Healthcare in New Developments Task and Finish Group – Final Report

Committee considering report:	Health Scrutiny Committee
Date of Committee:	11 June 2024
Task Group Chairman:	Councillor Carolyne Culver
Date Task Group Chairman agreed report:	30 April 2024
Report Author:	Vicky Phoenix

1 Purpose of the Report

1.1 This report presents the work undertaken by the Healthcare in New Developments Task and Finish Group and their final recommendations.

1.2 Members of the Task Group would like to thank all the officers, witnesses and Members who gave evidence and supported this scrutiny review.

2 Recommendation

2.1 To consider the Task and Finish Group's final recommendations as outlined in Section 6 of the report and to agree whether these be referred to the Executive and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) for consideration.

2.2 To agree that the Health Scrutiny Committee keeps this under review and invites updates on progress in implementing the report's recommendations.

3 Implications and Impact Assessment

Implication	Commentary
Financial:	There are no financial implications arising directly from this report, although if proposals are accepted, this may result in financial implications which will be assessed in detail if they are taken forward.

Human Resource:	There are no HR implications arising directly from this report, although if proposals are accepted, this may result in HR implications, which will be assessed in detail if they are taken forward.
Legal:	There are no Legal implications arising directly from this report, although if proposals are accepted, they may result in Legal implications which will be assessed in detail, if they are taken forward.
Risk Management:	There are no risk management implications arising directly from this report, although if proposals are accepted, this may result in risk management implications, which will be assessed in detail if they are taken forward.
Property:	There are no property implications arising directly from this report, although if proposals are accepted, this may result in property implications, which will be assessed in detail if they are taken forward.
Policy:	There are no policy implications arising directly from this report, although if proposals are accepted, this may result in policy implications, which will be assessed in detail if they are taken forward.

	Positive	**Neutral**	**Negative**	**Commentary**
Equalities Impact:				
A Are there any aspects of the proposed decision, including how it is delivered or accessed, that could impact on inequality?	X			There are no equalities implications arising directly from this report. However, if accepted, proposals would lead to reductions in health inequalities as detailed in the report.

B Will the proposed decision have an impact upon the lives of people with protected characteristics, including employees and service users?		X		The proposed decision does not have any impact upon the lives of people with protected characteristics.
Environmental Impact:		x		There are no environmental impacts arising directly from this report.
Health Impact:	x			There are no health impacts arising directly from this report. However, if accepted, proposals would lead to improvements in health as detailed in the report.
ICT Impact:		x		There are no ICT impacts arising directly from this report.
Digital Services Impact:		x		There are no Digital Services impacts arising directly from this report.
Council Strategy Priorities:	x			There are no impacts arising directly from this report, but if adopted, the report's recommendations would help to deliver aspects of the Council Strategy related to the priority 'A Prosperous and Resilient West Berkshire' and 'Thriving Communities with a Strong Local Voice'.
Core Business:	x			The report's recommendations support core business activities within Planning and Public Health.
Data Impact:		x		There are no data impacts associated with this report.

Consultation and Engagement:	• Elisabeth Gowens (Senior Programme Officer for the Wider Determinants of Health). • Laura Callan (Planning Policy Manager). • Bob Dray (Development Manager). • Peter Redman (Senior Programme Manager - Primary Care Estates, Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB)). • Jeffrey Ng (Senior Primary Care Estate Manager, BOB ICB). • Helen Clark (Deputy Place Director Berkshire West, BOB ICB) • Cllr Tony Vickers - Executive Portfolio Holder: Planning and Community Engagement. • Dr Heike Veldtman (GP, Thatcham Medical Centre). • Dr Andrew Buroni (Director of Health and Social Impact Assessment Environment and Infrastructure, Savills).

4 Executive Summary

4.1 The Health Scrutiny Committee (HSC) established a Task and Finish Group to look at healthcare in new developments.

4.2 A key concern regarding proposed new developments is ensuring adequate healthcare services are provided. There is a need to ensure that healthcare commissioners are adequately consulted on the requirements for the primary care services to serve new developments when local populations increase, and that developers engage with health commissioners and planners.

4.3 There is also opportunity to ensure that new developments are designed to promote health and wellbeing, and therefore prevent future demand on primary care services. There is therefore a need to review how the planning application process is encouraging developers to design with long-term prevention and health promotion for all residents across the life-course of the development.

4.4 The scope of the review was broken down into three key areas:

- Part 1: Assessment of health needs in new developments
- Part 2: Health in planning policy and planning consultations
- Part 3: Funding and delivery of primary care and public health care services in new developments.

4.5 The task group has identified a number of recommendations arising from this work, which are set out in Section 6 of this report. The HSC is invited to review the recommendations and consider whether these should be put to the Executive and to the ICB.

5 Supporting Information

Introduction

5.1 The HSC established a Task and Finish Group to look at healthcare in new developments. The Terms of Reference were drafted in collaboration with officers in Public Health and Planning. The scope of the review was broken down into three key areas:

- Part 1: Assessment of health needs in new developments
- Part 2: Health in planning policy and planning consultations
- Part 3: Funding and delivery of primary care and public health care services in new developments.

5.2 The full Terms of Reference are provided in Appendix A.

Background

5.3 A key concern regarding proposed new developments is ensuring adequate healthcare services are provided. There is a need to ensure that healthcare commissioners are adequately consulted on the requirements for the primary care services to serve new developments when local populations increase, and that developers engage with health commissioners and planners.

5.4 The original intention was for the task group to look specifically at healthcare provisions in new developments. After collaboration with Public Health and Planning, the Task Group decided to review the Terms of Reference. The planned work by Public Health on the draft Healthy Planning Protocol (HPP) and Health Impact Assessments (HIA) were also addressing the working relationships and planning processes that impacted on healthcare in new developments. By widening the scope of the Task Group, Members could review this wider work whilst also addressing the concerns regarding provisions and have an opportunity to influence the work whilst it was being developed. The reviewed terms of reference were agreed at the Health Scrutiny Committee on 12 December 2023.

5.5 The Task and Finish Group held 4 sessions to gather key evidence:

Meeting Date	Focus of Meeting	Witnesses
30 January 2024	• Review of current mapping of primary care provision. • Form an understanding of Health Impact Assessments (HIAs), their implementation and the wider preventative approach. • Review how Berkshire Observatory ward data will be used.	Elisabeth Gowens Laura Callan Bob Dray Peter Redman Helen Clark
27 February 2024	• Review the draft Healthy Planning Protocol.	Elisabeth Gowens Laura Callan Bob Dray

	• Review the draft HIA templates and supporting documentation. • Consider engagement and the planning consultation process.	Peter Redman Jeffrey Ng Helen Clark Cllr Tony Vickers
26 March 2024	• Understand how primary care services for new developments are funded. • Review the level of support provided to GP surgeries in securing funding and delivering proposals. • Understand developer contributions for local health infrastructure. • Consider barriers in delivering plans for future population growth.	Elisabeth Gowens Laura Callan Peter Redman Jeffrey Ng Helen Clark Dr Veldtman
10 April 2024	• Interview Savills	Elisabeth Gowens Laura Callan Dr Buroni

Findings

Mapping of primary care provision

5.6 Peter Redman (Senior Programme Manager, BOB ICB) and Helen Clark (Deputy Place Director Berkshire West, BOB ICB) were invited to give evidence in relation to the mapping of primary care provision, in particular GP surgery facilities and GP surgery workforce. Dr Veldtman was invited to share their view from a GP perspective.

5.7 The BOB ICB commission primary care services. This is delivered through GP contracts. The ICB do not have the ability to hold capital nor own estate. They are entirely reliant on third party developers to source buildings and provide capital finance. Primary care estates are indirectly funded through reimbursement of rents and business rates by the ICB. New primary care developments (whether a new building or an extension) need to be GP-led.

5.8 The 16 GP practices across West Berkshire have joined up to form 4 Primary Care Networks (PCNs). The Additional Roles Reimbursement Scheme (ARRS) provides funding for additional healthcare professionals within primary care such as pharmacists, social prescribers and paramedics. ARRS was funded through the Long-term Plan of 2019 to encourage diversifying the workforce. This funding has been extended for a further year. It was noted that there was no additional funding from the ARRS scheme for the space that these roles used. This was a fundamental challenge.

5.9 Data was provided by the BOB ICB detailing GP Practice workforce in all the surgeries in West Berkshire. It was noted that ARRS in GP practices was regarded as very beneficial, but it meant that it was not straightforward to compare resources at practices by looking only at the number of GPs per population. The sizes of practices varied, and the skill mix varied. In addition, the population served by GP Practices varied. For example, deprivation, rurality and age impacted the patient needs of a local area and therefore the health provisions required. There were no official guidelines around workforce per number of patients.

5.10 The BOB ICB would need to be assured that any new estate could be staffed. It was highlighted that it was important to have long term plans around the staffing of primary care to respond to population growth in local areas. Future workforce planning also needed to take into account the age demographic of the workforce, and the numbers approaching retirement.

5.11 The NHS use a strategic health planning system called SHAPE to estimate population growth in each area. For each PCN area, the ICB provided estimated population growth figures.

5.12 Based on BOB ICB experience, a new development needs to be more than 4000 units to warrant a standalone GP Practice. This was rarely the case in local developments, although smaller housing schemes could support new on-site GP premises developments where an existing GP Practice is able to vacate an existing facility . Other mitigations include reconfiguration or expansion of an existing GP practice to provide additional clinical spaces or relocation of existing GP practice(s) to a new GP facility in response to any local population growth.

5.13 The GP described that housing developments and increases in population were an issue. They were working at full capacity, and they could not always get a locum when needed. The demographic of new developments needed to be considered. It would likely be more young families and so this was an opportunity to look at prevention.

5.14 Due to workforce issues, GP practices were tending to focus more on survival than expansion. Some were not currently thinking strategically and so were far less interested in taking on long term leases with third party developer landlords than previously. In other areas, GP practices had expressed that they were not in a position to take on new estate to cater for population growth.

5.15 It was advised that satellite surgeries, such as those used in rural areas, were challenging to staff and it was difficult to help staff feel supported in those settings. There were also time constraints as satellite practices might be further away and more inaccessible by public transport, and other extra costs are associated with them. It was felt from a GP perspective that health improvement opportunities were with bigger practices. A one stop shop for patients for example to see specialists such as physiotherapists.

5.16 The ICB confirmed that the location of primary care estates was a question for GPs. The location of the estate impacted which GPs were consulted about a planning application, but the ICB were flexible on the site location. The ICB supported what was best for GPs and that it was funded by developers' contributions as much as possible.

5.17 It was highlighted that accessibility to surgeries was essential, in rural areas as well as in towns. Enhanced transport links may be needed. It was confirmed by the ICB that in any decision making around the siting of future surgeries or movement, that transport links were taken into account. It was also noted that additional capacity through extensions was difficult due to constrained sites and alternatives may not be ideal. It was important to involve developers in discussions around transport links.

5.18 It was noted that health visitors no longer worked in surgeries, and that public health and prevention should be included in the ICB planning. The ICB confirmed it was

important to think about how primary care worked in the future and how primary care estates were developed to reflect that. That included co-location with other services, preventative work and outreach into communities. The ICB were taking a holistic approach in what they wanted to see happening in primary care going forward. The primary care strategy was in draft currently and this would drive this work going forward.

5.19 Primary care also includes Pharmacy, Optometry and Dentistry (POD). For the purposes of the review, the focus has been on GP provision. This is because POD is very different in relation to provision of healthcare when compared to general practice. The three services are all responsible for their own estate (unlike general practice where the BOB ICB reimburse the cost). They also do not have a registered list and so people can receive treatment anywhere.

5.20 Gaps in community pharmacy service are described in the Pharmaceutical Needs Assessment (PNA) which is regularly reviewed and monitored by the Health and Wellbeing Board. Any significant gap in provision of community pharmacy as a result of a housing development would be reflected in the PNA.

5.21 High street dentistry does not have a registered list and it would therefore be unlikely that the ICB would look to establish a new practice as a result of new developments. Dentistry has very complex and differing challenges which were not under the scope of this review.

5.22 There is more evidence to be heard about integrated planning across all healthcare providers to ensure that future needs are met. This is being considered for review by the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Scrutiny Committee (BOB JHOSC).

Funding of primary care services in new developments

5.23 Bob Dray (Development Manager) provided an overview of the Community Infrastructure Levy (CIL) and S106 for the Task and Finish Group.

5.24 The task group learned that there was a shift towards CIL, however development specific planning obligations (S106) were still needed for major sites as it was a mechanism to secure infrastructure and mitigate the impacts of a development proposal. CIL (developer contribution) was the most effective way to collect contributions for small developments.

5.25 CIL and S106 funds could be used to pay for the same piece of infrastructure if it was directly relating to the development, was necessary and reasonable. It was clarified that CIL had not replaced S106 as intended. S106 was now only for major sites.

5.26 CIL and S106 was guided by legislation, however consultation provided the direction as to what was needed on individual developments. For example, if a larger or new surgery was needed then a S106 negotiation could be made. The need would be largely determined through consultation with the ICB. There would be discussion around when those payments would be made by the developer. It was possible to also do a separate CIL charge.

5.27 The CIL charging structure was renewed every five to ten years. The Clinical Commissioning Group (CCG) (CCGs were the local NHS body prior to the formation of ICBs in 2022) was consulted at the last renewal, but it had been difficult to get a response from them. It was hoped that the charging structure would be renewed in the near future and that the ICB would be clear in communicating to the Council about how much was needed for new developments. It was important to highlight that the CIL charging structure was very influential. Infrastructure providers needed to work together to negotiate appropriate developer contributions. It was in the community interest to do so. This was complicated by the number of stakeholders involved, particularly within the NHS.

5.28 Primary care estates were funded through reimbursement of rents and business rates by the BOB ICB. In the case of owner-occupied premises, the Practice also received a reimbursement figure predicated on an assumed notional lease. The District Valuer (DV) assessed these rents/notional rents, given that the BOB ICB reimburse these amounts. In the case of a Practice relocation to a new facility, rent reimbursement per square metre for a new build facility would be higher than their current premises reimbursement and so this such a relocation would be a significant revenue burden for the ICB to reimburse. Other current challenges to new developments being procured noted included higher interest rates, high build-cost inflation and a reduction in capital values for third party developers.

5.29 The BOB ICB used a proforma which includes a formula to calculate the contribution requested in response to a planning application in circumstances where a very large housing developments could support a stand-alone GP premise. This could translate to a per dwelling cost that varied depending on the size of the dwellings.

5.30 The ICB did not receive capital funding for infrastructure development in their annual budgets and so unless significant S106 or CIL contributions were made, a new facility became extremely expensive when they already had significant revenue challenges across all their budgets.

5.31 One key challenge for the ICB was in relation to the timing of S106 money which meant that the GP premises would be built after the completion of the development. An existing GP surgery would not have the capacity to cope with the extra demand in the meanwhile. To be proactive ahead of the population increase, they needed to receive funding earlier. It was also noted third party developers would not be interested in building the premises prior to receiving the S106 contributions and the BOB ICB would need to see such contributions translating into a lower rent reimbursement.

5.32 Planning advised the profile of this could be raised as local authorities could potentially negotiate with developers to get S106 funding at an early stage within each housing development. However, the constraint for developers was they did not have the revenue from the development at the start of the project to pay the contributions. They built in phases and had the right to appeal. There were other infrastructure requirements and so it could not always be insisted upon especially for a larger site. For a major application there would be pre-application discussions which would engage with infrastructure providers. The ICB could put forward a view and it would be looked at on a case-by-case basis. They advised that they were aware of an example where a GP surgery (not in an ICB area) had been one of the first provisions created in a new estate.

Engagement with the planning process

5.33 The task group reviewed a number of previous and current development consultations. These were chosen in collaboration with all Councillors and Planning. Members asked witnesses questions about engagement on those specific consultations and more generally.

5.34 It was clarified that the CIL / S106 negotiations were evidence based. For healthcare it would include understanding the patient yield, the capacity and whether it could be accommodated. This would take place during the application process and through any pre-application discussions.

5.35 The NHS (ICBs and Primary Care Trusts) are a non-statutory consultee so there is no national guidance on how and when the ICB should be consulted. Historically the local authority consulted the NHS for larger schemes based on site area, but the ICB would now be consulted for any development of ten or more dwellings. The ICB had a duty to cooperate, and they were happy to have regular meetings with planning and in exploring opportunities to be involved in discussions as to when and how the ICB would be consulted.

5.36 The task group found that on some occasions there were no responses recorded from the NHS on a planning application consultation, the responses were delayed or did not have the evidence based behind it. There was an example of the consultation response being after the S106 agreement had been drafted. The GP advised that support from the ICB for primary care regarding major developments could be better. They were not part of the initial discussions and hoped that this would be improved in the future.

5.37 The ICB advised that there were issues with CCG engaging with planning, but that had been improved. They had recently recruited a town planner who would have greater knowledge of the estates and would improve a coordinated approach to town planning across the ICB. This would help the ICB in the timeliness to respond to applications. Planning noted that it was also their role to engage and consult with relevant parties and so they would ensure that primary care was included.

5.38 The ICB advised that they made representations in response to the Local Plan Review consultation in March 2023 but that a response was delayed. The ICB have now met with planning to discuss this in more detail, and they have submitted constructive representations to the Local Plan examination. At the time of this report being drafted, the examination of the Local Plan is about to commence.

5.39 The ICB and planning met between task group meetings to discuss how they would work together in the future. From this they agreed to meet regularly to discuss applications and to find flexible mechanisms to improve how they worked together in the future.

5.40 A key thread throughout the task group's evidence gathering was around best practice and sharing new ways of working. It was noted that health in planning was largely carried out at a local level. The ICB shared some good practice from South Oxfordshire District Council which had a dedicated policy for health facilities and had CIL allocated for facilities. NHS England had a town planner and so the BOB ICB would liaise with them to see if there was anything that could be considered / adapted as this was an

issue nationally. This would continue to be a key part of the regular meetings between the ICB and planning.

5.41 One example highlighted was in Pincents Lane where the developer offered a community building to the NHS. At the time the NHS could not justify a new surgery. A cascade system was implemented so that the building would be offered to the NHS first for the first 2 years. It would then cascade for a different use.

5.42 Ward Members were highlighted as a key stakeholder to be consulted when S106 was being agreed as they would understand the local area.

Planning policy and the delivery of primary care services in new developments

5.43 The task group received input on planning policy including the Infrastructure Delivery Plan (IDP) and the WBC Capital Programme, which distributed CIL funds, from Laura Callan (Planning Policy Manager). It was noted that healthcare was only one of the 'other services' that were allocated 10% of CIL spending. The IDP was due to be updated.

5.44 Examples of good practice from South Oxfordshire District Council and the Vale of the White Horse District Council were shared. This included more emphasis on CIL funding apportioned to healthcare and to support its infrastructure. In South Oxfordshire and Vale of White Horse District Council, 20% of CIL funding was allocated to community health. The BOB ICB found this very useful. They NOW had two decent sized surgery extensions with planning consent in the process of being fully funded by CIL via a funding agreement. This worked well for an extension to an existing site. To do this at WBC, there needed to be a CIL spending strategy and a working group was needed to develop that. CIL had some conditionality, but the ICB found it more able to be used flexibly. Any changes to make the process more flexible would be helpful.

5.45 Recommendations from the Royal Town Planning Institute (RTPI) and the Town and Country Planning Association highlighted the importance of collaboration, and resourcing to facilitate the collaborative working, for creating healthy places.

5.46 The task group discussed the importance of improving health care prevention through local facilities. This was especially the case in rural areas and transport to facilities was key. It was confirmed that the policies to do that were there but needed to be linked up. Health in all Policies was in place and needed more emphasis.

5.47 It was highlighted that CIL spending had to be directly related to the development and be evidenced. There were opportunities in match funding from other sources, but it was for infrastructure to serve that development and evidence was needed on each case to see if it fitted the criteria.

5.48 Other barriers were learned regarding the delivery of primary care services for new developments which included:

- Workforce challenges in primary care meant that GPs were focussing on survival rather than strategic thinking for population growth. It was also noted that GP core business should be with patients rather than estate management / project management.

- Complications associated with expanding existing premises. These included a lack of space to expand, the return on investment, funding to commission feasibility / pre-work studies, the availability of S106 contributions and landlord consent.

- Complications associated with relocating a surgery - if the building was owned, and there had been a high turnover of partners, properties could have become in negative equity due to re-mortgaging. For leased premises they would need landlord permission to end the lease early. It was noted that it was often better to optimise their own space first, expand locally and to look at what was nearby primarily. A move to a new site was probably more costly.

- As a new GP surgery would only generally be sustainable for a new development of 4000 homes, a redevelopment or a relocation of a surgery would be needed. However, that scenario would require the housebuilder to agree to build a larger site which under CIL rules would be not be required to mitigate their own particular development.

5.49 Collaboration between WBC and the ICB at an earlier stage and for WBC to consider being a development partner in a new GP build was suggested. This would involve the local authority owning the estate and the GP surgery would lease from them. This was a departure from the third party developer model which the ICB have been reliant upon for new estates. Further to that it was agreed that NHS requirements should be built into the Council's wider thinking around multipurpose community hubs where a community centre would benefit a local community. It was noted that there was opportunity in local authorities working directly with GPs which would help to avoid the complications from the rent reimbursement scheme currently used by the ICB.

Preventative approach

5.50 Elisabeth Gowens (Senior Programme Officer for the Wider Determinants of Health) advised the task group throughout the review on the public health approach to primary prevention and reducing health inequalities. It was highlighted that there is a 4-year life expectancy gap and 7-year healthy life expectancy gap between the most and least deprived Lower Super Output Areas (LSOA's) in West Berkshire. There is also inequality in health behaviours and health outcomes between those areas. These are directly related to the environments in which people live, work and play.

5.51 Both Elisabeth Gowens and Andrew Buroni (Director of Health and Social Impact Assessment, Environment and Infrastructure, Savills) advised the task group that to improve these health inequalities and reduce the burden on health and social care services, there needed to be a long term, strategic and cross-service approach to health protection, health promotion and healthcare. The local authority, public health and NHS colleagues need to work together to have happy, healthy and prosperous communities and a sustainable and productive workforce.

5.52 The task group heard that the built environment had one of the biggest influences on our decision making, health behaviours and the opportunities available to us in our lives which impacted our quality of life. Evidence was heard that only 10% of population health and wellbeing was related to healthcare. Planning with health in mind prevents more disease than NHS can ever treat and that health legacy is built into the places and spaces that we live. Designing health-promoting environments is one of the most impactful ways that local authorities can embed primary prevention in their work. That if done poorly, it compounds existing poor health and prevents opportunities to build age and neurodiversity friendly design features in later.

5.53 It was highlighted that while planning contributions were helpful, they were not the only way to approach health in new developments. For example, in infrastructure delivery it was beneficial to ensure that a new school was built with SEND capabilities (eg. an adaptive community asset, SEND library, play facilities), a community health centre was multi-functional and adaptive (for example space for a mobile screening unit), a community hub was multifunctional to support networking and housing was intergenerational and for key workers.

5.54 A key theme discussed was homes for life and ensuring the built environment was inclusive for older people and people with reduced mobility. In West Berkshire there was social isolation, an ageing population and high housing costs. For larger infrastructure developments it was therefore essential for health to be integral in planning. For example, dementia friendly design, neurodiversity friendly design, adaptive and resilient design to enable people to be healthy and independent for longer.

5.55 It was explained that there were huge financial costs of poor design for the NHS and local authorities. By providing the right infrastructure that enables an inclusive environment to help all to thrive, it reduces pressure on adult social care and children's services in the future. An example shared was that spaces and places embedded with neurodiversity friendly design supported families and built connections in communities taking pressure off children's services. Dementia friendly design allows intergenerational living and relieves pressure on adult social care services. Community hubs, retirement areas, vibrant communities etc help to address barriers to positive health behaviours.

5.56 It was highlighted that it was no longer viable to have treatment-only healthcare. Diagnostic services and treatment should be embedded in communities By creating 'health hubs' rather than GP surgeries, there would be space to overlap with social care and childcare. Space for GP's, community nursing, phlebotomy, an age and social care adviser, health promotion expert etc. This is not only good for people and a community, but it helps to build the viability of a surgery. This is essential because as the population increases in age, the costs of health and social care increase at such a rate that it is not sustainable. The developer representative, the GP, the ICB, planning and public health were all in agreement that this was the way forward for communities and for financial viability. The ICB primary care strategy includes prevention as a key aspect. For example, someone with raised blood pressure could attend group sessions that provided advice on diet and lifestyle. There could be discounted exercise and meal plan support. Targeted work to support young families in deprived areas. The GP supported de-medicalising of healthcare, the focus on prevention and in multipurpose hubs. These would need health and local authorities to work together and for the infrastructure to be available.

5.57 It was advised that developers were keen to build healthy places but needed guidance and the health benefit of places to be given weight in planning decisions. It was advised that current best practice was to have policy in the Local Plan to support delivery of the Joint Strategic Needs Assessment (JSNA).

Healthy Planning Protocol

5.58 The Public Health proposal is to develop and implement a Healthy Planning Protocol (HPP) to enable the integration of better health promotion and primary prevention into the design of West Berkshire homes, streets and communities. This consists of a suite of policy and guidance documents including the Health Impact Assessment (HIA). HIAs are considered best practice by the Office for Health Improvement and Disparities (OHID) and the Department of Health and Social Care (DHSC). HIAs are not mandated nationally, but Policy DM3 in the Local Plan would enable HIAs to be mandated locally.

5.59 The HPP will be a one stop shop for all the policies, service level agreements and templates for the HIA process. It includes the policy for developers, the service level agreement for the HIA refresh and maintenance and the service level agreement regarding the HIA review process. The HPP also includes a service level agreement on how planning and public health would work together and a roadmap for promoting health through the Local Plan. This is to help each stakeholder to understand what they can contribute and at what stage. Within the draft documents shared with the task group were the rapid HIA template (for developments below a defined threshold), the priority checklist by ward and the detailed HIA evidence checklist to support applicants and officers reviewing the HIA. The review checklist and response template were to make sure that any review of a HIA and HIA response was standardised whether by Planning or Public Health. The West Berkshire Observatory will hold the data and documents. This would enable them to be kept up to date as the health needs of the population changed.

5.60 Throughout the task group's work, Members reviewed the draft documents. They did this in collaboration with the ICB and planning who supported the work and met with public health outside of the task group to review in detail the draft documents and to discuss how to implement it at the pre-application stage. An officer task and finish group will be needed to finalise the HPP. The task group have welcomed the opportunity to work with public health and other stakeholders to carry out pre-scrutiny during the development of the draft HPP. Recommendations from the task group are proposed in section 6 of this report.

5.61 Members agreed that the HPP was very interesting, detailed and comprehensive. The standardised processes were welcomed. The detail on considering provision of public toilets, green spaces, benches, and growing areas were noted as examples.

5.62 Members noted that collaborative working with stakeholders was essential as well as officer capacity to do so. In particular to ensure healthcare needs as well as primary prevention were considered in reviewing HIAs when submitted and to maintain all the documents within the HPP so they remained fit for purpose and effective. As data was not always perfect, it was important to have supporting guidance that was effective and robust. This would ensure that local intelligence, for example from Members, and other public health intelligence was used.

5.63 It was advised that a strong policy and supporting documents were essential in ensuring this was robust in the appeals process. Firstly, it needed to be mandated in the Local Plan. Secondly, it was critical to keep the supporting data and documents up to date. The Planning Inspector would interrogate the evidence base and justification behind any requirements. If the evidence was sound, then the decision would more likely be upheld.

5.64 The task group were advised that the HPP would be a catalyst for more technical conversations with specific teams such as licencing around takeaways, alcohol consumption and vape stores. In addition, if a number of buildings were being developed that would prospectively be used for those types of licensing those conversations could happen early on. It was clarified that there was a process in place for reviewing licencing of hot food takeaways. Planning also had some say through land use class as takeaways needed a separate planning application and so the internal planning policies would be relevant.

5.65 Public Health engaged with the public as much as possible in their health needs assessments. It was more difficult for technical processes like this and so it was important the guidance documents were refreshed regularly, and that part of that should include public consultation. Opportunity for engagement could be built in, but it was highlighted that the evidence base needed to come from many sources such as data and public health intelligence from outreach programmes. It was clarified that public engagement was also an important part in the planning process right from the start. The public were keen to understand how developments were contributing to doctor's surgeries. The expectations on developers' engagement could be looked at. There could be guidance on what developers should be asking the public before HIAs were completed.

5.66 It was confirmed that large housebuilders were very well versed in HIAs. They would have specific experts with the knowledge needed to undertake the process. It may be more difficult for smaller developers and so the guidance alongside HIAs was very important. The rapid HIA was more straightforward and more likely to be used by the smaller developers. Public Health needed to provide any assistance and review the HIAs. As this wasn't a statutory function this could potentially be offered as a discretionary service that would be charged for.

5.67 Currently developers look to remove hazards they may be creating for example through environmental regulations, air quality, noise, traffic etc. In terms of factors to protect health, the promotion aspect is more difficult as it is more emotive and bespoke to a community. The HPP approach encourages the consideration of health-related circumstances specific to the district, a focus on health promotion as well as illness prevention, and suggests healthy features that developers can use in design.

5.68 It was confirmed that developers needed encouragement and guidance. The local authority should set the context, the issues and design solutions that would be encouraged that promote or enhance health, social care and children's services. For example, being clear about what health facility is needed, where and what size. This gives developers weight at the planning committee and so developers want to provide it and actively compete to be the healthiest. Without any weight being placed on health promotion and care in the planning balance, you just won't see the investment needed.

5.69 It was advised that negotiating S106 contributions should not be the first priority. There are advantages for developers to work with local authorities. By working together, the developer's viability is improved and they become more embedded in the community. It helps them retain staff. Developer contributions are too late.

5.70 The task group further considered the introduction of design guides to supplement the HPP. Design guides influence the design of new developments including green infrastructure, open spaces, play areas and design of buildings and homes. An alliance with a broad membership would bring the designs together. It was noted that the design guides would be an opportunity for a clear direction to developers before applications were made. Once at the pre-application stage, the influence was limited. These would need to be accessible and communicated clearly. Strategic health design meetings at local authorities bring planning and public health together would be needed. The ICB can be involved and awareness of this can be raised at the Developers Forum. These needed to be set up annually as health needs change.

5.71 It was asked to what extent could planning ask for certain aspects such as green space and benches. It was confirmed that there was high level support from the National Planning Policy Framework (NPPF). Negotiations need to focus on a package of works to show how developers would be creating an inclusive community and addressing the health indicators. Examples of good practice could be shared with developers as part of the HPP. DM3 in the Local Plan was to hold developers to account. It was highlighted that engagement with an appeal produced some useful statements from the Inspector who said that it was right for public open space and community centre land to be offered to the local council. It was hoped this could be used as a precedent for other developments.

5.72 It was confirmed that the Council has the 'policy hooks' in our emerging Local Plan. Policy DM3 health and wellbeing, SP7 Design Quality - which refers to Healthy Place Making and Policy SP10 which requires protection and enhancement of existing Green Infrastructure assets for the benefit of the health and wellbeing of the community. There is national guidance the Council can rely on in the meantime to strengthen the approach. The local authority can work with developers at the pre-application stage, can use the approach in master plans and implement through the planning process.

5.73 There was a discussion around insulation and noise reduction. Well-insulated properties were essential to tackle fuel poverty and for health and wellbeing. It was confirmed this was predominantly covered by building regulations and so planning were only occasionally involved if there was a conflicting land use. Policy CS15 of the West Berkshire Core Strategy and policy DM4 in the emerging Local Plan also supported this.

5.74 Representatives from the ICB supported the Healthy Planning Protocol and advised they would like to be involved in the development of the procedure / guidance on how Planning, ICB and applicants would work together to ensure the role and position of the ICB was clear. They agreed with the trigger points for reviewing it and the SLA's.

5.75 The task group highlighted that it was important that Members were involved in the development of the ward checklists because wards were not homogenous. Any LSOA's of particular concern could be flagged within the checklist. Member development sessions on health in all policies, the West Berkshire Observatory, the HPP and the public health prevention approach would be very beneficial.

5.76 A concern was raised around how facilities and amenities would be embedded in the community and maintained in the long term. Involving town and parish councils would be essential for continuity and accountability as well as local community engagement. This should be in collaboration with the local authority. Public Health involvement in monitoring and the build out phase was important. An example was shared where a bus route paid for by the developer for an initial two years was now an integral part in the bus network. These elements fitting in with the planning process can be integral keeping the communities sustainable.

5.77 A key challenge noted in the discussions was in communication between planning / developers and public health as they had differing priorities. However, it was advised that they were all working to the same objective. Developers were working for a profit, however there was Environmental and Social Governance (ESG) which they have responsibility to work to. There are also financial incentives. For example, if amenities and facilities were in the first phase of development, there is a premium on the land for the second phase. It was in developers' interest to embed and invest in communities. They can showcase the first phase. It was advised that the main approach needed to get developers on board was in recognising if they were providing healthy design and providing health features. To give them some credit for it and to encourage others to do the same. For those that are not, there is no planning weight to be received. They need credit for ticking all ESG components.

5.78 A further challenge was that there was no top-down directive for health in planning and so it needed to be raised by local authorities who defined their own local policy. There are limited resources in local planning teams and limited training and experience in HIAs. The quality of HIAs would be limited if they were not reviewed fully when submitted, if the implementation was not monitored and if the delivery was not confirmed. The resources needed to be available to make the HPP effective.

5.79 It was confirmed that other local authorities in Berkshire West were not as far ahead with this work, but there were other local authorities in other parts of the country further ahead and best practice was used in developing the policy and guidance. The task group felt that a review of the work by OHID would be very beneficial. When it was ready it would need to go to the developer's forum and a review of the communications around it should be carried out.

6 Recommendations

6.1 The Task and Finish Group wishes to put forward the following recommendations for consideration by the Executive and the BOB ICB.

6.2 **Recommendation 1**: **Planning and Health to continue to improve collaboration on planning consultations and in developing flexible ways of working well together**.

a) The Development Manager, Planning Policy Manager, Senior Primary Care Estate Manager and Senior Programme Manager (Primary Care Estates) to meet regularly to review their engagement on applications and that responses are timely and evidenced. To seek out and together review best practice regularly and make improvements in their ways of working. To hold each other to account and communicate effectively. To work closely on negotiations and to think broadly about the needs of the community and involve other stakeholders.

b) The West Berkshire Council Planning Team to work with GP practices directly to understand their needs and requirements for new developments.

c) The ICB to review how they work with GPs regarding the primary care needs of new developments and to consider any improvements that could be made.

6.3 Recommendation 2: New opportunities in funding and delivery of primary care in the community.

a) The Senior Primary Care Estate Manager and Senior Programme Manager (Primary Care Estates) to consider how they can input into the CIL charging structure when it is next reviewed. To be prepared through seeking best practice elsewhere to provide evidence requested and to be clear how much is needed for new developments.

b) The Planning Policy Manager to consider a review the CIL spending strategy.

c) The Council, in collaboration with key stakeholders, to consider the opportunity of health hubs or multipurpose community facilities. This could be owned by the local authority and leased to the ICB or GPs, or created by developers in the first phase of development and sold to GP practices for a nominal fee. To consider best practice, the local approach and new ways of delivering provisions. The NHS requirements to be built into the Council's wider thinking around multipurpose hubs.

d) The ICB to continue work on workforce planning and staffing to support any infrastructure and to work closely with the local authority. The Berkshire West Place Director to keep the Health Scrutiny Committee updated.

6.4 **Recommendation 3: The Healthy Planning Protocol**.

a) The Senior Programme Officer for the Wider Determinants of Health to request a peer review of the Healthy Planning Protocol from relevant colleagues at the Department for Health and Social Care (DHSC) that specialise in healthy place shaping and the planning process. Consider implementing any changes and recommendations that arise through the review.

b) Further collaboration by Senior Programme Officer for the Wider Determinants of Health, the Development Manager and Planning Policy Manager with developers to finalise guidance and supporting documents with developers. To consider how to guide developers when consulting with the public for HIAs.

c) The Health Scrutiny Committee to endorse the Healthy Planning Protocol, including Health Impact Assessments and any associated Service Level Agreements, to Heads of Service and Corporate Board.

6.5 **Recommendation 4: Implementation of the Healthy Planning Protocol.** Resources are needed to facilitate collaborative working and stakeholders need to be trained and have the appropriate expertise.

a) The Health Scrutiny Committee to endorse an application to Corporate Board/Financial Review Panel to approve a new Officer post whose role would include:

i. Overseeing the implementation of the HPP.
ii. Monitoring and maintaining all the documents within the HPP so they remained fit for purpose and effective.
iii. Reviewing submitted HIAs.
iv. Maintaining an active relationship with the ICB.
v. Supporting and guiding developers.
vi. Working with other stakeholders.
vii. Leading on the next phase of this work.

b) The Senior Primary Care Estate Manager and Senior Programme Manager (Primary Care Estates) to work with the Senior Programme Officer for the Wider Determinants of Health to ensure the HPP is suitable for the ICB and staffed accordingly. The ICB to ensure there is suitable resource to implement this effectively in collaboration with stakeholders.

c) The Planning Policy Manager and Development Manager to review if Planning have adequate resources needed to implement HIAs, improve collaboration and deliver the appropriate training. National guidance is available which can begin to strengthen the approach whilst the HPP is in development.

d) The Senior Programme Officer for the Wider Determinants of Health, Development Manager and Planning Policy Manager to consider how best to engage with developers, for example via the developers' forum, to encourage them to use healthy design, provide health features in developments, and remind them that such actions help to fulfil their own companies' ESG commitments.

e) Public Health to deliver a public health prevention approach workshop for all elected Members, including public health data skills (the West Berkshire Observatory and Public Health Outcomes Framework data) and the HPP.

f) The Senior Programme Officer for the Wider Determinants of Health, Development Manager and Planning Policy Manager to consider further training on healthy places in planning for all Members.

6.6 **Recommendation 5: Wider approach to Healthy Places.** The task group have heard evidence regarding the importance of creating a health-promoting legacy in new developments. In addition to the HPP, the below are recommended for further consideration:

a) The Council to explore 'design guides' or frameworks to supplement the HPP and supporting documents for prospective developers. These to be shaped around public health and council priorities.

b) The Council to consider community engagement and engagement with town and parish councils and West Berkshire Council Members for continuity and accountability in design and in keeping the communities sustainable.

6.7 The HSC may choose to accept the Task and Finish Group's recommendations in full or in part or amend the recommendations before putting them to the Executive and the BOB ICB. Alternatively, the HSC may choose not to put any of the Task and Finish

Group's recommendations to the Executive or ICB if it considers that they are not appropriate.

7 Conclusion

7.1 For the reasons outlined above, the recommendation is for HSC to accept the Task and Finish Group's recommendations in full and put them to the Executive and the BOB ICB for consideration.

8 Appendices

8.1 Appendix A – Healthcare in New Developments Task and Finish Group Terms of Reference.

Subject to Call-In:

Yes: ☐ No: ☒

The item is due to be referred to Council for final approval	☐
Delays in implementation could have serious financial implications for the Council	☐
Delays in implementation could compromise the Council's position	☐
Considered or reviewed by Scrutiny Commission or associated Committees, Task Groups within preceding six months	☒
Item is Urgent Key Decision	☐
Report is to note only	☐

Wards affected: All wards

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1	19 April 2024	Draft for Task Group / Officer feedback	
2	30 April 2024	Amended with Member and Officer feedback. For Corporate Board.	