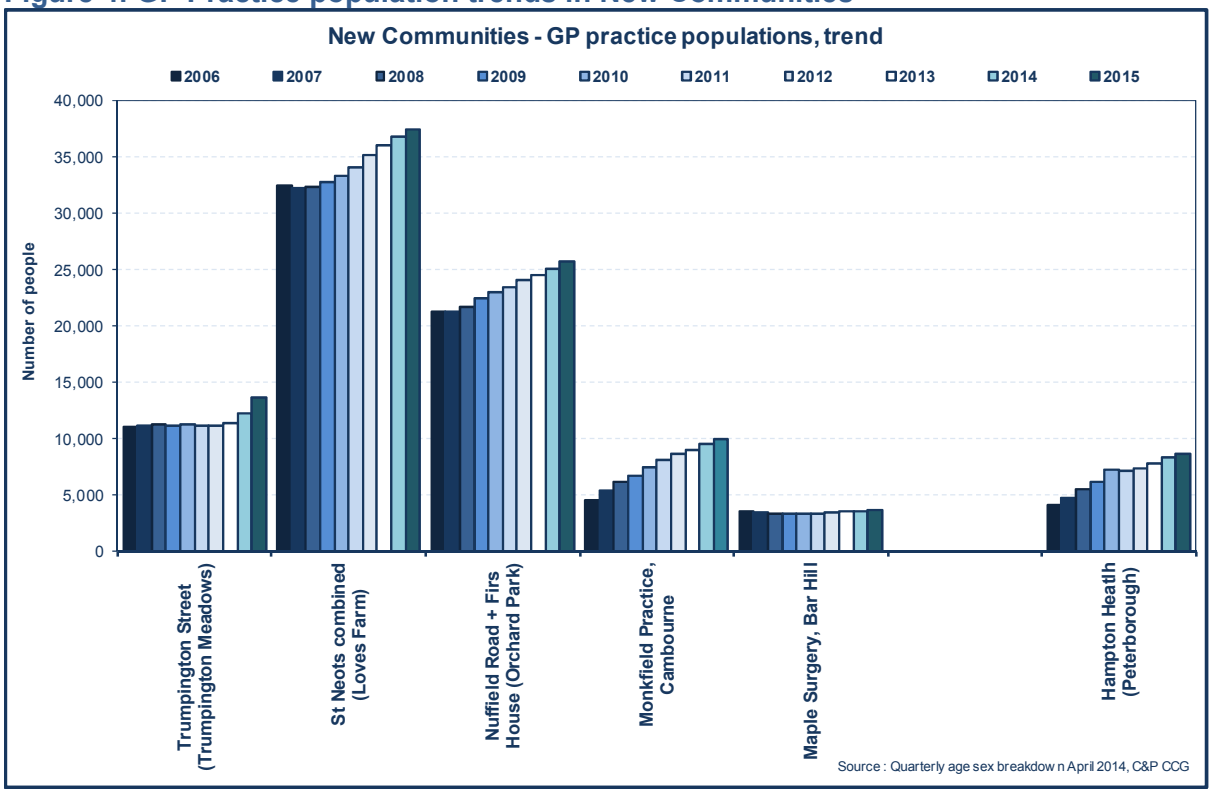
The analysis of the data includes for these practices:

- population trends,
- age breakdowns,
- population forecasts,
- Ethnicity profiles,
- births rates,
- Quality and Outcomes Framework data,
- patient satisfaction data,
- housing information.

3.1.1 Populations trends in the Primary Care Practices Serving New Developments

Population trends in the GP Practice populations serving new developments show a steady increase each year from 2006 to 2015, except the Bar Hill Practice, which has remained constant indicating that the population in Bar Hill has matured and is settled.

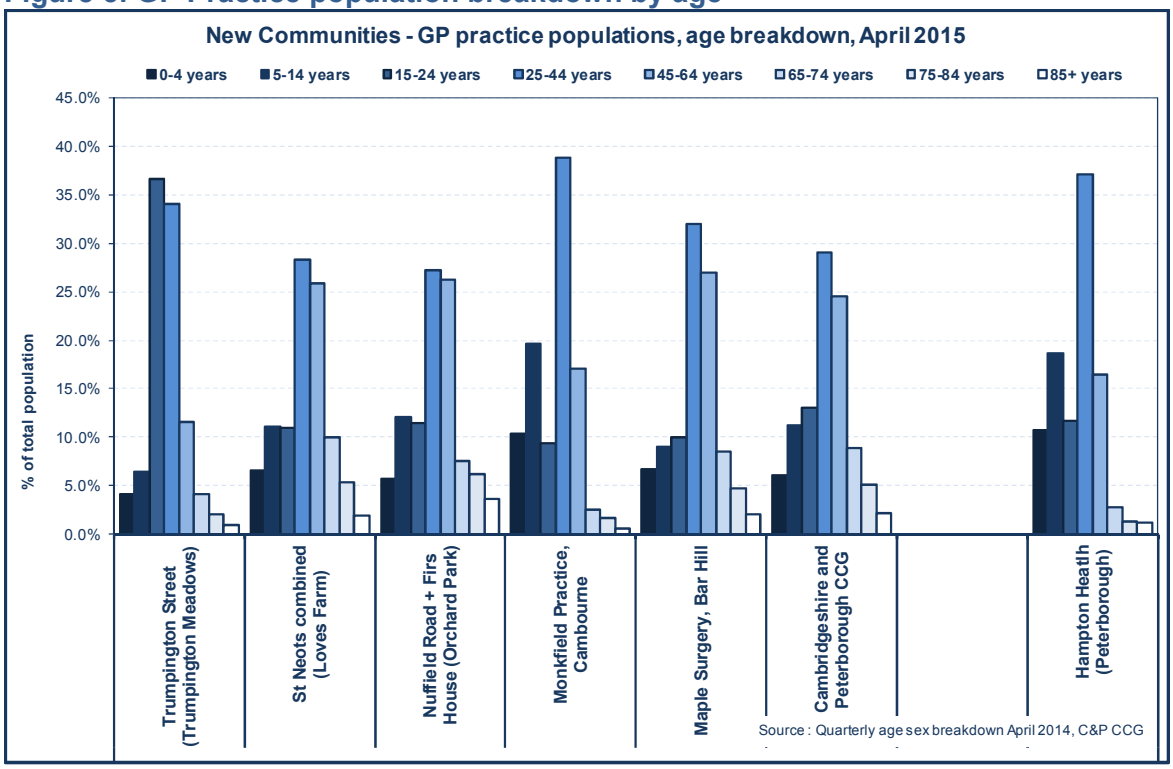
Figure 4: GP Practice population trends in New Communities



3.1.2 Age Profiles in the Primary Care Practices Serving New Developments

The age profile breakdown for GP Practice populations serving new developments show that the majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.

Figure 5: GP Practice population breakdown by age



3.1.4 Patient Satisfaction

Table 5: Patient Satisfaction survey in new communities (1 of 3)

Development		Response rate	Overall experience	
			Good experience	Recommend GP surgery to someone who has just moved to the local area
Cambourne	Monkfield Medical Practice	30.9%	55.3%	45.4%
St Neots	Almond Road,	40.8%	82.3%	78.8%
	Cedar House	40.0%	76.9%	65.5%
	Eaton Socon	46.1%	74.0%	65.1%
	St Neots Health Centre	31.3%	89.6%	89.3%
Orchard Park	Nuffield Road, Cambridge	33.3%	93.2%	88.3%
	Firs House, Histon	44.9%	92.4%	89.5%
Southern Fringe	Trumpington St, Cambridge	25.2%	94.6%	96.5%
Bar Hill	Maple Surgery	41.0%	73.8%	63.2%
Hampton	Hampton Health	31.1%	74.4%	65.4%
Cambridgeshire and Peterborough CCG		37.5%	86.0%	80.6%
Statistically significantly worse compared to CCG				
Statistically significantly better compared to CCG				

Table 6: Patient Satisfaction survey in new communities (2 of 3)

Development		Accessing GP		Opening hours	
		% who have seen or spoken to a GP in the past 6 months	% who have seen or spoken to a nurse in the past 6 months	Satisfaction with opening hours	GP surgery currently open at times are convenient
Cambourne	Monkfield Medical Practice	57.4%	50.3%	42.3%	42.7%
St Neots	Almond Road,	65.2%	57.7%	75.6%	70.4%
	Cedar House	72.2%	60.4%	74.6%	76.3%
	Eaton Socon	58.4%	59.8%	62.0%	52.7%
	St Neots Health Centre	81.0%	72.4%	96.2%	93.7%
Orchard Park	Nuffield Road, Cambridge	75.3%	48.1%	77.1%	73.5%
	Firs House, Histon	76.8%	65.2%	78.0%	72.4%
Southern Fringe	Trumpington St, Cambridge	69.6%	50.8%	70.3%	71.8%
Bar Hill	Maple Surgery	72.3%	58.6%	82.3%	83.2%
Hampton	Hampton Health	63.1%	57.3%	64.5%	56.8%
Cambridgeshire and Peterborough CCG		69.0%	56.6%	75.9%	74.1%
Statistically significantly worse compared to CCG					
Statistically significantly better compared to CCG					

Table 7: Patient Satisfaction survey in new communities (3 of 3)

Development		Managing health			
		Long standing health condition	In last 6 months, had enough support from local services or organisations to help manage long-term health condition(s)	Confident in managing own health	Activities limited today due to recent illness or injury
Cambourne	Monkfield Medical Practice	47.2%	70.1%	93.6%	16.6%
St Neots	Almond Road,	54.2%	59.9%	98.7%	13.0%
	Cedar House	50.2%	64.7%	97.4%	15.2%
	Eaton Socon	47.9%	52.1%	95.9%	13.2%
	St Neots Health Centre	53.7%	70.9%	95.2%	15.8%
Orchard Park	Nuffield Road, Cambridge	58.4%	69.0%	90.0%	19.8%
	Firs House, Histon	53.9%	60.2%	94.6%	14.1%
Southern Fringe	Trumpington St, Cambridge	39.8%	71.5%	92.6%	12.6%
Bar Hill	Maple Surgery	58.8%	60.5%	94.1%	19.3%
Hampton	Hampton Health	41.0%	48.1%	90.6%	12.3%
Cambridgeshire and Peterborough CCG		52.3%	63.7%	93.6%	15.7%
Statistically significantly worse compared to CCG					
Statistically significantly better compared to CCG					

A number of practices in the new development areas have significantly worse overall experience ratings compared to the CCG. Bar Hill is one of these practices and it is considered a “settled” community indicating that the picture of satisfaction is more complicated than just a reflection of serving a new development area. Cambourne Practice has a considerably worse score possibly reflecting local anecdotal evidence from the Cambourne community on the difficulty of getting appointments at the practice, which is a reflection of the inability of the practice to recruit to vacant GP posts. The other finding is that the St Neots Health Centre performs better than the CCG area on opening hours,probably a reflection of the drop in nature of the practice.

3.1.5 Quality and Outcomes Framework Data

Table 8: Quality and Outcomes Framework 2014/15: Summary for New Communities (1 of 3)

Quality and Outcomes Framework 2014/15:
Summary for New Communities

						Cardiovascular						
		Total Population (Jan 16)	Population 0-17 years	Population 18-64 years	Population 65+ years	Atrial fibrillation	Coronary heart disease	Cardiovascular disease – primary prevention (30-74 years)	Heart failure	Hypertension	Peripheral arterial disease	Stroke and transient ischaemic attack
Cambourne	Monkfield	10,486	34%	62%	5%	0.54	1.10	0.62	0.17	5.77	0.14	0.55
St Neots	Almond Road	7,189	21%	63%	16%	1.62	3.37	0.65	0.51	12.51	0.44	1.19
	Cedar House	13,948	22%	60%	18%	1.72	3.23	0.80	0.58	13.98	0.61	1.44
	Eaton Socon	11,466	20%	58%	22%	2.13	4.02	0.78	0.59	15.21	0.51	1.58
	St Neots Health Centre	5,100	22%	72%	6%	0.46	1.22	1.27	0.19	6.72	0.19	0.71
Orchard Park	Nuffield Road	14,004	20%	64%	15%	1.91	3.14	0.46	0.93	12.60	0.68	1.87
	Firs House, Histon	12,300	21%	60%	19%	2.08	3.03	0.92	0.63	13.49	0.48	1.81
Southern Fringe	Trumpington St	14,901	14%	79%	7%	0.68	0.96	0.60	0.19	4.71	0.17	0.59
Bar Hill	Maple Surgery	3,689	19%	66%	15%	1.29	2.91	0.98	0.49	13.18	0.33	1.18
Hampton	Hampton Health	8,834	33%	61%	5%	0.67	1.09	0.63	0.27	5.83	0.26	0.72
C&P CCG		929,926	20%	64%	16%	1.52	2.88	0.90	0.61	12.72	0.55	1.45
England		57,539,930	21%	62%	17%	1.63	3.25	1.07	0.72	13.79	0.63	1.73

Key: Compared to the England average / comparison to relevant threshold

	Values are not statistically significant		Values are statistically significantly lower/better
	Values are statistically significantly higher/worse		

Table 9: Quality and Outcomes Framework 2014/15: Summary for New Communities (2 of 3)

		Respiratory system		High dependency and long term conditions				Musculoskeletal	
		Asthma	Chronic Obstructive Pulmonary Disease	Cancer	Chronic kidney disease (18+ years)	Diabetes mellitus (17+ years)	Palliative care	Osteoporosis (50+ years)	Rheumatoid Arthritis (16+ years)
Cambourne	Monkfield	6.46	0.33	1.26	1.15	2.52	0.07	0.07	0.47
St Neots	Almond Road	4.75	2.32	2.27	0.77	5.52	0.21	0.04	0.71
	Cedar House	6.64	1.76	2.36	3.96	5.92	0.23	0.14	0.93
	Eaton Socon	5.67	1.99	3.28	5.74	5.97	0.23	0.13	0.86
	St Neots Health Centre	6.25	1.34	1.09	1.22	3.09	0.02	0.00	0.55
Orchard Park	Nuffield Road	7.32	1.87	2.06	4.10	5.47	1.55	0.20	0.68
	Firs House, Histon	6.23	1.18	2.49	2.34	4.48	0.15	0.15	0.93
Southern Fringe	Trumpington St	5.16	0.71	1.06	0.48	1.57	0.13	0.15	0.28
Bar Hill	Maple Surgery	7.53	1.29	2.53	2.79	4.75	0.16	0.15	0.69
Hampton	Hampton Health	5.60	0.53	1.06	1.87	3.69	0.80	0.00	0.29
C&P CCG		6.26	1.65	2.31	3.26	5.68	0.43		0.74
England		5.99	1.82	2.26	4.13	6.37	0.31	0.17	0.73

Table 10: Quality and Outcomes Framework 2014/15: Summary for New Communities (3 of 3)

		Mental health and neurology					Lifestyle
		Dementia	Depression (18+ years)	Epilepsy (18+ years)	Learning Disabilities	Mental Health	Obesity (16+ years)
Cambourne	Monkfield Medical Practice	0.18	11.04	0.37	0.17	0.55	6.88
St Neots	Almond Road,	0.38	12.45	0.84	0.84	0.90	3.79
	Cedar House	0.65	6.68	0.77	0.35	0.76	8.87
	Eaton Socon	0.75	4.46	0.74	0.42	0.38	9.21
	St Neots Health Centre	0.27	8.70	0.47	0.36	0.71	10.32
Orchard Park	Nuffield Road, Cambridge	2.17	8.85	0.84	0.58	1.34	9.37
	Firs House, Histon	1.06	5.35	0.59	0.26	0.69	5.25
Southern Fringe	Trumpington St, Cambridge	0.25	3.35	0.26	0.12	0.78	3.41
Bar Hill	Maple Surgery	0.44	5.34	0.94	0.33	0.60	10.81
Hampton	Hampton Health	0.80	14.90	0.57	0.35	0.60	9.05
Cambridgeshire and Peterborough CCG		0.67	6.97	0.70	0.41	0.77	8.48
England		0.74	7.33	0.79	0.44	0.88	9.03

3.1.6 Birth Data

Birth rates per 1,000 female population aged 15-44 in all but one of the growth areas are higher than the CCG area. The rate in Loves Farm is twice the CCG area rate and the rate in the southern fringe area is lower. There is no obvious explanation for this but it might be related to the socio-demographic profile of females moving into Trumpington Meadows.

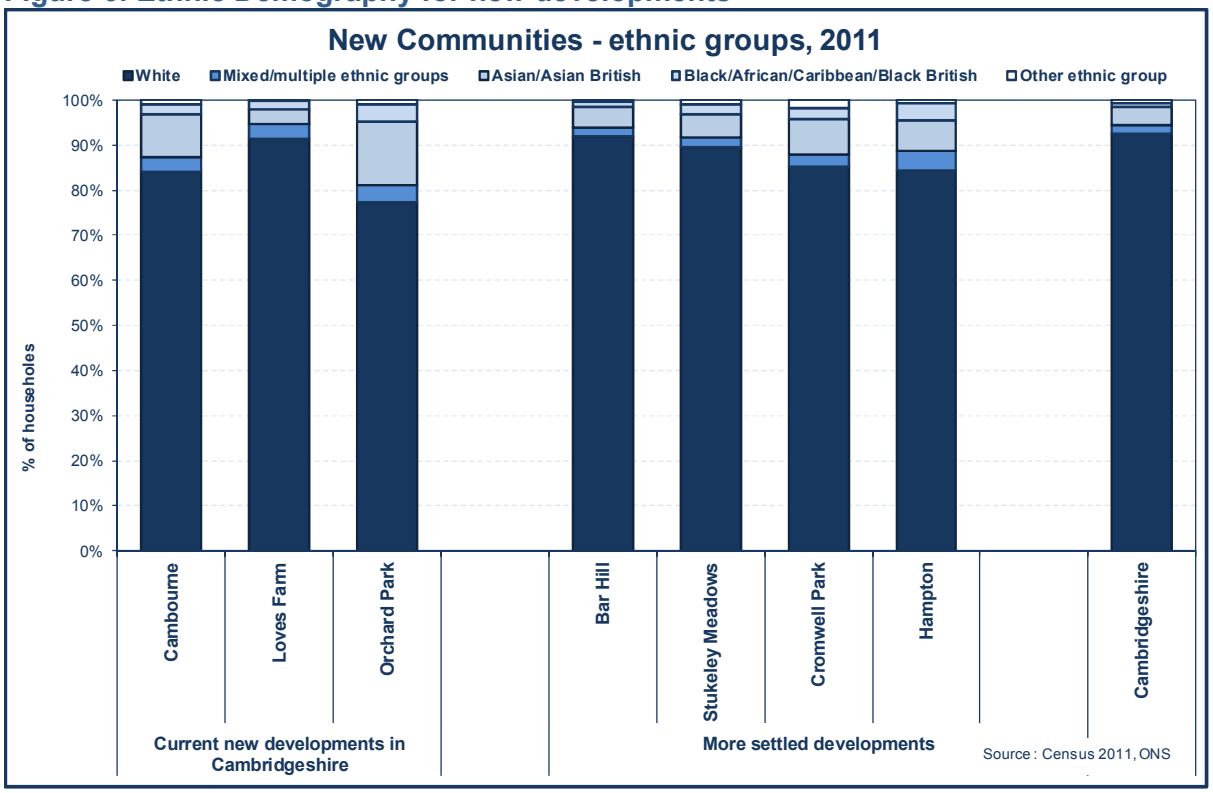
Table 11: Birth rates per 1000 females in new developments

Development	Births		
	Number	Rate per 1,000 female population aged 15-44 years	95% CI
Cambourne	180	65.9	(59.4 - 79.9)
LovesFarm	95	104.2	(80.4 - 121.5)
Orchard Park	61	72.9	(34.6 - 58.0)
SouthernFringe	42	55.7	(41.6 - 78.0)
Cambridgeshire County	7,268	58.4	(57.4 - 60.1)

3.1.7 Ethnicity

All the developments show a predominance of “white” as the main ethnic classification, mirroring the Cambridgeshire ethnic profile, there are small differences between the growth sites with Orchard Park and Cambourne both showing increased percentage of Asian/Asian British households. Both of which are also higher than Cambridgeshire as a whole.

Figure 6: Ethnic Demography for new developments



3.2 HOUSING

3.2.1 Average Household Size in New Developments

Average household size in the new developments tend to be larger than the standard multiplier used of 2.5, with Cambourne, Cromwell Park and Orchard Park seeing average household sizes of 2.8. This has implications for not only the service delivery in new developments (ie coping with an increase in population compared to predicted populations) but also for design on these development sites in the longer term (eg households with a household size of 2.8 is likely to need more space and more car parking facilities).

Table 12: Average household size in new developments

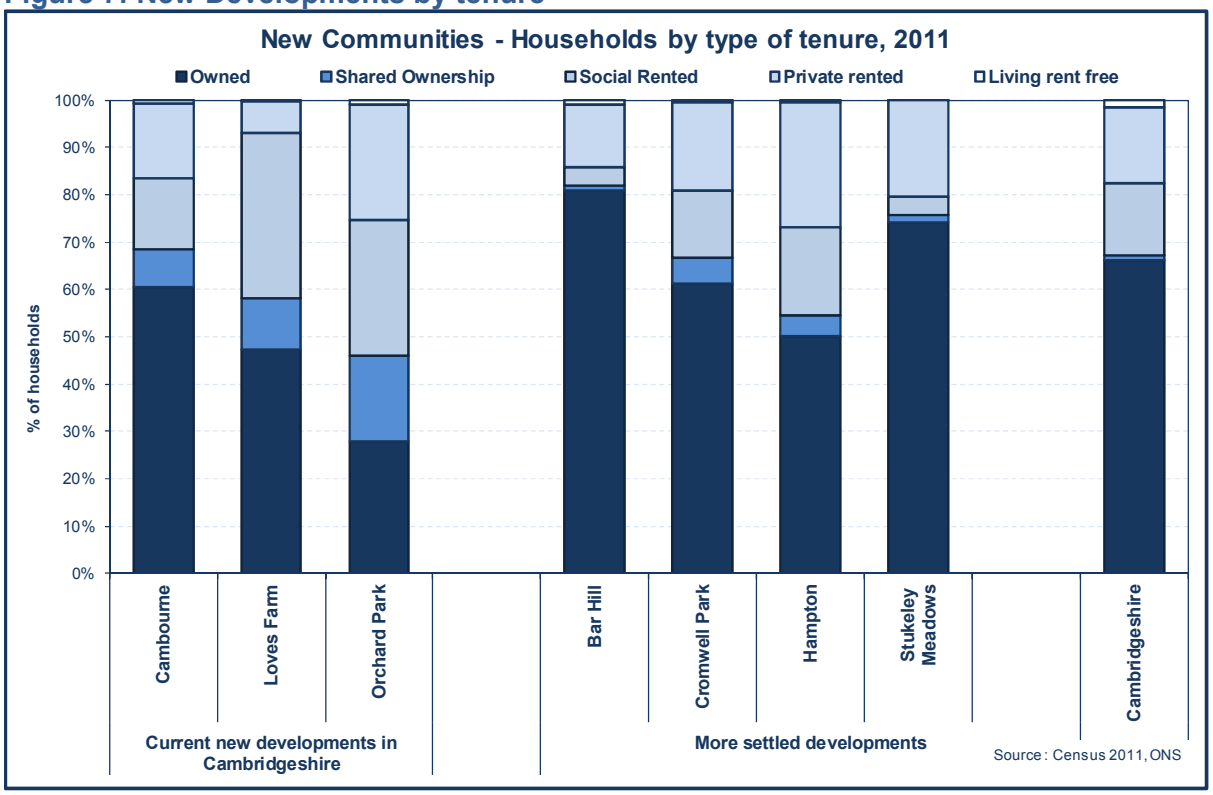
Development	Residents in households	Households	Average Household Size
Bar Hill	4,026	1,725	2.3
Cambourne	8,186	2,964	2.8
Cromwell Park	1,817	646	2.8
Hampton	10,398	3,903	2.7
Loves Farm	1,602	619	2.6
Orchard Park	1,885	670	2.8
Stukeley Meadows	3,320	1,259	2.6

Source: Cambridgeshire Research Group and ONS Population Census 2011

3.2.2 Tenure

There is a marked difference in tenure across the new developments, with Bar Hill showing over 80% of properties privately owned compared to 70% across Cambridgeshire. Orchard Park shows less than 30% of properties are in private ownership with a high percentage in both the private rented and social rented sector.

Figure 7: New Developments by tenure



3.2.3 Strategic Housing Market Assessment (SMHA) Summary.

The SMHA summary shows the need for affordable housing compared to the dwellings contained in the Local Plan, Cambridge City's affordable housing need is greater than the total housing (market and affordable) proposed. The majority of the affordable housing need (62%) is in Cambridge City and South Cambridgeshire.

Table 13: Dwelling change (all tenures), net affordable housing need and jobs increase 2011 to 2031

	Dwelling change 2011 to 2031	Affordable housing need 2011 to 2031 Based on 2011/12 data	Jobs increase 2011 to 2031
Cambridge	14,000	14,418	22,000
East Cambridgeshire	13,000	3,517	7,000
Fenland	12,000	3,527	5,000
Huntingdonshire	17,000	7,212	15,000
South Cambridgeshire	19,000	9,011	22,000
Cambridgeshire to 2031	75,000	37,684	71,000
Forest Heath	7,000	3,742	3,000
St Edmundsbury	11,000	3,437	7,000
Housing sub-region	93,000	44,863	81,000

3.3 POPULATION FORECASTS

The population forecasts for the new developments all show a similar pattern with a steep increase in the population aged 20-64 in the first 10-20 years of the development with a slow decline then onwards. The 0-19 aged population has a steady increase during this time but not so steep, reflecting that not all residents moving into a new development have or will have children. The 65+ age group shows a steady increase year on year but starts from a low base, suggesting that the increase is mainly due to a naturally ageing population rather than a large influx of older people moving into new developments. There are population forecasts for:

- North West Cambridge – University Site
- North West Cambridge – Darwin Green/NIAB site
- Southern Fringe/Trumpington Meadows
- Ely North
- St Neots
- Hatchford Farm, March
- Alconbury
- Northstowe

Figure 8: Population forecast: University Site

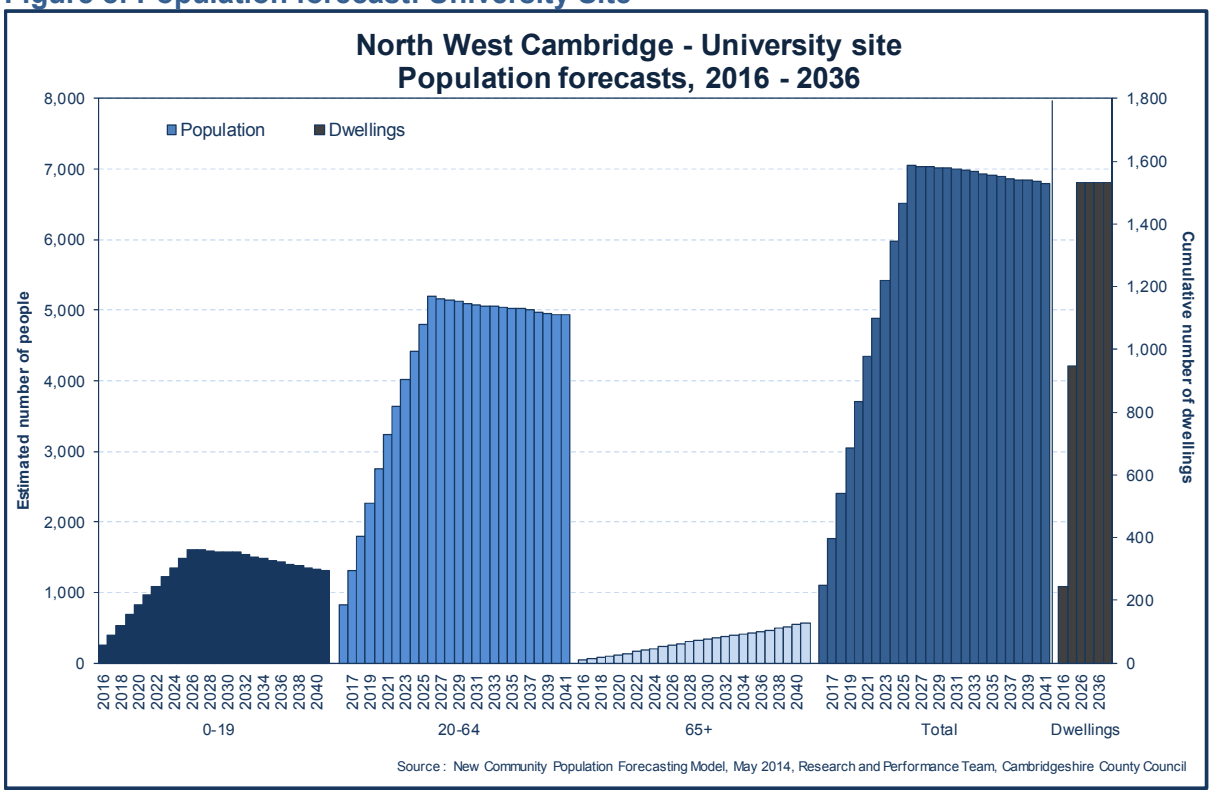


Figure 9: Population forecast: NIAB Site

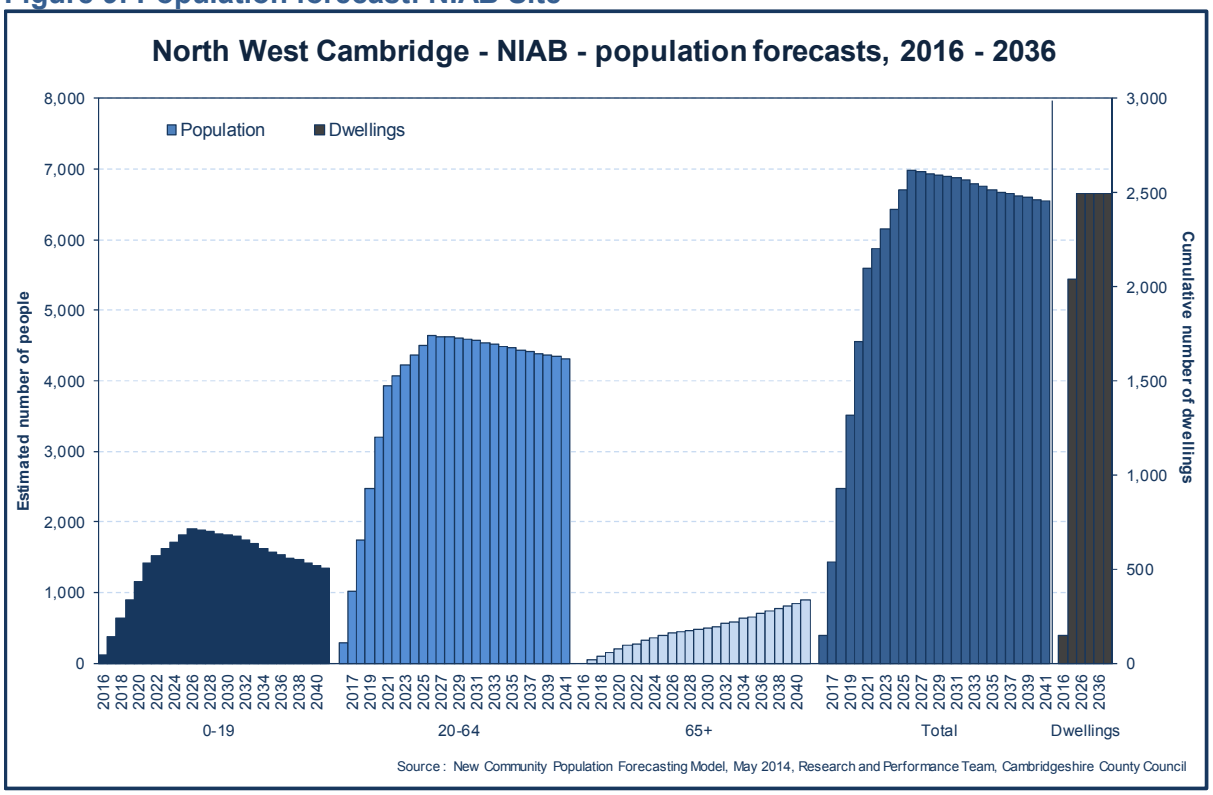


Figure 10: Population forecast: Trumpington Meadows Site

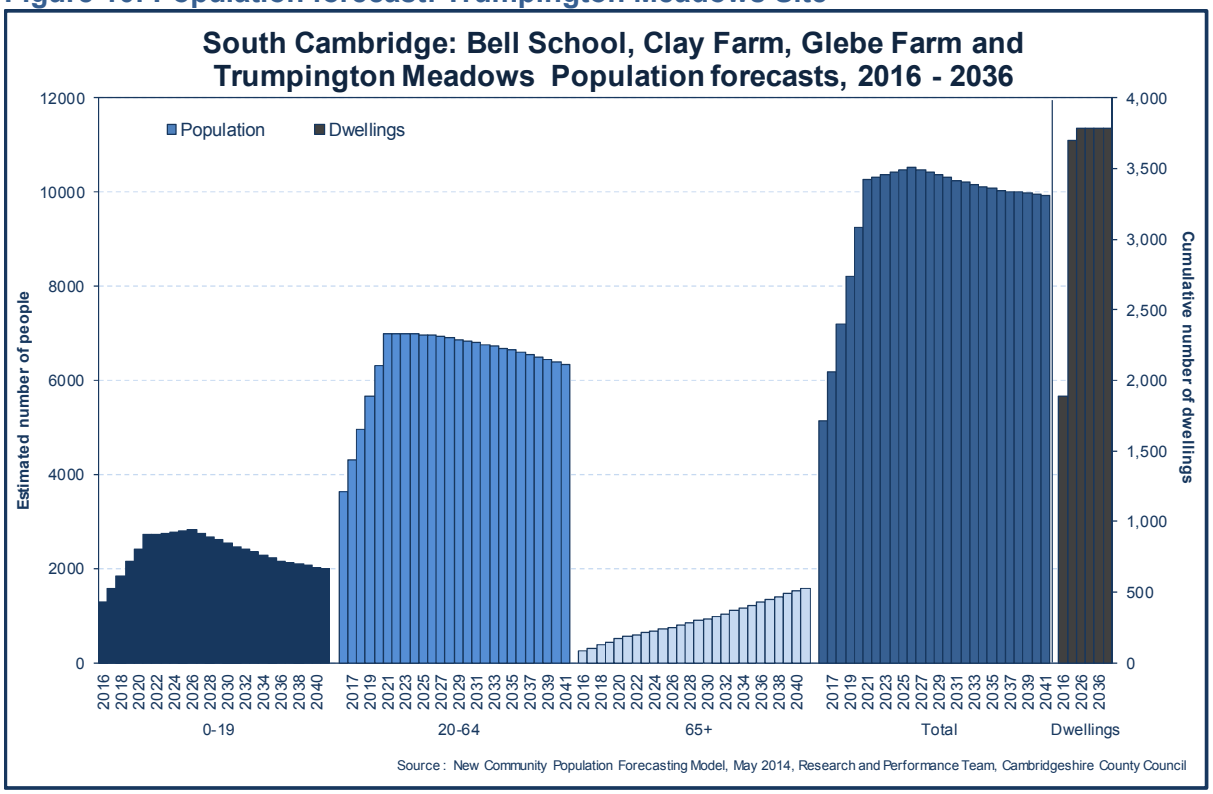


Figure 11: Population forecast: Ely North Site

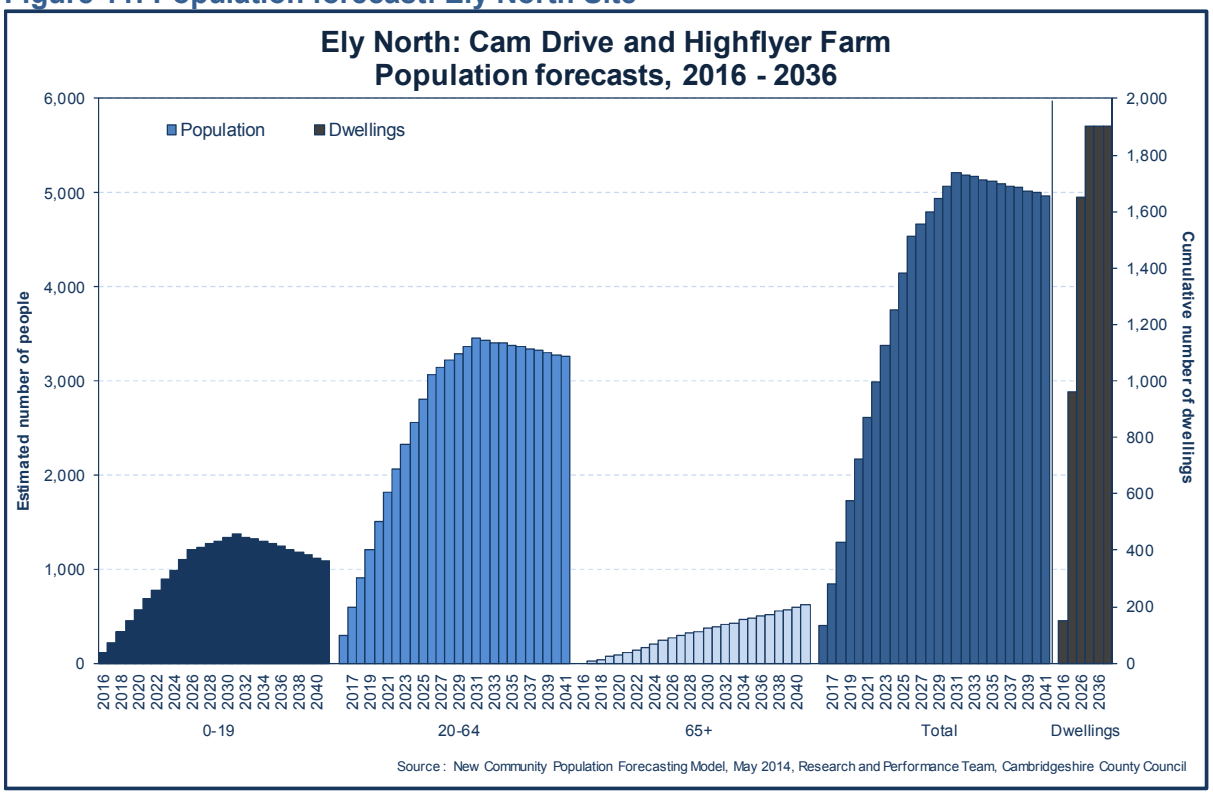


Figure 12: Population forecast: Loves Farm Site

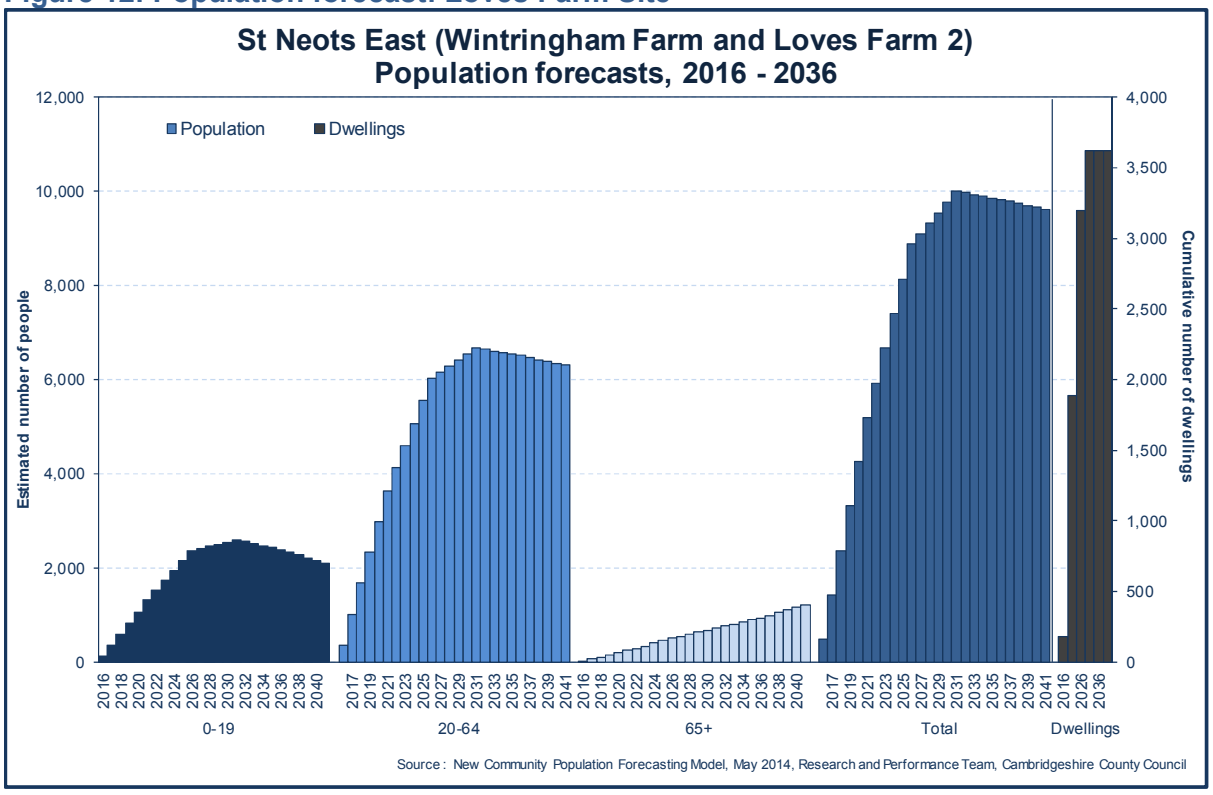


Figure 13: Population forecast: Hatchford Farm Site

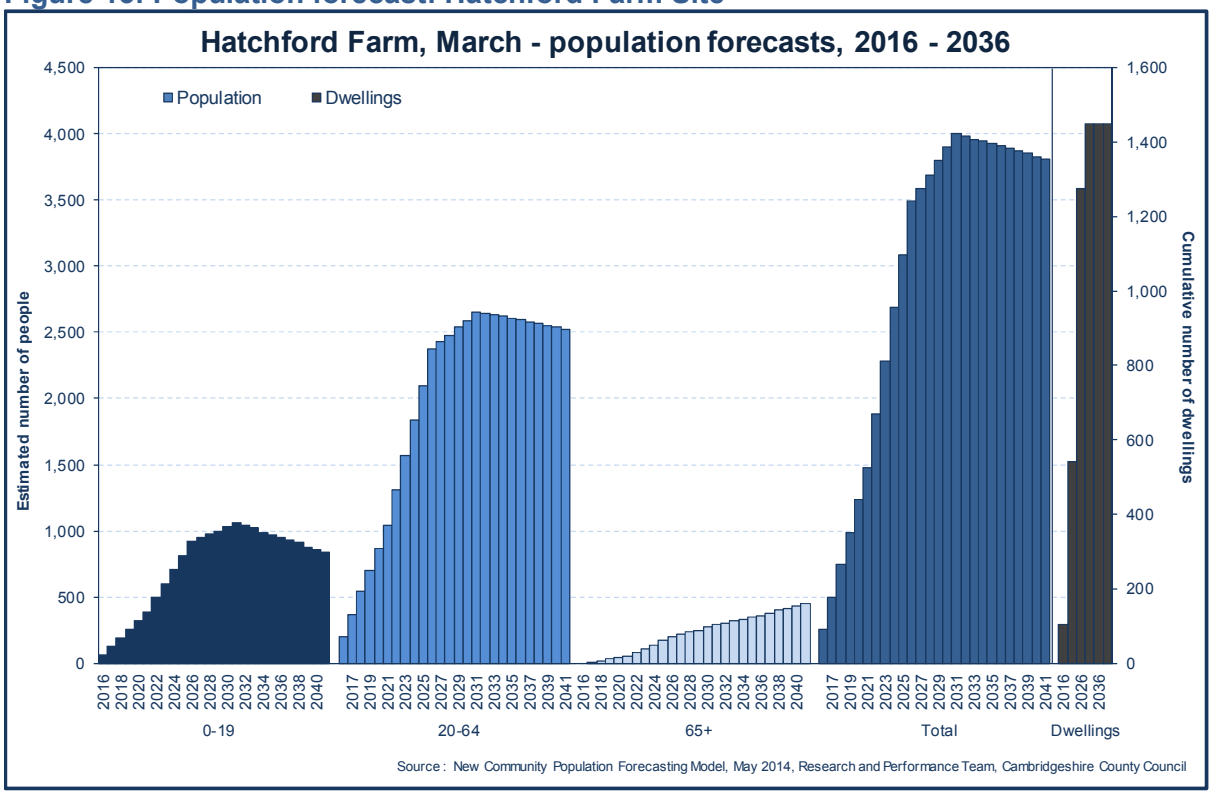


Figure 14: Population forecast: Alconbury Site

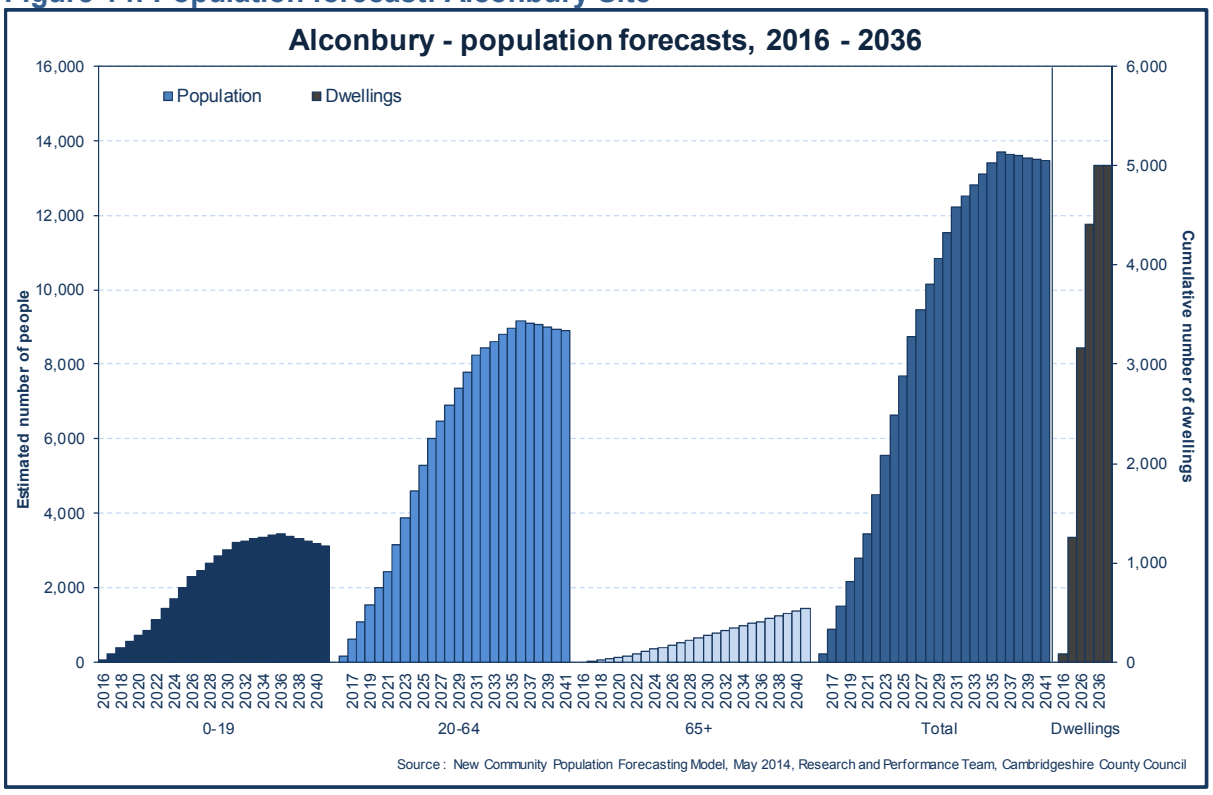
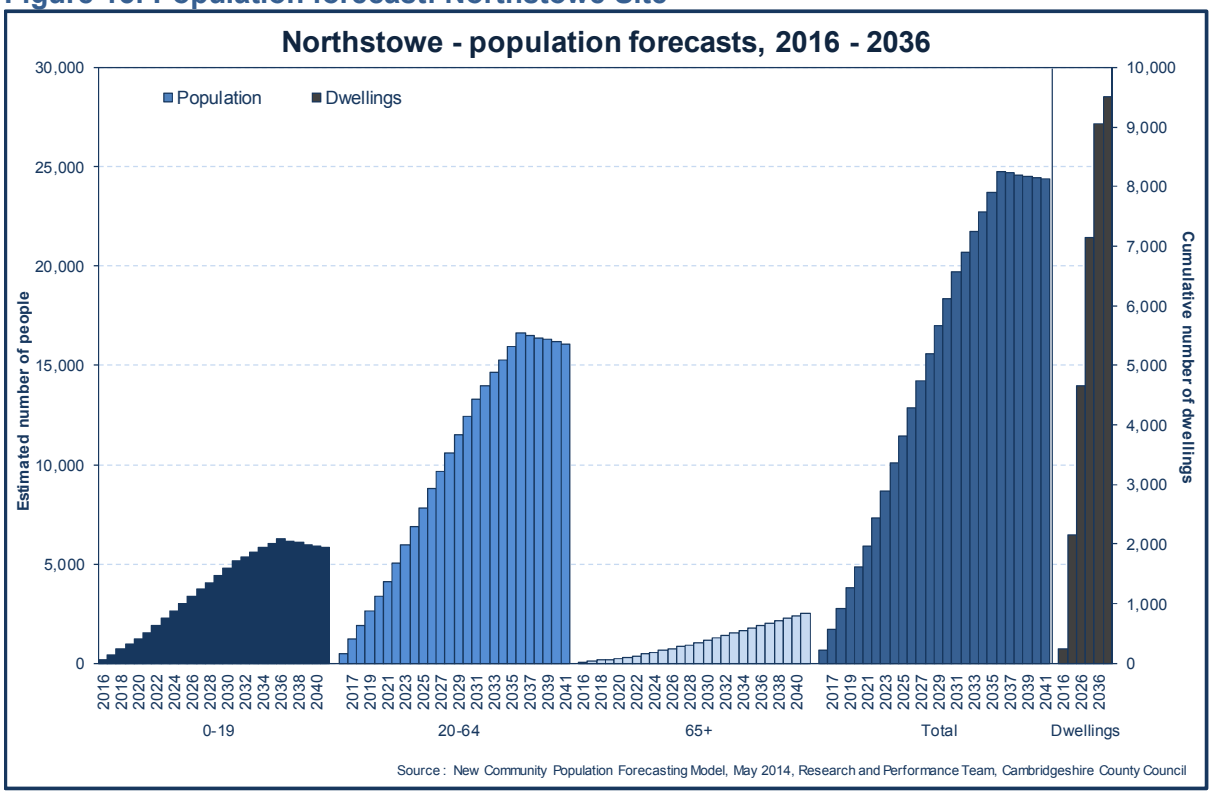
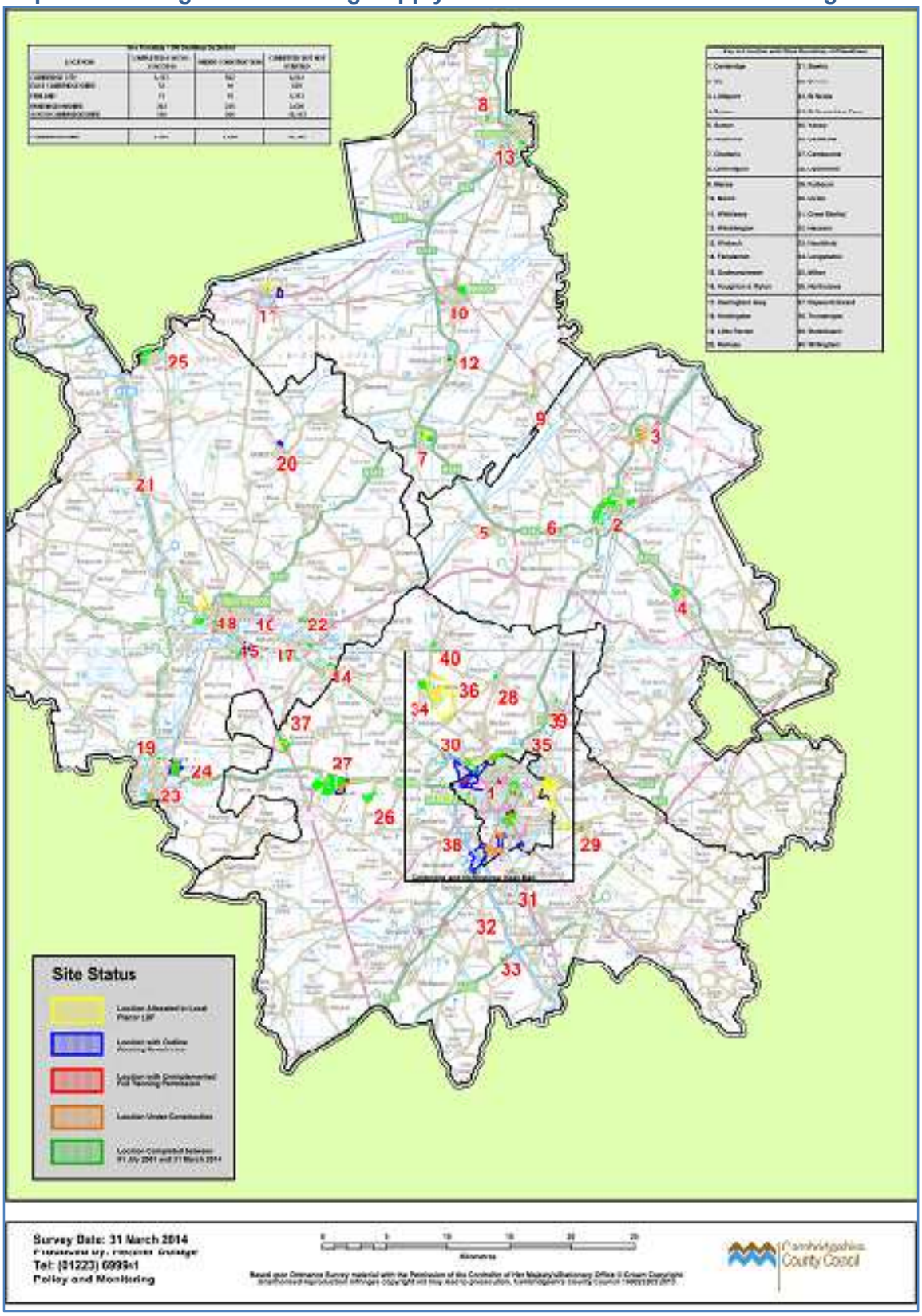


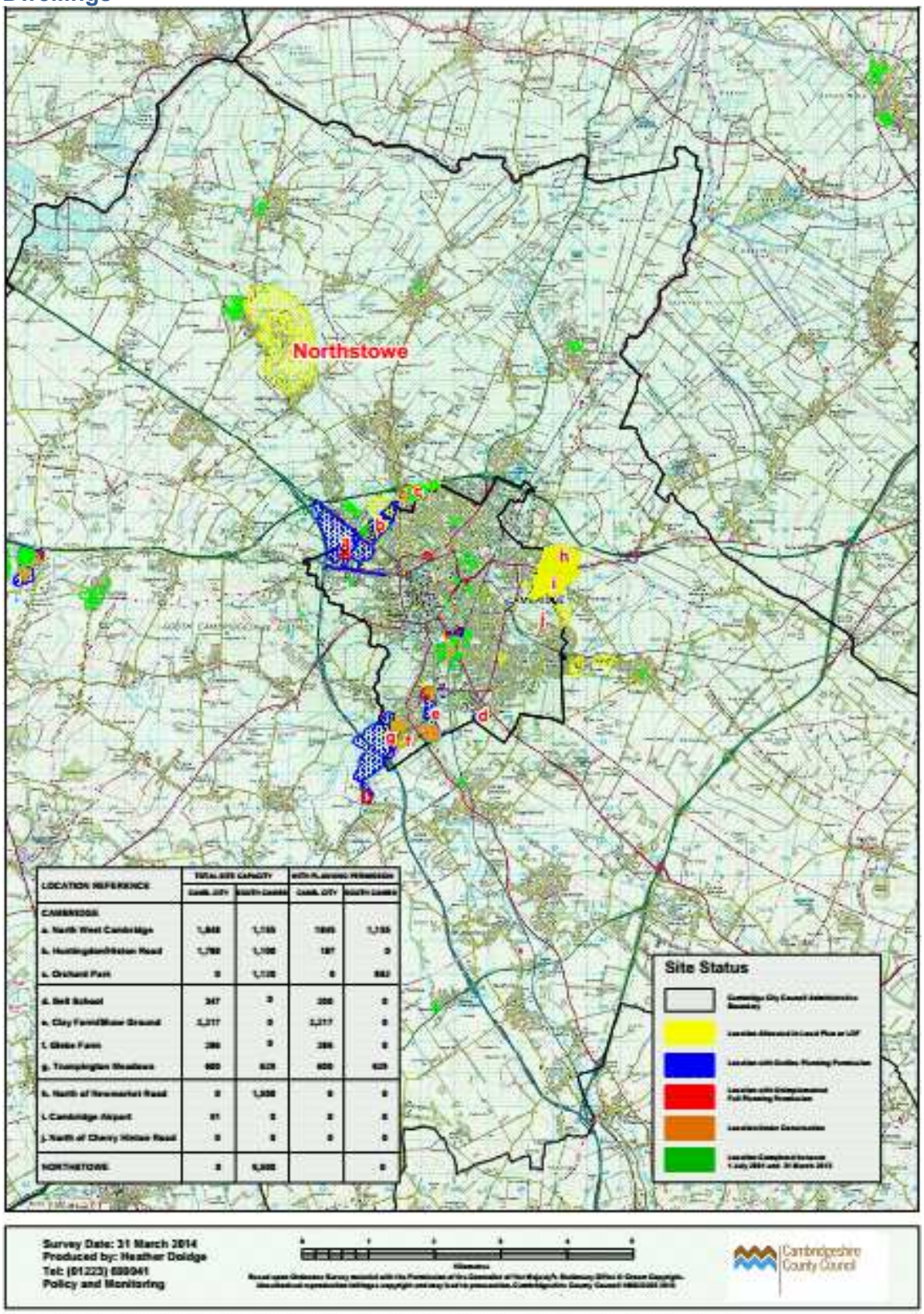
Figure 15: Population forecast: Northstowe Site



Map 2: Cambridgeshire Housing Supply on Sites Greater than 100 Dwellings



Map 3: Cambridge City and Northstowe Housing Supply on Sites Greater than 100 Dwellings



BUILT ENVIRONMENT

1. KEY FINDINGS

- There is a lack of consistency across the Local Authority Local Plans with regard to the inclusion of policies to improve health. The main policies to include in future plans need to focus on green infrastructure, active travel, suicide prevention, Health Impact Assessment requirements.

- There is a lack of consistency and understanding on the funding of Primary Care facilities and securing Community Infrastructure Levy/Section 106 funding.

- Importance of accessible green space and parks, which need to be designed to maximise potential use. There is a need for an open spaces specific design codeto complement the policies on open space within Local Plans, design code should cover provision of paths, cycleways and unstructured routes through and to the green space, provision of toilets and other facilities.

- The importance of providing infrastructure to enable people to make more active travel choices.

- Securing what can be perceived as “nice to have” infrastructure as part of the overall design of new development to support healthy ageing, e.g. street furniture, public toilets.

- The need to consider suicide prevention and public mental health as part of the design of highrise private and public buildings to limit their access and opportunities for suicide.

- The NHS Local Estates Plan should be reflected in the District/City Councils local plans and Infrastructure Delivery Plans.

2. INTRODUCTION

2.1 HOW DOES THE PLANNING SYSTEM WORK?

2.1.1 The role and purpose of Spatial Planning

“The planning system helps us to decide who can build what, where and how. It makes sure that buildings and structures that the country needs (including homes, offices, schools, hospitals, roads, train lines, power stations, water pipes, reservoirs and more) get built in the right place to the right standards. A good planning system is essential for the economy, environment and society.”(6)

Good planning should ensure that the right development is built in the right place at the right time.

2.1.2 An introduction to the national planning system

The planning law requires that applications for planning permission must be determined in accordance with the Councils' development plan, which includes the Local Councils' Local Plan (See section 2.1.3 below) and neighbourhood plans (See section 2.1.5 below).

The National Planning Policy Framework (NPPF) must be taken into account in the preparation of these local and neighbourhood plans, and is a material consideration in planning decisions. Planning policies and decisions must reflect, and where appropriate, promote relevant EU obligations and statutory requirements. There is also guidance to complement the NPPF in the National Planning Policy Guidance (NPPG) document.

What is it?
The National Planning Policy Framework *- sets out the Government's planning policies for England and how these are expected to be applied. It provides a framework within which local people and their accountable councils can produce their own distinctive local and neighbourhood plans, which reflect the needs and priorities of their communities.*

The National Planning Policy Guidance (NPPG) states that local planning authorities should aim to involve all sections of the community in the development of Local Plans and in planning decisions, and should facilitate neighbourhood planning.

The NPPG further outlines that planning policies and decisions should aim to achieve places which promote:

- opportunities for meetings between members of the community who might not otherwise come into contact with each other, including through mixed-use developments, strong neighbourhood centres and active street frontages which bring together those who work, live and play in the vicinity;
- safe and accessible environments where crime and disorder, and the fear of crime, do not undermine quality of life or community cohesion;
- safe and accessible developments, containing clear and legible pedestrian routes, and high quality public space, which encourage the active and continual use of public areas.

What is it?
The National Planning Policy Guidance *- adds further context to the NPPF and the two documents should be read together. It replaced over 7,000 pages of planning guidance that was previously published in separate documents.*

In order to deliver the social, recreational and cultural facilities and services the community needs the NPPG, recommends planning policies and decisions should:

- plan positively for the provision and use of shared space, community facilities (such as local shops, meeting places, sports venues, cultural buildings, public houses and places of worship) and other local services to enhance the sustainability of communities and residential environments;
- guard against the unnecessary loss of valued facilities and services, particularly where this would reduce the community's ability to meet its day-to-day needs;
- ensure that established shops, facilities and services are able to develop and modernise in a way that is sustainable, and retained for the benefit of the community;
- ensure an integrated approach to considering the location of housing, economic uses and community facilities and services.

2.1.3 What is a Local Plan?

Planning involves making decisions about the future of cities, towns and countryside. This is vital to balance the desire to develop the areas where we live and work with ensuring the surrounding environment isn't negatively affected. It includes considering the sustainable needs of future communities.

In order to ensure health impacts are assessed and successful outcomes are achieved opportunities to include health related policies in local planning policy documents and local planning guidance should be sought. Health impacts may already be assessed in a range of assessments that are submitted with large scale planning applications, these may include assessments of air quality, noise and transport for example as well as Health Impact Assessments.

The consideration of health impact assessment (HIA) in the Government's impact assessment process is mandatory. As part of the White Paper 'Choosing Health' 2004, the Government gave a commitment to building health into all future legislation by including health as a component in regulatory impact assessment (RIA). The Cabinet Office has revised RIA to become impact assessment (IA) and HIA is one of the specific impact tests. This means that health and wellbeing are designed into national policy.

In order to ensure that a new development makes a positive contribution to the health and wellbeing a specific policy requirement must be contained in the Local Plan, for example at its simplest level if the Local Plan does not have a policy requiring the provision of open green space, then the developer is under no obligation to provide open green space. There may be opportunities to require open green space if the Local Plan has a general policy requiring that development proposals should contribute to creating a healthy, living environment. An overview of the Local Plans in Cambridgeshire is given in section 3.1

What is it?
***The Local Plan** - is a plan for the future development of the local area, it is drawn up by the Local Planning Authority. It guides decisions on whether or not planning applications can be granted.*

The Local Plan should plan positively for the development and infrastructure communities need, setting out the strategic priorities for the area in the Local Plan. This should include policies to deliver:

- housing, including affordable homes;
- retail, leisure and other commercial development;
- infrastructure for transport, minerals, waste, energy, telecoms, water supply and sewage treatment;
- education, health, police and community facilities;
- energy, including from renewable sources;
- protection and enhancement of the natural and historic environment, including landscape, wildlife, open space, listed buildings and archaeology;
- protection of homes and property from flooding from rivers and the sea.

Local Plans should be aspirational but realistic. They should address the spatial and land use implications of economic, social and environmental change. The Local Plan is normally in two sections, the first contains the vision for the plan area and the policies to achieve this, and the second is a set of maps of the area indicating where development will normally be permitted.

2.1.4 Other plans

In addition to the local plan there are other Community Planning Tools & Options that can be used to improve health and wellbeing at a local level, the most relevant are "Community led/Parish Plans", "Neighbourhood Plans", "Neighbourhood Development Orders", "Community Right to Build Orders", and "Village Design Statements".

Community led/Parish Plans – create a vision for how a community wants to develop and identifies the actions needed to achieve it. It explores key services and facilities needed by a parish and demonstrates how the character of the parish might be protected. It also identifies challenges and opportunities. A good Parish Plan will address issues the whole community feels are important and, which it intends to address itself. It must contain an action plan.

Advantages	Challenges
• Very high community participation rates. • Focuses on the things people in a community care about. • Good collaboration between different interests. • Led by members of the community. • An established process: over 4,000 plans produced nationwide. • Track record of deploying a range of engagement techniques. • Fosters and capitalises on local social capital. • Can help to secure funding for projects identified in them by providing evidence of robust community consultation. • Potential formal adoption by Parish Council. • Provides detailed knowledge and insight not otherwise available to the Local Planning Authority (LPA). • Effective identification of locally perceived problems/assets. • Must include an action plan so they are practical.	• Cannot make specific land use proposals. • No legal power. • If dependent on external pots of money or a "community's wealth", there is a risk that resource and finance won't be available to deliver the actions. • Uncertain power to implement proposals.

Neighbourhood Plans – identify a shared vision and common goals for a designated "neighbourhood area". They define where new homes, shops, offices and other development should be built; identifying and protecting local green space; and influencing what new buildings should look like.

Neighbourhood Plans can only be initiated by parish councils in parished areas (or Neighbourhood Forums where there is no parish council). A Neighbourhood Plan must broadly conform to the strategic policies set out in the local planning authorities Local Plan. It can be used to promote more development than is set out in the Local Plan (in both numbers and/or detail) but *cannot be used to promote less or prevent development*. It must

also comply with national planning policy and other national and EU requirements. Independent examination and endorsement via a local referendum are statutory requirements.

Advantages	Challenges
• The plan has a statutory status, and will become part of the Local Plan for that district council. • Planning applications in an area with a neighbourhood plan will be determined by using the policies in that neighbourhood plan. • Whilst a Neighbourhood Plan must conform to the strategic policies in the Local Plan, Planning decisions are made in favour of the Neighbourhood Plan where non-strategic policies conflict, unless material considerations indicate otherwise. • Enables strong community influence over land use and development, including through a democratic process (referendum). • The Local Planning Authority has a duty to assist with producing a Neighbourhood Plan. • Builds on local knowledge and insight • Is the responsibility of a formal part of representative democracy, i.e. Parish Council. • Could respond practically to local housing need by allocating development sites. • Should stimulate greater ownership of planning decisions among local communities. • Areas with a Neighbourhood Plan benefit from a 10% uplift in the Community Infrastructure Levy (CIL) from 15% to 25% on any development in the area, not only that proposed in the Neighbourhood Plan.	• Must follow government regulations in preparing them. Requires various stages of formal consultation, independent examination and referendum before being 'made' or adopted. • Need to scope the policies in the plan to see if full sustainability appraisal is needed which can be a complex task. • Needs to have a strong evidence base to withstand potential legal challenge. Must be able to justify policies in the plan. • Could become a vehicle for conflict within the community or between community and developers in disputes over development land. • Current arrangements can be bureaucratic and time-consuming. • Non-land use related issues that a community might wish to address are better addressed through a separate document, e.g. a parish plan. They will not be looked at by the independent examiner. • Cannot be used to alter Green Belt boundary. • CIL benefits are limited where small-scale developments are proposed .

Neighbourhood Development Orders – grant planning permissions for certain types of development in a designated 'neighbourhood area'. They can apply to a specific site, sites or a wider geographical area. They can grant planning permission outright or subject to conditions and can exclude certain areas from Neighbourhood Development Order projects. They must meet the same minimum requirements as the Neighbourhood Plan with regard to compliance, examination and referendum. Only a parish council can prepare one.

Advantages	Challenges
• Removes the need for planning permission for the types of development permitted by the order. • Minor changes could avoid a formal planning application or be delegated to a local body. • Might help stimulate local democracy. • Promotes projects with locally distinctive design. • Local community formally involved in planning decisions.	• Limited range of permitted development proposals. • Long and complex process to establish the Order. • Where the Order creates exemptions from planning consent, there is less guarantee of locally appropriate design. • Without the framework of a Local Plan, Neighbourhood Plan or Design Statement development might be uncoordinated and potentially unattractive. • There are continuing liabilities for whoever manages them.

Community Right to Build Orders – is a specific type of Neighbourhood Development Orders that allows development without a lengthy and difficultplanning process. They can be created as part of a Neighbourhood Plan or separately. They aim to give communities certain powers to decide what is built in their area. They allow small-scale developments where they have the agreement of the local community. Communities can build family homes to sell on the open market, affordable housing for rent or to convert disused farm buildings into affordable homes, supported housing for older local residents, low cost starter homes for young local families, or facilities such as a new community centre or a children's playground.

Advantages	Challenges
• Follows a streamlined version of the Neighbourhood Planning process. • Subject to lighter consultation requirements and examination levels than Neighbourhood Plans – the examiner's report is binding on the Local Planning Authority. • Has to go through a referendum. Where 50%+1 of those voting approves the Order, the Local Planning Authority has a duty to implement it. • Allows communities to take forward small-scale development even where the Local Planning Authority is opposed. • Benefits (such as profits generated) are kept and managed by a community organisation on behalf of the whole community, regardless of ownership of the development. • Groups can ensure affordable housing remains affordable in perpetuity. • Development can be located in the Green Belt as long as National Planning Policy Framework Green Belt criteria are met.	• Can be used in conjunction with Community Right to Bid. Simultaneous use of the Community Rights could be advantageous but as timescales for each Community Right are different, this would be difficult to achieve. • Little to be gained by Community Right to Build if there is little chance of development being delivered – to make it happen community may have to acquire the land/engage with a willing developer. • Community must find funding to cover costs of the process. • Only for use by community organisations in which local people (based on electoral register) have majority voting rights and directorships and include different people from at least 10 different addresses within the area (preventing developers gaining easy planning permission against a community's wishes). • Proposals requiring an Environmental Impact Assessment (EIA) or having a significant impact in terms of Habitats Regulations are not eligible.

• Particularly beneficial in rural areas with a need for small-scale development and/or economic regeneration. • If built by a developer, the Community Infrastructure Levy and New Homes Bonus apply.	• Proposals must not be at odds with conservation and listed building legislation, or be at odds with the strategic policies in the Local Plan or Neighbourhood Plan, (if there is one). • Community Right to Bid only gives the community the right to bypass normal planning consents. (land acquisition, financial processes (including raising finance) and building regulations apply).

Village Design Statements – aim to record, celebrate and enhance what a community feels are the distinctive features that make a village unique. It uses those characteristics to frame guidelines on how future development might look (not whether or where development might take place). The aim is to ensure a close relationship with the statutory planning system to maximise effectiveness.

Advantages	Challenges
• Very clear focus on design and local distinctiveness. • Can be adopted as material planning considerations by the Council and taken into account when planning applications are being considered. • Provides local insight and information not otherwise available to local planning departments. • Clear parameters – how, not whether or where, development should take place. • Can draw developers into the process. • 20 year+ track record.	• Might attract only 'design-aware' residents and not the whole community. • Can be initiated to prevent development, which is not their purpose. • Emphasis is on conservation and replication and can, therefore, be limited. • Can require management of different opinions about design-related matters. • Can be dependent on motivated individuals with the right skills. • The Council may not be willing to adopt it. • Not straight forward to turn into a Supplementary Planning Document (SPD). There are strict regulations for producing SPD and it would have to bementioned in the Council's Local Plan.

2.1.4 What is a Health Impact Assessment (HIA)

HIA is commonly defined as "*a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population*." (7)It is a tool to appraise both positive (e.g. creation of new jobs) and negative (e.g. generation of pollution) impacts on the different affected subgroups of the population that might result from the development. Public participation is considered a major component of the process.

It usually assesses a policy or proposal that does not have health improvement as a primary objective. The implementation of the development may result in intended objectives being met but may also result in consequences that are unintended and unanticipated. These unintended effects may be beneficial or adverse for people's health and wellbeing.

The Health Impact Assessment aims to identify all these impacts on health in order to enhance the benefits for health and minimise any risks to health. It includes specifically a

consideration of the differential impacts on different groups in the population, because certain groups are potentially more vulnerable to negative impacts from development such as those on a low income, people involved in the criminal justice system, minority ethnic groups, young, disabled (physically and learning) older people.

A HIA is usually forward looking (prospective) and done at a time when it is possible to change the proposed development if necessary, e.g.during or prior to the masterplanning stage. It may be necessary to submit two HIAs, one at the outline stage of a planning application and one the reserved matters stage. This will be dependent on how detailed the outline application is.

A Health Impact Assessment should:

- Appraise the potential positive and negative health and wellbeing impacts of the proposed development on planned new communities and the adjacent existing communities in the development area.
- Highlight any potential differential distribution effects of these impacts among groups within the population by asking ‘who is affected?
- Suggest actions and/or mitigations that aim to minimise any potential negative health impacts and maximise potential positive health impacts, referencing where possible the most affected vulnerable group(s).

Table 14: Common features of HIA and other Assessments

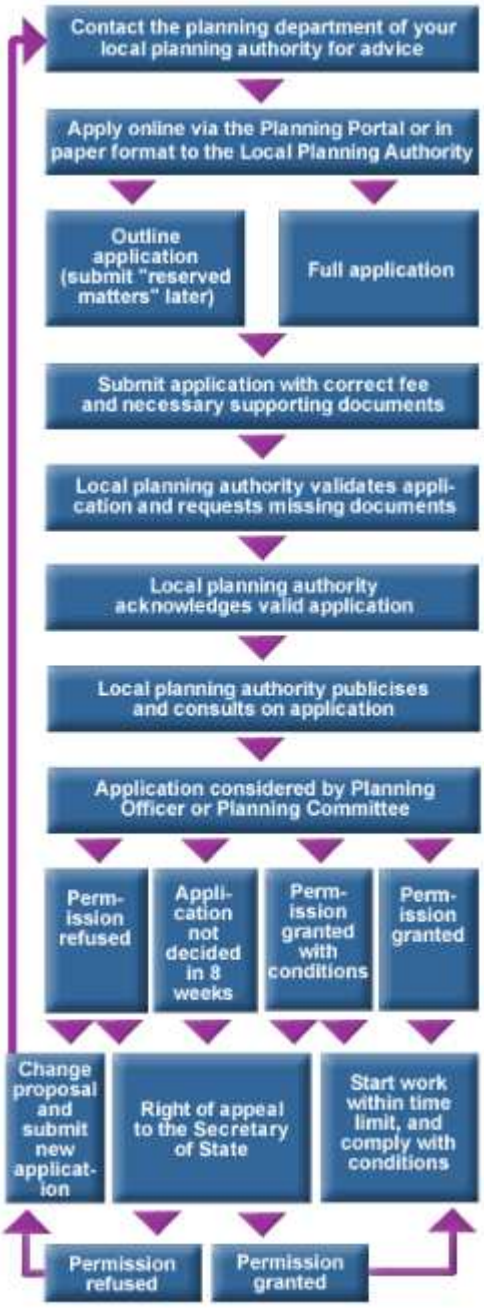
	Health Needs Assessment	Health Impact Assessment	Integrated Impact Assessment	Health Equity Audit	Equality Impact Assessment	Environmental Impact Assessment
Starting point	Population	Proposal	Proposal	Services and resources	Proposed policyor organisational function	Proposal requiring planning permission
Primary output	Informs decisions about strategies, service priorities, commissioning and local delivery plans, and informs future HIAs and IIAs	Recommends how to maximize benefits and minimise negatives of a proposal to inform decision making and improve joined-up working	Recommends how to maximise benefits and minimise negatives of a proposal to inform decision making and improve joined-up working	Agreed and acted upon interventions that equitably distribute services and resources	Ability of organisation to demonstrate it is meeting legal requirements to promote equality in its policies and functions	Agreed and acted upon interventions that reduce any negative impact on the environment arising from a proposal
Aims to take account of inequalities	Describes health needs and health assets of different groups in local population. Helps improve health and reduce health inequalities	Compares impact of proposals on most vulnerable groups in the population. Helps improve health and reduce health inequalities	Compares impact of proposals on most vulnerable groups in the population. Helps improve health and reduce health inequalities	Compares health needs and outcomes in the local population with use and access to services and resources. Helps improve health and reduce inequalities	Assesses how far a policy or function may promote equality and good race relations. Helps reduce organisational and racial inequity	Describes environmental impact of a proposal and should identify groups that are particularly vulnerable to associated health issues.
Involvement of stakeholders	Always	Always	Always	Always	Always	Always
Involvement of community	Always	Ideally (dependent on resources)	Ideally (dependent on resources)	No	Always	Ideally (dependent on resources)
Involvement from many sectors	Sometimes	Usually	Always	Always	Sometimes	Sometimes
Based on determinants of health	Usually	Ideally	Always	Usually	No	No
Best available evidence used	Always	Always	Always	Always	Always	Always
Uses data from other approaches; informs other approaches	Always	Always	Always	Always	Always	Always

2.1.5 What is the process for determining a planning application?

In order for a new development to start, the developer/landowner must obtain planning permission from the local planning authority (LPA).

The **local planning authority** (LPA) – usually the district or borough council (in Cambridgeshire the five District/City Councils are the LPAs (the County Council is the planning authority for Highways and Waste infrastructure) is responsible for deciding whether a proposed development should be allowed to go ahead and planning permission granted. The application is assessed against compliance with that LPA's Local Plan.

Figure 16: The Planning Process



Validation
All applications are checked to make sure all documents and the required fee(s) have been submitted.

Consultation and publicity
Consultations are sent to various statutory and non-statutory bodies to obtain their expert view. Advertisements, where required, are placed in the appropriate local paper and on site.

Consideration
The site is inspected and the application assessed by the planning case officer, taking into account planning policies, consultation responses and public representations.

Recommendation
The planning officer will make a recommendation, via the officers' report to the relevant committee of the council or individual who has delegated powers to make the decision.

Decision
A decision is taken on the application by the appropriate body.

Local planning authorities are expected to determine planning applications within a time period of 8, 13 or 16 weeks (depending on the type of development).

2.1.6 Who are the Statutory and Non-Statutory Consultees for planning applications?

Planning law prescribes where consultation must take place between a local planning authority and certain organisations (dependant on the type of planning application), prior to a decision being made on an application. The consultees in question are under a duty to respond to the local planning authority within a set deadline and must provide a substantive response to the application in question. Where statutory consultation is required, statutory consultees are under a duty to respond within 21 days.

Table 15: List of Statutory Consultees (Planning Practice Guidance (Paragraph: 009 Reference ID: 15-009-20140306))

Statutory Consultees	
Adjoining landowners	Canal and River Trust
Coal Authority	Control of major-accident hazards competent authority (COMAH)
County Planning Authorities	Crown Estates Commissioners
Department of Energy and Climate Change	Environment Agency
Forestry Commission	Garden History Society
Greater London Authority	Health and Safety Executive
Highways Authority	Highways England
Historic England	Local Highway Authority
Local Planning Authorities	National Parks Authorities
Natural England	Parish Councils
Rail Infrastructure Managers	Rail Network Operators
Sport England	
Non-statutory Consultees	
Emergency Services and Multi-Agency Emergency Planning	Forestry Commission
Health and Safety Executive	Ministry of Defence
Office of Nuclear Regulation	Police and Crime Commissioners
Rail Network Operators	
Business Improvement Districts	

It is important to note that the NHS is not a consultee for planning applications in any capacity.

2.1.7 What are the main types of planning applications?

There are two main types of planning applications: applications for full planning permission; and applications for outline planning permission.

Full Planning Permission – allows for a decision on all aspects of the proposed development, although it would generally be subject to various conditions.

Outline Planning Permission – allows for a decision 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 'reserved matters'.

Reserved matters – are the aspects of a proposed development which an applicant chose not to submit details of with an outline planning application, (ie they can be 'reserved' for later determination). These are defined in article 2 of the Town and Country Planning (Development Management Procedure) (England) Order 2015 as:

- 'Access' – the accessibility to and within the site, for vehicles, cycles and pedestrians in terms of

Applications can also be made for:

- *approval of reserved matters;*
- *discharge of conditions;*
- *amending proposals that have planning permission;*
- *amending planning obligations;*
- *lawful development certificates;*
- *prior approval for some permitted development rights;*
- *non-planning consents (such as advertisement consent, consent required under a Tree Preservation Order and hazardous substances consent).*

the positioning and treatment of access and circulation routes and how these fit into the surrounding access network.

- 'Appearance' – the aspects of a building or place within the development which determine the visual impression the building or place makes, including the external built form of the development, its architecture, materials, decoration, lighting, colour and texture.
- 'Landscaping' – the treatment of land (other than buildings) for the purpose of enhancing or protecting the amenities of the site and the area in which it is situated and includes: (a) screening by fences, walls or other means; (b) the planting of trees, hedges, shrubs or grass; (c) the formation of banks, terraces or other earthworks; (d) the laying out or provision of gardens, courts, squares, water features, sculpture or public art; and (e) the provision of other amenity features;
- 'Layout' – the way in which buildings, routes and open spaces within the development are provided, situated and orientated in relation to each other and to buildings and spaces outside the development.
- 'Scale' – the height, width and length of each building proposed within the development in relation to its surroundings.

Planning Conditions

A planning condition is a condition placed on the grant of planning permission. These conditions permit development to go ahead only if certain circumstances are satisfied. Conditions can include time limits on development, undertakings regarding environmental and noise issues and limits on the size and external appearance of a new development.

Planning permissions are usually granted subject to a planning condition which requires the development to be commenced within a set number of years. Some of these conditions will need to be complied with before any work starts on site; others will take effect once the development is commenced, or later.

Developer Contributions

Developers may be asked to provide monetary contributions for infrastructure in several ways. Either through the Community Infrastructure Levy (CIL) and/or through planning obligations in the form of Section 106 agreements.

The CIL is intended to provide infrastructure to support the development of an area, rather than making individual planning applications acceptable in planning terms. As a result, some site specific impact mitigation may still be necessary in order for a development to be granted planning permission. Some of these needs may be provided for through the CIL but others may not, particularly if they are very local in their impact. Therefore, there is still a role for development specific planning obligations to enable a local planning authority to be confident that the specific consequences of a particular development can be mitigated.

A planning obligation needs to meets all of the following tests:

- *necessary to make the development acceptable in planning terms;*
- *directly related to the development; and*
- *fairly and reasonably related in scale and kind to the development.*

However, in order to ensure that planning obligations and the CIL can operate in a complementary way, the CIL Regulations 122 and 123 place limits on the use of planning obligations in three respects:

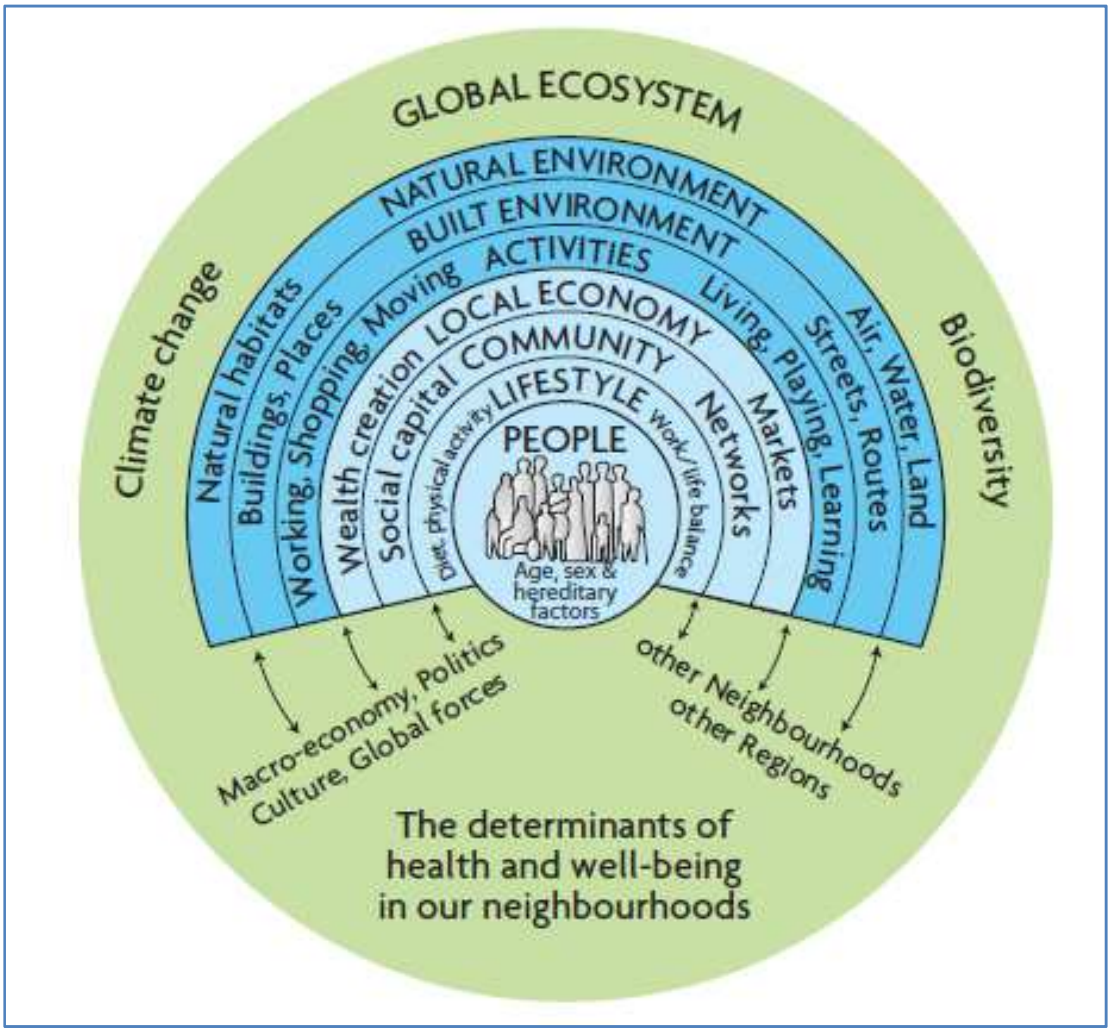
- they put the Government's policy tests on the use of planning obligations on a statutory basis, for developments that are capable of being charged the CIL
- they ensure the local use of the CIL and planning obligations does not overlap; and
- they impose a limit on pooled contributions from planning obligations towards infrastructure that may be funded by the CIL.

Therefore, it is possible to require both a CIL contribution and a Section 106 Planning Obligation contribution from the developer for the same application.

2.2 WHAT FEATURES OF THE BUILT ENVIRONMENT AFFECT HEALTH AND WELLBEING?

Place and space have an impact on health andwellbeing and individual actions to improve lifestyle or health and wellbeing status are likely to beinfluenced by the environmental and socioeconomic context in which they take place. Theterm “built environment”includes open space, networks and connectivity between areas as well as the physical structures. This includes the places where people work, live, play and socialise. The connections between these spaces, both manmade and natural features are also important. The built environment includes several material determinants of health,including housing, neighbourhood conditions and transport routes, all of which shape thesocial, economic and environmental conditions for which good health and wellbeing is dependent, these determinants of health are depicted in Figure 17.

Figure 17: The determinants of health and wellbeing in our neighbourhoods. Diagram by Barton, H & Grant, M, 2006, derived from Whitehead, M & Dahlgren, G, The determinants of health and well-being, 1991.



Due to the scale of the topic of the built environment and health a pragmatic approach of grouping the evidence by the broad themes which emerged from the literature has been taken.The evidence is, therefore, presented in the following themes:

- Generic evidence supporting the built impact on health
- Green space
- Developing sustainable communities
- Community design (to prevent injuries, crime, and to accommodate people with disabilities)
- Connectivity and land use mix
- Communities that support healthy ageing
- House design and space
- Access to unhealthy/"Fast Food"
- Health inequality and the built environment

2.2.1 Generic evidence supporting the built environment's impact on health

There is a clear association between the built environment and physical activity(1), where the physical characteristics of neighbourhoods are identified as having a positive impact on health, wellbeing, physical activity and walkability, these characteristics are: choice and diversity; well-kept environments; affordable and efficient public transport; safe and sociable play areas; the presence of greenspace; well-lit and pedestrian-friendly footpaths; and street patterns that provide opportunities for informal contact among residents(2). In addition, the Cambridge quality charter(3) sets out a series of basic principles for achievinghigher quality developments under four broad themes; Community, Connectivity, Climate, and Character ie building a sense of **community** through providing a greater choice of housing along with the active participation of people in the way their neighbourhoods are run. New developments should be located where people can benefit from high **connectivity** to jobs and services, and the infrastructure upgraded to match the pace of development. **Climate change** should be tackled through imaginative landscaping that treats water as a friend not an enemy, and through innovative approaches to transport, energy and waste. Finally, places of **character** should be created, with distinctive neighbourhoods and a first class public realm.

2.2.2 Green space

Provision of green space and infrastructure supports health through bringing with it the co-benefits that occur when accessing it eg physical activity and social interaction. (4)Contact with nature has a positive impact on blood pressure, cholesterol, outlook on life and stress reduction. (5)

The term Green Spaceincludes parks, forests, playing fields, river corridors, play areas and cemeteries.

The NICE physical activity and environment guidance conclude that people are more like to walk or cycle if there is an attractive streetscape with well-maintained and unobstructed pavements, although there does not seem to be a clear association between the amount and availability of green space and physical activity. (6)

There is anecdotal evidence from community members and local organisations that note the positive health benefits including increased physical activity, improved sense of security and increased social capital with community gardens.(7)

Dutch data on the self-reported health of over 10,000 people combined with land-use data on the amount of greenspace in their living environment concluded that living in a green environment was positively related to *Self-reported health indicators* (iethe number of

symptoms experienced in the last 14 days, perceived general health, and scores on the Dutch version of the General Health Questionnaire (GHQ) which indicate a person's propensity to psychiatric morbidity). Analyses on subgroups showed that the relationship between greenspace and one of the health indicators was somewhat stronger for "housewives" and the elderly, two groups that are assumed to be more dependent on, and therefore exposed to, the local environment. Furthermore, for all three health indicators the relationship with greenspace was somewhat stronger for lower educated people.(8) The study also concluded that having 10% more green space in the living environment is associated with a decrease in age related symptoms (in the last 14 days) that is comparable with a decrease in age by five years.

Green space and mental health
Garden users in a children's hospital found that they felt more relaxed and less stressed after visiting the garden.(9)

A study from MIND comparing groups taking part in two walks in contrasting environments, a country park compared to a shopping centre found that the group in the country park reported significant improvement in self-esteem, depression, anger, tension, confusion, fatigue compared to the group walking in the shopping centre.(10)

Green spaces and social ties
Evidence indicates that natural features within urban environments can encourage greater use and facilitate higher levels of social contact/integration.(11) A study in the US reported that the presence of trees and grass is related to social activity that takes place within them and the proportion of social to non-social activities they support.(12)

Green space and the elderly
Walkable green spaces near the residences of older people aged 75+ significantly and positively influences five-year survival.(13) The probability of five year survival increased in accordance with the space for taking a stroll near the residence ($p<0.01$), parks and tree lined streets near the residence ($p<0.05$), and their preference to continue to live in their current community ($p<0.01$). Two environment related factors emerged, the factor of walkable green streets and spaces near the residence and the factor of a positive attitude to a person's own community. The factor of walkable green streets and spaces near the residence showed significant predictive value for the survival of the urban senior citizens over the following five years ($p<0.01$). The study concluded that living in areas with walkable green spaces positively influenced the longevity of urban senior citizens independent of their age, sex, marital status, baseline functional status, and socioeconomic status.

Characteristics of green space
There are differences in the use of parks by ethnicity, a study found that Caucasian users of a large attractive urban park, lived locally and walked daily, while non-Caucasian users lived further away, visited the park infrequently as a family, and for passive recreational pursuits.(14)

Qualitative and quantitative surveys suggest that factors influencing use of Public Open Space include perceived proximity and accessibility (i.e. the absence of major roads); aesthetic features of the park such as the presence of trees, water (e.g., a lake) and birdlife, park maintenance (e.g., irrigated lawns), park size (which, in turn provides variety and opportunities to "lose oneself"), and the availability of amenities such as walking paths. Larger parks tend to have more attributes that provide more satisfying experiences for the user.(15)

Several studies have shown that parks with paved trails, unpaved trails, or wooded areasare more than seven times as likely to be used for physical activity compared to parks without these facilities. The presence of paved trails (OR=32.41; 95% CI=3.27, 320.36; P=.01), unpaved trails (OR=7.11; 95% CI=1.40, 36.12; P=.02), and wooded areas (OR=6.75; 95% CI=1.40, 31.90; P=.02) were significantly related to park-based physical activity when examined independently. In the unadjusted analyses, a greater number of both facilities (OR=1.85; 95% CI=1.18, 2.90; P=.01) and amenities (OR=1.49; 95% CI=1.04, 2.14; P=.03) was significantly associated with increased odds of at least some physical activity occurring in the park. (16)(17)

A systematic review of qualitative evidence on characteristics of park use and physical activity: showed both adults and children report multiple attributes within parks that encourage use, including those that support active and passive pursuits. Toilet facilities, water fountains, barbeques, picnic areas, seating, signage, and shade were all identified as important amenities within parks.(18)Similar attributes associated with park use are reported among quantitative research (Cronan et al., 2008; Reed et al., 2008; Kaczynski et al., 2008; Giles-Corti et al., 2005a; Floyd et al., 2008; Gobster, 2002; Shores and West, 2008). The review also found that features of parks that facilitated both structured (i.e., sports fields, courts) and unstructured (i.e., paths, trails) physical activity were important for encouraging park visits, and recent quantitative research suggests that parks with walking paths and trails were visited more often than parks containing sports-related facilities. Parks that support passive activities such as sitting may contribute to incidental physical activity if individuals seeking these activities use an active mode of transport to travel to or through the park. Moreover, the provision of amenities such as water fountains and toilets may allow parks to be used for longer periods, which in turn may encourage increased levels of physical activity.

Distance to public open space
Public open spaces closer to a person's home is associated with higher levels of use. Families that live further away visited parks less frequently. Overall use of Public Open Spaceis positively associated with accessibility.

Accounting for attractiveness as well as distance does not produce a stronger trend with level of access. However, when size was also taken into account, the odds ratio (OR) increases for those with very good access. Compared with those with very poor access, those with very good access to large attractive public open spaces are twice as likely to use it. These results suggest that after distance to public open spaces is taken into account, size was more important than attractiveness in encouraging use.(15)

Those parks with good access to attractive and large public open spaces were 50% more likely to achieve high levels of walking (six walking sessions a week totalling >180mins (15).

Natural England(19) has developed an Accessible Natural Greenspace Standard (ANGSt) which provides local authorities with a detailed guide as to what constitutes accessible green space. The Accessible Natural Greenspace Standard not only recommends the distance people should live from certain types of green spaces but also recommends the size of the green spaces in conjunction with distance to homes. All people should have accessible natural green space:

- of at least two hectares in size, no more than 300m (five minutes' walk) from home;
- at least one accessible 20 hectare site within 2km of home;
- one accessible 100 hectare site within 5km of home;
- one accessible 500 hectare site within 10km of home.

In 2008, Bristol City Council developed an accessible green space standard(20), known as the distance standard, which sits alongside both quality and quantity standards. The aim of the distance standard is to safeguard and encourage an accessible network of green spaces.

The standard is based on local research which identified the distance Bristol residents felt they could reasonably walk to access green space which coincided with the layout of Bristol's green spaces to ensure the standards were credible.

The distances proposed include:

- distance to the nearest green space – 400m/nine minutes' walk;
- children's play space – 450m/10 minutes' walk;
- formal green space – 600m/15 minutes' walk;
- informal green space – 550m/13 minutes' walk;
- natural green space – 700m/18 minutes' walk.

Allotments

Allotment gardeners report higher levels of physical activity in summer than a control group of neighbours significantly or marginally better than the control group on several measures of health and well-being. Allotment gardeners of 62 years and older reported better scores on all measures of health and wellbeing than neighbours, whereas younger allotment gardeners did not differ in health and wellbeing from younger neighbours.(21)This is supported by other reports outlining the importance of allotment gardens in achieving physical activity(22), (23), (24), in addition other studies have highlighted these benefits for the older people (25), (26).

Farmers Markets

Farmers markets are a crucial place for social interaction in the lives of older people as well as families and children, when market shopping is a time "to bump into friends and chat at leisure". In addition, market stalls take on the important role of including low income groups, who may be excluded from other shopping sites.(27)

Studies have also shown proximity of local food produce rather than fast food outlets to be associated with a lower rate of obesity amongst the population.(28), (29), (30)

2.2.3 Developing sustainable communities:

Design principles that have shown to produce health and occupational benefit (31), which in turn has been shown to reduce work place stress and absenteeism, reduce energy expenditure and building maintenance, these design principles include:

- Maximising natural daylight
- Solar collectors
- Passive cooling
- Non-toxic materials
- Harvesting rain water
- Creating pedestrian and bike greenways
- Filling buildings with plants, art, natural air
- Social cohesion and connectivity

2.2.4 Community design to prevent road trafficinjuries, crime, and to accommodate people with disabilities.

Environments designed to encourage walking and cycling contribute to lower pedestrian and cyclist injury rates in Holland and Germany than in the United States. Traffic-calming measures and other improved road and trail designs that take into account potential conflicts

between pedestrians, bicyclists, and motorists may lead to reductions in motor vehicle collisions and injuries.(32)

Rates of crime and fear of crime are associated with features of the physical environment within neighbourhoods, such features range from housing configurations that facilitate “eyes on the street” to abandoned buildings that suggest vulnerability to crime. The Crime Prevention Through Environmental Design (CPTED), which include design recommendations for housing layout, land use, territoriality, and physical maintenance, was developed to improve public safety, the UK version is called “secure by design”.

Communities that have user-friendly transportation systems and are compact and walkable are more accessible for persons with disabilities, allowing them to participate more fully in the community by working, shopping, and living within the integrated setting. Wheelchair users generally benefit whenever a community is made more walkable, as long as appropriate accommodations (such as curb cuts) are included in such community improvements. Older people without disabilities may receive similar benefits in improved quality of life from community designs that aid people with disabilities.(33)

2.2.5 Pavements

Urban developments contribute towards increasing the risk ofsurface water flooding as a result of continued development on floodplains and the increased use of impervious materials which increase surface water runoff. As runoff increases, so too does the risk of flooding and contamination from microbial and chemical agents. Exposure to contaminated floodwater increases the risk of respiratory illness, gastrointestinal illness and high blood pressure, and many of the chemical contaminants found in floodwater are carcinogenic.

2.2.6 Connectivity and land use mix

Well-connected and attractive public places and streets can encourage more people to exercise and make active travel choices. Having access to local services and resources (shops, sports centre, financial services) is associated with positive health outcomes. Places which enable people to carry out daily routines (eg shopping, banking, exercising, meeting people) within walking distance of their homes are likely to have higher levels of walking and cycling.

The availability and accessibility of parks, recreation and sports facilities strongly influence physical activity levels, and areas of socioeconomic disadvantage often suffer due to the poor quality or unequal distribution of such resources. Having access to local services and resources (shops, sports centre, financial services) is associated with positive health outcomes (The location and accessibility of some local services may influence the ‘obesogenic’ environment in terms of encouraging or discouraging physical activity and providing for a healthy diet). Local schoolscater for young families but also acts as centres for other social activities.

2.2.7 Communities that support healthy aging

The design of the environment must consider the declining visual, auditory, and kinaesthetic senses to maintain mobility, autonomy, independence, and well-being. Impaired hearing and vision need to be compensated for by louder signals and increased lighting. Changes in gait and balance mean that hazards such as steps, uneven pavements, and obstacles may lead to falls and subsequent health problems. Loss of cognitive functioning may inhibit way finding and orientation, so clear signage is required. More resting places may also be required for older adults who have low stamina.

Traffic has an impact on how older people navigate their surroundings, improvements can be made through the designing out of high speed through traffic, designing in traffic calming designs (narrower roads, more curves, street parking, slower speed limits), locating shop and amenities in locations which are accessible without having to cross busy streets.(34)

2.2.8 House design and space

Quantitative analysis noted the importance of adequate space in providing personal privacy, reducing depression, anxiety and stress, giving children room to play and a good nights sleep.(35) The cramming of different activities (studying, socialising, and relaxing) into limited space may adversely affect family life, creating a difficult dynamic which may play a part in the breakdown of relationships

Poor housing encompassing a lack of private study space for children is associated with underachievement. There is strong evidence that children with better quality homes gain a greater number of GCSEs, "A" levels and degrees and therefore have greater earning power(36), (37), (38)

Studies have linked this with an increase in anti-social behaviour. Children especially, teenagers deprived of adequate space at home may be disruptive and aggressive. In addition, low space standards contribute to poor health and low educational attainment that can express itself in incidences of antisocial behaviour.(39), (40)

The case for space(37) concludes that adequate space enables:

- Socialisation both with other family members and with guests (and having the privacy to do so).
- Having more storage space.
- Having more space for solitary activities and good circulation spaces which can also act as storage.
- Spaces for outdoor items such as prams, umbrellas and shoes.
- Relaxation, engaging in private study within bedrooms.
- Reorganisation of rooms internally, if need be, by making openings or converting pitched roofs.
- Working from home (e.g. to improve life-work balance).(41)
- Having more space in the kitchen so that children can play under the supervision of their parents; more space for waste and recycling bins.
- Improves day light and ventilation.

Large floor spaces allows long term utility of a house, creating the so called life time home. Çavusoglu et al (2008) argue that such adaptability delivers long-term accessibility as well as long-term sustainability as adequate space in dwellings will allow residents to adapt space to their changing needs over the life course: homes will become future proof.(37), (41)

It is important to create minimal space standards, similar to the London housing minimal space standards, which is based upon the Park Morris standard.(39)

Housing that is of a reasonable size and is affordable to heat is associated with positive health outcomes. Improved warmth and energy efficiency measures, which are often part of wider rehousing and retrofitting programmes, can lead to improvements in health. Reports indicate that increased usable indoor space as a result of improvements in thermal comfort and affordable warmth can have many benefits for householders, which may lead to improved physical and mental health.(42)

Qualitative studies have found that homes with improved thermal comfort reported: increase in usable indoor space; improvements in diet, privacy and household/family relationships. Although no clear evidence on health improvement, respondents made links to improvement in physical and mental health.(43), (44), (45)

2.2.9 Health inequality and the built environment

Individuals from lower income groups, older people and those with disabilities are less likely to have access to personal transport (Lavin et al., 2006). These groups may find that access to services such as shops and health care is reduced. Consequently, they may spend a higher proportion of their income on transport (Lavin et al., 2006). (46)

Access to transport that enables residents to move outside of their own community has been shown to positively correlate with a reduced fear of social isolation and positive mental health (Whitley et al, 2005). For those on higher incomes, this is by car or taxi. However, for those on lower incomes, access to public transport is important (Whitely et al, 2005). (46)

Lack of facilities such as public toilets (Greed, 2006) impacts on vulnerable groups, for example young children, older people and those with illnesses or chronic diseases. Lack of suitable areas for resting, for example benches and seating may also limit the ability for certain groups to explore or walk longer distances. For older people this impacts negatively linking to social isolation. (46)

Moreover, lack of availability and accessibility of municipal services such as libraries, health facilities, doctors' surgeries, schools and social support can have a negative social impact on communities and affect both physical and mental health (Horowitz et al, 2005; Lavin et al, 2006). Places which lack facilities often become ghettoised fostering a risk of further criminal activities (Horowitz et al, 2005) (46)

Inequitable distribution of physical activity facilities in communities is significantly associated with disparities in health related behaviours and obesity. Availability of resources to allow for physical activity decreases the relative odds of an overweight status, Particularly there is reduced equity amongst ethnic minorities and those of a lower socio-economic status. (47)

2.2.10 Obesity and access to unhealthy/fast food establishments in developments.

Children living close to fast food outlets more likely to be overweightChildren living in areas surrounded by fast food outlets are more likely to be overweight or obese. Centre for Diet and Activity Research (CEDAR) research looked at weight data from more than a million children and compared it with the availability of unhealthy food from outlets including fish and chip shops, burger bars, pizza places, and sweet shops. The results show that older children living in more deprived areas, which have higher density of unhealthy food outlets, are more likely to be obese. In particular, they are more likely to be overweight when living in close proximity to a high density of unhealthy eating outlets. For older children, unhealthy food outlets partly explained the association between deprivation and obesity but only by a small amount. The prevalence of fast food and other unhealthy food outlets explained only a small proportion of the observed associations between weight status and socioeconomic deprivation. Children's weight status may be influenced by their local environment, particularly older children, but associations between obesity and deprivation do not appear strongly due to local food environment characteristics.(48)

There is little evidence that food retailing around schools may influence student body mass index (BMI). A CEDAR study examined associations between food retailing and BMI among

a large sample of primary school students in Berkshire. By controlling for individual, school and home characteristics and stratifying results across the primary school years, it aimed to identify if the food environment around schools had an effect on BMI, independent of socio-economic variables. The results showed that there were no significant associations between retailing near schools and student BMI, but significant positive associations between fast food outlets in home neighbourhood and BMI z-scores. Year 6 students living in areas with the highest density of fast food outlets had an average BMI z-score that was 0.12 (95% CI: 0.04, 0.20) higher than those living in areas with none.(49)

Socio-ecological models of behaviour suggest that dietary behaviours are potentially shaped by exposure to the food environment ('foodscape'). Research on associations between the foodscape and diet and health has largely focussed on foodscapes around the home, despite recognition that non-home environments are likely to be important in a more complete assessment of foodscape exposure. CEDAR research characterises and describes foodscape exposure of different types, at home, at work, and along commuting routes for a sample of working adults in Cambridgeshire.

Home and work locations, and transport habits for 2,696 adults aged 29–60 were drawn from the Fenland Study. Density of and proximity to food outlets was characterised at home and work. Commuting routes were modelled based on the shortest street network distance between home and work, with exposure (counts of food outlets) that accounted for travel mode and frequency. For all types of food outlet, the research found very different foodscapes around homes and workplaces (with overall outlet exposure at work 125% higher), as well as a potentially substantial exposure contribution from commuting routes. On average, work and commuting environments each contributed to foodscape exposure at least equally to residential neighbourhoods, which only accounted for roughly 30% of total exposure. Furthermore, for participants with highest overall exposure to takeaway food outlets, workplaces accounted for most of the exposure. Levels of relative exposure between home, work and commuting environments were poorly correlated.(50)

Exposure to takeaway food outlets is positively associated with consumption of takeaway food. Among domains at home, at work, and along commuting routes, associations are strongest in work environments, with evidence of a dose-response effect. Exposure to takeaway food outlets in home, work, and commuting environments combined is associated with marginally higher consumption of takeaway food, greater body mass index, and greater odds of obesity. Government strategies to promote healthier diets through planning restrictions for takeaway food could be most effective if focused around the workplace.(51)

2.2.11 Suicide and new developments

Suicide is a major issue for society and a leading cause of years of life lost.
The Government's "Preventing Suicide in England" (59)report identified a number of objectives and areas for action, one of which is directly related to the built environment:

Reduce access to the means of suicide, as reducing access to high-lethality means of suicide i.e.jumping from a height is one of the most effective ways to prevent suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass. Suicide in high-risk locations and those on the rail and underground networks are most amenable to intervention.

Jumping from a high place is an important method of suicide to address. Suicides by jumping almost inevitably occur in public places, have a very high fatality rate and are

extremely traumatic for witnesses and people living and working in the surrounding area. Jumps also tend to attract media attention, which can lead to copycat suicides. All the world's most notorious suicide locations are jumping sites.

Locations that offer easily accessible means of suicide include vehicle and pedestrian bridges, viaducts, high-rise hotels, multi-storey car parks and other high buildings, and cliffs. Most new development sites will have structures that lend themselves to suicide attempts.

The risk of suicide can be reduced by limiting access to these sites and making them safer.

Evidence suggests that loss of life can be prevented when local agencies work together to discourage suicides at high-risk locations, including sites that temporarily become suicide hot-spots following a suicide death.

Effective approaches to reducing suicides at high-risk locations or from jumping includepreventative measures – for example barriers or nets on bridges, including motorway bridges, from which suicidal jumps have been made, and providing emergency telephone numbers, e.g. Samaritans.

Local authority planning departments and developers can include suicide in health and safety considerations when designing structures such as multi-storey car parks, bridges and high-rise buildings which may offer suicide opportunities.

Suicide by jumping or lying in front of trains and other moving vehicles is similarly an important method to address. While suicide rates have been falling generally, suicide deaths on the railway network have increased slightly, to about 210 people a year in England, Scotland and Wales. Most (about 80%) are men and most are in the 15–44 age range. The Rail Safety and Standards Board (RSSB) and the British Transport Police collect extensive information on railway deaths and incidents, including suicides and attempted suicides.

3. LOCAL DATA

3.0 WHAT IS IN THIS SECTION?

This section is split into two parts: the first gives a short overview of the five Local Plans in Cambridgeshire, their status and indication of the policy focus for each plan and the second part compares polices in each plan against the evidence themesthatemerged in section 2.2 above.

3.1 THE LOCAL PLANS OF CAMBRIDGESHIRE

Although each Council in Cambridgeshire has its own local plan "the statutory duty to cooperate" requires the authorities to work together to address strategic planning issues, including the additional homes and jobs needed in the area. Recognising both the need to work together and the statutory duty, the authorities in Cambridgeshire and Peterborough work closely with each other, and with neighbouring authorities.

The authorities set up the Cambridgeshire & Peterborough Joint Strategic Planning Unit (JSPU) in 2012, in response to the removal of statutory strategic planning functions. The JSPU works with the Cambridgeshire & Peterborough local authorities, and with relevant strategic bodies, to help develop a coherent approach to planning across the area.

3.2 THE FENLAND DISTRICT COUNCIL LOCAL PLAN

3.2.1 Overview of the local plan

The Fenland Local plan was adopted in May 2014 and the plan period is for 20 years
The main introduction to the plan contains a health summary highlighting that poor health is a key issue for Fenland and that the following health indicators are significantly worse in Fenland compared to the England average:

- Life expectancy for men.
- Levels of obesity amongst children.
- Levels of adult smoking.
- Levels of physical activity amongst adults.
- Levels of people diagnosed with diabetes.
- Rates of road injuries and deaths.
- Numbers of hospital stays for alcohol related harm.

Fenland remains relatively sparsely populated, but has experienced considerable housing and population growth in recent years, in line with growth across Cambridgeshire. In the decade up to 2001, the district's population grew at four times the national average and has continued to grow rapidly since. The 2011 Census suggests Fenland has a population of approximately 95,300, compared to 83,700 in 2001 and 75,500 in 1991. Chatteris and March in particular have accommodated significant new house building, as have Doddington, Wimblington and Manea.

Growth in employment in Fenland has not matched workforce expansion and out-commuting is increasing. Currently, almost 40% of Fenland's working population commute out of the district for work.

Fenland is Cambridgeshire's most deprived district (ranking as 94th most deprived authority out of 326 nationally). Deprivation levels in Fenland are generally more severe to the north of the district, and this is evident in Wisbech in particular.

Fenland's local plan has specific objectives to improve the quality, range and accessibility of services and facilities (eg health, transport, education, training, leisure opportunities and community activities); and ensure all groups thrive in safe environments and decent, affordable homes, and to create and enhance open space that is accessibleand improves opportunities for people to access and appreciate wildlife and wild places. There are also objectives to redress inequalities related to age, gender, disability, race, faith, location and income.

The Plan recognizes the need to address:

- appropriate housing;
- improved access to quality local services;
- healthy transport choices such as cycling and walking;
- access to green infrastructure and active recreation;
- good place making (including creating new, and connecting with existing, vibrant and successful communities);
- promoting renewable energy and energy efficiency to help address fuel poverty;
- improve the health and wellbeing of its residents including mental health;
- the promotion of community cohesion;
- reduction of crime, the fear of crime and anti-social behaviour;
- promote access to healthy and local food.

3.2.2 Developer Contributions Requirements

Developers will either make direct provision or will contribute towards the provision of local and strategic infrastructure required by the development either alone or cumulatively with other developments. Fenland do not operate the Community Infrastructure Levy system at the present time and is unlikely in the short term up to 2018, relying on developer contributions through the Section 106 process.

Fenland require developer contributions for the following infrastructure:

- Transport
- Community Facilities
- Education Facilities
- **Healthcare Facilities**
- Open Space and Play Areas
- Water, Drainage, Flood Protection and Energy Provision
- Culture, Leisure and Heritage
- Waste Collection and Disposal

Case Study 1: Health Facilities Policy - Fenland

Case Study – Fenlands policy on Health Care facilities:
When a new development is proposed, a common public comment is along the lines of 'but the doctor's/ dentist's surgery is too full – we will need a new one/or expanded one'. However, in simple terms, such surgeries are in effect a private business with complicated funding mechanisms linked, amongst other matters, to the number of patients. It could be said that, like a shop, doctor/ dentist surgeries are 'market-led'.

However, for very large strategic sites, which in themselves would generate demand for a new doctor's or dentist's surgery, we would expect a broad concept plan to make space available for such facilities. To determine whether a site should provide such a space, it will require the developer to research local capacity/ demand, and provide such evidence with a planning application or broad concept plan.

It is, therefore, likely that most planning proposals will not require a developer contribution towards healthcare facilities. The exception could be very large sites, which provide a space for such facilities with an appropriate agreement in place to secure the site.

3.3 Huntingdonshire District Council Local Plan(s)

3.3.1 Overview of the local plan(s), current and proposed

Huntingdonshire is in the process of adopting its new local plan, the current Huntingdonshire Local Plan Part One was adopted in December 1995.

The 1995 Local Plan
The plan doesnot mention health and wellbeing and the environment and the policies which have a positive impact of health do not mention these benefits.
The plan recognizes the need to address:

- Open space, community recreational facilities, children's play areas.
- Infrastructure, services and amenities.
- Environmental pollution which would be detrimental to housing.

- Noise pollution and housing sites.
- Specialist communal housing.
- Economic and employment growth to reduce commuting.
- Traffic management, pedestrian routes, and segregated cycleway routes.
- Bus travel.
- Recreation and leisure provision.
- Basic provision of a meeting place for each village.
- Retain existing allotment provision.
- Access for the disabled.
- Crime prevention.
- Health and social services.
- Need for nursing homes, residential homes, sheltered accommodation and small hostels.
- Library services.
- Public conveniences.

Huntingdonshire's Draft Local Plan to 2036

The introduction to the plan contains a summary of the demography highlighting that Huntingdonshire's residents are generally healthierthan the national average with 6% of residents having long-term health or disability issues which limit theirday to day activities a lot compared to 8% for England as a whole. Car ownership in Huntingdonshire is significantly higher than the national average reflecting the relatively rural nature of most of the district with consequent dependence on private cars for personal transport. Only 19.3% of employed residents travelled to work by public transport, cycling or walking.

There are 22 General Practices operating within the district with some having satellite surgeries in villages to provide more local facilities to patients. Hinchingbrooke Hospital provides medical services for residents of Huntingdonshire and some surrounding areas, the hospital has a major treatment centre which has allowed a significant increase in day case patients.

The spatial vision and objectives for Huntingdonshire include an objective that Huntingdonshire will be a destination of choice as a place to live, work and invest. It will offer attractive homes, jobs and a high quality of life providing opportunities for all residents and workers to achieve their maximum potential and enjoy healthy and sustainable lifestyles.

The plan recognises the need to address:

- High quality, well designed, locally distinctive sustainable development that is adaptable to climate change and resilient to extreme weather.
- Better job opportunities and more affordable homes.
- Opportunities for people to pursue a healthy lifestyle and to actively participate in their community and to have a high quality of life.
- Maintain an up-to-date Infrastructure Business Plan to identify the infrastructure needs of proposed developments.
- Sustainable modes of travel and minimise the needs for unnecessary travel priority is to be given to use of public transport, cycling or walking.
- Adequate infrastructure to meet the needs of new growth and facilitate active, cohesive communities and sustainable lifestyles.
- Inclusive and accessible provision for community needs including education, health, social care, policing, sports, play and open space and integrated community facilities.
- Range of market and affordable homes that enables choice between types, sizes and tenures as well as over lifetimes and within individual communities.

- Opportunities for vulnerable people to live independent lives with support to meet their needs.
- Attractive, safe and distinctive residential neighbourhoods in which people can meet their day-to-day social, health, educational, recreational and convenience shopping requirements.
- Opportunities for minimising energy and water use and securing carbon emission reductions.
- Waste management and pollution control practices which minimise contributions to climate change and do not incur unacceptable impacts on the local environment or endanger human health.

3.2.2 Developer Contributions Requirements

Community Infrastructure Levy

Applicable developments will be liable to pay the Community Infrastructure Levy (CIL) as set out in the Huntingdonshire Community Infrastructure Levy Charging Schedule or successor documents.

Planning Obligations (Section 106)

Contributions in addition to the CIL may be necessary to make the proposals acceptable in planning terms.

Case Study 2: Health Facilities Policy - Huntingdonshire

Case Study – Huntingdonshire's policy on Health Care facilities:

The District Council will continue to seek to secure appropriate health service facilities related todevelopment sites. In considering whether contributions will be sought towards the provision of healthservice facilities, the Council will liaise with their local National Health Service (NHS) Primary Care Trust(PCT), or successor bodies, and other relevant agencies. Consideration will be given to relevant healthdocuments such as the Strategic Plan Document 2010 - 2015, the Corporate Strategy and the StrategicServices Delivery Plan (currently under development 2011). Health needs are informed by the JointStrategic Needs Assessment (JSNA) which is a suite of documents that include an overall summary plusclient group or themed areas including a JSNA for New Communities.

In addition, the Government White Paper "Our Health, Our Care, Our Say", the Lord Darzi Interim Reviewof the NHS, the latest White Paper "Equity & Excellence; Liberating the NHS" and the NHS Future Forumrecommendations seek to shift more health and social care into community settings, closer to people'shomes and continue the ongoing modernisation of service delivery. The impact of development thereforegoes far beyond the need for GP facilities and services which have often been the only element of healthservices considered in the past.

The District Council will continue to seek to secure appropriate health service facilities to meet the needsof communities from new development sites in accordance with the Adopted Core Strategy, the DevelopmentManagement DPD: Proposed Submission 2010, or successor documents as appropriate.

Specifically, Core Strategy Policy CS10 sets out the contributions that for infrastructure may be requiredand will be applied to all development proposals across the administrative area of Huntingdonshire.

Huntingdonshire's Sustainable Community Strategy 2008 – 2028 shows how HDC with its partners willbuild a better future for Huntingdonshire. It reflects key strategies, specifically the Local DevelopmentFramework, which will be the delivery mechanism for the spatial elements of the strategy.

Types of facilities/services for which provision may be required:
On site provision of land for space within development to accommodate identified health needs. In certaincircumstances it may be more appropriate to have the facility at an alternative location off site. In suchcircumstances, where more than 50% of need for infrastructure is generated by the proposal, a proportionatefinancial contribution to purchase the land or provision of the land as an in-kind payment will be required. Contributions will also be needed in all cases for the construction or funding of these health servicefacilities. The range of services that this could include is:

3.3 EAST CAMBRIDGESHIRE DISTRICT COUNCIL LOCAL PLAN

3.3.1 Overview of the local plan

The East Cambridgeshire Local plan was adopted in April 2015 and the plan period is for 20 years. The main introduction to the plan contains a health summary highlighting thatAccording to a 2012 survey(52), East Cambridgeshire's residents have the best quality of life of any rural area in Great Britain. In particular, health and life expectancy are amongst the highest of rural areas. However, there are variations across the district and pockets of deprivation exist.

The plan also makes reference to the needs of older people. There is an identified need in the district to provide care accommodation for various groups of people for rehabilitation and out of hospital care, including the elderly, people with disabilities and vulnerable people.

The forecast change in population by broad age groups for the period 2011-2031 predicts significant growth in the over 60 age group. The proportion of people aged 75+ years will rise by 93% and those aged 85+ years will grow by 144%.

Accommodation for the elderly and others in need of care is moving towards more flexible forms of living and support which seek to maintain their independence and control of their lives. There are several options where residents can enjoy their own self-contained home within a site offering extra facilities. These include retirement homes/villages, and 'extra care' housing, where varying levels of care and support are provided in the home. These models often include a restaurant or dining room, health & fitness facilities and hobby rooms on site. Other forms of accommodation include care or nursing homes, which comprise single rooms within a residential setting where residents receive varying levels of care. Care can range from primarily personal care to nursing care for those who are bedridden, very frail or have a medical condition or illness.

The plan outlines the key issues and challenges as:

- **Infrastructure provision** – Recent high levels of growth have placed pressure on local services and facilities including health, education and leisure. The provision of a good broadband service is also critical to support business growth, especially in the rural areas where the current service can be poor. The challenge is to ensure that services and facilities are delivered alongside growth.
- **Sustainable travel** – The district is predominantly rural with a dispersed population, which creates challenges in providing a comprehensive public transport network. Many local communities are reliant on the car as their only transport option. This impacts on carbon dioxide emissions, air quality, noise, public safety and the quality of the environment in towns and villages. The challenge is to ensure that development is directed to sustainable locations and that sustainable modes of transport are encouraged to reduce reliance on the car.
- **Rural services** – The retention of local services is a key issue, particularly for rural communities. The challenge is to resist the loss of important facilities and support the delivery of new ones. This will be especially important in the context of the district's ageing population, and the dispersed rural nature of the district.

The spatial vision for East Cambridgeshire includes improved social, recreational, health and educational facilities. The needs of elderly, young and lower-paid people will receive special attention. Existing vital community services will be retainedand new infrastructure and services required to support growth will be delivered on time to meet the needs of new residents. The levels of crime and the fear of crime will have been further reduced.

Transport deficiencies will be tackled and accessibility improved. Public bus services between market towns and villages will be improved (including to settlements in neighbouring areas). Better cycling and pedestrian facilities and links will be provided, including segregated cycle routes along key routes linking towns and villages.

The Strategic objectives include:

- Ensure that new development is of high quality and sustainable design which reflects local character and distinctiveness, provides attractive and safe environments, and is supported by appropriate facilities and services.
- Provide greater opportunities to reduce car use, by locating most development where there is good access to jobs, services and facilities, and supporting improvements in public transport and walking/cycling networks.
- Ensure a high quality of life by maintaining and delivering strategic and local infrastructure and facilities needed to support local communities.

3.3.2 Developer Contributions and CIL

East Cambridgeshire District Council has adopted the Community Infrastructure Levy (CIL), and most residential and retail development is required to pay a CIL charge. In some cases, it will also be necessary for development to make provision for site-specific infrastructure needed in relation to a particular scheme. This may be provided on-site, or through financial contributions from developers secured through Section 106 agreements. Section 106 agreements will need to meet tests set out in Regulations, and may be sought for a variety of infrastructure and benefits, including:

- Community facilities including library and public health services.
- Education facilities including primary, secondary and special schools.
- Sport, leisure, open space and recreation facilities.

- Transport infrastructure.
- Flood mitigation and improvement measures
- Environmental improvements.

East Cambridgeshire requires contributions for the following infrastructure:

Table 16: CIL and Section 106 Requirements, East Cambridgeshire District Council

Type of infrastructure	**Section 106 infrastructure/mitigation**	**CIL funded infrastructure**
Affordable housing	Affordable housing	
Education	Development specific schools and educational facilities on large strategic housing sites	School and educational places/facilities not on large strategic housing sites
Community facilities	Development specific community meeting space(s) and library/lifelong provision on large housing sites	Improvement of existing library services and community buildings not on large strategic housing sites Art facilities and museums
Health	**Development specific new healthcare facilities on large housing sites**	**Other healthcare provision**
Transport	Local site-related road/transport requirements	Other road and transport infrastructure projects
Economic development	Development specific economic initiatives on large strategic sites	Other economic development measures not on large strategic sites
Environment	Local site-related habitat/nature/heritage requirements	Other environmental/heritage provisions and infrastructure
Open Space	Provision of on site or site related informal open space, land, play facilities and recreational equipment	Development of district wide infrastructure network (where off site and unrelated to specific developments)
Sport Facilities	Development specific formal sports land & facilities on large housing sites	Formal sports land and facilities not on large strategic sites or related to a large strategic site
Emergency Services	Development specific police service provision	District wide Police service infrastructure requirements
Flood defence/drainage	Site-related flood defence/drainage infrastructure	Other flood defence/drainage infrastructure

Case Study 3: Health Facilities Policy - East Cambridgeshire

Case Study – East Cambridgeshire's policy on Health Care facilities:
Context
Cambridgeshire Primary Care Trust (PCT) is currently responsible for the planning and securing of health services and improving the health of the local population. This section looks at the need for primary healthcare infrastructure (which includes GP and dentist provision) within the district.

What is required?
New residential development will be required to contribute to the improvement or expansion of existing healthcare facilities unless there would be sufficient capacity in available health infrastructure within the locality to cater for the needs arising from the new development. CIL funds will generally be used to address the cumulative impacts of developments on healthcare facilities. Where the expansion of existing healthcare facilities is required this will be considered for inclusion on the Regulation 123 list.

Planning obligations will be used to secure new healthcare facilities associated with specific development schemes, e.g. large strategic housing sites which generate the need for new facilities, and where the PCT (or successor bodies) have identified the site as a preferred location for a new facility. The need for new facilities will be dependent upon the capacity of existing healthcare facilities and the proximity of facilities to new residential developments, and will take account of the following national provision guidelines: one GP per 1,800 population, and one dentist per 2,000 population. Applicants will be required to make on-site provision of land which is required to accommodate the identified healthcare facilities. They will also be required to make a financial contribution to the delivery of new healthcare facilities required on-site – as detailed in the section below.

In certain situations, planning obligations may also be used to deliver a new healthcare facility required by a small number of medium/large scale developments – with the facility provided on a nearby site. This can include situations where a site for healthcare facilities has been identified by the Cambridgeshire PCT (or successor bodies) for this purpose. The Council will ensure that these facilities will not be funded through CIL receipts, that the obligations meet the statutory tests, and that no more than five separate planning obligations are secured for the same facility.

Financial contributions
Contributions will be sought towards the cost of constructing and fitting out facilities, in addition to land provision. The following tables provides indicative costs for new community facilities (excluding land purchase costs). The figures are intended to be used as a guide by applicants and will vary depending upon the proposed location, development specifics and the timing of the development.

Type of community facility	Cost per m^2	Source
Healthcare facilities	£2200	**NHS Cambridgeshire**

Facility	Expected cost of building
Healthcare Facility (375m2)	£825,000

3.4 SOUTH CAMBRIDGESHIRE DISTRICT COUNCIL LOCAL PLAN(S)

3.4.1 Overview of the local plan(s), current and proposed

South Cambridgeshire is in the process of adopting its new local plan, the current South Cambridgeshire Local Plan was adopted in January 2007.

The 2007 Local Plan

The introduction to the plan gives an overview of the location and surrounding environment but does not give an indication as to the health status of the district.

The Plan recognizes the need to address:

- Locate development where access to day-to-day needs foremployment, shopping, education, recreation, and otherservices is available by public transport, walking and cyclingthus reducing the need to travel, particularly by private car.
- Ensure the provision of appropriate community facilities tomeet the needs of new developments, working in partnershipwith other service providers and voluntary organisations.
- Ensure that major new developments create distinctive,sustainable and healthy environments that meet the needs ofresidents and users, and contribute towards the creation ofvibrant socially inclusive communities.
- Achieve a permeable development for all sectors of the community and all modes of transport, including links to existing footways, cycleways, bridleways, rights of way, green spaces and roads.
- Provide high quality public spaces.
- Provide an inclusive environment that is created for people, that is and feels safe, and that has a strong community focus.
- Safe and secure cycle parking.
- Outdoor play space.
- Safe and convenient access for all to public buildings and spaces, and to public transport, including those with limited mobility or those with other impairment such as of sight or hearing.
- A design and layout that minimises opportunities for crime.
- Encourage the provision of public art in new development.
- To meet the formal and informal sport and recreation needs of the district, including provision of high quality indoor and outdoor facilities.
- Protect and enhance important areas of local and strategic open space for their recreation and amenity value, and create connectivity with existing public rights of way and the wider countryside.
- The provision of adequate health facilities, including mental health provision, in appropriate accommodation and locations to cater for the existing andproposed population of Cambridgeshire.
- Natural environment (noise environment, light pollution, re-use of land, air quality).

The 2007 plan does have a requirement for a Health Impact Assessment to be submitted for major developmentsie

- Residential development: the erection of 20 or more dwellings, or, ifthis is not known, where the site area is 0.5 hectares or more; or
- Other development: where the floor area to be created is 1,000 m_2 ormore, or the site area is 1 hectare or more.

South Cambridgeshire's Draft Local Plan to 2031
South Cambridgeshire is a prosperous area with high levels of economic activityand low levels of unemployment. Its 350 square miles of countryside provides a highquality setting for its 105 settlements. In recent decades the district has experiencedsignificant growth, reflecting the success of the local economy and the need for newhomes. These high levels of growth have managed to balance development withmaintaining a high quality social, built and natural environment which is valuedlocally and has ensured that South Cambridgeshire regularly performs well innational quality of life surveys.

The vision for South Cambridgeshire is that South Cambridgeshire will continue to be the best place to live, work and study in the country. The district will demonstrate impressive and sustainable economic growth. The residents will have a superb quality of life in an exceptionally beautiful, rural and green environment.

Two of the six key objectives of the Local Plan are:

- To ensure that all new development provides or has access to a range of services and facilities that support healthy lifestyles and wellbeing for everyone, including shops, schools, doctors, community buildings, cultural facilities, local open space, and green infrastructure.
- To maximise potential for journeys to be undertaken by sustainable modes of transport including walking, cycling, bus and train.

The 'health' of people living in the district is generally better than the average for England. Good health leads to an aging population with the highest growth expected to occur in the 65+ age group. In national indices of multiple deprivation (2010), out of 326 English local authorities where a rank of 1 is the most deprived authority in England, and a rank of 326 the least deprived authority, our score was 322 (meaning South Cambridgeshire is one of the most successful areas in England).

The indices take account of income, employment, health and disability, education skills and training, barriers to housing and other services, crime, and the environment.

Age structure is a key factor for planners and service providers as it affects requirements for services such as education, health, leisure, arts and sports facilities. It influences household composition and therefore the overall size of a new development's population.

People who move into new developments can have very different population characteristics to the surrounding area. Initial populations tend to have a young age structure, with many young couples and young children, and very few older people.

Population age structures change markedly over time as developments mature, with children and adults ageing and the age structure gradually becoming older and more similar to the surrounding population. This process may take as long as 30 years.

Rural shops and services are vital for maintaining communities and supporting access for the less mobile members of society.

Sport and play space is important for supporting healthy lifestyles.

There are high levels of demand for new allotments, which provide opportunities to support healthy lifestyles.

Areas around the A14 north of Cambridge, and the centre of Cambridge, are designated as Air Quality Management Areas.

National Noise Action Plans First Priority Locations have been identified within the district in areas close to the M11, A14 and A10, and other busy roads.

The Plan recognizes the need to address:

- Design Principles, which includes: permeable development; safe and convenient access for all users and abilities; cycleparking and storage; mix of use; landscaping and public spaces; health and amenity of occupiers; crime.
- Public Art.
- Green Infrastructure, including Local Green Space.
- Residential Space Standards for Market Housing.
- Shared Social Spaces in Employment Areas.
- Health Impact Assessment.
- Protection of Village Services and Facilities.
- Meeting Community Needs.
- Hospice Provision.
- Outdoor Play Space, Informal Open Space and NewDevelopments.
- Lighting.
- Noise Pollution.
- Contaminated Land.
- Air Quality, including Odour and Other Fugitive Emissions to Air.
- Sustainable Travel.

3.4.2 Developer contributions requirements

South Cambridgeshire is currently consulting on the adoption of the Community Infrastructure Levy (CIL), so is reliant on Section 106 contributions

Case Study 4: Health Facilities Policy - South Cambridgeshire

Case Study – South Cambridgeshire Policy on Section 106 and CIL Contributions
The sites allocated in the Local Plan identify where new communities will be developed over the plan period. Experience from developing Cambourne, and the ongoing work to deliver Northstowe and the urban extensions to Cambridge, have informed the content of this policy. New large scale major developments will need to include a wide range of services and facilities to become successful communities. Smaller village developments will not usually need to include new services and facilities on-site but may need to contribute to the expansion of existing facilities and sometimes provide land for that expansion. The provision of facilities and services will be secured via a planning obligation when mitigating a site specific impact or more generally through a Community Infrastructure Levy contribution (CIL).

The Proposed CIL Regulation 123 infrastructure list:

- Pre-school education
- Secondary school education
- Libraries and lifelong learning
- Public and community transport
- Strategic green infrastructure
- Village halls and community centres

The Proposed CIL Regulation 123 infrastructure list (Continued):

- Household recycling centres
- **Primary health care**
- Major transport schemes identified in the Transport Strategy for Cambridge and South Cambridgeshire

The Policy within the proposed local plan is:
1. Planning permission will only be granted for proposals that have madesuitable arrangements for the improvement or provision of infrastructurenecessary to make the scheme acceptable in planning terms. The nature,scale and phasing of any planning obligations and/or CommunityInfrastructure Levy (CIL) contributions sought will be related to the formof the development and its potential impact upon the surrounding area.

2. Contributions may also be required towards the future maintenance andupkeep of facilities either in the form of initial support or in perpetuity inaccordance with Government guidance.

Contributions may be necessary for some or all of the following:

- Affordable housing, including for Key Workers.
- Education (including nursery and pre-school care).
- Health care.
- Public open space, sport and recreation facilities (including Strategic OpenSpace);
- Improvements (including infrastructure) for pedestrians, cyclists, equestrians,highways and public and community transport.
- Other community facilities (eg community centres, youth facilities, libraryservices social care, and the provision of emergency services).
- Landscaping and biodiversity.
- Drainage/flood prevention.
- Waste management (pursuant to the Cambridgeshire & Peterborough Minerals and Waste Development Plan).
- Arts and cultural provision.
- Community development workers and youth workers.
- Other utilities and telecommunications.
- Preservation or enhancement of the historic landscape or townscape.

Depending on the nature of the services and facilities, contributions may also berequired to meet maintenance and/or operating costs either as pump priming or inperpetuity, provided through an obligation.

Development can create additional demands for physical infrastructure and socialfacilities, as well as having impacts on the environment. In such cases planningobligations will be required, in accordance with government guidance, to make thenecessary improvements, provide new facilities, or secure compensatory provisionfor any loss or damage created. Such obligations will take account of the widerneeds of the Cambridge Sub-Region, in order to achieve wider planning objectives,with contributions pooled where appropriate to meet strategic requirements. In suchcases, the nature and scale of contributions sought will be related to the size of thescheme and the extent to which it places additional demands upon the area.

3.5 CAMBRIDGE CITY COUNCIL LOCAL PLAN

3.5.1 Overview of the local plan(s), current and proposed

Cambridge City Council is in the process of adopting its new local plan, the current Local Plan was adopted in 2006.

The 2006 Local Plan

The introduction to the plan gives an overview of the location and surrounding environment but doesnot give an indication as to the health status of the district. The Local Plan sets the context for economic growth, identifying that Cambridge is an important centre for employment, services, government, healthcare and shopping, and is nationally and internationally important for its higher education, knowledge-based industries and tourism.

Cambridgeshire has one of the fastest growing economies and populations in Britain. In the past much of this growth was directed to the villages beyond the Green Belt, resulting in a growth of commuting by car to Cambridge, and congestion and pollution in the cramped road network of the city. A lack of local housing that people can afford has reinforced these trends and forced people to live further away from Cambridge, a city which has almost twice as many jobs as residents in work.

The Plan recognizes the need to address:

- Creating Successful Places
- Open Space and Recreation Provision Through New Development
- The Design of External Spaces
- Protection of Open Space
- Pollution and Amenity
- Air Quality Management Areas
- Lighting
- Protection of Existing and provision of new Community Facilities
- Protection of, and provisionof new Leisure Facilities
- Food and Drink Outlets, including cumulative impacts
- Connectivity including: transport Impacts; Walking and Cycling Accessibility; Pedestrian and Cycle Network; Cycle Parking; Public Transport Accessibility
- Outdoor Sports Facilities: including Grass Pitches; Artificial Turf Pitches (ATPs)
- Indoor Sports
- Provision for Children and Teenagers
- Allotments

Cambridge City's Draft Local Plan to 2031

The vision for Cambridge's new development will be to secure innovative and will promote the use of sustainable modes of transport,helping to support the transition to a more environmentally sustainable andsuccessful low carbon economy. There are 15 strategic objectives for the implementation of the local plan, the most relevant ones to health and wellbeing are to requireall new development in Cambridge to:

- Assist the creation and maintenance of inclusive, environmentallysustainable communities.
- Promote social cohesion and sustainability and a high quality of life bymaintaining and enhancing provision for open space, sports andrecreation, community and

leisure facilities, including arts and culturalvenues that serve Cambridge and the sub-region.
- Be located to help minimise the distance people need to travel, and bedesigned to make it easy for everyone to move around the city and accessjobs and services by sustainable modes of transport.
- Ensure appropriate and timely provision of environmentally sustainableforms of infrastructure to support the demands of the city, includingdigital and cultural infrastructure.
- Promote a safe and healthy environment, minimising the impacts ofdevelopment and ensuring quality of life and place.

The Plan recognizes the need to address:
- Strategic transport infrastructure
- Contaminated land
- Light pollution
- Protection of human health from noise and vibration, poor air quality, odour and dust
- Housing in multiple occupation
- Residential space standards, inside and out
- Lifetime Homes and Lifetime Neighbourhoods
- Creating successful places
- Protection of open space
- Open space and recreation provision through newdevelopment
- Community, sports and leisure facilitiesNew facilities
- Loss of facilities
- Healthcare facilities
- Supporting sustainable access to development
- Mitigating the transport impact of development

Developer Contributions and CIL Requirements

Planning obligations and/or a future CIL could be required for the following:
- transport infrastructure
- public transport
- drainage and flood protection
- waste recycling facilities
- education
- **healthcare**
- leisure and recreation facilities
- community and social facilities
- cultural facilities, including public art
- emergency services
- green infrastructure
- open space
- affordable housing

This infrastructure is required if development is to be achieved in a timelyand sustainable manner. Infrastructure in this category is unlikely to preventphysical development in the short term, however, failure to invest could leadto delays in the medium term. The most common type of necessaryinfrastructure is social and community infrastructure such as schools, healthfacilities and children's play space. The category has the potential to allowinfrastructure prioritisation if funding shortfalls occur.

Case Study 5: Health Facilities Policy - Cambridge City

Case Study – Cambridge City's Policy on Health Care facilities
New or enhanced healthcare facilities will be permitted if:

- the scale, range, quality and accessibility of healthcare facilities would beimproved;
- they are located in the area they are expected to serve; and
- where possible and appropriate they are co-located with complementaryservices.

The Council will work with Local Commissioning Groups to provide highquality and convenient local health services in all parts of Cambridge, butparticularly in areas of population growth.

Planning permission will be granted for new primary healthcare facilities inlocations accessible by road, by walking, by cycling and by public transport,where this will meet an existing deficiency, or support regeneration or newdevelopment.

It is essential that the planning process supports the provision of good localhealthcare facilities of the right type and in the right locations. The provisionand location of community-based, out-of hospital, health-care should aim tomeet the needs of existing and new residents. The impact of household andstudent growth should not worsen healthcare provision for existingresidents. Healthcare facilities, for the purposes of this policy, do not includeteaching hospitals, which are covered by Policy 43, on university facultydevelopment.

Clinical Commissioning Groups (CCGs) are statutory bodies representinggroups of GPs responsible for designing local health services in England.Every GP practice will need to be a member of a CCG. Local CommissioningGroups (LCGs) are smaller groups of GP practices with a focus on more localissues than the CCG. The Cambridgeshire and Peterborough CCG includestwo LCGs responsible for patients in Cambridge and South Cambridgeshire.

Over recent years, there has been considerable change in the way healthcare services are delivered, with an ongoing shift away from hospital settingsinto community- based settings, delivering services as close to home aspossible. Advancements in medicine and technology have also had considerable impact on the way services are delivered and what can now bedelivered outside of hospitals.

The shift in location and delivery of services also requires more flexibility inplanning agreements and the detailed planning and procurement of healthfacilities. One key principle that should be considered is the co-location ofnon-NHS community, voluntary sector and commercial spaces alongsideprimary and community care services if their addition accords with thephilosophy of care and can improve affordability/accessibility.

Co-locating services may provide benefits including: a focal point for thecommunity, promotion of healthy lifestyles as part of an integrated healthand community care approach, better connectivity with other services andopening up new possibilities for residents, increased building/site usage, thecreation of a critical mass of linked services, increased convenience for users,improved funding; and more sustainable transport links. Examples of collocated facilities include those already built in Cambourne and in theplanning for Northstowe, Cambridge Southern Fringe and North WestCambridge.

3.6 COMPARISON OF THE LOCAL PLANS AGAINST THE THEMES FROM THE EVIDENCE REVIEW

Using the themes from the evidence review, each District's local plan has been reviewed against these themes to see if there are specific policies to address the impact the built environment can have on health, the themes identified were:

- Generic evidence supporting the built environment's impact on health
- Green space
- Developing sustainable communities
- Community design (to prevent injuries, crime, and to accommodate people with disabilities)
- Connectivity and land use mix
- Communities that support healthy ageing
- House design and space
- Access to unhealthy/"Fast Food"
- Health inequality and the built environment

Table 17: Comparison of the Local Plans Against the Themes from The Evidence Review

Key	Specific Policy in Local Plan	Not a specific policy, but policy/aim is relevant	No Policy in local Plan	No Policy but theme is contained in supporting text		
Policy		**South**	**City**	**Hunts**	**East**	**Fenland**
		Policy Ref:	Policy Ref:	Policy Ref:	Policy Ref:	Policy Ref:
	General HWB					LP2
	Health Impact Assessment	SC/2	Only relating to aviation (83)			LP2
Green Space	General policy on requiring Green Space	S/7 NH12	68	LP30	Policy Growth 3	LP16, Appendix B
	GS Near older peoples housing	SC/1 SC/7	Appendix I			
	Design to include paths etc.					Appendix B
	Distance to open space		Appendix I			Appendix B
	Size of open space	SC/8	Appendix I	Section B Developer contributions SPD		Appendix B
	LAP/NEAP/MUGA etc.	SC/8	Appendix I	Section B Developer		Appendix B

				contributions SPD		
	Allotments	SC/8	Appendix I	Section B Developer contributions SPD		Appendix B
	Farmers Markets					LP2
Developing Sustainable Communities	Max natural daylight	HQ/1	60	LP15		
	Solar/renewables	CC/3	29	LP5	ENV6	LP14
	cooling	HQ/1		Supporting text for policy LP5		
	harvesting rain water					LP14
	creating pedestrian and cycleways	TI/2	80	LP17	COM7	LP15, LP17
	public art	HQ/2	56		ENV2	
	social cohesion		Supporting text for policy 56	LP24		Introduction
Community Design	traffic calming		Supporting text for policy 80		Site Specific	
	secure by design	HQ/1	56	LP15	ENV2	LP16, LP17
	wheelchair friendly design		Supporting text for policy 80		Site Specific	LP17
Connectivity & Land Use Mix	walking and cycling	Site specific & HQ/1	80	LP17, LP18	COM7	LP15
	location of facilities/shopping	E/22	10	Site Specific	COM2	LP6
	concept of neighbourhoods	Site specific	Site specific	Objective 13	Site Specific	LP7
Healthy Ageing	signage		56	LP13		
	distinctive design		56	LP13		LP16
	street furniture		56	LP13		
and space Standards	minimum room size	H/11	50			
	Mix	H/8	Site specific	LP24	HOU1	LP17

	Lifetime Homes	H/8	51	LP13		LP5
	Fuel Poverty		30	LP14		LP14
Access to fast food	Location near sensitive receptors eg schools, workplaces etc.		Supporting text for policy 72			No Policy, but narrative in section 3.3.8
	Density		Supporting text for policy 72			
Health Inequality	Access to transport		75, 74, 50	LP17	COM7	LP15
	Provision of public toilets				Site Specific	Appendix B
	Street furniture eg benches				Site Specific	LP15
	municipal services	SC/4		Supporting text for policy LP20	Supporting Text for Developer Contributions	
	Libraries	SC/4		Supporting text for policy LP20	Supporting Text for Developer Contributions	Infrastructure Delivery Plan
	Health facilities	SC/4	75	Supporting text for policy LP20	Supporting Text for Developer Contributions	Infrastructure Delivery Plan, LP2
	Schools	SC/4	74	Site Specific	Supporting Text for Developer Contributions	Infrastructure Delivery Plan, LP7
	Community facilities	SC/4	Site Specific	Supporting text for policy LP20	COM4	Infrastructure Delivery Plan

From Table 8 above there are gaps across all the local plans relating to control of unhealthy/fast food outlets, the areas for further attention include healthy ageing, design of open space to include footpaths, facilities etc.

SOCIAL COHESION/COMMUNITY DEVELOPMENT

1. KEY FINDINGS

The evidence on the need for community development in the early stages of new developments is strong.

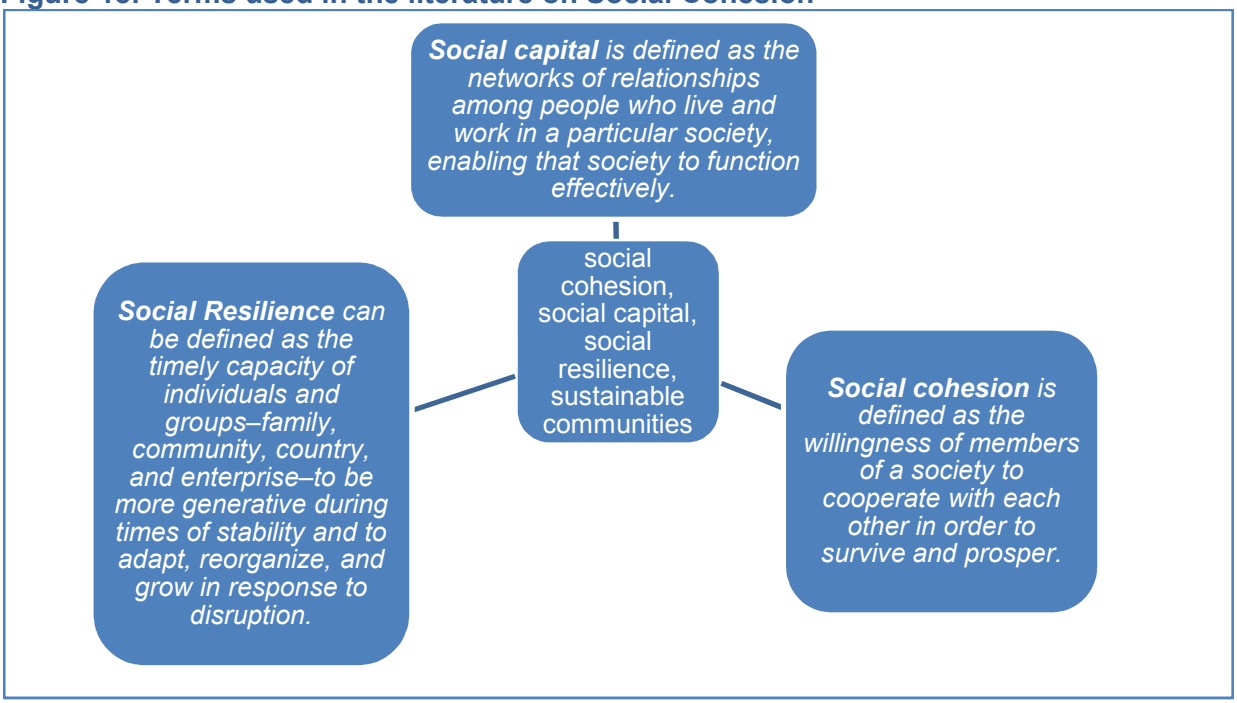
More research is needed locally into the measure of and approaches taken to improve social cohesion and community resilience in new developments, and the funding opportunities available to secure this.

Community development work needs to continue to focus on building resilient empowered communities rather than dependent communities. This should be carried out with other key agencies. Responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

2. INTRODUCTION: HOW DOES THE BUILT ENVIRONMENT AFFECT SOCIAL COHESION AND HEALTH & WELLBEING?

The evidence around what makes communities strong and healthy varies in quality and definitions.The terms, social cohesion, social capital, social resilience, sustainable communities are all very similar and are often interchangeable in the literature. Therefore, a broad inclusive approach has been taken to the terms used in this chapter.

Figure 18: Terms used in the literature on Social Cohesion



The Cambridgeshire County Council: Strategy for supporting new communitiesencourages building a self-supporting community rather than imposing an intervention. One conclusion from the strategy suggests this can be helped by providing ‘anchor’ spaces such as libraries and community hubs, at home library serviceswhich visits the most vulnerable in society. This allows a community to support itself and aids social cohesion. People with greater social capital tend to have greater wellbeing and a greater sense of belonging.

Examples of projects promoting self-supporting communities include:

- **Mums networks** where new mothers are given email addresses of other new mothers living in the same area, to help build new networks of support.
- **Stepping stone project** which works with young people who have learning disabilities and/or physical disabilities. The project allows staff to assess a person's sporting needs and helps them to engage with sport.
- **Time credits** are incentives given to people who volunteer to beinvolved in community projects, which in turn they can "cash in" for work for themselves.
- **Family by Family**which offers training and resourcing to families that have overcome tough times (sharing families) and putting them in contact with families who would like things to change.

2.1 Delivering mixed, balanced communities

In order to achieve physical interaction between people "pepper potting" is often usedwhich provides a "graduated range of different house types within the same street" from affordable units to more executive market housing. This is proposed to aid social cohesion. In addition, it is suggested to target population mixes near significant potential areas of interaction e.g. nurseries and primary schools, community centres, shops, pubs and parking areas, paths and communal areas.(54)A cohesive community requires a balanced age profile. So it's important to have a mix of housing stock i.e. for rent or to buy etc.(53)

The Young Foundation examined citizen engagement and concluded that activities that encourage interaction between individuals from diverse backgrounds can increase trust and understanding. For example, contact with the elderly, children with disabilities and those with mental health problems.(55), (56)

Sustainable communities are places where people want to live and work, now and in the future. The Egan Review (57) examined the factors that go to make a sustainable community and presented them as a set of eight vital components (Active, inclusive and safe; Well run; Environmentally sensitive; Well designed and built; Well connected; Thriving; Well served; and Fair for everyone). These components make up the Egan Wheel.

Active, inclusive and safe, means being fair, tolerant and cohesive with a strong local culture and other shared community activities. It suggests a diverse, vibrant and creative local culture encouraging pride in the community and cohesion within it. It also suggests an active voluntary and community sector.

Well run, involves sound governance with effective and inclusive participation, representation and leadership. Strong leadership is essential if a community is to respond positively to change. Effective engagement and participation by local people, groups and businesses is vital especially in the planning, design and long-term stewardship of their community.
Environmentally sensitive, means providing places for people to live that are considerate of the environment. It requires a safe and healthy local environment with well-designed public and green space.

Well designed and built, means providing or retaining a high quality built and natural environment. A community must be of sufficient size, scale and density and have an effective layout to support basic amenities in the neighbourhood and minimise use of resources (including land). Buildings both individually and collectively must meet different needs over time, and minimise the use of resources. A sustainable community requires a well-integrated mix of decent homes of different types and tenures to support a range of household sizes, ages and incomes. The community should have a 'sense of place'.

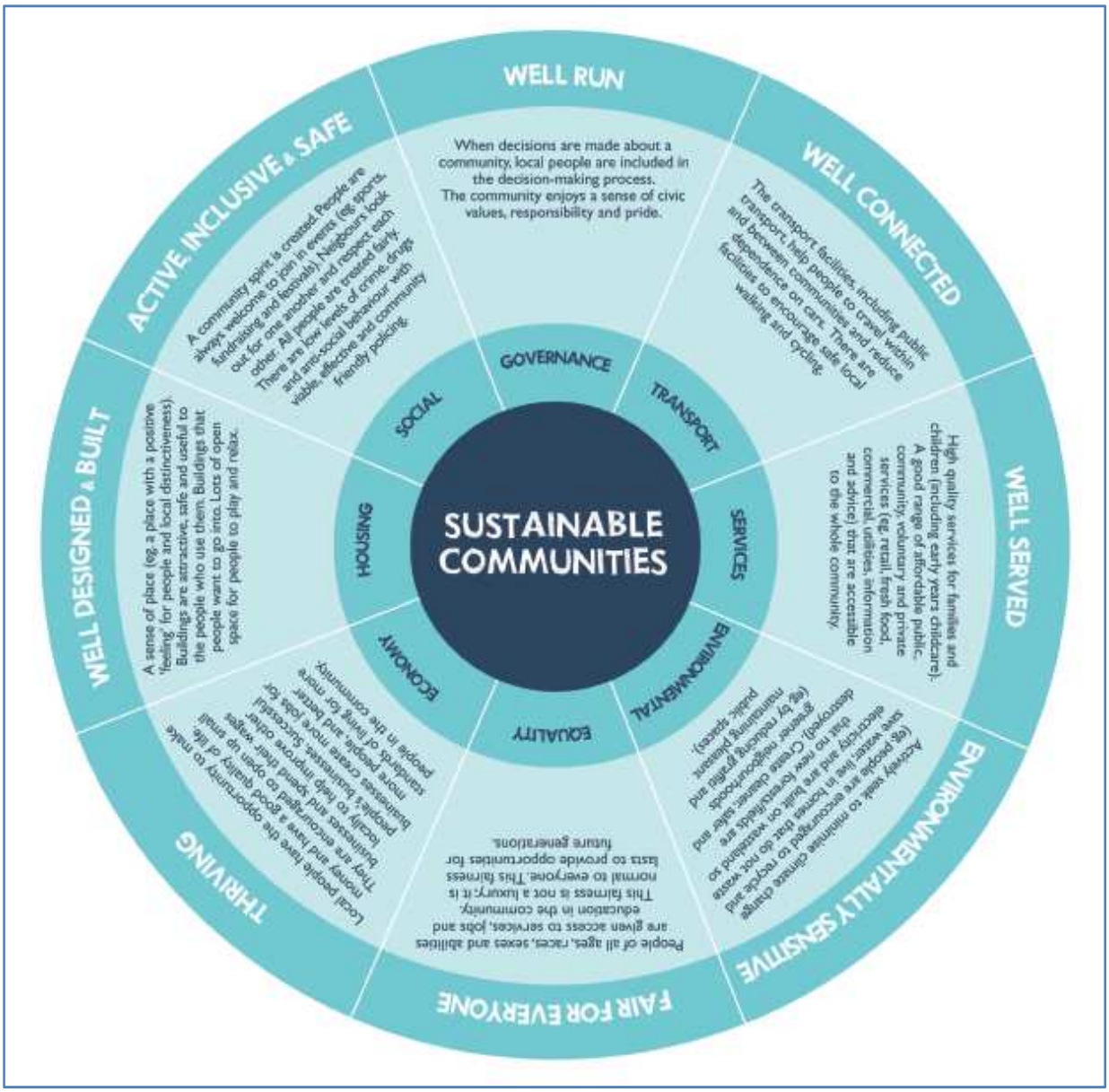
Well connected, means providing good transport services and communication linking people to jobs, health and other services. Good public transport and other transport infrastructure is needed both within the community and linking it to urban, rural and regional centres, as well as with the wider national and international community.

Thriving, involves a flourishing and diverse local economy to provide jobs and wealth.

Well served, involves providing public, private, community and voluntary services that are appropriate to people's needs and accessible to all. Good quality, local public services should be available including education and training opportunities, health care, community and leisure facilities.

Fair for everyone, involves consideration of the needs of those living in other communities both now and the future. All our individual and communal choices may impact adversely on others especially in terms of the overall need for sustainable development.

Figure 19: The Egan Wheel



2.1 Empowerment

Community participation is a key objective of community development which in turn can empower community citizens. "Highly participative voice mechanisms such as deliberative forums, citizens' juries, citizens' summits are likely to provide citizens with subjective empowerment.(58)

The "Pathways to participation project" (59) showed that being involved with the provision of community services, providing support for vulnerable members of the community etc. provides a range of cultural activities to enrich the lives of community members. Participation can help strengthen citizenship skills. The benefits given byparticipating interviewees included:

- **instrumental benefits;**
    - skills;
    - connections;
    - networks;
    - self-help;
    - improved access to job opportunities;
- **transformative benefits;**
    - sense of community,
    - confidence,
    - self-worth,
    - wellbeing.

Studies have showed that increased participation in local projects and community life or 'associational life' develops skills and confidence which can then be used in future. A study from South Africa showed citizens had learnedcampaigning and advocacy during the anti-apartheid movement and were using the same skills in the fight against HIV/AIDs through the treatment access campaign.(60) Another study in Brazil showed those involved in protests were more likely to be involved in participatory budgeting processes locally.

2.3 Community cohesion and mental health

The evidence shows that cohesive communities foster better mental health through the creation of neighbourhoods and communities that are in control and that pull together to shape the world around them. Evidence also shows that fostering and supporting social action, social inclusion and volunteering can improve wellbeing.

Local community groups such as local voluntary groups; peer support services, user led self-help groups, mentoring and befriending enables service users to be both providers and recipients of support. This allows members of a community to play an active role in their own wellbeing and that of their community(61).

2.4 Loneliness

Loneliness is a growing problem amongst older people. It is associated with poor health outcomes, specifically higher blood pressure, depression and higher rates of mortality comparable to those associated with smoking and alcohol(62).

Solutions include creating age friendly communities, which in turn makes the locality more socially inclusive(63), such communities should include:

- Availability of public meeting places and public seating
    - Improving street safety
    - Street lighting

- Ward assemblies to encouraging local decision making, encouraging intergenerational contact
- Local bus services and community transport alternatives
- Improving parking for those with restricted mobility
- Providing accessible clean public toilets
- Ensuring local shops and services are within easy reach

In addition to the above, the national planning policy framework suggests(64):

- Assurances that shops, facilities and services are able to develop and modernize in a way that is sustainable and retained for the benefits of the community, and
- Existing open spaces, sport and recreational buildings and land should not be built on unless the land is shown to be surplus to requirements or there is an adequate replacement or the development is for alternative sports/recreational provision which is of greater benefit.

3. LOCAL DATA

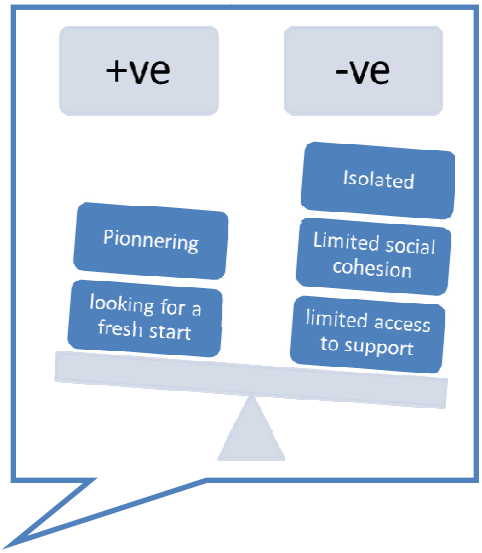
3.1 WHAT LESSONS CAN WE LEARN FROM PAST DEVELOPMENTS?

3.1.1 Lessons from Cambourne

One of the findings from the learning from Cambourne report is to provide and incorporate community buildings early in the stages of the development. (65)One of the downfalls in a new community is not having community halls/meeting places built early on i.e. Community halls, pubs, youth clubs, sport provisions. There also needs to be provision for younger children such as play areas, skate parks etc. It was noted that the small skate park built was not particularly well lit, which discouraged children from using it.

Loneliness and mental health problems were issues coming out of Cambourne partly due to the initial lack of community buildings. It is important to recognise that that people moving into communities may be moving away from their traditional support systems i.e. family and established communities with provisions to meet people and friends. Further information on the learning from Cambourne report can be found in the 2010 New Communities JSNA (http://www.cambridgeshireinsight.org.uk/cambridgeshire-jsna/new-communities).

In order to explain these patternsa shift in focus is needed away from buildings to people. Planning concentrates on buildings and landi.e.creating a pleasant built environment, it tends not to look beyond the houses being built and can focus on community development not building communities. This can result in the early residents feel displaced & isolated with the social networks taking time to form. Service providers are often underprepared and support can be difficult to find.



3.2 New housing development surveys

Research to find out more about who moves into new housing developments and reactions to the developmentsof residents across new developments in the Cambridgeshire housing sub-region was carried out between 2006 and 2012 by the Cambridgeshire County Council Research Group. In total 9,287 postal surveys were sent out during that period and 2,784 were returned (a response rate slightly under 30%) giving an overall confidence rating of +/-3%at the 95% confidence interval which is normal for this type of survey.

The developments surveyed were split into three categories:

- New town (where the numbers of dwellings doubled).
- Substantial extension (where the numbers of dwellings increased by >20%).
- Infill(where the numbers of dwellings increased by <20%).

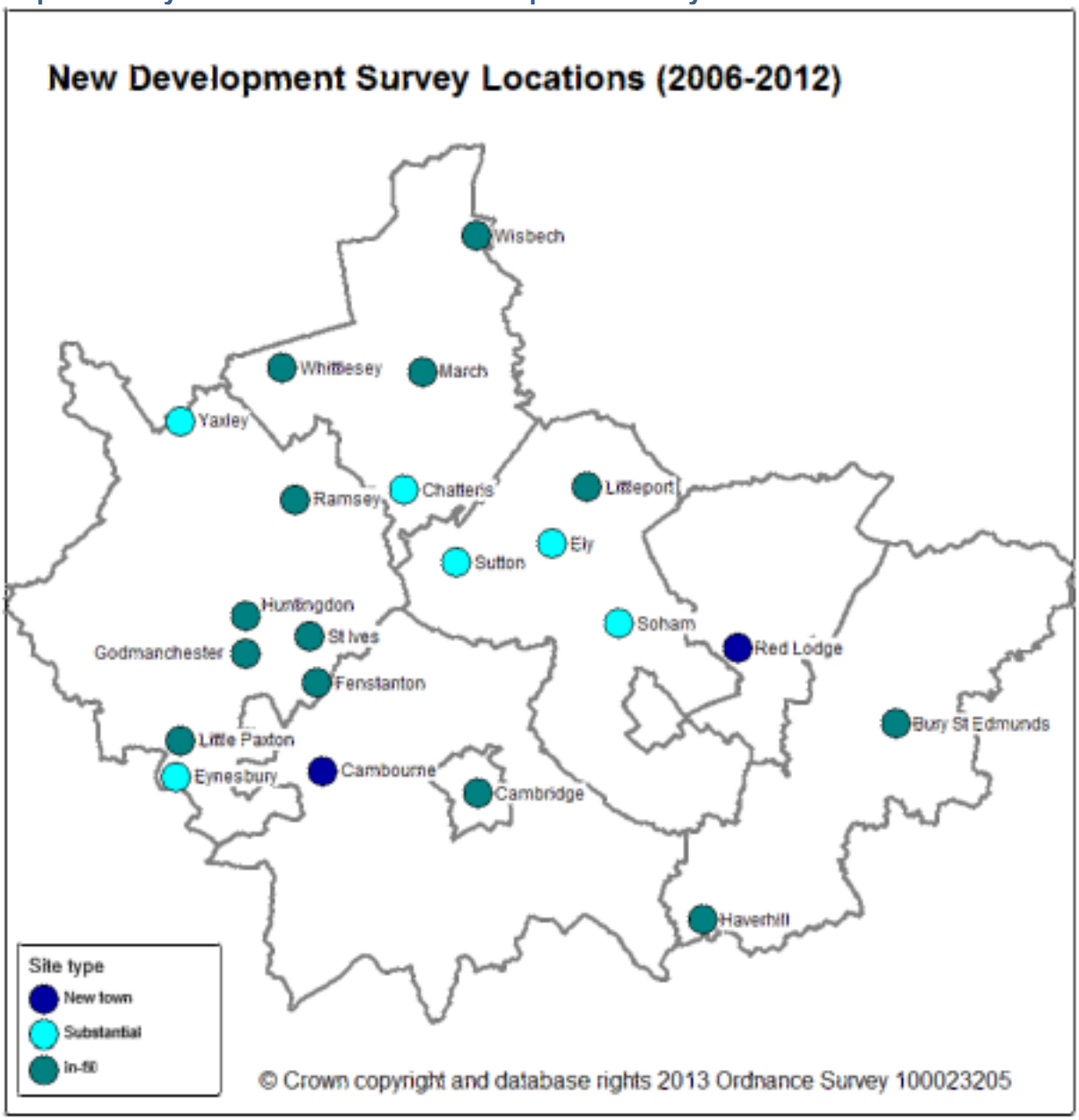
People were asked:

- Where they were moving from & reasons for leaving.
- Household structure on the new development - to help assess change to population, additional demand for school spaces, size and types of homes needed.
- Where they work, study and shop and how they travel to these locations.
- Opinions about the area, positive and negative.

When were the surveys undertaken?

Cambourne	*2006*
Huntingdonshire	*2007*
East Cambridgeshire	*2009/10*
Fenland	*2010*
Cambridge City	*2012*
Red Lodge in Forest Heath	*2011*
St Edmundsbury	*2011*

Map 4: Survey location for the New Development Surveys



3.2.1 Findings

Why do people move to new developments?

The main "push factors" for people moving are:

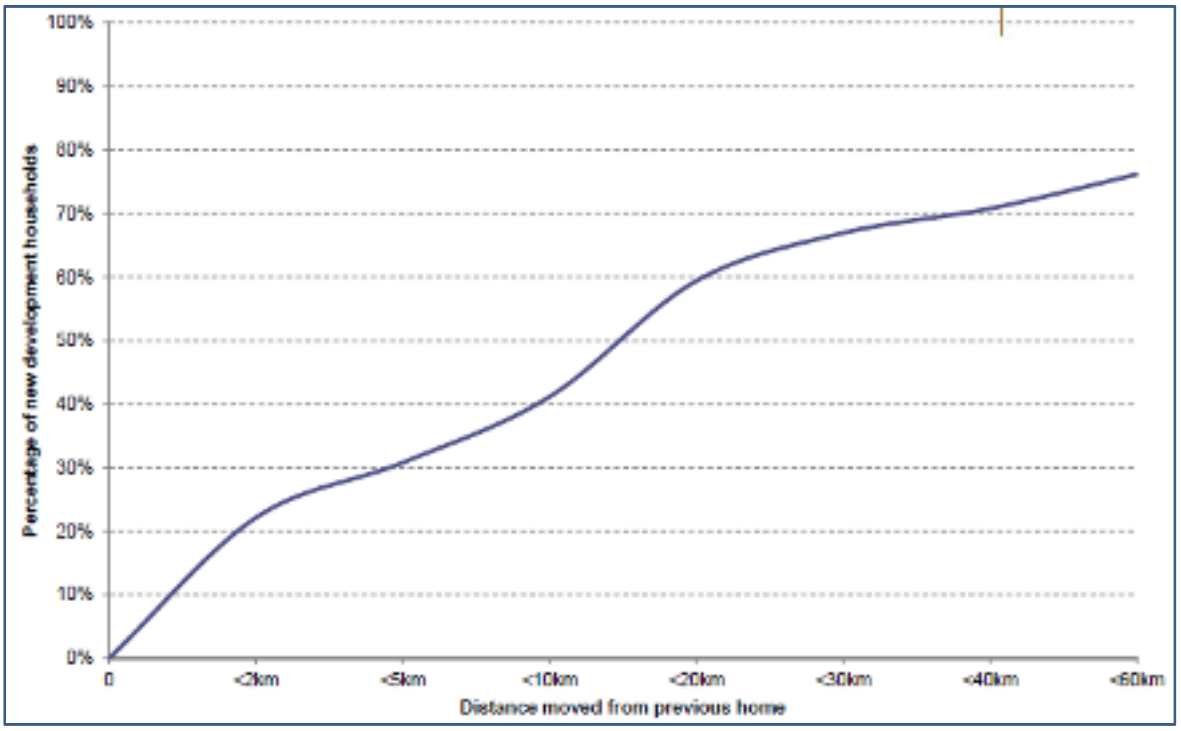
- To move to a larger or smaller home.
- Wanting to set up own home.
- To move nearer to work or new job.

The main "pull factors" for people moving are:

- Like the design of the new home or development.
- Price/affordability compared to neighbouring areas.
- Like the idea of living in a new development.

There is almost a linear relationship between the numbers of people in new developments and the distance moved, with over 70% of new residents having moved over 40km

Figure 20: Where do people move from?



There is a mix of movement between tenures with the largest move seen from the private rented sector to the owner occupied sector.

Figure 21: Moves between tenures

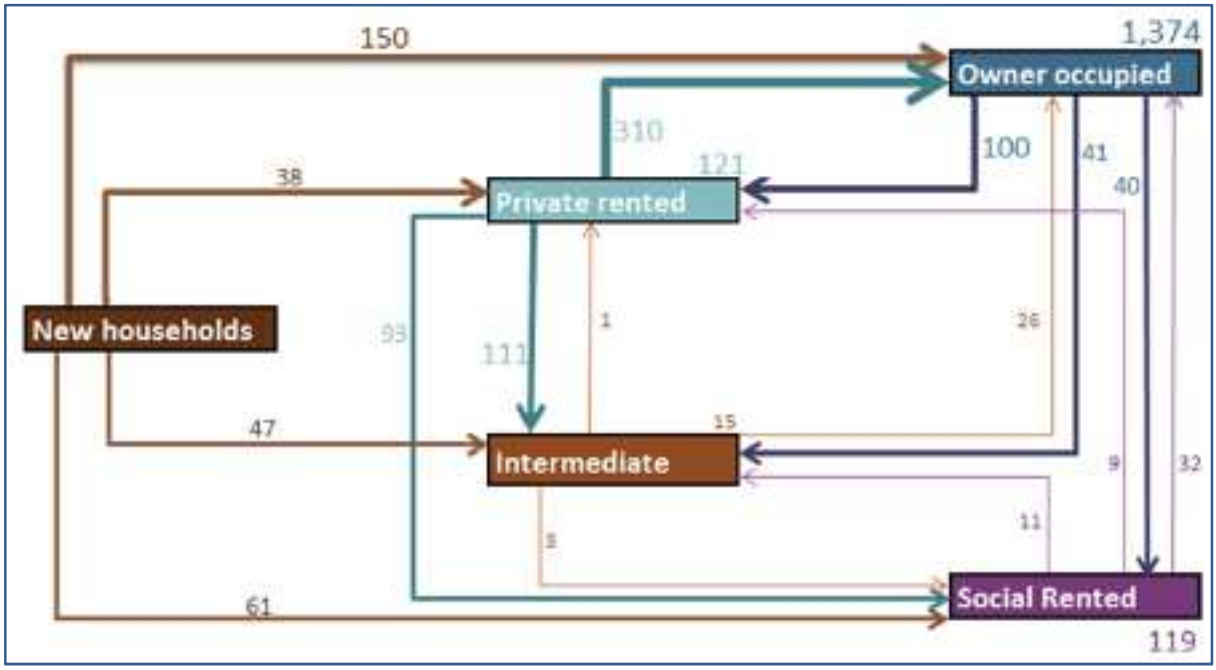
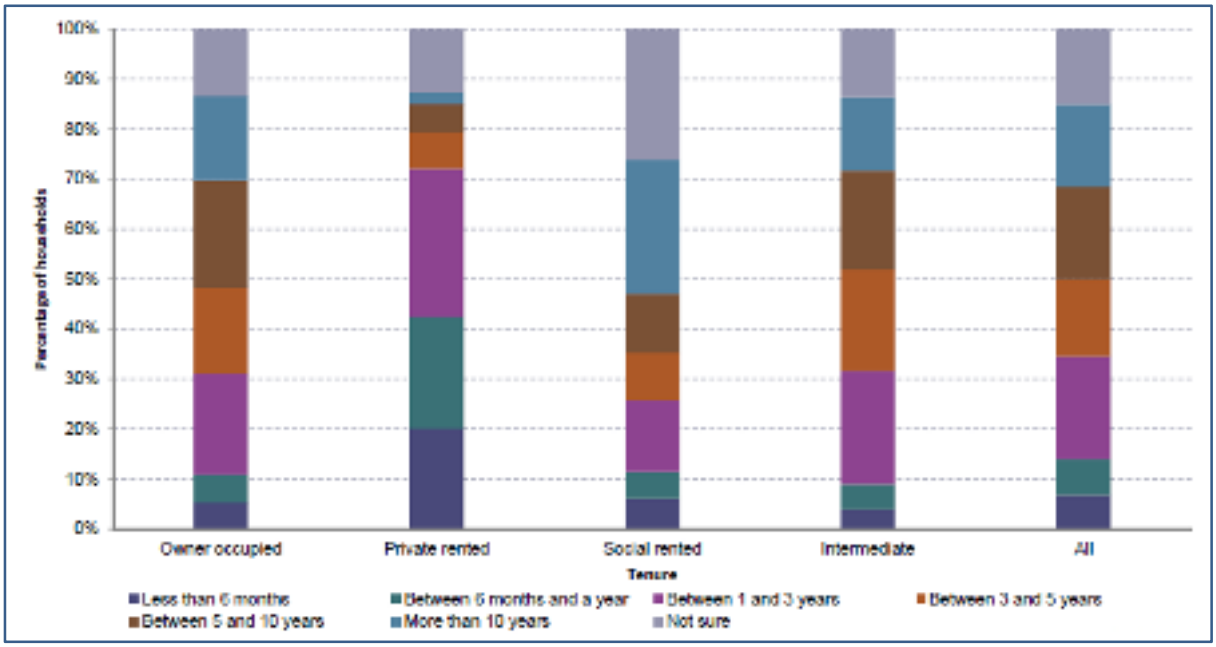
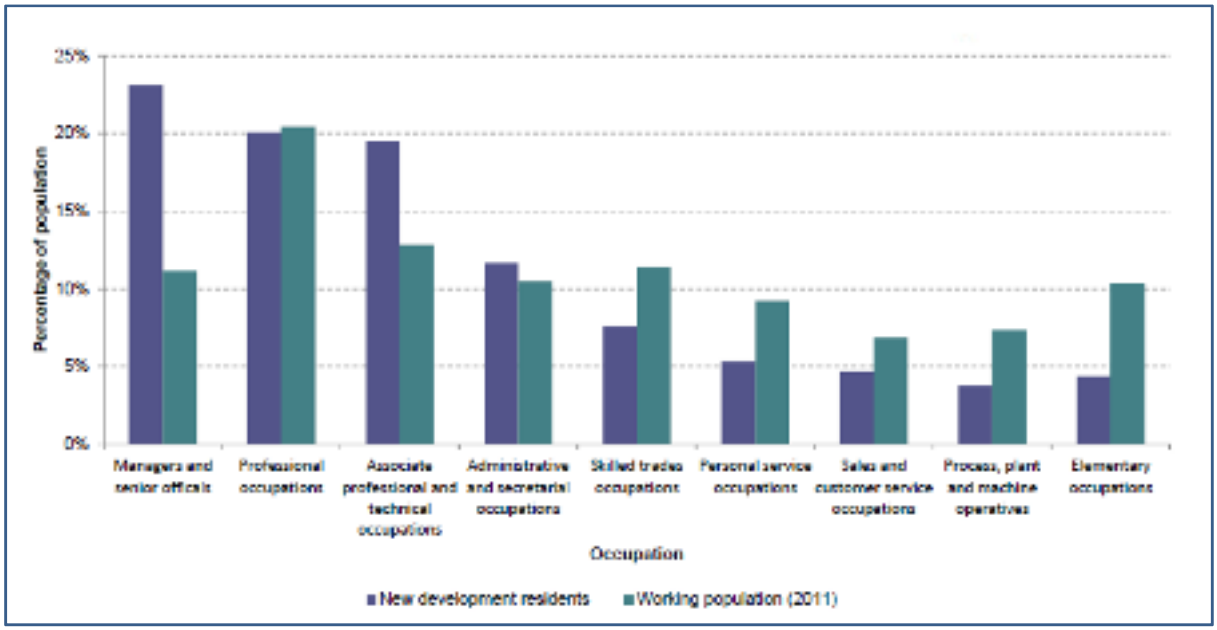


Figure 22: How long do people intend to stay at their current address?



There is a marked difference between those occupying private rented market homes and other tenures in the amount of time those occupiers intend to stay in those properties, with the majority intending to stay less than three years. This is replicated in the moves between tenures (Figure 8 above) indicating that private rented may be a stop-gap location until people can afford to buy, this has implications for service delivery in new developments as outlined in Chapter Four.

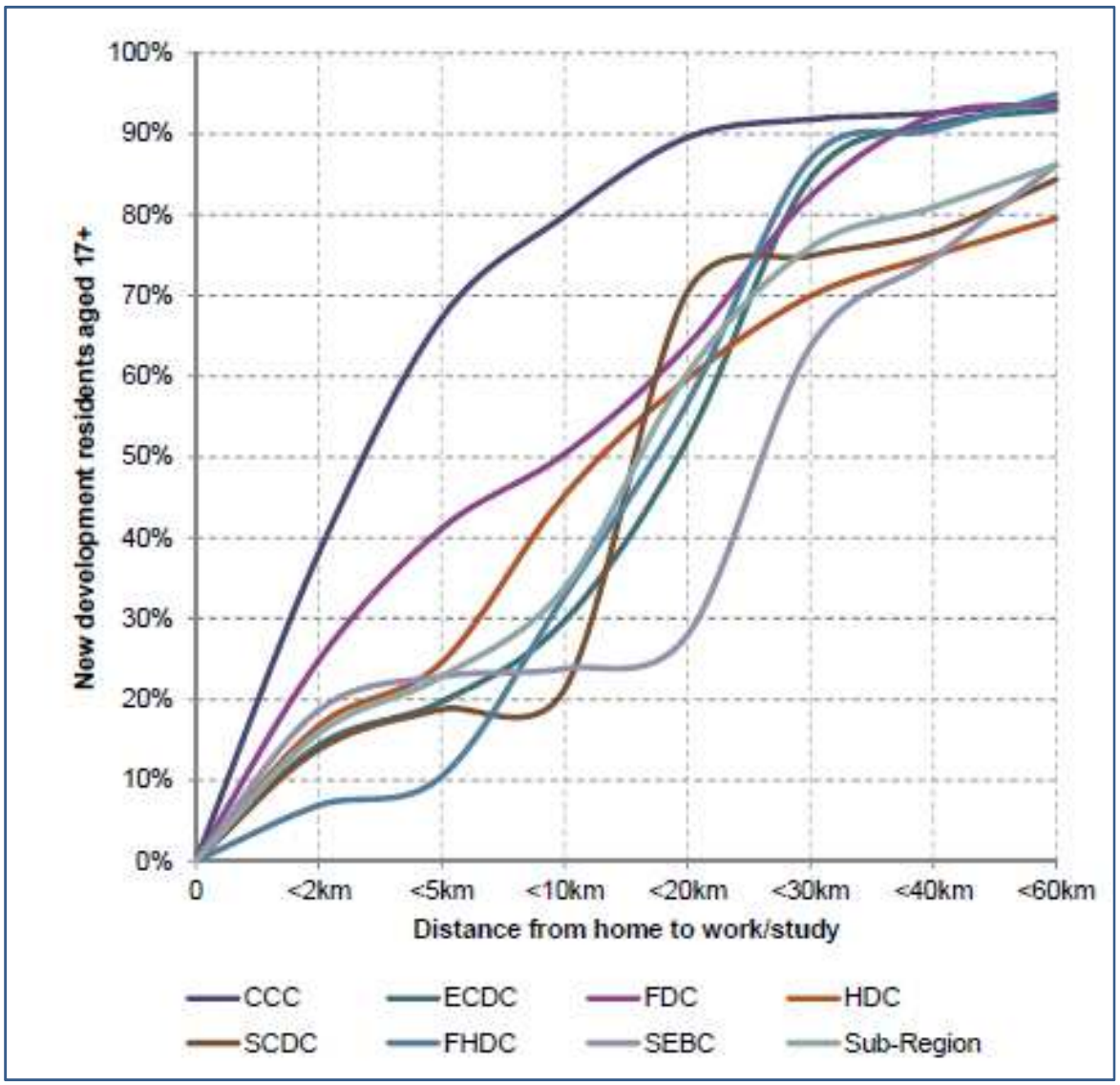
Figure 23: Occupation of new developmentresidents and working population



The occupiers in new developments show a difference in occupations compared to the working population as a whole with more residents employed in the: managers and senior officials, associate professional and technical occupation sectors and less in the skilled trade, sales and customer service, process, plant and machine, and elementary occupation

sectors. This may be related to the location of new developments and income v's house prices.

Figure 24: Where do people work?



Cambridge is a major centre of employment for most of the new development residents eg 28% of residents in Cambourne, 18% of residents in Forest Heath. Peterborough is a more important centre for households in the north of Huntingdonshire and Fenland.

Specific issues – why do people move?

Attractions

- To be near a school with good reputation.
- Access to good quality shopping, entertainment, education & health care.
- Good links to other areaseg Cambridge, Peterborough and Bury St Edmunds for both employment and non-food shopping.
- Good public transport. More satisfied with public transport where there is rail and less satisfied where the development is only served by bus.

Deterrents

- A lack of facilities.
- A poor range of shops.

- The lack of a post office.
- The lack of a pub.
- The lack of sporting facilities.

Sizes of homes
The most popular reasons for wanting to move was “to find a larger or smaller home”. This implies a mix of property sizes helps encourage moves, and so may help attract people.

Tenure
Some people were positive about the mix of social groups and tenures on their development.However, some mentioned the mix of tenures as a negative factor. Typically, people were negative about the amount of social housing developed, however, in Cambridge some respondents felt there were too many privately rented properties.

Design of homes and the development
Respondents said the most popular reason for choosing a new home was design or appearance of the home or development. The second most popular reason was price or affordability compared to neighbouring areas. The idea of living in a new development was also attractive for many, as is the quality of the development and its landscape and maintenance, respondents also mentioned that new homes are cheaper to run.

On the negative side respondents didn’t like the lack of privacy due to being overlooked, small or no garden and living on a partially finished development. Respondents also had concerns about anti-social and youth behaviour; it is uncertain if the design of new developments contributes to this.

Terms such as “friendly” and “good community spirit” were mentioned more than the negative terms such as “unfriendly” and “no community spirit”. However, some people said that they felt isolated, again it is uncertain if the design of new developments is a contributory factor.

Population comparison
New towns and substantial developments have:

- Higher numbers of under-16s than in the ‘host’ district.
- Higher proportion of 30-44 year olds.
- Lower proportion of older people.

In-fill sites

- Slightly older population than new towns and substantial developments with more people aged 60+.
- Although the proportion of 60+ is lower than the ‘host’ district.

Travel
Some 77% of new development residents in the sub-region travel to work/study by car (alone or shared). Across all the new development surveys, new housing development residents have a slightly higher number of cars per household, compared to the ‘host district’ population, however, Cambridge, East Cambridgeshire and Fenland are exceptions where there are fewer cars per household compared to all residents.

Figure 25: How do you travel to work?

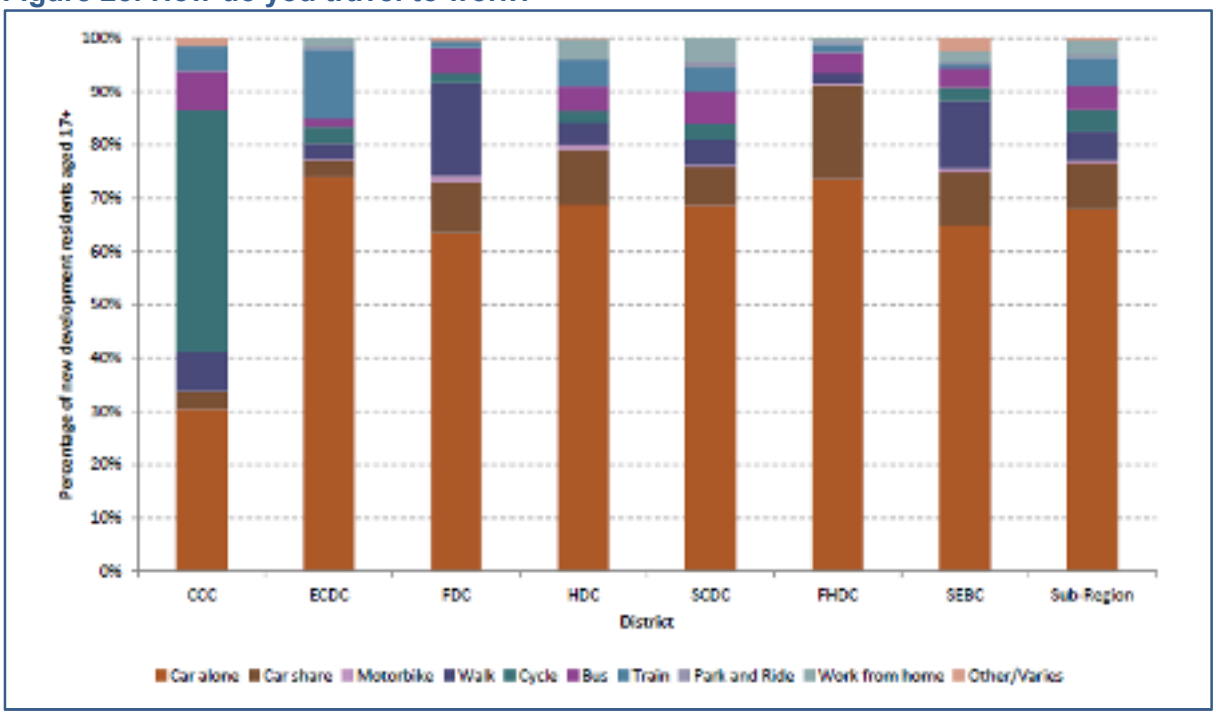


Figure 26: Summary of the "best" things and "worst" things about living in a new development, by development

BEST THINGS				
Quiet	Attractive area	Local facilities	Close to shops	Other
George Nuttall Close	Ely North	Hales Barn	March	Cromwell Road
Littleport	Ely West	Hanchett End	King's Ripton	Headlands
Soham	Barford Road	Hardwick Gate	Cotton Lane	NIAB
Sutton	Mill Lane		Springfield Gate	Co-op Farm
Chatteris	Pig Lane			Red Lodge
Villages	Roman Way			
Whittlesey	Cambourne			
Wisbech				
Bury Road				

WORST THINGS				
Parking	Traffic/busy roads/ speeding	Lack of/ quality of shopping facilities	Lack of facilities/services	Other
Cromwell Road	Sutton	NIAB	March	Cotton Lane
George Nuttall Close	Headlands	Ely North	Whittlesey	Soham
Barford Road	Kings Ripton Road	Ely West	Co-op Farm	Wisbech
Hales Barn	Pig Lane	Littleport	Cambourne	Chatteris
Hanchett End	Roman Way	Bury Road		Mill Lane
Hardwick Gate		Red Lodge		Villages
Springfield Gate				

ASSETS AND SERVICES

1. KEY FINDINGS

- Planning processes – A joint strategy is needed to develop a way to engage and attract the leisure market into new communities early in the development. This could be through ensuring the units are built early, opening units at discounted/nil business rate, allowing locals to use the units as pop up shops etc.

- Further research to understand the length that referral to Social Services cases are open, and what was the primary reason for referral to better conclude if there are particular social reasons for referrals that can help establish whether new communities are prone to certain social needs.

- During the pre-application stage of the planning process, services and the community should be engaged and a working group of people centred support established so that there is a clear co-ordinated effort and communication channels between services and the planning of the new community. This will enable co-ordinate response to planning applications through to service/support delivery. Where possible these groups should be led by the community whether this is parish council, residents association etc. with support from the local authority. Where the community is not willing or able to lead, the local authority will lead but with a clear hand over strategy for when the community is able to lead. These groups will have engagement from the widest group of services (but not necessarily attending physically) and agree, achievable action and communication plans

- Additional support to be provided to schools to enable them to deal with the additional challenges that new community schools can expect to face. Ensure that during the selection process these challenges are clearly detailed and ask how the prospective sponsor of the school would face these challenges and work with the community to help secure positive outcomes for all new community schools.

- Provide incentives to attract full day care/early years providers to developments, such as free plots of serviced land etc.

- Further research into categories of crime committed and to look into other new communities and compare them to the county

2. INTRODUCTION

2.1 Summary

The vision for new growth in Cambridgeshire includes a commitment to deliver high quality, sustainable new communities. Sustainable new communities are more than just economic and environmentally sustainable but also socially sustainable. To be sustainable, a community must promote health and wellbeing as well as foster social cohesion and inclusion. To support and promote health and wellbeing, new communities will require access to certain support and services to help them stay healthy and well. However, it is important that the assets of new communities are taken account of in planning and that these assets are built upon when considering what services are needed in new communities.

Assets are a thing, person or quality that services as an advantage, support or source of strength. Assets in new communities are very important because they are the primary building blocks of sustainable community development. Each new community is different so it is impossible to provide an asset assessment for new communities, however, looking primarily at the new communities of Cambourne, Southern Fringe and Loves Farm several themes have emerged:

- Purpose built community facilities.
- The existing community.
- Community leaders and shared experience.
- Ability to design optimal solutions in partnership with the community.
- Funding (capital and revenue).

There are a number of new communities in Cambridgeshire, of the larger new communities feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. Using data from some new communities in Cambridgeshire we can analyse whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services. This is not to take the focus from assets but to understand what services have been utilised to establish whether there is a gap in support in new communities.

From data available, of three of the four new communities there are higher referral rates to higher tier children's services, expected/average referrals to lower tier children's services and very low use of adult social care. In regard to children's services, Orchard Park has very low usage of any children's services at all tiers (data was not available to assess adult social care). Commercial leisure services that impact health and wellbeing are lacking in new communities and although voluntary services and local authorities try to fill the void they are unable to provide the level of services provided by commercial sector.

Engaging services early in the planning process is essential to ensure that the right infrastructure is available and so there is a co-ordinated plan to use the assets available to develop healthy new communities and to prevent the high needs. Due to the complexity and changeable nature of services and because each new community is different it is not possible to provide a comprehensive list of all services needed in new community. However, to help replicate and develop good practice the chapter provides the following outcomes and guiding principles which have been established based on experience of new and developing communities in Cambridgeshire.

Outcomes identified:

- All people, regardless of their needs, live well independently.
- People are and feel safe.
- People lead a healthy lifestyle.
- Local economy prospers for all.
- All people have a voice and control in decision that affect their community.

In order to achieve the outcomes it is crucial that activities are delivered effectively and in a co-ordinated manner to avoid duplication or gaps in provision. The following principles are intended to support achieving the identified outcomes.

- Partnership working
- Co-location and integration
- Community Resilience
- Timing

The success of the outcomes cannot be the sole responsibility of one agency but will require the whole planning and delivery system to work together.

The chapter also recognises that there are going to be barriers to services and assets being utilised and recommends some possible mitigation so these do not block new communities being delivered in the most effective way. Barriers include:

- Lack of co-ordination and clear communication.
- Long planning and delivery process.
- Funding and lack of capacity.
- Existing community and local representatives.
- Digital infrastructure.

2.2 Introduction – what are assets and services?

Sustainable new communities are more than just economic and environmentally sustainable but also socially sustainable.To be sustainable, a community must promote health and wellbeing as well as foster social cohesion and inclusion. To support and promote health and wellbeing, new communities will require access to certain support and services to help them stay healthy and well. However, it is important that the assets of new communities are taken account of in planning and that these assets are built upon when considering what services are needed in new communities.

There are many services that support us to stay healthy and well and it would be impossible to name them all. For clarity, when this chapter refers to services these are services that can be provided by a variety of organisations (public, voluntary or community sector) that contribute to health and wellbeing of the community. There are many municipal services that contribute to our health and wellbeing such as water supply but these types of services will not be included in this chapter as they are so firmly established. Therefore, this chapter is solely focused on services that deliver people-centred support (ie services that work directly with people).

This chapter seeks to understand the assets available in new communities and the utilisation of services in new communities with the aim of replicating or developing good practice to ensure that new and evolving new communities are well-served.

2.2.1 Assets

An asset is defined as ‘thing, person, quality, etc, that serves as an advantage, support, or source of strength. (74) The assets of a community are very important because they are the primary building blocks of sustainable community development. Not recognising the significant assets available in new communities may result in only seeing needs in the community and ignoring the strengths. This may result in services coming in and ‘doing to’ the community rather than using all available assets to ‘work with’ the community to help build a strong, sustainable, and healthy new community.

2.2.2 Purpose built community facilities

New community facilities are often made available at little or no cost to the community or to public services, as they are typically funded by the developer. Consequently, these facilities can be designed to act as flexible, accessible multifunctional spaces that provide the community with a place to meet, participate in activities and afford access to public, voluntary and community-led services.

There can be some risks and issues associated with community facilities in new communities. For example, schools are considered to be community facilities which can sometimes mean that minimal additional space is provided for the wider community. There are some notable examples of community-focused schools (such as Cambridgeshire village colleges) and, because schools are often built first, they can provide the community with indoor space right from first occupation. It is important to recognise however that the primary purpose of school buildings is the education of children and young people and the needs of the students will naturally be put above those of the wider community. Schools may not always be able to provide the access that the community needs. They may also have to restrict access to the public while pupils are present due to safeguarding concerns. Furthermore, school buildings can alienate some population who may not see the school as a space for them due to previous negative experiences at schools

Examples of this include use of the marketing suite in the Southern Fringe development, or the use of a temporary community wing (or similar) in the primary school in Loves Farm (also planned for Northstowe). However, caution must be taken to ensure that adequate community space is available throughout the development.

In large developments, it may not be practical to make the definitive community buildings available from the outset. It is recognised that, due to the often lengthy build- out rate of new communities, the provision of permanent facilities scaled for the whole community and available from the very beginning may not be practical or financially responsible, as they may be underused for an indeterminate length of time until the community becomes larger. However, as reference in much research and more locally in the 'Lessons from Cambourne' article published in 2007, the community needs a place for people to meet from very early on and informal places to meet.(65)Therefore, in order to ensure that there will always be space available for the community, the utilisation of temporary facilities is a suitable interim stage.

2.2.3 Existing Community

It is very rare that a new community is built with no established existing community in the vicinity. The established community can be a huge asset to a new community with existing groups and activities open to new residents to join and access to already developed social networks. It also allows for community involvement at the early stages of planning, thus representing the views of people living in the area.

However, sometimes an existing community does not always welcome the presence of a new community and a 'us and them' attitude can become established. If new community facilities risk putting existing facilities out of business this can cause division and is of benefit to no one. In addition, new communities have brand new facilities which could lead to existing communities seeing it as the new development being favoured over the existing community. Furthermore, if the existing community objected to the new community from the planning stages then there can be opposition that is very difficult to overcome. Ensuring that the existing community is able to engage with the new development and that it receives reliable communication can help to stop divisions between the new and old communities.

Case Study 6: Southern Fringe

Case Study – Southern Fringe
In the Southern Fringe development, a community development officer has been working part time with the existing community prior to the development beginning to be built. This has helped to ensure that all new community facilities complement the existing facilities rather than put them out of business and supports the building of closer connections to the new and existing community.

Furthermore, volunteers from Trumpington are welcoming new residentsthrough the issuing of welcome packs and inviting them to already established community groups. The residents' association is also helping to share the culture and history of the area with the new community so that they can develop roots in the community giving them a sense of belonging. Community development officers and funding for public art/community are important tools to help facilitate and co-ordinate the community building between existing and new. This has been evident in southern fringe where the community developer officer has played a key role in facilitating linking existing and new but has done it in such a way that the community is still leading and therefore owning it so that it is sustainable.

2.2.4 Community leaders and shared experience

When people move they are making a fresh start and are often interested in taking up new activities and making the community they live in sustainable and ultimately a nice place to live. Often the first residents to new communities are willing to do the work to achieve an established positive community; one which relies less on public services. Furthermore, as all residents are new residents there is an automatic connection between them.

New residents are usually willing to volunteer, whether that is to set up community groups (if they donot already exist) or volunteer for other community groups or wider organisations such as Homestart, or a statutory service such as the local library.

Nurturing and supporting volunteering and leaders in the community will ensure that the community feels it has ownership of what is in its community and a say on how things are run. This again is an important role of community development officers and other local groups.

This support ensures that there is the help to support volunteers so that they do not come across avoidable barriers in volunteering or becoming community leaders.

In Cambridgeshire libraries currently have three times as many volunteers as staff. All communities will have access to a library, whether that is a mobile library, a permanent library in a neighbouring village/town or a brand new library built for the new community.

Support such as the local churches in Trumpington which have helped identify needs and set up new groups with volunteers from the congregation.

2.2.5 Ability to design optimal solutions in partnership with the community

Not only do new communities present an opportunity to build new community facilities but they also provide an opportunity to develop optimal solutions in conjunction with the community.Service commissioners and providers can work with the new community to co-

produce services allowing the community to shape what support is available and how it is delivered. This will allow the community to feel ownership for the services and, where relevant, run the service themselves.

However, this means that organisations need to co-ordinate and work together with the community. This can often be challenging and it requires someone to take the lead to bring the community and the services together. In addition, as the community is constantly changing, it will be a challenge to ensure that all the community is represented and kept informed.

2.2.6 Additional funding

New communities often benefit from additional funding to establish new infrastructure and activities in the area. Section 106 funding and CIL are available for new developments and while they primarily support large infrastructure, they can also provide revenue funding to fund community development, services and activities.

As recognised in the previous JSNA on New Communities, new communities bring new opportunities to look at services afresh, and to explore new and more appropriate models of delivery.

However, developers routinely assert that the projects' viability limits the scope for providing funds. This can jeopardise securing developer funding as obligations for community development and revenue funding is frequently compromised when development viability is threatened. Furthermore, even when funding is secured there is a tendency for overreliance on the developer funding and insufficient planning to ensure sustainability after the funding ends.

2.3 Services

To have a positive physical, social and mental state people will need and want. Access to day-to-day services such as shops, entertainment facilities and restaurants where they can meet others, relax and enjoy themselves promotes a positive physical, social and mental state. Access to good quality facilities for shopping and entertainment are highlighted as attractions of new developments. (66)

Lessons from Cambourne demonstrated that one of the reasons people did not likeCambourne was the poor range of shops – shops not arriving until later in the development caused frustration and resentment (73).

Without a destination or activity people are more likely to remain isolated and lonely which can result in anxiety, depression and other mental health issues.
However, these types of services are market driven and with the long build out rates of new communities it is difficult to entice these services to set up early in new communities as it is difficult to make a profit. Many community groups, voluntary and statutory services have attempted to fill the void with community cafés and other activities that provide entertainment and a chance to meet with other people.

In Southern Fringe the local residents association run a soft play café every Saturday morning and the local church runs a café on Wednesday mornings but feedback from those working is that there is never community events on that suits their lifestyle.

However, these types of events may not appeal to everyone and they are only available at limited times. For example, a commercial café will be open almost every day for a number of hours whereas a community café may only be open for one morning a week; this may not be convenient for people or fit with their work schedule and therefore limits people's choice.

Voluntary organisations, community groups and statutory services have a very valuable role to play in bringing about the benefits that the leisure sector bring but financial constraints will limit their ability to provide these services.

2.3.1 Essential service available when they are needed

Engaging services early in the planning process is essential to ensure that the right infrastructure is available and so there is a co-ordinate plan to use the assets available to develop healthy new communities and to prevent the high needs.

Due to the complexity and changeable nature of services and because each new community is different it is not possible to provide a comprehensive list of all services needed in new community. Each new community is different and will have access to different resources and assets depending on a variety of factors such as location and demographics. Listing services would be too prescriptive and would limit the community's role in shaping service delivery in their community.

3. LOCAL DATA

The vision for new growth in Cambridgeshire includes a commitment to deliver high quality, sustainable new communities

The new communities in Cambridgeshire have possessed many assets that support the health and wellbeing of the community. Each new and developing new community is different so it is impossible to provide an asset assessment for new communities. However, looking primarily at the new communities ofCambourne, Southern Fringe and Loves Farm in Cambridgeshire, several themes have emerged:

- Purpose built community facilities.
- The existing community.
- Community leaders and shared experience.
- Ability to design optimal solutions in partnership with the community.
- Funding (capital and revenue).

Often permanent community facilities are not delivered until later into the development, such as with the Loves Farm development where the permanent community building opened in October 2015, some seven years after the start of the development. If access to good quality temporary provision had been in place then this may have not been a problem, but once the primary school needed to use the temporary space previously provided to the community, the community were left without any indoor community facilities for three years. It is essential that continuity of access to good quality provision is sustained. If temporary accommodation is provided in schools there should be no gap in provision when the temporary access ceases.

In addition, the management and cost of running community facilities must be considered when determining the need and designing the community facility. Many new facilities will need financial support to make them viable in the early years and to ensure that the facilities are able to offer space for the whole community rather than just for the community that can afford it. For example, Trumpington pavilion located near the new community of Southern Fringe received developer funding to improve the building. The City Council own the land and property and lease it to the residents association to manage on the City Council's behalf. The City Council give a set fee each year to assist with the running costs in the form of a service level agreement; the agreement includes a requirement to allocate 10 hours a week of free community use so groups which may otherwise struggle to afford to rent the space are able to use the building.

However, it is important to note that communities of the past have often had a high turnover of residents because many of the properties are 'bought to let'. This may have an impact on the community development as it requires people to be committed to the area. If a large proportion of the residents are not intending to stay then they are less likely to put effort into establishing roots within the community. This may cause a division between those who have bought their homes and those on short term lets and impair the ability of the community to build.

3.1 Health and social care utilisation in new communities

There are a number of new communities in Cambridgeshire,of the larger new communities feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. In a County Council Member led review in 2010, it was acknowledged that new communities have unique needs, generally higher levels of mental health issues and

greater prevalence of domestic issues: the challenges faced by public services in new communities are, very frequently greater than they are elsewhere.(66)

Using data from some new communities in Cambridgeshire we can analyse whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services.

This is not to take focus from assets but to understand what services have been utilised to establish whether there is a gap in support in new communities. By identifying gaps, we can look to the assets and how to build upon those to close any gaps in future new communities.

The following services are not an exhaustive list of all services that are in new communities but are services where we have been able to access data.

Figure 27: Health Visitor Referrals in the New Developments

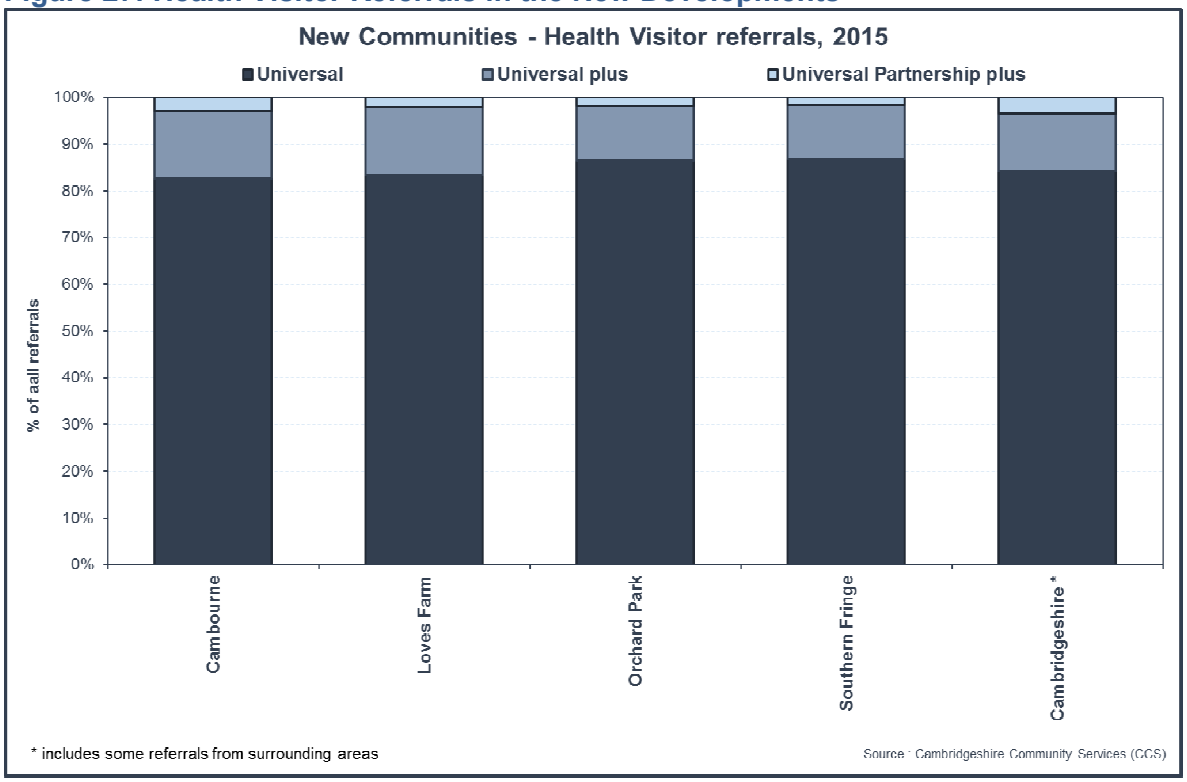


Table 18: Health visitor referrals 2015

Development	Universal		Universal plus		Universal Partnership plus		Total	Number of births	Rate of referrals per 100 births	95% confidence intervals
	Number	% of development total	Number	% of development total	Number	% of development total				
Cambourne	484	82.7%	84	14.4%	17	2.9%	585	203	288.2	(0.0 - 0.0)
Loves Farm	241	83.4%	42	14.5%	6	2.1%	289	118	244.9	(0.0 - 0.0)
Orchard Park	96	86.5%	-	-	-	-	111	40	277.5	(0.0 - 0.0)
Southern Fringe	204	86.8%	-	-	-	-	235	70	335.7	(0.0 - 0.0)
Cambridgeshire *	18,651	84.1%	2,752	12.4%	766	3.5%	22,169	7,795	284.4	(0.0 - 0.0)

	Statistically significantly higher than Cambridgeshire
	Statistically significantly lower than Cambridgeshire
-	denotes fewer than 6 cases or removed due to disclosure
*	includes some referrals from surrounding areas

Cambourne appears to have a higher rate of universal plus referrals per 100 births than Cambridgeshire but, due to small numbers, the rate does not differ significantly.

Figure 28: New Communities Hospital Admission & Attendance rates

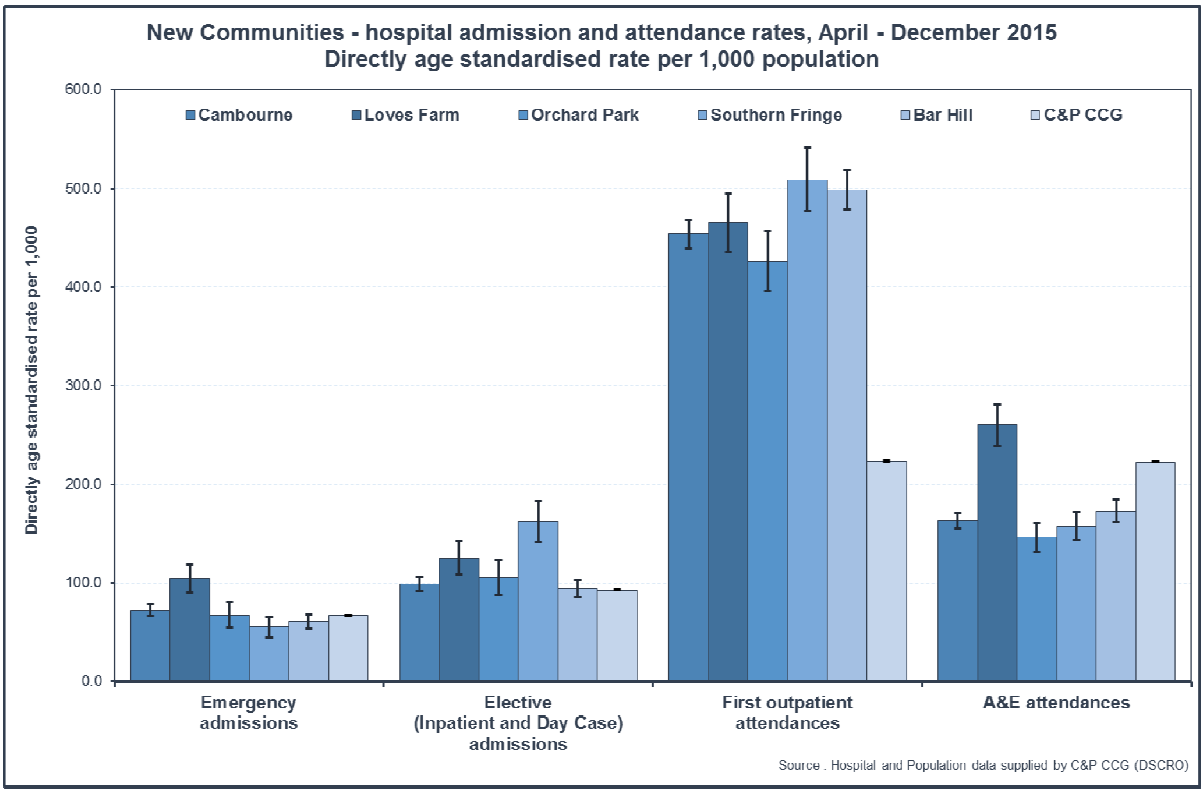


Table 19: Hospital Did Not Attend Figures 2014/15

Development	First outpatients		
	Number of DNA's	% DNA	95% CI
Cambourne	182	5.1%	(4.6% - 6.1%)
LovesFarm	102	7.8%	(7.1% - 10.2%)
Orchard Park	40	5.5%	(4.3% - 7.8%)
SouthernFringe	46	6.3%	(5.1% - 8.9%)
C&P CCG	370	5.8%	(5.6% - 6.8%)

Table 20: Hospital data, April - December 2015

Development	Emergency			Electives (Inpatient and day case)			First outpatient			A&E		
	Number	DASR per 1,000	95% CI	Number	DASR per 1,000	95% CI	Number	DASR per 1,000	95% CI	Number	DASR per 1,000	95% CI
Cambourne	520	72.4	(66.2 - 78.7)	712	98.9	(91.7 - 106.2)	3,584	453.8	(438.9 - 468.7)	1,694	163.1	(155.3 - 170.9)
LovesFarm	215	104.6	(90.6 - 118.6)	246	125.5	(117.7 - 151.3)	967	465.2	(435.9 - 494.5)	592	260.5	(239.6 - 281.5)
Orchard Park	107	67.6	(54.8 - 80.4)	136	105.7	(88.0 - 123.5)	775	426.6	(401.4 - 462.2)	389	146.3	(131.8 - 160.9)
SouthernFringe	114	55.5	(45.3 - 65.7)	235	162.5	(141.7 - 183.2)	955	509.1	(476.8 - 541.4)	466	157.3	(143.0 - 171.6)
C&P CCG	57,757	67.0	(66.5 - 67.6)	77,601	92.8	(92.2 - 93.5)	196,555	223.1	(222.1 - 224.1)	207,291	222.8	(221.9 - 223.8)
Bar Hill	288	61.2	(54.1 - 68.3)	452	94.5	(85.8 - 103.3)	2,396	498.8	(478.8 - 518.8)	866	173.1	(161.6 - 184.6)

3.1.1 Cambridgeshire County Council Children's Services

Cambridgeshire County Council supports children, young people and their families via two different but linked services: Children's Social Care and Enhanced and Preventative Services. Enhanced and Presentative services support children and young people with emerging and additional needs whereas children's social care support children and young people whose needs are more complex, severe and who may need protection[i].

Children's social care services protect children who may be in danger or at risk of harm. Children's social care does this by supporting children and families and providing protection services and child protection plans. Where it is not possible for children to remain in their families, social workers support children with extended family, foster carers or adoptive parents.

Cambridgeshire County Council Enhanced and Preventative Services deliver a range of universal preventative services for children, young people and their families and some more specialist services for vulnerable children, young people and their families. Many of the services provided by Enhanced and Preventative Services are delivered by one of 14 multi-disciplinary locality teams. These teams are responsible for providing joined up, responsive services for children and families living in each area. Locality teams provide a range of support such as providing information and advice on education, employment and training, they work with young people who have behavioural problems, and provide support and advice for families who need additional help with parenting.

To understand how children's services are being utilised in new communities the number of referrals to children's social care and locality teams have been compared to the rest of the locality in which each development is located in (removing the referrals from the new community within the locality).

Due to how recent the new communities are being developed and the continued expansion due to new housing, it is very difficult to get accurate estimates of the 0-19 population for the new communities. Therefore, the 0-19 population of new communities considered in this research(67) has been estimated based on total number of completed houses in the new developments at that period of time multiplied by the average number of children per dwelling in Cambourne 2006 (0.74). This method of estimating population was chosen as it factored that new communities tend to have a higher than average younger person population and allowed for the constant increases in population due to the continued building of houses. Population of the localities was determined from the CFA Metrics provided by the CCC Children, Families and Adults Management Information team minus the population estimates of the new community.

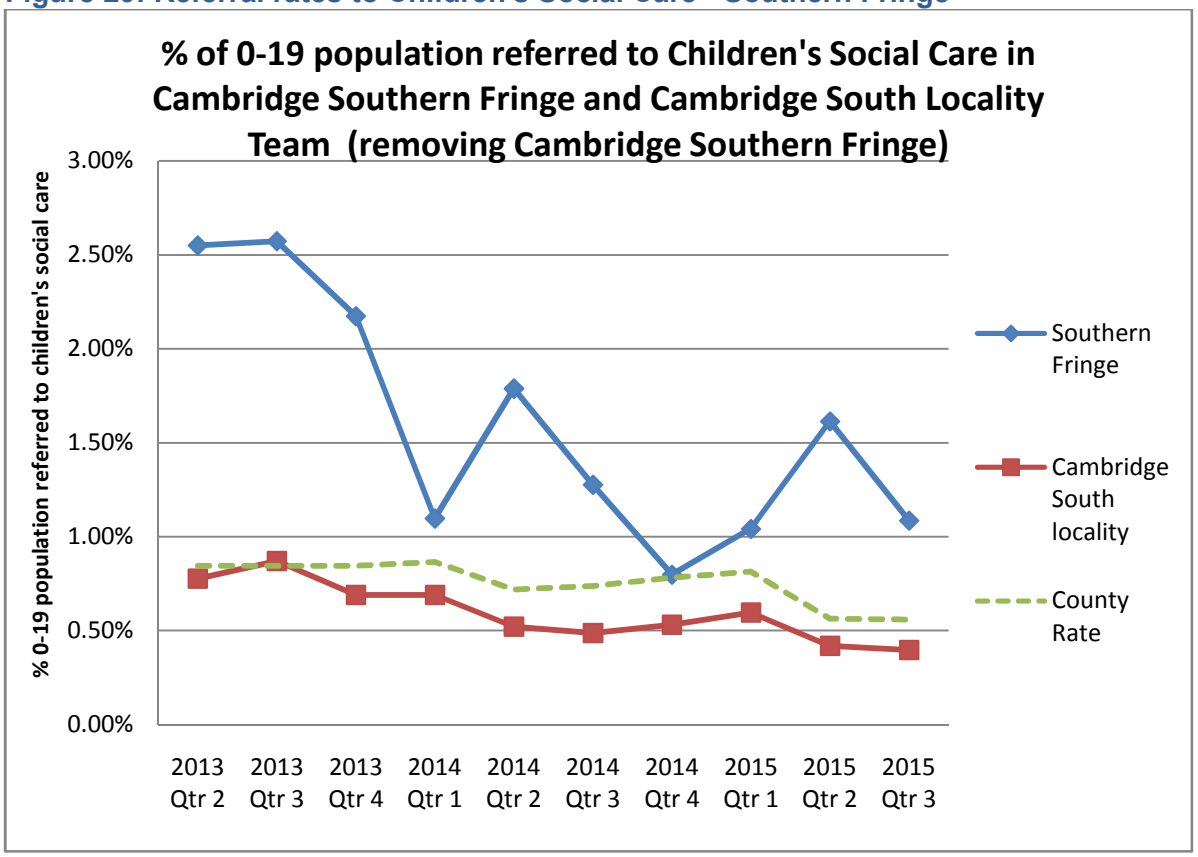
3.1.2 Children's Social Care

Due to changes in 2011 in how CCC recorded children's social care data only data from 2011 onwards is accessible. Furthermore, it is only possible to run reports of social care usage based on the child or young person's current address (as of January 2016) rather than their address at the point of the referral. Therefore, it is not possible to determine whether the child or young person was living at their current address at the point of referral or at a different address.

3.1.3 Southern Fringe

There were on average more referrals to children's social care per population from Southern Fringe development compared to the rest of the locality. From the second quarter of 2013 to the third quarter of 2015 (data from 2012 has not been used because numbers of housing completions were very low) an average of 1.60% of the 0-19 population in Southern Fringe development were referred to children' social care in comparison to 0.60% of the Cambridge South locality.

Figure 29: Referral rates to Children's Social Care - Southern Fringe



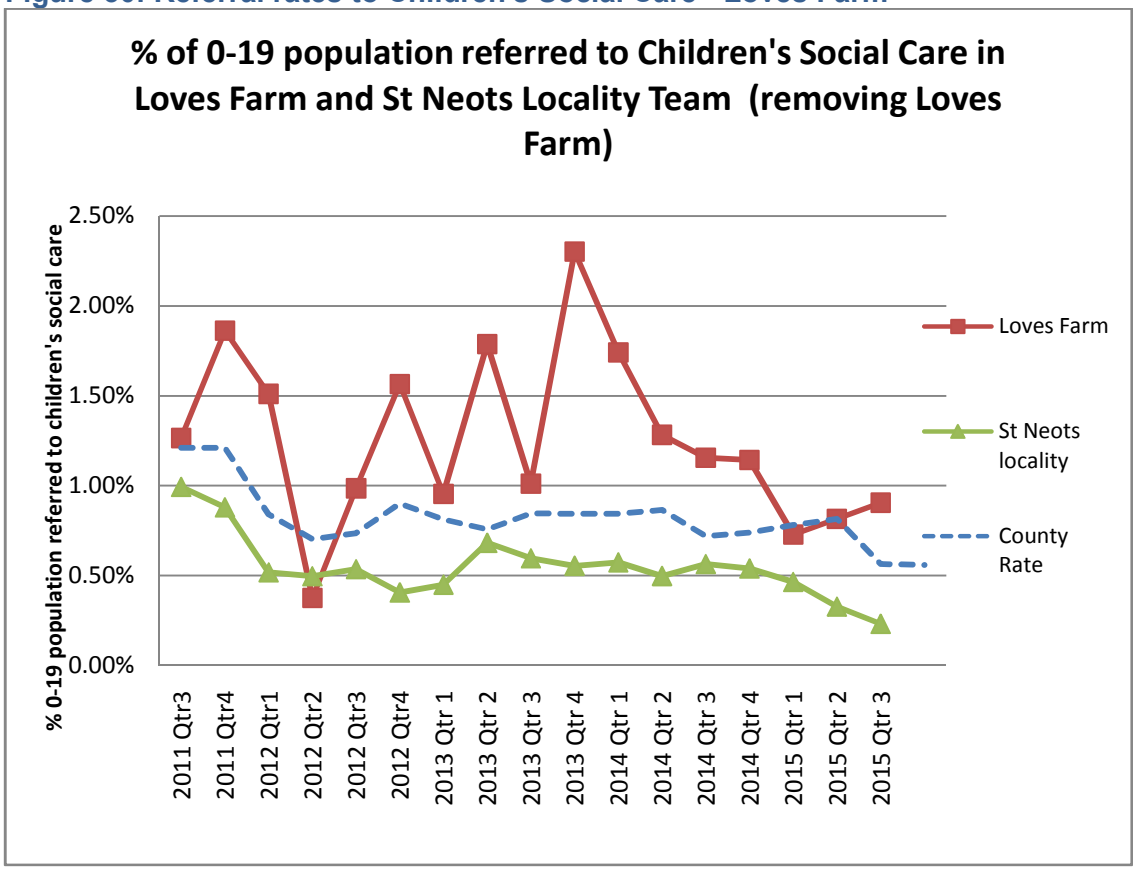
Source: One ICS, CFA Management Information Team and Strategy Service

In 2013-14 of the children and young people referred to children's social care in the Southern Fringe 73% of those referred had previously accessed children and young people's services from CCC (including Enhanced and preventative service) and 27% had never accessed children and young people's services prior to moving to the new community
The average distance the families who were referred to children's social care in Southern Fringe moved is seven miles.

3.1.4 Loves Farm

There were also on average more referrals to children's social care per population from the Loves Farm development compared to the rest of the locality. From the third quarter of 2011 to the third quarter of 2015 there was an average of 1.26% of the 0-19 population of Loves Farm referred to children's social care compared to 0.55% of the St Neots Locality.

Figure 30: Referral rates to Children's Social Care - Loves Farm



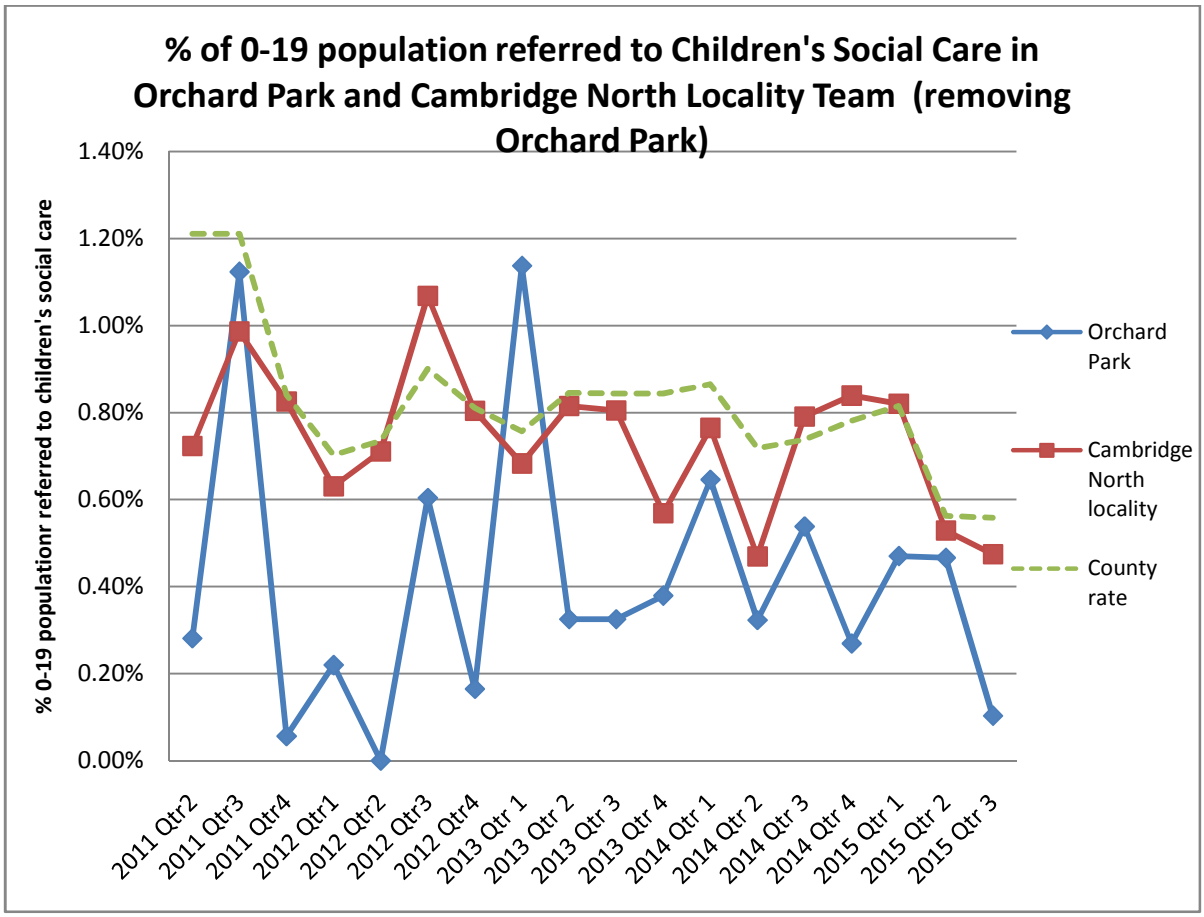
Source: One ICS, CFA Management Information Team and Strategy Service

From 2011-2014 of the children and young people referred to children's social care in Loves Farm, 55% had previously accessed children and young people's services from CCC (including Enhanced and Preventative service) and 45% had never accessed children and young people's services prior to moving to the new community. The average distance the families who were referred to children's social care in Loves Farm moved is six miles.

3.1.5 Orchard Park

On average in Orchard Park there were less referrals to children's social care per population compared to the rest of the locality. From the second quarter of 2011 to the third quarter of 2015 an average of 0.41% of the Orchard Park 0-19 population were referred to children' social care in comparison to 0.74% of the Cambridge North Locality.

Figure 31: Referral rates to Children's Social Care - : Referral rates to Children's Social Care - Orchard Park

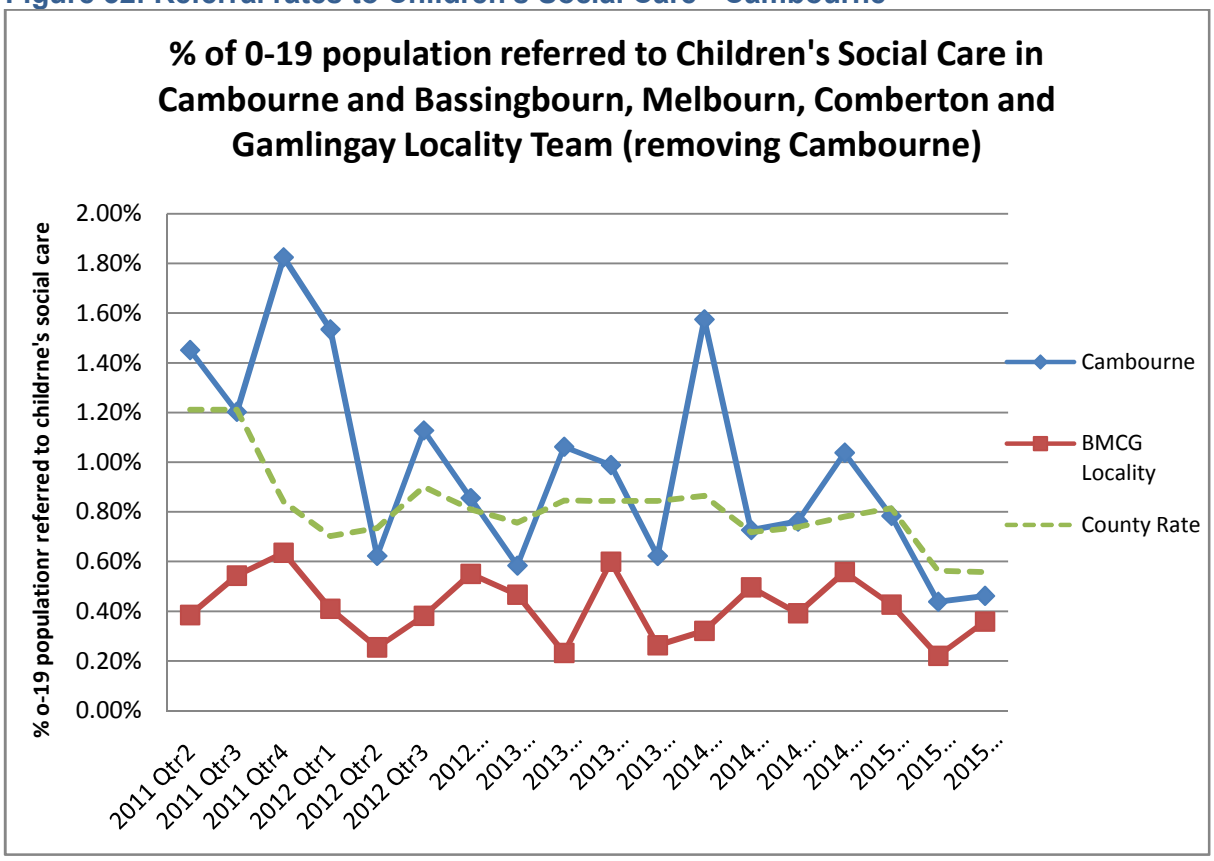


Source: One ICS, CFA Management Information Team and Strategy Service

3.1.6 Cambourne

For Cambourne there were on average more referrals from Cambourne per population compared to the rest of the locality. In Cambourne, from the second quarter of 2011 to the third quarter of 2015 an average of 0.98% of the 0-19 population were referred to children' social care in comparison to 0.42% of the Bassingbourn, Melbourn, Comberton and Gamlingay Locality

Figure 32: Referral rates to Children's Social Care - Cambourne



Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2 Enhanced and Preventative Services

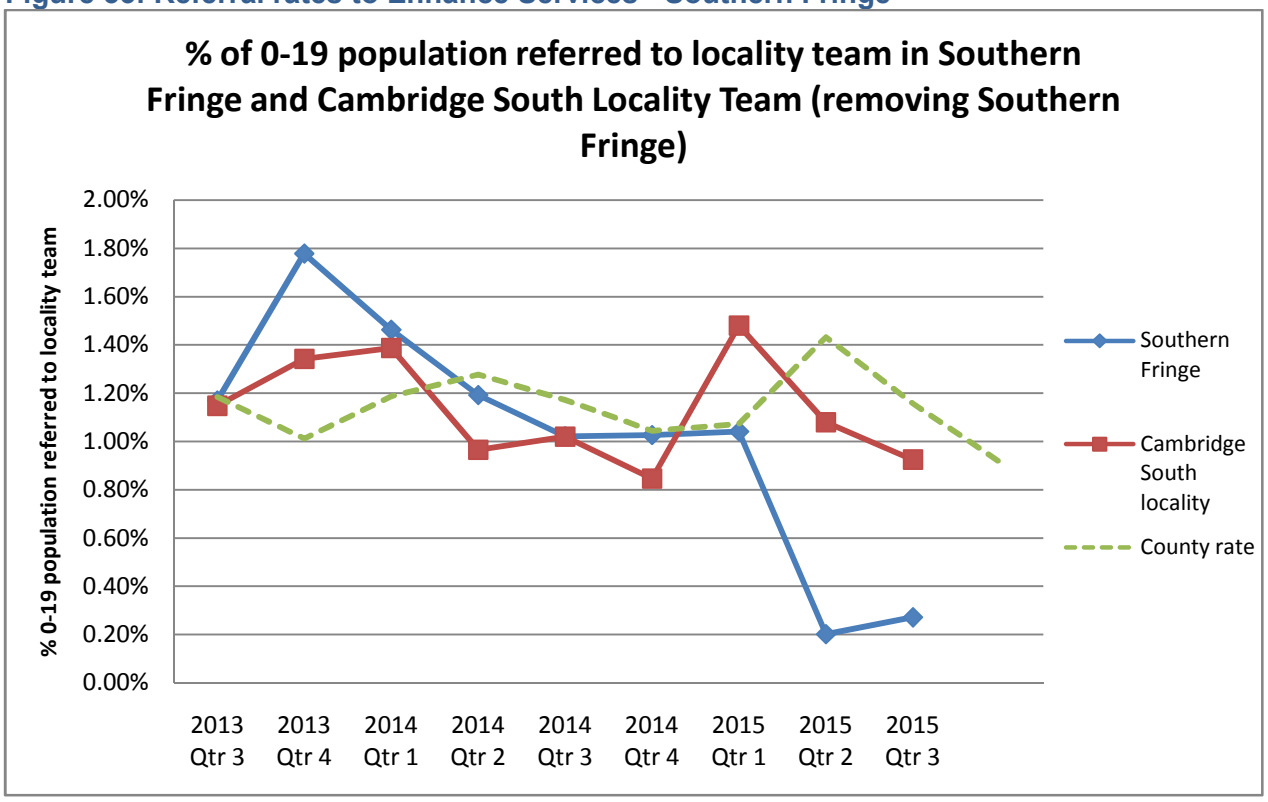
Data for locality referrals is only available from April 2013 as any data available prior to this date is less consistent. As with data from children's social care, it is only possible to run reports of locality usage based on the child or young person's current address (as of January 2016) rather than their address at the point of the referral. Therefore, it is not possible to determine whether the child or young person was living at their current address at the point of referral or at a different address.

It is also important to note that the referrals do not include all services that the locality provides as not all services provided by locality teams are accessed via the referrals, for example locality teams also do group work and drop in sessions which are not reflected within the referral data. Therefore, the data below should be seen as only part of how locality teams support communities.

3.2.1 Southern Fringe

Referrals to Cambridge South locality from Southern Fringe development were consistently higher than the rest of the locality for 2013-2014, however, there was a distinct dip in referrals in 2015. From the third quarter of 2013 to the third quarter of 2015 on average 1.02% of the Southern Fringe 0-19 population were referred to locality team compared to 1.13% of the locality. However in the first three quarters of 2015 an average of only 0.5% of the Southern Fringe 0-19 population were referred to locality team compared to an average of 1.13% Cambridge South locality.

Figure 33: Referral rates to Enhance Services - Southern Fringe

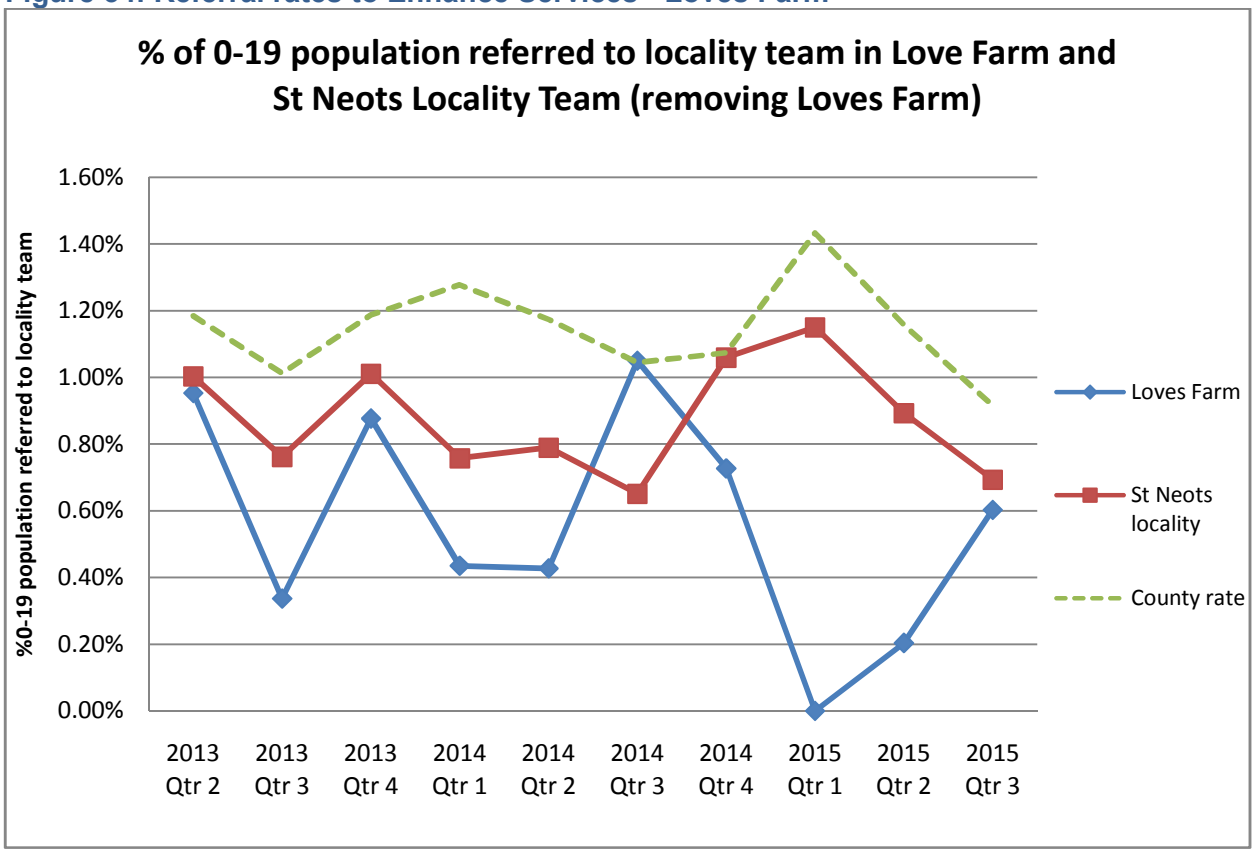


Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.2 Loves Farm

Referrals to St Neots locality team from Loves Farm are all but one quarter lower per population compared to the rest of the locality. From second quarter 2013 to the third quarter 2015 on average 0.56% of Loves Farm 0-19 population were referred to the locality team compared to 0.88% of the rest of the locality

Figure 34: Referral rates to Enhance Services - Loves Farm

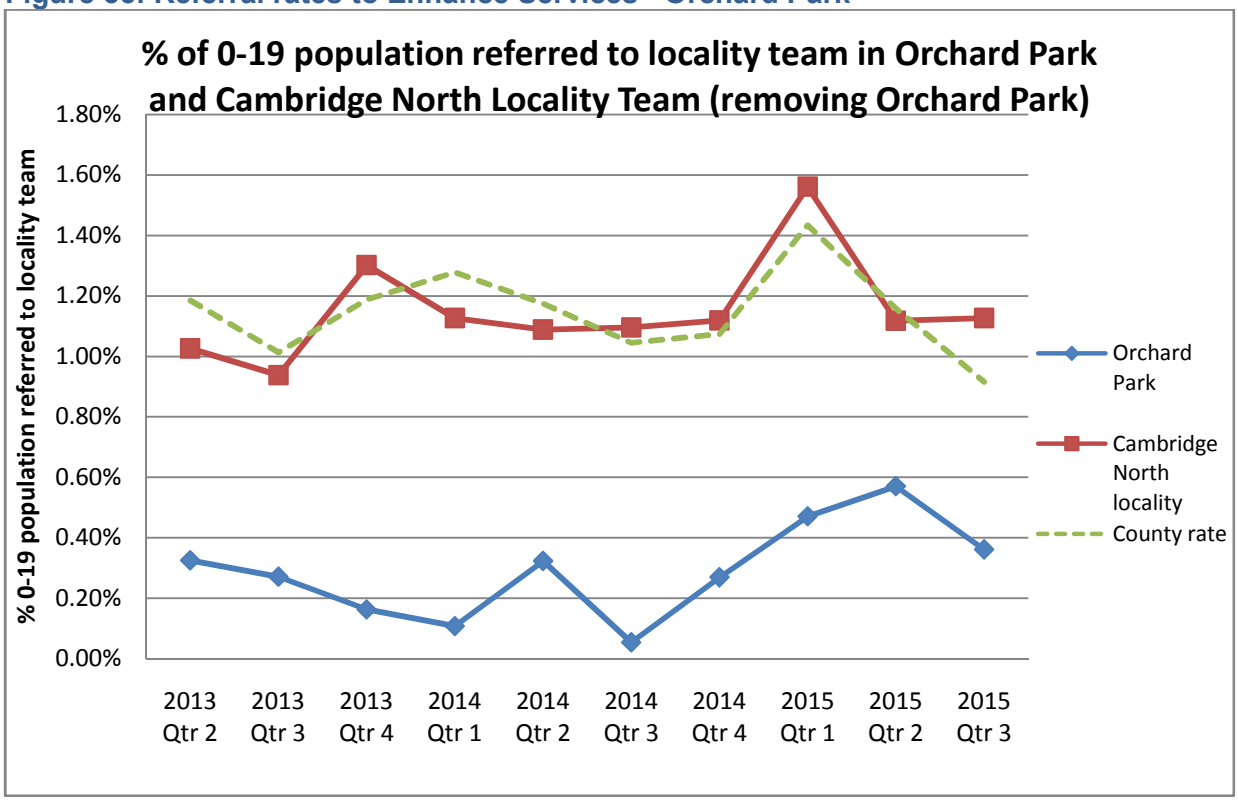


Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.3 Orchard Park

Referrals to the locality team from Orchard Park are lower than the rest of the locality. In contrast to Loves Farm and Southern Fringe, Orchard Park is consistently lower than the rest of the Cambridge north locality. On average, from the second quarter of 2013 to the third quarter of 2015 0.29% of Orchard Park 0-19 population were referred to the Cambridge North locality team compared to 1.15% of the rest of the locality.

Figure 35: Referral rates to Enhance Services - Orchard Park

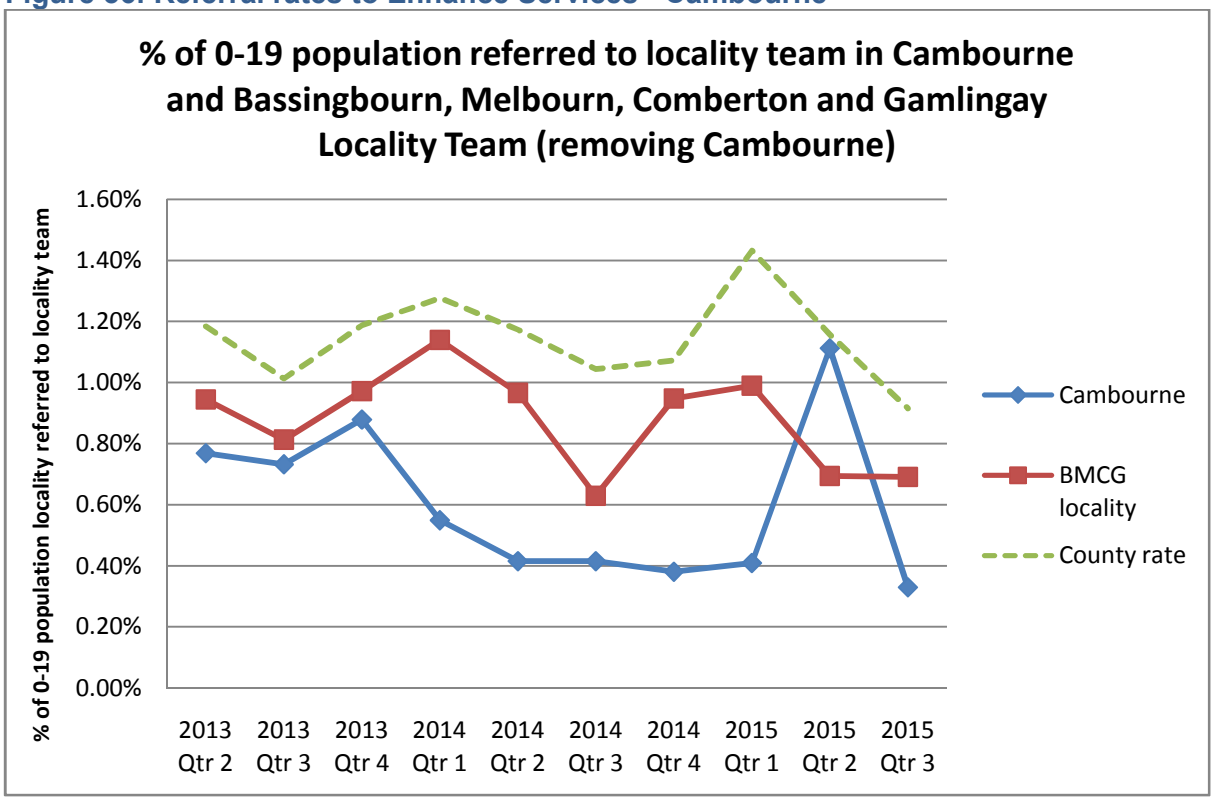


Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.4 Cambourne

Other than one quarter, the percentage of the 0-19 population in Cambourne referred to the locality team is also consistently lower than the rest of the locality. From second quarter of 2013 until the third quarter of 2015 on average, 0.6% of the Cambourne 0-19 population was referred to Bassingbourn, Melbourn, Comberton and Gamlingay Locality Team (BMCG) locality team compared to an average of 0.88% for the rest of the locality.

Figure 36: Referral rates to Enhance Services - Cambourne



Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.5 Conclusion

Although social care referrals are higher in Loves Farm and Cambourne, the referrals to locality teams are lower than the rest of the locality. In Southern Fringe while prior to 2015 referrals to locality are around the same if not slightly higher than the rest of the locality they are not much higher, whereas referrals to social care are on average quite a bit higher than the rest of the locality.

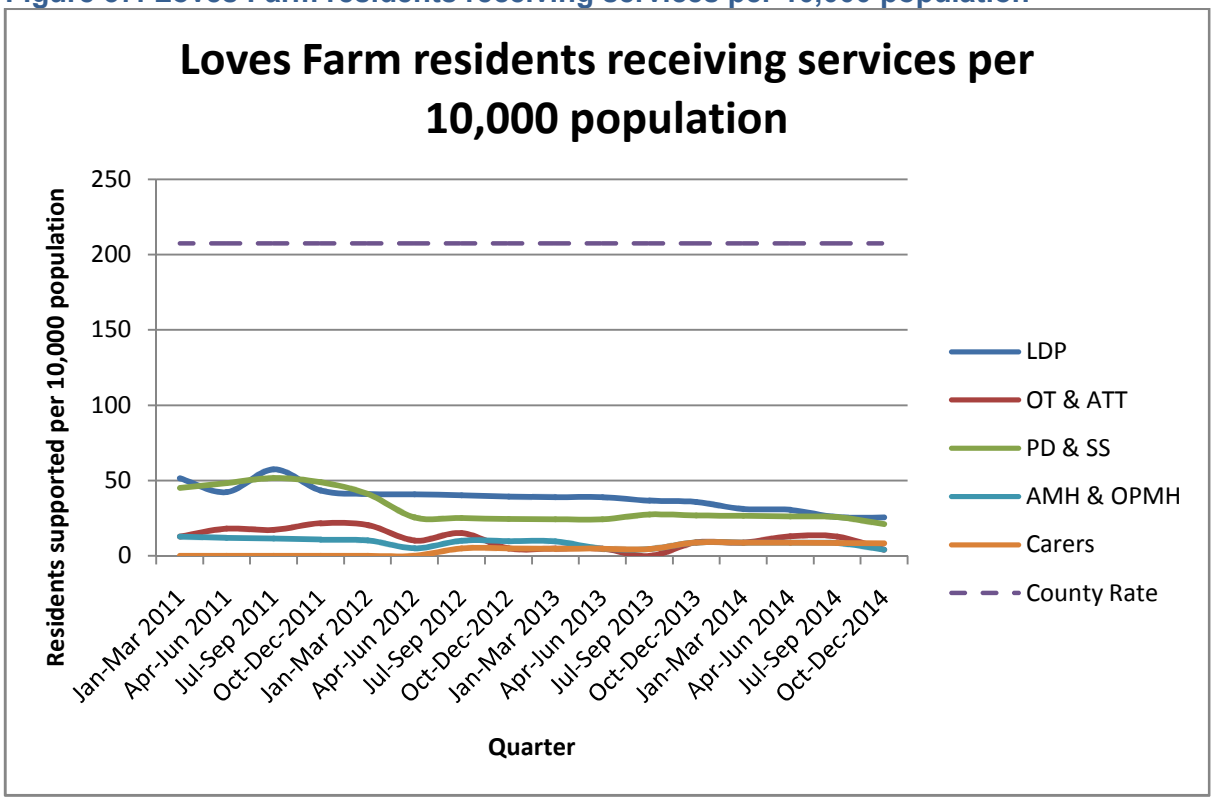
What referrals do not show is how long cases stay open or if there are any patterns for the primary reasons for referrals.

3.3 Adult Social care

Adult social care (including Older People and Mental Health (OPMH)) support adults who meet eligibility criteria set by the Care Act, due to their needs being assessed as significant and in need of specific packages of support which might take place in the home, community or in an institutional setting. This may include people who have difficulty carrying out basic personal care or domestic routines, struggle to carry out family responsibilities or are at significant risks in terms of their wellbeing. Adult social care supports these adults to maintain choice and to live healthy, socially engaged independent lives. They also offer support and advice and assessment to people who pay for their own care and their careers.

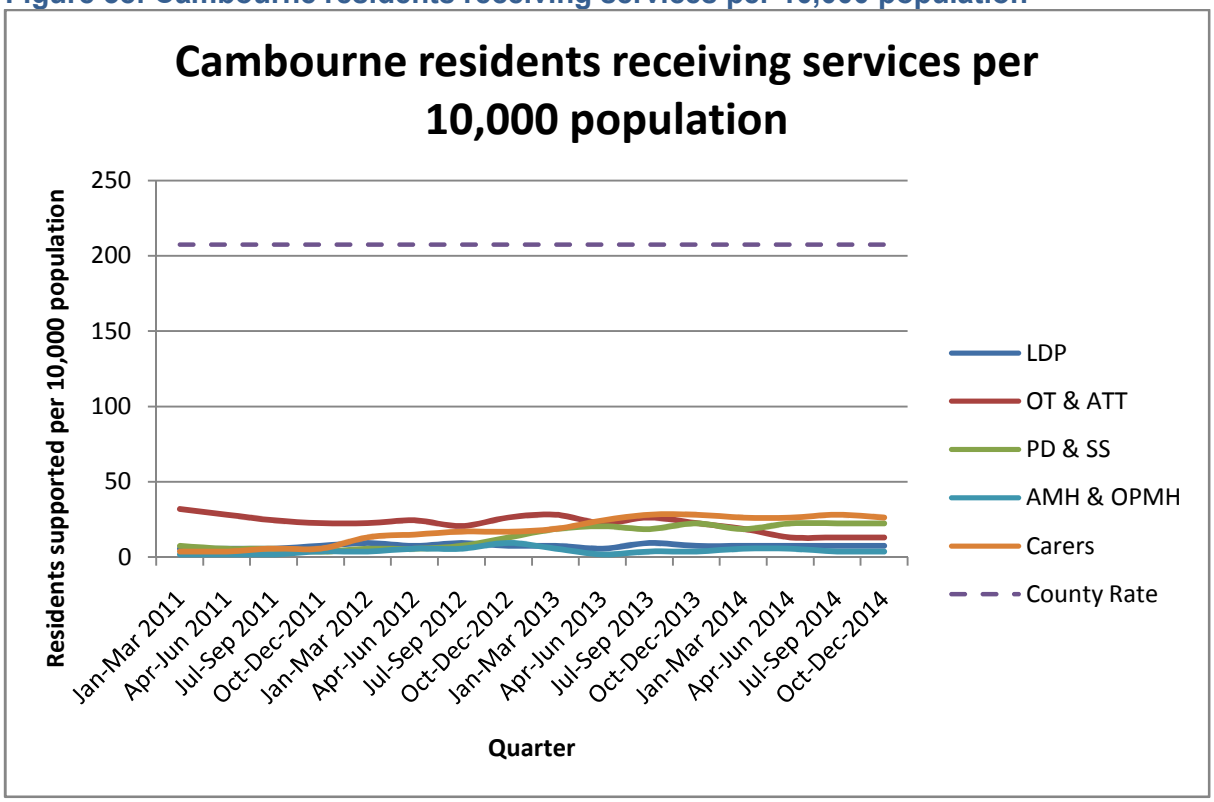
In Loves Farm and Cambourne there are significantly less people who access CCC adult social care services and older people services compared to the county average. (NB Southern Fringe was not included in the analysis because the numbers were too small). Adult social care services include: Learning Disability Partnership (LDP), Occupational Therapy and Assistive Technology and Tele-care (OT & ATT), Physical Disability and Sensory Service (PD & SS), Adult Mental Health and Older People Mental Health (AMH and OPMH), Carers and Older People Services.

Figure 37: Loves Farm residents receiving services per 10,000 population



Source: Swift. Population of Loves Farm was estimated by multiplying the number of houses by average number of adults per household in Cambourne (Cambridgeshire County Council & NHS Cambridgeshire, 2010)

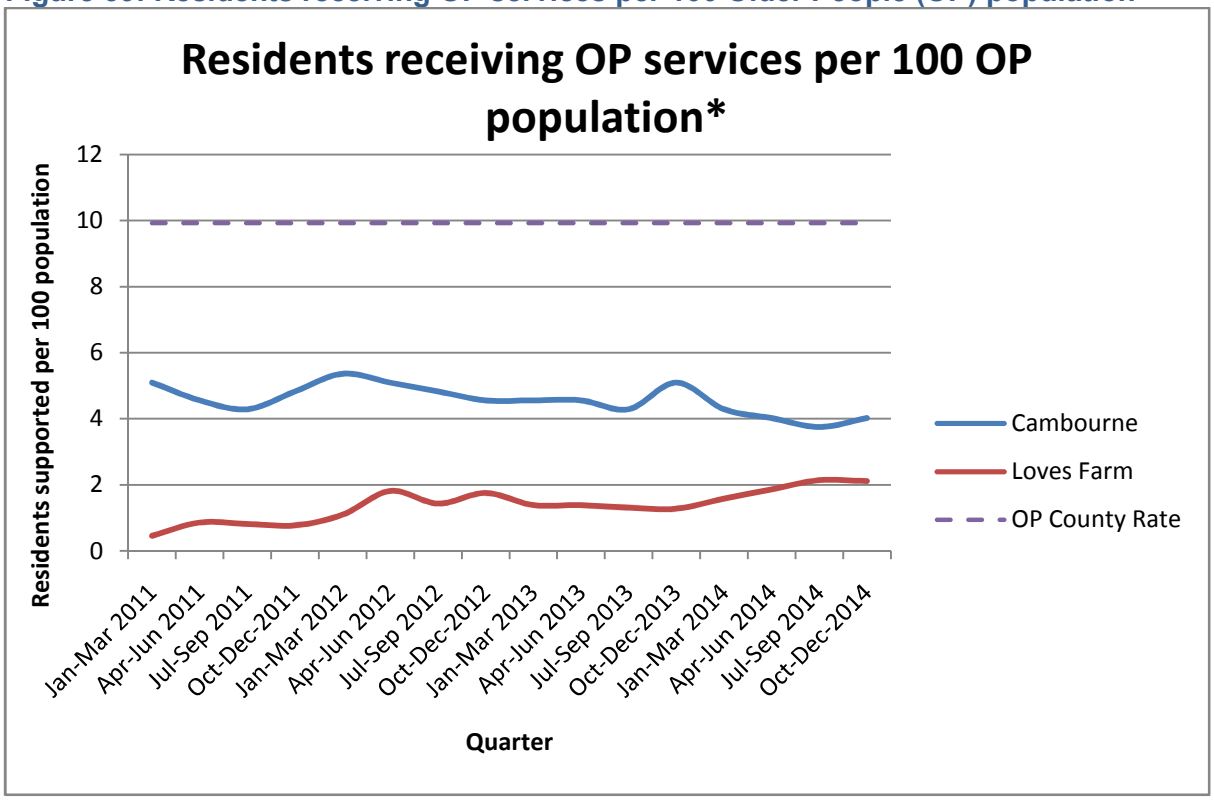
Figure 38: Cambourne residents receiving services per 10,000 population



Source: CFA Management Information, Swift. ONS mid population predictions 2013

The same conclusion for older people services:

Figure 39: Residents receiving OP services per 100 Older People (OP) population



Source: Swift. CFA Management Information Team *Cambourne population calculated using ONS Mid-year 2013 Data (Residents aged 65+). Loves Farm population calculated using increasing quarterly estimate

3.4 Schools and Early Years

While the school building is a recognised asset in new communities there are certain challenges faced by schools in new communities that are not faced by schools in more established communities. The 2010 County Council member led review noted that the sudden increase in pupil number and higher turnover of pupils, existing socio-demographics and high numbers of pupils with English as a second languages placed pressure of new community schools unlike schools within established communities.(66)

The majority of new schools opening in Cambourne, Loves Farm, Orchard Park and Southern Fringe have received good Ofsted inspection judgements, however, some of the schools have struggled in the early years.

Table 21: Ofsted findings for schools in New Developments in Cambridgeshire

School	Year Open	Ofsted inspection overall judgement
Monkfield Park Primary School, Cambourne	1999	2001 – no judgement, positive report 2006 – Good 2011 – Good 2015 – Good
The Vine Inter-Church primary school, Cambourne	2005	2007 – Satisfactory 2010 – Good 2014 – Good

Jeavons Wood Primary School, Cambourne	2009	2011 – Good 2015 - Good
Cambourne Village College (Secondary), Cambourne	2013	2015 – Outstanding
The Round House Primary School/Academy, Loves Farm	2008	2010 – Satisfactory 2013 – Requires Improvement 2015 – Good (first inspection as an academy)
Orchard Park Community Primary School, Orchard Park	2007	2009 – Good 2011 – Good
Trumpington Meadows Primary School, Southern Fringe	2012	2014 – Inadequate 2015 – Requires Improvement

Source: http://reports.ofsted.gov.uk/

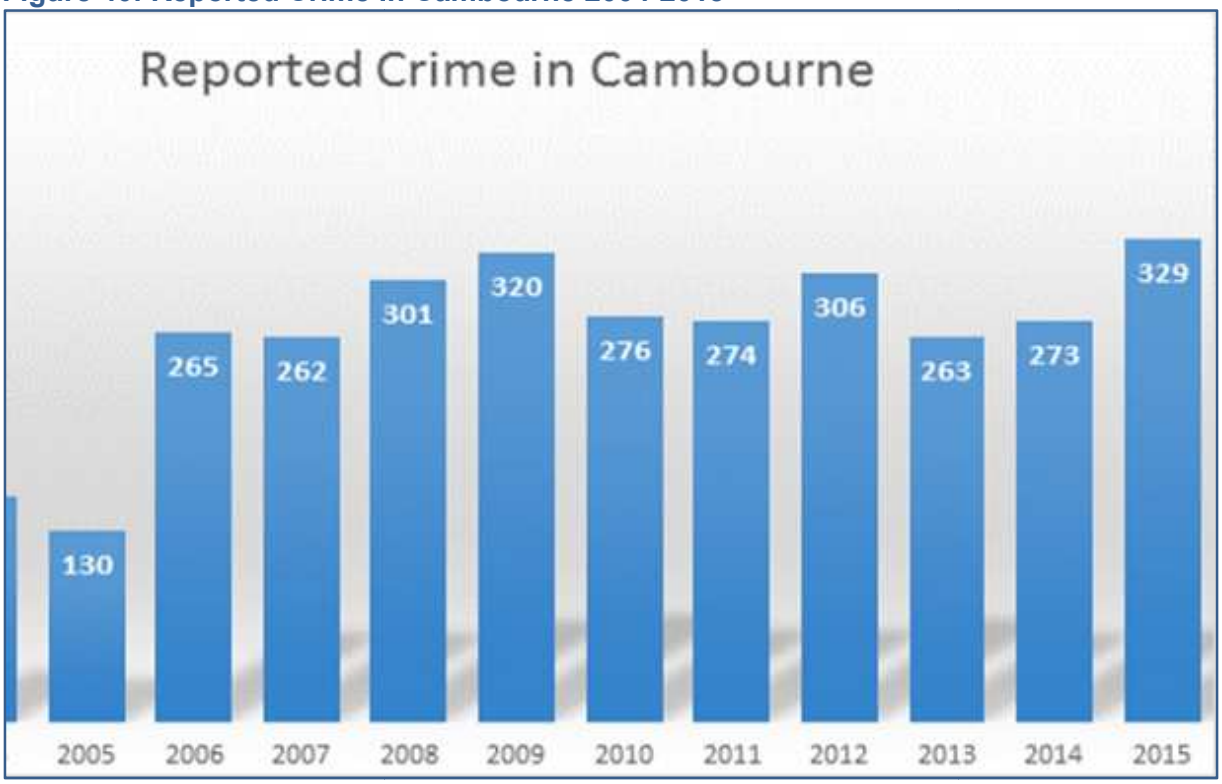
The Ofsted inspections of almost all schools listed above note that the same challenges recognised in the Member-led review are still occurring. The schools have to deal with the rapid growth due to significant increase in pupil numbers, high numbers of staff joining the school at the same time. Half of the class teachers at Vine Inter-Church School in Cambourne had joined the year of their Ofsted inspection, high staff turnover, vastly higher rates of pupil mobility (total movement in and out of school by pupils other than at the usual times of joining and leaving). The schools also tend to have above average number of students who speak a variety of languages and a number ethnic backgrounds are represented. Some of these challenges can put extreme pressure on new community schools outside the usual pressures schools face – this can make it very difficult to ensure smooth running and can lead to poorer outcomes.

In addition to schools, new communities face pressure on early years (children below five years old) care/education. New communities on the whole still face higher birth rates which has a significant impact on the need for early years provision (this include child minders, nurseries, pre-schools etc.). Although the Local Authority can ensure that space is provided for sessional provision there is often short falls in full day care on new developments. This is currently occurring in Southern Fringe, where it is proving difficult to get providers in early enough to meet the needs of the community meaning that parents are having to travel distances to ensure adequate care for their young children, if they can access it at all, this may mean that parents are not in employment when they want to be due to lack of childcare.

3.5 Crime data

Due to limitations of available data it is only possible to provide details of reported crime in Cambourne from 2004. What is interesting from the data is that that reported crime doubled in Cambourne between 2005 and 2006 and then remained constant ever since – even though almost an additional 2,000 houses have been built since 2006.

Figure 40: Reported Crime in Cambourne 2004-2015



Source: Area Commander- South Cambridgeshire

It is not clear why this doubling occurred. There were an additional 377 houses completed in financial year 2005-06, in 2005 the second primary school opened in temporary accommodation, and in 2006 the youth building was completed, the vets and dentist opened and the pub opened.

Table 22: Number of dwelling completions in Cambourne 2001-2007

Year	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Dwellings built in year	213	337	620	151	377	267	219
Cumulative total	574	911	1531	1682	2059	2326	2545

Source: Cambridgeshire County Council, Research and Performance Team 2012

3.6 Libraries

Although there is no local data for usage in new communities a recent study into health and wellbeing benefits of library engagement found that library use is positively associated with subjective wellbeing, high life satisfaction, higher happiness and higher sense of purpose in life.(68) Libraries are a valued part of society and have a role in people's quality of life with 76% of library users in principle willing to pay an increase in council taxes to keep all services their local library offers, and 63% of non-library users would be willing to pay something. (68) These benefits can save the public purse with benefits that can reduce GP visits, social

The provision of libraries is a statutory duty of local authorities and they are one of the few universal services provided by local authorities. Libraries do not just lend books but also provide computer access, children's activities, activities for older people, act as an information hub, host and provide training courses, lectures and meeting spaces.

care usage and improve education, skills training and employment.

3.7 Are there patterns that can tell us something?

Building community resilience and developing the community is essential to the health and wellbeing of the community and to reduce progression to problems that require more intensive services. Simply making more opportunities for people to meet will not reduce this high need and pressure on services – for some people new developments are lonely and they need support to help them settle. (65) Building meeting spaces is just one of the steps involved: it is the services and support that are key to community development .

To help replicate and develop good practice some outcomes and guiding principles have been developed. These outcomes and principles have been established based on experience of new and developing communities in Cambridgeshire.

3.7.1 Outcomes

If we have been successful in supporting the development of sustainable new communities that are healthy and well, we could expect the following five outcomes to have been achieved. These cannot be the sole responsibility of one agency but will require the whole planning and delivery system to work together with the community towards an agreed vision

All people, regardless of their needs, live well independently
All residents of new communities should be resilient, able to live well and independently, especially those who may be vulnerable to social isolation, and engage with their community without the need of intervention. All barriers that could block someone's engagement in the community are removed and all members of the community should be involved as much as they choose and have control over their own lives

People are and feel safe
All residents of new communities should feel and be safe within their environment whether out in the community or at home. This will enable all residents, especially those at higher risk of harm, to have the opportunity to be positive contributors to their community and society as a whole and enjoy being engaged with all members of the community.

People lead a healthy lifestyle
All residents of new communities can pursue a healthy lifestyle, families are able to make healthy choices, be active, and free of substance misuse

Local economy prospers for all
All residents of new communities are able to achieve their learning potential, are equipped and have the opportunity to go onto further learning or work, maintain employment, and have the knowledge, skills, and confidence to make positive changes in their communities. All barriers to learning and employment are removed and communities are supported to enable them to maximise their full potential; building on the assets of the community rather than by being dictated by organisational structures and boundaries.

All people have a voice and control in decisions that affect their community
All residents are able to activity engage in decision making. There are high levels of community participation in decision making and the planning and delivery of services at local and strategic level.

3.7.2 Principles

In order to achieve the outcomes, it is crucial that activities are delivered effectively and in a co-ordinated manner to avoid duplication or gaps in provision. The outcomes define what it is we want to achieve and the guiding principles detail how we go about doing it.

Partnership working
Lessons learnt in previous new communities have shown that service and support can often appear disjointed and confusing to new residents. All services throughout the planning and delivery of new communities must work together and with the community to ensure best use of assets and to help ensure services are available when the community needs them. Co-ordinated effective partnership working will help to ensure that the community are appropriately supported early to prevent escalation and are supported back to independence. Several services providing similar activities to the same families/individuals is not only financially irresponsible but does a disservice to the family and individual.

Co-location
It is important to provide a central focal point for the community and services so that all members of the community are able to meet together and access services from within the community. Co-locating community spaces and service provision not only increases opportunities for community cohesion but is also more financially sustainable as it enables the sharing of overheads and running costs. This does not necessarily mean a large structure but rather is flexible space that provides focal point which all the community can access.

Co-locating various spaces provides the community with necessary community space and allows them to access a variety of services. Anchoring in a neutral universal service such as a library or GP surgery means that all members of the community will use the building and also provides a degree of anonymity as no one will know which services or activity you are accessing as all are based in one location. Co-location also provides greater opportunity for better integration between services which benefits the services and the community and they receive a better service.

However, there is a risk with co-location in that if they are large, with a number of public services based in them then then is much less likely to be run by the local community. It is important that the principles of co-location are not lost regardless of the size, but also essential that the needs and assets of the community are looked at when considering type and management options of a community space.

Community Resilience
As detailed in Chapter 3 – Social Cohesion, community building/resilience/development is essential in new communities. Community development uses the assets of a community to build resilience. Services have an interest in supporting community development as a resilient community with high social capital is less likely to need more intensive and invasive services. This will help maintain capacity within services so they are able to support people and enables them to have shorter intervention as a resilient community will be better placed to support the individual or family rather than continuous need of services.

Timing
All people centred services and the community need to be engaged in the planning process at the earliest stage (pre-application where possible) and kept involved through to delivery. Ensuring that all services are aware and able to engage with the planning of the new community will enable services to plan together to ensure the new community is well supported to develop into a healthy and well community, enable them to effect design of

infrastructure and ensure clear communication between all levels of services and the community.

It is also imperative that support, services and infrastructure are available at the right time for the community. Ensuring that all services and the community are engaged in the planning process will aid delivery of infrastructure, support and services when the community need it.

Case Study 7: Southern Fringe - Community Development

Case study: Southern Fringe Children, families, community development and wellbeing subgroup:

The group consists of Children's Centre and locality team, communities, arts and recreation service (City Council), local schools, local churches, residents association, housing association, representative from Haslingfield and officer from South Cambridgeshire District Council. Health are often not represented but are linked in through other partnership groups. The group meets every other month

The purpose of the group is to develop a Southern Fringe Community Development Action Plan, to plan and implement arrangements for welcoming new residents, provide information and advice to local services on occupations, create opportunities for new and existing residents to meet and develop joint community activities and services, build the knowledge, skills and confidence of residents to enable them to create and sustain community groups, social networks and representative community organisations, support community engagements and administer the Community Chest (funding for community activities).

The group is very beneficial for networking and has many successes to date including: identifying potential strains on services by sharing information regarding new occupations, target services where new hot-spots are identified, identified shared community needs and responded – such as running welcome events, event for volunteers, show-casing community projects, run targeted workshops on specific themes. In the coming year the group will be coordinating meeting for facility managers to share experience and support each other and looking at capacity and how voluntary sector may be able to take on more as Section106 funding finishes.

3.8 Barriers to services and assets being utilised

In the past there have been some barriers that have resulted in a new community being put at a disadvantage and not being delivered in the most effective way. It is hoped that the outcomes and principles detailed above can alleviate some of these barriers but this may not always be possible.

Lack of co-ordination and clear communication

Lack of communication can make it very challenging for services to adequately plan and can frustrate the local community. This can result in rumours emerging which can be hard to dispel and may be a catalyst for the community to oppose the development.

> Potential mitigation: at the pre-application stage the planning authority/developer produces a communication strategy and action plan that must be agreed by developer and statutory services prior to planning application being submitted for all sites over 100 homes.

Long planning and delivery process
The planning process and delivery of new communities can take 10-20 years to complete. Services are often working on annual plans and due to uncertainty with finances it can be difficult to contribute to planning for a community that is so far in the future. Staff turnover during this long process can also result in things becoming lost and never completed.

> Potential mitigation: Working groups formed (detailed in recommendation above) and create agreed objectives and action plan. This is monitored and amended by the group as the new community is developed.

Funding and lack of capacity
Even when services are engaged and willing they may not be able to support the development of the new community due to lack of capacity. Reducing budgets increases in population and higher needs in new communities' results in services simply not having the financial capacity to grow with the population and adequately serve the existing and new community.

> Potential mitigation: Well evidenced and co-ordinated requests for developer funding are submitted to ensure there is appropriate capacity in the early years of the new community when needs are highest. Clear communication and co-ordination enables service planning to take account of the growth sites in advance so that new communities are not discounted.

Existing community and local representatives
Although an important asset the existing community and local representatives may instead be a barrier if they do not support the new development. Although it is essential that the local community have a voice and can object to the planning application, it can result in the local community being less willing to engage. This can make it very difficult to engage the community, even parts of the population who may be supportive of the proposed development, which may mean they miss opportunities to influence the planning application or to co-produce services using existing assets.

> Potential mitigation: clear communication strategy is agreed from pre-application stage so that the community and local representatives and privy to all information and able to engage appropriately with local planning authorities and services regardless of their views towards the development.

Digital infrastructure
As technology advances many services are supporting and serving people virtually. This means that good access to the internet is required for the community to access these services (not to mention the potential the online community has for advancing community cohesion). However, some new communities are left without quality access leaving them unable to access necessary services and information. For example, it took 18 months until there was a reliable broadband connection in the Southern Fringe development.

> Potential mitigation: planning requirements necessitate that digital infrastructure is delivered at the same time as other necessary infrastructure and prior to any

NHS COMMISSIONING

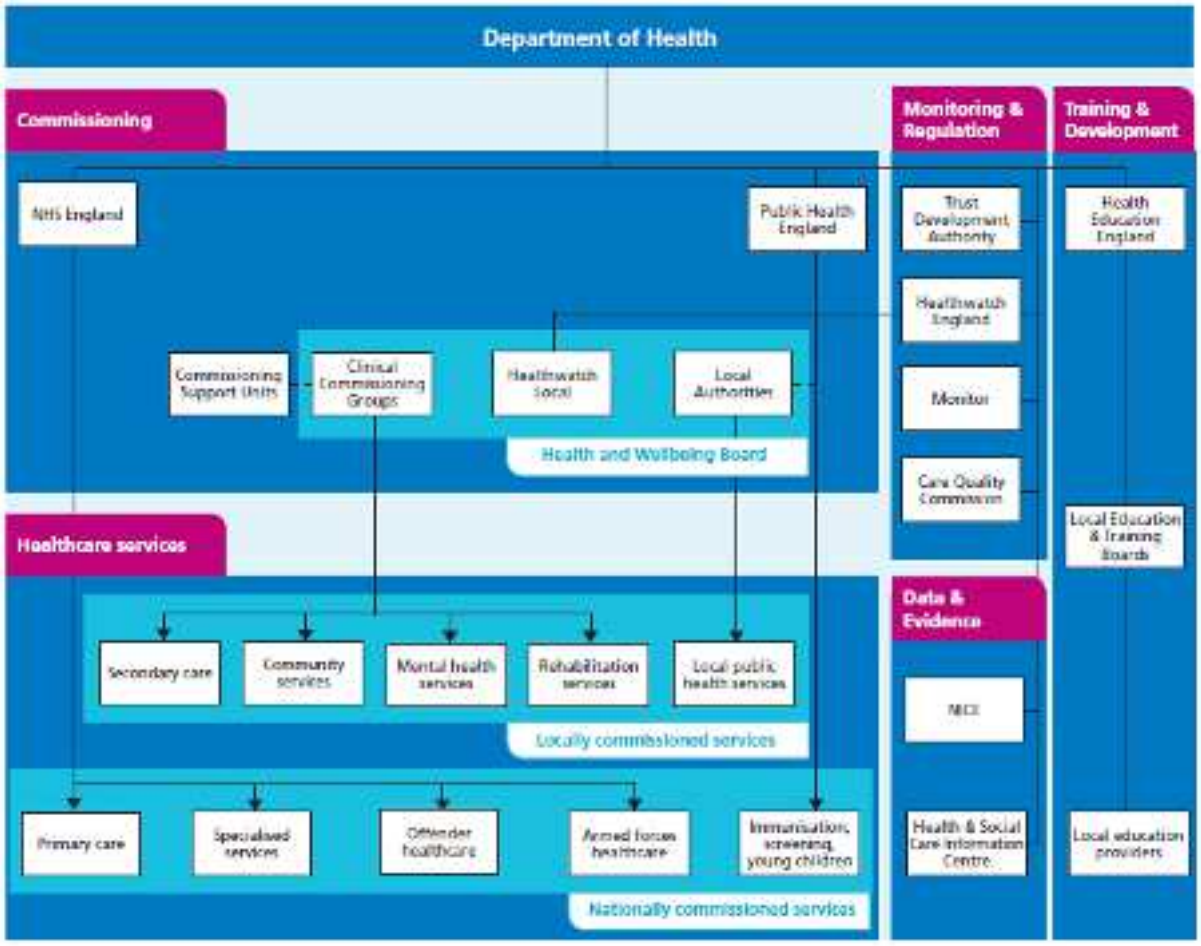
1. KEY FINDINGS

- The current engagement between Planning Authorities, CCG and NHSEngland need to be improved.
- NHSEngland/CCG need a robust case when seeking Section 106/CIL contributions with a defined need and costed solution.
- Ensure that all health partners including Primary Care Practices are consulted on planning applications. In addition, health partners should come together at the earliest opportunity to discuss needs at strategic sites.

2. INTRODUCTION – WHAT IS THE CURRENT NATIONAL NHS COMMISSIONING LANDSCAPE?

2.1 WHAT ARE THE MAIN NHS SERVICES AND WHO COMMISSIONS THEM?

Figure 41: The NHS Commissioning Landscape



Source: UNDERSTANDING THE NEW NHS – A guide for everyone working and training within the NHS, NHS England 2014

NHS services are many and varied, ranging from services delivered on a national basis to local services delivered in General Practice settings. This JSNA is primarily concerned with the local NHS services needed in new communities and how they are provided.

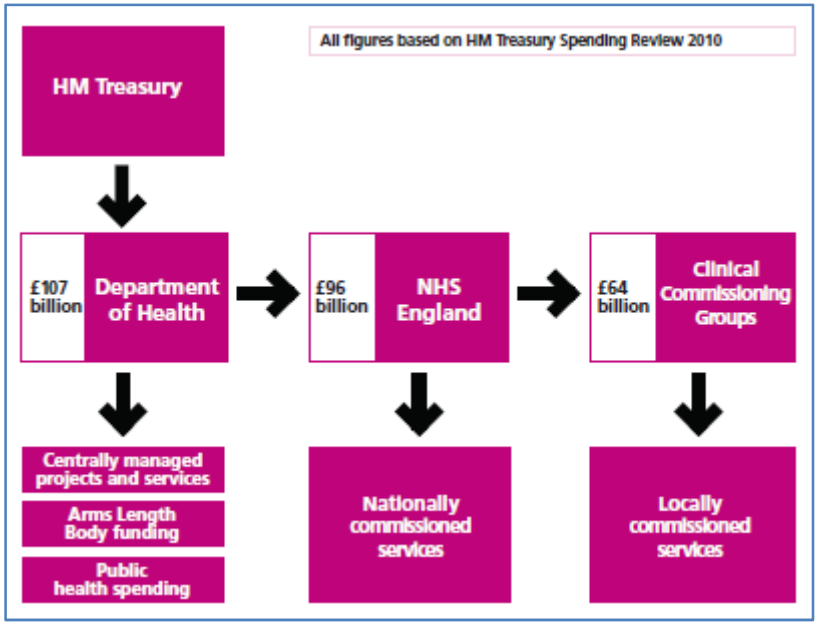
The Secretary of State for Health - *has overall responsibility for the work of the Department of Health (DH). DH provides strategic leadership for public health, the NHS and social care in England.*

Who does what? The Department of Health - *is responsible for strategic leadership and funding for both health and social care in England.*

Most services required in a new community will be delivered in a primary care facility, around 90% of patient's first point of contact with the NHS is with primary care services, and includes GP practices, dental practices, community pharmacies and optometrists.

How is the NHS Funded?

Figure 42: The NHS Funding Flows



Source: UNDERSTANDING THE NEW NHS – A guide for everyone working and training within the NHS, NHS England 2014

2.1.1 Primary Care

Within the current legal framework, NHS England is responsible for commissioning primary medical services for anyone present in England. This includes the services that NHS England commissions from GP practices under GMS, PMS or APMS contracts (which are explained further below) and the out-of-hours services that CCGs commission on NHS England's behalf. However, CCGs have a duty to support NHS England in securing continuous improvements in the quality of primary medical care[ii].

In May 2014, Simon Stevens invited CCGs to take on an increased role in the commissioning of primary care services and it is expected that many CCGs will opt to

implement joint or delegated primary care commissioning arrangements. However, should a CCG assume co-commissioning responsibilities, NHS England will retain liability for the discharge of its statutory functions in relation to primary care commissioning.

In addition, a CCG may commission services in its own right from GP practices, provided that:

- The services go beyond what a practice is required to provide under the current GMS, PMS or APMS contracts held by NHS England.
- The CCG follows an appropriate procurement route, which may (depending on the circumstances) involve undertaking a competitive procurement, establishing a framework of providers from which patients can choose, or procuring through a single tender action (for instance where there are no other capable providers).
- The CCG manages any conflicts of interest in accordance with NHS England guidance: Managing conflicts of interests: Guidance for clinical commissioning groups and code of practice: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services.

CCGs can fund GP practices to improve the quality of existing primary care services provided that:

- The improvement can be expected to improve wider outcomes for the CCG's population.
- The area team agrees it is over and above what it would expect a GP practice to provide under its existing GP contract.

For example:
Under the national childhood immunisation target payment scheme, NHS England pays GP practices for immunising children with the recommended vaccines, with rewards for 70% uptake by age two and 90% uptake by age five. If a CCG is concerned about achievement in its area (compared to other similar CCGs), it could introduce additional incentives to encourage practices to exceed these target levels of uptake.

Under statute financial and legal accountability for the improvement remains with the CCG.

A CCG may invest in developmental support for GP practices or GP premises development provided that the CCG can demonstrate that the investment is calculated to facilitate, or is conducive or incidental to the provision of primary medical care and that no other body has a statutory duty to provide that funding.

How are General Practices funded?
General Practices' receive income through a number of different funding streams for different services including essential services, additional services, the Quality and Outcomes Framework (QOF) and enhanced services. Some practices may also receive seniority factor payments and payments for dispensing services.

The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.
The GMS contract covers:

- The global sum, which uses the Carr-Hill formula to distribute the core funding. It covers essential and some additional services. Payments are made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age and deprivation. The Global sum is commissioned by NHS England.

- The quality and outcomes framework (QOF), which covers the two areas of clinical and public health. (QOF is voluntary but most practices with GMS contracts, as well as many with Personal Medical Services (PMS) contracts, take part in QOF).
- Enhanced services (ES), which covers additional services that practices can choose to provide. These services can be commissioned nationally or locally to meet local healthcare needs.

Who does what?
NHS England *- is an independent body, at arm's length to the government. Its main role is to improve health outcomes for people in England. It also commissions primary care and specialist services*

The Personal Medical Services (PMS) contract is similar to the GMS contract but allows flexibility to pay additional monies above the GMS contract level to GP Practices, eg for additional costsassociated with a new GP practice in a growth area. Both the GMS and PMS contracts are reviewed quarterly.

What is a federated model of GP Provision?
A Federation is a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local communities.

Who does what?
Clinical commissioning groups (CCGs) *are responsible for the planning and commissioning of healthcare services for their local area. They commission most secondary care services.*

The concept of a primary care Federation was first set by the Royal College of General Practitioners in September 2007. Its publication, *The RCGP Roadmap*, focused on a model where practices would work together more closely to share resources, expertise and services. A Federation, whilst not typically part of the day-to-day language of NHS general practice and primary care, has however gradually come further to the fore, usually in relation to practices grouping together for either commissioning or service provision activity.

2.1.2 Dentistry

NHS England commissions all dental services, which includes primary, community and hospital services and urgent and emergency dental care. NHS England commissioners each have Local Professional Networks (LPNs) for dentistry. The LPN Chairs together with Public Health England (PHE) Consultants in Dental Public Health (CsDePH) are the clinical voices to dental commissioners. Public Health departments within the Local Authority commission dental screening and oral health improvement.

Dental practices usually accept NHS patients and private patients. The amount of NHS dentistry a practice can carry out is agreed annually with NHS England. Once a dental practice has reached its annual limit it can then only offer dentistry on a private basis.

There are currently two types of contract for NHS dentists: the General Dental Services (GDS) contract and the Personal Dental Services (PDS) agreement.

A GDS contract gives dentists the flexibility of taking on a partner but sometimes have lower Units of Dental Activity (UDA) values.

Since April 2006, UK NHS dentists have been paid according to how many "Units of Dental Activity" (UDA) they do in a year. One UDA is worth between £15 and £25 - it varies around the country. A UDA depends on the type of work undertaken. A dentist is contracted by NHS England to do a set number of UDAs and dentists have to be within 4% of their targets.

2.1.3 Pharmacy

Any organisation can commission services from community pharmacies. Those most likely to do so are the CCG and local authorities. However, they can only commission services that are not NHS Pharmaceutical Services as defined by the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 and therefore cannot be described as enhanced services.

NHS England is the only organisation that can commission NHS Pharmaceutical Services. They are therefore responsible for managing and performance monitoring the Community Pharmacy Contractual Framework.

Where there is evidence of a change in needs for pharmaceutical services then the Health and Wellbeing Board (HWB) is required to decide whether it needs to produce a new Pharmaceutical Needs Assessment (PNA). If as a result a new service is needed, Commissioners are required to consider the new NHS (Procurement, Patient Choice & Competition) Regulations 2013 when commissioning the required service.

What is a Pharmaceutical Needs Assessment (PNA)? *The statutory responsibility for producing the PNA rests with the Health and Wellbeing Boards. NHS England's decision can be appealed and challenged via the courts, it is therefore important that PNAs are kept up-to-date.*

Decisions on whether to open new pharmacies are made by NHS England.Pharmacies must submit a formal application to NHS England for approval. The relevant NHS England Area Team reviews the application and decides if there is a need for a new pharmacy in the proposed location. NHS England is required to refer to the local Pharmaceutical Needs Assessment (PNA) as part of its decision making process.

2.1.4 Optometry

NHS England is responsible for the commissioning and administration of NHS General Ophthalmic Services (GOS) which include NHS sight tests and vouchers for spectacles for eligible individuals, including children. Optical contractors are commissioned to carry out a sight test for a fee.

CCGs commission services from community optometrists for the provision of community ophthalmic services. These arrangements are outside the GOS contract and the service specifications and remuneration would need are negotiated by the commissioner and provider.

Unlike GPs and dentists, optical contractors are not normally responsible for screening orrefining their own referrals under the GOS. They are neither paid nor allowed to managepatients in their own practices within the limits of their clinical competency. Instead they mustrefer all patients who show signs of injury, disease or abnormality in the eye, or elsewhere,and require medical treatment or are unlikely to see satisfactorily with corrective lenses. Thisis required by their GOS contract

Normally, optometrist referrals would go straight to ophthalmology outpatient departmentsbut unrefined referrals can clutter these clinics unnecessarily. Referral refinement servicesand other locally commissioned or enhanced services provided in high street optometristpractices can prevent or greatly reduce this.

These type ofservices include:

- Referral refinement and/or assessment especially to eliminate false positive glaucoma suspects.
- Cataract monitoring – pre and post extraction.
- Low vision services including low vision aids.
- Stable glaucoma monitoring.
- Red eye/acute anterior segment.

Children's vision screening services, eg screening at school entry are the responsibility of Local Authority Public Health Departments.

2.1.5 Secondary Care

Clinical commissioning groups commission secondary care, which includes:

- planned hospital care (Electives)
- rehabilitative care
- urgent and emergency care (including out-of-hours)
- most community health services
- mental health and learning disability services

Who does what?
Acute Trusts *- Hospitals in England are managed by acute trusts – some of which already have gained foundation trust status. Acute trusts ensure hospitals provide high-quality healthcare and check that they spend their money efficiently. They also decide how a hospital will develop, so that services improve.*
Acute trusts employ a large part of the NHS workforce, including nurses, doctors, pharmacists, midwives and health visitors. They also employ people doing jobs related to medicine, such as physiotherapists, radiographers, podiatrists, speech and language therapists, counsellors, occupational therapists, psychologists and healthcare scientists.

There are many other non-medical staff employed by acute trusts, including receptionists, porters, cleaners, specialists in information technology, managers, engineers, caterers, and domestic and security staff.
Some acute trusts are regional or national centres for more specialised care, while others are attached to universities and help to train health professionals.

Acute trusts can also provide services in the community – for example, through health centres, clinics or in people's homes.

Who does what?
NHS foundation trusts*, first introduced in April 2004, differ from other existing NHS trusts. They are independent legal entities and have unique governance arrangements. They are accountable to local people, who can become members and governors. Each NHS foundation trust has a duty to consult and involve a board of governors (including patients, staff, members of the public and partner organisations) in the strategic planning of the organisation.*

They are set free from central government control and are no longer performance managed by health authorities. As self-standing, self-governing organisations, NHS foundation trusts are free to determine their own future.

They have financial freedoms and can raise capital from both the public and private sectors within borrowing limits determined by projected cash flows, and are therefore based on affordability. They can retain financial surpluses to invest in the delivery of new NHS services.
Foundation trusts are overseen by Monitor.

Table 23: Differences between Trusts

Differences between NHS foundation and NHS trusts		
	NHS foundation trust	NHS trust
Government involvement	Not directed by government, therefore more freedom to make strategic decisions	Directed by government
Regulation: Financial Quality	Monitor CQC	Trust Development Authority CQC
Finance	Free to make their own financial decisions according to an agreed framework set out in law and by regulators. Can retain and reinvest surpluses	Financially accountable to government

Who does what?
Mental health trusts *provide health and social care services for people with mental health problems.*

Mental health services can be provided through GPs, other primary care services, or through more specialist care. This might include counselling and other psychological therapies, community and family support, or general health screening. For example, people experiencing bereavement, depression, stress or anxiety can get help from primary care or informal community support. If they need more involved support, they can be referred for specialist care.

More specialist care is normally provided by mental health trusts or local council social services departments. Services range from psychological therapy to very specialist medical and training services for people with severe mental health problems. At least one in four people experiences a diagnosable mental health problem in any one year, and one in six experiences this at any one time.

Who does what?
Public Health England (PHE) – *is an operationally autonomous executive agency of the Department of Health and was established in April 2013 in place of the Health Protection Agency.*

The main functions of PHE are:			
Health protection	Health improvement	Knowledge and information	Operations
For example, notifiable disease outbreak prevention, recording and management and major incident response	Responsible for developing a 21st century health and wellbeing service addressing health inequalities – for example, health promotion and screening services	For example, disease registration, research and development	Ensuring delivery of consistently high-quality services – for example, the national microbiology unit

Section 106 Planning Contributions for Health Facilities

Developers applying for planning permission can be asked to contribute financially and in other ways to the infrastructure needed to support the new development, including health infrastructure. See Chapter 2 on the Built Environment for an outline of the Planning System.

Section 106 of The Town and Country Planning Act 1990 allows local authorities to enter into a legal agreement with a developer to ensure the appropriate infrastructure and/or financial contribution is provided. Section106 is therefore one way of funding new healthcare facilities and services to cope with the changing population.

The Healthy Urban Design Unit (HUDU) has developed a model to calculate indicative health contributions arising from development proposals which is in widespread use across London (and by some NHS organisations outside London).

HUDU Model

The HUDU Planning Contributions Model is a comprehensive tool to assess the health service requirements and cost impacts of new residential developments. The model is licensed by HUDU for use within the NHS.

The model uses a range of assumptions based on the most up to date information available. However, users can also manually adjust or input new assumptions – for example, where an area may have carried out a recent survey of the population characteristics of new residential developments occurring in an area.

The model calculates:

- The net increase in population resulting from new development.
- Health activity levels.
- Primary healthcare needs (GPs and community health facilities).
- Hospital beds and floor space requirements.
- Other healthcare floorspace.
- Capital and revenue cost impacts.

This information can then be used to influence the planning process via Section 106 planning negotiations or CIL and to gain necessary resources for health improvements or expansion.

Current land values when negotiating Section 106 developer contributions are approximately: £10k per acre agriculture, £150k per acre Greenfield (with planning permission) £500k per acre Brownfield. Comparing it to other infrastructure costs, it costs £150k for 100m single estate road, and for dual carriageways the costs are greater with costs of £10m per mile-Complete, £1200 per linear mile tarmac (no junction), and £5m per junction.

Recent case law has confirmed that Section 106 requirements for healthcare facilities need to be precise, and related to the specific development in question, as the case study below shows.

Case Study – Section 106 and Health Care Facilities
Appeal Decisions
Decision date: 29 July 2015
Appeal A: APP/X1545/A/14/2224678
Land south of New Moor Farm and east of North End, Southminster

The appellant company has also been working to address a number of mattersrelating to the securing of the provision of infrastructure related to thedevelopment. Two signed and completed unilateral planning obligations undersection 106 of the Town and Country Planning Act (UUs) were submitted atthe Inquiry dealing with the following matters;

- commuted healthcare contribution (both appeals), including provision of landfor a medical facility (Appeal B only);

Health provision

The appeal proposals would generate additional residents who, quitereasonably, could expect to access local health provision. The problem, aseloquently put by Ms Morley, Practice Manager for the William Fisher MedicalCentre, is that the existing practice, whilst still accepting new residents, isworking at capacity. With new housing developments in Southminstercurrently under construction, the residents of which the Practice has agreed totake on, extreme pressure on the working of the Practice and the ability forresidents to access health services will ensue. The responsible body in respectof health provision in Southminster is NHS England. Ms Morley was unaware ofany forward planning or strategy in place for the development of healthcareservices in this area by NHS England or the Council.

The evidence of Mr Addae-Bosompra, on behalf of the Council, was that with nohealth facility in place to ensure access to health provision for the futureresidents of the development, permission should be withheld until such time asan appropriate medical facility was provided, ideally before the new houseswere occupied. He suggested an embargo on further development in thevillage until such time as this deficiency had been addressed. He alsosuggested, as a solution, the imposition of a planning condition that workwould not commence until such time as a medical centre had been built.

However, the provision of a new medical centre to serve not only the futureresidents of the proposed developments but also the rest of the village, wouldbe a disproportionate and unjustified response, out of scale and kind to thedevelopment proposed, which would place an onerous burden on the appellantcompany. Moreover, a Council imposed embargo on development wouldfrustrate development and would not further Government aims to boost thesupply of housing.

The responsibility for health provision lies with NHS England. The appellant company agreed to a health care contribution as promoted by NHS England paid through the termsof the UUs. However, the calculation of thiscontribution was not adequately explained. In addition, no evidence wassubmitted by NHS England that further provision was required over and above the contributions secured. No evidence was provided either, of a specified project or area of service improvement which has been identified which could beconsidered to be directly related to the development, other than a general capacity issue.

The respective sums would not be sufficient to build a new medical centre, and there was no suggestion that there were pooled contributions available from other new developments in Southminster to either contribute to a new medical centre, or that there was a strategy in place either with NHS England or the Council or in partnership to address this situation.

From the evidence I heard, it seems to me that the proposed development would generate a need for additional local health services. However, whilst I heard anecdotally that existing facilities were stretched and would continue to be so possibly to a point of closing the practice to new patients, the response of the responsible body was that an appropriate financial contribution would mitigate the effect of the appeal proposals on health care services (although as set out above, it was not clear how). The appellant company has responded to the request for such a requirement. Also, in response to the concern of the Council, land has been reserved for a medical facility within Appeal B51. I heard from Ms Morley that the William Fisher Medical Centre has no money to build a new centre even if the land were a gift. NHS England favours schemes involving the rental of premises rather than new build, although there is some money available for capital projects, but this is administered by NHS England on a priority basis. There was no evidence that NHS England would support or fund a new medical centre in Southminster.

In closing the Council highlighted that in their view no solution to this problem had been identified and that this was not an acceptable state of affairs. I agree. The stifling of development due to a perceived capacity issue would stifle the provision of much needed housing, including affordable housing in the District. However, the appellant company has complied with the request from NHS England to provide a healthcare contribution and that is all that has been asked of them by the relevant provider of that service. Whilst I acknowledge the concerns of the practitioners at the William Fisher Medical Centre and others, the weight of evidence is that NHS England is content that such a contribution would address the impact of the development appropriately. On this basis it is only for me to consider whether the extent of that contribution is justified or not.

Paragraph 204 of the Framework sets out that planning obligations should only be sought where they are necessary to make the development acceptable in planning terms; directly related to the development; and fairly and reasonably related in scale and kind to the development. This is in accordance with Regulation 122 of the Community Infrastructure Levy (CIL) Regulations.

Taking into account the lack of direction/details from NHS England in respect of the development of health provision in Southminster and the immediate locality, I heard nothing that gave me confidence that the contribution requested was likely to be spent in accordance with the relevant tests. For this reason, I do not consider it reasonable to take this aspect of the UUs into account. The lack of a NHS plan where the available funding would beappropriately targeted is a serious flaw which undermines any justification forthe contribution. Further, without an official explanation for and commitmentto build a new health centre in Southminster, the requirement for land for suchprovision would be a benevolent offer on behalf of the appellant company, butnot justified on the evidence before me.

3. LOCAL DATA

3.1 LOCAL NHS PRESSURES

Some Primary Care practices in or near the major growth sites are struggling to cope with the current and forecasted demand for services, this is not helped by a national shortage of GPs.

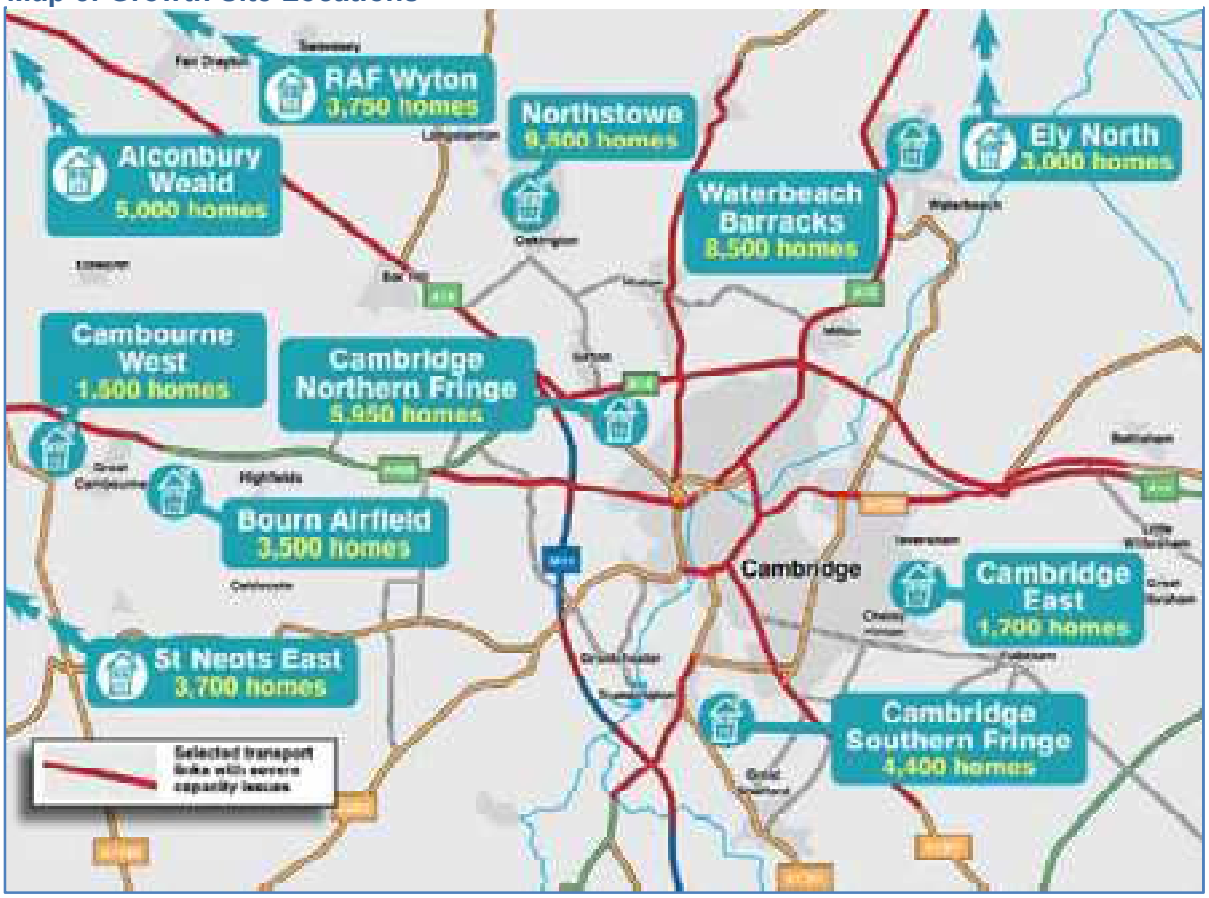
Property portfolio overview

There are 212 NHS related properties across Cambridgeshire and Peterborough, comprising of 184 clinical sites, 21 hospital buildings, six office administration. There is a mixture of tenure of properties, some a freehold, some leased, some owned by NHS Property Services.

Who does what?
NHS Property Services *is a limited company owned by the Department of Health in the United Kingdom that took over the ownership of around 3,600 National Health Service facilities in April 2013.*

GP Capacity by practice in the growth sites

Map 5: Growth Site Locations



Map of GP Catchment Areas

Awaiting data from CCG/NHSE to overlay the GP catchment areas and capacity pressure with the map of the growth sites.

Primary Care Transformation Fund

The Primary Care Transformation (formerly Infrastructure) Fund is a multi-year £1billion investment programme to help general practice make improvements, including in premises and technology. It is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set out in the NHS Five Year Forward View.

Delegated commissioning

Cambridgeshire and Peterborough are seeking to take on delegated commissioning responsibilities for primary medical services from NHS England from 1 April 2016.

The scope of the delegated responsibility for the CCG can be quantified as follows:

- 106 primary medical services contracts **(c.£84.6m)**
  - GMS, PMS (£73.7m)
  - APMS incl. pipeline of re-commissioning (£4.7m)
  - Portfolio of enhanced services (DES, LES) (£6.2m)
- Quality and Outcomes Framework (QOF) **(c.£10.1m)**
- Premises reimbursements **(c.£13.2m)**
- Other primary care contracts **(c.£10m)**
- In addition to CCG commissioned services **(c.£9.3m excl. OOH and 111)**
- **Total c.£127m**

Local Authority Infrastructure Development Strategies.

Each District has produced an infrastructure delivery strategy/plan which identifies the capital requirements to deliver infrastructure across the county.Health requirements have been captured in these plans and can be seen in Appendix 1.

Mismatch between LA Planning system (sec 106) and primary care commissioning system

There is a mismatch between the system required by the “NHS” for GP practices to submit business cases for funding and the Local Authority Planning system. These systems need to align to make the best use of funding sources.

CASE STUDIES

Case Study 9: Orchard Park

Case Study - Orchard Park
Following a Member's suggestion at Council in June 2014 Scrutiny & Overview Committee agreed on 3 July 2014 to set up a Working Group to review the lessons learned from Orchard Park. It was agreed that the group's remit would be to look at how the recommendations made in 2008 by the Scrutiny and Overview Committee regarding Orchard Park [then called Arbury Park] had been implemented, if they had been applied to subsequent developments and what the effects of them had been. The initial timescale for this work was estimated to be 12 months. However, in the light of the NJDCC being required to consider in July the application for Phase 2 of that development, the interim recommendations of the Working Group were considered to provide useful information to support its deliberations and were presented to them for that purpose.

Interim recommendations were presented to the Scrutiny and Overview Committee on 30 April 2015 and endorsed by Cabinet on 9 July 2015. The interim recommendations were also presented to the NJDCC for consideration and were endorsed prior to its deliberations on 29 July 2015:

Recommendation 1 – The decision to require a road adoption strategy for Northstoweshould be replicated on all future developments.

Recommendation 2 – The good practice of school provision concurrent with first occupations should be continued.

Recommendation 3 – More consideration should be given to a greater variety of opportunities for social interaction for early occupants of new developments.

Recommendation 4 – South Cambridgeshire District Council should adopt the charging strategy used by Cambridge City Council in connection with pre-application advice.

Recommendation 5 – Consideration should be given to further work being carried out on 'New Town Blues' and the referral rates to social services and their impacts on costs for councils and other public services.

Recommendation 6 – Funding should be secured for training and/or technical support to be provided for parish councils affected by strategic development applications. There should be greater flexibility in the use of funds allocated.

Orchard Park cont

The following additional recommendations have been agreed by the Working Group:
Recommendation 7 – Further clarification should be sought from the County Council on their guidance to developers regarding materials so that conflict at the point of road adoption is avoided.

There is still some evidence of contrary views on the use of new technologies/materials at different stages in the process, notably at pre-application and adoption stages. Delays in road adoption are cited by residents as a significant cause for concern. This recommendation seeks to resolve one of the issues that may cause those delays.

Recommendation 8 – Despite individual phases having their own design code, consideration needs to be given to including a review mechanism so that lessons can be incorporated as required particularly in developments with long build out rates.

This recommendation has been made in view of evidence gathered that some flexibility is required to allow for advances in design etc over long build out periods.

Recommendation 9 – Consideration be given to strengthening the formal monitoring process and increasing the proportion of developments scoring highly in connection with 'Building for Life'.
'Building for Life' allows a real measure of the quality of life that residents can expect. Its value should be emphasized through this recommendation.

Recommendation 10 – Care should be taken to ensure community development work continues to focus on building resilient empowered communities rather than dependent communities. This should be done together with other key agencies.
To achieve the best outcomes it is now acknowledged that responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

Recommendation 11 – Appropriate noise readings should be considered on any future development where a noise barrier is proposed and where there are residential developments on both sides.
The original recommendation reflected apparently unique circumstances to date. It is considered, however, that this recommendation is a necessary precaution against similar circumstances arising in the future.

Recommendation 12 – Consideration should be given to providing advice/guidance to clerks of parishes affected by large scale developments and clerks should be included as officers in officer working groups.
This recommendation seeks to learn from the very good practice at Cambourne where an experienced clerk has been included in officer working groups. This has allowed the benefit of local knowledge as well as increasing community engagement.

Recommendation 13 – The Council should develop some local principles for carrying out Community Governance Reviews, making it clear how and when a review will be considered in major growth areas.
Experience has shown that there is a fine balance to be struck in the timing of carrying out a Community Governance Review. This recommendation seeks to endorse work that is being undertaken to establish good practice.

Recommendation 14a – Replicate on other developments the good practice at Northstowe where close communication between the site manager and local residents has been established to address local concerns effectively and promptly.
Recommendation 14b: A communications protocol should be established at the start of each development to be used by the local authorities, master developers, house builders etc.
The value of communication can never be overstated and efforts for continuous improvement should be pursued.

Recommendation 15 – Permissions and S106 Agreements should always recognise the possibility that a master developer may not remain on site for the complete duration of the build out.
It is acknowledged that with the increasing size of developments coming forward and the consequent long build out it may not be reasonable to expect that the master developer will be there for the whole period. This recommendation seeks to ensure that precautions are taken against this eventuality and avoid unnecessary complications that may result.

Recommendation 16 – Master developers should be asked to consider facilitating with parcel developers a central information point.
Previous experience at Cambourne, which was developed by a consortium of developers, showed the value of a central information point. Where a consortium is not in place there may not be spontaneous motivation to provide this resource.

Recommendation 17 – Ensure that all health partners are consulted on planning applications and take on board the findings of the New Communities Joint Strategic Needs Assessment which will outline a mechanism for health partners to come together. In addition, health partners should come together at the earliest opportunity to discuss needs at strategic sites.
This links to recommendation 10 and supports achievement of the same beneficial outcomes.

Recommendation 18 – That both these recommendations and those from 2007 apply not just to strategic sites, but as appropriate to all majors.
This review process has been acknowledged by stakeholders to have been beneficial to efforts for continuous improvement and it has been suggested that for consistency the recommendations should apply more widely.

Recommendation 19 – That this exercise is repeated at appropriate intervals. This might be in conjunction with the drafting of a new local plan.
As with recommendation 18, stakeholders have identified the benefits of carrying out a review and have suggested it should be repeated at appropriate intervals. It has been suggested that the appropriate time might be to coincide with the drafting of a new local plan in order that any recommendations can be appropriately reflected in policy.

Recommendation 20 – Developers should be encouraged to commence engagement with parish councils at pre-application stage.
The original task and finish group was convened to carry out work when something has already been identified as having gone wrong. This recommendation reflects a desire to be proactive and avoid as much as possible, any recurrence of such a need.

BIBLIOGRAPHY

1. **Board, Cambridge Sub-Region Housing.***Housing Market Bulletin 27.* 2015. 27.

2. *Preamble to the Constitution of the World Health Organization as adopted by the nternational Health Conference.* **(WHO), World Health Organisation.** New York : s.n., 19-22 June 1946, and entered into force on 7 April 1948.

3. **Department for Environment, Food and Rural Affairs (DEFRA).***Sustainable development indicators in your pocket.* London : DEFRA, 2009.

4. *Health and Wellbeing in the Workplace: A Review and Synthesis of the Literature.* **R.W, Danna K. & Griffin.** 1999, Journal of Management , Vol. 25(3), pp. 357-384.

5. **CABE.***Future health: sustainable places for health and well-being.* s.l. : CABE, 2009.

6. **Government, Department for Communities and Local.***A plain English guide to the Localism Act.* 2011.

7. **Policy, European Centre for Health.***Gothenburg Consensus Paper on Health Impact Assessment.* Brussels : WHO-Euro, 1999.

8. *The Relationship Between Built Environments and Physical Activity: A Systematic Review.* **O. Ferdinand A, Sen B, Rahurkar S, Engler S, Menachemi N.** 2012, Am J Public Health [Internet], pp. 102(10):e7–13.

9. *The built environment and health.* **Rao M, Prasad S, Adshead F, Tissera H.** 2007, The Lancet, pp. 370(9593):1111–3.

10. **Horizons, Cambridgeshire.***Cambridgeshire Quality Charter for Growth.* 2008.

11. *Green Infrastructure , Ecosystem Services , and Human Health.* **Coutts C, Hahn M.** 2015, International Journal of Environmental Research and Public Health, Vol. 12(8), pp. 9768–98.

12. *Healthy nature healthy people: "contact with nature" as an upstream health promotion intervention for populations.* **C, Maller.** 2005, Health Promotion International, Vol. 21(1), pp. 45–54.

13. **(NICE), National Institute for Health and Clinical Excellence.***Physical activity and the environment (PH8).* 2008.

14. *Growing urban health: Community gardening in South-East Toronto.* **Wakefield S, Yeudall F, Taron C, Reynolds J, Skinner A.** 2007, Health Promotion International, Vol. 22(2), pp. 92-101.

15. *Natural environments...healthy environments? An exploratory analysis of the relationship between greenspace and health.* **De Vries S, Verheij R a, Groenewegen PP, Spreeuwenberg P.** 2003, Environment and Planning A, Vol. Vol. 35, pp. 1717-1731.

16. **Commission, Sustainable Development.***Health, place and nature: How outdoor environments influence health and well-being.* 2008.

17. **MIND.***Ecotherapy – the green agenda for mental health Key findings Green exercise at local Mind groups .* 2007.

18. *The Fruit of Urban Nature: Vital Neighborhood Spaces.* **WC, Sullivan.** 2004, Environmental Behaviour, Vol. 36(5), pp. 678-700.

19. *Urban residential environments and senior citizens' longevity in megacity areas: the importance of walkable green spaces.* **Takano T, Nakamura K, Watanabe M.** 2002, Journal of Epidemiology Community Health, Vol. 56(12), pp. 913-8.

20. —.**Takano T, Nakamura K, Watanabe M.** 2002, Journal of Epidemiology Community Health, Vol. 56(12), pp. 913-8.

21. *Park Usage, Social Milieu, and Psychosocial Benefits of Park Use Reported by Older Urban Park Users from Four Ethnic Groups.* **Howard E. A. Tinsley, Diane J. Tinsley & Chelsey E. Croskeys.** Issue 2, 2002, Leisure Sciences: An Interdisciplinary Journal, Vol. Volume 24, pp. 199-218.

22. *Increasing walking.* **Giles-Corti B, Broomhall MH, Knuiman M, Collins C, Douglas K, Ng K, et al.** 2005, American Journal of Preventative Medicine, Vol. 28(2), pp. 169-76.

23. *Association of Park Size, Distance, and Features With Physical Activity in Neighborhood Parks.* **Kaczynski AT, Potwarka LR, Saelens BE.** 2008, American Journal of Public Health, Vol. 98(8), pp. 1451-6.

24. *Associations between self-reported and objective physical environmental factors and use of a community rail-trail.* **Troped PJ, Saunders RP, Pate RR, Reininger B, Ureda JR, Thompson SJ.** 2001 [cited 2015], Preventative Medicine, Vol. 32(2), pp. 191-200.

25. *Characteristics o furban parks associated with park use and physical activity: A review of qualitative research.* **Gavin R.McCormack, MelanieRock, AnnM.Toohey, DanicaHignell.** March 2010, Health &Place, Vol. 16, pp. 712–726.

26. **England, Natural.***'Nature Nearby' Accessible Natural Greenspace Guidance.* 2010.

27. **Council, Bristol City.***Bristol's parks and green space strategy.* 2008.

28. *Allotment gardening and health: a comparative survey among allotment gardeners and their neighbors without an allotment.* **Van den Berg AE, van Winsum-Westra M, de Vries S, van Dillen SME.** 2010, Journal of Environmental Health, Vol. 9(1).

29. **Wiltshire R, Burn D.***Growing in the community (2nd edition).* 2009.

30. *Can You Dig it ? Meeting community demand for allotments.* **Hope N, Ellis V.** 2009, Communities .

31. **environment, Ministry of infrastructure and the.***Summary National Policy Strategy for Infrastructure and Spatial Planning.* 2011.

32. *A Comparison of Leisure Time Spent in a Garden with Leisure Time Spent Indoors: On Measures of Restoration in Residents in Geriatric Care.* **Ottosson J, Grahn P.** 2005, Landscape Research, Vol. 30(1), pp. 23–55.

33. **S, Rodiek.***Influence of an Outdoor Garden on Mood and Stress in Older Persons.* 2002.

34. **Watson S, Studdert D (Joseph Rowntree Foundation).***Markets as sites for social for social interaction: spaces of diversity.* 2006.

35. *Relation between local food environments and obesity among adults.* **Spence JC, Cutumisu N, Edwards J, Raine KD, Smoyer-Tomic K.** 2009, BioMed Central: Public Health, Vol. 9:192.

36. *A national study of the association between food environments and county-level health outcomes.* **Ahern M, Brown C, Dukas S.** 2011, Journal of Rural Health, Vol. 27(4, pp. 367–79.

37. *The association between the food environment and weight status among eastern North Carolina youth.* **Jilcott SB, Wade S, McGuirt JT, Wu Q, Lazorick S, Moore JB.** September 2011, Public Health Nutrition, Vol. 14(9), pp. 1610–7.

38. *Creating healthy communities, healthy homes, healthy people: initiating a research agenda on the built environment and public health.* **Srinivasan S, O'Fallon LR, Dearry A.** 2003, American Journal of Public Health, Vol. 93(9), pp. 1446–50.

39. *The Impact of Community Design and Land-Use Choices on Public Health: A Scientific Research Agenda.* **Dannenberg AL, Jackson RJ, Frumkin H, Schieber R a., Pratt M, Kochtitzky C, et al.** 93(9 2003, American Journal of Public Health, pp. 1500–8.

40. **Dr Russell Jones, Gregor Yates.***BRIEFING PAPER 11 CONCEPTS SERIES: The built environment and health: an evidence review.* Glasgow Centre for Population Health. 2013.

41. *The Role of the Built Environment in Healthy Aging: Community Design, Physical Activity, and Health among Older Adults.* **Kerr J, Rosenberg D, Frank L.** 2012, Journal of Planning Literature, pp. 43-60.

42. **Shelter.***Full house? How overcrowded housing affects families.* 2005.

43. **Friedman, Danny.***Social impact of poor housing.* ECOTEC. 2010.

44. **Carmona M, Gallent N, Sarkar R.***Space standards: the benefits.* University College London for CABE. 2010.

45. **Cassen R, Kingdon G.***Tackling low educational achievement: An examination of the factors underlying low achievement in British education.* Joseph Rowntree Foundation. 2007.

46. **Authority, The Greater London.***Homes for London: The London Housing Strategy.* 2014.

47. **Walker J, Thompson C, Laing K, Raybould S, Coombes M, Procter S, et al.***Youth Inclusion and Support Panels : Preventing Crime and Antisocial Behaviour?* Institute of Health and Society, University of Newcastle Upon Tyne, Newcastle Centre for Family Studies. 2007.

48. **Ömer Çavusoglu, Caroline Gould, Paul Long, Monica Riera.***Emerging typologies & density.*

49. *Housing improvements for health and associated socio-economic outcomes.* **Thomson H, Thomas S, Sellstrom E, Petticrew M.** 2013, Cochrane database of Systematic Reviews, Vol. 2(3).

50. **Basham M, Shaw S, Barton A.***Central heating: Uncovering the impact on social relationships in household management.* 2004.

51. *Living in cold homes after heating improvements: Evidence from Warm-Front, England's Home Energy Efficiency Scheme. .* **Critchley R, Gilbertson J, Grimsley M, Green G.** 2007, Applied Energy, pp. 147-58.

52. **Harrington BE, Heyman B, Merleau-Ponty N, Stockton H, Ritchie N, Heyman A.***Keeping warm and staying well: Findings from the qualitative arm of the Warm Homes Project.* Health Social Care Community. 2005;13(3):259–67. .

53. **Grant M, Bird C, Marno P.***Working paper Health inequalities and determinants in the physical urban environment : Evidence briefing Health inequalities and determinants in the physical urban environment : Evidence briefing.* 2012.

54. *Inequality in the Built Environment Underlies Key Health Disparities in Physical Activity and Obesity.* **P., Gordon-Larsen.** 2006, Pediatrics, Vol. 117(2), pp. 417–24.

55. *Understanding the relationship between food environments, deprivation and childhood overweight and obesity: Evidence from a cross sectional England-wide study.* **Jones, Andy.** May 2014, Health & Place, Vol. Volume 27, pp. 68–76.

56. *Associations between Food Outlets around Schools and BMI among Primary Students in England: A Cross-Classified Multi-Level Analysis.* **Williams J, Scarborough P, Matthews A, Townsend N, Mumtaz L, Burgoine T, Rayner M.** 17 July 2015, PLoS ONE , Vol. 10(7):.

57. *Characterising food environment exposure at home, at work, and along commuting journeys using data on adults in the UK.* **Thomas Burgoine, Pablo Monsivais.** 2013, International Journal of Behavioral Nutrition and Physical Activity, Vol. 10:85.

58. *Associations between exposure to takeaway food outlets, takeaway food consumption, and body weight in Cambridgeshire, UK: population based, cross sectional study.* **Burgoine T, Forouhi NG, Griffin SJ, Wareham NJ, Monsivais P.** March 2014, BMJ, Vol. 348.

59. **Government, HM.***Preventing suicide in England - A cross-government outcomes strategy to save lives.* s.l. : Department of Health, 2012.

60. **Group, Lloyds Banking.***Halifax Rural Areas Quality of Life Survey 2012.* Bank of Scotland plc. 2012.

61. Delivering mixed , balanced communities. 2009, p. Chapter 26.

62. **Government, Department for Communities and Local.***Transferable Lessons from the New Towns.* 2006.

63. **Davies A, Simon J.***The value and role of citizen engagement in social innovation.* 2013.

64. **GW., Allport.***Formation of In-Groups. The Nature of Prejudice. .* 1954. . pp. p. 29–47. .

65. **Egan, Sir John.***The Egan Review: Skills for Sustainable Communities.* Office of the Deputy Prime Minister. 2004.

66. **McLean, S and Andersson, E.***Activating Empowerment: Empowering Britain from the bottom up. .* 2009.

67. **Brodie E, Miller S.***Pathways through participation : What creates and sustains Summary report. .* 2011.

68. *Gaining comprehensive AIDS treatment in South Africa: the extraordinary "ordinary." .* **S., Friedman.** 2010 [cited November 2015], R4D.

69. **Government., HM.***No health without mental health Outcomes Strategy for People of All Ages. :1–100. .*

70. **M., Cattan.***Preventing Social Isolation and Loneliness Among Older People. .* 2010.

71. **Harkness V, Cameron D, Latter J, Ravat M, Bridges L.***Preparing for an Ageing Society : Evaluating the Ageing Well programme Parts 1 and 2.* 2012.

72. **Government., Department of Communities and Local.***National Planning Policy Framework .* 2012.

73. **S., Platt.***Lessons from Cambourne.* 2007.

74. **Dictionary, Oxford English.**

75. **Committee, Cambridgeshire County Counil Children and Young People's Services Scruitiny.***Integrating CHildren and Young People's Services and Social INfrastructure Provision into the County's New Communities: Member led review.* 2010.

76. **Cambridgeshire County Council and NHS Cambridgeshire.***Joint Strategic Needs Assessment New Communities.* 2010.

77. *The Health and Wellbeing Benefits of Public Libraries.* **Arts Council.** 2015.

78. *REFLECTION AND ATTENTIONAL RECOVERY AS DISTINCTIVE BENEFITS OF RESTORATIVE ENVIRONMENTS.* **Herzog TR, Black AM, Fountaine KA, Knotts DJ.** 1997 [cited 2015 June 7], Journal of Environmental Psycology, Vol. 17(2), pp. 165-70.

79. *Natural environments...healthy environments? An exploratory analysis of the relationship between greenspace and health.* **De Vries S, Verheij R a, Groenewegen PP, Spreeuwenberg P.** 2003, Environment Plan A.

80. *A Comparison of Leisure Time Spent in a Garden with Leisure Time Spent Indoors: On Measures of Restoration in Residents in Geriatric Care.* **Ottosson J, Grahn P.** 2005, Landscape Research, Vol. 30(1), pp. 23–55.

81. *Area deprivation and the food environment over time: A repeated cross-sectional study on takeaway outlet density and supermarket presence in Norfolk, UK, 1990–2008.* **Eva R. Maguire, Thomas Burgoine , Pablo Monsivais.** May 2015, Health Place, pp. 142-7.

82. **Platt, Stephen.***Lessons from Cambourne .* 2007.

83. **Council, Cambridgeshire County.***Cambridge Sub Region New Development Surverys 2006-2012: Summary and Comparison.* 2013.

APPENDIX 1 – INFRASTRUCTURE DELIVERY PLANS

To follow as a Technical Appendix.

[i] For more information on the different level of needs please see the Model of Staged Intervention framework available at: http://www.cambridgeshire.gov.uk/info/20076/children_and_families_practitioners_and_providers_information/298/children_and_families_procedures_and_resources/6

[ii] Section 14S of the NHS Act 2006, as amended by the Health and Social Care Act (2012)