Healthy Places

Joint Strategic Needs Assessment 2024

Executive Summary

The places where people live, work, study, and travel have a significant impact on their health and wellbeing. Healthy places are environments that allow people to be as healthy as possible, whether it is improving air quality around schools, mitigating risk of flooding in a village, or creating opportunities for people to get to know one another. Healthy places are created holistically and designed to support the local needs of a community.

The Healthy Places Joint Strategic Needs Assessment (HP JSNA) provides the evidence base for how we can ensure Cambridgeshire and Peterborough best support the health and wellbeing of our communities. The HP JSNA draws on an evidence base of data from hundreds of published studies; local, regional, and national policy and guidance; case studies of good practice and lessons learned, both across Cambridgeshire and Peterborough and beyond; and the values and lived experiences of residents.

The HP JSNA aligns with the corporate ambitions of Cambridgeshire County Council and Peterborough City Council, as well as directly supporting the Cambridgeshire and Peterborough Integrated Care System's Priority 2, *Create an environment to give people the opportunity to be as healthy as they can be*. Furthermore, this work complements Cambridgeshire and Peterborough Combined Authority's *State of the Region* and *Shared Ambitions*. At a time of national planning reform and a shift from hospital-based treatment of disease to community-focused prevention of ill health, the HP JSNA provides timely direction for the system to align with national priorities.

Chapter 1, *Demography and Households*, outlines the differences in demographic profiles between new and existing communities. New communities, defined by living in developments built since 2011, have lower average ages, higher birth rates, more people per household, and greater ethnic diversity. These factors impact of the health and care needs of new communities. This chapter also presents data on housing affordability, as well as population forecasting and expected changes in age structures across Cambridgeshire and Peterborough.

Chapter 2, *Climate Change*, summarises evidence on the current and likely future impact of climate change on human health. The two key sources of evidence used are the UK Health Security Agency's 2023 Health Effects of Climate Change report and the Cambridgeshire and Peterborough Independent Commission on Climate Change. Major risks include excessive heat, flooding, and vector borne disease. The role of the built environment in mitigation and adaptation is described, alongside the

importance of reducing healthcare-related carbon emissions through a focus on prevention.

Chapter 3, *Built and Natural Environment*, introduces the planning system, the NHS Healthy New Towns Programme, and standards for assessing healthy places. A comprehensive overview of the evidence for how the built and natural environment impact on human health is then outlined. This evidence base covers topics including air quality, active travel, and local food environments, as well as highlighting specific impacts on children and young people, older adults, and people with disabilities.

Chapter 4, *Infrastructure and Services*, describes the role of local built and digital infrastructure and explores on the need for robust healthcare-related infrastructure delivery plans. New communities' usage of primary and secondary health services is described using local data.

Chapter 5, *Communities and Social Cohesion*, explores community development and engagement, highlighting the roles of community development officers, the Voluntary, Community and Social Enterprise, and community forums. The functions of community safety partnerships and local resilience forums are also described, highlighting their role in supporting social cohesion.

To understand residents' views on the built environment across Cambridgeshire and Peterborough, the HP JSNA undertook a community survey that explored what people value in their local built environment, and if their current access aligns with these values. Across over 700 responses, the most important areas of unmet need were around access to local healthcare and healthy, affordable food. Further engagement has been performed through Healthwatch's Health and Care Forums and Partnership Boards to explore survey responses across the Cambridgeshire districts and Peterborough, and to understand how the built environment impacts specific vulnerable groups.

This HP JSNA has produced 43 policy recommendations aim to bring together diverse partners across our system and to create healthier places across Cambridgeshire and Peterborough. These recommendations are presented below, alongside key findings from each of the five chapters. A full list of recommendations is presented at the end of this document. However, the recommendations have been prioritised using a matrix which scores; "Magnitude of individual level benefit", "Strength of Evidence", "Health Inequalities", "Total cost of the service", and "Acceptability". The recommendations which scored the highest (the top five) and therefore should be prioritised are:

Recommendation Number	Recommendation
2.1	Local plans should include policies that account for the current and likely future impacts of climate change. Specifically, local plans should include policies on risk of excessive heat, flooding, and vector borne disease. Other policies may include wildfires, aeroallergens, food and agriculture, drought, and solar radiation.

3.6	Local plans should include policies that address the health impacts associated with: - Air pollution (especially around schools and healthcare facilities) - Noise pollution - Green spaces (including provision, accessibility, quantum and distance from settlements) - Provision of accessible and age-appropriate equipment (e.g., seating, play equipment, etc) - Active travel - Dwelling design (e.g., home working environment and minimum room sizing) - Fast food / takeaways (e.g., takeaway exclusion zones, mandatory HIAs for new fast food establishments, or limiting the density of fast food establishments in urban areas) - Healthy food provision (e.g., community allotments or orchards, edible hedgerows, sites for community farming) - Suicide prevention (e.g., adopting the principles in Public Health England's Preventing Suicides in Public Places document, with a specific threshold requiring jumping restrictions to be installed at high-risk locations) - Healthy ageing and people with disabilities (lifetime homes, age-friendly housing, higher proportion of accessibility standards, or adopting the principles of age-friendly communities) - Meanwhile uses (e.g., a supportive policy that allows flexible interim uses recognising their benefits meanwhile uses have for social cohesion)
3.15	System partners should collaborate to develop a design guide for health, based on the evidence in this Healthy Places JSNA, to be adopted as a Supplementary Plan (formerly Supplementary Planning Document (SPD) across Cambridgeshire and Peterborough.
2.6	The integrated care system should ensure appropriate EPRR plans are in place and kept up-to-date for the major local risks posed to human health by climate change (i.e., major flooding and excessive heat)
3.4	A system-wide task and finish group should be established to develop a place-based scoring system to objectively assess new and existing localities and developments, including the healthier street principles. This scoring system should include specific consideration of children and young people, older adults, and people with disabilities. For example, the *Place Standard* tool used in Scotland.

Chapter 1 – Demography and Households

Key findings

Development classification

- For the purposes of this JSNA, the following classification of developments has been used:
    - New: Substantial build undertaken between 2011 and 2021
    - Older: Majority of build was before 2011
    - Future: Build is currently limited or not yet started
- Currently there are 15 large new development sites across Cambridgeshire and Peterborough, with Northstowe (South Cambridgeshire), Alconbury Weald (Huntingdonshire) and Wintringham Park (Huntingdonshire) being the largest.
- There are a further 15 sizeable sites planned or proposed for future development, with the largest (where planning has been approved) being Waterbeach New Town (South Cambridgeshire) and Great Haddon (Peterborough).

Demographics by development type

- New housing developments across Cambridgeshire and Peterborough generally have a younger, more ethnically diverse population living in them, who have higher levels of educational attainment, employment, and good health than more settled populations. As these new developments age, their demographics become more similar to those of more settled areas.
- The demographic differences seen in new developments have implications for the services required to meet their health and care needs. These services must be prepared for an overall younger population, including the high proportion of children and young people and high birth rates.

Households in new developments

- The average household size in new developments is over 10% higher than in settled areas. This is a significant factor to consider when planning the provision of services and amenities for a new development. For example, for every 1,000 households built in a new development, consideration needs to be given for at least 300 additional people than would be expected if using the average household size for all housing types.
- Households in new developments have a higher proportion of ownership with a mortgage compared to settled areas, and conversely a lower proportion of outright ownership. Social renting is also higher, likely to be driven by affordable housing policies.

Who moves to a new development?

- Around two-thirds of people who move into new developments do so from within Cambridgeshire and Peterborough, with relatively low external and international migration.
- The biggest draws to a new development are the design/appearance of properties, liking the idea of living in a new development and the price/affordability.
- However, satisfaction with local amenities in new developments is low, especially relating to poor access to retail shops, supermarkets, and healthcare facilities.

Affordability

- Affordability varies widely across Cambridgeshire and Peterborough, when comparing median house prices to median income, with affordability highest in the north (Fenland and Peterborough) and lowest in the south, most notably in Cambridge. Likewise, new dwellings are less affordable that existing dwellings.

Population forecasts

- The population of Cambridgeshire is forecast to increase by 11.5% (79,600 people) to 2031, with decreases expected in 5 to 14 year olds and in people in their fifties, set against notable increases in all other adult age bands. As a result of the considerable planned new housing, the number of babies and children aged under 5 years are also forecast to substantially increase.
- The population of Peterborough is forecast to increase by 7.5% (16,400 people) to 2031, with considerable changes expected in the overall age structure. Decreases are expected in under 15 year olds, most notably in 5 to 9 year olds. Increases are forecast in all other ages and are most marked in young people aged 15 to 19 years, people in their forties and people aged 65 years and over. The wards predicted to see the largest demographic growth across Cambridgeshire and Peterborough are associated with housing developments.

Recommendations

Chapter 1: Demography and Households	
1.1	System partners should account for the differences in demographic profiles between new and existing communities.
1.2	To facilitate informed service commissioning and provision, system partners should develop an integrated approach to compiling a single electronic resource of data related to major new developments across Cambridgeshire and Peterborough.
1.3	Local planning authorities and ICS commissioners should ensure correct housing multiplies are applied, accounting for the higher number of people per home in new developments compared with existing communities.
1.4	Local Plans and Housing strategies should plan for a mixture of accommodation types, according to population projections and likely demographic profile changes. These strategies should ensure that future health needs will be addressed through appropriate provision of accessible housing and care facilities (e.g., for older people, learning disability, physical disabilities, autism and specialist mental health, social care, etc).
1.5	Local Plans should, where possible, include a policy requiring major, mixed-use new developments to co-locate housing with local employment opportunities.
1.6	System partners should develop and integrated approach for addressing the higher rates of mild-to-moderate mental illness in new communities.

Chapter 2 – Climate Change

Key findings

The health effects of climate change

- Climate change is the single greatest threat to human health. Nationally and internationally, there are diverse initiatives and plans aiming to mitigate the societal impacts of climate change, as well as meeting net zero targets. Cambridgeshire County Council, Peterborough City Council, Cambridgeshire and Peterborough Combined Authority, and the Integrated Care System all have climate change strategies. It is vital that robust plans are put in place and enacted to mitigate the health impacts of climate change. At a local level, excessive heat, flooding, and vector-borne disease are likely to have the largest impacts on health.
- Heat
    - Excessive heat is associated with increased risk of morbidity and mortality, adverse pregnancy outcomes, and poorer mental health.
    - Without additional adaptation or global decarbonisation, UK deaths related to heat could increase nearly 6-fold from a 2007 to 2018 baseline average estimate of 1,602 deaths per year, to 10,889 annual deaths in the 2050s.
    - The greatest driver of both heat and cold related deaths in the UK is the vulnerability of older adults to extreme temperatures. This is due to a range of factors including older adults having more co-morbid health conditions and being more dependent on caregivers and intact medical delivery systems.
    - Other, people at greater risk of excess heat will be those living in urban areas, south-facing and top-floor flats, and homes with little shading or windows only on one side of the property or with restricted opening. Approximately 20% of homes are estimated to be at risk of overheating.
    - The ICC report recommends a range of adaptation strategies, such as modifying the built environment and infrastructure, expanding green infrastructure, and promoting adaptive behaviours and increasing the resilience of key infrastructure such as workplaces, hospitals, schools, care homes.
- Flooding
    - Flooding is a threat to life as well as to health and wellbeing. Health impacts and mortality may results from drowning, physical injury through contact with flood waters, associated motor vehicle collisions, hypothermia, and wider risks associated with flood recovery such as carbon monoxide poisoning. Flooding carries long term mental health impacts for those affected.

    - The social costs of flooding include the direct impacts on health (including treatment costs), and the indirect health impacts (such as days of work lost), as well as damage to property and possessions.
    - The frequency and magnitude of flooding events is projected to increase in the UK, with associated harmful impact on human health. In the UK approximately 6.1 million people currently live in flood prone areas, with additional populations at-risk coastal flooding due to sea-level rise.
    - Based on current locations and not allowing for future development, nearly 1 in 10 homes and 1 in 4 agricultural and industrial production facilities could face river flooding by the end of the century. Communities, farms, and industry in the areas of Wisbech, Whittlesey, Huntingdon, St Ives and the eastern edge of Peterborough face the highest risk. The region may also face tidal flooding from storm surges, particularly at high tide if the Ouse and/or Nene rivers are already in flood.
- Vector-borne disease
    - Vector-borne diseases are caused by infections with parasites, viruses and bacteria which are transmitted to humans and animals by blood-feeding arthropods (vectors), such as mosquitoes, ticks, midges, sand-flies and fleas.
    - Risk of vector-borne diseases is increasing due to changes in climate and land use, alongside international travel and transport routes. In particular, warmer temperatures in England may increase the distribution of tick species (e.g., those that cause Lyme disease) and could lead to introduction and establishment of invasive species of mosquito (e.g., those that cause dengue, chikungunya and Zika).
- Other health impacts of climate change include wildfires, aeroallergens, food and agriculture disruption, drought, and solar radiation.

Climate change and the built environment

- Local authorities and partners can control and influence carbon emissions through a wide array of measures, ranging from those in their direct control (buildings, operations, travel), through procurement and commissioning, and wider influences such as engaging and involving local communities in climate-related initiatives.
- Local data on Energy Performance Certificates (EPC) show that from 2008 to 2017, EPCs remained relatively constant. However, since 2017, there have been notable improvement in the proportion of EPCs scoring A-C.
- The Healthy Streets approach, developed by Lucy Saunders and championed by the Mayor of London, has built a significant body of evidence regarding what makes a healthy street. This evidence includes consideration for climate change. Work is currently underway spatially mapping the determinants of Healthy Streets across Cambridgeshire and Peterborough.
- There are numerous opportunities for the built environment to mitigate its impact on climate change, as well as associated health impacts. These may

include nature-based solutions (e.g., expanding or creating new forests, building green roofs or walls), infrastructure to support active transport, or emergency preparedness and planning that includes likely climate-related health impacts.

Sustainable healthcare

- Healthcare services account for a substantial proportion of national carbon emissions; around 3.5% of all road travel in England is related to the NHS. As such, reform of healthcare services to reduce carbon emissions is critical to achieving net zero ambitions.
- The most impactful way to reduce carbon emissions from healthcare services is reducing the need for those healthcare services. In the same way that reducing the purchase of plastic bottles is preferable to reducing plastic emissions through production processes and recycling, prevention of healthcare need is better than reducing carbon emissions associated with addressing need. For every person not requiring healthcare during a given episode, all emissions associated with this episode are avoided. In turn, lower carbon emissions lead to fewer health impacts of climate change, thus creating cycle of positive reinforcement.

One Health

- One Health is a multidisciplinary approach to improving health outcomes that recognises the interplay between human health, animal health, and environmental health. One Health seeks to identify and implement win-win-win solutions to complex problems at the human-animal-environment interface.

In 2019 the British Veterinary Association published a report summarising a range of UK-based case studies exemplifying a One Health approach addressing a range of topics such as mental health and wellbeing, antimicrobial resistance, non-communicable diseases, among others. This resource could be used to support local One Health initiatives.

Recommendations

Chapter 2: Climate Change	
2.1	Local plans should include policies that account for the current and likely future impacts of climate change. Specifically, local plans should include policies on risk of excessive heat, flooding, and vector borne disease. Other policies may include wildfires, aeroallergens, food and agriculture, drought, and solar radiation.
2.2	System partners should consider the carbon emission reductions and health co-benefits of increasing the proportion of plant-based products in food provision, procurement and catering policies.
2.3	System partners should develop a consistent, integrated approach to monitoring the carbon emissions associated with their activities.

2.4	Health and care providers should ensure that appropriate EPRR plans are integrated into their clinical delivery strategies to account for the major local risks posed by extreme weather (e.g., ambulance routes impacted by flooding, or hospital care delivery in excessive heat)
2.5	The integrated care system should make explicit consideration for the likely future impact of climate change in its estates strategy and work to reduce this impact through mitigation and adaptation.
2.6	The integrated care system should ensure appropriate EPRR plans are in place and kept up-to-date for the major local risks posed to human health by climate change (i.e., major flooding and excessive heat)

Chapter 3 – Built and Natural Environment

Key findings

Planning and health

- Planning and the National Planning Policy Framework
    - Good planning should ensure that the right development is built in the right place at the right time.
    - The National Planning Policy Framework (NPPF) sets out the Government's planning policies for England and how these are expected to be applied. The NPPF was last updated in December 2023. The NPPF must be taken into account in the preparation of local and neighbourhood plans.
    - The NPPF requires that local planning polices and decisions take into account and support the delivery of local strategies to improve health, social and cultural well-being for all sections of the community. This Healthy Places JSNA is one of these strategies.
- Health impact assessments (HIAs)
    - HIAs systematically and objectively evaluate the potential health effects of a policy, programme or project on a population.
    - Recommendations are produced for decision-makers and stakeholders with the aim of maximizing the proposal's positive health effects and minimizing the negative ones.
    - HIAs are not a legal requirement. Local Plan policies may require HIAs triggered by certain thresholds (e.g., for developments of over 100 homes).
- Developer contributions
    - Developers may be asked to provide monetary contributions for infrastructure either through the Community Infrastructure Levy (CIL) and/or through planning obligations in the form of Section 106 (s106) agreements.

Healthy New Towns Programme and place-based standards

- NHS England launched the Healthy New Towns Programme in 2015 with the goal of exploring how to create healthier, more connected communities with access to high-quality health services across 10 'demonstrator sites'. Northstowe, Cambridgeshire, was one of these sites.
- Learnings from across the Healthy New Towns Programme have been published ("*Putting Health into Place*") and are summarised under 10 principles.
- Quantifying how 'healthy' a place is allows better understanding of wider determinants of health, targeting areas of improvement, measuring the change in an area over time, and comparing and contrasting different local areas. In Scotland, the *Place Standard* tool is used for this purpose.

- A local equivalent to the Place Standard would help to quantify and monitor the healthiness of localities across Cambridgeshire and Peterborough, as well as evaluating the impact of planning policies and decisions.

The impact of the build environment on health

- Air quality
    - The major air pollutants known to impact human health are particulate matter (PM), ammonia (NH_3), nitrogen dioxide (NO_2), sulphur dioxide (SO_2), carbon monoxide (CO), and ozone (O_3). Other pollutants include radon, asbestos, and polycyclic aromatic hydrocarbons, among others.
    - Air pollution is associated with a with range of health impacts, most significantly with cardiovascular and respiratory disease. Children are particularly vulnerable to air pollution (increased risk of asthma and chest infections).
    - Cambridgeshire and Peterborough air quality has improved in recent years. The main source of local air pollution is motor vehicles. Air pollution is concentrated in urban areas.
    - Mitigation strategies should focus on reducing motor vehicle use, especially in urban areas and around schools.
- Noise
    - Excessive noise exposure over time is associated with cardiovascular disease and poor mental health.
    - Urban greenspace has a strongly protective effect on the impact of noise on cardiovascular mortality.
    - Noise from motor vehicles are aircrafts are most associated with negative impacts on health. However, these sources of noise fall outside the statutory nuisance remit and so are not regularly monitored.
- Physical activity
    - Physical activity is associated with a wide array of physical and mental health benefits. Physical inactivity is associated with 1-in-6 deaths in the UK with an estimated cost of £7.4 billion annually in the UK.
    - Examples of built environment interventions that promote physical activity are creating play spaces for children and young people, improving infrastructure and accessibility in parks and green spaces, and traffic calming measures.
    - The highest proportion of active adults (16+) are in Cambridge and South Cambridgeshire and lowest in Fenland and Peterborough.
    - Health economic modelling indicates that investment into wellbeing and leisure services carries substantial, system-wide return on investment.
- Active travel
    - The positive health impacts of active travel align with those of physical activity. Using estimates from the World Health Organisation, research has shown than in England, if all regions increased their walking and cycling to be in line with the most active regions of the country, over 1,000 early deaths could be prevented annually.

    - Research has found that, broadly speaking, interventions that combine both incentives for active travel (“carrot”) and disincentives for non-active transport (“stick”) may be more effective than either approach alone.
    - In March 2024, Cambridgeshire’s Active Travel Toolkit for new developments was published. This toolkit sets out a checklist of minimum expectations that should be met by new developments to promote safe and accessible active travel.
- Infrastructure and design
    - Local infrastructure and design can impact health in a variety of ways. For example, through increased connectivity and walkability of the urban environment or co-location of services. Accessibility and safety are important considerations.
    - In Cambridgeshire, two multidisciplinary planning panels may input into design and infrastructure features of new developments and infrastructure: the Design Panel (Cambridge City and South Cambridgeshire only) and Quality Panel (all of Cambridgeshire). There are not currently equivalent panels for Peterborough.
- Green and blue spaces
    - Exposure to green and blue spaces have well evidenced benefits to mental and physical health. For example, decreased risk of cardiovascular disease and asthma, reduced risk of depression and anxiety, and lower rates of childhood obesity.
    - Major factors influencing likelihood that people engage with nearby greenspace are travel distance, accessibility, and quality and range of facilities within greenspace. For example, cardiorespiratory health benefits are more consistently observed in areas with tree canopy, compared with grassland.
    - The authors of one review note that "only guaranteeing access is not enough", maintenance, renovation, proximity to residential areas, planning interactive activities, and perceived security are all important considerations.
- Housing and buildings
    - Poor quality housing has significant impacts on a range of health outcomes. Major hazards and their impact on health are assessed using the Housing Health and Safety Rating System (HHSRS).
    - Cold and/or damp homes are associated with poorer respiratory health (asthma, COPD, allergies, respiratory infections), cardiovascular disease (high blood pressure, heart disease, heart attacks), and mental health (both causing new mental health conditions but also worsening existing mental ill health).
    - Overcrowding is mostly robustly associated with worse respiratory health (in children and adults) and infectious diseases (especially tuberculosis and meningitis).
    - Other important considerations are around care facilities, ventilation, affordability, and homelessness. Given changes in working patterns, it’s

essential that housing is suitable for home-based working to ensure peoples' working conditions are conducive to good health.

- Food environment
    - To be health-promoting, local food environments should seek to promote access to healthy foods and restrict access to unhealthy foods.
    - Unhealthy local food environments have been associated with increased prevalence of cardiovascular disease, colorectal cancer, obesity (adults and children), and poor oral health (tooth decay, gum disease, and oral cancer).
    - Greater exposure to takeaway food outlets increases consumption of takeaway food. School environments with more unhealthy food retailers nearby or on the journey to/from school lead to more frequent purchases of unhealthy foods in secondary school aged children.
    - The presence of fast food outlets within a small radius around a family's home increases the risk of overweight and obesity in children and adolescents. This impact may be stronger in younger children and girls.

Vulnerable groups and the built environment

- Children and young people
    - Children and young people are frequently one of the most sensitive groups to the health impacts of the built environment.
    - An additional important consideration for children and young people is the provision of age-appropriate spaces for outdoor plan and physical activity. The most important factors to increase outdoor free play are availability and accessibility of formal or informal play spaces close to home.
    - Acceptability of play spaces is related to perceptions of social safety, greenness, natural features (especially trees), shade, park facilities, seating, all-weather provisions, safety and quality of play equipment, age-appropriate equipment, and opportunities to play with other children.
    - Considered design and a variety of park equipment availability significantly improve physical activity.
- Healthy ageing
    - In 2023, the Chief Medical Officer published his annual report titled *Health in an Ageing Society*. The report highlighted the increasing percentage of the population aged 75 years and older alongside the implications of this demographic change.
    - Older adults tend to move out of larger cities, settling instead in coastal, semi-rural or peripheral areas.
    - Age-friendly housing stock is essential to allow older adults to stay healthy and independent for longer. Poor quality housing contributes to the development and exacerbation of many long-term health

conditions. Older adults typically spend a greater proportion of their time at home than younger adults and children, hence are more impacted by poor quality housing.
    - Beyond housing, local built environments should be designed to be ‘age-friendly’. Multiple frameworks already exist to guide planning authorities and decision makers as to how spaces can better support and ageing population.
- People with disabilities
    - Accessibility for people with physical and/or mental disabilities is vital to ensure inclusivity across the built and natural environment. Social and physical exclusion can cause substantial detriment to health, as well as missing out on the positive benefits that an appropriate built environment can offer.
    - National Building Regulations Part M “access to and use of buildings” contains standards about visitability, accessible and adaptable homes, and about wheelchair homes. Planning authorities can specify the proportion of homes required to meet these standards in new developments.
- Mental health and the built environment
    - Chapter 2 of the Cambridgeshire and Peterborough Mental Health Needs Assessment highlights the prevalence of mental health issues, and how mental health issues disproportionately affect specific cohorts within our population.
    - There is strong evidence that suicide prevention (specifically, means restriction for jumping from high places) is a cost-effective intervention to reduce suicide attempts. Local data can be used to identify high-risk areas that may benefit from means restriction infrastructure.

Recommendations

Chapter 3: Built and Natural Environment	
3.1	Local plans and the integrated care system should use the Healthy New Town principles to guide planning and service provision in new developments.
3.2	The ICB should designate a single point of contact to ensure a robust and co-ordinated response to planning applications and local plan consultations.
3.3	Local planning authorities should add the ICB, Public Health, and Designing Out Crime Officer to their list of non-statutory consultees for planning applications and local plan consultation. Threshold of involvement should be co-determined by local planning authorities and ICB.
3.4	A system-wide task and finish group should be established to develop a place-based scoring system to objectively assess new and existing localities and developments, including the healthier street principles. This scoring system should include specific consideration of children and young people, older adults, and people with disabilities. For example, the *Place Standard* tool used in Scotland.
3.5	Local plans should include a policy requiring health impact assessments. Thresholds may differ based on local circumstances.
3.6	Local plans should include policies that address the health impacts associated with: - Air pollution (especially around schools and healthcare facilities) - Noise pollution - Green spaces (including provision, accessibility, quantum and distance from settlements) - Provision of accessible and age-appropriate equipment (e.g., seating, play equipment, etc) - Active travel - Dwelling design (e.g., home working environment and minimum room sizing) - Fast food / takeaways (e.g., takeaway exclusion zones, mandatory HIAs for new fast food establishments, or limiting the density of fast food establishments in urban areas) - Healthy food provision (e.g., community allotments or orchards, edible hedgerows, sites for community farming) - Suicide prevention (e.g., adopting the principles in Public Health England's Preventing Suicides in Public Places document, with a specific threshold requiring jumping restrictions to be installed at high-risk locations) - Healthy ageing and people with disabilities (lifetime homes, age-friendly housing, higher proportion of accessibility standards, or adopting the principles of age-friendly communities) - Meanwhile uses (e.g., a supportive policy that allows flexible interim uses recognising their benefits meanwhile uses have for social cohesion)
3.7	Local planning authorities should work with applicants and developers to ensure community engagement activities are submitted as part of major planning applications, and that these activities are inclusive and accessible.

	For example, ensuring the perspectives of classically underrepresented ("hard to reach") groups are sought and appropriately considered.
3.8	Peterborough City Council should establish a Quality Panel to review and input into planning application, akin to the Cambridgeshire Quality Panel.
3.9	All major developments should be reviewed by the Quality Panel, with a formalised threshold for review.
3.10	The Quality Panel should explicitly consider health outcomes in its charter.
3.11	Recommendations made by the Quality Panel or by the Design Panel should be monitored to understand how developments have evolved as a result of advice provided.
3.12	Health service providers should increase social prescribing of green and blue space interventions.
3.13	The integrated care system should explore the return-on-investment associated with improvements to housing standards for individuals with long-term health conditions known to be worsened by poor quality housing (i.e., cold and damp homes).
3.14	System partners should prohibit advertising, sponsorship, and promotion of HFFS foods and beverages on their own premises and land.
3.15	System partners should collaborate to develop a design guide for health, based on the evidence in this Healthy Places JSNA, to be adopted as a Supplementary Planning Document across Cambridgeshire and Peterborough.
3.16	Local plans should explicitly seek to reduce health inequalities. Planning authorities should make consideration for health inequalities in their decision making.
3.17	Local planning authorities should ensure that their Statement of Community Involvement explicitly considers how people with disabilities are meaningfully consulted on planning applications, planning policy, and neighbourhood planning.
3.18	Local plans should ensure that local need for affordable housing is explicitly considered, documented, and addressed in policies and decisions regarding affordable housing percentages in new developments.

Chapter 4 – Infrastructure and Services

Key findings

Local infrastructure

- Community hubs are flexible spaces that serve as focal points to bring residents, local groups and businesses together. These hubs can be used to promote place-based health and wellbeing activities.
- Digital infrastructure underpins the delivery of digital healthcare, including remote patient monitoring and telehealth. It's important that digital infrastructure is deployed efficiently and universally across Cambridgeshire and Peterborough, to avoid exacerbating health inequalities in rural or deprived areas.
- Interim or "meanwhile use" community buildings in new developments can bridge the gap for key services between residents moving into to an area and the creation of permanent facilities.
- The NHS can act as an anchor institution, supporting its surrounding communities and influencing upstream determinants of health, such as housing, employment, transportation, and sense of community.
- Co-creation and co-delivery involve local communities in decision-making processes and can be leveraged for formal planning-related matters or broader engagement with stakeholders.

Infrastructure delivery plans for health

- Infrastructure delivery plans (IDPs), sometimes also referred to as infrastructure delivery schedules, are documents that set out *what*, *where*, *when,* and *how much* of future infrastructure requirements to support a local population. They should provide answers to the following set of questions:
    - *What infrastructure is required for the future?*
    - *Where is this infrastructure needed?*
    - *When will this infrastructure be required?*
    - *How much is this infrastructure likely to cost?*
        - *How will it be funded and who is responsible for providing it?*
        - *Are there any identified funding gaps? If so, how are they likely to be overcome?*
- Although most of the areas within Cambridgeshire and Peterborough do have existing IDPs, there is limited detail with respect to the health infrastructure components. This lack of detail is particularly missing with respect to identifying specific locations of required infrastructure, timing, and funding.
- To ensure future health needs can be met, it's essential that health partners and planners collaborate to robustly describe health infrastructure requirements in IDPs.

Primary and secondary health services

- Quality Outcomes Framework data indicates that the prevalence of major non-communicable diseases (e.g., hypertension, diabetes mellitus, asthma) is lower in populations living in New Developments and Older Developments, compared with those in Settled Areas. This reflects the older demographic of communities in Settles Areas.

Education

- Education forms the cornerstone of a healthy start to life. The health benefits associated with school attendance range from the short-term (e.g., access to school nursing or educational psychology) through to the long-term (e.g., reduced risk of diabetes, heart disease, and overall mortality).
- People with less education have higher risk of smoking, physical inactivity, obesity, and suffering from alcohol-related harm.
- Provision of high-quality early years, childcare, primary and secondary school services (including special education needs and disability) is vital to help reduce health inequalities and provide children with the best possible start to life.

Recommendations

Chapter 4: Infrastructure and Services	
4.1	Commissioners and health service providers should ensure that there are adequate healthcare facilities and services in place from day one of first occupation. These should be designed to be adaptable and evolve as the resident population expands.
4.2	Local planning authorities should ensure that there is adequate provision of community spaces (e.g., community building, green space, etc) delivered by day one of first occupation in major new developments.
4.3	System partners should develop mechanisms to financially support commercial enterprises during the early years of a new development (e.g., café, community shop). For example, rent-free periods or subsidised business rates. Support should be contingent on the enterprise being able to demonstrate intent to benefit the physical and/or mental health of residents (e.g., through promoting healthy eating or facilitating community cohesion). Support should be time-limited until the resident population is sufficiently large to make the enterprise independently commercially viable.
4.4	System partners should ensure that digital connectivity and access to digital-enabled healthcare are universal across Cambridgeshire and Peterborough.
4.5	Local plans should have a flexible approach to developer contributions (Section 106 and Community Infrastructure Levy), ensuring funding can be used for revenue, as well as capital, adapting to the changing needs of the community.
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4.7	The ICB should survey its healthcare infrastructure to ensure that estates are compliant with accessibility standards.
4.8	Education directorates should explicitly take into account the evidence presented in Chapters 2 and 3 of this JSNA when considering prospective sites for new schools.
4.9	Local plans should include policies to prevent business covenants on new build dwellings (e.g., to facilitate childcare businesses in new developments).

Chapter 5 – Communities and Social Cohesion

Key findings

How does social cohesion impact on health and wellbeing?

- Social networks, capital, and cohesion are related terms that encompass the positive aspects of neighbourhood community life including relationships, ability for people to rely on one another, and sense of community and belonging.
- People with wider social networks and stronger social relationships have been shown to have better health outcomes:
    - Reduced mortality
    - Faster recovery from illness
    - Better mental health and wellbeing

Communities

- "Community" refers to a group of people connected to one another by shared a shared characteristic. They are often distinguished into communities of place or geography (e.g., the population of a village, residents in a care home, or students in shared accommodation) and communities of interest or identify (e.g., faith groups, LGBTQ+ people, or people living with a specific health condition).
- Loneliness and social isolation are associated with poorer physical and mental health: increased risk and earlier onset of dementia, depression and anxiety, suicide, long-term physical health conditions such as asthma and hypertension, and premature death from all causes. Physical and social infrastructure can help to mitigate loneliness and social isolation.
- Sense of belonging and trust in fellow residents can be low in a new community, especially during the early phases of development when occupation is low and there are few (if any) community facilities. This phenomenon is termed "New Town Blues" and presents as elevated levels of mental distress in the community.

Community development

- Community development is a process where people come together to take collective action on what matters to them and to engage in the design and delivery of future spaces. Community development may be performed either with or without the aid of community development professionals.
- Asset Based Community Development (ABCD) is a form of community development that identifies and builds on a community's assets and strengths

rather than its problems and needs. Although evaluating outcomes from community development can be challenging, emerging evidence indicates that ABCD approaches may generate greater collective action than traditional community development and support individual-, community-, and organisational-level outcomes.

- Community development officers (CDOs) are professionals who support community development, especially in this early phase of development. CDOs help to identify and address needs, concerns, and issues that affect new and neighbouring communities. CDOs work with communities to address these needs through making connections with relevant stakeholders and partner organisations, or potentially identifying funding sources to leverage.
- The voluntary, community and social enterprise sector (VCSE), are key partners in working to build community cohesion. A key strength of community organisations is their awareness and knowledge of local issues and culture within their specific areas. Organisations working at a neighbourhood level can offer a unique understanding of local people, their community and an opportunity to involve even those who are hardest to reach.
- Community forums aim to keep people aware and informed about future development plans, and act as a space to raise emerging or perceived issues to local authorities, housebuilders, or developers. Community leaders may act as part of, or external to, community forums, helping to champion the voices of a community and drive positive change.

Community safety

- Crime and community safety (whether objective or perceived) are important determinants of a community's social cohesion, utilisation of community facilities, and health outcomes, particularly mental health outcomes.
- Community Safety Partnerships (CSPs) are multi-agency groups that aim to reduce crime and anti-social behaviour in their communities. The responsible authorities who make up a CSP are the Police, Fire and Rescue Authority, local authorities, health partners and probation services.
- Community resilience is the capacity for a community to be aware of, plan and prepare for, respond to, and recover from shocks and stresses, in both short- and long-term situations. Local resilience forums are the formal mechanism for preparedness, response and community resilience at the local level.

Recommendations

Chapter 5: Communities and Social Cohesion	
5.1	Local planning authorities should require developer contributions for community development officers in major new developments.
5.2	Community development officers should establish community forums in new major developments.
5.3	System partners should collaborate with the local resilience forum to encourage reporting of local incidents of flooding, which can be used to support funding to improve local flooding infrastructure.
5.4	System partners to work together with the LRF to develop a model for asset-based community resilience that can be applied across integrated neighbourhoods.

Recommendations – Full List

Chapter 1: Demography and Households	
1.1	System partners should account for the differences in demographic profiles between new and existing communities.
1.2	To facilitate informed service commissioning and provision, system partners should develop an integrated approach to compiling a single electronic resource of data related to major new developments across Cambridgeshire and Peterborough.
1.3	Local planning authorities and ICS commissioners should ensure correct housing multiplies are applied, accounting for the higher number of people per home in new developments compared with existing communities.
1.4	Local Plans and Housing strategies should plan for a mixture of accommodation types, according to population projections and likely demographic profile changes. These strategies should ensure that future health needs will be addressed through appropriate provision of accessible housing and care facilities (e.g., for older people, learning disability, physical disabilities, autism and specialist mental health, social care, etc).
1.5	Local Plans should, where possible, include a policy requiring major, mixed-use new developments to co-locate housing with local employment opportunities.
1.6	System partners should develop and integrated approach for addressing the higher rates of mild-to-moderate mental illness in new communities.

Chapter 2: Climate Change	
2.1	Local plans should include policies that account for the current and likely future impacts of climate change. Specifically, local plans should include policies on risk of excessive heat, flooding, and vector borne disease. Other policies may include wildfires, aeroallergens, food and agriculture, drought, and solar radiation.
2.2	System partners should consider the carbon emission reductions and health co-benefits of increasing the proportion of plant-based products in food provision, procurement and catering policies.
2.3	System partners should develop a consistent, integrated approach to monitoring the carbon emissions associated with their activities.
2.4	Health and care providers should ensure that appropriate EPRR plans are integrated into their clinical delivery strategies to account for the major local risks posed by extreme weather (e.g., ambulance routes impacted by flooding, or hospital care delivery in excessive heat)
2.5	The integrated care system should make explicit consideration for the likely future impact of climate change in its estates strategy and work to reduce this impact through mitigation and adaptation.
2.6	The integrated care system should ensure appropriate EPRR plans are in place and kept up-to-date for the major local risks posed to human health by climate change (i.e., major flooding and excessive heat)

Chapter 3: Built and Natural Environment	
3.1	Local plans and the integrated care system should use the Healthy New Town principles to guide planning and service provision in new developments.
3.2	The ICB should designate a single point of contact to ensure a robust and co-ordinated response to planning applications and local plan consultations.
3.3	Local planning authorities should add the ICB, Public Health, and Designing Out Crime Officer to their list of non-statutory consultees for planning applications and local plan consultation. Threshold of involvement should be co-determined by local planning authorities and ICB.
3.4	A system-wide task and finish group should be established to develop a place-based scoring system to objectively assess new and existing localities and developments, including the healthier street principles. This scoring system should include specific consideration of children and young people, older adults, and people with disabilities. For example, the *Place Standard* tool used in Scotland.
3.5	Local plans should include a policy requiring health impact assessments. Thresholds may differ based on local circumstances.
3.6	Local plans should include policies that address the health impacts associated with: - Air pollution (especially around schools and healthcare facilities) - Noise pollution - Green spaces (including provision, accessibility, quantum and distance from settlements) - Provision of accessible and age-appropriate equipment (e.g., seating, play equipment, etc) - Active travel - Dwelling design (e.g., home working environment and minimum room sizing) - Fast food / takeaways (e.g., takeaway exclusion zones, mandatory HIAs for new fast food establishments, or limiting the density of fast food establishments in urban areas) - Healthy food provision (e.g., community allotments or orchards, edible hedgerows, sites for community farming) - Suicide prevention (e.g., adopting the principles in Public Health England's Preventing Suicides in Public Places document, with a specific threshold requiring jumping restrictions to be installed at high-risk locations) - Healthy ageing and people with disabilities (lifetime homes, age-friendly housing, higher proportion of accessibility standards, or adopting the principles of age-friendly communities) - Meanwhile uses (e.g., a supportive policy that allows flexible interim uses recognising their benefits meanwhile uses have for social cohesion)
3.7	Local planning authorities should work with applicants and developers to ensure community engagement activities are submitted as part of major planning applications, and that these activities are inclusive and accessible. For example, ensuring the perspectives of classically underrepresented ("hard to reach") groups are sought and appropriately considered.
3.8	Peterborough City Council should establish a Quality Panel to review and input into planning application, akin to the Cambridgeshire Quality Panel.

3.9	All major developments should be reviewed by the Quality Panel, with a formalised threshold for review.
3.10	The Quality Panel should explicitly consider health outcomes in its charter.
3.11	Recommendations made by the Quality Panel or by the Design Panel should be monitored to understand how developments have evolved as a result of advice provided.
3.12	Health service providers should increase social prescribing of green and blue space interventions.
3.13	The integrated care system should explore the return-on-investment associated with improvements to housing standards for individuals with long-term health conditions known to be worsened by poor quality housing (i.e., cold and damp homes).
3.14	System partners should prohibit advertising, sponsorship, and promotion of HFFS foods and beverages on their own premises and land.
3.15	System partners should collaborate to develop a design guide for health, based on the evidence in this Healthy Places JSNA, to be adopted as a Supplementary Plan (formerly Supplementary planning Document) across Cambridgeshire and Peterborough.
3.16	Local plans should explicitly seek to reduce health inequalities. Planning authorities should make consideration for health inequalities in their decision making.
3.17	Local planning authorities should ensure that their Statement of Community Involvement explicitly considers how people with disabilities are meaningfully consulted on planning applications, planning policy, and neighbourhood planning.
3.18	Local plans should ensure that local need for affordable housing is explicitly considered, documented, and addressed in policies and decisions regarding affordable housing percentages in new developments.

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