Nottinghamshire County Council

# Nottinghamshire Spatial Planning and Health Framework 2019- 2022

Health Impact Assessment May 2019

# CONTACTS

***Nina Wilson***

Principal Planning Officer

Nottinghamshire County Council

Tel:  0115 977 3793

Nina.wilson@nottscc.gov.uk

***Jenny Charles Jones***

Public Health & Commissioning Manager

Nottinghamshire County Council

Tel: 0115 977 2500

Jenny.charles-jones@nottscc.gov.uk

# Contents

# Glossary of Terms & Abbreviations

**Community Infrastructure Levy (CIL)** - The Community Infrastructure Levy (CIL) is a charge that local authorities can set on new development to raise funds to help fund the infrastructure, facilities and services - such as schools or transport improvements - which are needed to support new homes and businesses in the areas.

**Clinical Commissioning Group (CCG)** - Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012 and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. There are now 195 CCGs in England.

**Environmental Impact Assessment (EIA)** - Environmental Impact Assessment (EIA) is a process of evaluating the likely environmental impacts of a proposed project or development, considering inter-related socio-economic, cultural and human-health impacts, both beneficial and adverse.

**Health Impact Assessment (HIA)** - HIA is intended to produce a set of evidence-based recommendations to inform decision making HIA seeks to maximise the positive health impacts and minimise the negative health impacts of proposed polices, programs or projects.

**Health Urban Development Unit (HUDU)** - The HUDU Planning Contributions Model is a comprehensive tool to assess the health service requirements and cost impacts of new residential developments. The information can then be used to influence the planning process via S106 planning negotiations or CIL and to gain necessary resources for health improvements or expansion.

**Integrated Care System (ICS)** – In 2016, NHS organisations and local councils came together to form 44 sustainability and transformation partnerships (STPs) covering the whole of England, and set out their proposals to improve health and care for patients. An integrated care system, a new type of even closer collaboration where NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

**Joint Strategic Needs Assessment (JSNA)** – A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area. Nottinghamshire Joint Health and Wellbeing Strategy (JHWBS) - It is the County's overarching plan for improving health and wellbeing outcomes for our residents whilst also reducing health inequalities. It is the main way in which the Nottinghamshire Health and Wellbeing Board executes its legal duty to work on: improving the health and wellbeing of the people in their area, reducing health inequalities and promoting the integration of services.

**Local Authority Health Profile (LAHP)** - The Local Authority Health Profiles provide an overview of health for each local authority in England. They pull together existing information in one place and contain data on the range of indicators for local populations, highlighting issues that can affect health in each locality. The profiles are intended to help local government and health services make plans to improve the health of their local population and reduce health inequalities. Local Health profiles provides health information for small areas within local authorities, enabling users to explore differences at a more local level.

**Local Planning Authority (LPA)** - A local planning authority (LPA) is the local government body that is empowered by law to exercise planning functions for a particular area.

**Local Transport Plan (LTP)** - Local transport plans, divided into full local transport plans (LTP) and local implementation plans for transport (LIP) are an important part of transport planning in England. Strategic transport authorities such as Nottinghamshire County Council are expected to prepare them as forward-looking plans covering a number of years to include: an outline of the current baseline regarding transport, accessibility and pollution, set out challenging but achievable objectives, set out the programme for achieving these objectives and Outline 'bids' for funding from the Department of Transport.

**Marmot Review** – The Marmot Review into health inequalities in England was published on 11 February 2010. It proposes an evidence-based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities.

**Minerals Local Plan (MLP)** - The current Nottinghamshire Minerals Local Plan was adopted December 2005. It gives certainty as to the location of future minerals development. The Plan includes mechanisms aimed at reducing the demand for primary mineral use, recycling more aggregate and safeguarding mineral resources, reserves and important facilities.

**National Health Service (NHS)** – the National Health Service (NHS) is the publicly funded national healthcare system in the United Kingdom.

**The National Institute for Health Care Excellence (NICE)** - The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

**NHS Long Term Plan** is a new plan for the NHS to improve the quality of patient care and health outcomes to strengthen its contribution to prevention and health inequalities that will help people stay healthy.

**National Health Service (NHS England)** – NHS England is an executive body of the Department of Health and Social Care that oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012. It holds the contracts for GPs and NHS dentists.

**National Health Service Strategic Estates Planning Team (SEP)** - The NHS Strategic Estates Planning Service (SEP) provides ongoing support to systems through a team of Strategic Estates Advisers (SEA). SEP is a national centre of excellence set up to advise STPs/ICSs and to help them develop and then successfully implement their Estates Strategy, enabling the NHS to transform its estate to meet local clinical need, implementing contemporary service models, delivering the best service for patients, and achieving national policy objectives. The service is jointly managed by NHS Improvement and NHS England reflecting the fact that its role extends across all elements of the health system as well as encouraging partnerships across the wider public sector.

**National Planning Policy Framework (NPPF)** – Government planning policy is contained in the National Planning Policy Framework (NPPF). This covers all national planning issues, such as planning for housing, shops, offices and good design. The only planning issues on which the Government issues guidance that are not completely covered by the NPPF are

planning for waste and some parts of planning for minerals extraction. These issues are covered in separate policy statements.

All local planning policies and decisions on planning applications must take what the NPPF says about different types of land use into account. It is the main statement of Government policy on how development should happen in England.

**Neighbourhood Plan (NP)** - Neighbourhood Plans give rights and powers for local communities to have a greater say in shaping the future of places where they live and work. They are developed by 'Neighbourhood Forums', a Neighbourhood Plan can set out general planning principles for the development of the Neighbourhood. Neighbourhood Plans are about supporting growth and must be consistent with national planning policy and the policies in Local Plans.

**Nottinghamshire Health and Wellbeing Board** a statutory body introduced under the Health and Social Care Act 2012 whereby local authorities are required to form a committee bringing together HS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.

**Nottinghamshire Planning Obligations Strategy** – Planning obligations are sometimes known as planning contributions, developer contributions, section 106 agreements or planning gain. Planning obligations look at how facilities/services/assets are affected by a particular development. It looks at how this can be protected, enhances, maintained or where appropriate new provisions can be made. For example, when a new development takes place there may be a need to improve transport or expand education facilities. The County Council have undertaken a review of its Planning Obligations Strategy and the updated document was adopted as Council Policy on 12th September. The Updated Strategy can be downloaded below:

**Nottinghamshire Rapid Health Impact Assessment Matrix** – sets out a planning and health checklist that has 12 features to assess the impact of development proposals and plans on the built environment and health.

**Nottinghamshire and Nottingham Waste Local Plan (WLP)** – The Waste Local Plan was adopted in January 2002. It is being progressively replaced by the Replacement Waste Local Plan

**One Public Estate (OPE)** - The One Public Estate programme is an established national programme delivered in partnership by the LGA and the Office of Government Property (OGP) within the Cabinet Office. One Public Estate began in 2013 with just twelve areas, today they are working with more than 300 councils on projects transforming local communities and public services right across the country.

**Public Health England (PHE)** - an executive agency of the Department of Health and Social Care provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific expertise and support. To protect and improve the nation's health and wellbeing, and reduce health inequalities through world-leading science, knowledge and intelligence, advocacy, partnerships and providing specialist public health services.

**Public Health Outcomes Framework (PHOF)** - The Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting*

*transparency* sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life. The Public Health Outcomes Framework is not a performance management tool for local authorities. PHOF data will enable local authorities to benchmark and compare their own outcomes with other local authorities.

**S106 –** A Section 106 is a legal agreement between an applicant seeking planning permission and the local planning authority, which is used to mitigate the impact of your new home on the local community and infrastructure.

**Statutory Consultees** - statutory consultees are those organisations and bodies, defined by statute, which local planning authorities are legally required to consult before reaching a decision on relevant planning and listed building consent applications and are primarily set out in Schedule 4 of the Development Management Procedure Order.

**Strategic Environmental Assessment (SEA)** - is the process by which environmental considerations are required to be fully integrated into the preparation of plans and programmes prior to their final adoption. The objectives of SEA are to provide for a high level of protection of the environment and to promote sustainable development.

**Supplementary Planning Document (SPD)** – Are documents which add further detail to the policies in the Local Plan. They can be used to provide further guidance for development on specific sites, or on particular issues, such as design. Supplementary planning documents are capable of being a material consideration in planning decisions but are not part of the development plan.

**Sustainability Appraisal (SA)** - is a tool used to appraise planning policy documents to promote sustainable development. Social, environmental and economic aspects are all taken into consideration.

**Town and Country Planning Association (TCPA**) – a long standing charity that promotes the values of progressive planning and place-making which shaped the Garden City movement and campaigns for the reform of the UK's planning system to make it more responsive to people's needs and aspirations and to promote sustainable development.

# 1. Introduction

## Executive Summary

1.1. The Nottinghamshire Spatial Planning and Health Framework 2019-2022 brings together the Spatial Planning for Health and Wellbeing for Nottinghamshire 2016 and Planning and Health Engagement Protocol 2017 into a single guidance document.

1.2. The purpose of this document is to present a holistic overview of health and planning across Nottinghamshire and provide robust planning and health responses so that health is fully embedded into the planning process. To maximise health and wellbeing and ensuring that health/social care infrastructure requirements are considered to meet the growth requirements of the population of Nottinghamshire.

1.3. Local planning policies play a vital role in ensuring the health and wellbeing of the population are considered in the planning process; there is substantial evidence supporting the fact that health and environment are inextricably linked and that poor environments contribute significantly to poor health and health inequalities.

## Status of this Document

1.4. Whilst this document has no statutory status. The Nottinghamshire Spatial Planning and Health Framework 2019-2022 is supported by the Joint Health and Wellbeing Strategy for Nottinghamshire 2018-2022 and supports its vision for healthy and sustainable places. It provides guidance on addressing the impact of a proposal or statutory plans on the health and wellbeing of the population and sets out good practice to ensure health requirements are met across Nottinghamshire.

## Background

### The Planning System

1.5. The linkages between health and the built and natural environment have long been established and the role of the environment in shaping the social,

economic and environmental circumstances that determine health is increasingly recognised (Figure 1). For example, the Marmot Review developed an objective to 'Create and develop healthy and sustainable places and communities' recommends that the planning transport environmental health systems address the social determinants of health.

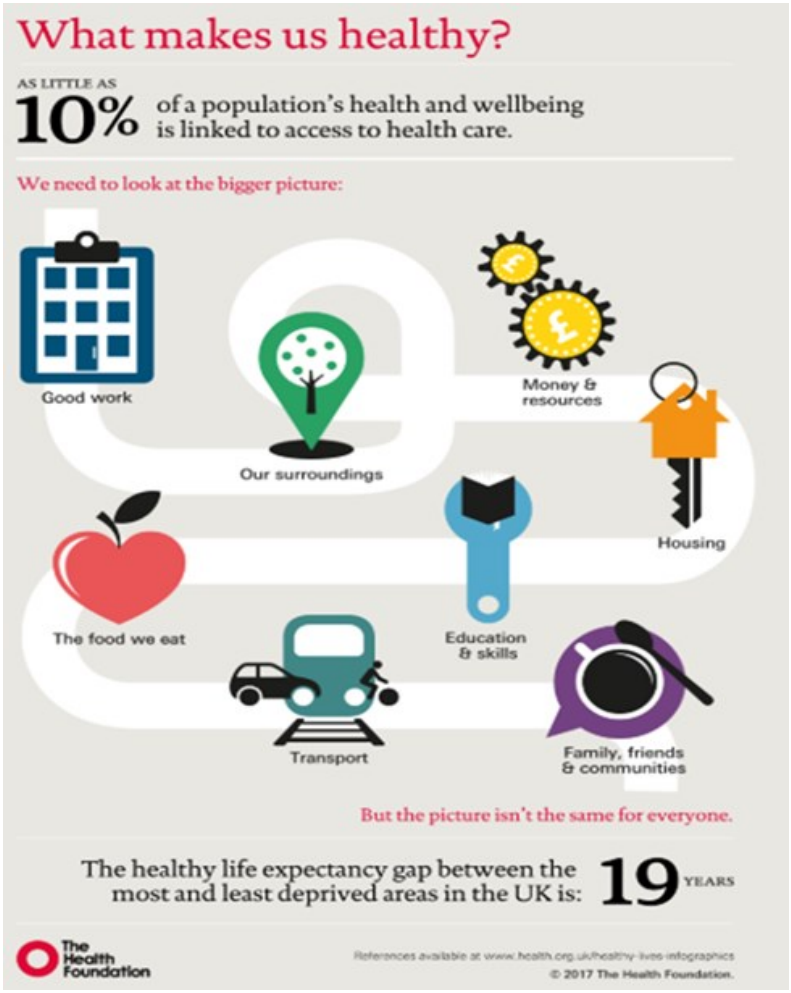



*Figure 1: Source: The Health Foundation 2017. What makes us Healthy?*

1.6. Therefore, the environment in which we live in is inextricably linked to our health across the life course. For example, the design of our neighbourhoods can influence physical activity levels, travel patterns, social connectivity, mental and physical health and wellbeing outcomes.

1.7. A good planning system can create better places where it is easy for people to lead healthier lifestyles, in which illness is prevented, people's lives are improved with health and social care costs cut. The planning function in local government is an important lever to shape the natural and built environment

through green spaces, housing, transport and our high streets and town centres.

Local Planning Authorities

1.8. Within Nottinghamshire a two-tier system of local government applies. In a planning context, the county's district and borough councils are the Local Planning Authorities (LPA) for the vast majority of planning applications and are ultimately responsible for granting planning consents and producing Local Plans.

1.9. Nottinghamshire County Council have a statutory duty to prepare Minerals and Waste Local Plans and are responsible for determining planning applications for waste and mineral developments and County Council developments.

Local Authority Public Health

1.10. Nottinghamshire County Council has had a statutory responsibility for Public Health since the introduction of the Health and Social Care Act 2012. Public Health can be defined as the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public, private, communities and individuals. It is population focused rather than caring for individuals. It addresses small, medium and whole population issues related to geography, activity and health conditions. The County Council Public Health Division are responsible for:

- Public Health Intelligence - providing and sharing data on population health
- Health protection - working on threats from environmental hazards, infections or radiation
- Health improvement - promoting good health and working with others in health and social care to provide effective good quality health care and improve health.
- Healthcare public health and preventing premature mortality

NHS Health and Integrated Care System

1.11. There are currently six Clinical Commissioning Groups (CCG) in Nottinghamshire called Nottingham North and East CCG, Nottingham West CCG, Mansfield and Ashfield CCG, Newark and Sherwood CCG, Rushcliffe CCG and Bassetlaw CCG. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

1.12. Integrating Health and Care Services in Nottingham and Nottinghamshire has evolved out of the Sustainability and Transformation Partnership (STP) process to become Nottingham and Nottinghamshire Integrated Care System (ICS). This is where NHS organisations, in partnership with the Local Authority and district councils and others, take collective responsibility for managing resources to improve health and wellbeing of the Nottinghamshire population they serve.

1.13. Similarly, South Yorkshire and Bassetlaw ICS are working in partnership together across five 'places' within South Yorkshire and Bassetlaw – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

1.14. The Nottingham and Nottinghamshire's ICS and NHS England are responsible for the commissioning of healthcare services and facilities which are linked to the work of the Health and Wellbeing Board and the local Director of Public Health. These bodies are consultees for Local Plans.

1.15. These bodies, in consultation with local healthcare providers, will be able to assist a Local Planning Authority regarding its strategic policy to deliver health facilities and its assessment of the quality and capacity of health infrastructure as well as its ability to meet forecast demand. They will be able to provide information on their current and future strategies to refurbish, expand, reduce or build new facilities to meet the health needs of the existing population as well as those arising because of new and future development.

1.16. The document intends to make Nottinghamshire a place that improves the mental and physical wellbeing of residents, reduces health inequalities and promotes the use of Checklist for Planning, Nottinghamshire Rapid Health Impact Assessment Matrix throughout the plan making stages.

## What this document does not address

1.17. It is important to understand that this document does not address the issue of NHS service delivery, this lies outside the remit of both County and Local Planning Authorities. The document aims to raise awareness and provide sustainable solutions to guide people to make healthy lifestyle choices that can be facilitated using sound spatial planning and joined up planning decisions.

# 2. The Built Environment and health

2.1. The Health Map (Figure 2) aids the understanding of the built and natural environment and health first devised by Dahlgren and Whitehead (1991) and later updated by Barton and Grant (2006). The map is focused on the roles of neighbourhood and planning emphasised the importance of the built and natural environments contribution to health and well-being outcomes.

2.2. The Health Map provides a dynamic tool which can provide the basis for discussions between spatial planners, health professionals, ecologists, urban designers and other service providers to ensure that awareness on what affects health and wellbeing is recognised within all these professions and that the best outcomes are achieved through the planning process.

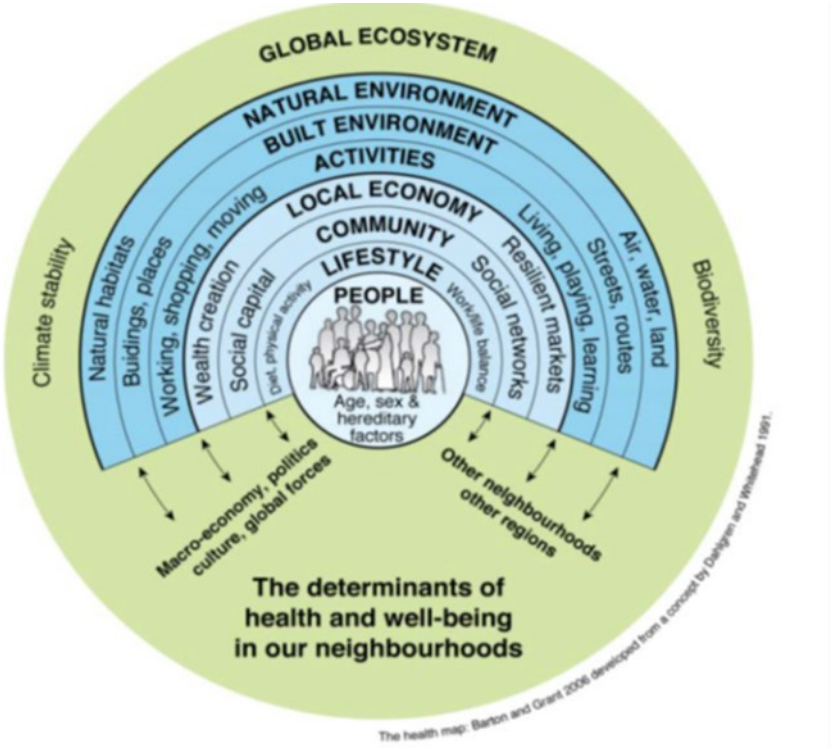



*Figure 2: The Health Map Barton & Grant (2006) developed from a concept by Dahlgren and Whitehead (1991)*

2.3. RE-imagine the way we use planning powers.
There are a range of specific guidance that cover the role of planning system and its the impact on health. The following are important examples sourced from Town and Country Planning Association (TCPA), Sport England and Public Health England.

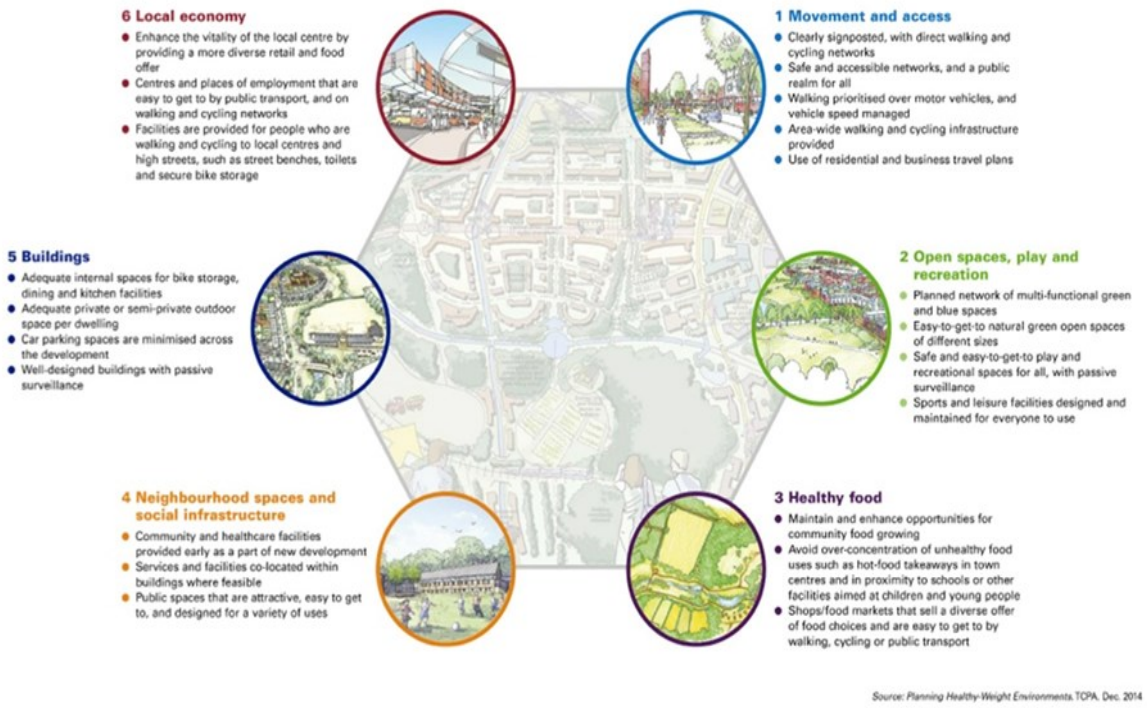



*Figure 3: Planning Health Weight Environments – Source: Town and Country Planning Association (TCPA) and Public Health England (PHE) 2014.*

The Town and Country Planning Association (TCPA) 'Six Planning Healthy Weight Environments' framework sets out and illustrates a range of interventions in the planning and design of a new development, or an existing community, that can help create an environment which supports healthier lifestyle choices categorised under the following themes:

I. movement and access: sustainable travel or active travel;
II. open spaces play and recreation: green infrastructure, formal and informal play areas;
III. healthy food environments: food growing and access to healthy food retail;
IV. neighbourhood spaces: public realm, social and healthcare facilities and services;
V. buildings: design and layout of homes and commercial spaces;
VI. local economy: town centre retail and food diversity.

2.4. Active Design recognises the link between sport and physical activity through the design and layout our built environment which is rooted in the Sport England's aims and objectives as a step towards healthier and more active lifestyle. Ten principles for active design are outlined in Figure 4 giving

examples of how to promote environments that offer individuals and communities the greatest opportunity to lead active and healthy lifestyles.

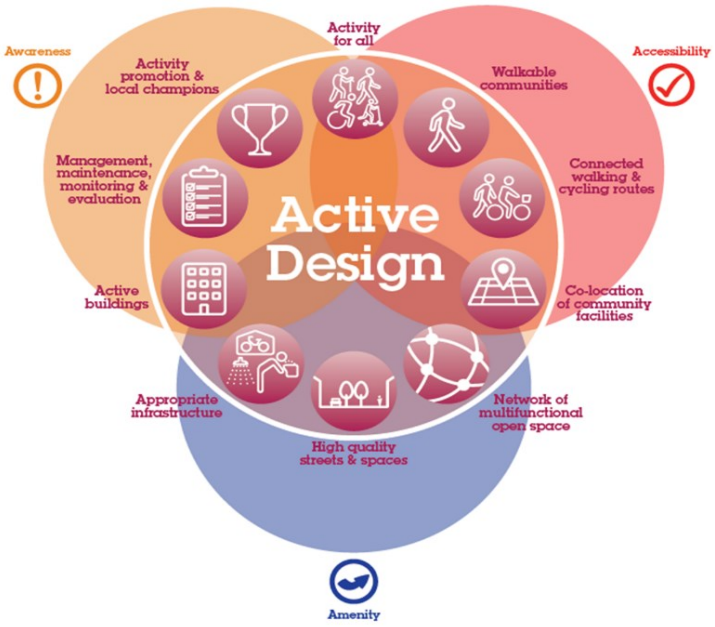



*Figure 4: Active Design Planning for health and wellbeing through sport and physical activity 2015 Source: Sport England and Public Health England*

2.5. The NICE Guidance Quality standard (QS181) Air pollution: outdoor air quality and health and states that LPA assess proposals to minimize and mitigate road-traffic-related air pollution in planning applications for major developments.

2.6. Air Quality is a key environmental factor that impacts health. Clean air is essential for our good health and wellbeing, with air pollution associated with having adverse impacts on health and wellbeing. It is recommended that the recently finalised East Midlands Air Quality and Emissions Mitigation Guidance for Developers (July 2018) will be available via email contact to planning.publichealth@nottscc.gov.uk

**The Health and Wellbeing Strategy and the Joint Strategic Needs Assessment**

2.7. The introduction of the Health and Social Care Act 2012 intended to improve quality and efficiency of access to healthcare services. Resulted in the introduction of the Nottinghamshire Health and Wellbeing Board bringing together NHS Senior Managers, County and District councillors, doctors and a

representative of the local people through Healthwatch to focus on improving the health and wellbeing of Nottinghamshire residents.

*2.8.* The formation of the Health and Wellbeing Board led to the statutory requirement for the production of the Joint Strategic Needs Assessment (JSNA), The JSNA identifies the current and future health needs of the Nottinghamshire population which has been in progress since 2007 and a statutory duty placed on the Director of Public Health, Children's Services and Adult Services.

*2.9.* Currently, the second Health and Wellbeing Strategy for Nottinghamshire refers to as the Joint Health and Wellbeing Strategy (JHWS) 2018 -2022 It reaffirms and builds upon the first strategy with the introduction of 4 key ambitions;-

- To give everyone a good start in life.
- To have healthy and sustainable places.
- To enable healthier decision making.
- To work together to improve health and care services.

2.10. Healthy and sustainable places where spatial planning is identified as a key priority for the delivery of the Joint Health and Wellbeing Strategy, to impact on the health and wellbeing of Nottinghamshire residents to create places which maximise the health benefits for those people who live or work in our communities.

**National Planning Policy Framework (NPPF)**

2.11. The National Planning Policy Framework (NPPF) 2018 sets out national planning guidance for local authorities and recognises that the planning system can play an important role in facilitating social interaction and creating healthy and inclusive communities.

2.12. Chapter 8 of the NPPF focusses on promoting healthy communities ensuring that local communities are engaged in the planning process at all levels and that mechanisms are embedded to encourage people to choose healthy lifestyles.

2.13. The NPPF places great emphasis on the importance of accessibility for all too high-quality open space, safe communities, recreational facilities/services, rights of way and cultural facilities and the provision of and access to trusted

and reliable information, advice and learning which can all make an important contribution to the health and wellbeing of communities.

2.14. Chapter 9 of the NPPF relates to promoting sustainable travel and seeks to ensure that such issues are considered early in the planning process. This would address the potential impacts on transport networks, identify opportunities from existing or proposed transport infrastructure, and changing transport technology and usage, provide opportunities to promote walking, cycling and public transport use, take account of the environmental impacts of traffic and transport infrastructure and identify patterns of movement, streets, parking and other transport considerations are integral to the design of schemes, and contribute to making high quality places.

2.15. The planning system should actively manage patterns of growth in support of these objectives. Significant development should be focused on locations which are or can be made sustainable, through limiting the need to travel and offering a genuine choice of transport modes. This can help to reduce congestion, emissions and improve air quality and public health. However, opportunities to maximise sustainable transport solutions will vary between urban and rural areas, and this should be taken into account in both plan-making and decision-making"

**Planning and Public Health Context**

The Public Health Outcomes Framework (PHOF)

2.16. The Public Health Outcomes Framework (PHOF) Healthy lives, healthy people: Improving outcomes and supporting transparency sets out a vision for public health, desired outcomes and indicators to help understand how well public health is being improved and protected. The PHOF concentrates on two high-level outcomes to be achieved across the public health system. These are:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities

2.17. These outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas in our

society. A set of supporting indicators to cover the full spectrum of public health are grouped into four domains:

- Improving the wider determinants of health.
- Health improvement.
- Health protection.
- Healthcare public health and preventing premature mortality

**County Council Development Plans and Local Plans of District and Borough Councils**

*2.18.* Within Nottinghamshire a two-tier system of local government applies. County Councils are responsible for the provision of certain services, such as education, libraries, highways and waste disposal. Other services, such as the provision of housing, environmental health, licensing, leisure centres and waste collection, fall to District and Borough councils.

*2.19.* In a planning context, the County Council are responsible for determining planning applications for Mineral and Waste Development, Education and County Council planning applications. Also, the County has responsibility for public health and social care. The Local Planning authorities within Nottinghamshire are responsible for determining all other planning applications such as for housing, employment and retail.

*2.20.* Nottinghamshire County Council has a statutory duty to prepare a Minerals and Waste Local Plan and Local Transport Plan, the Nottinghamshire District and Borough councils prepare Local Plans and Supplementary Planning Documents.

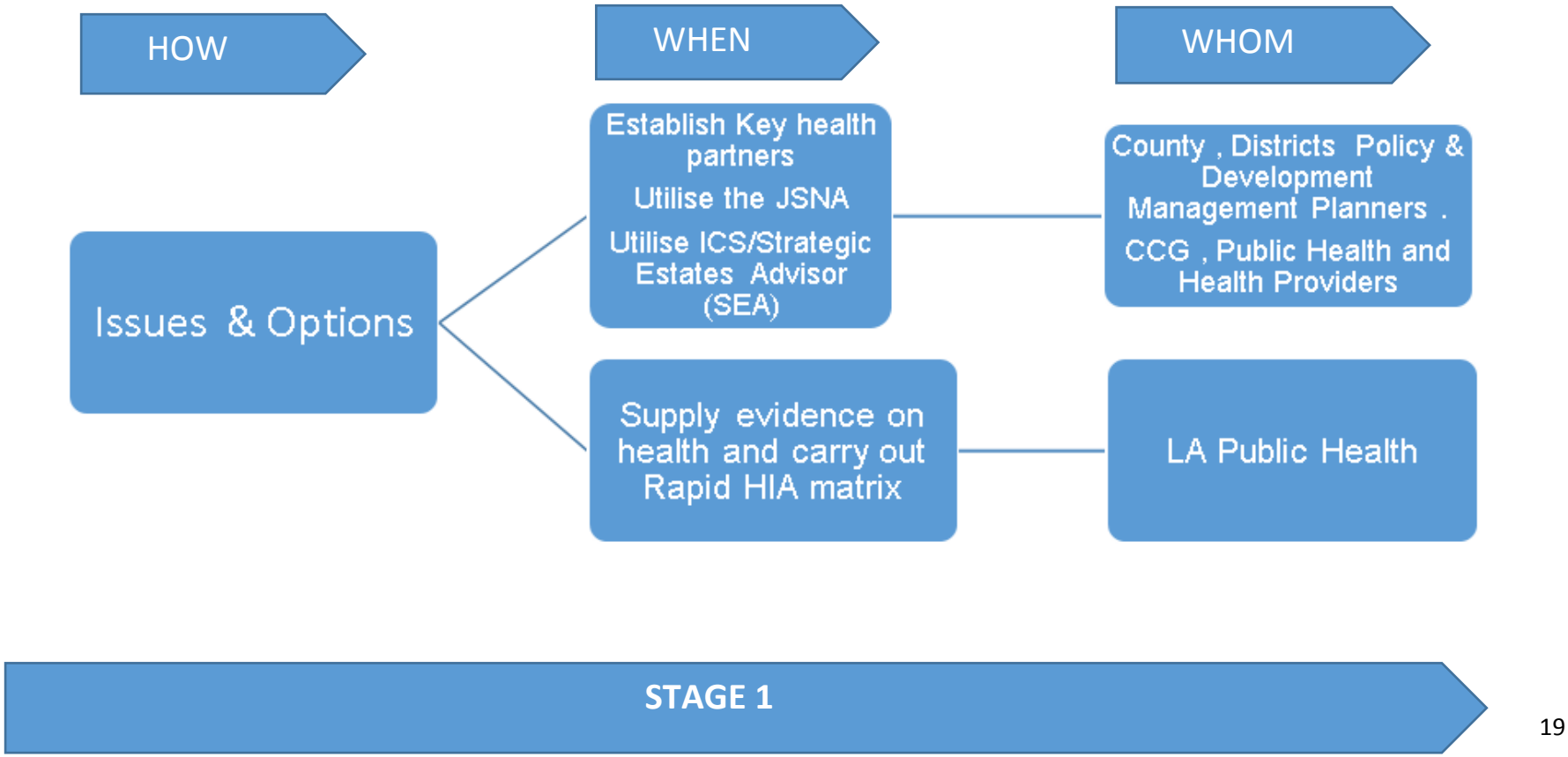
*2.21.* Neighbourhood Plans give communities direct power to develop a shared vision for their neighbourhood and to shape the growth and development of their local area. There are three types of organisations that can qualify as bodies, they are Parish/Town Councils, a neighbourhood forum and a community organisation.

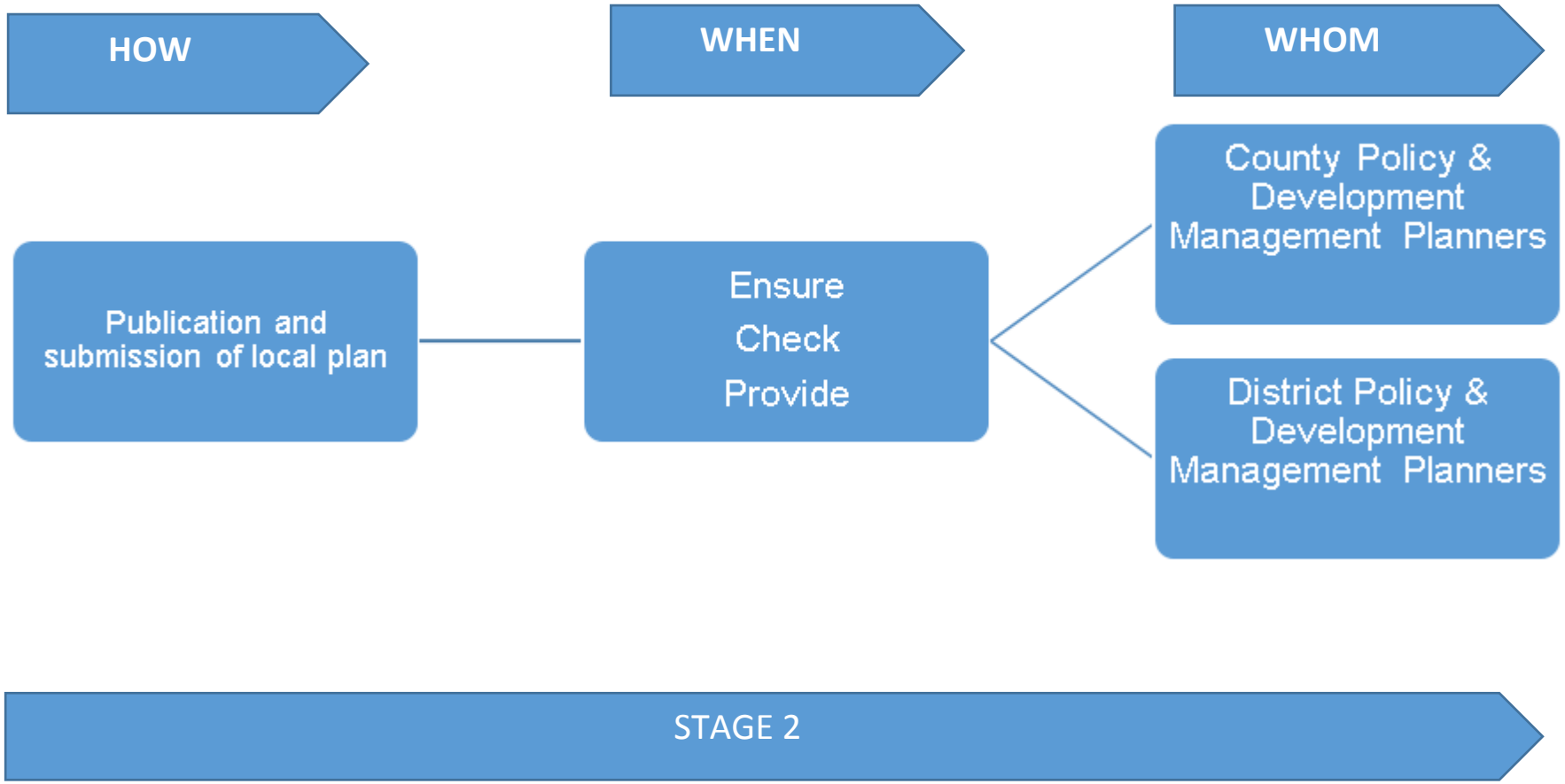
*2.22.* The LPA role is to take decisions at key stages in the neighbourhood planning process and provide assistance to the qualified body. The principles of the NPPF in relation to health and wellbeing should be encompassed in Neighbourhood plans in the same way these principles apply to the development of Local Plans and Strategies.

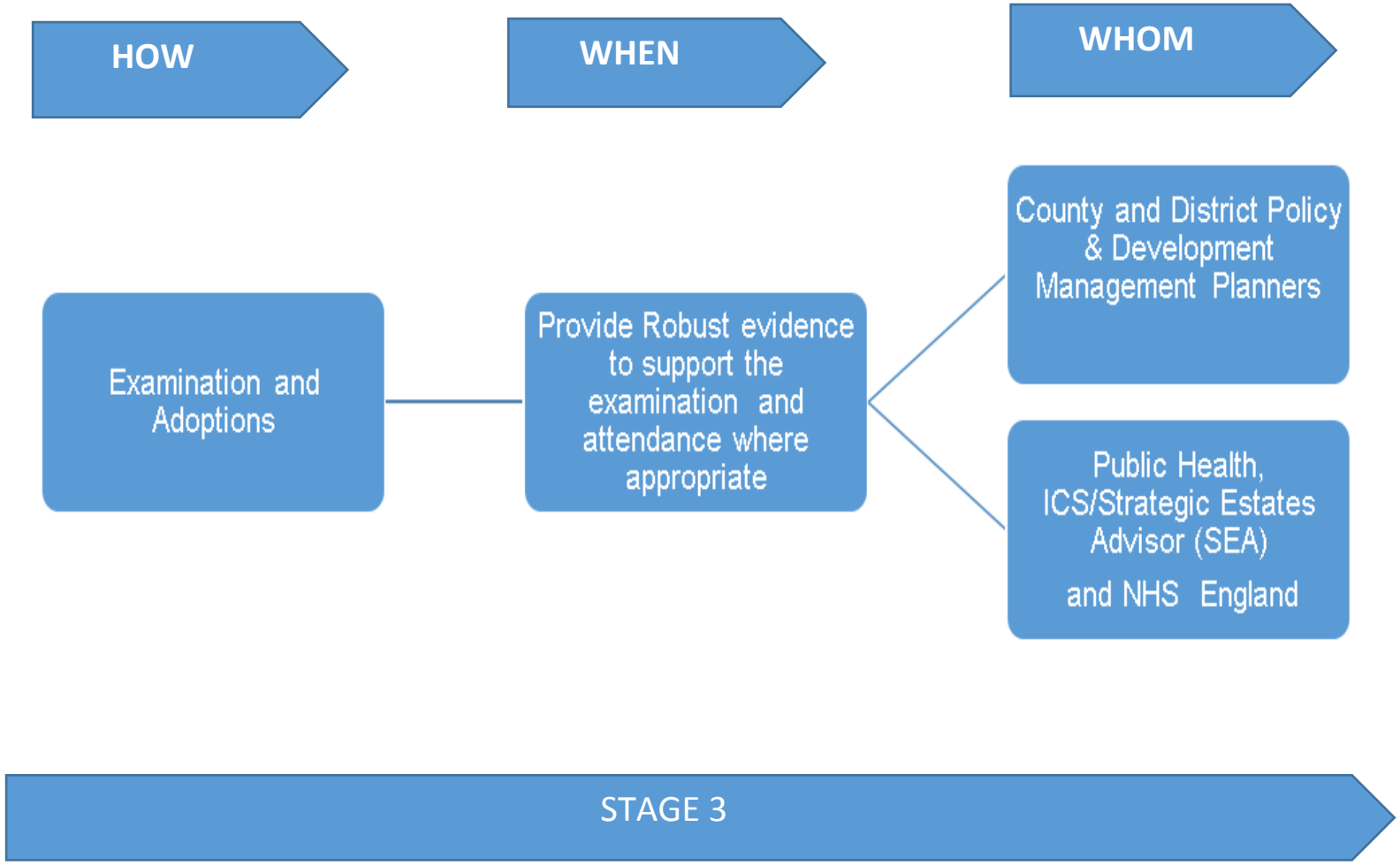
# 3. Plan Making involving Health

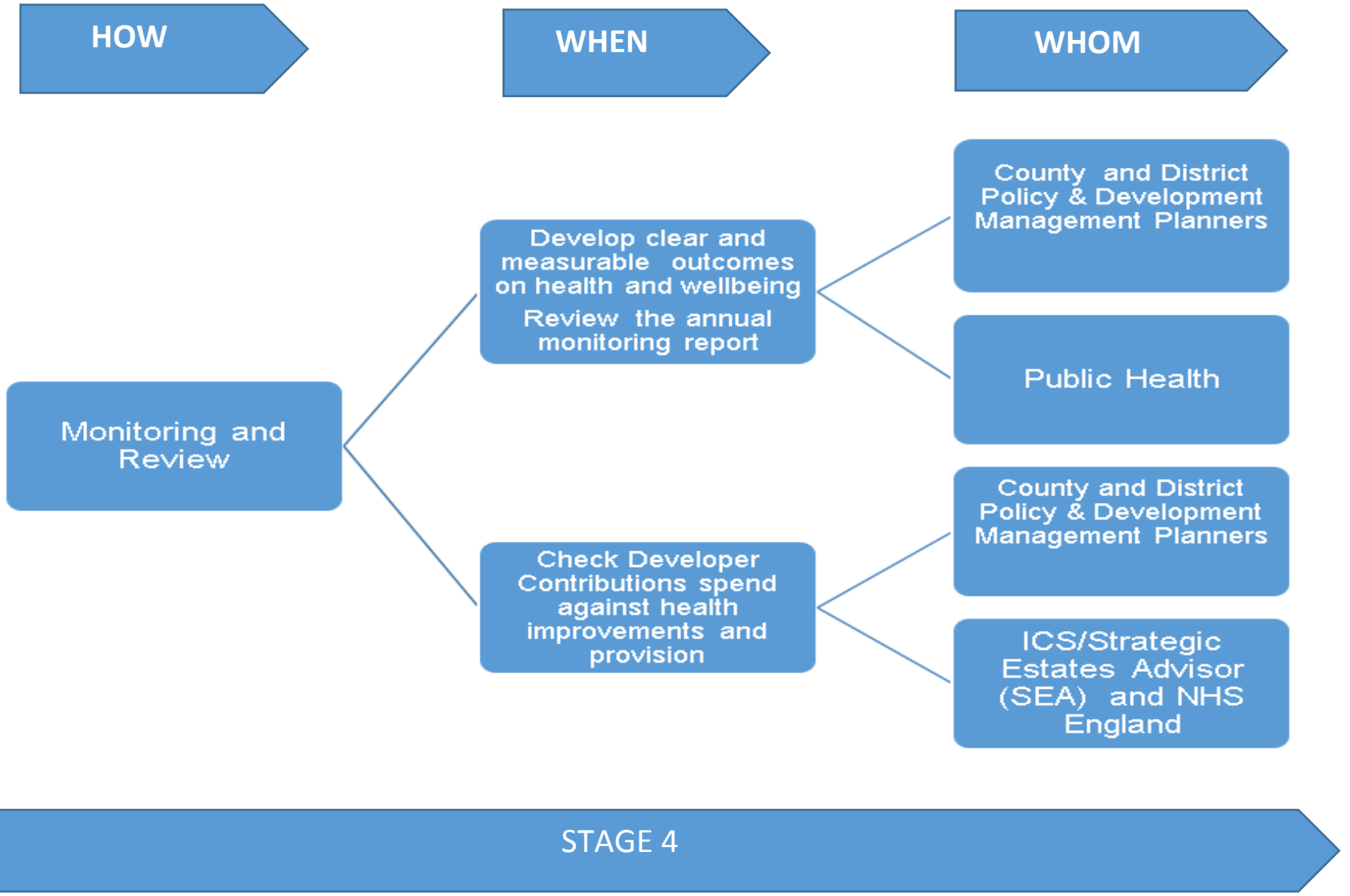
3.1. The Local Plan process offers extensive opportunities for health partners to get involved to ensure that strategic level planning policies reflect their own strategic priorities. Flow charts 1 outlines the responsibilities of planners and health partners during the Local Plan making stages 1 -4.

The Local Plan making stages, How and When to engage and with Whom.




HOW
WHEN
WHOM
Publication and submission of local plan
Ensure
Check
Provide
County Policy & Development Management Planners
District Policy & Development Management Planners
STAGE 2


HOW
WHEN
WHOM
Examination and Adoptions
Provide Robust evidence to support the examination and attendance where appropriate
County and District Policy & Development Management Planners
Public Health, ICS/Strategic Estates Advisor (SEA)
and NHS England
STAGE 3

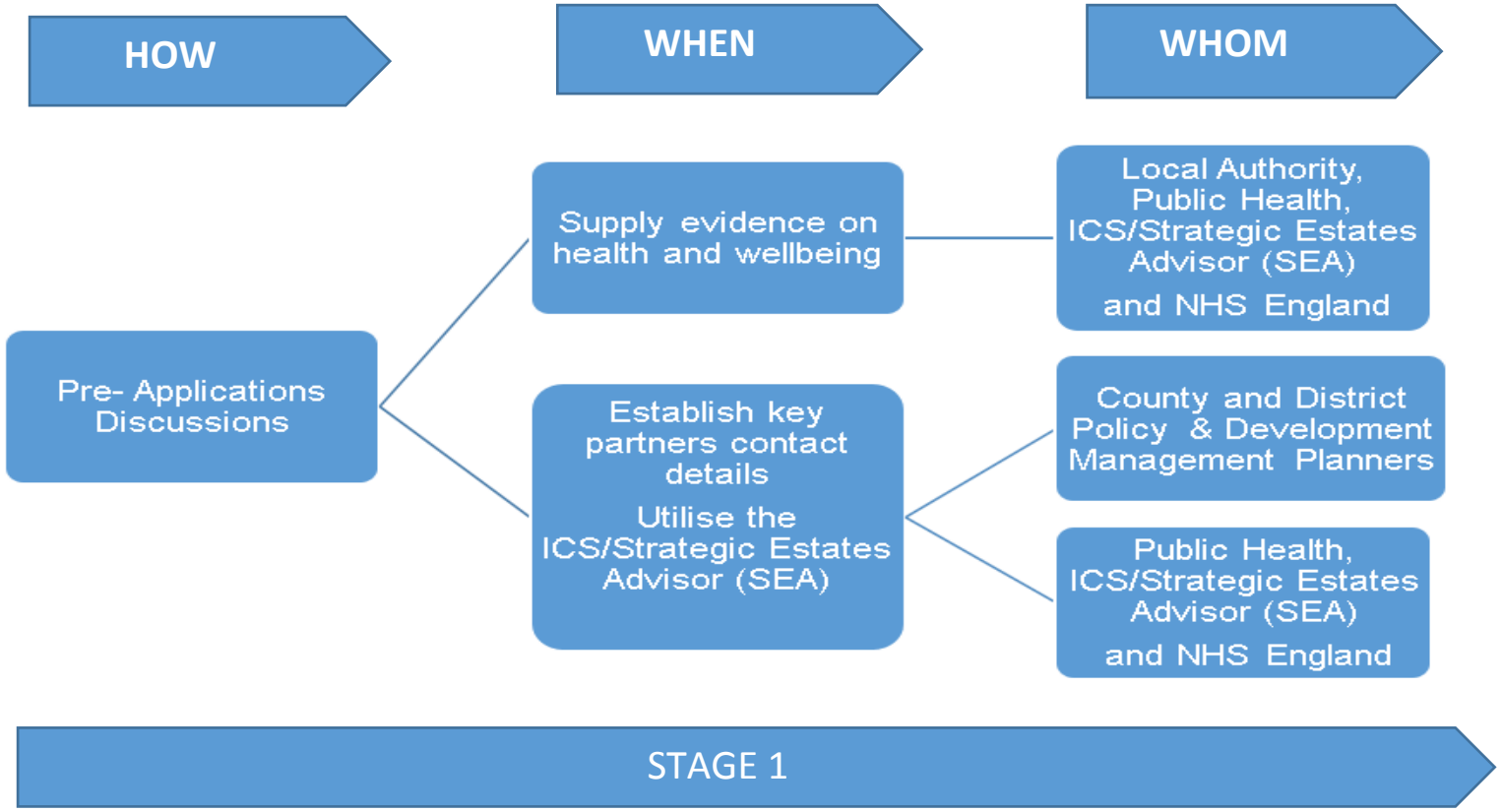

HOW
WHEN
WHOM
Monitoring and Review
Develop clear and measurable outcomes on health and wellbeing
Review the annual monitoring report
Check Developer Contributions spend against health improvements and provision
County and District Policy & Development Management Planners
Public Health
County and District Policy & Development Management Planners
ICS/Strategic Estates Advisor (SEA) and NHS England
STAGE 4

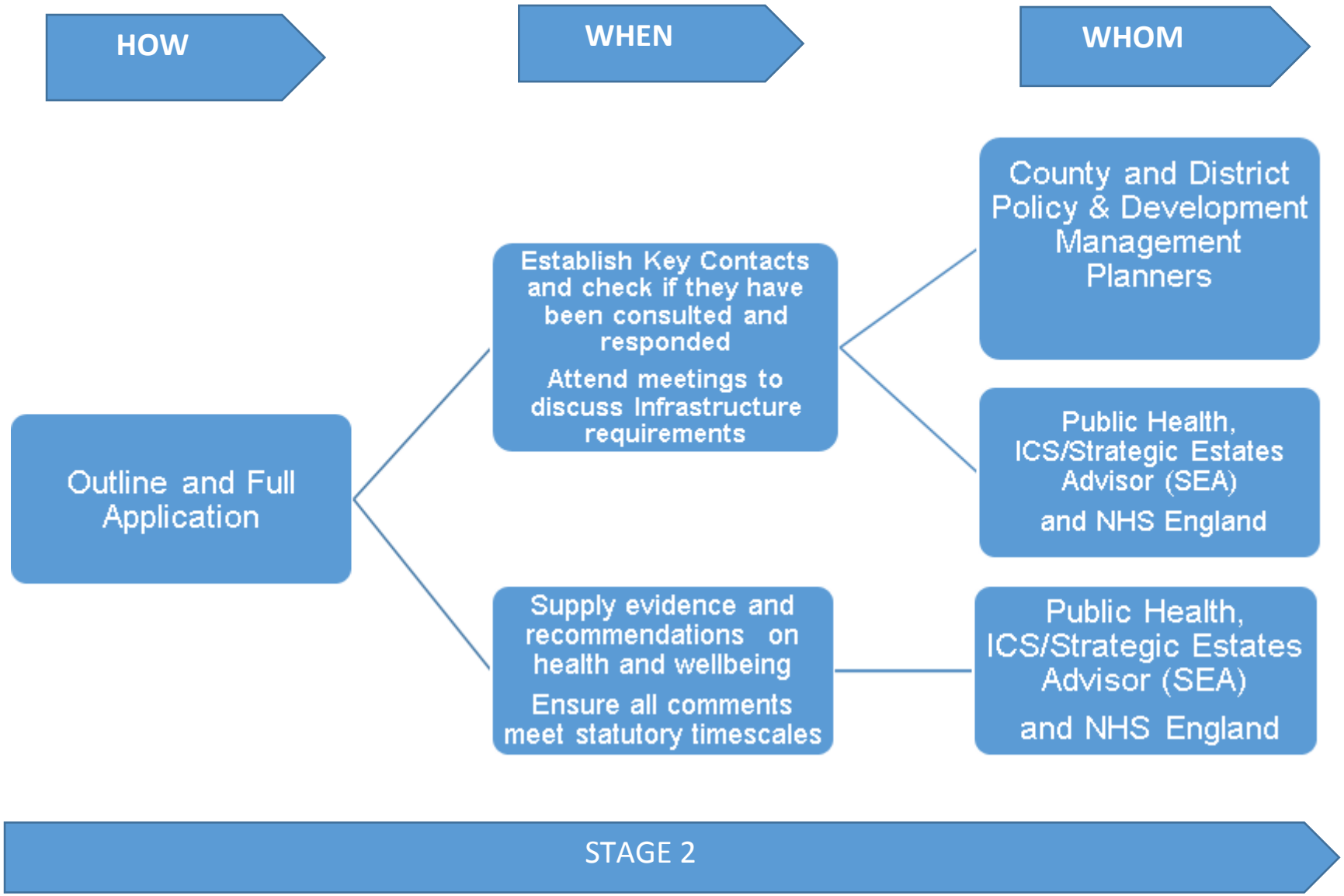
# 4. Planning Applications

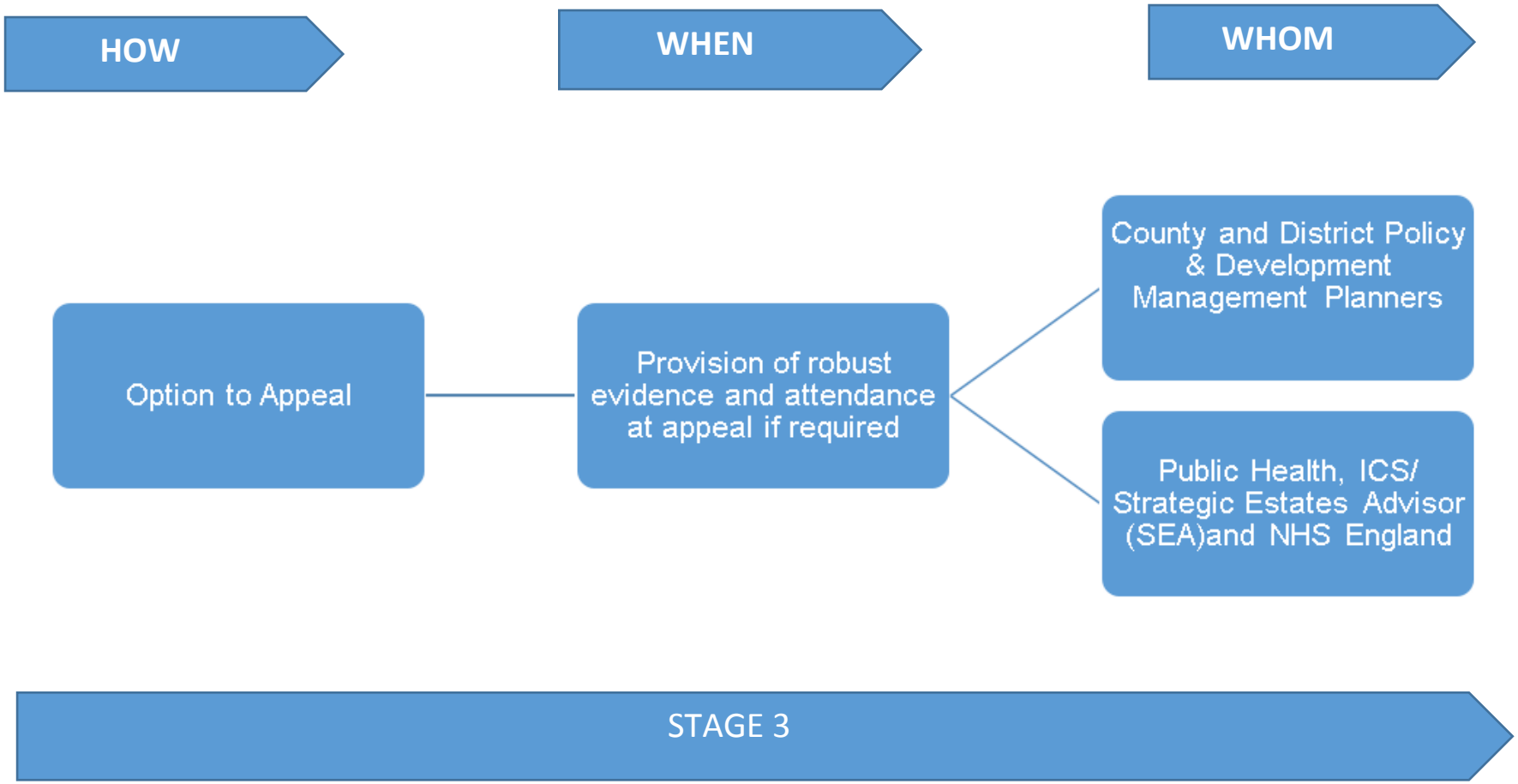
4.1. It is important that health partners are aware of and consulted alongside relevant statutory consultees on all developments. This should be done at all stages of the planning application process, including pre-application discussions. On a reciprocal basis Health Partners need to commit to responding to consultations by the statutory deadlines, or those agreed with the LPA. Failing to respond within the specified statutory deadline gives rise to several implications. Flowcharts outlines the responsibilities of planners and health partners in the pre-application and application processes.

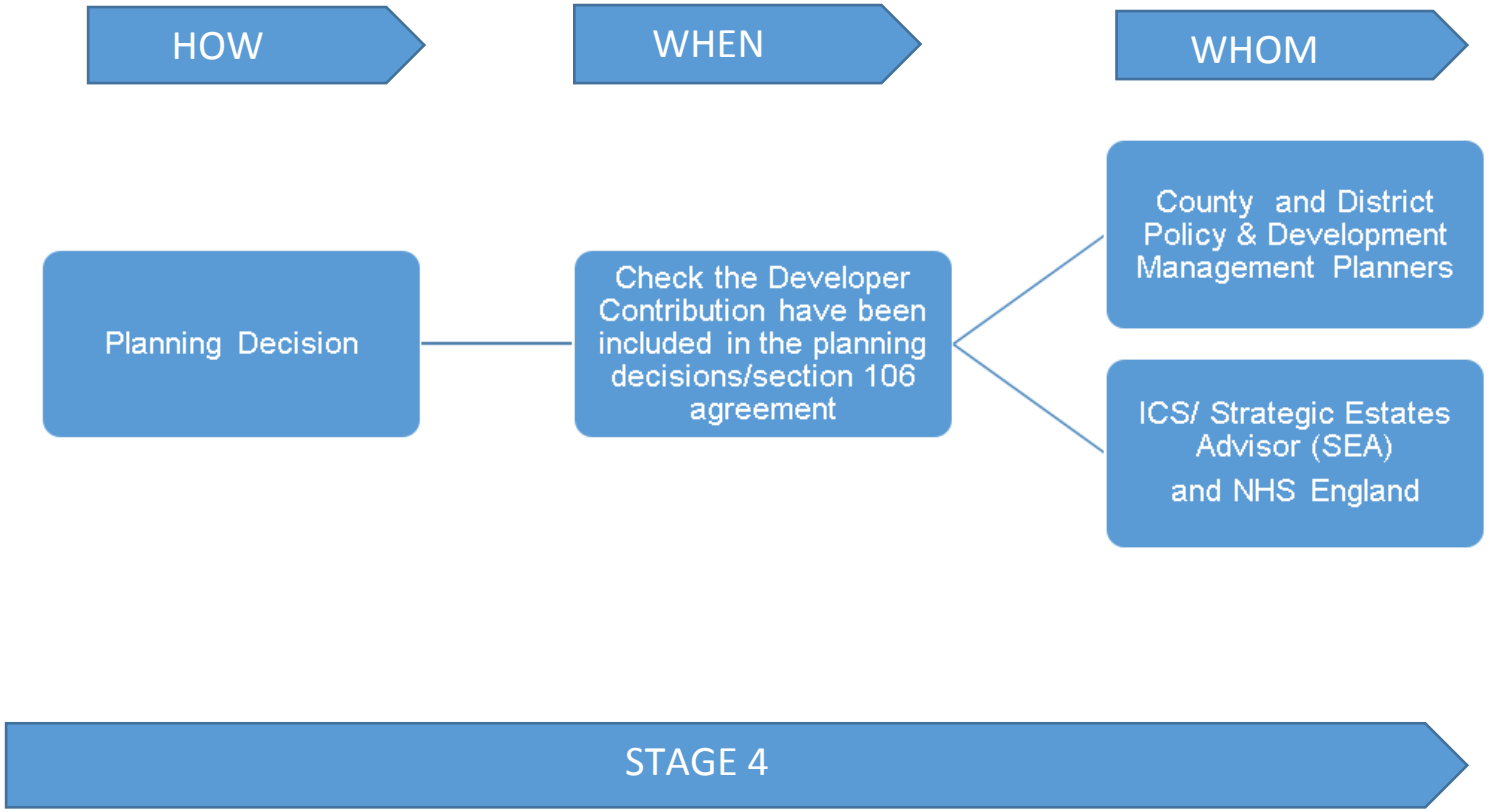
4.2. Discussions and comments provided on all planning applications will make use of the criteria (Appendix 2). The purpose of the Nottinghamshire Spatial Planning and Health Framework 2019-2022 is to present a holistic overview of health and planning across Nottinghamshire and provide robust planning and health responses so that health is fully embedded into the planning process. The Checklist for Planning and Health' – this is set out in the document. Local Authority planners, health partners and developers should utilise the checklist when assessing development proposals and plans.

4.3. Flow chart 3: Stages 1-4 the planning application process of How and When to engage and with Whom




HOW
WHEN
WHOM
Outline and Full Application
Establish Key Contacts and check if they have been consulted and responded
Attend meetings to discuss Infrastructure requirements
Supply evidence and recommendations on health and wellbeing
Ensure all comments meet statutory timescales
County and District Policy & Development Management Planners
Public Health, ICS/Strategic Estates Advisor (SEA)
and NHS England
Public Health, ICS/Strategic Estates Advisor (SEA)
and NHS England
STAGE 2


HOW
WHEN
WHOM
Option to Appeal
Provision of robust evidence and attendance at appeal if required
County and District Policy & Development Management Planners
Public Health, ICS/ Strategic Estates Advisor (SEA)and NHS England
STAGE 3


HOW
WHEN
WHOM
Planning Decision
Check the Developer Contribution have been included in the planning decisions/section 106 agreement
County and District Policy & Development Management Planners
ICS/ Strategic Estates Advisor (SEA)
and NHS England
STAGE 4

# 5. Developers Contributions

**Collection and spending of Section 106**

5.1. NHS England / Clinical Commissioning Groups (CCG's) may seek contributions towards new / improved healthcare facilities which are required to mitigate the impact of development on their service provision. These may be provided on site as part of the wider community infrastructure or off-site as part of existing health facilities in the area i.e. cycling and walking infrastructure or air quality related infrastructure.

**Nottinghamshire County Council (NCC) Planning Obligations Strategy**

5.2. NCC has a Planning Obligations Strategy which sets out the standard requirements that the County Council may seek in association with new developments, to mitigate against the impact of these upon the services it provides.

5.3. The document has no statutory status; however, it is a material consideration in the determination of planning applications and if development proposals do not comply, the strategy may be used as a reason or reasons for the refusal of planning permission by a Local Planning Authority.

**Health service commissioners and providers**

5.4. Health service commissioners and providers appreciate that the economic downturn has significantly increased developer caution and the assessment of increased financial risks in bringing sites forward for development. At the same time there has been a significant reduction in the level of public funding available to deliver infrastructure necessary for local communities.

5.5. It is acknowledged that the ability of development to meet the shortfall in public funding and provide improvements to the amenities of an area is therefore much stretched. The result of these pressures has been that two key issues are fundamental to any planning promotion: sustainability and viability.

5.6. It is important that robust evidence in support of Health service commissioners and providers requirements for developer contribution is provided as Local Planning Authorities cannot request a contribution without the evidence of a shortfall.

5.7. Paragraph 17 of the National Planning Policy Framework (NPPF) makes it clear that LPA should “take account of and support local strategies to improve health, social and cultural wellbeing for all, and deliver sufficient community and cultural facilities and services to meet local needs”.

5.8. The NPPF goes on to state that LPA should work proactively with applicants to secure developments that improve the economic, social and environmental conditions of the area. It is therefore clear that a balance needs to be struck between economic growths and ensuring that new developments do not have an adverse impact on existing and future communities.

**Consultation and Advice on Planning**

5.9. Local health care providers and other partners will be consulted through organisational infrastructures such as ICS/ Strategic Estates Advisor (SEA) or the One Public Estate (OPE) where there is collaboration across all public-sector bodies to create robust solutions to property-focused programmes.

5.10. Both Public Health England (PHE) and Directors of Public Health fall into the class of non-statutory consultees for local planning applications. It is down to individual local, upper tier planners (who deal with waste and mineral planning applications) and National Park Authorities to decide who they will consult. If Local Planning Authorities consult PHE, PHE sends its response directly to the planners.

5.11. Consultation with Local Authority Public Health team is determined by internal arrangements at a local level (see appendix 3). The process has been developed by Nottinghamshire County Council Public Health. This has been reviewed and changed following discussions with the Planners. A response will be provided either as informal advice or as part of a consultation process.

# 6. The Engagement Protocol

6.1. The Engagement Protocol is to bring together LPA Planners (Policy and Development Management) and health service commissioners and providers as well as Public Health England (PHE) and upper tier Local Authority Public Health teams to ensure comments on planning policy documents and planning applications are received and considered during the planning process.

6.2. How, when and whom to engage set out in sections 3 and 4 ensures expertise is shared and collaborative working is promoted between planners and health partners.

6.3. The engagement protocol ensures that the potential positive and negative impacts on health and wellbeing of proposals are considered in a consistent, systematic and objective way, identifying opportunities for maximising potential health gains and minimising harms. It ensures that health is given consideration at the earliest possible stage during the planning process with agreement as to when a health impact assessment should be undertaken and addressing inequalities taking account of the wider determinants of health.

6.4. Through local plans (which set the land and development vision for each district) and approaches to planning applications health and wellbeing can be improved and negative impacts mitigated against. The Spatial Planning and Health framework includes using a Health Impact Assessment checklist and ensures that the health and wellbeing of residents is considered when decisions on planning applications, plans and strategies are made.

**Monitoring and Evaluation**

6.5. Health Impact assessments play an important part in monitoring and evaluation by providing a practical and flexible framework by which the effects of proposals on health and inequalities can be identified. This has relevance to planning and health through examples of strategic environmental assessments (SEA), sustainability appraisals (SA) or environmental impact assessments (EIA).

6.6. The use of monitoring and evaluation is reinforced within the document which considers the impact on health from a planning and development perspective through the checklist for planning and health, Nottinghamshire Rapid Health Impact Assessment matrix (Appendix 2).

6.7. The checklist for planning and health, The Nottinghamshire Rapid Health Impact Assessment matrix provides the framework to assess the effects of planning and development proposals.

**Nottinghamshire Rapid Health Impact Assessment Matrix**

6.8. The Nottinghamshire Rapid Health Impact Assessment Matrix uses existing evidence to rapidly assess the impacts of a development plan or proposal. The matrix set out in Appendix 2 is based upon the London Healthy Urban Development Unit 'Healthy Urban Planning Checklist' (Third Edition 2017) and aims to ensure that the health and wellbeing of residents is considered when decisions on planning applications, plans and strategies are made.

6.9. The Nottinghamshire Rapid Health Impact Assessment Matrix focuses on the built environment and issues directly or indirectly influenced by planning decisions. As a rapid assessment tool, its purpose is to quickly ensure that the health impacts of a development proposal are identified, and appropriate action is taken to address negative impacts and maximise benefits.

6.10. There are several factors that contribute to improve the health and quality of life of the residence of Nottinghamshire. These include the following and are set out in the checklist of the Nottinghamshire Rapid Health Impact Assessment Matrix.

I. Housing quality and design.
II. Access to healthcare services and other social infrastructure.
III. Access to open space and nature.
IV. Air Quality, noise and neighbourhood amenity.
V. Accessibility and active transport.
VI. Crime reduction and community safety.
VII. Access to healthier food.
VIII. Access to work and training.
IX. Social Cohesion and lifetime neighbourhoods.
X. Minimising the use of resources.
XI. Climate Change.
XII. Health Inequalities.

6.11. Local Authority planners, health partners and developers should utilise the checklist when assessing development proposals and plans. The Nottinghamshire Rapid Health Impact Assessment Matrix can be used by planners, applicants, developers and public health teams in the following ways:

- By planners in Local Plan Review and the development of neighbourhood plans.

- By applicants/developers in master planning applications to accompany planning application, subject to local validation requirements.
- By development management.
- By public health as a screening `desktop' assessment for potential health impacts as part of Public Health Planning and Health consultation process (see appendix 3).
- By internal and external consultees when responding to planning consultations.

6.12. It is important that the Nottinghamshire Rapid Health Impact Assessment Matrix is monitored and evaluated to reflect changes in planning and health policies, local circumstances and to ensure it is fit for purpose and is achieving its intended outcomes.

**NHS Health and Planning Infrastructure**

6.13. The planning of population growth and needs are important to both health and social care. The projection of need for health and social care interest is set out in appendix 4 of the framework.

6.14. The NHS Strategic Estates Planning Service (SEP) provides ongoing support to systems through a team of Strategic Estates Advisers (SEA). SEP is a national centre of excellence set up to advise STPs/ICSs and to help them develop and then successfully implement their Estates Strategy, enabling the NHS to transform its estate to meet local clinical need, implementing contemporary service models, delivering the best service for patients, and achieving national policy objectives

6.15. The introduction of the ICS has meant there is more of a system approach to estate and infrastructure planning. In accordance with the NHS Long-Term Plan both health commissioning bodies and Local Government will be focusing on more 'PLACE' based care programmes. As a result, programmes such as these, will have a series of planned measures, related events and co-ordinated activities in pursuit of enabling the commissioning objectives, resulting in a suite of individual projects which enable the programme to achieve its goals.

6.16. Both the programme and the suite of individual projects will have their own governance in place. Governance will assess, by working collaboratively with Local Planning Authorities, Public Health, and the impact of growth locally to where projects will be delivered. The investment required as part of enabling

the projects to happen, will help to mitigate the impact on existing or new health facilities.

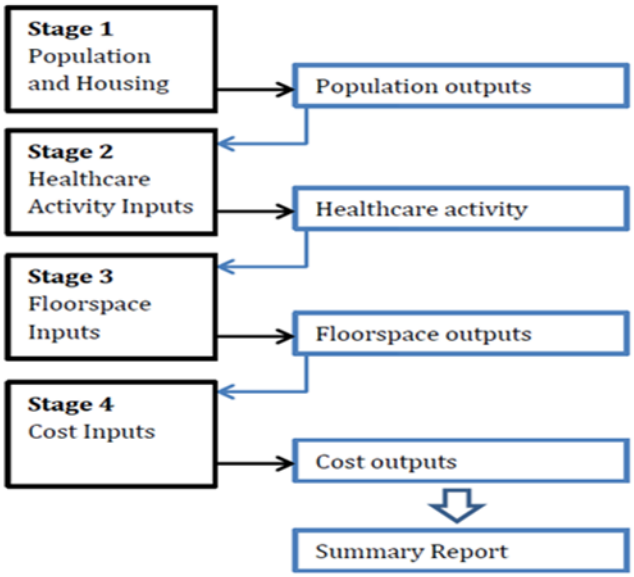
**Healthy Urban Development Unit (HUDU) Toolkit[1]**

6.17. The HUDU Planning Contributions Model (the HUDU Model) has been developed to assist NHS organisations and local authorities address the impact of new residential development on healthcare services and help secure developer contributions. The HUDU model provides a standardised and transparent approach to help calculate potential contributions.

6.18. The HUDU model uses a step-by-step approach whereby the user progresses through the screens and calculations in sequence, with outputs generated at the end of each stage.

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

Figure 5: HUDU Model step by step approach source: London Healthy Urban Development Unit.



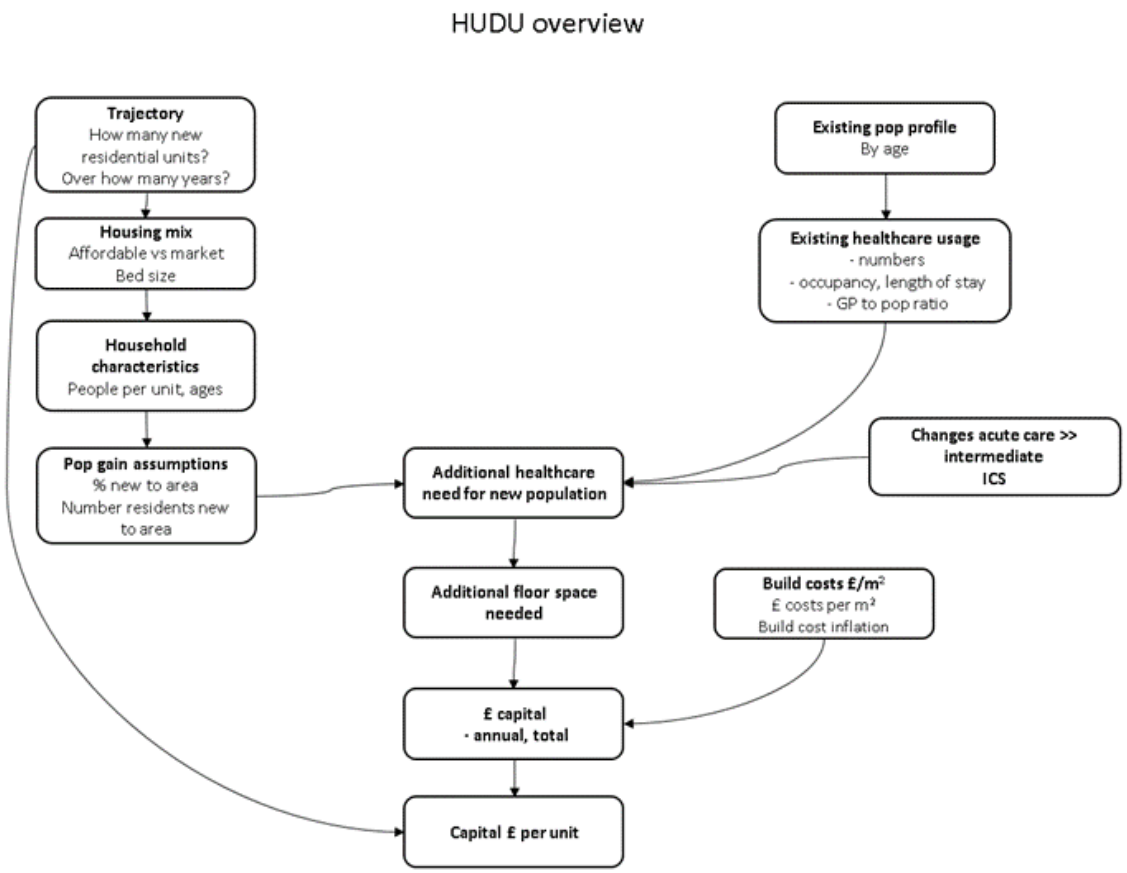

6.20. The flowchart above gives an overview of the HUDU model which calculates:

1 https://www.healthyurbandevelopment.nhs.uk/our-services/delivering-healthy-urban-development/hudu-model/

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

6.21. The use of the HUDU model locally is encouraged and supported by Public Health It can also assist both planners and NHS partners to provide evidence to support future healthcare provision and to make the case for the allocation and release of development contributions where new capacity is needed to mitigate the impacts of population growth resulting from new development.

Figure 6: HUDU Overview



# 7. Conclusion

Early engagement in the planning process is fundamental to ensure that health and wellbeing is fully embedded and will enable the consideration of health/social care infrastructure requirements to meet the needs of the population of Nottinghamshire.

The Nottinghamshire Spatial Planning and Health Framework (2019- 2022) ensures that the potential positive and negative impacts on health and wellbeing of proposals are considered in a consistent, systematic and objective way, identifying opportunities for maximising potential health gains and minimising harms.

Ensuring that health is given consideration at the earliest possible stage during the planning process with agreement as to when a Checklist for Planning and Health – Nottinghamshire Rapid Health Impact Assessment Matrix should be undertaken and taking account of the wider determinants of health to address any inequalities.

Appendix 1: Health Profile for Nottinghamshire 2018

Public Health England

Protecting and improving the nation's health

# Nottinghamshire

County

This profile was published on 3 July 2018

Smoking prevalence in adults (18+) local count revised 10 July 2018

## Local Authority Health Profile 2018

This profile gives a picture of people's health in Nottinghamshire. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

### Health in summary

The health of people in Nottinghamshire is varied compared with the England average. About 15% (21,100) of children live in low income families. Life expectancy for women is lower than the England average.

### Health inequalities

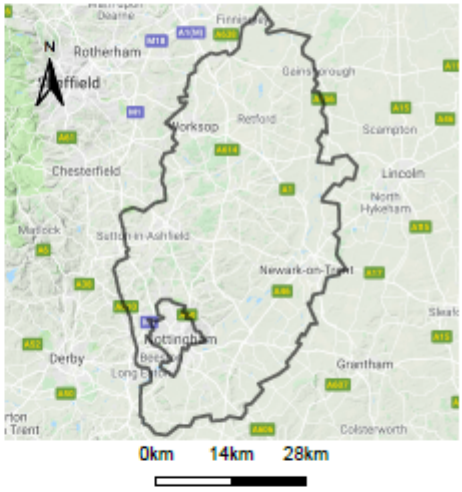
Life expectancy is 9.3 years lower for men and 8.1 years lower for women in the most deprived areas of Nottinghamshire than in the least deprived areas.**

### Child health

In Year 6, 17.4% (1,340) of children are classified as obese, better than the average for England. Levels of smoking at time of delivery are worse than the England average. Levels of GCSE attainment are better than the England average.

### Adult health

Estimated levels of adult excess weight are worse than the England average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime and early deaths from cardiovascular diseases are better than average.






For more information on priorities in this area, see:

- www.nottinghamshire.gov.uk
- http://nottinghamshireinsight.org.uk

Visit www.healthprofiles.info for more area profiles, more information and interactive maps and tools.

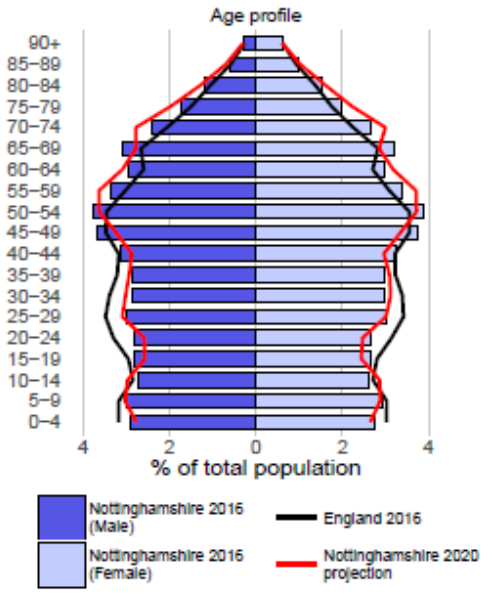
Local Authority Health Profiles are Official Statistics and are produced based on the three pillars of the Code of Practice for Statistics: Trustworthiness, Quality and Value.

Follow @PHE_uk on Twitter

* rate per 100,000 population

** see page 3

# Population




Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

| | Nottinghamshire (persons) | England (persons) |
|---|---|---|
| Population (2016)* | 811 | 55,268 |
| Projected population (2020)* | 831 | 56,705 |
| % population aged under 18 | 20.2% | 21.3% |
| % population aged 65+ | 20.3% | 17.9% |
| % people from an ethnic minority group | 4.0% | 13.6% |

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

# Deprivation

The level of deprivation in an area can be used to identify those communities who may be in the greatest need of services. These maps and charts show the Index of Multiple Deprivation 2015 (IMD 2015).

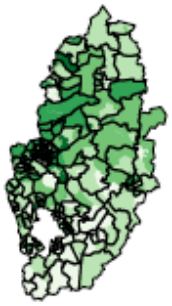
**National**

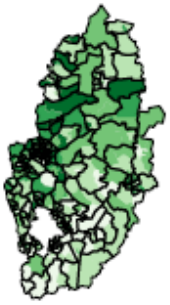
The first of the two maps shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of IMD 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

The chart shows the percentage of the population who live in areas at each level of deprivation.

**Local**

The second map shows the differences in deprivation based on local quintiles (fifths) of IMD 2015 for this area.



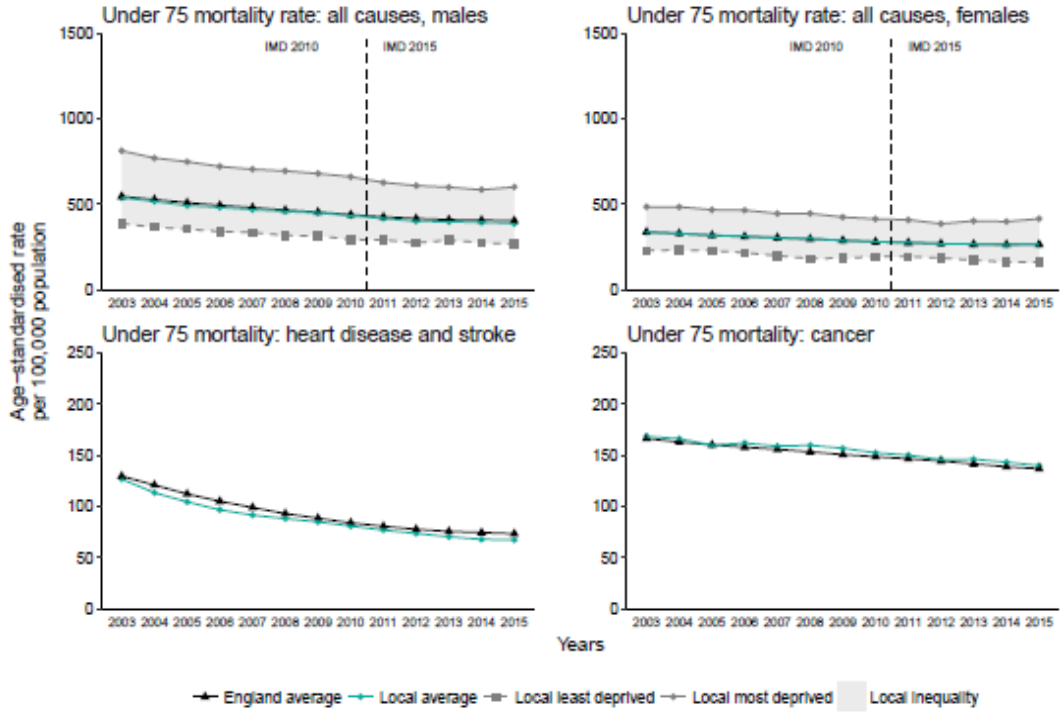

Lines represent electoral wards (2017). Quintiles shown for 2011 based lower super output areas (LSOAs). Contains OS data © Crown copyright and database rights 2018. Contains public sector information licensed under the Open Government Licence v3.0

## Health inequalities: life expectancy

The charts show life expectancy for males and females within this local authority for 2014-16. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015). The life expectancy gap is the difference between the top and bottom of the inequality slope. This represents the range in years of life expectancy from most to least deprived within this area. If there was no inequality in life expectancy the line would be horizontal.


## Trends over time: under 75 mortality

These charts provide a comparison of the trends in death rates in people under 75 between this area and England. For deaths from all causes, they also show the trends in the most deprived and least deprived local quintiles (fifths) of this area.




Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with the time period of the data. This provides a more accurate way of examining changes over time by deprivation.

Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

# Health summary for Nottinghamshire

The chart below shows how the health of people in this area compares with the rest of England. This area's value for each indicator is shown as a circle. The England average is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. However, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared


| | Indicator names | Period | Local count | Local value | Eng value | Eng worst | Eng best |
|---|---|---|---|---|---|---|---|
| Life expectancy and causes of death | 1 Life expectancy at birth (Male) | 2014 – 16 | n/a | 79.5 | 79.5 | 74.2 | 83.7 |
| | 2 Life expectancy at birth (Female) | 2014 – 16 | n/a | 82.7 | 83.1 | 79.4 | 86.8 |
| | 3 Under 75 mortality rate: all causes | 2014 – 16 | 7,397 | 327.0 | 333.8 | 545.7 | 237.8 |
| | 4 Under 75 mortality rate: cardiovascular | 2014 – 16 | 1,524 | 67.4 | 73.5 | 141.3 | 45.6 |
| | 5 Under 75 mortality rate: cancer | 2014 – 16 | 3,180 | 139.9 | 136.8 | 195.3 | 100.0 |
| | 6 Suicide rate | 2014 – 16 | 176 | 8.2 | 9.9 | 18.3 | 6.1 |
| Injuries and ill health | 7 Killed and seriously injured on roads | 2014 – 16 | 986 | 40.8 | 39.7 | 71.3 | 13.5 |
| | 8 Hospital stays for self-harm | 2016/17 | -[99] | -[99] | 185.3 | 578.9 | 50.6 |
| | 9 Hip fractures in older people (aged 65+) | 2016/17 | -[99] | -[99] | 575.0 | 854.2 | 364.7 |
| | 10 Cancer diagnosed at early stage | 2016 | 1,764 | 49.9 | 52.6 | 44.7 | 60.0 |
| | 11 Diabetes diagnoses (aged 17+) | 2017 | n/a | 80.4 | 77.1 | 54.3 | 96.3 |
| | 12 Dementia diagnoses (aged 65+) | 2017 | 7,472 | 75.2 | 67.9 | 53.8 | 90.8 |
| Behavioural risk factors | 13 Alcohol-specific hospital stays (under 18s) | 2014/15 – 16/17 | -[99] | -[99] | 34.2 | 100.0 | 6.5 |
| | 14 Alcohol-related harm hospital stays | 2016/17 | -[99] | -[99] | 636.4 | 1,151.1 | 388.2 |
| | 15 Smoking prevalence in adults (aged 18+) | 2017 | 97,883 | 15.1 | 14.9 | 23.1 | 8.1 |
| | 16 Physically active adults (aged 19+) | 2016/17 | n/a | 66.4 | 66.0 | 53.3 | 78.0 |
| | 17 Excess weight in adults (aged 18+) | 2016/17 | n/a | 64.4 | 61.3 | 74.9 | 40.5 |
| Child health | 18 Under 18 conceptions | 2016 | 239 | 18.3 | 18.8 | 36.5 | 4.6 |
| | 19 Smoking status at time of delivery | 2016/17 | 1,155 | 14.8 | 10.7 | 28.1 | 2.3 |
| | 20 Breastfeeding initiation | 2016/17 | 5,637 | -[99] | 74.5 | 37.9 | 96.7 |
| | 21 Infant mortality rate | 2014 – 16 | 115 | 4.4 | 3.9 | 7.9 | 1.6 |
| | 22 Obese children (aged 10–11) | 2016/17 | 1,340 | 17.4 | 20.0 | 29.2 | 11.3 |
| Inequalities | 23 Deprivation score (IMD 2015) | 2015 | n/a | 18.9 | 21.8 | 42.0 | 5.7 |
| | 24 Smoking prevalence: routine and manual occupations | 2017 | n/a | 28.4 | 25.7 | 38.9 | 13.9 |
| Wider determinants of health | 25 Children in low income families (under 16s) | 2015 | 21,050 | 15.1 | 16.8 | 30.5 | 6.1 |
| | 26 GCSEs achieved | 2015/16 | 4,854 | 61.1 | 57.8 | 44.8 | 74.6 |
| | 27 Employment rate (aged 16–64) | 2016/17 | 375,500 | 75.6 | 74.4 | 60.9 | 82.4 |
| | 28 Statutory homelessness | 2016/17 | 70 | 0.2[99] | 0.8 | 9.6 | 0.0 |
| | 29 Violent crime (violence offences) | 2016/17 | 12,953 | 16.1 | 20.0 | 42.2 | 7.0 |
| Health protection | 30 Excess winter deaths | Aug 2013 – Jul 2016 | 1,545 | 20.8 | 17.9 | 28.9 | 7.4 |
| | 31 New sexually transmitted infections | 2017 | 2,876 | 564.2 | 793.8 | 3,215.3 | 329.4 |
| | 32 New cases of tuberculosis | 2014 – 16 | 79 | 3.3 | 10.9 | 69.0 | 1.3 |

For full details on each indicator, see the definitions tab of the Health Profiles online tool: www.healthprofiles.info

**Indicator value types**
1, 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15, 16, 17 Proportion - % 18 Crude rate per 1,000 females aged 15 to 17 19, 20 Proportion - % 21 Crude rate per 1,000 live births 22 Proportion - % 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % 26 Proportion - % 5 A*-C including English & Maths 27 Proportion - % 28 Crude rate per 1,000 households 29 Crude rate per 1,000 population 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

€"Regional" refers to the former government regions.
-[99] Value not published for data quality reasons -[99] Value is not presented due to an issue with HES coding in Nottingham University Hospitals Trust in 2016/17, for which over 30% of records did not have a valid geography of residence assigned. In 2015/16, over 20% of patients that attended hospital from this area were treated at Nottingham University Hospitals Trust. ^[85] Aggregated from all known lower geography values

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

NB

District Local Health Profiles are available on PHE Fingertips which provides access to information, data and original research about what it's like to live in Nottinghamshire

https://fingertips.phe.org.uk/profile/health-profiles

Appendix 2: Checklist for Planning and Health

## Nottinghamshire Rapid Health Impact Assessment Matrix

| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| **1. Housing quality and design** | | | | |
| 1. Does the proposal seek to address the housing needs of the wider community by requiring provision of variation of house type that will meet the needs of older or disabled people?<br>[For example, does it meet all Lifetime Homes Standards, Building for Life etc?] | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 2. Does the proposal promote development that will reduce energy requirements and living costs and ensure that homes are warm and dry in winter and cool in summer | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **2. Access to healthcare services and other social infrastructure** | | | | |

| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| 3. Does the proposal seek to retain, replace or provide health and social care related infrastructure? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 4. Does the proposal address the proposed growth/ assess the impact on healthcare services? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 5. Does the proposal explore/allow for opportunities for shared community use and co-location of services? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **3. Access to open space and nature** | | | | |
| 6. Does the proposal seek to retain and enhance existing and provide new open and natural spaces to support healthy living and physical activity? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 7. Does the proposal promote links between open and natural spaces and areas of residence, employment and commerce? | ☐ Yes<br>☐ Partial<br>☐ No<br>☐ | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |

| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| 8. Does the proposal seek to ensure that open and natural spaces are welcoming, safe and accessible to all? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 9. Does the proposal seek to provide a range of play spaces for children and young people (e.g. play pitches, play areas etc.) including provision for those that are disabled? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **4. Air quality, noise and neighbourhood amenity** | | | | |
| 10. Does the proposal seek to minimise construction impacts such as dust, noise, vibration and odours? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 11. Does the proposal seek to minimise air pollution caused by traffic and employment/ commercial facilities? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 12. Does the proposal seek to minimise noise pollution caused by traffic and | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral | |

| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| employment/ commercial facilities? | | | ☐ Uncertain | |
| **5. Accessibility and active transport** | | | | |
| 13. Does the proposal prioritise and encourage walking (such as through shared spaces) connecting to local walking networks? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 14. Does the proposal prioritise and encourage cycling (for example by providing secure cycle parking, showers and cycle lanes) connecting to local and strategic cycle networks? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 15. Does the proposal support traffic management and calming measures to help reduce and minimise road injuries? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 16. Does the proposal promote accessible buildings and places to enable access to people with mobility problems or a disability? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |

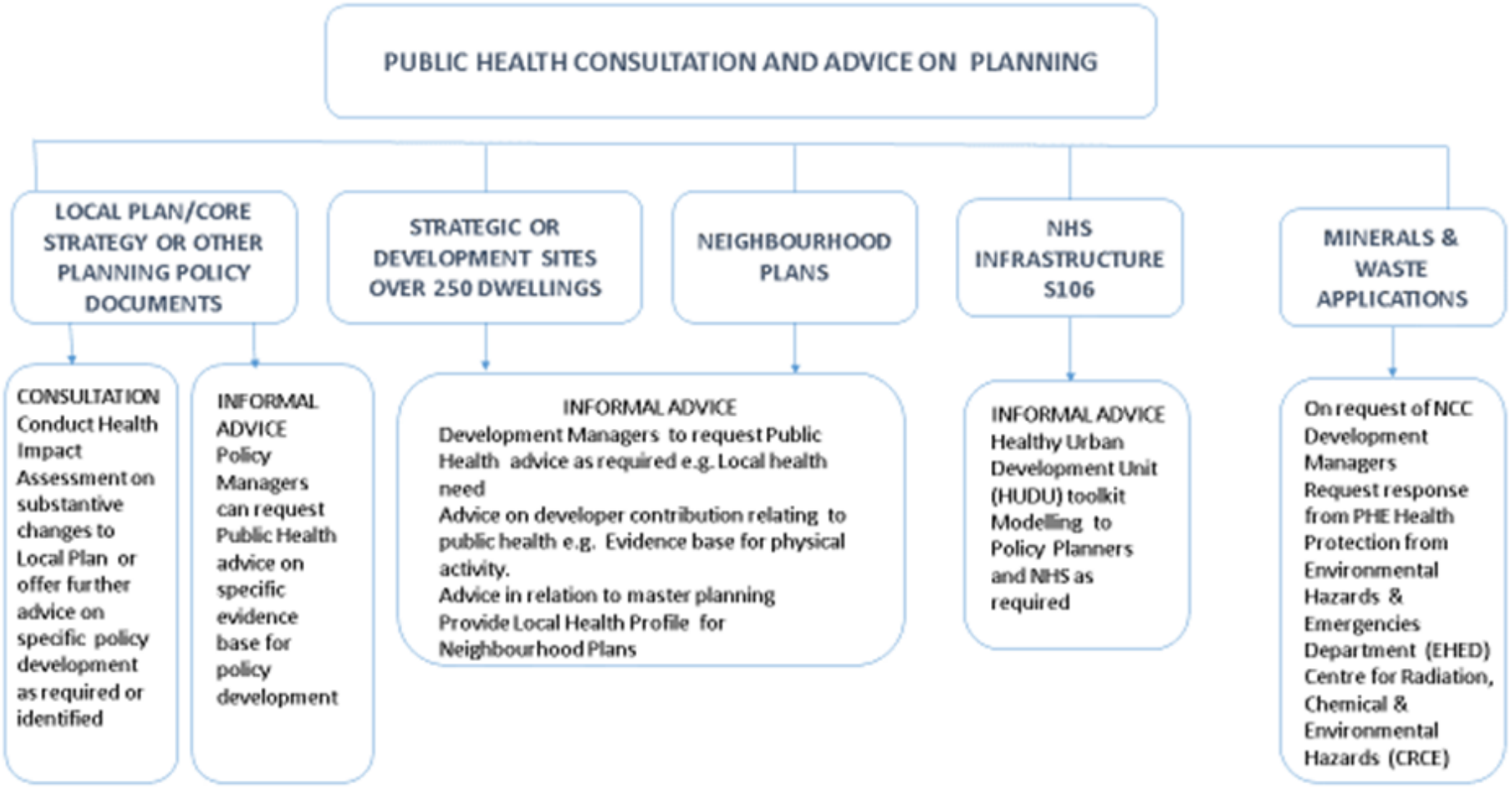
| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| **6. Crime reduction and community safety** | | | | |
| 17. Does the proposal create environments & buildings that make people feel safe, secure and free from crime? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **7. Access to healthy food** | | | | |
| 18. Does the proposal support the retention and creation of food growing areas, allotments and community gardens in order to support a healthy diet and physical activity? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 19. Does the proposal seek to restrict the development of hot food takeaways (A5) in specific areas? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |

| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| **8. Access to work and training** | | | | |
| 20. Does the proposal seek to provide new employment opportunities and encourage local employment and training? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **9. Social cohesion and lifetime neighbourhoods** | | | | |
| 21. Does the proposal connect with existing communities where the layout and movement avoids physical barriers and severance and encourages social interaction?<br>[For example, does it address the components of Lifetime Neighbourhoods?] | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **10. Minimising the use of resources** | | | | |
| 22. Does the proposal seek to incorporate sustainable design and construction techniques? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |

| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| **11. Climate change** | | | | |
| 23. Does the proposal incorporate renewable energy and ensure that buildings and public spaces are designed to respond to winter and summer temperatures, i.e. ventilation, shading and landscaping? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| 24. Does the proposal maintain or enhance biodiversity | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **12. Health inequalities** | | | | |
| 25. Does the proposal consider health inequalities and encourage engagement by underserved communities? | ☐ Yes<br>☐ Partial<br>☐ No | | ☐ Positive<br>☐ Negative<br>☐ Neutral<br>☐ Uncertain | |
| **Any other comments** | | | | |
| | | | | |
| Name of assessor and organisation | | | | |

| Assessment criteria | Relevant? | Details/evidence | Potential health impact? | Recommended amendments or enhancement actions to the proposal under consideration |
|---|---|---|---|---|
| Date of assessment | | | | |

Appendix 3: Public Health Consultation and Advice on Planning



# Appendix 4: Planning, population growth and needs for health and social care 2018-2022

## Introduction

Projections of need for health and social care are of interest to upper- and lower-tier local authorities, commissioners and care providers.

This piece of work projects the change in need for four high level pathways across four areas of health and social care need, each using three scenarios of housing growth. Projections are given for lower-tier Local Authorities and Clinical Commissioning Groups in Nottinghamshire County.

## Scenarios for population change

The three scenarios presented below are intended to cover the extremes of possible change in populations and need:

1. **Natural change**
   The existing population ages produces new babies and dies. Net migration is assumed to be zero and there is no new housing.
2. **High growth**
   The same population change as in (1), but with the *addition* of new populations as a result of new-build housing. This set of models assumes that new household sizes are the same as the 2011 Census average for *non-single person* households in the relevant area and that inward-migration to take up the new housing is high (100%). This model is likely to represent very high inward migration of young families who move to new housing or to live in housing vacated by existing resident who move to new housing.
3. **Low growth**
   The same population change as in (1), but with the *addition* of new populations as a result of new-build housing. This set of models assumes that new household sizes are the same as the 2011 Census average for *all* households in the relevant area and that inward-migration to take up the new housing is low[2]. This model is likely to represent areas where there is higher local housing pressure; existing populations takes up a substantial proportion of any new housing with a lower number of people moving from outside the local area.

## High level pathways

Projected need for services has been calculated for four high-level pathways. Each of these incorporates need across the whole health and social care system.

2 Estimates for each local authority based on data published as part of the CURDs 2010 report 'Geography of Housing Market Areas in England', available at http://www.ncl.ac.uk/curds/research/defining/NHPAU.htm . See links for Migration statistics for Local HMAs / single tier set of HMAs.

Please note that this is not an attempt to predict the increase in need for specific services. Some types of care provider (for example GPs and primary care staff) perform work across all these pathways; the overall impact of population growth on these services will be an aggregate of the expected change in each pathway for the relevant services. Others can expect the dominant change to be from within one of the high-level pathways (for instance Accident and Emergency services might expect increases to follow the urgent and planned care set, with smaller effects from mental health and social care).

- **Mental health**
  This includes all aspects of mental health as an aggregate marker of need (common mental health issues such as depression and anxiety are included with severe and enduring mental health issues). Resources across relevant parts of primary care, MH urgent care (including A&E, crisis resolution and related admissions), outpatients and IAPT are all affected, and can all expect the same change in need.
- **Urgent and planned care**
  These two pathways are considered together because the projected *change* in demand is identical for both, given populations of the same demography. The **urgent pathway** incorporates all categories of ambulance and emergency response call-out, 111 service, general practice in- and out-of-hours emergency response, A&E, minor injuries and associated admissions to hospital and related clinic activity.
  The **planned care pathway** covers planned primary care activity, community services and out-patient care and day surgery.
- **Social care**
  Social care includes care provided to younger adults as well as older people. Social care service provision, nursing and residential care as well as domiciliary and other services are incorporated into this pathway. Related aspects of primary care resources use (e.g. time spent referring from GPs) are also expected to change in a similar pattern.
- **Pregnancy and maternity**
  This relates to all healthcare activity from conception through to birth. The number of conceptions, terminations, community midwifery, GP checks, maternity unit activity and births (with or without complications) are all part of this pathway.

**Projected new-build & timescales**

The projected number of new-build housing completions (housing trajectories) was taken from planning documents for each relevant local authority. These vary in timescale as in table 1.

| Local authority | Projections available to: |
|---|---|
| Ashfield | 2013/14 |
| Bassetlaw | 2019/20 |
| Broxtowe | 2027/28 |
| Gedling | 2027/28 |
| Mansfield | Documents in preparation: projections developed in 2027/28 using the 'Option C: medium level of new housing' in planning policy consultations. |
| Newark & Sherwood | 2025/26 |
| Rushcliffe | 2027/28 |
| Nottingham City | 2027/28 |

*Table 1 Housing projection availability by Local Authority.*

For each area, it was assumed that **all** planned housing would be developed and available for occupation in the stated year. Where available, net completions were used (i.e. any planned demolition is accounted for) and 'windfall' development allowances were included.

Housing developments were allocated to CCG geography based on CCG footprint and analysis of detail from the local authority housing trajectories.

**Base populations**

For ease, the base population used for all projections was the 2014 resident population for each Local Authority area and within each CCG area footprint. For CCGs, this will differ from the more usual registered population (the numbers registered with each GP practice) but the overall scale of change in need will be very similar between registered and resident populations. As the modelling results are presented as the change in need compared to 2015, this is not a major weakness.

Where the CCG footprint is the same as the Local Authority area (Bassetlaw LA/ CCG, Broxtowe LA/ Nottingham West CCG, Rushcliffe LA/ CCG) the projections are identical.

**Calculations**

Sex and age-specific models of household and population change were developed in Excel for each LA and CCG area and the current number of deaths and births in each area derived from Office for National Statistics data. Population projections and the models of need for each pathway were developed using Scenario Generator (discrete event simulation software developed by the Simul8 Corporation for high-level, whole system health and social care planning: http://simul8healthcare.com/scenario-generator.htm )

**Presentation**

The results are presented in chart and table form in Section 2. Each scenario (natural change, low growth and high growth) is presented for each high-level pathway and for each local authority or CCG footprint. The tables and charts show the percentage change in need compared to 2015 (which is always 0).

No attempt has been made to estimate the change in demand for specific services. This is for two reasons: first and most importantly, models of care are likely to change across health and social care systems over the foreseeable future. Predicting the number of hospital beds or GP practices needed may be possible, but such projections would only be valid if no health and social care integration or system redesign takes place. The second reason is that the models are designed to reflect changing **need** as opposed to **demand.** Modelling the demand for services would necessarily involve some assumptions about people's and organisations' behaviour (for example how people might use A&E differently or how social service thresholds for care might change) and are outside the scope of this work.

Section 3 contains the annual cumulative, projected population change for each LA or CCG footprint for each population change scenario. Section 4 presents the CCG registered and Local Authority resident population totals for 2014.

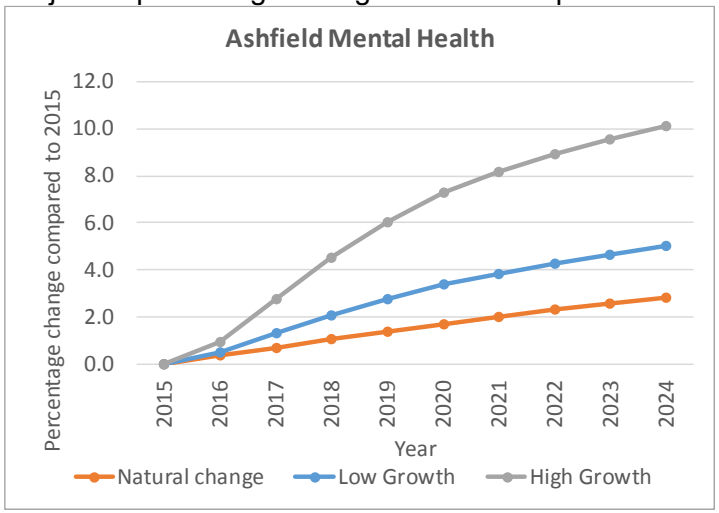
**Your comments, questions and constructive criticism are welcome.**

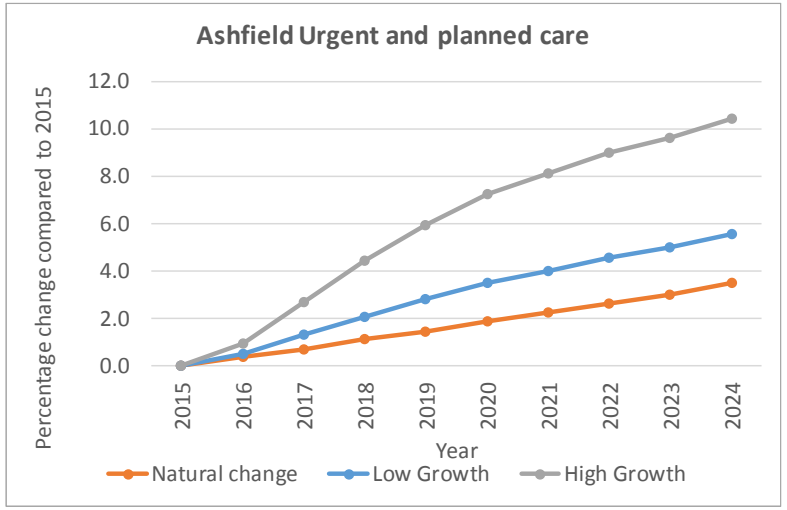
**For further information, please contact:** David Gilding

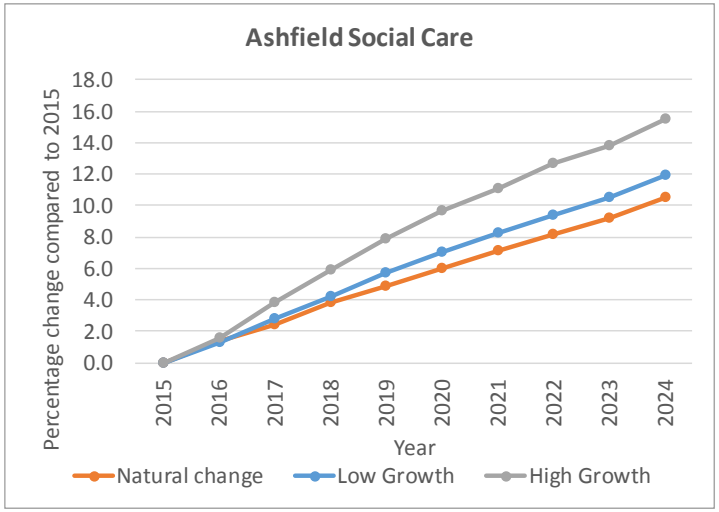
Public Health Intelligence Team, Nottinghamshire County Council
david.gilding@nottscc.gov.uk
Review Date 2022

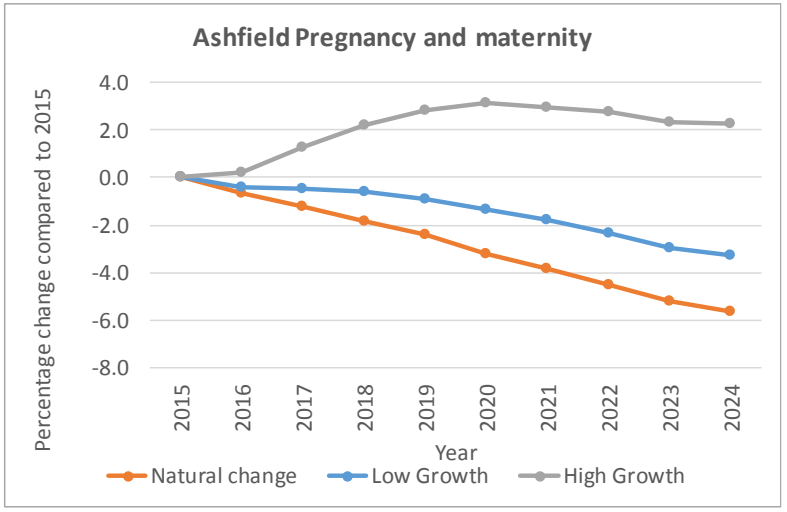
**Ashfield District**

Projected percentage change in need compared to index year of 2015



**Ashfield District**
Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.37* | *0.71* | *1.06* | *1.38* | *1.70* | *2.02* | *2.30* | *2.58* | *2.84* |
| Planned and unplanned care | *0.00* | *0.39* | *0.72* | *1.11* | *1.48* | *1.87* | *2.27* | *2.65* | *3.02* | *3.51* |
| Social Care | *0.00* | *1.37* | *2.45* | *3.78* | *4.81* | *5.96* | *7.13* | *8.17* | *9.20* | *10.54* |
| Pregnancy and maternity | *0.00* | *-0.67* | *-1.19* | *-1.86* | *-2.42* | *-3.18* | *-3.85* | *-4.50* | *-5.20* | *-5.63* |

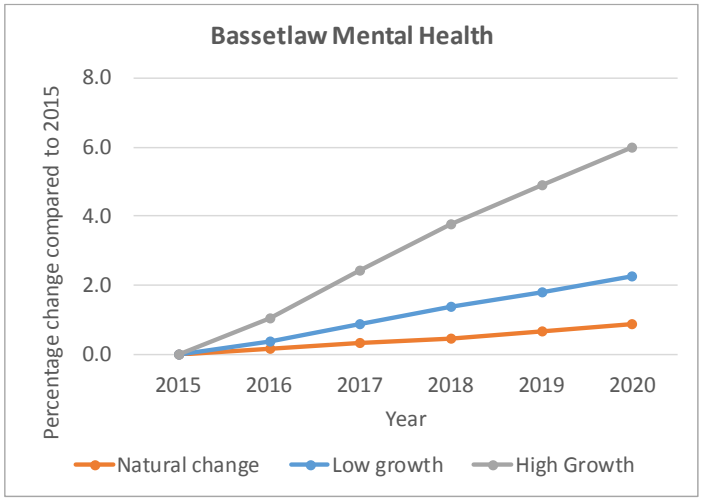
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.51* | *1.30* | *2.07* | *2.77* | *3.36* | *3.85* | *4.27* | *4.64* | *5.00* |
| Planned and unplanned care | *0.00* | *0.52* | *1.31* | *2.09* | *2.85* | *3.51* | *4.04* | *4.54* | *5.00* | *5.60* |
| Social Care | *0.00* | *1.25* | *2.78* | *4.22* | *5.74* | *7.04* | *8.20* | *9.37* | *10.46* | *11.95* |
| Pregnancy and maternity | *0.00* | *-0.40* | *-0.45* | *-0.58* | *-0.88* | *-1.37* | *-1.77* | *-2.33* | *-2.95* | *-3.28* |

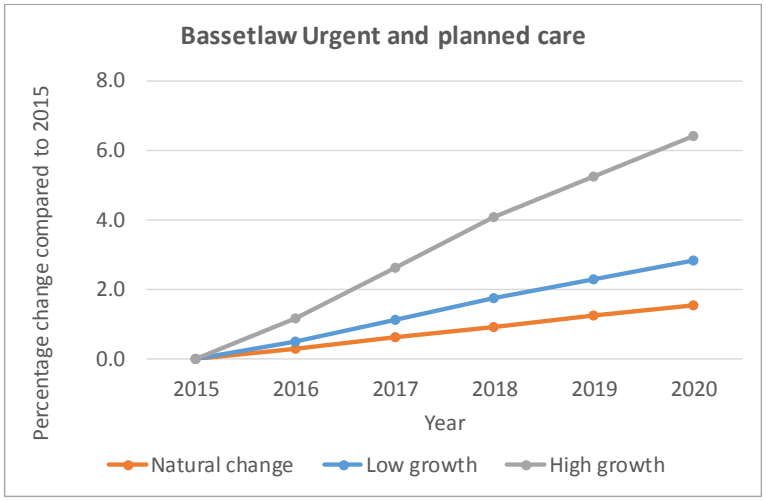
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.96* | *2.75* | *4.55* | *6.02* | *7.27* | *8.14* | *8.94* | *9.53* | *10.09* |
| Planned and unplanned care | *0.00* | *0.95* | *2.70* | *4.46* | *5.97* | *7.25* | *8.15* | *8.99* | *9.64* | *10.42* |
| Social Care | *0.00* | *1.58* | *3.83* | *5.91* | *7.83* | *9.66* | *11.05* | *12.62* | *13.82* | *15.52* |
| Pregnancy and maternity | *0.00* | *0.20* | *1.26* | *2.21* | *2.86* | *3.14* | *2.99* | *2.77* | *2.36* | *2.28* |

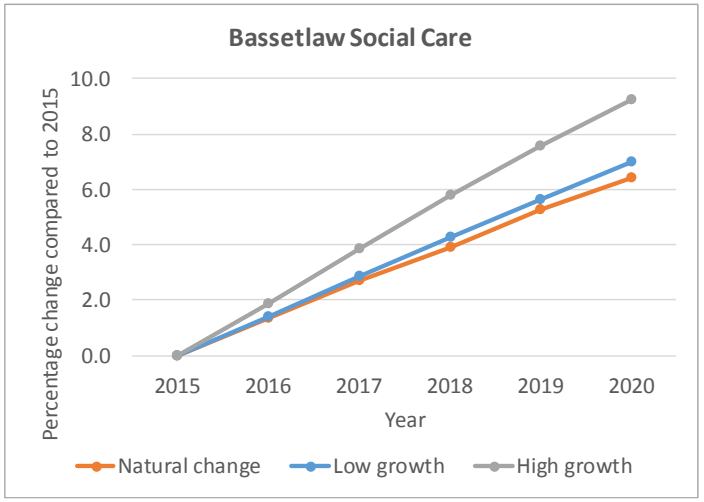
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

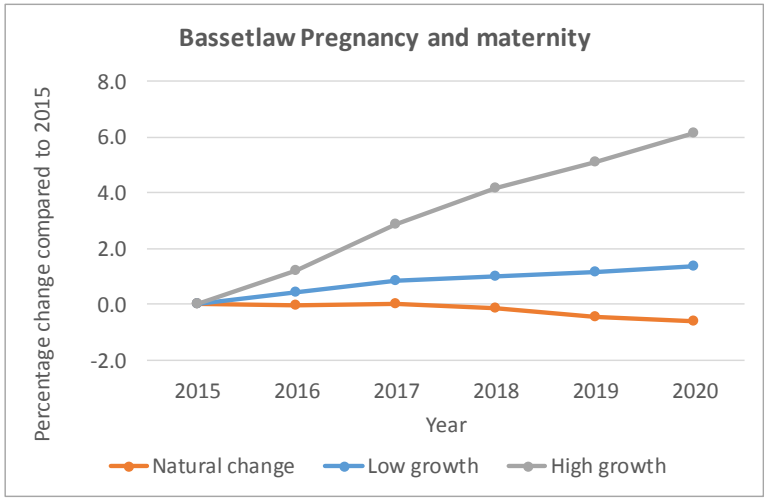
**Bassetlaw District and Bassetlaw CCG**

Projected percentage change in need compared to index year of 2015



**Bassetlaw District and Bassetlaw CCG**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** |
|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.15* | *0.33* | *0.47* | *0.68* | *0.88* |
| Planned and unplanned care | *0.00* | *0.32* | *0.62* | *0.92* | *1.26* | *1.55* |
| Social Care | *0.00* | *1.34* | *2.68* | *3.90* | *5.24* | *6.43* |
| Pregnancy and maternity | *0.00* | *-0.03* | *0.01* | *-0.16* | *-0.45* | *-0.63* |

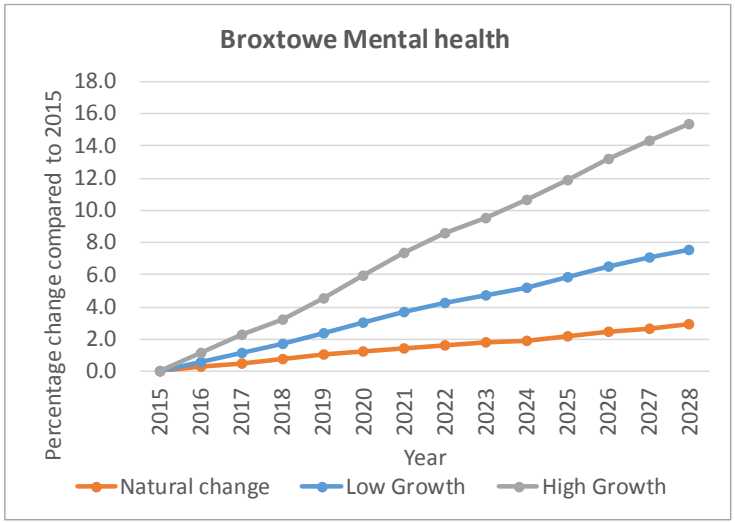
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** |
|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.38* | *0.88* | *1.36* | *1.82* | *2.27* |
| Planned and unplanned care | *0.00* | *0.52* | *1.14* | *1.75* | *2.29* | *2.83* |
| Social Care | *0.00* | *1.37* | *2.83* | *4.26* | *5.64* | *6.99* |
| Pregnancy and maternity | *0.00* | *0.43* | *0.87* | *1.01* | *1.17* | *1.36* |

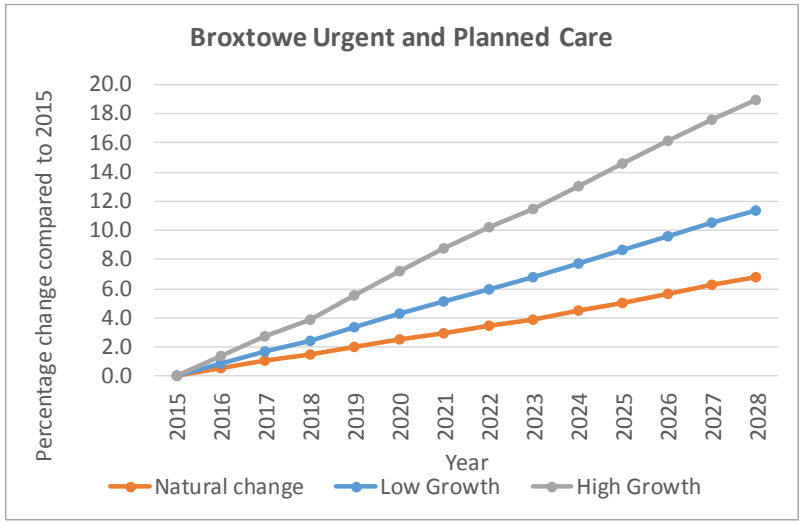
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** |
|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.05* | *2.42* | *3.77* | *4.90* | *5.99* |
| Planned and unplanned care | *0.00* | *1.16* | *2.64* | *4.09* | *5.27* | *6.41* |
| Social Care | *0.00* | *1.86* | *3.83* | *5.77* | *7.58* | *9.26* |
| Pregnancy and maternity | *0.00* | *1.19* | *2.85* | *4.16* | *5.09* | *6.12* |

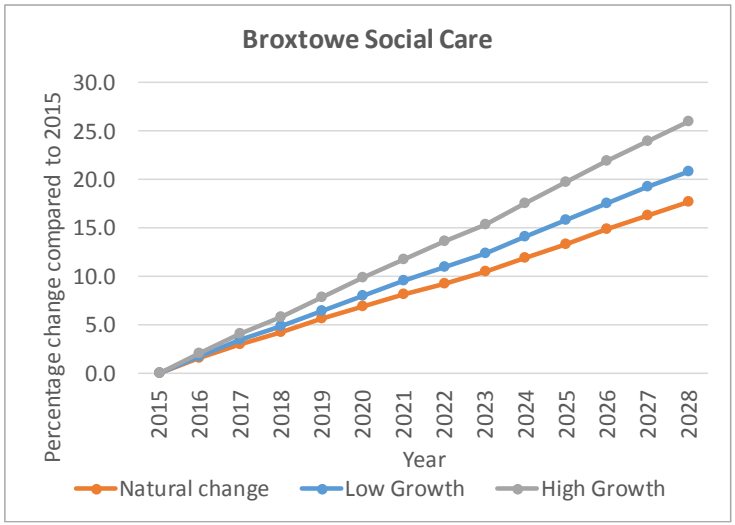
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

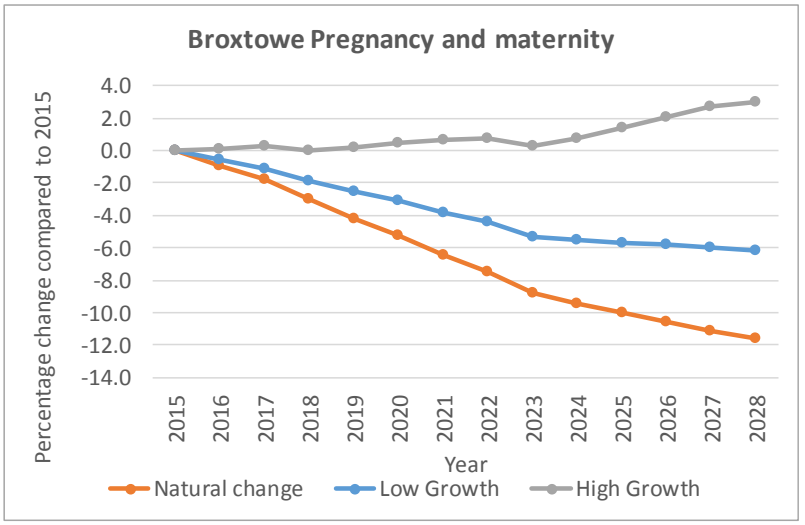
**Broxtowe Borough and Nottingham West CCG**

Projected percentage change in need compared to index year of 2015



**Broxtowe Borough and Nottingham West CCG**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.27* | *0.52* | *0.76* | *1.00* | *1.22* | *1.42* | *1.60* | *1.78* | *1.93* | *2.17* | *2.41* | *2.65* | *2.88* |
| Planned and unplanned care | *0.00* | *0.52* | *1.02* | *1.52* | *2.03* | *2.50* | *2.98* | *3.42* | *3.92* | *4.49* | *5.07* | *5.67* | *6.25* | *6.82* |
| Social Care | *0.00* | *1.47* | *2.85* | *4.20* | *5.59* | *6.82* | *8.09* | *9.18* | *10.46* | *11.87* | *13.30* | *14.83* | *16.28* | *17.69* |
| Pregnancy and maternity | *0.00* | *-0.96* | *-1.80* | *-2.96* | *-4.17* | *-5.22* | *-6.45* | *-7.48* | *-8.78* | *-9.43* | *-10.00* | *-10.52* | *-11.10* | *-11.62* |

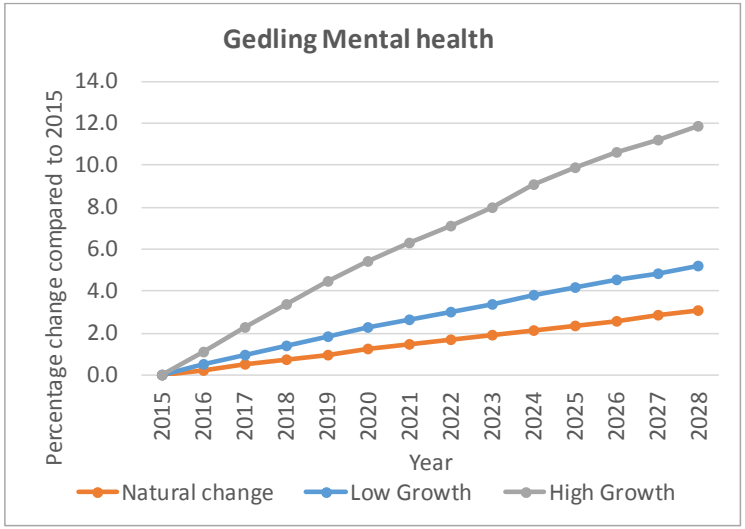
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.58* | *1.17* | *1.67* | *2.32* | *3.00* | *3.63* | *4.22* | *4.67* | *5.20* | *5.82* | *6.46* | *7.05* | *7.56* |
| Planned and unplanned care | *0.00* | *0.82* | *1.66* | *2.40* | *3.31* | *4.24* | *5.12* | *5.97* | *6.73* | *7.67* | *8.63* | *9.59* | *10.50* | *11.33* |
| Social Care | *0.00* | *1.63* | *3.32* | *4.74* | *6.33* | *7.94* | *9.43* | *10.85* | *12.29* | *13.98* | *15.74* | *17.49* | *19.17* | *20.74* |
| Pregnancy and maternity | *0.00* | *-0.55* | *-1.11* | *-1.84* | *-2.52* | *-3.06* | *-3.83* | *-4.40* | *-5.35* | *-5.55* | *-5.73* | *-5.75* | *-5.95* | *-6.14* |

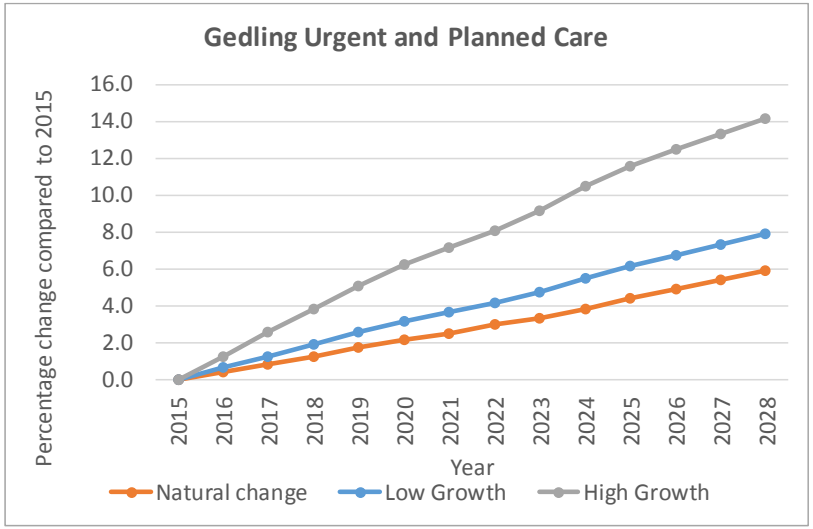
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.11* | *2.24* | *3.20* | *4.56* | *5.97* | *7.30* | *8.58* | *9.48* | *10.64* | *11.91* | *13.17* | *14.36* | *15.36* |
| Planned and unplanned care | *0.00* | *1.35* | *2.70* | *3.88* | *5.51* | *7.15* | *8.72* | *10.22* | *11.43* | *12.97* | *14.54* | *16.10* | *17.59* | *18.89* |
| Social Care | *0.00* | *2.01* | *3.97* | *5.68* | *7.80* | *9.81* | *11.75* | *13.60* | *15.33* | *17.45* | *19.67* | *21.83* | *24.01* | *25.96* |
| Pregnancy and maternity | *0.00* | *0.07* | *0.32* | *0.03* | *0.16* | *0.51* | *0.66* | *0.78* | *0.33* | *0.79* | *1.44* | *2.09* | *2.68* | *3.00* |

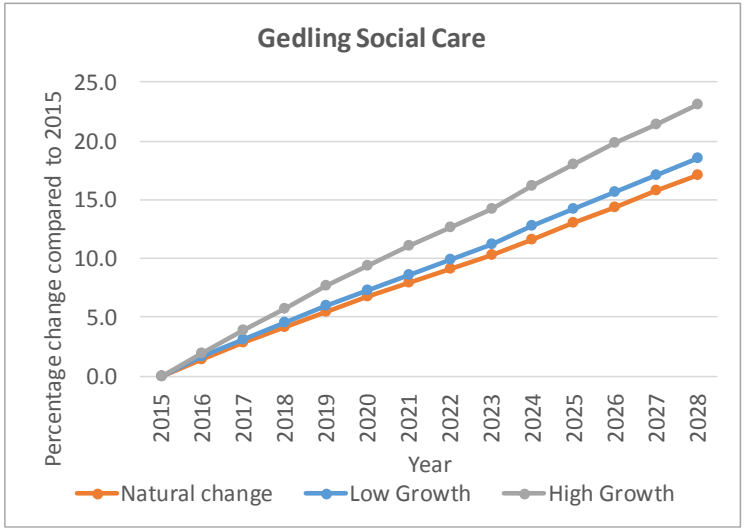
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

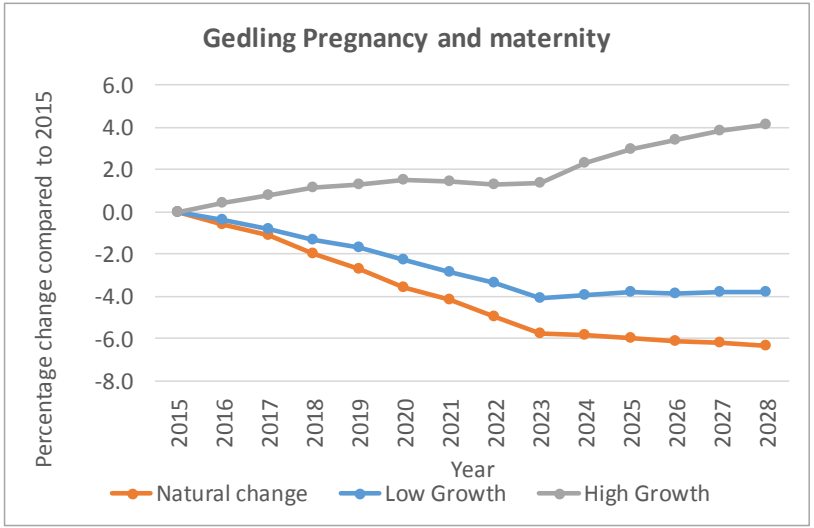
**Gedling Borough**

Projected percentage change in need compared to index year of 2015



**Gedling Borough**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.25* | *0.49* | *0.71* | *0.98* | *1.21* | *1.43* | *1.69* | *1.89* | *2.09* | *2.33* | *2.58* | *2.84* | *3.06* |
| Planned and unplanned care | *0.00* | *0.43* | *0.88* | *1.31* | *1.75* | *2.17* | *2.55* | *2.98* | *3.38* | *3.88* | *4.40* | *4.92* | *5.45* | *5.95* |
| Social Care | *0.00* | *1.39* | *2.81* | *4.10* | *5.48* | *6.74* | *7.85* | *9.14* | *10.30* | *11.60* | *13.00* | *14.38* | *15.77* | *17.06* |
| Pregnancy and maternity | *0.00* | *-0.62* | *-1.12* | *-1.96* | *-2.73* | *-3.55* | *-4.17* | *-4.94* | *-5.77* | *-5.82* | *-5.96* | *-6.16* | *-6.17* | *-6.32* |

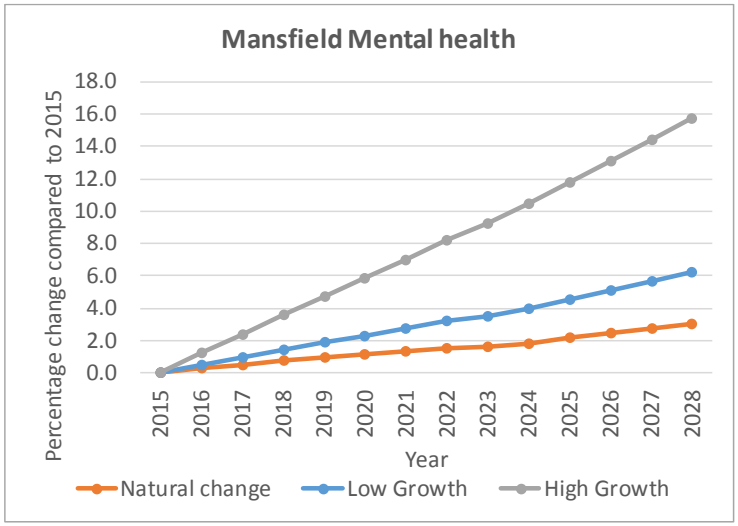
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.48* | *0.92* | *1.37* | *1.82* | *2.24* | *2.61* | *2.98* | *3.37* | *3.80* | *4.19* | *4.54* | *4.87* | *5.18* |
| Planned and unplanned care | *0.00* | *0.67* | *1.30* | *1.95* | *2.57* | *3.16* | *3.69* | *4.22* | *4.80* | *5.52* | *6.16* | *6.79* | *7.37* | *7.95* |
| Social Care | *0.00* | *1.61* | *3.09* | *4.53* | *5.93* | *7.31* | *8.59* | *9.87* | *11.21* | *12.74* | *14.19* | *15.67* | *17.08* | *18.44* |
| Pregnancy and maternity | *0.00* | *-0.41* | *-0.80* | *-1.30* | *-1.72* | *-2.28* | *-2.86* | *-3.38* | *-4.08* | *-3.93* | *-3.81* | *-3.85* | *-3.83* | *-3.79* |

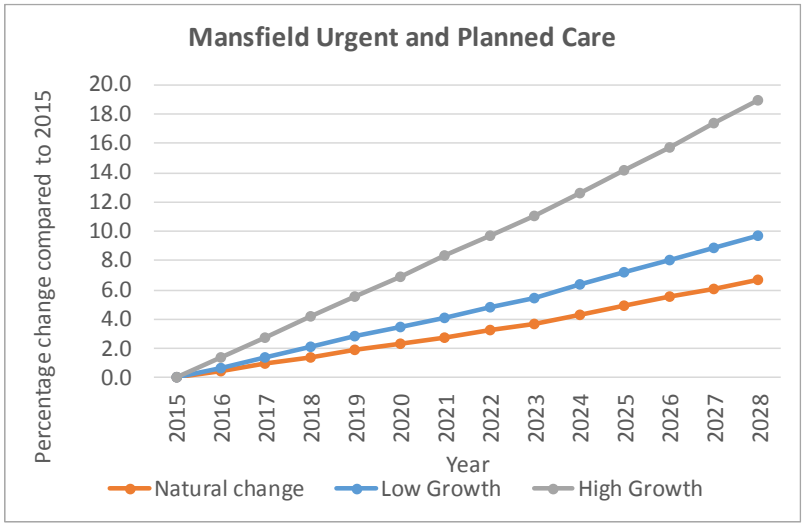
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.12* | *2.25* | *3.35* | *4.49* | *5.46* | *6.30* | *7.10* | *8.02* | *9.07* | *9.92* | *10.64* | *11.21* | *11.84* |
| Planned and unplanned care | *0.00* | *1.30* | *2.57* | *3.86* | *5.13* | *6.23* | *7.20* | *8.13* | *9.20* | *10.49* | *11.59* | *12.52* | *13.32* | *14.19* |
| Social Care | *0.00* | *1.93* | *3.92* | *5.73* | *7.63* | *9.36* | *11.02* | *12.63* | *14.23* | *16.15* | *18.04* | *19.78* | *21.34* | *23.10* |
| Pregnancy and maternity | *0.00* | *0.41* | *0.77* | *1.12* | *1.31* | *1.53* | *1.45* | *1.30* | *1.35* | *2.32* | *2.94* | *3.38* | *3.87* | *4.16* |

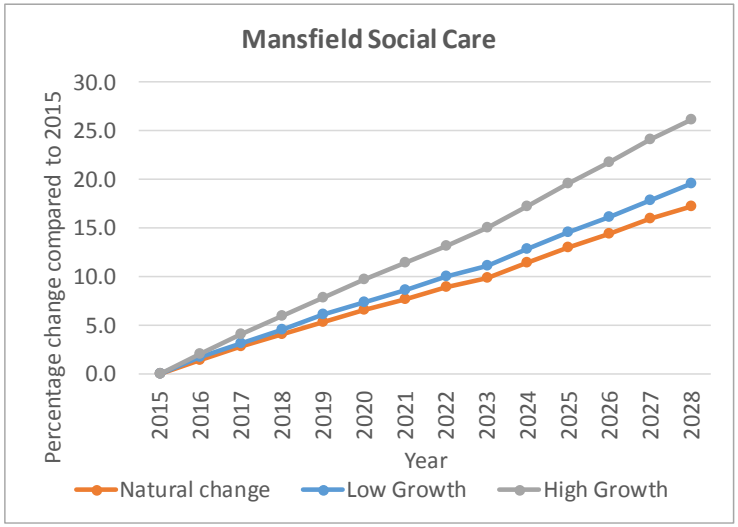
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

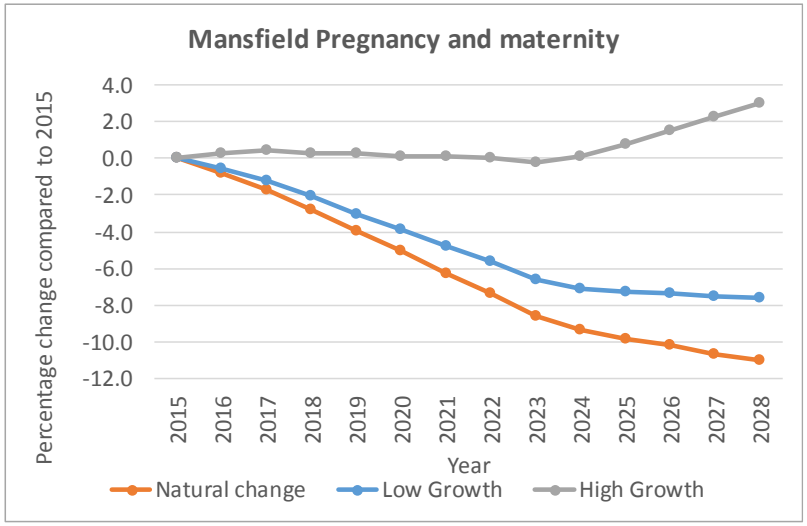
**Mansfield District**

Projected percentage change in need compared to index year of 2015



**Mansfield District**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.25* | *0.51* | *0.73* | *0.94* | *1.13* | *1.32* | *1.51* | *1.64* | *1.81* | *2.15* | *2.45* | *2.76* | *3.05* |
| Planned and unplanned care | *0.00* | *0.47* | *0.94* | *1.39* | *1.86* | *2.32* | *2.76* | *3.21* | *3.64* | *4.26* | *4.90* | *5.49* | *6.10* | *6.68* |
| Social Care | *0.00* | *1.41* | *2.79* | *4.08* | *5.31* | *6.51* | *7.65* | *8.80* | *9.82* | *11.34* | *12.97* | *14.37* | *15.87* | *17.26* |
| Pregnancy and maternity | *0.00* | *-0.83* | *-1.67* | *-2.83* | *-3.99* | *-5.05* | *-6.28* | *-7.38* | *-8.59* | *-9.34* | *-9.85* | *-10.20* | *-10.66* | *-11.05* |

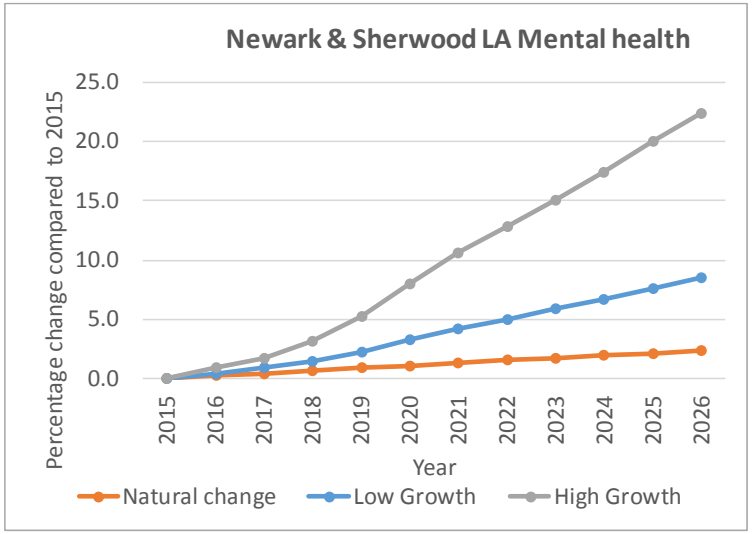
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.50* | *0.97* | *1.43* | *1.88* | *2.30* | *2.74* | *3.16* | *3.53* | *3.95* | *4.50* | *5.06* | *5.62* | *6.18* |
| Planned and unplanned care | *0.00* | *0.70* | *1.38* | *2.07* | *2.79* | *3.46* | *4.13* | *4.80* | *5.47* | *6.32* | *7.17* | *8.00* | *8.86* | *9.69* |
| Social Care | *0.00* | *1.58* | *3.08* | *4.52* | *6.02* | *7.30* | *8.61* | *9.89* | *11.12* | *12.79* | *14.50* | *16.13* | *17.89* | *19.51* |
| Pregnancy and maternity | *0.00* | *-0.56* | *-1.21* | *-2.05* | *-3.03* | *-3.87* | *-4.79* | *-5.66* | *-6.58* | *-7.08* | *-7.24* | *-7.37* | *-7.55* | *-7.60* |

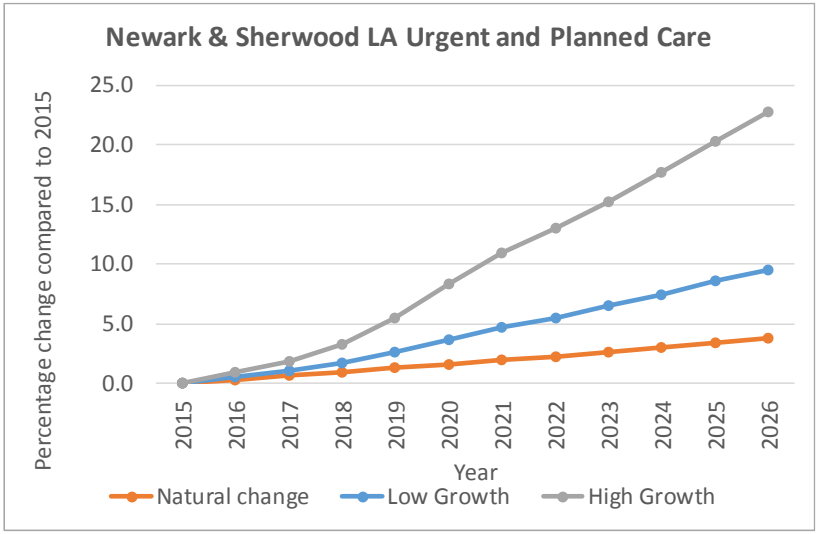
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.19* | *2.36* | *3.54* | *4.70* | *5.86* | *7.01* | *8.15* | *9.27* | *10.44* | *11.76* | *13.08* | *14.41* | *15.71* |
| Planned and unplanned care | *0.00* | *1.38* | *2.77* | *4.16* | *5.55* | *6.93* | *8.30* | *9.67* | *11.05* | *12.64* | *14.20* | *15.76* | *17.35* | *18.89* |
| Social Care | *0.00* | *1.99* | *3.95* | *5.88* | *7.76* | *9.61* | *11.40* | *13.14* | *14.93* | *17.21* | *19.47* | *21.71* | *24.04* | *26.19* |
| Pregnancy and maternity | *0.00* | *0.28* | *0.46* | *0.31* | *0.26* | *0.14* | *0.08* | *0.00* | *-0.19* | *0.14* | *0.75* | *1.55* | *2.30* | *3.07* |

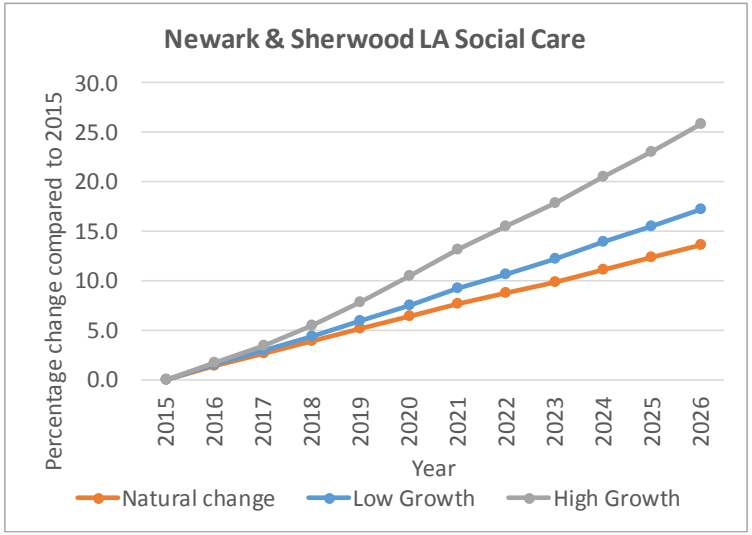
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

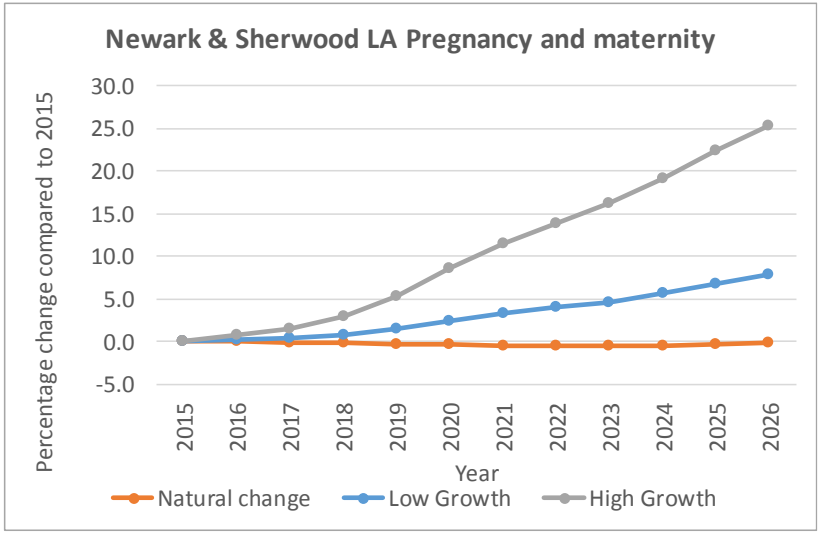
**Newark & Sherwood District**

Projected percentage change in need compared to index year of 2015



**Newark & Sherwood District**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.22* | *0.44* | *0.64* | *0.87* | *1.10* | *1.33* | *1.54* | *1.74* | *1.93* | *2.13* | *2.33* |
| Planned and unplanned care | *0.00* | *0.32* | *0.65* | *0.97* | *1.29* | *1.63* | *1.95* | *2.26* | *2.57* | *2.97* | *3.36* | *3.75* |
| Social Care | *0.00* | *1.31* | *2.67* | *3.92* | *5.12* | *6.35* | *7.55* | *8.68* | *9.80* | *11.08* | *12.31* | *13.54* |
| Pregnancy and maternity | *0.00* | *0.02* | *-0.14* | *-0.12* | *-0.27* | *-0.29* | *-0.43* | *-0.45* | *-0.49* | *-0.44* | *-0.23* | *-0.05* |

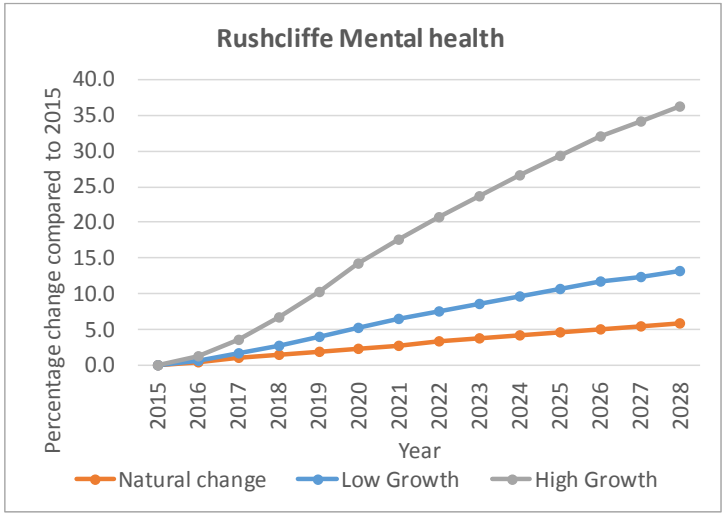
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.44* | *0.87* | *1.39* | *2.23* | *3.22* | *4.21* | *5.02* | *5.84* | *6.69* | *7.63* | *8.49* |
| Planned and unplanned care | *0.00* | *0.52* | *1.04* | *1.69* | *2.58* | *3.64* | *4.69* | *5.56* | *6.47* | *7.49* | *8.56* | *9.58* |
| Social Care | *0.00* | *1.49* | *2.96* | *4.33* | *5.90* | *7.51* | *9.19* | *10.64* | *12.21* | *13.86* | *15.54* | *17.20* |
| Pregnancy and maternity | *0.00* | *0.18* | *0.36* | *0.82* | *1.51* | *2.46* | *3.30* | *4.02* | *4.68* | *5.63* | *6.82* | *7.79* |

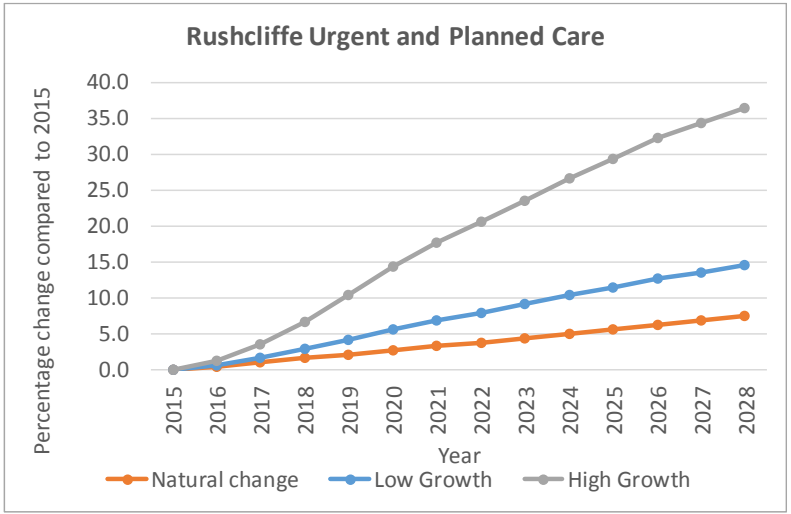
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.87* | *1.74* | *3.12* | *5.27* | *8.04* | *10.65* | *12.84* | *15.06* | *17.40* | *19.94* | *22.34* |
| Planned and unplanned care | *0.00* | *0.95* | *1.88* | *3.34* | *5.51* | *8.29* | *10.90* | *13.05* | *15.29* | *17.73* | *20.30* | *22.75* |
| Social Care | *0.00* | *1.71* | *3.38* | *5.44* | *7.71* | *10.48* | *13.11* | *15.41* | *17.87* | *20.47* | *23.06* | *25.75* |
| Pregnancy and maternity | *0.00* | *0.83* | *1.59* | *2.92* | *5.35* | *8.55* | *11.46* | *13.85* | *16.26* | *19.11* | *22.48* | *25.41* |

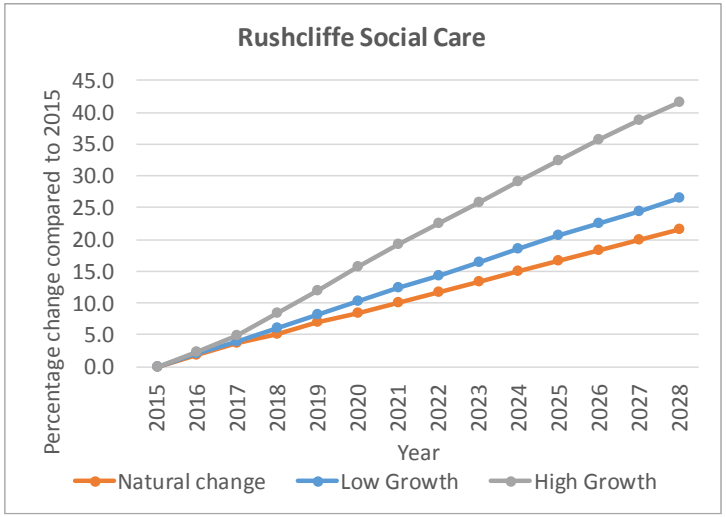
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

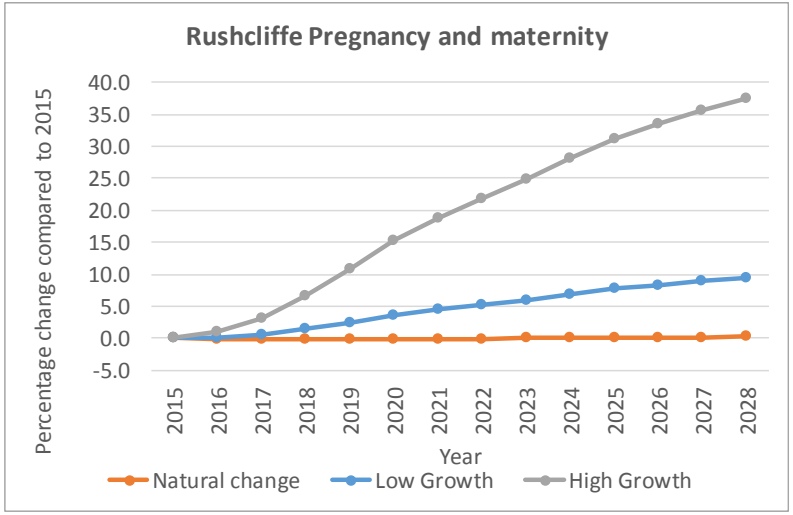
**Rushcliffe Borough and Rushcliffe CCG**

Projected percentage change in need compared to index year of 2015



**Rushcliffe Borough and Rushcliffe CCG**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.51* | *1.00* | *1.45* | *1.91* | *2.37* | *2.82* | *3.26* | *3.71* | *4.15* | *4.56* | *4.96* | *5.39* | *5.78* |
| Planned and unplanned care | *0.00* | *0.55* | *1.10* | *1.68* | *2.23* | *2.79* | *3.34* | *3.88* | *4.42* | *5.04* | *5.67* | *6.28* | *6.92* | *7.51* |
| Social Care | *0.00* | *1.78* | *3.57* | *5.19* | *6.84* | *8.48* | *10.11* | *11.66* | *13.22* | *14.88* | *16.59* | *18.20* | *19.93* | *21.46* |
| Pregnancy and maternity | *0.00* | *-0.10* | *-0.16* | *-0.13* | *-0.16* | *-0.06* | *-0.10* | *-0.06* | *0.01* | *0.10* | *0.10* | *0.13* | *0.13* | *0.22* |

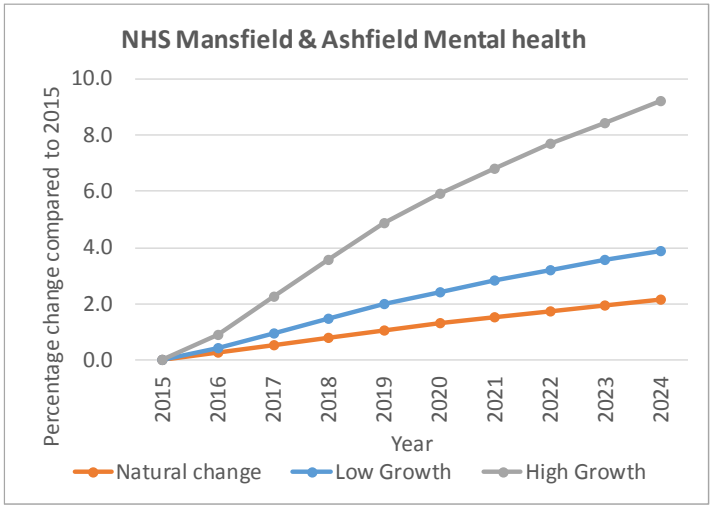
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.71* | *1.61* | *2.74* | *3.99* | *5.31* | *6.48* | *7.53* | *8.62* | *9.67* | *10.67* | *11.63* | *12.44* | *13.23* |
| Planned and unplanned care | *0.00* | *0.77* | *1.69* | *2.94* | *4.26* | *5.66* | *6.89* | *8.01* | *9.15* | *10.36* | *11.52* | *12.66* | *13.62* | *14.62* |
| Social Care | *0.00* | *1.97* | *3.88* | *5.99* | *8.11* | *10.36* | *12.40* | *14.32* | *16.35* | *18.49* | *20.50* | *22.56* | *24.43* | *26.47* |
| Pregnancy and maternity | *0.00* | *0.07* | *0.58* | *1.50* | *2.55* | *3.56* | *4.55* | *5.35* | *6.05* | *6.88* | *7.77* | *8.36* | *8.97* | *9.34* |

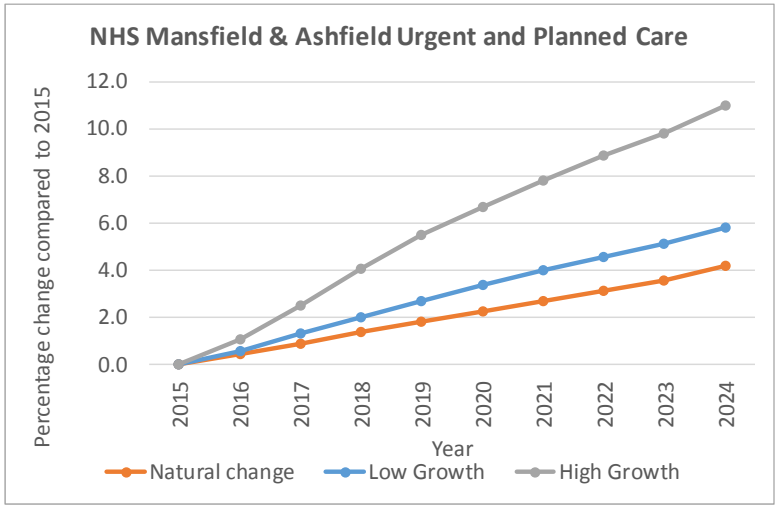
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.28* | *3.48* | *6.64* | *10.34* | *14.28* | *17.64* | *20.65* | *23.62* | *26.56* | *29.37* | *32.06* | *34.10* | *36.09* |
| Planned and unplanned care | *0.00* | *1.32* | *3.51* | *6.72* | *10.42* | *14.34* | *17.68* | *20.66* | *23.60* | *26.56* | *29.45* | *32.19* | *34.29* | *36.35* |
| Social Care | *0.00* | *2.19* | *4.94* | *8.28* | *11.88* | *15.72* | *19.16* | *22.54* | *25.77* | *29.14* | *32.42* | *35.76* | *38.63* | *41.63* |
| Pregnancy and maternity | *0.00* | *0.94* | *3.06* | *6.55* | *10.83* | *15.25* | *18.86* | *21.90* | *24.89* | *28.03* | *31.07* | *33.61* | *35.62* | *37.51* |

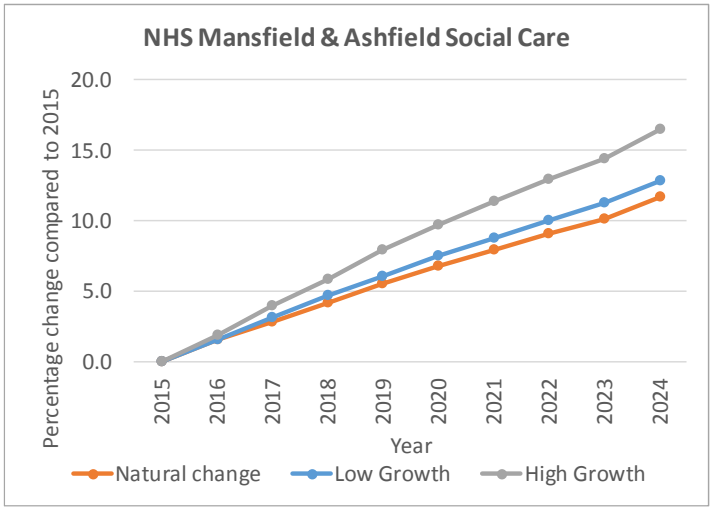
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

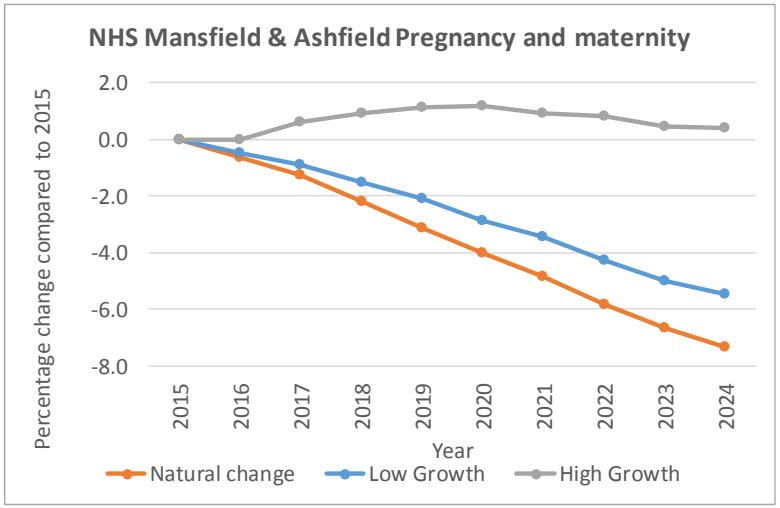
**NHS Mansfield & Ashfield**

Projected percentage change in need compared to index year of 2015



**NHS Mansfield & Ashfield**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.28* | *0.54* | *0.81* | *1.04* | *1.29* | *1.52* | *1.74* | *1.92* | *2.13* |
| Planned and unplanned care | *0.00* | *0.47* | *0.90* | *1.36* | *1.83* | *2.28* | *2.71* | *3.16* | *3.57* | *4.18* |
| Social Care | *0.00* | *1.49* | *2.80* | *4.16* | *5.47* | *6.71* | *7.89* | *9.08* | *10.15* | *11.69* |
| Pregnancy and maternity | *0.00* | *-0.63* | *-1.28* | *-2.18* | *-3.13* | *-4.01* | *-4.86* | *-5.81* | *-6.66* | *-7.32* |

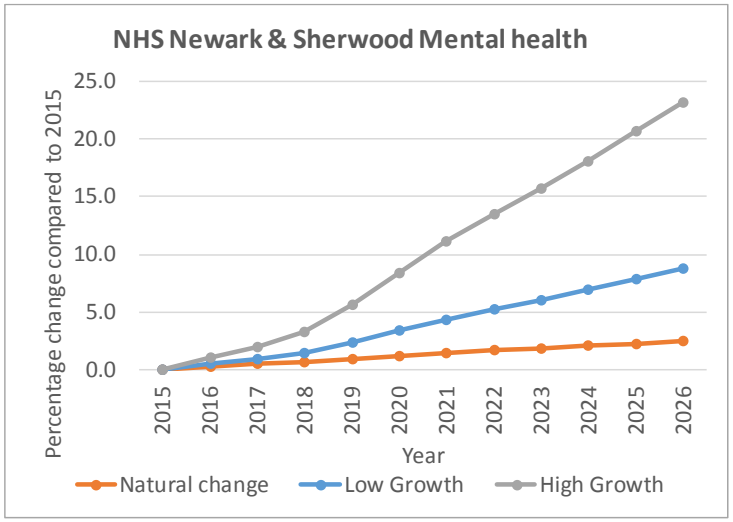
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.43* | *0.96* | *1.49* | *1.99* | *2.42* | *2.84* | *3.22* | *3.55* | *3.89* |
| Planned and unplanned care | *0.00* | *0.59* | *1.30* | *2.03* | *2.72* | *3.39* | *3.98* | *4.56* | *5.13* | *5.85* |
| Social Care | *0.00* | *1.48* | *3.06* | *4.61* | *6.04* | *7.48* | *8.77* | *10.03* | *11.28* | *12.84* |
| Pregnancy and maternity | *0.00* | *-0.48* | *-0.90* | *-1.54* | *-2.09* | *-2.85* | *-3.46* | *-4.27* | *-5.00* | *-5.46* |

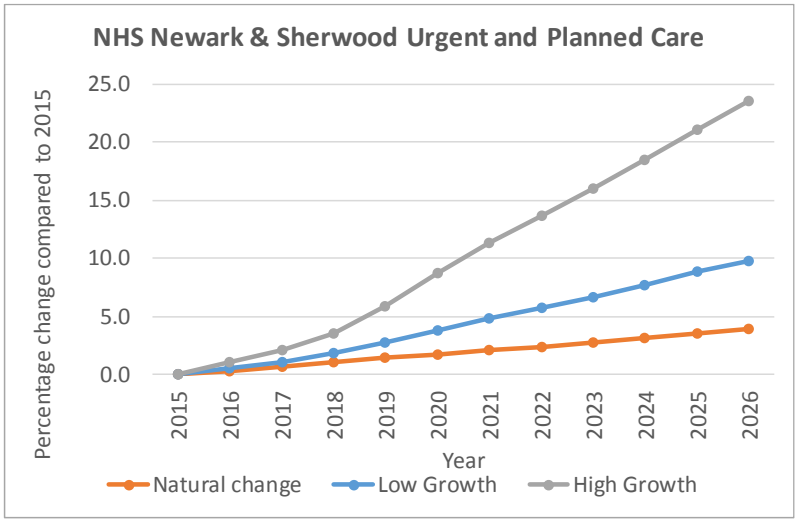
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.89* | *2.23* | *3.57* | *4.85* | *5.89* | *6.82* | *7.67* | *8.42* | *9.21* |
| Planned and unplanned care | *0.00* | *1.06* | *2.54* | *4.04* | *5.50* | *6.71* | *7.83* | *8.84* | *9.82* | *10.98* |
| Social Care | *0.00* | *1.79* | *3.89* | *5.85* | *7.94* | *9.63* | *11.38* | *12.93* | *14.43* | *16.47* |
| Pregnancy and maternity | *0.00* | *-0.01* | *0.63* | *0.94* | *1.11* | *1.19* | *0.95* | *0.80* | *0.45* | *0.43* |

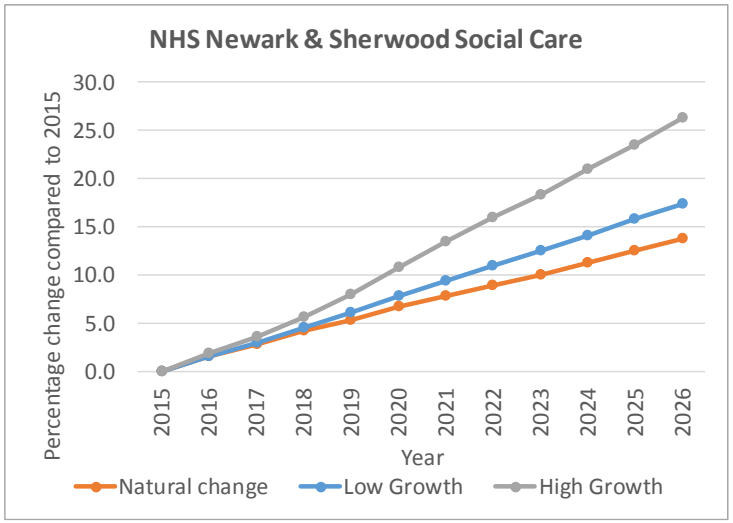
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

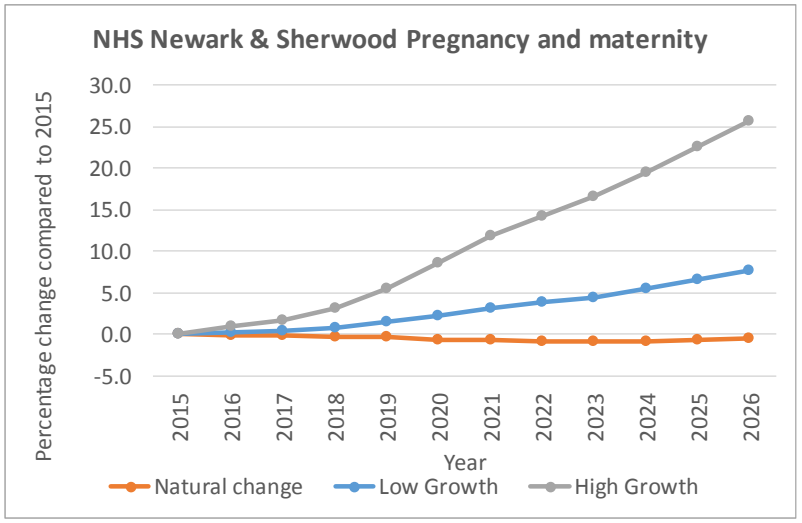
**NHS Newark & Sherwood**

Projected percentage change in need compared to index year of 2015



**NHS Newark & Sherwood**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.25* | *0.50* | *0.70* | *0.94* | *1.21* | *1.42* | *1.66* | *1.87* | *2.07* | *2.28* | *2.49* |
| Planned and unplanned care | *0.00* | *0.36* | *0.72* | *1.06* | *1.41* | *1.78* | *2.09* | *2.42* | *2.76* | *3.15* | *3.56* | *3.94* |
| Social Care | *0.00* | *1.42* | *2.82* | *4.09* | *5.32* | *6.63* | *7.74* | *8.88* | *10.03* | *11.25* | *12.50* | *13.67* |
| Pregnancy and maternity | *0.00* | *-0.09* | *-0.09* | *-0.34* | *-0.37* | *-0.59* | *-0.62* | *-0.81* | *-0.87* | *-0.78* | *-0.68* | *-0.46* |

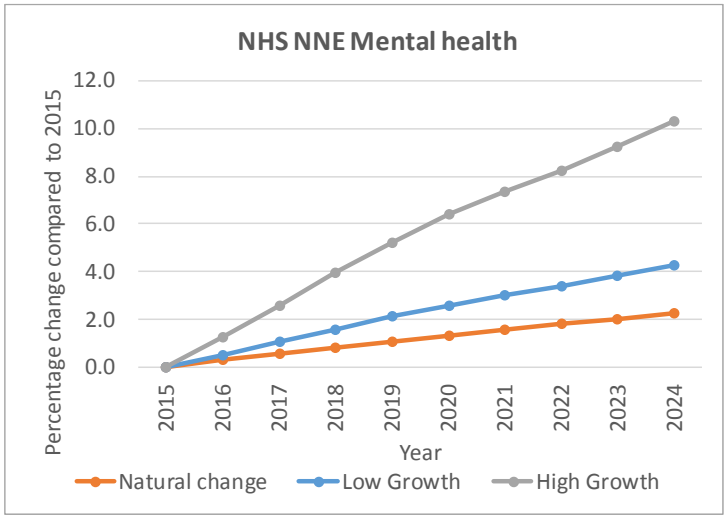
| **Low growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.47* | *0.91* | *1.48* | *2.34* | *3.37* | *4.36* | *5.20* | *6.04* | *6.90* | *7.85* | *8.72* |
| Planned and unplanned care | *0.00* | *0.58* | *1.10* | *1.80* | *2.71* | *3.83* | *4.88* | *5.79* | *6.70* | *7.72* | *8.81* | *9.81* |
| Social Care | *0.00* | *1.49* | *2.91* | *4.42* | *5.99* | *7.76* | *9.37* | *10.89* | *12.41* | *14.01* | *15.72* | *17.27* |
| Pregnancy and maternity | *0.00* | *0.31* | *0.49* | *0.85* | *1.59* | *2.30* | *3.20* | *3.82* | *4.48* | *5.48* | *6.55* | *7.62* |

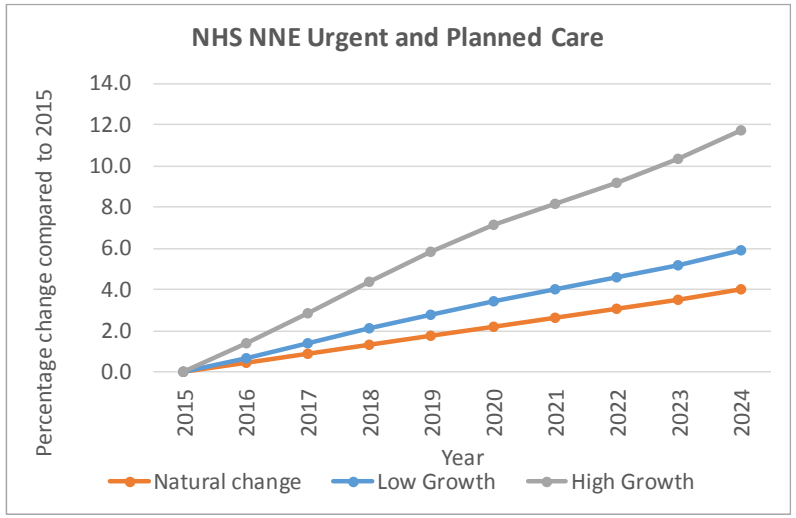
| **High growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.04* | *1.94* | *3.34* | *5.57* | *8.43* | *11.15* | *13.42* | *15.70* | *18.09* | *20.71* | *23.17* |
| Planned and unplanned care | *0.00* | *1.13* | *2.09* | *3.58* | *5.83* | *8.70* | *11.40* | *13.67* | *15.95* | *18.43* | *21.06* | *23.56* |
| Social Care | *0.00* | *1.84* | *3.56* | *5.53* | *7.95* | *10.80* | *13.45* | *15.87* | *18.32* | *20.87* | *23.53* | *26.25* |
| Pregnancy and maternity | *0.00* | *1.02* | *1.73* | *3.14* | *5.48* | *8.69* | *11.81* | *14.18* | *16.53* | *19.46* | *22.63* | *25.66* |

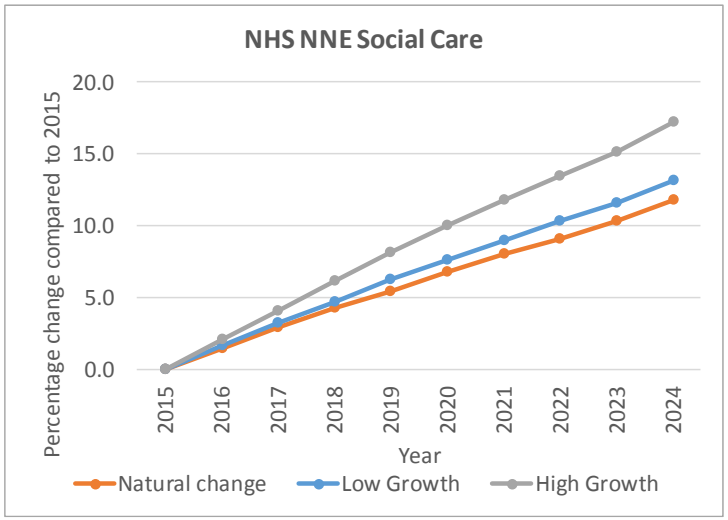
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

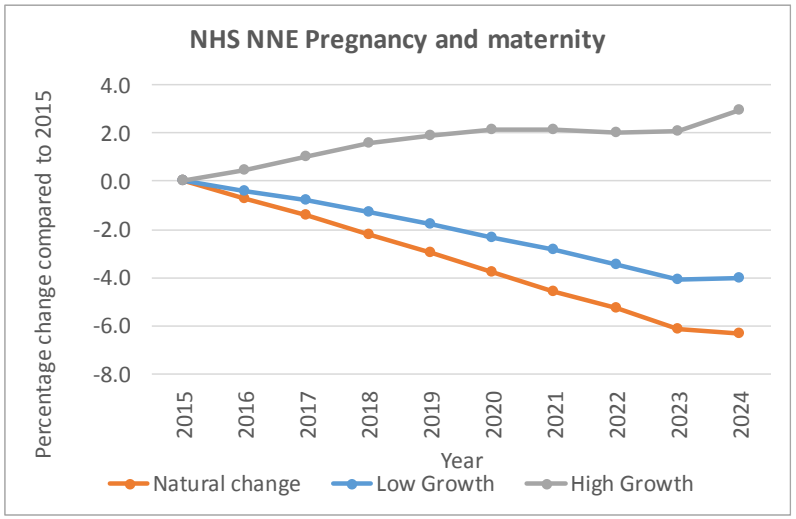
**NHS Nottingham North & East**

Projected percentage change in need compared to index year of 2015



**NHS Nottingham North and East**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.29* | *0.54* | *0.81* | *1.05* | *1.33* | *1.58* | *1.79* | *2.03* | *2.25* |
| Planned and unplanned care | *0.00* | *0.45* | *0.90* | *1.36* | *1.77* | *2.24* | *2.66* | *3.05* | *3.48* | *4.04* |
| Social Care | *0.00* | *1.44* | *2.83* | *4.21* | *5.40* | *6.79* | *7.99* | *9.08* | *10.31* | *11.76* |
| Pregnancy and maternity | *0.00* | *-0.70* | *-1.43* | *-2.20* | *-2.96* | *-3.75* | *-4.58* | *-5.26* | *-6.15* | *-6.35* |

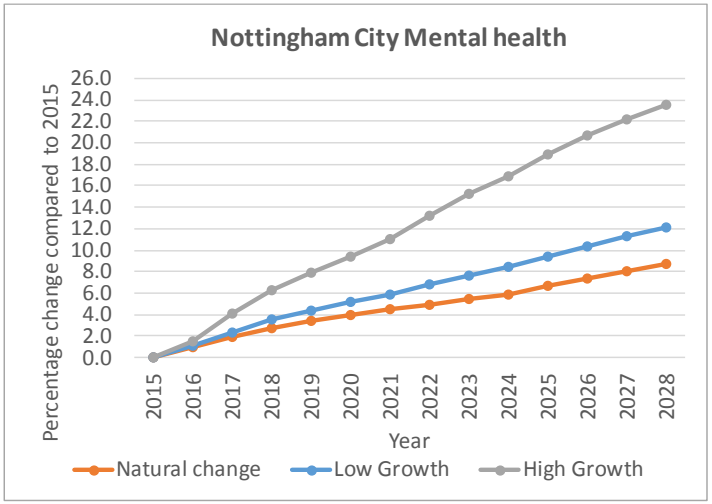
| **Low growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.52* | *1.05* | *1.57* | *2.11* | *2.57* | *3.00* | *3.41* | *3.82* | *4.24* |
| Planned and unplanned care | *0.00* | *0.69* | *1.39* | *2.10* | *2.79* | *3.43* | *4.03* | *4.59* | *5.19* | *5.93* |
| Social Care | *0.00* | *1.62* | *3.17* | *4.64* | *6.20* | *7.56* | *8.97* | *10.26* | *11.59* | *13.12* |
| Pregnancy and maternity | *0.00* | *-0.42* | *-0.78* | *-1.27* | *-1.78* | *-2.34* | *-2.86* | *-3.48* | *-4.08* | *-3.99* |

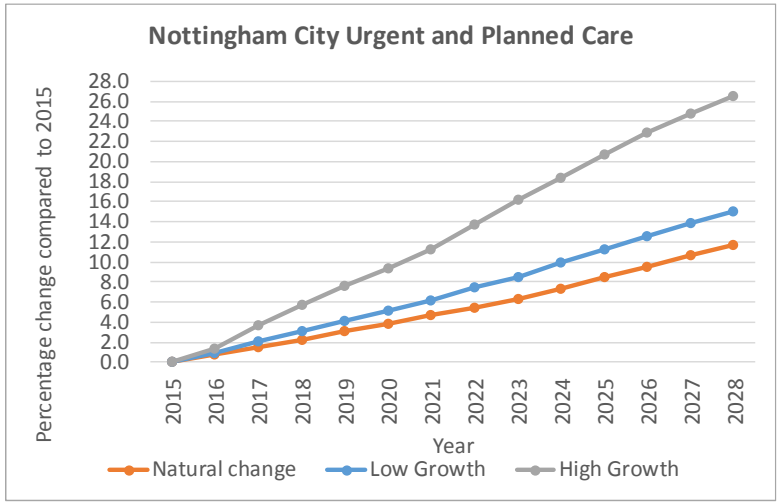
| **High growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.23* | *2.58* | *3.97* | *5.22* | *6.39* | *7.33* | *8.22* | *9.23* | *10.30* |
| Planned and unplanned care | *0.00* | *1.37* | *2.88* | *4.42* | *5.80* | *7.12* | *8.19* | *9.22* | *10.36* | *11.71* |
| Social Care | *0.00* | *2.01* | *4.06* | *6.18* | *8.11* | *10.04* | *11.74* | *13.40* | *15.13* | *17.22* |
| Pregnancy and maternity | *0.00* | *0.44* | *1.05* | *1.58* | *1.90* | *2.15* | *2.14* | *2.01* | *2.09* | *2.94* |

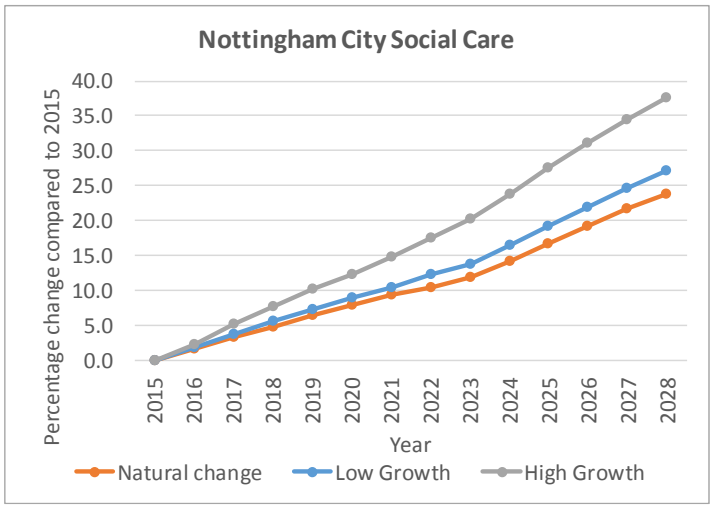
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

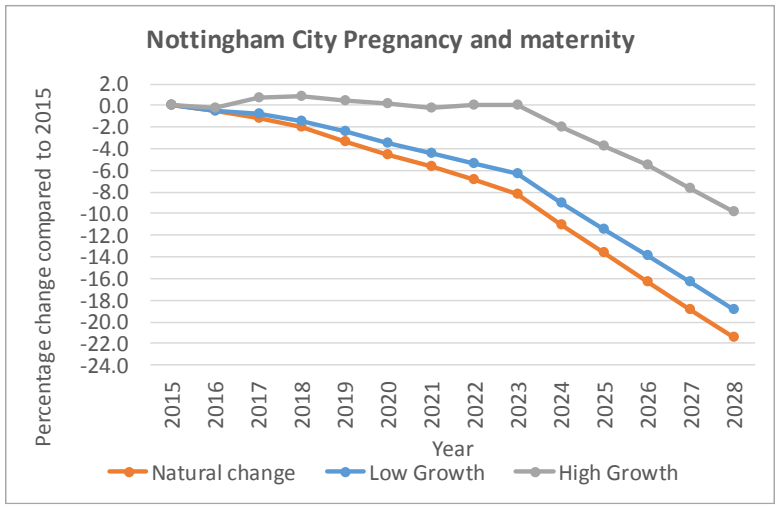
**LA Nottingham City / Nottingham City CCG**

Projected percentage change in need compared to index year of 2015



**LA Nottingham City / Nottingham City CCG**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.93* | *1.89* | *2.81* | *3.38* | *3.91* | *4.46* | *4.96* | *5.42* | *5.91* | *6.62* | *7.31* | *8.00* | *8.67* |
| Planned and unplanned care | *0.00* | *0.75* | *1.55* | *2.27* | *3.12* | *3.91* | *4.72* | *5.49* | *6.31* | *7.38* | *8.46* | *9.54* | *10.62* | *11.65* |
| Social Care | *0.00* | *1.57* | *3.33* | *4.81* | *6.48* | *7.86* | *9.29* | *10.50* | *11.91* | *14.27* | *16.77* | *19.23* | *21.71* | *23.91* |
| Pregnancy and maternity | *0.00* | *-0.54* | *-1.15* | *-2.04* | *-3.30* | *-4.50* | *-5.68* | *-6.85* | *-8.15* | *-10.97* | *-13.59* | *-16.22* | *-18.87* | *-21.39* |

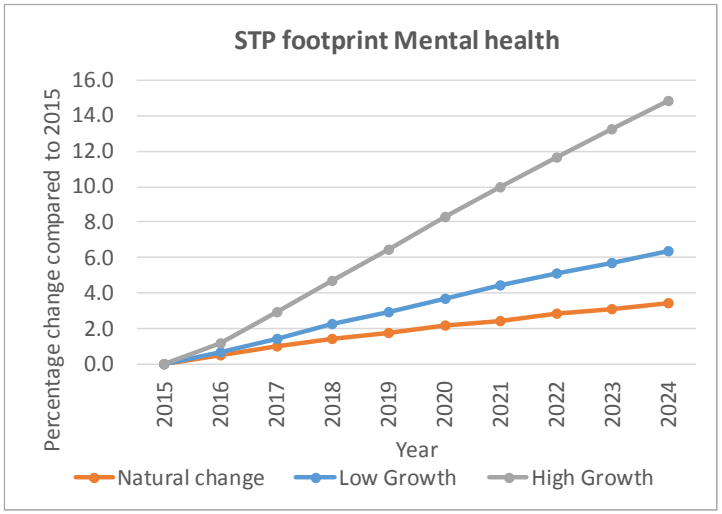
| **Low growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.07* | *2.39* | *3.62* | *4.40* | *5.17* | *5.93* | *6.87* | *7.66* | *8.43* | *9.40* | *10.36* | *11.24* | *12.07* |
| Planned and unplanned care | *0.00* | *0.91* | *2.05* | *3.08* | *4.12* | *5.17* | *6.20* | *7.41* | *8.53* | *9.89* | *11.24* | *12.57* | *13.84* | *15.07* |
| Social Care | *0.00* | *1.84* | *3.76* | *5.57* | *7.27* | *8.94* | *10.53* | *12.32* | *13.73* | *16.48* | *19.23* | *21.97* | *24.62* | *27.19* |
| Pregnancy and maternity | *0.00* | *-0.48* | *-0.73* | *-1.41* | *-2.38* | *-3.40* | *-4.42* | *-5.29* | *-6.26* | *-8.95* | *-11.38* | *-13.79* | *-16.27* | *-18.79* |

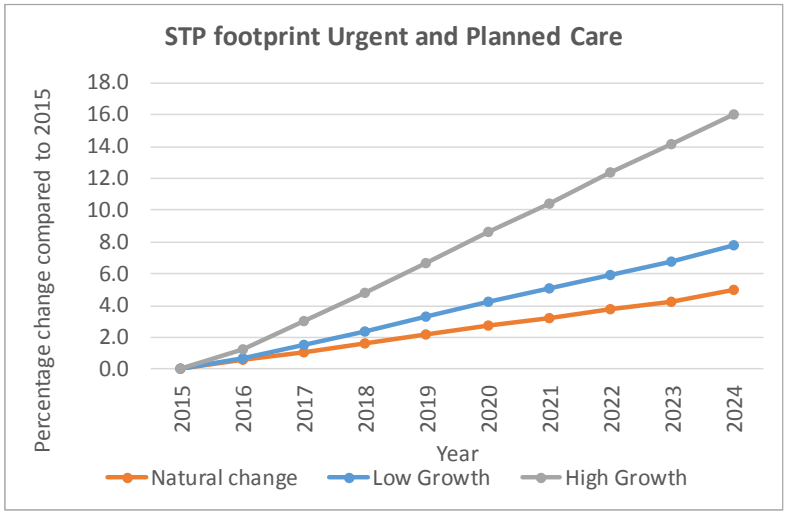
| **High growth** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** | **2028** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.49* | *4.09* | *6.29* | *7.84* | *9.41* | *10.99* | *13.24* | *15.29* | *16.90* | *18.86* | *20.64* | *22.16* | *23.53* |
| Planned and unplanned care | *0.00* | *1.32* | *3.76* | *5.75* | *7.57* | *9.39* | *11.24* | *13.77* | *16.18* | *18.38* | *20.72* | *22.89* | *24.80* | *26.58* |
| Social Care | *0.00* | *2.18* | *5.19* | *7.78* | *10.16* | *12.40* | *14.81* | *17.56* | *20.30* | *23.81* | *27.56* | *31.11* | *34.43* | *37.62* |
| Pregnancy and maternity | *0.00* | *-0.17* | *0.67* | *0.81* | *0.46* | *0.15* | *-0.24* | *0.10* | *0.09* | *-2.00* | *-3.73* | *-5.51* | *-7.64* | *-9.81* |

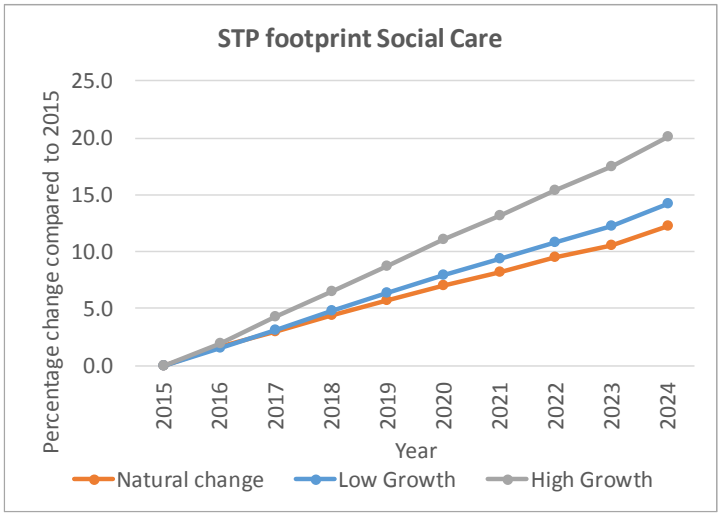
Negative numbers denote a **reduction** compared to 2015 activity, positive numbers an **increase** compared to 2015

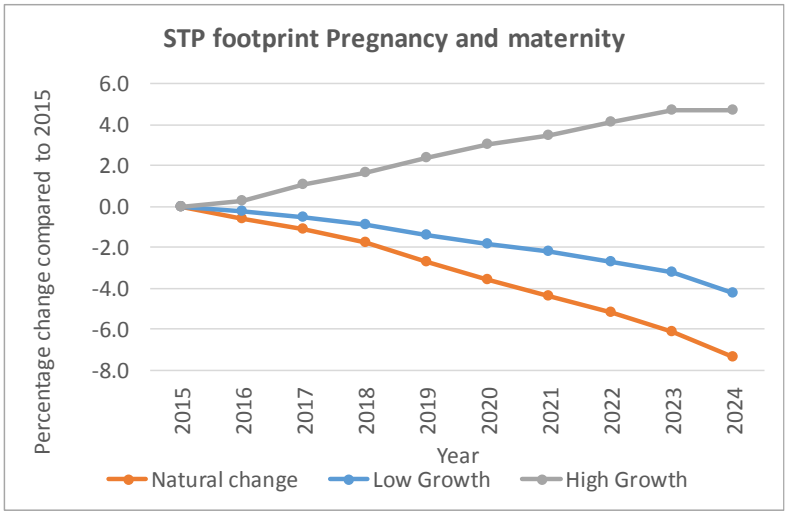
**Nottingham and Nottinghamshire STP Footprint**

Projected percentage change in need compared to index year of 2015



**Nottingham and Nottinghamshire STP Footprint**

Projected percentage change in need compared to index year of 2015

| **Natural growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.53* | *0.97* | *1.44* | *1.79* | *2.14* | *2.47* | *2.81* | *3.08* | *3.40* |
| Planned and unplanned care | *0.00* | *0.59* | *1.09* | *1.62* | *2.15* | *2.70* | *3.21* | *3.74* | *4.25* | *4.94* |
| Social Care | *0.00* | *1.69* | *2.98* | *4.36* | *5.67* | *6.99* | *8.17* | *9.46* | *10.56* | *12.22* |
| Pregnancy and maternity | *0.00* | *-0.59* | *-1.09* | *-1.80* | *-2.69* | *-3.55* | *-4.36* | *-5.19* | *-6.10* | *-7.38* |

| **Low growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *0.67* | *1.45* | *2.25* | *2.97* | *3.72* | *4.41* | *5.10* | *5.72* | *6.37* |
| Planned and unplanned care | *0.00* | *0.71* | *1.54* | *2.39* | *3.29* | *4.22* | *5.08* | *5.95* | *6.80* | *7.81* |
| Social Care | *0.00* | *1.55* | *3.13* | *4.74* | *6.32* | *7.97* | *9.40* | *10.83* | *12.24* | *14.16* |
| Pregnancy and maternity | *0.00* | *-0.26* | *-0.55* | *-0.89* | *-1.36* | *-1.86* | *-2.22* | *-2.74* | *-3.21* | *-4.22* |

| **High growth** | **2015** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|---|
| Mental health | *0.00* | *1.20* | *2.93* | *4.69* | *6.45* | *8.25* | *9.92* | *11.62* | *13.24* | *14.79* |
| Planned and unplanned care | *0.00* | *1.23* | *2.99* | *4.79* | *6.68* | *8.66* | *10.45* | *12.33* | *14.12* | *16.00* |
| Social Care | *0.00* | *1.92* | *4.24* | *6.49* | *8.72* | *11.06* | *13.21* | *15.40* | *17.46* | *20.03* |
| Pregnancy and maternity | *0.00* | *0.27* | *1.05* | *1.62* | *2.36* | *3.06* | *3.50* | *4.12* | *4.70* | *4.70* |

**Cumulative change in population from 2015**

**Natural change**

| Local Authority | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LA Ashfield | 220 | 441 | 662 | 884 | 1,106 | 1,328 | 1,551 | 1,774 | 1,998 | | | | |
| LA Bassetlaw | -7 | -14 | -21 | -28 | -35 | | | | | | | | |
| LA Broxtowe | 224 | 449 | 675 | 901 | 1,127 | 1,354 | 1,581 | 1,808 | 2,036 | 2,265 | 2,494 | 2,723 | 2,953 |
| LA Gedling | 162 | 325 | 487 | 650 | 813 | 977 | 1,140 | 1,304 | 1,468 | 1,633 | 1,797 | 1,962 | 2,127 |
| LA Mansfield | 230 | 460 | 690 | 921 | 1,152 | 1,385 | 1,617 | 1,850 | 2,084 | 2,318 | 2,552 | 2,787 | 3,023 |
| LA Newark & Sherwood | 26 | 52 | 78 | 104 | 130 | 156 | 182 | 208 | 234 | 260 | 286 | | |
| LA Rushcliffe | 228 | 457 | 687 | 917 | 1,147 | 1,378 | 1,609 | 1,841 | 2,073 | 2,305 | 2,539 | 2,772 | 3,006 |
| LA Nottingham City | 1,919 | 3,850 | 5,794 | 7,750 | 9,720 | 11,702 | 13,698 | 15,707 | 17,729 | 19,764 | 21,813 | 23,875 | 25,951 |
| **CCG Footprint** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** |
| NHS Bassetlaw | -7 | -14 | -21 | -28 | -35 | | | | | | | | |
| NHS Mansfield & Ashfield | 385 | 770 | 1,157 | 1,544 | 1,931 | 2,320 | 2,709 | 3,100 | 3,490 | | | | |
| NHS Newark & Sherwood | 40 | 80 | 120 | 160 | 200 | 240 | 280 | 320 | 361 | 401 | 441 | | |
| NHS Nottingham North & East | 254 | 509 | 765 | 1,020 | 1,277 | 1,533 | 1,790 | 2,048 | 2,306 | | | | |
| NHS Nottingham West | 229 | 459 | 690 | 921 | 1,152 | 1,384 | 1,616 | 1,849 | 2,082 | 2,316 | 2,550 | 2,785 | 3,020 |
| NHS Rushcliffe | 228 | 457 | 687 | 917 | 1,147 | 1,378 | 1,609 | 1,841 | 2,073 | 2,305 | 2,539 | 2,772 | 3,006 |
| NHS Nottingham City | 1,919 | 3,850 | 5,794 | 7,750 | 9,720 | 11,702 | 13,698 | 15,707 | 17,729 | 19,764 | 21,813 | 23,875 | 25,951 |
| | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | | | | |
| **STP footprint** | 3,056 | 6,126 | 9,212 | 12,312 | 15,427 | 18,558 | 21,703 | 24,864 | 28,041 | | | | |

**Cumulative change in population from 2015**

**Low growth**

| Local Authority | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LA Ashfield | 472 | 1,257 | 2,064 | 2,741 | 3,323 | 3,766 | 4,162 | 4,506 | 4,828 | | | | |
| LA Bassetlaw | 301 | 723 | 1,134 | 1,442 | 1,749 | | | | | | | | |
| LA Broxtowe | 614 | 1,238 | 1,800 | 2,548 | 3,325 | 4,069 | 4,783 | 5,346 | 6,018 | 6,695 | 7,373 | 8,012 | 8,572 |
| LA Gedling | 440 | 872 | 1,314 | 1,746 | 2,128 | 2,469 | 2,796 | 3,178 | 3,587 | 3,927 | 4,219 | 4,478 | 4,743 |
| LA Mansfield | 498 | 996 | 1,494 | 1,993 | 2,492 | 2,993 | 3,493 | 3,994 | 4,496 | 4,998 | 5,500 | 6,003 | 6,507 |
| LA Newark & Sherwood | 286 | 572 | 1,055 | 1,851 | 2,880 | 3,852 | 4,644 | 5,457 | 6,322 | 7,258 | 8,120 | | |
| LA Rushcliffe | 477 | 1,225 | 2,274 | 3,488 | 4,766 | 5,868 | 6,842 | 7,811 | 8,760 | 9,682 | 10,550 | 11,220 | 11,866 |
| LA Nottingham City | 2,293 | 5,378 | 8,195 | 10,832 | 13,502 | 16,172 | 19,351 | 22,428 | 25,170 | 28,003 | 30,737 | 33,297 | 35,781 |
| **CCG Footprint** | | | | | | | | | | | | | |
| NHS Bassetlaw | 301 | 723 | 1,134 | 1,442 | 1,749 | | | | | | | | |
| NHS Mansfield & Ashfield | 709 | 1,648 | 2,608 | 3,508 | 4,312 | 5,049 | 5,750 | 6,432 | 7,097 | | | | |
| NHS Newark & Sherwood | 357 | 654 | 1,158 | 1,968 | 3,016 | 4,018 | 4,841 | 5,668 | 6,548 | 7,498 | 8,374 | | |
| NHS Nottingham North & East | 633 | 1,328 | 2,025 | 2,669 | 3,281 | 3,798 | 4,300 | 4,849 | 5,423 | | | | |
| NHS Nottingham West | 619 | 1,248 | 1,815 | 2,568 | 3,350 | 4,099 | 4,818 | 5,387 | 6,064 | 6,746 | 7,429 | 8,074 | 8,639 |
| NHS Rushcliffe | 477 | 1,225 | 2,274 | 3,488 | 4,766 | 5,868 | 6,842 | 7,811 | 8,760 | 9,682 | 10,550 | 11,220 | 11,866 |
| NHS Nottingham City | 2,293 | 5,378 | 8,195 | 10,832 | 13,502 | 16,172 | 19,351 | 22,428 | 25,170 | 28,003 | 30,737 | 33,297 | 35,781 |
| | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | | | | |
| **STP footprint** | 5,089 | 11,482 | 18,074 | 25,033 | 32,227 | 39,005 | 45,903 | 52,574 | 59,062 | | | | |

**Cumulative change in population from 2015**

**High growth**

| Local Authority | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LA Ashfield | 1,065 | 3,180 | 5,369 | 7,120 | 8,550 | 9,515 | 10,319 | 10,948 | 11,501 | | | | |
| LA Bassetlaw | 1,114 | 2,668 | 4,182 | 5,322 | 6,459 | | | | | | | | |
| LA Broxtowe | 1,274 | 2,574 | 3,706 | 5,339 | 7,048 | 8,667 | 10,204 | 11,337 | 12,759 | 14,194 | 15,631 | 16,964 | 18,083 |
| LA Gedling | 1,327 | 2,615 | 3,950 | 5,238 | 6,320 | 7,225 | 8,075 | 9,152 | 10,342 | 11,242 | 11,943 | 12,504 | 13,087 |
| LA Mansfield | 1,340 | 2,680 | 4,020 | 5,361 | 6,702 | 8,045 | 9,387 | 10,730 | 12,074 | 13,418 | 14,762 | 16,107 | 17,453 |
| LA Newark & Sherwood | 882 | 1,764 | 3,293 | 5,850 | 9,176 | 12,312 | 14,858 | 17,472 | 20,258 | 23,276 | 26,051 | | |
| LA Rushcliffe | 1,253 | 3,618 | 7,220 | 11,503 | 16,049 | 19,866 | 23,157 | 26,426 | 29,611 | 32,684 | 35,528 | 37,562 | 39,491 |
| LA Nottingham City | 3,593 | 10,681 | 16,527 | 21,527 | 26,626 | 31,682 | 38,966 | 45,750 | 50,989 | 56,593 | 61,704 | 65,991 | 69,892 |
| **CCG Footprint** | | | | | | | | | | | | | |
| NHS Bassetlaw | 1,114 | 2,668 | 4,182 | 5,322 | 6,459 | | | | | | | | |
| NHS Mansfield & Ashfield | 1,728 | 4,411 | 7,178 | 9,695 | 11,814 | 13,649 | 15,333 | 16,934 | 18,466 | | | | |
| NHS Newark & Sherwood | 1,105 | 2,008 | 3,607 | 6,237 | 9,666 | 12,939 | 15,612 | 18,296 | 21,158 | 24,255 | 27,104 | | |
| NHS Nottingham North & East | 1,843 | 3,941 | 6,046 | 7,932 | 9,676 | 11,026 | 12,309 | 13,785 | 15,366 | | | | |
| NHS Nottingham West | 1,279 | 2,584 | 3,721 | 5,359 | 7,073 | 8,697 | 10,239 | 11,378 | 12,805 | 14,245 | 15,687 | 17,026 | 18,150 |
| NHS Rushcliffe | 1,253 | 3,618 | 7,220 | 11,503 | 16,049 | 19,866 | 23,157 | 26,426 | 29,611 | 32,684 | 35,528 | 37,562 | 39,491 |
| NHS Nottingham City | 3,593 | 10,681 | 16,527 | 21,527 | 26,626 | 31,682 | 38,966 | 45,750 | 50,989 | 56,593 | 61,704 | 65,991 | 69,892 |
| | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | | | | |
| **STP footprint** | 10,802 | 27,244 | 44,298 | 62,253 | 80,904 | 97,860 | 115,617 | 132,568 | 148,395 | | | | |

**Clinical Commissioning Group registered population April 2014 (source: HSCIC)**

| Clinical Commissioning Group | Total population |
|---|---|
| NHS BASSETLAW CCG | 112,878 |
| NHS MANSFIELD AND ASHFIELD CCG | 186,539 |
| NHS NEWARK & SHERWOOD CCG | 129,552 |
| NHS NOTTINGHAM NORTH AND EAST CCG | 147,729 |
| NHS NOTTINGHAM WEST CCG | 94,112 |
| NHS RUSHCLIFFE CCG | 122,948 |

**Local Authority 2014 mid-year-estimate resident population (source: ONS)**

| Local Authority | Total population |
|---|---|
| Ashfield | 122,508 |
| Bassetlaw | 114,143 |
| Broxtowe | 111,780 |
| Gedling | 115,638 |
| Mansfield | 105,893 |
| Newark and Sherwood | 117,758 |
| Rushcliffe | 113,670 |