Association of Directors of Public Health Yorkshire & Humber

Healthy Places Community of Improvement

Response to the Ministry of Housing, Communities and Local Government's Consultation: National Planning Policy Framework – proposed reforms and other changes to the planning system

March 2026

Purpose of consultation

In this consultation, the government sought views on a revised National Planning Policy Framework (NPPF) and other changes to the planning system. Beyond the draft Framework there were questions related to energy thresholds and data centres, standardised inputs in viability assessments and reforming site thresholds.

About ADPH Yorkshire and Humber Network and our Healthy Places Community of Improvement response

Please note that this response was written before the ADPH Yorkshire and Humber work on communicating for impact about commercial influences was completed. There may therefore be opportunities to strengthen some of the phrasing to align with best-practice framing guidance.

The Association of Directors of Public Health Yorkshire and Humber Network (ADPH YH) is a professional network of Directors of Public Health and health system leaders from across Yorkshire and Humber. It exists to support the delivery of better public health outcomes in the region and is a regional sub-group of the UK-wide Association of Directors of Public Health.

This response was written by members of the Yorkshire and Humber Healthy Places Community of Improvement (CoI), an initiative of the ADPH Yorkshire and Humber Network. The CoI brings together public health, planning and related professionals from across the region to strengthen the role of place in improving health and reducing inequalities. Through shared learning, collaboration and sector-led improvement, the CoI supports local authorities to embed public health more effectively into planning policy

and decision-making, recognising that the places people live in are fundamental drivers of health outcomes.

Yorkshire and Humber experiences some of the widest and most persistent health inequalities in England. Spatial planning therefore represents a critical upstream lever for addressing avoidable harm and narrowing health gaps. The quality, affordability and location of housing; access to green space and safe active travel; exposure to pollution and environmental risks; access to everyday services; and the strength of social and community infrastructure all shape health and wellbeing across the life course. These wider determinants of health must be treated as core planning considerations, not as secondary or implicit benefits.

The draft NPPF therefore offers a timely opportunity to strengthen the role of planning in addressing health inequalities and promoting population health. We welcome many of the proposals but urge the government to ensure that health-critical infrastructure, including the wider determinants of health, is explicitly protected from viability negotiations; that higher-density development around stations incorporates robust health safeguards; and that traveller site policy is strengthened to address the significant health inequalities experienced by Gypsy and Traveller communities. We strongly recommend that explicit reference to reducing health inequalities is reinstated within the Healthy Communities chapter, alongside clearer recognition of these wider determinants, so that planning policy and decisions are equipped to address the root causes of poor health and can support the Government's health mission, including the shift from treatment to prevention.

As public health professionals working in a region where more lives are cut short by preventable illness such as cancers, cardiovascular diseases, respiratory diseases and liver disease than would be expected compared to the England average, we want to highlight the opportunity of this NPPF review to emphasise the role of good governance in preventing conflicts of interest from shaping the environments in which we are born, live, work and age. The extent to which planning policy and decision-making is protected from conflicts of interest and vested commercial influences has a direct impact on health, through its influence on the air we breathe, the quality of our housing, the jobs we can access, the marketing we are exposed to, and the options available to us to eat well and be physically active.

We urge the government to ensure that evidence-based decision-making is protected from undue influence by interests that prioritise profit over health and wellbeing, and that planning decisions are informed by appropriate professional competence. This reflects what Yorkshire and Humber residents have said they want to see from government action, as reflected in the findings of two recent representative citizens' juries on tobacco, alcohol and unhealthy food (summary report available at https://www.yhphnetwork.co.uk/links-and-resources/our-shared-ambitions-and-

workstreams/commercial-determinants-of-health/citizens-juries-on-health-and-harmful-products). It also aligns with previous findings from YouGov's 2025 online survey conducted on behalf of ASH; sixty-seven percent of Yorkshire and Humber respondents said that health policy should be protected from the influence of unhealthy food and drink manufacturers and their representatives, in line with the overall national response. (YouGov Plc. online survey 10/02/2025 - 10/03/2025 of 13,314 GB adults, of which 1109 were Yorkshire and Humber residents).

In this context, public health infrastructure should not be understood solely as NHS or clinical facilities. While access to healthcare services is essential, health is largely created outside the healthcare system through the design and function of neighbourhoods, streets, homes and public spaces. The planning system therefore plays a central role in shaping the wider determinants of health, supporting prevention, resilience and long-term wellbeing, particularly in communities facing the greatest disadvantage.

We recognise that there is much within the draft NPPF that we welcome, including its continued emphasis on place-making, design quality and access to services, and the recognition that planning has a role in shaping healthier places. However, while the draft Framework continues to reference health, the explicit commitment in the December 2024 NPPF to reducing health inequalities — alongside clear examples relating to the wider determinants of health — is no longer clearly stated. In particular, the Healthy Communities chapter now places greater emphasis on the provision and retention of community facilities and public service infrastructure, while giving less prominence to the wider determinants of health that are critical to addressing inequalities in practice, including housing quality, transport and active travel, the food environment, access to green space, and the design of neighbourhoods that support everyday wellbeing. To support this in practice, viability testing reforms should prevent the erosion of agreed health standards, ensuring that health-critical infrastructure and mitigation are treated as baseline requirements rather than negotiable outcomes. The same principle applies to climate mitigation and adaptation measures, including emissions reduction, overheating prevention and flood resilience. These are fundamental to public health and should be secured as baseline requirements, not traded away through viability or phasing.

Across Yorkshire and Humber, we also consider the potential impacts of the proposed reforms on groups who already experience poorer health outcomes, including children and young people, older and disabled people, minoritised ethnic communities, Gypsy and Traveller communities, and people living in more deprived areas. A planning framework that does not explicitly foreground health inequalities risks embedding or exacerbating existing disadvantage, particularly where development pressures are greatest and local plans are out of date.

We have seen significant progress in recent years in collaboration between public health professionals and the planning system across Yorkshire and Humber, at both plan-making and decision-making stages. In practice, Public Health teams are increasingly supporting the development of planning policy, contributing local health evidence, and advising on planning applications to help ensure decisions support healthier outcomes. Public Health professionals should be meaningfully engaged in major planning decisions, and public health should act as a guiding principle across policy areas that shape the built and natural environment. Those making judgements about public health implications must be appropriately qualified to interpret evidence on mechanisms of harm and free from conflicts of interest. Greater and more consistent use of Health Impact Assessment would provide a practical, proportionate, and evidence-based means of identifying the positive and negative health impacts of development, including how impacts are distributed across different groups, and how harms can be mitigated and benefits maximised. Clear and consistent recognition of Public Health within the NPPF would help sustain and strengthen this collaborative approach, supporting effective partnership working and enabling planning to play its full role in improving population health and reducing inequalities.

Responses to consultation questions

Question 2: Do you agree with the new format and structure of the draft Framework which comprises separate plan-making policies and national decision-making policies?

Partly agree

Public Health Comment:

We partly agree that separating plan-making policies from national decision-making policies could improve clarity and usability. However, from a Public Health perspective there is a risk that this structure unintentionally sidelines health inequalities at the decision-making stage. If inequality and health impacts are assumed to have been "settled" during plan-making, but decision-making policies are less explicit, then health and equity considerations may carry reduced weight precisely where proposal-specific harms and cumulative impacts become clearer.

To avoid this, the decision-making section should retain explicit reference to addressing health inequalities and the wider determinants of health, including reinstating an explicit requirement for planning policy and decisions to reduce health inequalities (as currently set out in paragraph 96(c) of the December 2024 NPPF), so that evidence of harm or disproportionate impact can be acted upon at application stage as well as in plan preparation.

Question 4: Do you agree with incorporating Planning Policy for Traveller Sites within the draft Framework?

Partly agree

Public Health Comment:

We partly agree and welcome having a clear national position on Gypsy and Travellers provision, given the significant health inequalities experienced by these communities. However, the integration must work in practice across both plan-making and decision-taking. There is a risk that other national policies, such as density and land-use intensification, could conflict with traveller site needs if not explicitly reconciled.

Question 5: Do you agree with the proposed approach to simplifying the terminology in the Framework where weight is intended to be applied?

Neither agree nor disagree

Public Health Comment:

The clarification is helpful, but community considerations should also be given sufficient weight. If there is concern about NIMBYism unnecessarily preventing development, Health and Wellbeing needs and evidence can help demonstrate and support the validity of community concerns in decision-making. While health is mentioned in paragraph 16, it would have more weight if it were set out as a distinct objective explicitly including reducing inequalities; alternatively, paragraph 16(b) could be expanded to include reducing inequalities, though this would be less explicit. It should also be noted that a healthy workforce contributes to a strong economy

Question 6: Do you agree with the role, purpose and content of spatial development strategies set out in policy PM1?

Partly agree

Public Health Comment:

The Health and Social Care Act (2012) gave Local Authorities new duties and responsibilities for health improvement and protection. Local Authorities are required to use every lever at their disposal to improve and protect public health.

We partly agree with the role, purpose and content of spatial development strategies in policy PM1, but they would be stronger if they explicitly embedded a Health in All Policies (HiAP) approach. HiAP recognises that many of the most important determinants of health sit outside the health system, so decisions on housing, transport, employment, green infrastructure and environmental quality should systematically consider health implications and inequalities. In addition to this, spatial development strategies should

explicitly integrate climate mitigation, climate adaptation and inequalities together, not as optional or downstream considerations.

To deliver this in practice, Directors of Public Health and local public health teams should have a clear and formal role within spatial development strategy preparation and governance, helping ensure strategies create healthier physical places and reduce health inequalities across the strategy area.

Question 9: Do you agree with the role, purpose and content of local plans set out in policy PM2?

Partly agree

Public Health Comment:

We partly agree with the content of local plans in policy PM2, but they would be stronger if they explicitly embedded a Health in All Policies (HiAP) approach throughout plan-making, recognising that many key determinants of health sit outside the health system. Local plans should also make health more explicit and embed Health Impact Assessment (HIA) within plan preparation, with a clear link to the Framework's information requirements so expectations are transparent to applicants from the outset and health impacts and inequalities are systematically identified and addressed rather than treated as implicit.

Question 14: Do you agree with the approach to identifying land for development in PM9?

Partly agree

Public Health Comment:

Although general health needs can be evidenced at plan-making stage, until development proposals are produced the intention to reduce health inequalities can be difficult to maintain at decision-making stage. This is because known health needs and inequalities can inform policy direction, but site-specific impacts and the need to go beyond national baselines will only become clear once proposals come forward. The Framework should therefore be clearer that health and inequalities considerations are not confined to plan-making and must remain explicit and actionable during decision-making.

Question 16: Do you agree that policy PM12 increases certainty at plan-making stage regarding the contributions expected from development proposals?

Partly agree

Public Health Comment:

Greater certainty is welcome, but only if agreed contributions for health-critical infrastructure are genuinely secured and future-proofed. Funding agreed for infrastructure improvements should be guaranteed and inflation-linked so local authorities can deliver the essential infrastructure required to create and support healthy communities, rather than seeing provision eroded through delay or renegotiation.

Question 21: Do you agree with the principles set out in policy DM1?

Partly disagree

Public Health Comment:

Community consultation is vital, but too often becomes a box-ticking exercise. The Framework should strengthen safeguards so engagement is meaningful and inclusive (not constrained by pre-loaded questionnaires, not digital-only, and reflective of the cultural mix of an area), ensuring communities can genuinely influence decisions that affect health, wellbeing and inequality.

Question 22: Do you agree with the policy DM2 on information requirements for planning applications?

Partly disagree

Public Health Comment:

DM2 is a key opportunity to embed health systematically into decision-making and should include a mandatory requirement for a Health Impact Assessment (HIA) for major developments, produced by a competent person, with proportionate post-construction monitoring where appropriate. A standardised Health Impact Assessment template would support consistency and reduce burden, and inclusion within Annex C would make health considerations explicit rather than optional. HIAs are specifically designed to assess both positive and negative impacts, including how impacts are distributed across different population groups and inequalities.

Question 24: Do you agree with the principles set out in DM3?

Partly agree

Public Health Comment:

We partly agree with the intent of DM3 to support timely decision-making, but it must not result in health and wellbeing impacts being overlooked where specialist input is needed to understand exposure, vulnerability and mitigation. Where information is insufficient to assess health-relevant impacts, decisions should not be expedited at the expense of safety, amenity or equity. DM3 would be strengthened by ensuring public health expertise is embedded earlier in the process (including co-production on major schemes) and by making the aim of maximising health outcomes and reducing health

inequities explicit, recognising that health equity underpins sustainable growth and wider social and economic development.

Question 39: Do you have any views on the specific categories of development which the policy would allow to take place outside settlements, and the associated criteria?

Partly disagree

Public Health Comment:

The focus on rail stations as the primary proxy for connectivity risks overlooking affordability and real-world access. Rail travel is often more expensive than buses and rail-adjacent development can introduce noise impacts, especially on well-served lines or where services operate late. A more health-supportive approach would recognise other high-quality public transport nodes (including frequent express bus corridors), require safe active-travel connectivity and multi-modal access, and ensure infrastructure capacity and mitigation (including noise/air quality) are explicit requirements rather than assumptions. This approach should also align with wider policy aims on living conditions and healthy communities.

Question 40: Do you agree with the proposed approach to development around stations, including that it applies only to housing and mixed-use development capable of meeting the density requirements in chapter 12?

Partly agree

Public Health Comment:

We partly agree with the proposed approach to development around stations. From a public health perspective, concentrating housing and mixed-use development around well-connected transport nodes can deliver significant health benefits through increased opportunities for active travel, improved access to services and reduced car dependency.

However, higher-density development must be accompanied by robust health safeguards. Policy L3 and associated guidance should explicitly reference adequate daylight and sunlight standards, essential for circadian rhythm regulation, mental health and vitamin D synthesis, in accordance with Policy P3. Children's play space should be provided regardless of density constraints, in line with HC1(1)(d), and green infrastructure should meet locally specific standards, also consistent with HC1(1)(d). There must be adequate capacity within community and public service infrastructure, including GP surgeries, dental services and community facilities. Segregated active travel networks should be provided in accordance with TR4(1)(b), and appropriate air quality mitigation measures should be incorporated in line with Policy P3.

In addition, “well-connected” should reflect inclusive, real-world access and not rail connectivity alone. Station-area intensification should require safe multi-modal links, including infrastructure that supports walking and wheeling, secure cycle parking and step-free/level access at stations.

We are also concerned that intensification around stations may inadvertently displace existing traveller sites or informal encampments as land values rise. Local planning authorities should assess potential impacts on existing traveller communities before designating station-area intensification zones, identify and secure alternative provision before any displacement occurs, and consider the health needs of disabled people, older people and families with young children to ensure high-density environments are accessible and inclusive.

Question 42: Do you agree with the approach to planning for climate change in policy CC1?

Partly agree

Public Health Comment:

The recognition of climate change as a high priority is welcomed. We particularly support the proactive approach to both mitigation and adaptation, as both will be critical to safeguarding human health in the coming years. Measures such as baseline carbon assessments, green infrastructure and nature-based solutions also offer wider public health benefits.

UKHSA’s Health Effects of Climate Change in the UK: State of the Evidence 2023 highlights that many infectious diseases are climate-sensitive and that the health risks of climate change are not distributed equally across the population. To strengthen CC1’s illustrative list of risks, we would recommend explicitly referencing disease vectors (e.g., mosquito and tick breeding habitats) to reflect emerging and increasing climate-related health risks relevant to planning.

We also recommend CC1 more explicitly frames health (including reducing health inequalities) as a core pathway through which climate change affects communities, and makes clear that mitigation and adaptation measures should be designed to avoid exacerbating existing inequalities, given the disproportionate impacts on disadvantaged groups.

See:

https://www.gov.uk/government/publications/climate-change-health-effects-in-the-uk

https://www.thelancet.com/countdown-health-climate *(health co-benefits; climate change as major health risk, including vector spread/food/air/mental health)*

Question 43: Do you agree with the approach to mitigating climate change through planning decisions in policy CC2?

Strongly agree

Public Health Comment:

We welcome the substantial weight given to improving the energy efficiency of existing buildings and expanding district heat networks and renewable or low-carbon energy sources. However, reforms relating to existing buildings should go further, for example, by introducing minimum energy efficiency standards that alterations must meet. The planning system requires tools to ensure that both new and existing buildings achieve appropriate efficiency standards.

In addition, decision-making should be clear that developments which would result in significant greenhouse gas emissions should not be supported where those emissions cannot be demonstrably avoided, reduced and mitigated, particularly given that climate change disproportionately harms the health of more deprived communities.

Question 44: Do you agree with the approach to climate change adaptation through planning decisions in policy CC3?

Partly agree

Public Health Comment:

Policy CC3 (and DP3) could go further in preventing overheating as summer temperatures rise and heatwaves become more frequent. Paragraph (d) misses opportunities to emphasise passive cooling measures within new homes, such as dual-aspect ventilation and shading, and the potential for heat networks to provide cooling in summer, not just heating.

We would also welcome references to sufficient warmth in cold periods as well as sufficient cooling in hot periods; consideration of storms, including wind impacts, building and transport resilience, and emergency planning; and blue infrastructure, including water harvesting. The public health co-benefits of adaptation measures, such as benefits to mental health, protection of vulnerable groups and access to medicines during emergencies, should be highlighted, alongside adaptation measures relevant to disease vectors, for example the use of mosquito screens.

See: https://www.gov.uk/government/publications/healthy-homes

Question 47: Do you have any other comments on actions that could be taken through national planning policy to address climate change?

There is a missed opportunity for national planning policy to explicitly promote Health Impact Assessment (HIA) as a practical tool to inform both plan-making and decision-taking, ensuring climate risks, mitigations and inequality impacts are assessed transparently.

National policy should also be clear that climate action must not be reduced to individual behaviour change: where proposals would materially increase emissions, the burden should sit with the proposer to demonstrate avoidance, reduction and mitigation, and to show benefits outweigh health harms, particularly given disproportionate impacts on more deprived communities.

National policy should enable local authorities to set evidence-based standards that respond to climate risk, inequality and place-specific circumstances, rather than treating national minimums as maximum.

More broadly, a whole-system, place-based approach is needed so planning policies across sectors align on climate mitigation and adaptation, including ensuring critical infrastructure (transport, water and wastewater) is low-carbon and climate-resilient. Active travel should be prioritised as a core mitigation measure, reducing car dependency while delivering direct health co-benefits.

Question 48: Do you agree the requirements for spatial development strategies and local plans in policy HO1 and policy HO2 are appropriate?

Partly agree

Comment:

We partly agree, but the requirements would be stronger if they more explicitly embed a Health in All Policies approach, with local public health teams and Directors of Public Health actively involved in both local plans and spatial development strategies and adequately resourced to contribute at the appropriate tiers of plan-making. Early Health Impact Assessment is a practical way to ensure health, wellbeing and equity are embedded into design and infrastructure decisions from the outset, rather than addressed downstream.

To support a consistent national approach, national policy should also be clearer on expectations for housing quality aligned with Healthy Homes principles; homes that are safe, affordable, accessible, not overcrowded, well-ventilated and resilient over the life course, including "future-proofing" for ageing populations. Poor housing conditions such as damp and mould are well-evidenced contributors to respiratory and mental health harms and disproportionately affect deprived communities.

Question 49: Is further guidance required on assessing the needs of different groups, including older people, disabled people, and those who require social and affordable housing?

Strongly agree

Public Health Comment

Guidance should clarify how needs are evidenced and translated into plan requirements (including where to source local/national data to justify M4(3) wheelchair-accessible housing and quotas) and recognise that "health infrastructure" extends beyond healthcare to features that enable daily living (e.g. seating, shade/shelter, safe access). A practical way to strengthen delivery would be to require a proportionate HIA for major schemes, demonstrating who is affected, how needs/inequalities have been addressed, and how relevant groups were involved in design.

Question 56: Do you agree our proposed changes to the definition of designated rural areas will better support rural social and affordable housing?

Partly agree

Public Health Comment:

In principle this could increase delivery of affordable homes in rural areas, but there is a risk that affordability in housing cost alone is prioritised while supporting infrastructure and services lag behind, leaving residents, especially older and low-income households, isolated and more dependent on expensive travel. Guidance should ensure rural "affordability" accounts for total cost of living, including transport and energy, and that development is only supported where access to essential services and infrastructure is in place or secured with clear delivery triggers.

Question 57: Do you agree with our proposals to ask authorities to set out the proportion of new housing that should be delivered to M4(2) and M4(3) standards?

Partly agree

Public Health Comment:

We support requiring authorities to set proportions for M4(2) and M4(3), but these should be based on robust assessment of predicted need (particularly given an ageing population) with a clear minimum floor for M4(3), and the remainder predominantly M4(2) to support lifetime homes and reduce health and care pressures; exemptions should be tightly limited (e.g. self-build only).

Question 58: Do you agree 40% of new housing delivered to M4(2) standards over the plan period is the right minimum proportion?

Strongly disagree

Public Health Comment:

A 40% minimum risks normalising under-provision of accessible and adaptable homes given population ageing and disability needs. National policy should move to M4(2) as the

minimum standard for all new homes, as set out in Homes England's *Healthy Homes* core requirements, with M4(3) delivered in line with evidenced local need. This approach supports inclusive, lifetime housing, reduces the need for disruptive and costly retrofits, and helps people live independently for longer.

https://www.gov.uk/government/publications/healthy-homes ***Question 59: Do you agree the proposals to support the needs of different groups, through requiring authorities to identify sites or set requirements for parts of allocated sites are proportionate?***

Partly agree

Public Health Comment:

We partly agree that requiring authorities to identify sites (or set requirements within sites) for different groups is proportionate and necessary to shift delivery from a purely market-led model toward a needs-led approach that better reflects local population needs and inequalities. This approach should also recognise a wider range of groups with specific housing needs, where evidenced locally, including people with mental health needs, cultural requirements, households with children, and people who meet statutory homelessness duties. Homes England's Healthy Homes, a foundation for healthier and resilient communities emphasises inclusive design and the need to plan for diverse needs across the life course, and provides a useful reference point for broadening the list.

To ensure these requirements translate into healthy outcomes, guidance should be clearer on demonstrating that the wider environment supports health and wellbeing, including an explicit expectation for proportionate Health Impact Assessment for major schemes so localised health inequalities and infrastructure needs are identified and addressed through healthy placemaking. This should draw on recognised best practice (e.g. Building for a Healthy Life / Healthy Homes principles) and ensure requirements are responsive to neighbourhood-level need where appropriate, rather than relying only on district-wide averages.

Question 60: Do you agree with our proposals to ask authorities to set out requirements for a broader mix of tenures to be provided on sites of 150 homes or more?

Partly agree

Public Health Comment:

We partly agree with requiring a broader mix of tenures (and a mix of price points for market homes) because it supports mixed, inclusive communities across the life course and can help reduce housing-related health and social inequalities. However, the proposed 150-home threshold is likely too high in many places where development commonly occurs in smaller schemes; this risks limiting the tenure range to

predominantly market housing (and "affordable market" products that can remain unaffordable in high-value areas), pushing low- to middle-income households into poorer quality private renting where health inequalities can be worsened.

We therefore support a lower threshold so more schemes contribute to mixed tenure delivery, for example 50+ homes in urban areas, and 25-49 homes in semi-rural/rural areas, or equivalent locally appropriate thresholds where site sizes are typically smaller. Strong enforcement of housing standards is also essential; clearer requirements in policy will not translate into healthier homes without adequate inspection and compliance activity to ensure building standards and housing quality expectations are met in practice.

Question 63: Do you agree that proposals to add military affordable housing to the definition of affordable housing, and allow military housing to be delivered as part of affordable housing requirements, will successfully enable the provision of military homes?

Neither agree or disagree

Public Health Comment:

This could help enable delivery, but the policy needs clearer definition of what "military affordable housing" includes (serving personnel, veterans, families after relationship breakdown, etc.) so it aligns with existing Armed Forces housing guidance and avoids confusion.

Because it is restricted to a specific population (and may be tied to employment), counting it toward general affordable housing requirements could make plans look compliant while not increasing access for the wider population; safeguards are needed so civilian affordable supply is not displaced, especially in areas with significant military presence.

See: https://www.gov.uk/government/publications/improving-access-to-social-housing-for-members-of-the-armed-forces/improving-access-to-social-housing-for-members-of-the-armed-forces***Question 64: Do you agree flexibility relating to the size of market homes provided will better enable developments providing affordable housing?***

Strongly disagree

Public Health Comment:

The policy should be explicit about what "flexibility" means and what trade-offs are permitted. Further reducing the size of market homes is not an acceptable route to enable affordable housing delivery: the Nationally Described Space Standard (NDSS) exists to prevent sub-standard internal space and remains a key planning benchmark.

Downsizing homes further risks cramped living conditions and poorer wellbeing, and can reduce adaptability for changing needs (including disability), increasing the likelihood of disruptive and costly moves and undermining independence.

Overcrowding and insufficient living space are associated with poorer physical and mental health, increased stress, disturbed sleep and higher accident risk. National policy should therefore strengthen and enforce space and storage expectations (rather than weaken them), and ensure adequate inspection/compliance so agreed standards are delivered in practice.

https://www.gov.uk/government/publications/technical-housing-standards-nationally-described-space-standard ***Question 65: Would requiring a minimum proportion of social rent, unless otherwise specified in development plans, support the delivery of greater number of social rent homes?***

Partly agree

Public Health Comment:

A national minimum proportion would help increase delivery, but the "unless otherwise specified in development plans" caveat could weaken the proposal if it becomes an easy route to opt out. Any exemptions should therefore be narrowly defined and require clear, sustained evidence to avoid the policy being circumvented.

On health and equity grounds, a minimum social rent proportion is particularly important in higher-value areas, but it should be paired with requirements that social rent is tenure-blind in practice: distributed throughout schemes (not clustered), provided in a range of sizes, built to the same standards as market homes, and located with equitable access to amenities and transport (not in the least favourable parts of sites).

Question 72: Do you agree the with the criteria set out regarding the locations of specialist housing for older people?

Partly Agree

Public Health Comment:

We partly agree with the location criteria, but guidance should go further by requiring specialist older people's housing to meet age-friendly principles that reduce isolation and support healthy ageing in place. This goes beyond proximity to services and should include an accessible public realm: walkable neighbourhoods, well-maintained and well-lit pavements, step-free routes, seating, toilets, shade/shelter, and convenient access to green and public spaces.

Policy should also ensure that associated infrastructure requirements are not only identified but tested for accessibility and capacity (for example, primary care and community services), and that schemes include appropriate long-term management/maintenance arrangements where needed.

Finally, planning for ageing would be strengthened by building a wider pool of "homes for life" through higher baseline accessibility (e.g. M4(2) and needs-led M4(3)), supporting flexibility and intergenerational communities rather than concentrating accessibility only in specialist schemes.

See: https://ageing-better.org.uk/age-friendly-communities/eight-domains

Question 78: Do you agree the proposals to set out requirements for traveller sites at policy HO12 adequately capture relevant aspects from Planning Policy for Traveller Sites, whilst ensuring fair treatment for traveller sites in the planning system?

Partly agree

Public Health Comment:

We welcome the consolidation of traveller site policy into the main NPPF and the explicit recognition of health considerations within Policy HO12. The requirements relating to access to education, welfare and health services (HO12(1)(b)); opportunities for healthy lifestyles, including adequate play areas (HO12(1)(c)); and minimising adverse impacts from noise and air pollution (HO12(1)(c)) represent meaningful progress. Evidence consistently shows that Gypsy, Roma and Traveller communities experience some of the poorest health outcomes in England, including reduced life expectancy, higher infant mortality and a greater prevalence of long-term conditions (Marcelline, 2024). Strengthening the policy framework is therefore essential.

To enhance the effectiveness of Policy HO12, we recommend adding explicit requirements for adequate water supply and sanitation facilities, which are fundamental determinants of health and frequently inadequate on traveller sites. Clear expectations are needed that site locations should facilitate registration with local GP practices and NHS dental services, given the well-documented challenges traveller communities face in accessing primary care. There should also be an explicit restriction on locating traveller sites in areas of high flood risk, recognising that mobile accommodation is particularly vulnerable, and strengthened requirements for meaningful engagement with traveller communities throughout site design, allocation and ongoing management. Finally, HO12(1)(d) should be reinforced so that sites do not merely avoid visual isolation but actively promote genuine integration with surrounding communities, including shared access to community facilities and public services. The reference to 'personal circumstances' in HO12(2)(b) should explicitly include health needs, which may be particularly acute for some traveller families and should be treated as a material consideration in planning decisions.

Question 84: Do you agree that more emphasis should be placed on relevant national strategies and the need for flexibility in planning for economic growth, as drafted in policy E1?

Neither agree or disagree

Public Health Comment:

We recognise the importance of aligning plan-making with relevant national strategies and allowing flexibility to respond to changing economic demands, as proposed in Policy E1. However, we are concerned that the stronger emphasis on flexibility and national growth priorities risks weakening the consideration of wider impacts where emerging forms of infrastructure, such as data centres, are concerned. While these developments are increasingly framed as essential to economic growth and innovation, including through AI Growth Zones, they also have significant and tangible spatial, environmental and health implications that require careful local planning judgement.

Parliamentary evidence highlights that data centres have a substantial physical footprint, including very high energy demand, significant water consumption, and pressures on local infrastructure, as well as cumulative impacts where developments are clustered. Requiring plans to allocate sites for data centres "where a need exists or is anticipated", without clearer safeguards, risks constraining local authorities' ability to consider local capacity, resilience, and community health impacts in a proportionate and evidence-led way.

Health and the economy are inextricably linked. Economic policies within the NPPF should better reflect the need to balance national growth objectives with long-term social, environmental and health outcomes. An approach without sufficient policy hooks for assessing impacts on communities, inequalities and essential resources risks undermining sustainable development over the long term. Weight being given to those industries and employers who demonstrate they will improve the quality of employment, skills and pay in our deprived areas. Policy E1 would therefore be strengthened by clearer recognition that economic growth must be compatible with local health, wellbeing, climate, and infrastructure resilience, particularly for infrastructure-intensive developments such as data centres.

See:

- PHE (2021). *Inclusive and Sustainable Economies: Leaving No-one Behind, available at:* https://www.gov.uk/government/publications/inclusive-and-sustainable-economies-leaving-no-one-behindHouse Of Commons Library (2025). *Data centres: planning policy, sustainability, and resilience available at: https://commonslibrary.parliament.uk/research-briefings/cbp-10315/*

Question 88: Do you agree with the proposed changes to policy for planning for town centres?

Partly agree

Public Health Comment:

The policy drafted in section TC1: Planning for town centres recognises the need for diverse town centre uses, particularly the shift away from retail-heavy development, which is positive for creating more vibrant communities. While requiring a town centre strategy is helpful, it may prove problematic for authorities that do not yet have one in place.

It would be useful to provide a clearer definition of 'vitality' and 'viability' that also promotes community outcomes. The current wording around 'adjacent to town centres' can be problematic for authorities that have not yet adapted policies to define this consistently. The need to allocate suitable sites outside of town centres would assist in managing applications that attempt to circumvent these provisions. Local discretion in the use of Article 4 directions is welcome, as permitted development rights can lead to poor developments and poorer health outcomes.

Question 89: Do you agree with the approach to development in town centres in policy TC2?

Partly agree

Public Health Comment:

Supporting vibrancy is welcome, but diversification should not encourage health-harming uses (e.g., hot-food takeaways and gambling) so that residents are not exposed to avoidable harms. If TC2 enables more residential development in town centres, it should also ensure sufficient supportive infrastructure (including health and community services) and access to amenity/green space. Maintaining access to local businesses is a positive inclusion.

See: Gambling harms evidence review (OHID/PHE) available at https://www.gov.uk/government/publications/gambling-related-harms-evidence-review

Question 90: What impacts, if any, have you observed on the operation of planning policy for town centres since the introduction of Use class E?

Public Health Comment:

The sequential test, particularly in authorities without an adopted town centre policy, is sometimes used by applicants as a means to find a loophole in other policy requirements, i.e., arguments for why paragraph 97 should not apply to their application. For example, applicants have cited a requirement for drive-through facilities and the lack of suitable locations within the centre as a reason to locate near the centre instead. It should be made clear that any application of the sequential test must comply with other policies in the development plan and should not be used to overrule them. The inclusion of Class E is positive in that potentially health-harming uses have been kept separate.

However, the breadth of Class E can make it harder to steer town centres toward the mix of uses that best supports community health needs, and national policy could do more to support healthy food and other health-promoting/community uses. In addition, given well-evidenced gambling-related harms, stronger national support for local policies that limit the clustering of gambling premises would be welcome.

Question 91: Do you believe the sequential test in policy TC3 should be retained?

Neither agree or disagree

Public Health Comment:

The sequential test should consider not only proximity to the town centre but also sustainable transport and health access metrics to avoid perverse outcomes. It has, in part, been used to try to overturn objections to hot-food takeaway developments due to a desire for drive-through facilities that town centres cannot accommodate. The policy must be clear that the sequential test must comply with other policies within the plan. While a sequential test can encourage a healthier high street, it could also deter development in more local communities; opportunities to promote sustainable development in local neighbourhoods should therefore be incorporated.

Question 92: Do you agree with the approach to town centre impact assessments in policy TC4?

Partly agree

Public Health Comment:

An impact assessment would be a valuable addition but must also focus on health outcomes, including walkability and car access, the food environment and social infrastructure, and demonstrate why the proposed development cannot take place in the designated centre.

Question 116: Do you agree policy L2 provides clear guidance on how development proposals should be assessed to ensure efficient use of land?

Partly agree

Public Health Comment:

While the proposals in policy L2 would suitably prioritise the reuse of land or the restoration of buildings that have fallen into poor condition, this should be considered alongside the proposed site use and its connections to active travel links and other community facilities. There is a risk that this policy could lead to proposals for residential developments in areas with poor surrounding infrastructure.

It is important to emphasise the remediation of land and ensure that all developments comply with rigorous standards in relation to environmental health and surrounding

infrastructure. Although there is guidance on the types of development and areas that can be considered, 'efficient' use of land must still include provision for community facilities, shops and school places, either within developments or within the immediate area.

Linked to the points above on-site suitability and surrounding infrastructure, there is also a risk that giving weight to the poor condition or underuse of land could unintentionally encourage landowners to allow buildings or sites to deteriorate in order to justify redevelopment. Policy L2 could be strengthened by making clear that neglect will not be rewarded, and that options such as maintenance, re-use or community use as a community asset should be considered where appropriate before redevelopment is supported.

Question 121: Do you agree policy L3 provides clear guidance on achieving appropriate densities for residential and mixed-use schemes?

Partly disagree

Public Health Comment:

While rail is a valuable sustainable form of transport, consideration should also be given to other 'hubs', including schools, community assets and corridors along bus routes.

There is a risk that an emphasis on increasing density, when combined with "character of area" considerations, could reinforce existing inequalities, with already dense, lower-amenity areas intensifying further while less dense areas remain unchanged. Policy L3 should recognise that some areas may already be sufficiently dense, and that appropriate maximum densities may be needed alongside minimums.

Question 122: Do you agree with the minimum density requirements set out within policy L3?

Neither agree or disagree

a) **Please provide your reasons, particularly if you disagree.**

b) **Could these minimum density requirements lead to adverse impacts on Gypsies and Travellers and other groups with protected characteristics? Please provide your reasons, including any evidence**

Public Health Comment:

It is vital that any development complies with the space standards included in the National Model Design Code, and that homes meet required standards for outdoor space while prioritising quality over density driven solely by 'connectivity'. The policy should include clear guidance to ensure that protected groups, such as Gypsy and Traveller communities, are not removed from designated settlements.

Minimum density requirements could adversely impact Gypsy and Traveller communities if existing sites are redeveloped or their form of living is considered incompatible with density-led approaches. Policy L3 should be explicit that minimum densities must not result in displacement and that all homes continue to meet nationally described minimum internal and external space standards.

Section 123: Do you agree that using dwellings per hectare is an appropriate metric for setting minimum density requirements? Additionally, is our definition of 'net developable area' within the NPPF suitable for this policy?

Neither agree nor disagree

Public Health Comment:

Dwellings per hectare is an appropriate measure of a site's development potential if used alongside minimum standards for housing, open space and paths, while ensuring that wider community requirements, such as schools and shops, are catered for either within developments or within walking distance.

Question 124: Do you agree with the proposed definition of a 'well-connected' station used to help set higher minimum density standards in targeted growth locations? In particular, are the parameters we're using for the number of Travel to Work Areas and service frequency appropriate for defining a 'well-connected' station?

Partly disagree

Reasons and preferred alternatives:

The proposed definition places too much emphasis on Travel to Work Areas and rail-based connectivity, which is increasingly misaligned with hybrid and flexible working patterns where daily commuting is not always required. Defining a "well-connected" station would be more meaningful if it reflected average journey times to key town or city centres, alongside the affordability, frequency and operating hours of services. Over-reliance on rail risks overlooking frequent bus services, which are often more accessible and affordable, and therefore more relevant to day-to-day connectivity and health equity.

Question 146: Do you agree that policy DP1 provides sufficient clarity on how development plans should deliver high quality design and placemaking outcomes?

Neither agree or disagree

Public Health Comment:

DP1, by itself, does not provide clarity on delivering high-quality design. DP2 offers further clarification but neglects the importance of ensuring that design guides prioritise

community health by setting minimum standards for housing, paths and open space, and by ensuring good connectivity to local amenities.

In addition, paragraph 141 of the current NPPF recognises the negative impact that advertisements can have on the quality and character of places. Retaining this wording within Chapter 14: Achieving well-designed places would support local planning authorities in addressing the visual and community impacts of advertising through local plans and decision-making.

Question 147: Do you agree with the approach to design tools set out in policy DP2?

Partly agree

Public Health Comment:

The emphasis on community consultation, along with monitoring and review processes, is welcome. However, design codes should primarily aim to create well-designed places by ensuring good housing standards, access to open space and high-quality walking and wheeling routes. While recognising local context, strengthening "existing character" needs to take account of where existing character is weak, absent or of poor quality, so that poor design is not recreated. Design tools (including design codes) provide useful ways for collaboration and agreeing objectives and outcomes to support delivery. Policy DP2 could be strengthened by linking more explicitly to planning's social, economic and environmental objectives in Chapter 1, paragraph 16. Further advice has been developed by the Office for Health Improvement and Disparities on design codes and health and published by the Quality of Life Foundation in 2025.

Question 148: Do you agree policy DP3 clearly set out principles for development proposals to respond to their context and create well-designed places?

Partly agree

Public Health Comment:

Much of the guidance in DP3 is clear, however there is an opportunity to strengthen its impact by being more explicit about the role of design in supporting healthy living and reducing health inequalities. While health is referenced within specific criteria, an overarching statement that DP3 seeks to create well-designed places that promote healthy living for all, particularly in areas with identified health needs, would provide greater clarity and weight.

There is further scope to maximise the benefits of good design by explicitly discouraging private motor-vehicle dominance, prioritising active travel, and ensuring developments are within easy reach of local amenities and services. Transport systems play a key role in reducing health inequalities by enabling access to employment, education and essential services for those who cannot afford or use a car.

The policy could also be strengthened by encouraging the use of Health Impact Assessments early in the design process, aligning key principles with the Building for a Healthy Life framework, and ensuring design decisions actively promote inclusion and social cohesion. Consideration should be given to the risk of gentrification exacerbating inequalities, with meaningful community engagement embedded to ensure development benefits existing as well as future residents. Adequate resourcing for local authorities will be essential to deliver these principles effectively.

Question 149: Do you agree with the proposed approach to using design review and other design processes in policy DP4?

Partly agree

Public Health Comment:

The proposed approach to design review and related processes should help maintain quality from design through to completion and support more consistent decision-making. Their effectiveness will depend on the expertise represented at panel stage, particularly the ability to resist late-stage changes that could undermine design quality, placemaking and health outcomes. Inclusion of Public Health expertise within design review processes would strengthen consideration of health, wellbeing and inequalities.

The introduction of mandatory Health Impact Assessments for certain developments (for example, based on site size or number of units) would further ensure that health considerations are systematically embedded within design decisions rather than addressed retrospectively.

In addition, the reinstatement of paragraph 141 of the previous NPPF would strengthen the planning framework by recognising the cumulative impact of outdoor advertising on the quality and character of places. Its removal risks weakening local authorities' ability to address poorly designed or excessive advertising through design review and local plan policies, despite evidence that such impacts can negatively affect community wellbeing and sense of place.

Question 150: Do you agree that policy TR1 will provide an effective basis for taking a vision-led approach and supporting sustainable transport through plan-making?

Partly agree

Public Health Comment:

Early engagement in transport planning and prioritising development where infrastructure already exists are positive steps, as is encouraging a mix of uses to reduce the need to travel. From a Public Health perspective, TR1 should also be explicit that transport policy is a determinant of health, shaping physical activity, air quality, road

safety, social connection and access to essential services, and therefore has a direct role in reducing health inequalities.

However, the emphasis on "transport" risks being interpreted as prioritising vehicle movement rather than sustainable travel. TR1 should place greater emphasis on designing-in measures that discourage car use from the outset, such as filtered permeability, reduced parking provision and high-quality walking, wheeling and cycling infrastructure.

While a vision-led approach is welcomed, delivery may be challenging in practice given that many public transport services are operated by private providers, limiting the ability to guarantee affordability, frequency and long-term connectivity. Affordable, reliable and accessible transport is essential for enabling access to healthcare, education, employment and other health-promoting services, particularly for people without access to a car, those on low incomes, young people, older people and disabled people.

Transport policy should be explicit that its purpose includes enabling healthy lives and reducing health inequalities, through safe active travel, reduced exposure to air/noise pollution, road safety, and access to essential services for people without access to a car.

Active travel should be central to TR1, with safety embedded into infrastructure design to support physical activity and reduce health inequalities. Public Health should be closely involved in shaping transport and active travel infrastructure, working with communities to ensure it is suitable, inclusive and effective. We also recommend that TR1 explicitly refers to transport being accessible and affordable, to better reflect its role in promoting health, equity and opportunity.

Question 151: Do you agree that policy TR2 strikes an appropriate balance between supporting maximum parking standards where they can deliver planning benefits, and requiring a degree of flexibility and consideration of business requirements in setting those standards?

Strongly agree

Public Health Comment:

Ensuring that local authorities consider parking standards as part of their development plans is welcome, as it can actively discourage private vehicle use.

Question 152: Do you agree with the changes proposed in policy TR3(1a), including the reference to proposals which could generate a significant amount of movement, and the proposed use of the Connectivity Tool?

Strongly agree

Public Health Comment:

Ensuring that areas likely to generate significant movement are located where sustainable travel can be easily supported is welcome. Environmental impact assessments, along with opportunities to mitigate effects, should lead to better health outcomes; this could also include wider impacts on sustainable travel. Use of the Connectivity Tool is welcome in planning development, and the emphasis on sustainable travel is supported.

Question 153: Do you agree that proposed policy TR4 provides a sufficient basis for the effective integration of transport considerations in creating well-designed places?

Partly agree

Public Health Comment:

Proposals to prioritise pedestrians and connect developments to neighbouring areas are welcome. TR4 would be stronger if it explicitly recognised that transport and street design are determinants of health, shaping physical activity, air quality, road danger, social connection and access to services, so that "integration of transport" is not interpreted narrowly as traffic movement.

This could be strengthened by explicitly requiring connections to local centres and amenities to ensure a high-quality network of provision. Facilities that support sustainable travel are positive, but the policy could be clearer about reducing continuous on-street parking. Building around existing or planned infrastructure is welcome and sustainable. A focus on street arrangement can promote safe, sustainable use; an explicit preference for avoiding cul-de-sacs to promote more accessible travel would strengthen the policy.

Question 154: Do you agree with policy TR5 as a basis for supporting the provision and retention of roadside facilities where there is an identified need?

Partly agree

Public Health Comment:

Guidance for roadside facilities supported by evidence and local need is positive. Any larger facilities should ensure that healthy options are prioritised and that unhealthy options are not clustered.

Question 155: Do you agree that the amended wording proposed in policy TR6 provides a clearer basis for considering when transport assessments and travel plans will be required, and for considering impacts on the transport network?

Strongly agree

Public Health Comment:

Requiring transport assessments for developments likely to have impacts is welcome, and the expectation that developments should proceed without adverse impacts is a good threshold. To strengthen TR6, the guidance should make clear that "impacts" include health impacts, such as road safety, air quality exposure, inclusive access to services, and whether walking, wheeling and cycling are safe and viable, particularly for groups without access to a car. Further guidance on what constitutes 'significant movement' would clarify where these requirements should apply.

Question 156: Do you agree the proposed text in policy TR7 provide an effective basis for assessing proposals for marine ports, airports and general aviation facilities?

Partly agree

Public Health Comment:

The emphasis on improving facilities is welcome. However, the reference to an 'acceptable' environmental effect on air quality and related impacts should be more robust, ensuring that there are no direct or indirect adverse effects on local residents.

Question 157: Do you agree with the additional policy on maintaining and improving rights of way proposed in policy TR8?

Strongly agree

Public Health Comment:

Maintaining and improving rights of way supports physical activity and active travel, improves access to green space and local services, and can help reduce health inequalities, particularly for people without access to a car.

Question 158: Do you agree with the approach to planning for healthy communities in policy HC1, including the expectation that the development plan set local standards for different types of recreational land, drawing upon relevant national standards?

Partly agree

Public Health Comment:

Distinguishing between community facilities and public service infrastructure is sensible, and the explicit expectation that development plans set local standards for recreational land is welcomed. Provision of outdoor recreational space, including the example uses identified, will have a significant positive impact on population health, and greater clarity on expected levels of provision will support more consistent delivery.

The development plan sets out the required needs for different types of recreational land within the district. The evidence base includes a review of specific needs within a locality and deficiencies of land for open space. The site-specific policy within the Local Plan has

more detail on the open space requirements, the details of which can be secured by way of condition and Section 106 Agreement. This approach provides certainty and confidence that facilities can be delivered to support health and well-being.

However, HC1 would be stronger if it defined what a "healthy place" is, beyond health service infrastructure alone. Healthy placemaking should be framed around the wider determinants of health: safe and accessible housing, walkable/wheelable neighbourhoods, access to green space and play, clean air, and access to affordable healthy food as part of everyday infrastructure.

However, the proposed approach places a strong emphasis on physical infrastructure. Greater focus should be given to healthy placemaking and to the built and natural environments as the fundamental building blocks of health and wellbeing, rather than viewing health outcomes as a byproduct of infrastructure provision alone.

The policy could be strengthened by making the reduction of health inequalities more explicit within HC1 itself, reflecting the chapter objective and aligning with existing national policy and legislation. The draft should reinstate an explicit requirement for planning policy and decisions to reduce health inequalities (as currently set out in paragraph 96(c) of the December 2024 NPPF), so this remains a clear and weighted consideration in both plan-making and decision-taking.

While health needs are identified at plan-making stage, a full understanding of site-specific health impacts will only emerge once development proposals are brought forward. Requiring Health Impact Assessments for major developments, in a similar way to transport assessments, would help ensure that both positive and negative health impacts are systematically identified and given appropriate weight in decision-making.

HC1 would also benefit from clearer guidance on what constitutes essential community infrastructure needed to support healthy communities, beyond broad use-class definitions. Without this, mixed-use developments may technically comply while failing to meet everyday needs such as access to affordable food, services and spaces that support healthy living. Local health evidence, including Joint Strategic Needs Assessments and community engagement, could help define these needs and address existing infrastructure deficits. This would help ensure that "healthy communities" is delivered in practice, not just in principle.

Question 159: Do you agree that Local Green Space should be 'close' to the community it serves?

Partly disagree

Public Health Comment:

Retaining the term "reasonably close" allows for necessary local flexibility to reflect variations in geography, settlement patterns, and population characteristics.

The proximity of Local Green Space directly affects accessibility and use, and therefore the opportunities for local communities to benefit in terms of health. Access to green space supports physical activity, mental wellbeing and social connectedness, while also helping to reduce exposure to air and noise pollution. Ensuring that green space is embedded within walking distance of homes is particularly important for children, older people, disabled people and those without access to private transport, across inner-urban, edge-of-settlement and rural locations.

Local Public Health authorities should be supported to implement NICE Guidance NG90 on physical activity and the environment, including the provision and ongoing maintenance of green spaces and associated facilities such as seating, toilets and safe access routes. Improving transport and active-travel connectivity to Local Green Space will further help maximise health benefits and promote equitable access.

Local green spaces should be accessible to the community. Access to high quality recreation and nature is important for your physical and mental health. We note that a specific distance hasn't been provided to distinguish between the terminology close and reasonably close. We need to consider the specific context of each case. Green space should be accessible to all users, which includes the quality of existing and new routes to access these features. There is also the size of the community that is served by the green space, as well as its location and value.

Question 160: Do you agree that the proposed policies at HC3 and HC4 will support the provision of community facilities and public service infrastructure serving new development?

Partly agree

Public Health Comment:

Giving weight to proposals that provide new or improved community facilities and public service infrastructure increases the likelihood that development will meet the needs of local communities, particularly where growth is likely to increase demand, such as large housing schemes. The emphasis on healthcare, education, transport and other core services is welcomed. Co-design of play and community facilities can further strengthen outcomes, provided engagement is inclusive and reflects the needs of a diverse range of residents.

To maximise health benefits, HC3 and HC4 could be strengthened by more explicitly linking infrastructure provision to identified health needs and the reduction of health inequalities. While the policies address key services, they do not fully capture wider social determinants of health, such as access to healthy food, skills, training and employment opportunities, or the cumulative impacts of environments shaped by unhealthy commercial uses and advertising. Clearer recognition of these factors would help ensure that new development not only provides infrastructure, but actively supports healthier, more equitable communities.

National standards would be helpful where local requirements are not in place. It would provide more certainty for the decision-making process. However, it is important that there is some flexibility built into the process. The design of proposals for play facilities could be evaluated more at the beginning of the development process. The Statement of Community Involvement that is prepared as part of the planning application submission could have a specific section on play-related facilities with reference to the public consultation that was completed beforehand. There is an opportunity to show how the proposals have evolved with regard to the design of these features.

Question 161: Do you have any views on whether further clarity is required to improve the application of this policy, including the term 'fast food outlets', and the types of uses to which it applies?

Public Health Comment:

Yes. Further clarity is needed to ensure this policy is applied consistently and effectively. Evidence from Yorkshire and Humber indicates it is already working in practice across planning and Public Health teams, with stakeholders supporting its retention and strengthening. Clarification should therefore build on what works, while tightening definitions and expectations around "fast food outlets", scope of uses, and proximity criteria.

"Fast food outlets" is ambiguous in planning practice, particularly where premises operate within broader Class E uses (e.g. restaurants and bakeries), allowing shifts in operation without new permission and limiting councils' ability to manage cumulative impacts. Definitions should also address hybrid restaurant/takeaway premises, delivery-led dark kitchens, and drive-through restaurants (Use Class E).

National policy should set more robust definitions, including consideration of a specific Sui Generis use class for fast-food outlets, and ensure HFSS premises with a takeaway offer are captured regardless of business model. Using the Department of Health and Social Care classification ("fast food outlets per 100,000 population") would provide a consistent evidence base.

Clarity is also required on proximity to schools and other places where children and young people congregate. "Reasonable walking distance" should be defined as a measured walking distance from the site boundary, accounting for barriers such as major roads. An 800-metre threshold is widely supported and aligns with the 20-minute neighbourhood concept; alternatively, national policy could encourage evidence-based measures such as National Travel Survey 85th-percentile walking distances.

Finally, removing HC1 wording on preventing ill health and access to healthier food represents a shift from the 2024 framework. Retaining a clear prevention-focused framing would better reflect the purpose of the policy and its role in supporting population health

OHID (2025) *Wider Determinants of Health: statistical commentary on the location of fast food outlets,* available at: https://www.gov.uk/government/statistics/wider-determinants-of-health-february-2025-update/wider-determinants-of-health-statistical-commentary-february-2025

Question 162: Do you agree with the proposed approach to retaining key community facilities and public service infrastructure in policy HC6?

Neither agree or disagree

Public Health Comment:

While the approach appears sensible and could help preserve vital infrastructure and community assets, having only one of a particular type of facility in a place could introduce inequalities in access, depending on where the facility is sited and the geography of the area. Care is needed to ensure this policy is not applied in ways that exclude people or introduce inequalities in access to key services and infrastructure.

Rather than focusing solely on retaining existing community facilities, the emphasis should be on ensuring adequate availability, quality and diversity of facilities to support health, wellbeing and community cohesion. In some areas, particularly those with high deprivation and a lower availability and mix of facilities, this may not be achievable by prioritising retention alone.

It is important that communities have access to essential services and facilities, particularly in neighbourhoods that experience significant levels of health deprivation. In more rural locations, those services or uses could already be limited, and residents and visitors could be of particular benefit to families with young children, people who are less mobile, and the more vulnerable people within the community.

We do not agree that public houses should be included within this category, as they are not health-promoting assets; alternative community assets would better meet the criteria for promoting health and cohesion and reducing inequalities.

The onus is on the applicants to provide a supporting statement which includes evidence of marketing and viability to show that the use is no longer possible. There also needs to be some flexibility because replacement facilities could be a more effective provision, albeit on a smaller scale.

Question 163: Do you agree with the approach taken to recreational facilities in policy HC7, including the addition of 'and/or' with reference to quantity and quality of replacement provision?

Partly agree

Public Health Comment:

We welcome the widening of the definition to include informal play space and allotments, which form an important part of local community infrastructure. Care should be taken with the proposed wording to ensure that access is not negatively affected by trading quantity for quality. This should include impacts on proximity and usability for different groups, not just the standard of the replacement facility. This could impact different groups unequally within a local area. We suggest including a requirement that there should be no negative impact on access, in addition to no net reduction in provision.

Given the change in wording (from expecting replacement provision to be equivalent in quality and quantity to allowing quality or quantity), we recommend the policy reverts to 'and' so that replacement provision secures both benefits and does not create or exacerbate inequalities in access.

This policy could provide more flexibility for cases where a reduction in the number of facilities is offset by the quality as part of the planning balance. We acknowledge that quality over quantity can be effective in specific cases. However, we also need to mindful that there isn't a net reduction in facilities as a whole.

Question 164: Do you agree with the clarification that Local Green Space should not fall into areas regarded as grey belt or where Green Belt policy on previously developed land apply?

Neither agree nor disagree

Public Health Comment:

This requires clarification. The current wording does not make clear whether Local Green Space currently maintains its protections if it falls within the grey belt and would now lose these protections, or whether it currently does not maintain protections and this change would better retain them. The lack of clarity risks misinterpretation and potentially inconsistent implementation, which could put Local Green Space at risk.

Question 165: Do you agree with policy P1 as a basis for identifying and addressing relevant risks when preparing plans?

Strongly agree

Public Health Comment:

Policy P1 provides a sensible and effective basis for identifying and addressing risks at an early stage of plan-making. Early identification helps avoid siting populations, particularly vulnerable groups, in locations that are unsuitable and could cause harm to health. The emphasis on reducing pollution through development and identifying land required for public safety and security is also welcomed.

However, clarification would be helpful in relation to P1(1)(b)(iii), which refers to "unacceptable levels of pollution". This wording implies the existence of acceptable levels without explicitly recognising the cumulative impacts of pollution on health or the unequal burden experienced by more deprived communities. Consideration of existing health impacts and health inequalities should therefore be embedded within the assessment of pollution risk, to ensure that plans do not exacerbate existing harms and instead contribute to reducing inequalities.

Question 167: Do you agree with the criteria set out in proposed policy P3 as a basis for securing acceptable living conditions and managing pollution?

Partly agree

Public Health Comment:

This policy is welcome, particularly the acknowledgement of a wide range of pollution types, including noise pollution, which can have significant adverse impacts on mental health. The inclusion of clear criteria helps define what is meant by "acceptable" living conditions and provides a stronger basis for consistent decision-making.

The policy could be strengthened by more explicitly referencing the role of high-quality building design and infrastructure in reducing exposure to pollution, including adequate ventilation, insulation and overheating mitigation. This would help address indoor air quality issues such as damp, mould and heat pollution, and support alignment with Awaab's Law.

Further clarity would also be beneficial in relation to how health impacts are assessed. The concept of an "unacceptable" adverse effect on health may vary depending on who is affected, particularly where vulnerable or disadvantaged groups experience disproportionate exposure. Requiring a Health Impact Assessment for relevant developments would help ensure that impacts on different population groups are clearly identified and addressed, and that acceptable living conditions are secured from the outset.

In addition, proactive measures to reduce pollution should be encouraged where feasible, including approaches to domestic combustion, waste processing impacts, and the promotion of low-emission transport. Care should be taken to ensure that pollution reduction strategies do not inadvertently exacerbate health inequalities.

Question 168: Do you agree policy P4 makes sufficiently clear how decision-makers should apply the agent of change principle?

Strongly agree

Public Health Comment:

The policy is broadly sound. Additional clarity will help ensure consistent application and require developers to own and mitigate any impacts of development on population health.

Question 169: Do you agree policy P5 provides sufficient basis for addressing possible malicious threats and other hazards when considering development proposals?

Strongly agree

Public Health Comment:

This is broadly sensible. Appropriate and consistent safeguarding in relation to hazardous sites will help ensure that potential impacts on population health are mitigated.

Question 170: Do you agree that substantial weight should be given to the benefits of development for defence and public protection purposes?

Partly agree

Public Health Comment:

Applying some additional weight is reasonable, but this should not remove the expectation that developers mitigate potential negative health impacts on local communities. All possible steps should be taken to identify and mitigate any adverse effects on population health. Developers should consult extensively with local communities to ensure voice and influence in the process and that concerns are considered. The NPPF should also clarify what constitutes a 'development for defence and public protection purposes', with rationale and examples.

Question 179: Do you agree that the proposed approach to planning for the natural environment in policy N1, including the proposed approach to biodiversity net gain, strikes the right balance between consistency, viability, deliverability, and supporting nature recovery?

Partly agree

Public Health Comment:

Clearer use of LNRS and minimum green infrastructure standards is positive and welcome. It should be clear that this is a balance between natural capital and development needs, with decisions taken in the best interests of local communities.

Question 180: In what circumstances would it be reasonable to seek more than 10% biodiversity net gain on sites being allocated in the development plan, especially where this could support meeting biodiversity net gain obligations on other neighbouring sites in a particular area?

Local planning authorities should determine their approach, supported by local evidence and insight, although national guidance on potential criteria would be helpful. One example would be where there are clear public health co-benefits or a need to address existing inequalities, for instance in heat-risk wards, air quality exceedance areas or LNRS priority corridors.

Requirements that exceed statutory expectations should be supported by a clear and transparent rationale and justification, drawing on local and national planning policy and considering viability. Local criteria for decision-making should be publicly available and applied consistently. Using higher BNG from particular sites to substitute for sites that cannot meet the statutory requirement should be approached with caution, as it could create inequalities if sites are not close to one another, i.e., one community benefits at another's expense. While the wording refers to 'neighbouring sites', that does not remove the risk of hyper-local inequalities. Developers should face a high burden of proof for not delivering the minimum statutory BNG on-site, having taken all reasonable steps before considering alternative locations.

It may also be reasonable to seek higher biodiversity net gain on sites located in areas where there is an existing and evidenced lack of access to public green space in the immediate vicinity, to help address long-standing deficits in environmental quality and associated health outcomes.

Question 181: Do you agree policy N2 sets sufficiently clear expectations for how development proposals should consider and enhance the existing natural characteristics of sites proposed for development?

Strongly agree

Public Health Comment:

Policy N2 provides a sensible and positive framework for ensuring development proposals recognise and enhance the existing natural characteristics of sites. This approach supports biodiversity, environmental quality and wider health and wellbeing outcomes.

There is an opportunity to further strengthen long-term public health benefits by encouraging additional measures such as minimum shade-tree ratios, noise-mitigation planting and community stewardship arrangements to support ongoing maintenance and use. Consideration could also be given to incorporating edible native planting and community gardens, which can improve access to affordable fresh food while supporting sustainability and community cohesion. The use of innovative and best-practice sustainable drainage systems could also help deliver multiple benefits, including biodiversity enhancement, cooling, and improved water management.

Question 182: Do you agree the policy in Policy N4 provides a sufficiently clear basis for considering development proposals affecting protected landscapes and reflecting the statutory duties which apply to them?

Partly agree

Public Health Comment:

Using 'substantial weight' for consistency is acceptable, provided parity with statutory duties is clear. It is positive that the importance of mitigation is emphasised. Mitigation should consider health impacts and seek to preserve or enhance access to ensure continuity of health benefits for all groups and communities. Compensation in cases of significant harm that cannot be mitigated may be necessary but is not desirable; if mitigation is not possible, whether the development should proceed at all should be carefully considered.

Question 183: Do you agree policy N6 provides clarity on the treatment of internationally, nationally and locally recognised site within the planning system?

Strongly agree

Public Health Comment:

This appears helpful and should support a clear and consistent approach. We would encourage accessible local site registers for transparency and to aid both developers and communities.

Question 184: Are there any further issues for planning policy that we need to consider as we take forward the implementation of Environmental Delivery Plans?

Environmental Delivery Plans should integrate health metrics, including shade, air quality, noise and active travel, set monitoring baselines with public reporting, and align with developer contribution menus to streamline delivery. Guidance should make clear that only fully policy-compliant schemes (including health infrastructure requirements) should be used as comparators, and that viability assessments must explicitly state whether comparator schemes met health-related policy requirements.

We also recommend publication of a register of policy-compliant schemes to inform benchmark values, and training and guidance for planning officers on identifying and excluding non-compliant comparators.

Question 193: Do you have any further thoughts on the policies outlined in this consultation?

Overall, the draft policies would benefit from more explicit and consistent consideration of the social determinants of health and a clearer intent to reduce inequalities. While health is referenced across the framework, it is often implicit rather than weighted in decision-making. Introducing a mandatory Health Impact Assessment for major

developments, alongside clearer expectations on meeting health and wellbeing needs, would help address this gap. In addition, flexibility over space standards and increased density, especially in town centres, risks reducing amenity and exacerbating existing deficits in green space and community infrastructure in more deprived areas. Stronger emphasis on social cohesion, cultural uses and the provision of communal spaces within higher-density development would help ensure growth supports inclusive, healthy and resilient communities.

The following part of the response was copied from the prepared introduction, as there was no-where else within the survey to submit it:

Our region, Yorkshire and Humber, experiences some of the widest and most persistent health inequalities in England. Spatial planning therefore represents a critical upstream lever for addressing avoidable harm and narrowing health gaps. The quality, affordability and location of housing; access to green space and safe active travel; exposure to pollution and environmental risks; access to everyday services; and the strength of social and community infrastructure all shape health and wellbeing across the life course. These wider determinants of health must be treated as core planning considerations, not as secondary or implicit benefits.

The draft NPPF therefore offers a timely opportunity to strengthen the role of planning in addressing health inequalities and promoting population health. We welcome many of the proposals but urge the government to ensure that health-critical infrastructure, including the wider determinants of health, is explicitly protected from viability negotiations; that higher-density development around stations incorporates robust health safeguards; and that traveller site policy is strengthened to address the significant health inequalities experienced by Gypsy and Traveller communities. We strongly recommend that explicit reference to reducing health inequalities is reinstated within the Healthy Communities chapter, alongside clearer recognition of these wider determinants, so that planning policy and decisions are equipped to address the root causes of poor health and can support the Government's health mission, including the shift from treatment to prevention.

As public health professionals working in a region where more lives are cut short by preventable illness such as cancers, cardiovascular diseases, respiratory diseases and liver disease than would be expected compared to the England average, we want to highlight the opportunity of this NPPF review to emphasise the role of good governance in preventing conflicts of interest from shaping the environments in which we are born, live, work and age. The extent to which planning policy and decision-making is protected from conflicts of interest and vested commercial influences has a direct impact on health, through its influence on the air we breathe, the quality of our housing, the jobs we can access, the marketing we are exposed to, and the options available to us to eat well and be physically active.

We urge the government to ensure that evidence-based decision-making is protected from undue influence by interests that prioritise profit over health and wellbeing, and that planning decisions are informed by appropriate professional competence. This reflects what Yorkshire and Humber residents have said they want to see from government action, as reflected in the findings of two recent representative citizens' juries on tobacco, alcohol and unhealthy food (summary report available at https://www.yhphnetwork.co.uk/links-and-resources/our-shared-ambitions-and-workstreams/commercial-determinants-of-health/citizens-juries-on-health-and-harmful-products). It also aligns with previous findings from YouGov's 2025 online survey conducted on behalf of ASH; sixty-seven percent of Yorkshire and Humber respondents said that health policy should be protected from the influence of unhealthy food and drink manufacturers and their representatives, in line with the overall national response. (YouGov Plc. online survey 10/02/2025 - 10/03/2025 of 13,314 GB adults, of which 1109 were Yorkshire and Humber residents).

In this context, public health infrastructure should not be understood solely as NHS or clinical facilities. While access to healthcare services is essential, health is largely created outside the healthcare system through the design and function of neighbourhoods, streets, homes and public spaces. The planning system therefore plays a central role in shaping the wider determinants of health, supporting prevention, resilience and long-term wellbeing, particularly in communities facing the greatest disadvantage.

We recognise that there is much within the draft NPPF that we welcome, including its continued emphasis on place-making, design quality and access to services, and the recognition that planning has a role in shaping healthier places. However, while the draft Framework continues to reference health, the explicit commitment in the December 2024 NPPF to reducing health inequalities — alongside clear examples relating to the wider determinants of health — is no longer clearly stated. In particular, the Healthy Communities chapter now places greater emphasis on the provision and retention of community facilities and public service infrastructure, while giving less prominence to the wider determinants of health that are critical to addressing inequalities in practice, including housing quality, transport and active travel, the food environment, access to green space, and the design of neighbourhoods that support everyday wellbeing. To support this in practice, viability testing reforms should prevent the erosion of agreed health standards, ensuring that health-critical infrastructure and mitigation are treated as baseline requirements rather than negotiable outcomes. The same principle applies to climate mitigation and adaptation measures, including emissions reduction, overheating prevention and flood resilience. These are fundamental to public health and should be secured as baseline requirements, not traded away through viability or phasing.

Across Yorkshire and Humber, we also consider the potential impacts of the proposed reforms on groups who already experience poorer health outcomes, including children and young people, older and disabled people, minoritised ethnic communities, Gypsy and Traveller communities, and people living in more deprived areas. A planning framework that does not explicitly foreground health inequalities risks embedding or exacerbating existing disadvantage, particularly where development pressures are greatest and local plans are out of date.

We have seen significant progress in recent years in collaboration between public health professionals and the planning system across Yorkshire and Humber, at both plan-making and decision-making stages. In practice, Public Health teams are increasingly supporting the development of planning policy, contributing local health evidence, and advising on planning applications to help ensure decisions support healthier outcomes. Public Health professionals should be meaningfully engaged in major planning decisions, and public health should act as a guiding principle across policy areas that shape the built and natural environment. Those making judgements about public health implications must be appropriately qualified to interpret evidence on mechanisms of harm and free from conflicts of interest. Greater and more consistent use of Health Impact Assessment would provide a practical, proportionate, and evidence-based means of identifying the positive and negative health impacts of development, including how impacts are distributed across different groups, and how harms can be mitigated and benefits maximised. Clear and consistent recognition of Public Health within the NPPF would help sustain and strengthen this collaborative approach, supporting effective partnership working and enabling planning to play its full role in improving population health and reducing inequalities.

Question 200: Would you support the use of growth testing for strategic, multi-phase schemes?

Partly agree

Public Health Comment:

We partly support growth testing for strategic, multi-phase schemes only if health-critical infrastructure is treated as a fixed baseline rather than a negotiable output. These schemes can deliver the biggest population-health gains, but only when green infrastructure, active travel, play space and healthcare capacity are embedded at the outset and secured through phase-gated triggers that prevent later dilution. Growth testing should not become a mechanism for deferring, down-specifying, or re-timing health measures beyond the point where early residents bear the health costs.

Question 201: Would you support the optional use of growth testing for regeneration schemes?

Partly agree

Public Health Comment:

Regeneration often takes place in areas with higher health need and deprivation, so flexibility may unlock delivery but also carries a heightened risk of entrenching inequalities if standards are weakened. Growth testing should therefore include explicit safeguards to prevent regeneration areas receiving lower quality environments or reduced health infrastructure, given historic patterns where deprived communities have borne disproportionate harms. The appropriate balance is to allow delivery flexibility around sequencing, not around minimum health standards or baseline infrastructure contributions.

Question 202: Do you agree greater specificity, including single figures, which local planning authorities could choose to diverge from where there is evidence for doing so, would improve speed and certainty?

Strongly agree

Public Health Comment:

Greater specificity would reduce the scope for negotiations that too often erode health outcomes through "value engineering". Clear benchmark assumptions (including a standardised developer return with evidence-based flexibility) can speed decisions if paired with an explicit rule that health-critical infrastructure costs are priced in first, not treated as residual. From a Public Health perspective, the key benefit of specificity is not just speed but protecting minimum health standards from being traded away.

Question 203: Are there any site types, tenures, or development models to which alternative, lower figures to 15-20% of Gross Development Value might reasonably apply?

Public Health Comment:

Lower return expectations may be reasonable where schemes deliver demonstrable public value above baseline, such as genuinely higher-than-policy affordable housing, measurable improvements to green infrastructure, or high-quality active travel provision that reduces car dependence. A lower allowance can also be appropriate for affordable tenures where risk profiles differ, provided this does not create a route to re-open health-critical infrastructure as negotiable. Any lower figure should therefore be conditional on full delivery of baseline health standards and transparent evidence of additional health and equity benefit.

Question 204: Are there further ways the government can bring greater specificity and certainty over profit expectations across landowners, site promoters and developers such that the system provides for the level of profit necessary for development to proceed, reducing the need for subjective expectations?

Public Health Comment:

Guidance should make explicit that land value expectations must adjust to policy requirements, not the other way round. To reduce subjectivity and protect health outcomes, government could publish standard cost assumptions for health-critical infrastructure and require viability reports to show these as non-discretionary inputs before profit is assessed. This would reduce "bargaining space" and ensure viability is not used to normalise under-provision of health-supportive environments.

Question 205: Existing Viability Planning Practice Guidance refers to developer return in terms a percentage of gross development value. In what ways might the continued use of gross development value be usefully standardised?

Public Health Comment:

If GDV remains the core metric, standardisation should focus on preventing health protections being reframed as optional. Whatever model is used, it should require a clear separation between baseline health requirements (treated as fixed) and truly discretionary enhancements. Standardisation must not inadvertently create a template that enables developers to justify reduced health infrastructure as a normal response to viability pressure.

Question 206: Do you agree there circumstances in which metrics other than profit on gross development value would support more or faster housing delivery, or help to maximise compliance with plan policy?

Neither agree nor disagree

Public Health Comment:

Alternative metrics may help in some contexts, but the key test is whether they secure required health outcomes with equal or greater certainty than GDV-based approaches. We would be neutral on the metric choice provided it does not enable trading away minimum health standards, and provided it still supports transparent scrutiny of whether schemes are meeting obligations for green infrastructure, active travel, play and healthcare capacity.

Question 207: Are there types of development on which metrics other than profit on gross development value should be routinely accepted as a measure of return e.g. strategic sites large multi-phased schemes, or build to rent schemes?

Public Health Comment:

It may be reasonable to accept alternative return metrics for strategic multi-phase schemes or build-to-rent models where cashflow, phasing and management structures differ. However, this should only occur where policy explicitly locks in baseline health-critical infrastructure through enforceable triggers and maintenance

arrangements. The metric should not matter if delivery is protected; the risk is only when a metric change creates new scope to renegotiate health safeguards.

Question 208: Do you agree that guidance should be updated to reflect the fact a premium may not be required in all circumstances?

Strongly agree

Public Health Comment:

It may be reasonable to accept alternative return metrics for strategic multi-phase schemes or build-to-rent models where cashflow, phasing and management structures differ. However, this should only occur where policy explicitly locks in baseline health-critical infrastructure through enforceable triggers and maintenance arrangements. The metric should not matter if delivery is protected; the risk is only when a metric change creates new scope to renegotiate health safeguards.

Question 209: Do you agree that extant consents should not be assumed to be sufficient proof of alternative use value, unless other provisions relating to set out in plans are met?

Strongly agree

Public Health Comment:

Extant consents often pre-date current standards for health, space, active travel and environmental mitigation, and should not automatically anchor benchmark land values. If treated as proof of alternative use value, they can entrench under-provision of green infrastructure, play space and healthcare capacity for the next generation of schemes. Extant consents should therefore only carry weight where they demonstrably met current health-related policy requirements.

Question 210: If extant consents were not to be assumed as sufficient proof of alternative use value, should this be at the discretion of the decision-maker, or should another metric (e.g. period of time since consent granted) be used? (Select from: Decision maker discretion / Another metric / Neither)

Decision maker discretion

Public Health Comment:

Decision-maker discretion is essential because the health implications of an older consent depend on what it delivered, not merely when it was granted. A time-based proxy risks embedding outdated standards and could legitimise weaker health provision. Discretion allows decision-makers to test whether relying on an extant consent would undermine present-day requirements for health-critical infrastructure.

Question 211: What further steps should the government take to ensure non-policy compliant schemes are not used to inform the determination of benchmark land values in the viability assessments that underpin plan-making?

Benchmark land values should be informed only by schemes that are demonstrably policy-compliant, including on health infrastructure. Viability reports should be required to state clearly whether comparator schemes met relevant health and wellbeing standards, and comparators that failed those standards should be excluded. A publicly accessible register of compliant comparators and targeted training for officers would strengthen consistency and reduce "race to the bottom" dynamics.

Question 212: Do you agree that the residual land value of the development proposal should be cross-checked with the residual land values of comparable schemes; to help set the viability assessment in context?

Strongly agree

Public Health Comment:

Cross-checking improves transparency and can deter manipulation, but only if the comparator set is credible. Comparable schemes used for cross-checks should demonstrate delivery of baseline health-critical infrastructure; otherwise the cross-check simply normalises poor health outcomes. This is a practical safeguard against embedding historic under-provision into future valuations.

Question 213: Do you agree that a 2.5 hectare threshold is appropriate?

Neither agree nor disagree

Public Health Comment:

A 2.5 hectare threshold may be workable administratively, but it should not obscure cumulative health impacts. Multiple sub-threshold schemes can collectively overload GP capacity, open space provision and safe active travel networks, particularly in growth areas. Guidance should therefore encourage cumulative impact assessment where there is evidence of clustering or phased delivery that would otherwise evade health-related obligations.

Question 214: Do you agree that a unit threshold of between 10 and 49 units is appropriate?

Partly agree

Public Health Comment:

A unit threshold may assist proportionality, but it risks creating incentives to fragment schemes to avoid requirements. Core health protections, particularly space standards, basic green infrastructure and safe walking/wheeling/cycling connectivity, should apply

irrespective of scheme size so that smaller developments do not cumulatively degrade health outcomes. Thresholds should govern process intensity, not whether minimum health standards apply.

Question 217: Do you have any views on whether the current small development exemption should be extended to cover a wider range of sites – indicatively to sites of fewer than 50 dwellings, or fewer than 120 bedspaces in purpose-built student accommodation?

We would caution against extending the exemption in ways that reduce the resources available to support building safety and safe living conditions. Purpose-built student accommodation should not be treated as lower priority from a health and safety perspective; it houses a concentrated population and should meet robust safety and wellbeing standards. Any exemption approach should be justified transparently and should not incentivise models that compromise internal space, amenity, or long-term maintenance and accountability.

Question 218: If the exemption were to be extended, do you have any views on whether the development of 120 purpose-built student accommodation bedspaces is an appropriate equivalent to a development of 50 dwellings for the purposes of the levy exemption?

Bedspaces and dwellings are not directly comparable units for the purposes of exemption because they can create different patterns of density, service demand, and management arrangements. If an equivalence is retained, it should be supported by evidence on occupancy, building form and safety management, and it should not weaken protections for building safety, internal space and wellbeing.

Question 220: If you do have views on possible changes to the small developments levy exemption, please specify the potential impact of the possible change of the levy exemption on people with protected characteristics as defined in section 149 of the Equality Act 2010.

Changes to exemptions could disproportionately affect people with protected characteristics if they reduce the supply of safe, accessible, genuinely affordable homes or delay delivery of supported housing and adaptations. Approaches that enable not-for-profit delivery models (including community-led housing) can support inclusion and stability, provided safety, accessibility and maintenance accountability are secured.

Question 221: What do you consider to be the potential economic, competitive, and behavioural impacts of possible changes to the levy exemption? Please provide any evidence or examples to support your response.

Extending exemptions may create behavioural incentives to favour development models that are less aligned with long-term affordability and stable communities. In some

markets, large volumes of PBSA can coincide with wider rental pressure and affordability challenges for local residents; the levy design should avoid worsening housing insecurity and should support safe, affordable homes that meet long-term need.

Question 224: Do you have any views on the impacts of the above proposals for you, or the group or business you represent and on anyone with a relevant protected characteristic? (Yes/No)

Yes

Public Health Comment:

People with protected characteristics are more likely to be affected by poor housing quality, inaccessible environments, unsafe streets, and lack of affordable transport and local services. Where the framework prioritises growth without explicit mechanisms to reduce existing inequalities, there is a risk that disadvantage becomes further entrenched, particularly in already deprived areas with limited green space and infrastructure. Ensuring developments support safe, inclusive communities and meet differing needs across the life course is central to reducing unequal health outcomes.

Question 225: Is there anything that could be done to mitigate any impact identified?

Impacts could be mitigated by making reducing health inequalities an explicit decision-making consideration and by requiring Health Impact Assessment for major developments, with clear expectations that findings are addressed through design and infrastructure commitments. Policy should also be clearer that health-critical infrastructure and minimum standards are baseline requirements, not optional elements subject to viability trade-offs.