



Faculty of Public Health (FPH) Healthy Places SIG – NPPF Consultation Response

The Faculty of Public Health (FPH) is the professional home for public health in the UK and supports over 5,000 members working across the public health system. Our vision is for a healthier and fairer society, where everyone has the opportunity to live a long and healthy life. Central to this vision is the promotion of policies that improve health and wellbeing, reduce health inequalities, and embed health as a priority across all areas of government action.

The FPH Healthy Places Special Interest Group (SIG) brings together practitioners working at the interface of public health and the natural and built environments. Our members span local government, the NHS, academia and the wider public health workforce, with expertise in spatial planning, housing, transport, environmental quality, and place-making.

We welcome the opportunity to respond to the Government's consultation on proposed reforms to the National Planning Policy Framework (NPPF). Spatial planning is one of the most powerful upstream levers for improving population health and reducing inequalities. The quality, location, and design of homes; access to green and open space; opportunities for active travel; exposure to pollution and noise; access to local services; and the strength of social and community infrastructure all shape the conditions in which people live, work and age. Together, these elements form the foundations of health and wellbeing across the life course.

In this context, it is important to recognise that health infrastructure is not limited to NHS buildings or clinical facilities. While access to healthcare services is essential, health is largely created outside the healthcare system. The places we plan and build act as health-creating infrastructure, shaping physical activity, social connection, mental wellbeing, environmental exposure, resilience to climate-related risks, and opportunities to live healthy lives. Planning policy therefore plays a critical role in shaping the wider determinants of health and preventing ill-health before it arises.



Our response is framed against the Government's wider health mission, including *Fit for the Future: the 10-Year Health Plan for England*, which sets out a clear shift towards prevention and earlier intervention. Achieving this ambition depends not only on changes to health services, but on creating healthier places that support everyday wellbeing.

We have seen significant progress in recent years in collaboration between public health professionals and the planning system, at both plan-making and decision-making stages. Ensuring that health is clearly and consistently embedded within the NPPF would help sustain and build on this positive progress, supporting effective partnership working and enabling planning to play its full role in improving population health and reducing inequalities.

We recognise that there is much within the draft NPPF that we welcome, including the continued recognition of the role of planning in shaping healthy places and the emphasis on place-making and design quality. However, we are concerned that the draft NPPF places less explicit emphasis on prevention, health inequalities, and the wider determinants of health than previous iterations of national policy. Throughout our response, we highlight where clearer national direction would better support local authorities to plan for healthier, more equitable places, particularly in communities facing the greatest disadvantage. This happens when planning legislation, devolution reforms and health strategy and policy all support the role of place in tackling health inequalities. Our submission focuses on those aspects of the draft NPPF with the greatest implications for population health, including housing quality and affordability, density and design, transport and active travel, town centres, green infrastructure, and community assets. 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, Gypsy and Traveller communities, and people living in more deprived areas. We also state the importance of advocating for evidence-based tools to embed health and address health inequalities, such as Health Impact Assessment (HIA).

To ensure the planning system effectively supports population health, prevention and the reduction of health inequalities, the Faculty makes the following key recommendations.



1. Embed public health input within National Development Management Policies (NDMPs)

As National Development Management Policies are finalised, implemented and developed over time, their preparation and application should include consultation with public health bodies and be informed by proportionate assessment of impacts on population health and health inequalities. This will help ensure that nationally applied policies support prevention and avoid unintended harm.

2. Preserve local flexibility within the plan-led system

The NPPF should be explicit that strategic and local planning authorities retain discretion to introduce locally justified policies that go beyond national minimums, where needed to address local circumstances, population health needs and health inequalities. This flexibility is essential to support place-based action and meet statutory public health duties.

3. Explicitly embed population health and health inequalities in plan-making

Plan-making policies should clearly require consideration of population health and the reduction of health inequalities, informed by local health evidence such as Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies. Health should be treated as a core consideration in spatial development strategies, local plans and supporting evidence.

4. Strengthen the role of health in planning decision-making

Decision-making policies should give explicit and appropriate weight to health and health inequalities. The Faculty recommends reinstating the December 2024 NPPF requirement for planning policy and decisions to reduce health inequalities, so this remains a clear and material consideration alongside economic and environmental objectives.

5. Treat health as a cross-cutting principle across the Framework

Health and health inequalities should be embedded consistently across relevant thematic chapters—including Climate Change, Housing, Transport, Design and the Natural Environment—rather than being confined to the Healthy Communities chapter or community facilities alone. In addition to this, the Healthy Communities chapter should be amended to reflect the role of the built and natural environment as



key determinants of health, including housing, well designed communities, healthy food, healthy transport, and the natural environment.

6. Recognise Health Impact Assessment as an enabling tool

National policy should explicitly recognise Health Impact Assessment (HIA) as an evidence-based tool that local authorities may use, proportionately and where justified, to address identified health needs and health inequalities, alongside Equality Impact Assessment. This would provide clarity and legitimacy without imposing a blanket requirement.

Question Responses

1) Do you have any views on how statutory National Development Management Policies could be introduced in the most effective manner, should a future decision be made to progress these?

The Faculty acknowledges it has been Government's intention to provide a consistent set of national considerations that apply widely in local decision-making.

The process for introducing NDMPs should include consultation with public health bodies such as the Office for Health Improvement and Disparities, NHS England and local Directors of Public Health as statutory consultees. NDMPs should be subject to Health Impact Assessment using appropriate HIA methodology to assess likely effects on population health and health inequalities.

The introduction of NDMPs should preserve local flexibility. We recommend Paragraphs 5-10 are clearer about empowering the discretion of strategic and local authorities to be able to include, if justified, policies that go beyond national minimums, where needed to address local circumstances, population health needs and health inequalities



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? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly agree.

The Faculty recognises the benefits of a clear distinction between plan-making and decision-making policies.

The NPPF is material consideration but is the primary means by which Government articulates land-use policy for England. However, it cannot identify every policy consideration that may be relevant in all local contexts at any one time, and that the plan-led system places the onus on local authorities, not Government, to bring forward local policies and decisions that reflect local needs and priorities. For example local authorities have a population health improvement duty under the Health and Social Care Act 2012 and the use of the planning system is important as part of their health in all policies approach.

The Faculty recommends MHCLG refines Paragraphs 5-10 to be clearer about empowering the discretion of strategic and local authorities to be able to include, if justified, further policies not already set out in the NPPF.

5) Do you agree with the proposed approach to simplifying the terminology in the Framework where weight is intended to be applied? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree



a) Please provide your reasons, particularly if you disagree

Partly agree.

Signifying where and how weight is intended to be applied in the decision-making policies can be useful to support local development management processes. However it is unclear how such weight has been determined for each policy area, and certain policy areas are best determined locally than by national government. Flexibility should be retained such that local priorities can help determine the final weighting of the decision.

The Faculty recommends MHCLG refines Paragraph 7 to be revised to enable local discretion if justified based on local needs and priorities.

PM1: Spatial Development Strategies

6) Do you agree with the role, purpose and content of spatial development strategies set out in policy PM1? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly agree

SDSs are a key strategy for delivering the priorities of strategic authorities including for population health and addressing health inequalities. Therefore, PM1 does not fully reflect the Planning and Infrastructure Planning Act in terms of requirements under Section 12G (2) (b) for SDSs to consider the health of persons in the strategy area, and health inequalities between persons living in the strategy area.

9) Do you agree with the role, purpose and content of local plans set out in policy PM2? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.



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

Partly agree.

We partly agree with the content of local plans in policy PM2, but they would be stronger if they explicitly included an objective to improve population health and address health inequalities as part of a Health in All Policies (HiAP) approach throughout plan-making. The policy should recognise that health is influenced by a range of factors ('wider and social determinants of health') and that improving health outcomes requires action to be taken across the determinants, beyond health service infrastructure alone. The policy should acknowledge the role of 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.

13) Do you agree with the approach to the preparation of plan evidence set out in policy PM8? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Strongly agree. PM8 sets out clear expectations and requirements for evidence for informing policies in the local plan. It would be useful for PM8 to clarify that evidence, such as on the population and health needs, should be sourced collaboratively from authoritative sources such as health statutory bodies such as local authority public health departments and the integrated care boards which are legally required to produce joint strategic needs assessment (JSNA). JSNAs should form a central evidence base for informing local plan policies. Many local public health departments have produced JSNAs for the built environment that can allow plan-makers to compile the right evidence efficiently and proportionately. In addition Integrated Care Boards and NHS England are a prescribed body in plan-making.

The Faculty recommends strengthening PM8 b. to state "Consider using relevant evidence produced by other plan-makers and statutory bodies, where doing so could avoid duplication and support alignment between plans".

22) Do you agree with the policy DM2 on information requirements for planning applications? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.



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

Partly agree. The Faculty agrees with DM2 but emphasises local discretion in determining local information requirement needs which are proportionate and address specific identified need. This includes the use of Health Impact Assessments which is an important tool for systematically taking into account and delivering strategic and local authorities' health needs and priorities. This aligns with the Planning Practice Guidance on Healthy and Safe Places on empowering the use of HIAs where there are significant impact from development.

34) Do you agree with the proposed approach to setting a spatial strategy in development plans?

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

Partly agree

The Faculty welcomes a strategic approach in principle provided it sufficiently incorporates good placemaking, aligns with strategic health policy and population health needs, and coordination with other infrastructure planning such as active travel and green infrastructure. An explicit requirement for health input should be included.

36) Do you agree with the revised approach to the presumption in favour of sustainable development?

Partly disagree,

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

Expanding a presumption in favour of sustainable development without sufficient safeguards in relation to health may mean that developments that pose a risk to population health may proceed. Caution should be shown with any policy that provides default approval without sufficient safeguards for green space, active travel infrastructure and prevention of car dependency and poor housing/community quality and design.

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.



We support placemaking that leads to more walkable, less car reliant communities because there are well evidenced links to health and wellbeing. Although development around stations can have a positive impact in relation to walkability and multi-modal active travel it is essential that any development is well designed and healthy, and has access to the services and amenities that support good health

a) Please provide your reasons, including any evidence that this policy would lead to adverse impacts on Gypsies and Travellers and other groups with protected characteristics. KH

Gypsy and Traveller populations experience both health and housing inequalities.

Those living in different types of sites and roadsides can experience poorer quality housing and greater exposure to hazards including poor air quality, noise and lack of basic facilities. Community consultation and EQIA are essential tools to ensuring that development does not lead to displacement, disadvantage underserved communities, or increase inequalities.

Office for National Statistics (ONS), released 7 December 2022, ONS website, statistical bulletin, [Gypsies' and Travellers' lived experiences, homes, England and Wales: 2022](#)

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

Partly Agree

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

National decision-making policies

a) Reasons

Climate change affects population health in the UK through heat-related mortality, flooding, air pollution, food insecurity, and impacts on mental health (UKHSA, 2023; Watts et al., 2023). Climate risks disproportionately affect disadvantaged populations, older adults and those with chronic conditions (Marmot, 2020; UK Climate Change Committee (CCC), 2023).

The policy should explicitly reference the impacts of climate change on health and health inequalities and propose mitigation and adaptation strategies specifically aimed at addressing these. For example, 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. The co-benefits of climate action for health should be acknowledged.

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

Partly Agree

a) If not, what additional measures could be taken to ensure climate change mitigation is given appropriate consideration?

Climate change affects population health in the UK through heat-related mortality, flooding, air pollution, food insecurity, and impacts on mental health (UKHSA, 2023; Watts et al., 2023). Climate risks disproportionately affect disadvantaged populations, older adults and those with chronic conditions (Marmot, 2020; UK Climate Change Committee (CCC), 2023). We propose the following additions:

- The policy should reference the substantial health co-benefits to climate mitigation, including reductions in cardiovascular and respiratory disease as well as increased physical activity through active travel, alongside improved air quality.
- Decision-making should make clear that development resulting in significant greenhouse gas emissions should not be supported where those emissions cannot be demonstrably avoided, reduced and mitigated in line with UK carbon-reduction commitments.
- Decision-making should encourage whole-life carbon assessments for major developments, aligned with the London Plan and RICS standards; adopt clear, legislation-aligned carbon-reduction benchmarks; and prioritise active travel and retrofitting existing housing.

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

Partly Agree



a) What additional measures could be taken to ensure climate change adaptation is given appropriate consideration?

Climate change affects population health in the UK through heat-related mortality, flooding, air pollution, food insecurity, and impacts on mental health (UKHSA, 2023; Watts et al., 2023). Climate risks disproportionately affect deprived communities, older adults and those with chronic conditions (Marmot, 2020; UK Climate Change Committee (CCC), 2023). CC3 could explicitly reference the impacts of climate change on health and health inequalities. The co-benefits of climate adaptation for health, 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.

The policy would benefit from clearer requirements to preserve and increase urban green spaces, build-in passive cooling standards, improve flood-resilient design, and protection of critical infrastructure such as healthcare facilities.

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

Partly agree

Housing is one of the building blocks of health, and multiple pathways link the nature, quality, affordability, stability, and security of housing to both physical and mental health outcomes. Housing supply should also be considered in the context of the local Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment, which will also refer to housing needs. Local public health teams and Directors of Public Health should be actively involved in both local plans and spatial development strategies and adequately resourced to contribute at the appropriate tiers of plan-making.

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 across the life course, including “future-proofing” for ageing populations

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

Local Plan Making Guidance is required to:

- Identify appropriate data sources and relevant expertise.
- Apply robust methodologies for assessing housing needs.
- Engage effectively with different population groups to understand their housing requirements.
- Undertake and apply Equality Impact Assessments (EIQAs)

The Housing needs of different groups guidance on GOV.UK should be updated to ensure it reflects the most current and robust evidence base.

50) Do you agree with the approach to incorporating relevant policies of Planning Policy for Traveller Sites within this chapter?

Strongly agree

Travellers are an inclusion health group, and their specific housing needs should be assessed alongside other more vulnerable and inclusion health groups.

51) Is further guidance needed on how authorities should assess the need for traveller sites and set requirement figures?

Strongly agree

Gypsy and Traveller accommodation needs assessments guidance previously published on GOV.UK should be updated to ensure it reflects the most current and robust evidence base.

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?

Strongly agree.

National minimum requirement standards for local plans are welcome, to meet the needs of an aging population and protect councils from challenges by developers

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

Partly disagree



National minimum requirement standards for local plans are welcome, to meet the needs of an aging population and protect councils from challenges by developers. The 40% M4(2) figure is already supported by local housing needs evidence, with higher populations of older people and 10% M4(3) figure is supported by advocacy groups and local precedents due to very low current delivery. However, there is also a strong public health argument for raising both thresholds, especially given the ageing population, prevalence of some Long-Term Conditions and disabilities, and the long-term costs of inaccessible housing. 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.

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

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

The proposal to require authorities to identify sites or set specific requirements for parts of allocated sites to meet the needs of different groups is proportionate in principle and necessary to shift delivery from a purely market-led model toward a needs-led approach that better reflects local population needs and inequalities experienced by older people, disabled people, Traveller communities, and those requiring supported or specialist accommodation. 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, based on neighbourhood-level need rather than district-wide averages.



HO8: Providing Affordable Homes

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? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly agree

We support the provision of health and affordable housing for military personnel and their families. Where provision is restricted to a defined population and linked to employment, counting it toward general affordable housing requirements risks creating unmet need among the wider population. Clear safeguards are needed to prevent displacement of civilian affordable housing, particularly in areas with a strong military presence.

64) Do you agree flexibility relating to the size of market homes provided will better enable developments providing affordable housing? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Strongly disagree.

The Faculty does not support policy that would reduce the standards or suitability of housing in new developments. Enabling affordable housing delivery by further reducing the size of market homes is not appropriate. The Nationally Described Space Standard (NDSS) exists to prevent substandard internal space and remains a critical benchmark in planning.

Reducing dwelling sizes risks cramped living conditions, poorer health and wellbeing, and reduced adaptability over time, including for disabled people and those with changing needs. This can increase the likelihood of disruptive and costly moves and undermine independence.

There is evidence that links overcrowding and inadequate internal space to poorer physical and mental health outcomes, including increased stress, disturbed sleep and higher accident risk. National policy should therefore reinforce, rather than weaken, expectations on space and storage, and ensure robust inspection and



compliance so that agreed standards, including the NDSS, are delivered in practice.

MHCLG (2025) *English Housing Survey 2023 to 2024: health and housing - fact sheet*

The Health Foundation (2024) *Trends in household overcrowding by tenure.*

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? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

If so, what would be an appropriate minimum proportion and development size threshold taking into account development viability?

Partly agree

Setting a national minimum proportion of social rent would be welcome. From a public health perspective, access to genuinely affordable and secure housing is fundamental to good health and to reducing health inequalities.

However, the caveat “unless otherwise specified in development plans” could weaken the policy if it allows routine opt-outs. Any exemptions should therefore be tightly defined and supported by clear and robust evidence.

A minimum proportion of social rent should also be accompanied by clear expectations about quality and integration. To support health and equity, social rent homes should be tenure-blind in practice: well distributed across sites, provided in a range of sizes, built to the same standards as market housing, and located with equal access to services, transport and green space. Concentrating social rent in poorer locations or delivering smaller or lower-quality homes risks reinforcing spatial and health inequalities and would undermine the draft NPPF’s aims to create healthy, inclusive communities.

66) Are changes to planning policy needed to ensure that affordable temporary accommodation, such as stepping stone housing, is appropriately supported, including flexibilities around space standards? If so, what changes would be beneficial?



Changes are needed — not to lower standards, but to clarify, strengthen and protect quality, particularly around space, suitability and duration

People living in temporary accommodation, including families with children, are already more likely to experience poor physical and mental health, stress, and wider social disadvantage. From a public health perspective, reducing space or other housing standards risks compounding these existing inequalities rather than addressing them.

Any flexibility introduced to support the delivery of temporary or “stepping stone” accommodation should therefore be limited, clearly defined and time-bound. It should not result in homes that are overcrowded, overheated, lack adequate storage or private space, or are unsuitable for family life. Poor-quality temporary accommodation is associated with stress, disrupted sleep, impacts on children’s development and increased use of health and support services.

National policy should focus on improving the quality, suitability and stability of temporary accommodation, while supporting rapid move-on into settled, long-term housing. Flexibility should be used to speed delivery and enable transition, not to justify lower living standards for households who are already vulnerable.

Homes England (2025), *Measuring the wellbeing impacts of temporary accommodation and social housing*

Fairbrother H., Burn A-M. et al. (2025). *Far from Home: Sharing families’ experiences of housing insecurity*. NIHR School for Public Health Research.

72) Do you agree the with the criteria set out regarding the locations of specialist housing for older people? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly agree



The criteria provide a helpful starting point by recognising the importance of locating specialist housing for older people in accessible locations, with good access to services and public transport. This is important for supporting independence, mobility and access to healthcare.

However, from a public health perspective, location criteria should go further by emphasising the importance of embedding specialist housing within existing communities, rather than focusing primarily on proximity to services and transport. Older people's health and wellbeing are strongly influenced by social connection, a sense of belonging and opportunities for everyday interaction. Specialist housing that is isolated, inward-facing or separated from wider neighbourhood life can increase the risk of loneliness and social isolation, even where services are technically nearby. Location criteria should therefore explicitly support integration with mixed-use, mixed-tenure neighbourhoods and access to community facilities, green space and informal social activity, not just formal services.

In addition, while specialist housing plays an important role, it should not be relied upon as the primary mechanism for meeting the housing needs of an ageing population. To safeguard future housing supply and support ageing in place, national policy should place greater emphasis on ensuring that a high proportion of general housing is built to M4(2) accessible and adaptable standards, and M4(3) wheelchair user standards. This approach supports flexibility over the life course, reduces the need for disruptive moves in later life, and helps prevent avoidable demand for specialist or residential care.

Strengthening the criteria to recognise both the importance of community integration for specialist housing and the role of accessible general housing would better align the policy with public health evidence on healthy ageing.

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? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Partly Agree



We welcome the consolidation of traveller site policy into the NPPF and the explicit recognition of health within Policy HO12, particularly the requirements on access to education, health and welfare services, opportunities for play, and minimising exposure to noise and air pollution.

However, the policy would be strengthened by a clearer focus on healthy environments rather than “healthy lifestyles” as this implies personal choice when choices for this community are often limited. Gypsy and Traveller communities experience some of the poorest health outcomes in England, driven largely by structural and environmental factors. Evidence shows that many traveller sites are located close to major roads, industrial land, and waste and recycling facilities, exposing residents to harmful air pollution, noise and other environmental hazards. Stronger safeguards are therefore needed to avoid siting traveller sites in locations that would be considered unsuitable for other forms of residential development.

We recommend that Policy HO12 explicitly requires:

- avoidance of locations with high environmental risk (including air pollution, noise and flood risk);
- provision of adequate water, sanitation and basic infrastructure as fundamental determinants of health;
- explicit recognition of health needs and protected characteristics within “personal circumstances” as a material consideration; and
- stronger wording to ensure sites are not only visually non-isolated but actively integrated with surrounding communities and shared services.
- A commitment to including Gypsy and Traveller communities in decisions that affect them

These changes would better reflect public health evidence, reduce the risk of implicit victim-blaming, and ensure fair and equitable treatment of traveller communities within the planning system.

Bloch, A. & Quarmby, K. (2024). *Environmental racism, segregation and discrimination: Gypsy and Traveller sites in Great Britain*. Critical Social Policy.

ONS (2022): *Gypsies' and Travellers' lived experiences, health, England and Wales*



NHS Race and Health Observatory (2023) – *Inequalities in Mental Health Care for Gypsy, Roma and Traveller Communities*

88) Do you agree with the proposed changes to policy for planning for town centres? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly agree

The proposed changes to policy TC1 are broadly welcomed, particularly the move towards more diverse town centre uses beyond retail, which can support more vibrant and resilient communities. However, clearer definitions of “vitality” and “viability” that explicitly reflect community and health outcomes would strengthen the policy. Our stakeholders tell how viability arguments systematically disadvantage health and equality outcomes.

The flexibility for local authorities to use Article 4 directions is supported from a public health perspective. Evidence shows that permitted development rights have often resulted in poor quality residential development, including inadequate space, poor daylight, noise exposure and limited access to green space, which are associated with poorer physical and mental health outcomes. We also have concerns that a combination of increased density with PDR could lead to further health issues from overheating and urban heat islands. Research by the Town and Country Planning Association highlights that permitted development has undermined local authorities’ ability to shape healthy places and has led to housing that fails to meet basic standards for health and wellbeing

Permitted development, housing and health: a review of national policy and regulations. (2024). TCPA, London.

89) Do you agree with the approach to development in town centres in policy TC2? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.



a) If not, please explain how you would achieve this aim differently?

Partly agree.

The focus on supporting town centre vitality in Policy TC2 is welcome, particularly where it supports a diverse mix of uses and maintains access to local businesses. However, “vitality” should be more clearly defined to reflect positive social, health and community outcomes, rather than simply increased activity or footfall.

Diversification should not encourage a concentration of health-harming uses such as hot-food takeaways or gambling. Where increased residential development is supported in town centres, this should be of good quality, accompanied by adequate supporting infrastructure, including access to health and community assets and green space.

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

Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly agree.

The sequential test should be applied in a way that considers not only proximity to the town centre, but also sustainable transport access, safe, inclusive active travel networks and health relevant factors, to avoid unintended outcomes. In practice, a narrow interpretation of the sequential test can favour development formats that are car dependent or difficult to accommodate in town centres, it also poses a risk that it can be used to overcome objections to drive through fast food developments. This risks undermining wider objectives around walkability, access to services and healthier placemaking.

The policy should therefore be explicit that meeting the sequential test does not override other relevant policies within the plan, including those relating to health, transport and environmental sustainability.



92) Do you agree with the approach to town centre impact assessments in policy TC4? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly agree.

The introduction of town centre impact assessments is welcomed, but their scope should be broadened to explicitly include health impacts, alongside economic considerations. This should include assessment of transport impacts and opportunities for active travel, the local food environment, exposure to noise, access to green or open space, and the adequacy of supporting infrastructure such as health and community services.

Embedding these considerations would help ensure that proposals support healthy, inclusive and sustainable town centres, and avoid developments that may undermine wellbeing despite meeting commercial or viability tests.

114) Do you agree policy L1 provides clear guidance on how Local Plans should be prepared to promote the efficient use of land? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Partly Disagree

115) If not, what further guidance is needed?

While L1 includes positive elements—such as mixed-use development, reduced travel demand, and net environmental gains—these benefits are only indirectly supportive of population health. As currently drafted, L1 does not provide clear or explicit guidance on how efficient land use should contribute to population health or the reduction of health inequalities.

This is an important omission because the stated purpose of the planning system is to contribute to sustainable development in the long-term public interest. The draft NPPF makes clear that sustainable development has social objectives alongside economic and environmental ones. Supporting population health is unambiguously part of that long-term public interest.



Evidence on the rising societal and economic costs of avoidable non-communicable diseases shows that health outcomes cannot be left to indirect or assumed impacts of planning policy. To be effective and defensible, the NPPF should explicitly recognise population health as a desired outcome of land-use planning.

To strengthen L1, national policy should require Local Plans to:

- Identify and respond to population health needs and health inequalities, using local evidence such as Joint Strategic Needs Assessments (JSNAs) where these exist.
- Give appropriate weight to amenities, facilities and environments that address identified health risks and deficits.

Explicit reference to health would ensure Local Plans fully support the NPPF's broader goals for sustainable development and secure the multiple benefits that good land-use planning can deliver.

L3: Achieving Appropriate Densities

121) Do you agree policy L3 provides clear guidance on achieving appropriate densities for residential and mixed-use schemes? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Partly disagree

a) If not, please explain how guidance could be clearer?

While L3 contains a number of strong elements, we partly disagree that paragraph 12.L3.1 provides clear guidance. From a public health perspective, we are concerned about the use of the term “healthy places”, which is insufficiently defined. Without a clear definition, the term is open to wide variation in local interpretation, including interpretations that may not align with evidence on population health, and is unlikely to be robust if tested at appeal.

This concern is grounded in the NPPF's own stated purpose: the planning system is intended to support sustainable development in the long-term public interest, and sustainable development includes social objectives alongside economic and environmental ones, as set out in the draft NPPF (December 2025). Supporting



population health is demonstrably in the long-term public interest, yet the current wording does not provide sufficiently clear or defensible guidance to secure this outcome.

Evidence on the rising economic, societal and NHS burdens associated with avoidable non-communicable disease shows that public health outcomes cannot be left to inference or indirect interpretation. To be effective, “healthy places” must be defined with reference to the best available evidence, and we recommend including such a definition in the NPPF glossary.

We also recommend increased precision in the terminology relating to density. Paragraph 12.L3.2 refers to the “density of the area”, while other parts of the NPPF use more specific terms such as “net developable area”. For clarity and consistency, a term such as “gross density of the area” should be considered, or an equivalent definition added.

These amendments would improve clarity for local planning authorities, strengthen consistency at appeal, and ensure that L3 effectively supports the NPPF’s broader aims for sustainable development, place-making and long-term public benefit.

122) Do you agree with the minimum density requirements set out within policy L3? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Partly disagree.

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

From a public health perspective, we support the intent of setting minimum density requirements, and we strongly agree that linking development density to public transport, local services and amenities is essential for population health and sustainable development. However, we partly disagree that the specific minimum density requirements in L3 are sufficient to secure the best outcomes.

A single minimum density threshold (even with two contextual variations) may be too blunt an instrument. Practical experience with graded or graduated density zoning shows that higher densities concentrated around transport nodes and key services can accommodate more people within walking distance of essential amenities, while



still supporting high-quality, liveable neighbourhoods. This approach would allow densities to increase progressively around identified centres, often exceeding the minimum thresholds in the draft NPPF where most beneficial.

We also highlight two further concerns relevant to population health and health inequalities:

1. The wording “appropriate” minimum densities is insufficiently directive. Given the strong evidence that well-designed higher densities support health, climate goals and access to opportunity, the policy wording should be firmer. Terms such as “required,” “strongly expected,” or a presumption in favour of minimum densities would better reflect the importance of density in delivering sustainable, connected places.
2. “Reasonable walking distance” is insufficiently defined.

Evidence shows that “reasonable” walking distances vary depending on the level of transport provision, the purpose of the trip, the characteristics of different population groups, and local topography,

We recommend including an evidence-based definition of “reasonable walking distance” to ensure consistent and defensible application. For example the National Travel Survey (NTS) analysis — 85th percentile distances (reasonable walking distance” is the distance that at least 85% of people are willing or able to walk for a given purpose, based on empirical travel behaviour data) from the NTS

In summary, while we support the purpose and direction of minimum density requirements, greater clarity and stronger wording are needed to ensure the policy fully supports public health, reduces inequalities, and delivers sustainable development.



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

Yes. Minimum density requirements could unintentionally create adverse impacts for Gypsies and Travellers and some other protected groups. These communities often require lower-density, culturally specific layouts, larger plots, space for vehicles, and multi-generational living arrangements. A rigid minimum density standard could therefore reduce the availability of suitable sites, limit culturally appropriate accommodation, and risk worsening existing health inequalities—an issue already noted in wider NPPF discussions on healthy, inclusive places. People with disabilities or mobility needs may also require lower-density or adapted layouts that do not align with uniform density thresholds.

To avoid these unintended harms, the NPPF should include a clear statement that minimum density requirements must not be applied rigidly to accommodation for Gypsies and Travellers or other protected groups, and that Local Plans must ensure provision of culturally appropriate, accessible and health-promoting accommodation where required.

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? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Partly disagree



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

While dwellings-per-hectare can be a useful density metric, the definition of net developable area within the NPPF is problematic because it includes “children’s play areas.” This narrow term typically refers to fixed-equipment spaces such as swings, climbing frames or fenced play zones. However, a growing body of evidence shows that children and young people need diverse places to play, including natural, unstructured environments such as woodland, streams, meadows, and adaptable open spaces. These environments support creativity, motor development, social interaction, emotional regulation and connection to nature in ways that fixed-equipment play areas often cannot.

Research demonstrates that naturalised play environments offer environmental, physical and emotional freedom, richer learning opportunities and more varied forms of play than traditional playgrounds. Studies also show that nature-based play spaces provide broader developmental benefits and promote diverse play, especially for children of different ages and competencies, compared to conventional equipment-focused play areas. National guidance further emphasises that children engage in more imaginative, cooperative and vigorous play in nature-rich settings, and that such environments support creativity, wellbeing and resilience. Systematic reviews confirm that nature-based play environments improve play quality and offer unique developmental affordances that non-natural playgrounds do not provide. [files.eric.ed.gov] [link.springer.com] [nwf.org] [frontiersin.org]

Including “children’s play areas” in net developable area risks placing these essential, health-promoting environments in competition with revenue-generating land uses. It may also incentivise the smallest possible fixed-equipment area, rather than the broader landscape of play children actually need.

To prevent this unintended consequence, we suggest that only under-5s play provision (where proximity and enclosure are developmentally appropriate) be included within net developable area calculations. For older children, young people and adults, play requires larger, more flexible and more natural spaces, which should instead be accounted for within gross density, ensuring they are protected, delivered at scale, and not squeezed out by density pressures.



DP1: A Strategy for Design

146) Do you agree that policy DP1 provides sufficient clarity on how development plans should deliver high quality design and placemaking outcomes? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Partly Agree

Design policies should be clear, specific and ambitious in achieving good design and healthy placemaking outcomes. Place-making should be based on evidence-based urban design.

Research published in the Journal of Planning Literature on current local plan policies on design identified that only 27% of design policies have been created to meet healthy placemaking outcomes. Part of the reason may indicate lack or poor engagement with health partners.

We note the separate Design and Placemaking PPG under consultation. The Faculty recommends that DP1 is strengthened to ensure the process for setting design expectations in plan-making includes meaningful involvement of statutory consultees and relevant stakeholders, including the local public health teams and the wider health system who can provide important evidence and research on how local health needs should be addressed through design. The Faculty recommends the following additional text to DP1

DP1 a. Ensuring the vision for the plan reflects the desired design and placemaking outcomes. This should be informed by an evaluation of the area's existing characteristics and potential and meaningful involvement with relevant stakeholders and statutory consultees"

147) Do you agree with the approach to design tools set out in policy DP2? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.



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

Strongly agree

Design tools including design codes provide useful ways for collaboration and agreeing objectives and outcomes to support delivery. The Faculty believes that DP2 can be strengthened to indicate that tools are expected to have a clear understanding by linking it more explicitly to the 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.

National policy could better support well-designed and healthy places by encouraging the use of structured assessment tools such as the Place Standard. This tool helps planners and communities understand how well an area functions, highlighting issues around movement, public space, safety, social connection and access to services. Using it in plan-making and design coding would strengthen evidence-based decisions, support healthier neighbourhoods, and ensure development responds directly to community-identified needs.

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

Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Strongly agree

The Faculty is supportive of DP3 requirement to set clear expectations for decision-makers to give substantial weight to design policies. It is important for design policies to be explicit from the outset about achieving health outcomes which can then be appropriately considered by decision-maker

DP4: The Design Process

149) Do you agree with the proposed approach to using design review and other design processes in policy DP4? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.



a) If not, what else would help secure better design and placemaking outcomes?

Partly Agree

The Faculty believes that the design process must be embraced when developing public service infrastructure such as local healthcare facilities. Integrating these design principles early in the development process for public service infrastructure can help ensure NHS estates are accessible, sustainable, and responsive to local needs. The faculty recommends DP4 should make explicit reference to “public service infrastructure

“DP4. The local planning authority should: a. Ensure that they have access to, and encourage the appropriate use of design review and other design tools and processes (especially for significant projects such as major housing, public service infrastructure and mixed-use developments)”

We support the continued use of design review and other design processes to promote high-quality, well-designed places. However, we are deeply concerned about the proposed removal of paragraph 141 of the current NPPF, which explicitly recognises the negative impacts that outdoor advertising can have on the quality and character of places.

Paragraph 141 is currently the only place within planning legislation, policy or guidance that acknowledges the cumulative impacts of outdoor advertising on neighbourhood amenity. Its removal represents a weakening of the planning framework and would reduce the ability of local planning authorities to address poorly sited, excessive or inappropriate advertising through local plans, design review and decision-making.

Outdoor advertising can have significant visual, environmental and community impacts, particularly in areas already experiencing deprivation. These impacts can undermine civic pride, contribute to poorer perceptions of place quality, and exacerbate existing health inequalities. Retaining paragraph 141 within Chapter 14: Achieving well-designed places would provide essential policy support for local authorities to consider cumulative impacts and to use design-led processes to protect and enhance the character and wellbeing of communities.



We therefore strongly recommend that paragraph 141 is retained within the revised NPPF to ensure that design review and related processes are supported by a clear policy framework that recognises the wider place-based and public health implications of outdoor advertising.

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? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

b) Please provide your reasons, particularly if you disagree.

Partly agree

Early engagement in transport planning and prioritising development where infrastructure already exists are welcome. However, TR1 currently does not sufficiently highlight the need to prioritise active travel and public transport- key to addressing health inequalities and climate change. It would benefit from a clearer definition of what is meant by a “vision-led” approach. Vision-led transport planning should begin with a shared ambition for how places should function for people’s health and wellbeing, and then shape transport and development accordingly, rather than forecasting traffic demand and providing primarily for motor vehicle movement.

Evidence from the University of the West of England highlights that vision-led planning prioritises creating safe, healthy, sociable and accessible places, directing investment towards walking, wheeling, cycling and public transport, rather than road capacity and car parking (UWE, 2025). From a public health perspective, housing developments and communities should be places where people can socialise, where children can play safely, and where everyday journeys can be made actively, rather than environments dominated by the movement and storage of motor vehicles.

TR1 should therefore place stronger emphasis on prioritising active travel and high-quality public transport, and on designing in measures that do not leave people dependent on cars, including filtered permeability and people-centred



street design. This is important given national evidence that air pollution from road transport is a major contributor to ill-health and health inequalities, particularly in more deprived communities.

Finally, where development relies on new or enhanced public transport, TR1 should require clear, written and timebound developer commitments, including specified years of revenue funding and mechanisms for monitoring and accountability by the relevant transport or highway authority, to ensure long-term delivery and sustainability.

To ensure a genuinely vision-led approach, site allocations for development should also take account of the potential to increase walking, wheeling and cycling, as the location and layout of sites can fundamentally shape whether active travel is a realistic first choice or whether car dependency is locked in from the outset.

Vision-led planning: how to plan development and transport infrastructure more sustainably. Centre for Transport and Society, UWE Bristol; Transport for Quality of Life.

Chief Medical Officer's Annual Report 2022: Air Pollution.
Department of Health and Social Care.

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, partly agree, neither agree nor disagree, partly disagree, strongly disagree.



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

Strongly agree

Policy TR2 provides a strong basis for setting local parking standards that support sustainable transport and healthier patterns of development. Requiring maximum parking standards where they encourage walking, wheeling, cycling and public transport, and support higher density development in well connected locations, is particularly welcome from a public health perspective.

The factors set out in TR2(3), including connectivity, access to everyday services, opportunities for active travel, and consideration of local car ownership and travel trends, allow for proportionate and locally responsive standards. The inclusion of flexibility to address genuine business needs, alongside provision for disabled people and cycles, strikes an appropriate and balanced approach.

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, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

b) Please provide your reasons, particularly if you disagree.

Strongly agree

The proposed changes to policy TR3 are welcomed. Ensuring that development likely to generate significant movement is located where sustainable travel can be easily supported is essential for reducing car dependency and supporting healthier travel behaviours. The emphasis on limiting the need to travel and offering a genuine choice of transport modes is particularly positive.

The requirement to identify and mitigate environmental impacts, including opportunities to reduce air pollution, should contribute to improved health outcomes. This could be strengthened further by more explicitly prioritising increased access to walking, wheeling and cycling, given their role in supporting physical activity and reducing inequalities.



The use of the Connectivity Tool alongside other evidence is supported, as it provides a more consistent and transparent basis for assessing accessibility and sustainable transport options when considering development proposals.

153) Do you agree that proposed policy TR4 provides a sufficient basis for the effective integration of transport considerations in creating well-designed places? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Please provide your reasons, particularly if you disagree.

Partly agree.

The emphasis in TR4 on prioritising pedestrians, connecting developments to surrounding areas, and building around existing or planned infrastructure is welcomed and supports more sustainable and inclusive placemaking. Well designed walking and cycling environments can increase physical activity and help reduce health inequalities.

The policy could be strengthened by explicitly requiring direct and safe connections to and between communities and local centres, services and amenities, ensuring developments contribute to a high quality, accessible network of everyday provision. While facilities that support sustainable travel are positive, clearer direction on reducing parking would help prioritise people centred street environments and improve safety and accessibility for those walking, wheeling and cycling.

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, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Strongly agree.

Requiring transport assessments for developments likely to have impacts is welcomed, and the expectation that schemes should proceed without adverse impacts provides an appropriate threshold. To strengthen TR6, it would be helpful to clarify that “impacts” include health impacts, such as road safety, air quality,



inclusive access to services and community assets, access to play areas and green space, and whether walking, wheeling and cycling are safe and realistic options, particularly for people without access to a car. Clearer guidance on what constitutes “significant movement” would also help ensure the policy is applied consistently

157) Do you agree with the additional policy on maintaining and improving rights of way proposed in policy TR8? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Strongly agree

We support the policy in its aims to develop and maintain PROW. TR8a should be amended as follows: “a. Maintain the network of public rights of way, including through suitable diversions agreed with the highway authority, where they maintain or enhance the overall route network; and”. This will ensure that the NPPF aligns to the NPPF consultation document where it states that “It also acknowledges that diversions may be acceptable where they maintain or enhance the overall route network”.

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

The Faculty welcomes improvements around closer specification for assessments around outdoor recreational land, explicit expectation that play and informal recreation form a “connected network” and explicit reference to health inequalities”. However, there are significant gaps.

The Faculty recognises that there is much within the draft NPPF to be welcomed, including the continued recognition of the role of planning in shaping healthy places and the emphasis on place-making and design quality. However, we are concerned that the draft NPPF places less explicit emphasis on prevention, health inequalities, and the wider determinants of health than previous iterations of national policy.



The Faculty would recommend strengthening HC1 through inclusion of the principles of paragraph 96 a) b) and c) from the NPF 2024 to recognise the wider role that places have in influencing health outcomes.

In particular, the Faculty recommends:

1. Reinstate an explicit requirement for planning policy and decisions to

reduce health inequalities: The policy 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, and align with existing national policy and legislation.

2. The NPPF should broaden the scope of ‘healthy communities’ beyond improvements to health and social infrastructure, recognising the wider role places have in influencing health outcomes:

Health is influenced by a range of factors (‘wider and social determinants of health’). Improving health outcomes requires action to be taken across these determinants. HC1 can be strengthened to define what a “healthy place” is, beyond health service infrastructure alone. Healthy placemaking should be framed around the wider determinants of health such as safe and accessible housing, walkable/wheelable neighbourhoods, access to good quality green space and play, clean air, and access to affordable healthy food as part of everyday infrastructure. A definition should note that places which are unhealthy can be hazardous to health. For example, we note that the removal of language in HC1 relating to 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.

3. Strengthening the role of Health Impact Assessments (HIA) in development

proposals: HIAs are an effective tool for systematically understanding the impact of developments on local communities. 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. The Faculty believes that Health Impact Assessments should inform development proposals at the earliest stage possible.



4. Widen the definition of essential community infrastructure beyond use

class: HC1 would also benefit from clearer guidance on what constitutes essential community infrastructure needed to support healthy communities, beyond broad use-class definitions. Local health evidence, including Joint Strategic Needs Assessments and community engagement, could help define these needs and address existing infrastructure deficits.

159) Do you agree that Local Green Space should be ‘close’ to the community it serves?

Partly disagree.

The term “*reasonably close*” should be retained, as it allows appropriate local flexibility to reflect differences in geography, settlement patterns and population characteristics.

Access to green space supports physical activity, mental wellbeing and social connectedness, and can help reduce exposure to air and noise pollution. Ensuring that green space is accessible within walking distance of homes (15 minutes) is important, in line with Natural England’s Green Infrastructure Framework’s Accessibility Standard. It should be acknowledge though, that populations and geographies are diverse and different groups will access green space differently.

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, well-designed access routes. Improving transport and active travel connectivity to Local Green Space will further help to maximise health benefits and promote equitable access.

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



HC3 and HC4 put communities first and the meaningful involvement of local people in decisions that protect, maintain, or enhance the material and social conditions in which they live. From a public health perspective, this approach is essential.

We recommend that local health evidence, including Joint Strategic Needs Assessments and community engagement, should be used to define community infrastructure needs and address existing infrastructure deficits.

NHS England guidance on 'Healthy New Towns' further outlines how to develop and provide services in a new place by using case studies, checklists and explanations to help professionals working across planning, health and development to come together in partnership to create healthier places

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?

We welcome the policy remaining in the NPPF, noting that it is already being used effectively at a local level by public health and planning teams. Its retention provides important national support for local authorities seeking to manage the health impacts of the food environment.

Further clarity would be helpful to improve consistent application, particularly through a clear and workable definition of "fast food outlets". Using the Office for Health Improvement and Disparities definition currently applied in the Wider Determinants of Health dataset would provide a strong starting point, with scope for further refinement through engagement with local government and public health stakeholders.

Clarification on how walking distance should be assessed would also be beneficial. Rather than specifying a fixed distance nationally, the policy could encourage the use of evidence based measures of reasonable walking distance, such as National Travel Survey 85th percentile distances, which are already widely used in transport planning. This would allow appropriate local discretion, recognising that suitable distances may differ between dense urban centres, towns and more rural areas, while remaining grounded in consistent behavioural evidence.

Finally, we note that the removal of language in HC1 relating to 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, February 2025

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

Strongly agree.

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

Evidence consistently shows that the erosion of key community facilities contributes to social isolation, reduced access to services, and widening health inequalities, particularly in areas affected by poverty. Protecting facilities that are the last of their kind in an area supports the Pride in Place agenda by maintaining inclusive, resilient communities and addressing the social determinants of health. This approach is proportionate and avoids unnecessary restrictions while safeguarding services that are essential to everyday life and community wellbeing.

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

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?

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

Partly agree

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

Replacement provision should consider long-term funding, safety, and maintenance to ensure facilities remain usable and beneficial over time. While improved quality



can sometimes offset reduced quantity, this flexibility must be applied cautiously. UK evidence shows that loss of accessible recreational space reduces physical activity, increases long-term demand on NHS services, and disproportionately affects deprived communities.

Important consideration is needed about how **authorities monitor whether replacement recreational provision delivers equivalent or better health outcomes in practice**. Replacement provision should therefore maintain accessible capacity and help prevent avoidable health inequalities, rather than shifting future health and social care costs onto the NHS (Sport England, Uniting the Movement, 2022).

165) Do you agree with policy P1 as a basis for identifying and addressing relevant risks when preparing plans? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Response: Strongly Agree.

The focus on "Clean, Liveable and Healthy Places" is a vital recognition of the urban environment as a health-shaping infrastructure. Public health evidence consistently shows that poor spatial planning exacerbates NCDs (non-communicable diseases) and health inequalities (The King's Fund, 2025).

To support effective decision-making, national policy should explicitly recognise Health Impact Assessment (HIA) as an evidence-based tool that local planning authorities may use, proportionately and where justified, to identify and address the potential health and health inequality impacts of development proposals. This is particularly relevant where developments may result in significant environmental exposures or cumulative impacts on communities.

The Faculty believes that P1 must prioritise active travel and public transport over private vehicle infrastructure to reduce PM2.5 and NO2 levels, aligning with WHO Global Air Quality Guidelines (WHO, 2021).



166) Are any additional tools or guidance needed to enable better decision-making on contaminated land?

Additional tools and guidance are required. Current frameworks often prioritise technical remediation (structural safety) over the long-term community health impacts due to contamination. The Faculty recommends the following:

1. **Health-First Remediation:** Guidance should include a requirement for psychosocial impact assessments for communities residing near formerly contaminated land to address the issue of legacy pollution (Eupha, 2023).
2. **Integrated Monitoring:** Tools should be developed to allow local health teams to monitor long-term health outcomes in residents of remediated sites, ensuring that land reuse does not perpetuate historical health inequalities.

P3: Living Conditions and Pollution

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

Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Partly Agree.

The criteria for acceptable living conditions are often too low and fail to account for the **cumulative impact** of multiple stressors (e.g., poor air quality, noise, and lack of thermal comfort). Research in the Journal of Public Health indicates that environmental noise is not just a nuisance but a physiological stressor linked to cardiovascular disease.

168) Do you agree policy P4 makes sufficiently clear how decision-makers should apply the agent of change principle? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

Response: Partly Agree.

The Agent of Change principle is essential for protecting community assets. However, the policy must ensure that mitigation responsibilities do not lead to social exclusion. The Faculty notes two concerns:



Equity Concern: If a new development mitigates noise from an existing community centre by sealing windows, it may inadvertently harm the community's social cohesion by reducing the visibility and accessibility of that centre (The King's Fund, 2025).

Health Stance: Mitigation should favour source-based controls over recipient-based measures to maintain a high-quality outdoor environment for all

170) Do you agree that substantial weight should be given to the benefits of development for defence and public protection purposes? Strongly agree, partly agree, neither agree nor disagree, partly disagree, strongly disagree.

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

Response: Partly Disagree

Giving "substantial weight" to defence/protection benefits must not automatically override health impacts. Public health professionals advocate that any development, regardless of its purpose, must be subject to the same rigorous health and environmental standards. These facilities are often located in or near marginalized communities.

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?

Partly disagree



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

The planning system should protect and enhance the natural environment not only for its intrinsic value and ecosystem services, but also because access to high-quality green and blue spaces is fundamental to physical and mental health, wellbeing, and health equity. When assessing proposals affecting the natural environment, decision-makers should also consider the implications for public health and wellbeing alongside ecological outcomes. The Faculty notes the following research:

- TCPA's *Planning for Health* resource emphasises green infrastructure as a determinant of health.
- Natural England's *Green Infrastructure Standards* link GI to physical activity, mental wellbeing, and resilience.
- NICE Guidance NG90 (*Physical Activity and the Environment*) recommends integrating green infrastructure to promote active travel and reduce health inequalities
- Marmot Review (*Fair Society, Healthy Lives*) identifies access to nature as a key factor in reducing health inequalities.

The Faculty recommends the following amendments to 1a and 1e:

Suggested wording amendments

N2: Improving the natural environment

1a – Suggested wording

Consider the environmental qualities of land proposed for development, including habitats, landscape character, the natural beauty of the countryside and their positive impacts on human health and well-being, identifying opportunities for those qualities to be conserved or enhanced (including through requirements for biodiversity net gain where these apply)

1e – Suggested wording

Use green infrastructure provided as part of the scheme and nature-based solutions to secure multiple benefits: such as for biodiversity; surface water and pollution management (including maintaining flow rates and water quality); climate change



mitigation and adaptation and ensure that these improvements contribute to healthier communities by reducing exposure to pollutants, mitigating heat stress, and supporting opportunities for active recreation.

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

a) If so, please explain who, which groups, including those with protected characteristics, or which businesses may be impacted and how.

People with protected characteristics are disproportionately affected by the conditions shaped by the planning system, including poor housing quality, inaccessible and unsafe environments, exposure to pollution, and limited access to affordable transport, green space and essential local services. Where planning policy prioritises growth without clear and explicit mechanisms to address existing inequalities, there is a risk that disadvantage is reinforced or widened, particularly in already deprived areas with constrained infrastructure and limited environmental assets. Ensuring that development delivers safe, inclusive and accessible places, and responds to differing needs across the life course, is therefore essential to reducing unequal health outcomes and meeting Public Sector Equality Duty obligations.

Centralisation through NDMPs may reduce local authorities' ability to embed locally tailored policies addressing local health inequalities, deprivation, accessibility and inclusion health needs. Local policy often contains bespoke protections for more vulnerable groups and communities, and these may be overridden or deprioritised if national policy is less specific.

Increased market-led housing delivery around transport hubs and the acceleration of house building, without the strengthening of affordable housing requirements, risks supply not matching the needs of carers, low income and vulnerable groups. Also, areas and communities without strong rail connectivity (e.g. rural, coastal) may experience reduced investment, worsening geographic inequalities. The proposals also introduce greater ambiguity around health-promoting design with the potential weakening of requirements to embed accessibility, active travel, green space, and healthy place principles.



1) ***Is there anything that could be done to mitigate any impact identified?***

Yes.

Potential adverse impacts could be mitigated by making the reduction of health inequalities an explicit consideration in planning policy and decision-making, rather than an implicit or secondary outcome. This should be supported by clear national recognition of Health Impact Assessment (HIA) as an evidence-based tool that local authorities may use, proportionately and where justified, to identify and address potential impacts on population health and health inequalities, alongside Equality Impact Assessment.

National policy should also be clearer that health-critical infrastructure and minimum standards — including those relating to housing quality, accessibility, green space and active travel — are baseline requirements, not discretionary elements to be reduced or removed through viability negotiations. Retaining flexibility in local plan-making is essential to enable place-specific responses to health inequalities and to meet Public Sector Equality Duty obligations in practice.

We propose:

1. Explicit national recognition of Health Impact Assessment (HIA) as an evidence-based tool that local authorities may use, proportionately and where justified, alongside Equality Impact Assessment, to identify and address impacts on population health and health inequalities.
2. Stronger health equity safeguards, including explicit requirements for inclusive design, accessible housing, and protection of vulnerable groups.
3. Retention of flexibility in local plan making process to address place-specific health inequalities.
4. Clear national expectations for affordable and supported housing.
5. Clear reference to the reduction of health inequalities reinstated in the Healthy Communities chapter