Milton Keynes City Plan 2050
Health Impact Assessment

Regulation 19

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Executive summary

1.1.1 Milton Keynes will undergo significant changes and growth by 2050, with the city providing up to 59,779 new homes and the population growing to 410,000. Development will be across all areas of the city. The major areas of additional residential development are at Central Milton Keynes, Campbell Park and Central Bletchley (17,184 homes in total), and the strategic extensions at the outer edges of the city (16,050 homes in total). Through the Milton Keynes City Plan 2050 (MKCP), the Council sets out how it will enhance infrastructure, housing provision, and public services to manage and to enable this growth.

1.1.2 The MKCP intends to *create prosperity and a better quality of life and wellbeing for **all*** and to create a sustainable, inclusive and healthy environment.

Health Impact Assessment of Milton Keynes City Plan 2050 – Regulation 19

1.1.3 A Health Impact Assessment (HIA) was undertaken as part of the Regulation 18 consultation. This HIA for the Regulation 19 consultation builds upon the evidence and recommendations presented in the previous HIA and the Council will take account of both HIAs when finalising the MKCP.

1.1.4 This HIA has been informed by interviews with the authors of the policies assessed within the HIA, supported by an updated baseline health summary of Milton Keynes, review of relevant policies and public health evidence.

1.1.5 The HIA considers the potential health impacts of the MKCP. It asks, what impact the MKCP is likely to have on health and wellbeing in Milton Keynes; what populations the policies will affect the most, and what can be done to strengthen the MKCP. Below, we present the findings of the HIA: the strong points of the MKCP; the opportunities to strengthen the MKCP and the recommendations.

Milton Keynes City Plan 2050 presents many opportunities to support health and wellbeing:

1.1.6 The Reg18 HIA identified many opportunities for the MKCP to promote health. These include:

- the strategic ambition to create People Friendly and Healthy Places;
- development that increases residential density and delivers services and other amenities;
- an emphasis on community;
- provision of opportunities for movement and transport;
- strategies to protect the health of children, such as limiting of retail outlets (e.g. takeaways, betting shops, shisha cafes) close to where children congregate;
- provision of accessible and safe green spaces and recreational areas;
- placing healthcare and social care within frameworks for new and existing communities;
- protecting the natural environment and supporting climate change adaptation.

1.1.7 In addition to the opportunities to promote health set out in the Reg18 HIA, this HIA has assessed the policies and offers further recommendations. Where these can be found in

the Reg19 HIA, and where they are discussed in the Reg18 HIA, are presented in Table 1.

Table 1 Policies assessed and recommendations offered on MKCP

Policy theme	Policies	Where assessed in Reg18 HIA	Where assessed in this Reg19 HIA report
Growth and the City	GS1, GS8 and GS9 (INF1); GS11 to GS19; CMK1 to CMK3; and CB1.	Section 3.2	Section 5.2
High Quality Homes	GS2, HQH1 to HQH10	Section 3.3	Section 5.3
People Friendly and Healthy Places	GS4, PFHP1, PFHP2, and PFHP5 to PFHP7	Section 3.4	Section 5.4
Retail	GS5, PFHP3 and PFHP4	Section 3.5	Section 5.5
Growth and the Countryside	GS6	Section 3.6	Section 5.6
Energy	GS7	Section 3.7	Section 5.7
Climate and environmental action	CEA1 – CEA15	Not assessed	Section 5.8
Movement and Access (Transport)	GS10	Section 3.8	Section 5.9

Opportunities to strengthen the Milton Keynes City Plan 2050 to promote health and wellbeing outcomes

1.1.8 The Reg18 HIA offered key opportunities to strengthen the MKCP:

1.1.9 **Growth for *all* MK residents:** There is a risk that the benefits of new development do not flow to existing residents, and particularly to residents living in more deprived areas or with different needs. It will be important to identify opportunities for the MKCP to support health equity considering both existing and new communities. For example, regeneration or providing infrastructure through the proposed strategic extensions (e.g. Mass Rapid Transport, parks) that can benefit all residents and particularly those with greatest need may provide these opportunities.

1.1.10 **Supporting key partners:** Healthcare partners and social care partners must both ensure they are resourced to advise developers about whether a proposed development will generate a demand for infrastructure for healthcare and social care and ensure that the adequate plans are in place to meet that demand.

1.1.11 **Managing growth and enabling integration:** Developing extension sites on the periphery of the city is likely to promote car use and risks social isolation. The Mass Rapid Transport scheme will provide good active sustainable travel links to the city centre and is important for health and health equity. Providing high quality and affordable links,

by means other than private cars, to other parts of the city and to places of employment will further help with the integration of new communities.

1.1.12 **Make the MKCP work:** The ambition and vision of the MKCP is excellent. The implementation – and particularly its cross-cutting themes - will need close attention. Specific areas for attention from a health perspective are transport (and Local Transport Plan 5); design guidance that is clear to all parties; and ensuring there are skills/awareness across the Council to support implementation and an active engaged public health team.

1.1.13 **Tracking the changes**: Establish a monitoring framework to track the implementation of the MKCP and its contribution to physical and mental health and wellbeing. Regular reviews and updates will help ensure that the MKCP remains responsive to emerging health issues and community needs.

1.1.14 In addition to the recommendations presented in the assessment, the Reg19 HIA offers the following considerations to strengthen the health and wellbeing outcomes of the MKCP:

a) The Plan sets out to 'deliver the right infrastructure at the right time and in the right places'. This approach is necessary for ensuring communities have access to needed infrastructure in early stages of development, however, MK has an ageing population and infrastructure that is built now may not be best suited to the needs of communities in the future. The expectation for management and maintenance of certain infrastructure may help to mitigate this issue. Providing new infrastructure that is accessible and appropriate to multiple users in the first instance, can also help to ensure that it remains appropriate to communities over time.

b) There is a strong emphasis on developing infrastructure that is most likely to benefit urban populations. It will be important to consider the needs of rural communities, including access to essential amenities, throughout the MKCP.

c) The Plan should strengthen approaches to serve the needs of diverse populations. This could include improvement of public amenities such as provision of wayfinding on routes, and shade and rest areas near open spaces. These approaches support more population groups, e.g. elderly people, to engage in the public realm.

d) Whilst the Plan considers key provisions that are needed to enable street use by elderly people or people with a disability, one notable omission is the provision of public toilets. Public toilets are an essential amenity of walkable environments and the lack of public toilets can be a barrier for many street users. Consideration should be given to how this can be addressed through provision of public amenities or contributions to social infrastructure.

e) While the Plan has a strong emphasis on ensuring access to public amenities and infrastructure, it is important to also consider whether these offerings are also appropriate, available and acceptable to the communities who want to use them. For example, accessibility to open space is important, however, if that open space is not designed to be appropriate and acceptable to the needs of the local community - such as providing seating, wayfinding, play structures, etc. - then it will not be used. Therefore, it may be necessary to demonstrate how new development provides amenities that are accessible and also appropriate and acceptable to communities.

f) It will be important to ensure that communities are provided with opportunities to engage in aspects of planning and development. With regard to regeneration, it will be necessary to ensure developers consult with communities to deliver amenities that are needed by the community. Development needs to happen in a way that respects local character, identity and meets the desired needs of the community, rather than perceived needs. This might require developers to demonstrate community input and how community consultation and social planning have been

considered within the design. Ensuring there are community benefits in places where communities are likely to bare some level of burden (for example, with regard to renewable energy infrastructure in the countryside) will also be important for protecting wellbeing and avoiding unintended or disproportionate impacts.

g) The MKCP strongly supports the expansion of active travel routes, including Redways, and public transport such as the MRT. This is greatly supported as a mechanism to support physical health and mental wellbeing, and can help to reduce inequalities when these options are accessible to a range of users. However, indirect public transport routes, such as those necessitating the need to transfer, can lengthen journey time, increase costs and add stress to journeys. Consideration will need to be given to how expansion of grid roads, which make car use easier, is balanced with active travel goals and the design of public transport routes which can make this option less attractive.

h) Milton Keynes will experience climate changes over the next 25 years. It is currently projected that global warming levels will reach 1.5ºC by 2050 which would lead to more summer days, more hot summer days, fewer frost days, and more cooling degree days in Milton Keynes, as well as increased flood risk and extreme heat, particularly in urban areas (1). This has clear health consequences including higher risk for heat-related hospital admissions and death, transport disruption, increased water demand and increased energy demand for cooling. In addition to extreme heat, the MKCC administrative area is also most vulnerable to flooding (including from rivers and surface water) (2). The Climate and Environmental Action chapter sets out approaches to help mitigate some of these actions. A distinction should be made between strategies that reduce climate change (e.g. GHG emissions) and those that enhance climate change adaptation and further consideration could be given to ensuring the MKCP achieves needs strategies. It should also more clearly link climate adaptation to public health benefits in both the CEA policies and the PFHP policies. This could also be further emphasised in the draft Sustainability Strategy 2025-2050.

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2 Assessment Methodology

2.1 Introduction

2.1.1 The Regulation 19 Health Impact Assessment (Reg19 HIA) seeks to build upon what is set out in the Regulation 18 Health Impact Assessment (Reg18 HIA). Some of the policies reviewed for Reg18 have changed and are no longer applicable to this HIA (for example, when multiple policies have been condensed to a single policy or they have been renamed). The findings of the Reg18 HIA and associated recommendations, where applicable, are relevant to this assessment. A short summary of findings from the Reg18 HIA is provided at the start of each policy assessment section, however, this HIA seeks not to duplicate text from the Reg18 HIA. In some cases, recommendations from the Reg18 HIA have already been integrated into the Reg19 policy. Both HIAs should be read in conjunction so as to develop a comprehensive understanding of the findings and recommendations provided by both.

2.1.2 HIA is a systematic process that examines a policy to determine potential health effects, particularly for vulnerable populations, and offers recommendations to enhance health benefits or avoid potential harms. The HIA identifies and provides strategic advice for the challenges and opportunities presented by the MKCP (3).

2.1.3 Health is defined ‘as a state of complete physical, mental and social wellbeing and not merely the absence of disease’ (4). Mental health is defined as a ‘state in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (5). In this report, the terms health and wellbeing are used interchangeably, and equal consideration is given to considering both physical and mental health outcomes.

2.1.4 The HIA follows the scope set out in the Health Impact Assessment Scoping report (6). This HIA does not duplicate the Reg18 HIA (7) or Sustainability Appraisal (SA) of the MKCP (8). The approach is consistent with the remit of assessing a strategic level plan.

2.1.5 The HIA follows relevant guidance, including IPH 2021 guidance (9), and the Wales Health Impact Assessment Support Unit guidance (10) which set out best practice for HIA. Consideration has also been given to the MK Health Impact Assessment SPD (2021)(11).

2.1.6 The HIA considers impacts on groups considered to be vulnerable by the MK Joint Strategic Needs Assessment (JSNA). The MK JSNA is summarised in section 2.2. When considering who will be most affected by a policy, the methods draw on the vulnerable population groups set out in IPH guidance (2021):

- Young age: Children and young people (including pregnant women and unborn children)
- Old age: older people (particularly frail elderly)
- Low income: People on low income, who are economically inactive or unemployed/workless
- Poor health: People with existing poor health; those with existing long-term physical or mental health conditions or disability that substantially affects their ability to carry out normal day-to-day activities
- Social disadvantage: People who suffer discrimination or other social disadvantage, including relevant protected characteristics under the Equality Act 2010 or groups who may experience low social status or social isolation for other reasons.

- Access and geographical factors: People experiencing barriers in access to services, amenities and facilities and people living in areas known to exhibit high deprivation or poor economic and/or health indicators.

2.1.7 Heightened vulnerability is rarely due to a single cause and people may experience multiple forms of vulnerability due to intersecting social processes that result in inequalities (e.g., socioeconomic status and income).

2.2 Approach

2.2.1 The HIA relies on evidence provided through the Reg18 HIA, relevant policies, a baseline health profile, and interviews with the MKCP chapter authors to inform the assessment.

2.2.2 Interviews were conducted in June 2025 with the twelve authors of policies considered within the HIA. Interviews were approximately 30-45 minutes and followed a standard interview protocol on: the changes in the Regulation 19 policies, how the policies had the potential to impact health, who was most likely to be affected by the policy, and any tensions between their policy area and other goals of the MKCP. Interviews were recorded and transcribed. A summary of the interview was shared with each author prior to publishing the Reg19 HIA report. This enabled authors to integrate considerations and recommendations arising from the interview in the drafting of the Reg19 policies.

2.2.3 When available, policy authors shared revised drafts of their policies intended for the Regulation 19 consultation, which have been considered for this HIA. When a revised draft was not available, the Regulation 18 MKCP was used as the basis for assessment.

2.2.4 In following guidance and good practice the report:

- takes a population health approach to assessing physical and mental health outcomes;
- considers the wider determinants of health that may be significantly affected directly or indirectly;
- assesses the potential for health inequalities to vulnerable groups; and
- considers opportunities to improve population health.

3 Policy Review

3.1 National policy and guidance

The National Planning Policy Framework

3.1.1 The National Planning Policy Framework (NPPF) (12) sets out the planning policies for England. Promoting healthy and safe communities is a central theme. Some of the key provisions of the NPPF that guide the HIA are:

- 96. Planning policies and decisions should aim to achieve healthy, inclusive and safe places which:
    - a) promote social interaction, including opportunities for meetings between people who might not otherwise come into contact with each other – for example through mixed-use developments, strong neighbourhood centres, street layouts that allow for easy pedestrian and cycle connections within and between neighbourhoods, and active street frontages;
    - b) are safe and accessible, so that crime and disorder, and the fear of crime, do not undermine the quality of life or community cohesion – for example through the use of well-designed, clear and legible pedestrian and cycle routes, and high quality public space, which encourage the active and continual use of public areas; and
    - c) enable and support healthy lifestyles, through both promoting good health and preventing ill-health, especially where this would address identified local health and well-being needs and reduce health inequalities between the most and least deprived communities – for example through the provision of safe and accessible green infrastructure, sports facilities, local shops, access to healthier food, allotments and layouts that encourage walking and cycling.
- 97. Local planning authorities should refuse applications for hot food takeaways and fast food outlets:
    - a) within walking distance of schools and other places where children and young people congregate, unless the location is within a designated town centre; or
    - b) in locations where there is evidence that a concentration of such uses is having an adverse impact on local health, pollution or anti-social-behaviour.
- 98. To provide the social, recreational and cultural facilities and services the community needs, planning policies and decisions should:
    - a) plan positively for the provision and use of shared spaces, community facilities (such as local shops, meeting places, sports venues, open space, cultural buildings, public houses and places of worship) and other local services to enhance the sustainability of communities and residential environments;
    - b) take into account and support the delivery of local strategies to improve health, social and cultural well-being for all sections of the community; […]
    - e) ensure an integrated approach to considering the location of housing, economic uses and community facilities and services.
- 101. To ensure faster delivery of other public service infrastructure such as health, blue light, library, adult education, university and criminal justice facilities, local planning authorities should also work proactively and positively with promoters, delivery partners and statutory bodies to plan for required facilities and resolve key

planning issues before applications are submitted. Significant weight should be placed on the importance of new, expanded or upgraded public service infrastructure when considering proposals for development.

National Planning Practice Guidance

3.1.2 The National Planning Practice Guidance (NPPG) (13) supports the NPPF and provides guidance across a range of topic areas. The NPPG 'Healthy and safe communities', recognises that a health impact assessment is a useful tool to use where there are expected to be significant impacts. The guidance also notes that planning and health need to be considered firstly in terms of creating environments that support and encourage healthy lifestyles, and secondly in terms of healthcare capacity.

NHS Plan 'Fit for the future: 10 Year Health Plan for England'

3.1.3 In July 2025 the Government released its new NHS Plan 'Fit for the future: 10 Year Health Plan for England' (14). The NHS Long Term Plan sets a 10-year vision for improving population health, reducing health inequalities, and integrating health services with community-based approaches. The relevant shifts in approach are 'from hospital to community care' and 'from an approach of treating sickness to prevention'. This HIA aligns with the Plan's objectives by assessing how the MKCP contributes to upstream prevention, supports place-based wellbeing and facilitates access to services that reduce future demand on health and social care systems. Specific consideration is given to housing quality, transport, open space, and community resilience.

3.2 Local policy

Health and Wellbeing Strategy 2018 – 2028

3.2.1 The MK Health and Wellbeing Strategy 2018 – 2028 (15) (HWBS) identifies strategic priorities for improving health outcomes and addressing health inequalities within Milton Keynes. These include tackling mental health, improving health outcomes across the life course, and enabling healthy ageing. This HIA has drawn on the Health and Wellbeing Strategy 2018 – 2028 to identify localised health priorities and vulnerabilities, including in the baseline. The Health and Wellbeing Strategy 2018 – 2028 prioritises:

- Staying Well, a strong focus on prevention;
- Closing the Gap, reducing inequalities in life chances; and
- One MK, an integrated, innovative approach to health and wellbeing.

3.2.2 The HWBS also sets out priorities for Lifelong Wellbeing, focussed on different life stages:

- Starting Well – priorities to support health and emotional wellbeing in early life;
- Living Well – improving health and wellbeing through preventative strategies, including how people live, work and play; and
- Ageing Well – adapting strategies for health and social care to address the needs of growing numbers of older people.

3.2 The HWBS is also used as the basis of scoping for the HIA, as described in the MK HIA Scoping Report (6).

Joint Strategic Needs Assessment (JSNA)

The JSNA (16) provides an evidence base of the current and future health and wellbeing needs of the local population. The JSNA highlights key health challenges across the city, such as rising levels of obesity, mental health challenges, and health inequalities linked to vulnerabilities including age, income, health status, social disadvantage, and geographic and access factors. The JSNA has been used to inform the baseline health profile, highlighting the distribution of health risks and identifying vulnerable groups. The JSNA provides data on:

- Population and place;
- Children and young people;
- Living and working well;
- Ageing well; and
- Specific vulnerabilities.

4 Milton Keynes Baseline Health Profile

4.1 Methods

4.1.1 Information for the health baseline has been collected through a detailed review of existing studies and datasets to provide an accurate overview of local health outcomes.

4.1.2 The analysis has had regard to the most recent Joint Strategic Needs Assessment (JSNA) for Milton Keynes (16) which offers in-depth insights into the health and wellbeing of the local population. Data from the 2021 Census (17) has been used to ensure demographic, socio-economic and general health indicators are up to date and reflective of current conditions. The English Indices of Deprivation 2019 (18) has been referenced to capture patterns of deprivation and inequality across the area. Public health indicators from the Office for Health Improvement and Disparities (19) have also been incorporated to provide up-to-date information on a wide range of health outcomes and determinants. These are summarised in Table 1.

Table 12: Summary of desk study sources used

Title	Year	Author	Date accessed
Joint Strategic Needs Assessment (JSNA)	2023	Milton Keynes City Council	20 June 2025
2021 Census	2021	Office for National Statistics	20 June 2025
Public health indicators	2021-2024	Office for Health Improvement & Disparities	20 June 2025
Indices of Multiple Deprivation	2019	Ministry of Housing, Communities & Local Government	20 June 2025

4.2 Community Profile

4.2.1 Population density

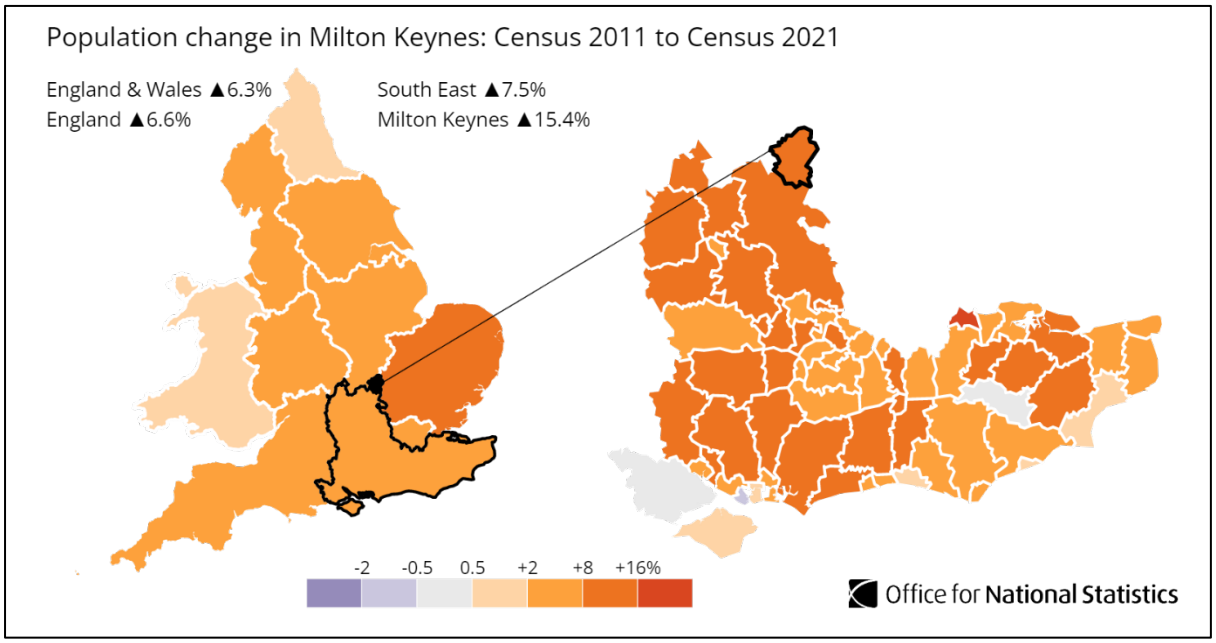


Figure 1: Population change in Milton Keynes: Census 2011 to Census 2021 (ONS, 2021)

4.2.1 The latest ONS statistics record 292,500 residents in Milton Keynes (20). Between the last two censuses (2011 and 2021), the population of Milton Keynes increased by 15.4%. This means Milton Keynes' population saw the second-largest percentage increase in the South East (20). The population of the South East increased by 7.5%, while the population of England rose by 6.6%.

4.2.2 Age

Table 23: Population age groups (ONS, 2021)

Age	Milton Keynes	South East	England
Aged 0 – 14	20.4%	18.6%	18.5%
Aged 15 – 64	65.5%	62.0%	63.0%
Aged 65+	13.8%	19.4%	18.3%

4.2.1 Milton Keynes has a notably younger age structure compared to both the South East region and England as a whole. The higher proportion of younger people (0-14 years) likely reflects the area's growing appeal to young families, supported by relatively affordable housing, modern infrastructure, and strong employment opportunities.

4.2.2 The working age population (15-64) make up 65.5% of the population in Milton Keynes, which is also higher than the South East (62.0%) and England (63.0%). This suggests a vibrant, economically active population base, reinforcing Milton Keynes' role as a major growth centre within the South East.

4.2.3 In contrast, older people aged 65 and over account for 13.8% of the Milton Keynes population, significantly below the South East (19.4%) and national (18.3%) averages. However, by 2031, the population of older adults in Milton Keynes is projected to rise

significantly, with those aged 60-70 increasing by 14.5%, and those aged 80 and over rising sharply by 58.3%, reflecting a major demographic shift toward an ageing population (16).

4.2.3 Ethnicity

Table 34: Ethnic groups (ONS, 2021)

Ethnic group	Milton Keynes	South East	England
Asian, Asian British or Asian Welsh	12.4%	7.0%	9.6%
Black, Black British, Black Welsh, Caribbean or African	9.7%	2.4%	4.2%
Mixed or Multiple ethnic groups	4.1%	2.8%	3.0%
White	71.8%	86.3%	81.0%
Other ethnic group	2.0%	1.5%	2.2%

4.2.1 Milton Keynes has a significantly more ethnically diverse population than both the South East region and England overall.

4.2.2 The ethnic minority with the largest representation in Milton Keynes is Asian, Asian British or Asian Welsh (12.4%); followed by Black, Black British, Black Welsh, Caribbean or African (9.7%) and Mixed or Multiple ethnic groups (4.1%). All of these are substantially higher compared to the South East and England.

4.2.3 The diversity of Milton Keynes likely reflects patterns of internal migration, internal mobility, and its role as a relatively new and economically urban centre with access to London and other employment hubs.

4.2.4 Sexual orientation

Table 45: Sexual orientation (ONS, 2021)

Sexual orientation	Milton Keynes	South East	England
Straight or Heterosexual	89.9%	89.8%	89.4%
Gay or Lesbian	1.2%	1.5%	1.5%
Bisexual	1.2%	1.3%	1.3%
All other sexual orientations	0.3%	0.3%	0.3%
Not answered	7.3%	7.0%	7.5%

4.2.1 89.9% of Milton Keynes residents identify as straight or heterosexual, in line with regional and national averages. Gay or lesbian residents make up 1.2% and bisexual residents 1.2%, both slightly below South East and England proportions.

4.3 Deprivation

4.3.1 Multiple Deprivation Inequalities

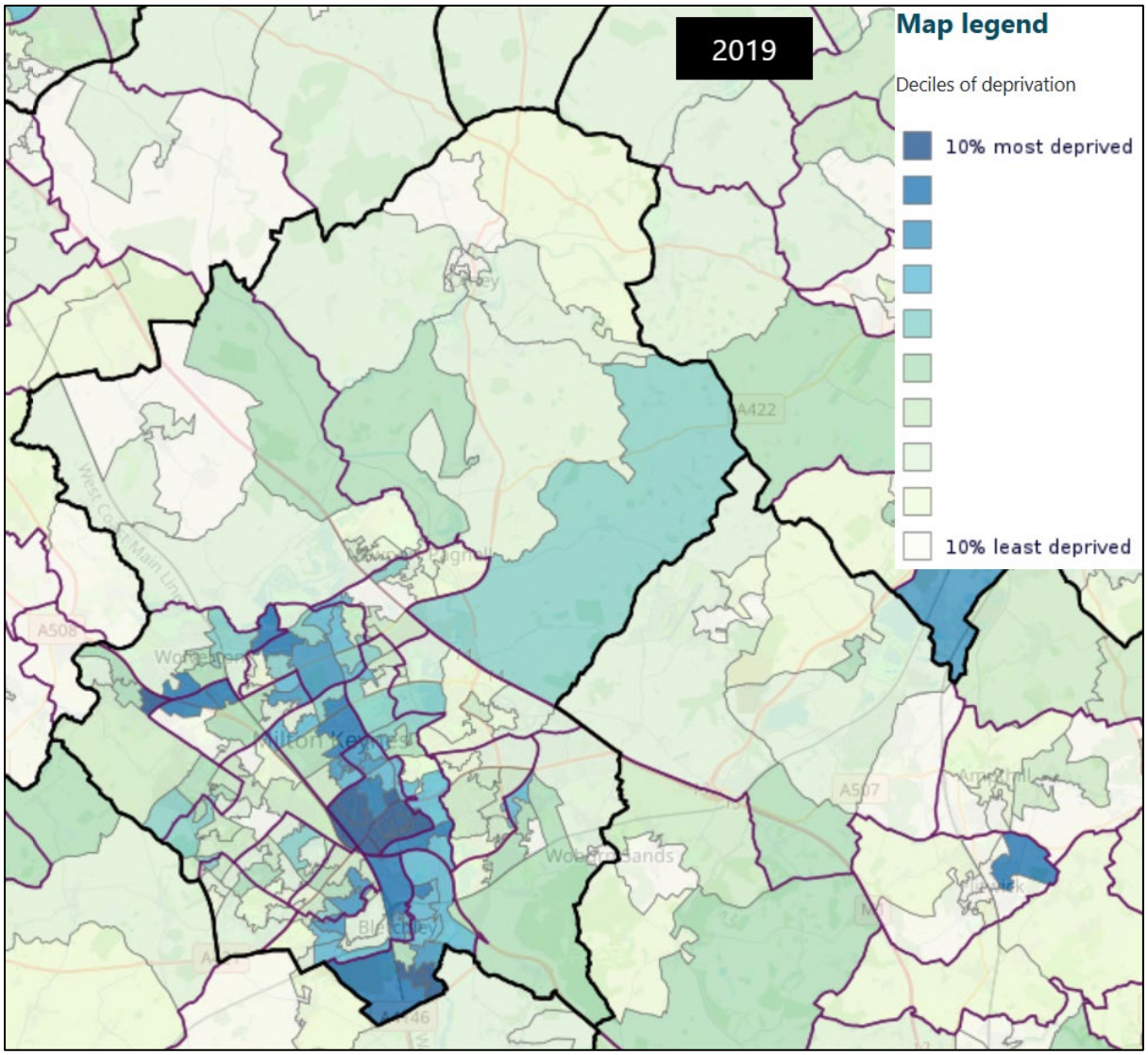


Figure 2: Representation of overall deprivation within Milton Keynes (IMD, 2019)

4.3.1 Milton Keynes ranks 107 out of 151 upper tier and unitary local authorities (where 1 is most deprived) and 172 out of 317 lower tier and unitary local authorities. The rankings in 2015 were 106 out of 152 and 164 out of 326 respectively, indicating that Milton Keynes now ranks marginally less deprived relative to other local authorities. However, this masks significant localised inequalities.

4.3.2 The latest IMD data suggests:

- The most deprived Lower Layer Super Output Areas (LSOAs) are Milton Keynes 032A and 023D, which fall within Bletchley East and Woughton and Fishermead Wards. Both are ranked in the 3% most deprived areas in England and are relatively more deprived than in 2015.
- There are 18 out of 152 LSOAs in Milton Keynes that are ranked in the most deprived 20% nationally (this is down from 21 in 2015), with 8 among the most deprived 10% (this is down from 9 in 2015).

- Overall, 81 LSOAs rank as more deprived in 2019 than in 2015, and 71 rank as less deprived.

4.3.3 Therefore, while Milton Keynes overall ranks marginally less deprived in 2019, this masks increasing deprivation in some areas and potentially widening inequalities across the borough.

Table 6: Households by deprivation dimension (ONS, 2021)

Household deprivation	Milton Keynes	South East	England
Household is not deprived in any dimension	51.3%	52.0%	48.4%
Household is deprived in one dimension	32.5%	32.8%	33.5%
Household is deprived in two dimensions	12.8%	12.2%	14.2%
Household is deprived in three dimensions	3.2%	2.8%	3.7%
Household is deprived in four dimensions	0.2%	0.2%	0.2%

4.3.4 As part of the 2021 Census, households in England and Wales were classified in terms of four different dimensions of deprivation, which are based on certain characteristics. The first is where any member of a household, who is not a full-time student, is either unemployed or long-term sick, and the second covers households where no person has at least five or more GCSE passes or equivalent qualifications, and no 16 to 18-year-olds at the home are full-time students. The third dimension is where any person in the household has general health that is “bad” or “very bad” or has a long-term health problem, and the fourth where the household’s accommodation is either overcrowded or is in a shared dwelling or has no central heating.

4.3.5 ONS data shows 48.7% of households in Milton Keynes were deprived in at least one of these dimensions. The area stood below the average across England and Wales, of 51.7%. The data also represented a drop for Milton Keynes from 53.3% at the time of the last census in 2011.

4.3.6 In Milton Keynes, the five areas with the highest deprivation rates were:

1. Stacey Bushes and Fullers Slade – 70.2% of households here were deprived in at least one dimension at the time of the 2021 census, down from 73.5% in 2011
2. Denbigh – 66.2%, falling from 73.9% in 2011
3. Eaglestone and Fishermead – 65.5%, a drop from 72.9% in 2011
4. Stantonbury and Bradville – 61.2%, down from 63.3% in 2011
5. Oldbrook and Coffee Hall – 59.4%, down from 63% in 2011

4.3.7 By contrast, the neighbourhood with the lowest level of deprivation was Broughton East, with 33.5% of households.

4.3.8 These patterns of deprivation reflect a combination of urban development history, housing tenure, and economic inequality. While Milton Keynes has experienced high levels of population growth and economic development, not all communities have benefitted equally. The proximity of highly deprived LSOAs to more affluent zones has resulted in

sharp spatial inequalities, which can exacerbate social exclusion and reduce access to opportunity for some residents.

4.3.2 Poverty

Table 67: Socio-economic health indicators (Fingertips, public health profiles)

Indicator name	Year	County Milton Keynes	Regional South East	National England
Inequality in life expectancy at birth[1] (Male) (yrs)	2021-23	9.1	8.5	10.5
Inequality in life expectancy at birth[1] (Female) (yrs)	2021-23	7.8	6.6	8.3
Income deprivation	2021	11.1%	N/A	12.9%
Children in relative low income families (under 16s)	2022-23	16.3%	13.1%	19.8%
Children in absolute low income families (under 16s)	2022-23	13.5%	10.6%	15.6%
Child Poverty Income, Deprivation Affecting Children	2019	15.0%	N/A	17.1%
Older People in Poverty, Income Deprivation Affecting Older People	2019	13.1%	N/A	14.2%

4.3.1 Inequality in life expectancy at birth for both males and females is lower (better) in Milton Keynes than in England overall, but higher (worse) than the South East. This suggests that while health inequalities exist in Milton Keynes, they are less pronounced than in many parts of the country.

4.3.2 Income deprivation in Milton Keynes affects 11.1% of the population, which is below the national average of 12.9%. This pattern is mirrored in child poverty measures, with all indicators performing better than the national averages. This is also the case for poverty and income deprivation in older people.

4.3.3 These figures indicate that while Milton Keynes fares better than England as a whole in terms of deprivation and inequality, it does not perform as strongly as the South East region. The city's position may reflect its rapid population growth, urban diversity, and pockets of disadvantage that persist alongside areas of relative affluence.

4.4 General Health

4.4.1 Life expectancy

4.4.1 Male life expectancy (at birth) is marginally lower in Milton Keynes (79.3 years) than for England (79.4). In contrast, female life expectancy (at birth) is slightly higher in Milton Keynes (83.2 years) than in England (83.1). Life expectancy differs widely across Milton Keynes, with the lowest in Woughton & Fishermead ward (M – 74.5, F – 78.4) and the

[1] The difference between the most and least deprived in the average number of years a person would expect to live based on contemporary mortality rates

highest in Olney ward (M – 81.9, F – 86.5), two of the most and least deprived areas within Milton Keynes.

4.4.2 Healthy life expectancy

4.4.1 Healthy life expectancy (HLE) is an estimate of the number of years a person is expected to live in good health, free from disease and/or injury. Male HLE in Milton Keynes has increased in recent years to 62.1 years, which is lower than that for England (63.1). Female HLE is higher in Milton Keynes at 65.2 years, compared to 63.9 for England. As with life expectancy, HLE differs widely across Milton Keynes, with the lowest in Woughton & Fishermead ward (M – 57.3, F – 60.4) and the highest in Olney ward (M – 64.7, F – 68.5).

4.4.3 Self-reported health status

Table 78: Self-reported health status (ONS, 2021)

Self-reported health	Milton Keynes	South East	England
Very good or good health	84.8%	84.0%	82.2%
Fair health	11.1%	11.8%	12.7%
Very bad or bad health	4.1%	4.2%	5.2%

4.4.1 The data suggests that, on average, residents of Milton Keynes perceive themselves as healthier than the national average and also slightly healthier than the broader South East region.

4.4.2 Milton Keynes consistently outperforms both the South East and England in self-reported health metrics. This is likely due to a combination of demographic advantages (younger population), urban planning (access to green spaces and modern amenities), and socioeconomic factors (employment and education). These factors are well-documented in public health research as contributing to better health outcomes.

4.4.4 Under 75 Mortality

Table 89: Under 75 mortality indicators

Indicator	Year	County Milton Keynes	Regional South East	National England
Under 75 mortality rate from all causes[2] (Persons, 1 year range)	2023	319.5	295.5	341.6
Under 75 mortality rate from causes considered preventable[2] (Persons, 1 year range)	2023	141.5	127.4	153.0

[2] Rate of deaths from all causes for people aged under 75

4.4.1 Under 75 mortality rates from all causes and those considered preventable in Milton Keynes are higher (worse) than those seen in the South East region, but lower (better) than the national average.

4.4.5 Disability

Table 910: Disability (ONS, 2021)

Disability	Milton Keynes	South East	England
Disabled under the Equality Act[3]: Day-to-day activities limited a lot	6.9%	6.2%	7.5%
Disabled under the Equality Act[3]: Day-to-day activities limited a little	9.9%	9.9%	10.2%
Not disabled under the Equality Act[3]	83.2%	83.9%	82.3%

4.4.1 Milton Keynes has a slightly higher proportion of residents whose day-to-day activities are "limited a lot" by disability under the Equality Act (6.9%) compared to the South East (6.2%), but a lower proportion than the national average (7.5%). The proportion of residents whose activities are "limited a little" is identical in Milton Keynes and the South East (both 9.9%), and just below the England average (10.2%).

4.4.2 These patterns may reflect the diverse demographic and socioeconomic profile of Milton Keynes. As a relatively new and economically active urban centre, Milton Keynes attracts a younger, working-age population, which typically has lower rates of disability. However, the slightly higher proportion of people with activities "limited a lot" compared to the South East could be influenced by the city's rapid population growth and diversity, which may include groups at higher risk of disability or with greater health needs.

4.4.6 Mental health

Table 1011: Mental health indicators (Public health indicators)

Indicator name	Year	County Milton Keynes	Regional South East	National England
Mental health: QOF prevalence[4] (All ages)	2023-24	0.8%	0.9%	1.0%
Depression: QOF prevalence[5] (All ages)	2022-23	11.0%	13.8%	13.2%
Hospital admissions for mental health conditions[6] (<18 years)	2023-24	54.9	80.9	80.2
Loneliness: Percentage of adults who feel lonely often or always	2021/22 – 22/23	8.4%	6.1%	6.8%

[3] People who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled. This definition of a disabled person meets the harmonised standard for measuring disability and is in line with the Equality Act (2010).
[4] Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses recorded on practice disease register
[5] Percentage of patients aged 18 and over with depression recorded on practice disease register
[6] Inpatient admission rate for mental health disorders per 100,000 population aged 0 to 17 years.

Self reported wellbeing				
People with a low satisfaction sore	2022/23	3.3%	5.1%	5.6%
People with a low worthwhile score	2022/23	2.7%	3.8%	4.4%
People with a low happiness score	2022/23	5.7%	8.6%	8.9%
People with a high anxiety score	2022/23	31.3%	24.0%	23.3%

4.4.1 Mental health indicators in Milton Keynes generally perform favourably compared to both the South East region and England overall.

4.4.2 Self-reported measures of loneliness suggest some challenges. The percentage of adults in Milton Keynes who report feeling lonely often or always is 8.4%, higher (worse) than the South East (6.1%) and England (6.8%).

4.4.3 By contrast, self-reported wellbeing scores show that a lower proportion of people (better) report low satisfaction, worthwhile and happiness scored compared to both the South East and England. Self-reported anxiety, however, is substantially higher (31.3%) in Milton Keynes than in the South East (24.0%) and England (23.3%).

4.4.4 These findings suggest that while diagnosed mental health conditions and depression are less prevalent in Milton Keynes, and hospital admissions for mental health among young people are lower, there are still significant concerns regarding loneliness and anxiety.

4.5 Wider Determinants of Health

4.5.1 Housing and Living Environment

Table 1112: Housing and living environment indicators (Public health indicators; 2021 Census)

Indicator	Year	County Milton Keynes	Regional South East	National England
Affordability of home ownership[7]	2023	8.9	10.2	8.3
Accommodation type				
Detached	2021	28.0%	28.0%	22.9%
Semi-detached	2021	29.3%	28.4%	31.5%
Terraced	2021	24.5%	21.3%	23.0%
In a purpose-built block of flats or tenement	2021	16.6%	16.8%	17.1%
Part of a converted or shared house, including bedsits	2021	0.7%	3.1%	3.5%
A caravan or other mobile or temporary structure	2021	0.1%	0.7%	0.4%
Household size				
1 person in household	2021	26.3%	28.4%	30.1%
2 people in household	2021	31.9%	34.8%	34.0%

[7] Measures the ratio of median house price to median gross annual residence-based earnings. A higher ratio indicates that home ownership is less affordable.

3 people in household	2021	17.8%	16.2%	16.0%
4 or more people in household	2021	23.9%	20.6%	19.9%
Households of multiple occupancy (HMO)[8]				
Is a small HMO	2021	336	17331	130733
Is a large HMO	2021	72	7425	44928

4.5.1 The affordability of home ownership ratio in Milton Keynes is lower (better) than the South East average but remains higher (worse) than the national average. This indicates relatively more accessible home ownership in Milton Keynes than in the surrounding region, although still slightly more challenging than the national picture.

4.5.2 The types of accommodation occupied in Milton Keynes closely mirror regional trends. Detached (28.0%) and semi-detached (29.3%) homes account for the majority of housing, with proportions closely aligned with the South East region, though they differ from the national average. Terraced housing is more common in Milton Keynes (24.6%) than in the South East (21.3%) and England (23.0%), suggesting a higher concentration of medium-density housing.

4.5.3 Flats in purpose-built blocks or tenements account for 16.6% of accommodation in Milton Keynes, which is similar to the regional average but slightly lower than the national average.

4.5.4 Milton Keynes records a higher proportion of larger households, with a combined total of 41.7% living in three- or four-plus person households, exceeding both the South East and national proportions. This trend may reflect the city's relatively young population structure, availability of modern housing stock with multi-bedroom units, and its appeal to young families relocating for employment opportunities in a growing urban centre. As a planned city with strong connectivity and economic growth, Milton Keynes may attract larger households seeking space and affordability with commuting distance to London and other regional hubs.

4.5.5 In 2021, Milton Keynes had 336 small and 72 large HMOs (houses in multiple occupation). The presence of both small and large HMOs in Milton Keynes reflects its role as a growing urban centre with a diverse and mobile population. HMOs are often associated with areas that have a high demand for flexible, affordable housing, such as cities with significant numbers of young professionals, students, or recent migrants.

4.5.6 Together, these figures highlight Milton Keynes as a relatively affordable and attractive location for families and young people. Home ownership is more affordable than the regional average, and the area offers a housing stock that includes a higher proportion of terraced properties, often suited to growing households. The prevalence of three- and four-plus person households suggests Milton Keynes is home to larger family units compared to regional and national norms. This may reflect the city's planned layout, availability of spacious and modern homes, and its appeal to families seeking affordability, green space, and good transport links with a growing economic hub.

[8] A dwelling where unrelated tenants rent their home from a private landlord is a HMO, if both of the following apply: at least three unrelated individuals live there, forming more than one household; toilet, bathroom or kitchen facilities are shared with other tenants. A small HMO is shared by 3 or 4 unrelated tenants. A large HMO is shared by 5 or more unrelated tenants.

4.5.2 Education and employment

Table 1213: Employment and education indicators (Public health indicators; 2021 Census)

Indicator	Year	County Milton Keynes	Regional South East	National England
Percentage of people in employment	2023/24	76.6%	79.6%	75.7%
16 to 17 year olds not in education, employment or training (NEET) or whose activity is not know	2023/24	3.0%	6.8%	5.4%
Economic inactivity rate	2023/24	21.7%	17.7%	21.2%
Unemployed	2021	3.7%	3.0%	3.5%
Highest level of education				
No qualification	2021	15.8%	15.4%	18.1%
Level 1 and entry level qualifications	2021	10.9%	9.8%	9.7%
Level 2 qualifications	2021	14.2%	13.9%	13.3%
Apprenticeship	2021	4.7%	5.1%	5.3%
Level 3 qualifications	2021	15.7%	17.4%	16.9%
Level 4 qualifications or above	2021	35.8%	35.8%	33.9%
Other qualifications	2021	2.9%	2.7%	2.8%

4.5.1 Across employment and economic inactivity indicators, Milton Keynes performs slightly worse than the regional (South East) averages, but slightly better than the national averages. Milton Keynes' employment indicators are robust, sitting between the regional and national averages, reflecting its strong local economy and job market. The city has a lower proportion of young people not in education, employment, or training (NEET), which may be linked to its rapid population growth, urban mobility, and younger, working-age population.

4.5.2 Milton Keynes has a slightly higher proportion of residents with no or only basic qualifications compared to the South East, and is mixed compared to the national average. The proportion of residents with higher-level qualifications (Level 4 and above) is higher than the national average. This suggests that Milton Keynes is attracting and developing a skilled workforce, with opportunities to further raise educational attainment.

4.5.3 Physical activity, Open space, leisure and play, and Transport and active travel

Table 1314: Physical activity, Open space, leisure and play, Transport and active travel indicators (Public health indicators; 2021 Census)

Indicator	Year	County Milton Keynes	Regional South East	National England
Percentage of adults walking for travel at least three days per week	2022/23	12.0%	18.2%	18.6%
Percentage of physically active adults	2023/24	68.3%	70.5%	67.4%

Percentage of physically inactive adults	2023/24	21.1%	18.9%	22.0%
Year 6 prevalence of overweight (including obesity)	2023/24	36.2%	32.7%	32.7%
Overweight (including obesity) prevalence in adults (using adjusted self-reported height and weight) (18+ yrs)	2023/24	66.7%	63.2%	64.5%
Killed and seriously injured (KSI) casualties on England's roads[9]	2023	61.4	89.8	91.9
Method used to travel to work (%)				
Work mainly at or from home	2021	36.4	35.8	31.5
Underground, metro, light rail tram	2021	0.2	0.2	1.9
Train	2021	1.3	2.2	2.0
Bus, minibus or coach	2021	3.2	2.5	4.3
Taxi	2021	2.0	0.5	0.7
Motorcycle. Scooter or moped	2021	0.3	0.5	0.5
Driving a car or van	2021	43.7	44.2	44.5
Passenger in a car or van	2021	4.9	3.5	3.9
Bicycle	2021	2.0	1.9	2.1
On foot	2021	5.1	7.6	7.6
Other method of travel to work	2021	1.0	1.0	1.0

4.5.1 Milton Keynes exhibits slightly lower (worse) levels of physical activity and higher inactivity among adults compared to both the South East region and England overall. This pattern is also reflected in travel habits: only 12.0% of adults in Milton Keynes walk for travel at least three days per week, compared to 18.2% in the South East and 18.6% nationally. Rates of overweight and obesity in Milton Keynes are higher (worse) than those seen regionally, but slightly better than national rates.

4.5.2 Road safety outcomes in Milton Keynes are less concerning than in the South East or England overall, with a lower rate of people killed or seriously injured (KSI) on the city's roads (61.4 per 100,000) compared to the South East (89.9) and England (91.9) (21).

4.5.3 Commuting patterns in Milton Keynes further reflect its car-oriented urban design. Only 5.1% of residents walk to work, compared to 7.6% in the South East and nationally. Use of public transport is also lower, with just 4.7% using underground, metro, light rail, or tram, train, bus, minibus or coach, compared to 5.2% regionally and 8.2% nationally. Car use, both as a driver and as a passenger, remains the dominant mode of travel to work in Milton Keynes (48.6%), which is higher than for the South East (47.7%) and England (48.4%).

4.5.4 Overall, the physical activity and travel patterns seen in Milton Keynes are shaped by its planned, car-centric urban environment. While the city offers good infrastructure for walking and cycling through the Redways, this has not fully translated into higher overall physical activity or lower obesity rates, and road safety remains a challenge. The reliance

[9] Number of people reported killed or seriously injured on the roads, all ages, per 1 billion vehicle miles travelled

on cars and relatively low uptake of walking and public transport highlights the ongoing influence of urban design on health and travel behaviours in Milton Keynes.

4.5.4 Climate change; Wider societal benefits

Table 1415: Climate change indicators (Public health indicators)

Indicator	Year	County Milton Keynes	Regional South East	National England
Fuel poverty (low income, low energy efficiency methodology)	2022	7.4%	9.7%	13.1%
Winter mortality index[10]	2021/22	6.7%	8.6%	8.1%

4.5.1 Climate change is an increasingly significant determinant of health, influencing both environmental conditions and wider societal infrastructure. Extreme weather events have direct and indirect impacts on population health, while the ability of communities to adapt and respond is shaped by factors such as housing quality, energy efficiency, and access to resources (22–25).

4.5.2 Milton Keynes has a lower prevalence of fuel poverty compared to both the South East region and England as a whole. This suggests that residents of Milton Keynes are less likely to struggle with the combined challenges of low income and poor energy efficiency in their homes, and reflects its newer and more energy efficient homes.

4.5.3 The winter mortality index in Milton Keynes for 2021/22 was 6.7%, also lower than both the South East and England. This indicates that Milton Keynes experiences fewer excess deaths during the winter months, which may be linked to better housing conditions, effective local health and social care services, and a generally milder urban microclimate.

[10] The winter mortality index (WMI) is a measure expressed as a ratio of the difference in all cause mortality during winter months (December to March) compared to the average in the non winter months (the preceding August to November and following April to July).

5 Review of the policies of the MK City Plan 2050

5.1 Introduction

5.1.1 This section builds upon the assessment in the Reg18 HIA. Each section comments on potential opportunities for each of the selected policies to improve health and wellbeing in MK. The commentary is based on expert opinion with reference to interviews conducted with MKCC policy authors, relevant literature, relevant policies as described in section 3, and health priorities identified in the HWBS.

5.1.2 As described in the Reg18 HIA, The MKCP aligns with conceptual models for the ways in which health is influenced by many factors in society. The MKCP states that a driving force 'is to make Milton Keynes a more people-friendly and healthy place to live, work and enjoy' and it emphasises that a 'focus on health is not at the cost of other issues' to which the MKCP responds.

5.1.3 The MKCP gives examples of how matters within its remit can lead to improving and protecting mental and physical health. There are other 'co-benefits', or 'win-win' solutions, throughout the Plan.

5.1.4 To improve and protect public health it is important to reduce inequalities between and across Milton Keynes. A public health perspective emphasises the importance of ensuring that the growth and the opportunities it seeks to enable can be made available to all who live and work in Milton Keynes. The recognition that 'well-planned ambitious growth has created prosperity and a better quality of life and wellbeing for all' is a reference to the importance of reaching all residents in Milton Keynes.

5.1.5 Each of the policies included in the scope of the HIA are assessed below. They are organised around relevant themes including: growth and the city; high quality homes; people friendly and healthy places; retail; growth and the countryside; energy; climate and environmental action; and movement and access.

5.2 Growth and the City

5.2.1 This section considers the strategic policy GS1 and the place-based policies GS8 and GS9 (INF1); GS11 to GS19; CMK1 to CMK3; and CB1.

Regulation 18 HIA Summary

5.2.2 Table 3-1 of the Reg18 HIA identifies the potential for the MKCP policies related to *Growth and the City* to contribute to the HWBS priorities and shows that these policies are relevant to different population groups in MK, including people considered to be vulnerable (see Table 6-5).

Regulation 19 Policy Assessment

GS1 Our Spatial Strategy

5.2.3 No updates from the Reg18 HIA.

GS8 Hanslope Park

5.2.4 No updates from the Reg18 HIA.

GS9 Supporting Growth with Infrastructure/ INF1 Infrastructure First

5.2.5 Policy GS9 has been replaced with Policy INF1: Infrastructure First. Infrastructure is a key priority in MK and it was felt that there was more that needed to be covered than what was considered in GS9. The Infrastructure First policy covers what infrastructure is and how it is prioritised; who delivers it; how infrastructure is funded, including a unique funding tool called the Milton Keynes Tariff and S106 contributions; and when it is delivered. The policy is supported by an Infrastructure Study that covers what is needed to support the city for growth and other priorities which will feed into the Infrastructure Delivery Plan (IDP) and Investment Strategy.

How does this policy affect health?

5.2.6 The policy defines infrastructure to include: transport, education, healthcare and social care, emergency services, community facilities, green and blue infrastructure, flood risk and water management, energy, waste management, and digital infrastructure. It also sets out a prioritisation structure for different types of infrastructure, ranging from those that are required before a site is suitable for development to those that support placemaking. The Plan takes a broad view of health infrastructure to include healthcare, social care, mental health, and child and adult services. The explicit focus on healthcare and social care is noted as being relevant for health, however, all types of infrastructure set out in the Plan are relevant to the building blocks of health, meaning that delivery of infrastructure of all kinds has the potential to influence health outcomes.

5.2.7 A key theme of the policy is the idea of 'infrastructure before expanding', highlighting the need to make sure that infrastructure that is needed by new residents, including schools, healthcare facilities and green spaces, are ready as early in the development process as possible. The HIA welcomes this approach, noting that access to infrastructure, particularly healthcare, is an important determinant of health, and that this reflects outputs from community consultation for the Reg18 HIA where it was expressed that people felt they did not have access to services when they needed them.

5.2.8 The policy also sets out expectations for management and maintenance of infrastructure, or temporary provision in the first instance, helping to 'deliver the right infrastructure at the right time and in the right places'. The emphasis on the provision of infrastructure to communities when it is needed is noted as being positive for health. However, MK faces a challenge of ensuring that infrastructure that is provided in the first instance remains useful to future residents. Newer sites tend to focus on providing infrastructure for young families (e.g. schools and play areas) because those are the sorts of communities that arrive in these areas. However, MK has an ageing population and infrastructure that is built now may not be best suited to the needs of communities in the future. Clearly specifying the expectation for management and maintenance of certain infrastructure may help to mitigate this issue by adapting, for example, community facilities to be appropriate to residents' needs. Providing new infrastructure that is accessible and appropriate to multiple users, such as elderly people or people with a disability, in the first instance, can also help to ensure that it remains appropriate to communities over time.

Who is most affected by this policy?

5.2.9 While site-specific infrastructure will be most valuable to new or nearby communities, the MK Infrastructure Strategy aims to support all of MK. Developer contributions through S106 or the Tariff, though limited in what they can provide for, may help to fund wider civic benefit. The Tariff has been used to contribute towards 18 portfolios of infrastructure in which MK is the delivery partner, another delivery partner is identified, or the developer delivers and MK discounts the contribution. This has been a successful model for enhancing benefits for the whole community of MK. Looking for opportunities to expand

the Tariff approach to other sites may contribute to broader community infrastructure that is supportive of health.

Further considerations and recommendations

5.2.10 Community amenities can include categories of infrastructure as set out in INF1, such as open space, primary health care facilities and schools. Access to community amenities is discussed as part of the PHFP policies, as set out in Table 3 and PFHP2. Consideration will need to be given as to how INF1, the IDP and Infrastructure Strategy accord with and support PFHP.

5.2.11 The recommendations set out in the Reg18 HIA for GS9 should be considered for INF1 to strengthen the health benefits of this policy.

GS11 Principles for Extensions to the City

5.2.12 The name of this policy will be changed from Reg18 to clarify that it applies to out-of-boundary extensions. The revised policy sets out that development should align with people friendly and healthy places principles. From a public health perspective this is supported.

How does this policy affect health?

5.2.13 While the policy might not be able to influence how development comes forward in other authorities, it sets out principles that should be followed to ensure places are well integrated across borders and facilitate the way MK wants development to come forward in a people friendly healthy way. The focus on early engagement between local authorities, infrastructure and service providers can help to ensure that health-supporting amenities and infrastructure like healthcare services and cross-boundary routes are put into place.

Who is most affected by this policy?

5.2.14 People living in new development, and those adjacent to it, will be most impacted, even when development takes place mostly outside of MK borders. For example, residents travelling into MK from new developments may add pressure to transport infrastructure, affecting other MK residents. The policy seeks to ensure that agreements are put in place to ensure that where people are using MK services, S106 contributions go to MKCC.

Further considerations and recommendations

5.2.15 The recommendations set out in the Reg 18 HIA for GS11 should be considered to strengthen the health benefits of this policy.

5.2.16 Include mention of assessing health as well as environmental effects in the supporting text. For example, “In these instances, it will be necessary for the Council, as Local Planning Authority, to assess the environmental, **health and wellbeing** effects of the whole proposal.” This will support the policy’s alignment with PFHP principles.

5.2.17 In the supporting text, regard should be given to the new INF1 policy (which replaces GS9) and the term ‘**healthcare** and social care’ should be used to distinguish that these are two different providers.

5.2.18 Include explicit mention of ‘healthcare and social care’ at A(1) in line with the recommendation above.

5.2.19 Include mention of ‘active travel’ at A(6). For example, “…hierarchy of routes within the development, along with off-site improvements **and active travel** and public transport measures”. This will support the policy’s alignment with PFHP principles.

GS12 Redevelopment of Wolverton Railway Works

5.2.20 No updates from the Reg18 HIA.

GS13 Redevelopment of Walton Campus

5.2.21 No updates from the Reg18 HIA.

GS14 Eastern Strategic City Extension

5.2.22 No updates from the Reg18 HIA.

GS16 Wavendon Strategic Buffers

5.2.23 No updates from the Reg18 HIA.

GS17 South of Bow Brickhill Strategic City Extension

5.2.24 No updates from the Reg18 HIA.

GS18 Levante Gate Strategic City Extension

5.2.25 No updates from the Reg18 HIA.

GS19 Shenley Dens Strategic City Extension

5.2.26 No updates from the Reg18 HIA.

CMK1 Central Milton Keynes Development Framework Area

5.2.27 The Central Milton Keynes policies have been condensed to two policies rather than three in order to avoid duplication between CMK1 and CMK2. CMK1 now focuses on land uses in Central Milton Keynes.

How does this policy affect health?

5.2.28 Land use allocation in CMK will be promoted to focus on retail, office, residential, cultural and leisure activities. The Plan notes that this is part of making the city centre a people friendly healthy place for a range of users. These land use allocations are noted as supporting health. The range of employment opportunities supported by the Plan, which is expected to support the creation of 26,900 additional jobs, is noted as being particularly beneficial for health. Education and employment are closely linked to health, shaping opportunities, income, and social status throughout life. Higher levels of educational attainment and secure, rewarding employment are associated with better health outcomes, while limited education and unemployment can increase the risk of poverty, social exclusion, and poor health (26–28). Employment opportunities that vary across skills levels, ranging from tech, digital and knowledge-intensive businesses, education, the creative and cultural sector, and retail and hospitality can support health equity (29).

5.2.29 This is further supported by housing allocations in CMK (around 11,000 additional new homes), allowing people from a range of socio-economic backgrounds to live and work in the city. The University and Tech Innovation area, if brought forward, may also support health equity by providing more local educational opportunities.

Who is most affected by this policy?

5.2.30 Section C promotes a more diverse range of home types in CMK. Promoting development that offers more than just 1-2 bedroom flats can support a more diverse range of people living in CMK, including families. Requirements for different types of tenures and number of adaptable and/or affordable homes is covered by other policies. The focus on commercial, residential, educational and leisure uses within CMK means that this policy will affect people living, working, studying and visiting the city centre.

Further considerations and recommendations

5.2.31 No updates from the Reg18 HIA.

CMK2 Central Milton Keynes Placemaking Principles

5.2.32 The revised CMK2 now focuses on placemaking principles, including: movement; parking; block & grid structure; streets & pavements; gardens, parks & city squares; density & heights; building design; and culture, heritage & community.

How does this policy affect health?

5.2.33 The Reg19 draft policy has a strong focus on placemaking that is beneficial to health, including open space, active travel, improved public realm, reduced reliance on cars, and cultural heritage offerings. There is also a focus on creating pocket parks. In CMK there is currently not a lot of diversity in the types of activities for which public spaces can be used. For example, Campbell Park is a large open space but has no play spaces, toilets, café or other amenities. There are some small bits of open space throughout CMK but many are hidden and do not act as a destination. The policy seeks to deliver a greater diversity of types of spaces (including play spaces) and natural spaces, and provide easier access to these throughout CMK rather than in one big park. This includes also having wayfinding within CMK so people know that these spaces are there and can access them.

5.2.34 While the policy relies on PFHP to provide most of the principles for healthy placemaking, the criteria offered in CMK2 reinforce those principles and may help to support healthier lifestyles. The policy aims to make a city centre that is welcoming and inclusive. This not only enhances social participation and connectivity, but also by offering more activities and having more people in the public realm leads to people feeling safer in the city centre. The perception of safety is just as important as actual safety in terms of promoting people to engage in activities outside of their homes (30). The policy also has a focus on active travel and encouraging people to be outside and not use their cars. This is likely to have both physical benefits but also contributes to mental wellbeing.

5.2.35 It is noted that the focus on dementia friendly/disability friendly development is moving up to cut across all policies, such as though the Dementia Friendly Neighbourhoods SPD. This is a welcomed approach.

Who is most affected by this policy?

5.2.36 The policy aims to support growth of CMK from 5,000 to 30,000 people. This means that the policy will affect not just those living there currently, but the large population expected

to arrive in the future. By making CMK a better place to work (rather than working at home), a better place to spend time, and a better place to live, this policy can impact those living in the city centre but also those who are working, studying, visiting, or passing through. The current population is also quite transient, so the policy also supports making a more settled community.

Further considerations and recommendations

5.2.37 To align with GS4, paragraph 102 could say "…create people-friendly **healthy places** and encourage more active forms of movement".

5.2.38 CMK2, A(2) of the policy notes releasing Midsummer Boulevard as a greenway creates opportunities for mental wellbeing. In truth, most of the open space being enhanced or created in the city centre (e.g. gardens, parks and city squares; culture, heritage and community; streets & pavements etc.) could create an opportunity for improved mental wellbeing. This would be further supported by making mental wellbeing part of all placemaking strategies, not just movement. The plan could say that all placemaking strategies should be used to enhance opportunities for mental wellbeing.

5.2.39 With regard to pocket parks, it would be helpful if these were defined to explain what sort of amenity the pocket park is expected to provide. It might be that the definition goes in the glossary or that the policy just refers to parks.

5.2.40 It is noted that design codes are not mandatory, and the current discussion is that the healthy placemaking principles could go either into a design code or directly into the policy. In deciding what approach to take it might be worthwhile to see this as an opportunity to clarify and reiterate the healthy built environment principles and the types of placemaking that would help to achieve the overall aim of the policy. It should tie in to reinforce (without repeating) GS4.

5.2.41 The focus on higher education within the business quarter means there will be an increased need for student accommodation. This will need to be developed accordingly to avoid new students being a burden on existing rentals. This can be supported through the market response to increases in educational provision and HQH5 which would cover some of the co-living requirements for students.

5.2.42 Section H of the policy mentions 'spaces that are socially inclusive for residents, workers and visitors'. The focus on social inclusion for cultural, heritage and community offerings across a range of population groups is important. To support this, it would help to emphasise that community events should also promote inclusivity (i.e. events that are inclusive of different cultural or socio-economic populations), for example, by having some activities that are free. This could also be reflected in section E(2) to say: "Diversifying the range of **inclusive**, open space functions available in the city centre…" This would also help to promote the 'greener and more sustainable' section of the CMK vision statement.

5.2.43 Section E(3) notes improved routes, wayfinding and legibility as important for maximising accessibility of active travel routes. This should be supported by public amenities, like shade and rest areas, to enable all populations (e.g. elderly and disabled) to use them. This could potentially say "Improving routes, **public amenities**, wayfinding and legibility to maximise accessibility and use…"

5.2.44 The recommendations set out in the Reg18 HIA for CMK2 and CMK3 should be considered to strengthen the health benefits of this policy.

CB1 Supporting investment in Central Bletchley

How does this policy affect health?

5.2.45 Bletchley is a major growth point for the city. There is more land available there for development than any other area, particularly in the city centre. There is also going to be a lot of new housing there with the expectation of over 1,000 new homes. The east/west railway line is opening with services commencing in late 2025 from Oxford which will serve as a major connection to other city centres. This will lead to more people living near the town centre and railway station. There has also been significant government investment in the town. The Brunel Centre development, for example, will be redeveloped within Bletchley to be largely residential with some mixed-use development. The emphasis on high-density development within Bletchley, with a focus on connectivity to the railway station, is likely to promote opportunities for health through greater physical activity, connectivity and community interaction.

Who is most affected by this policy?

5.2.46 This policy will affect people living, working, visiting or passing through Bletchley Central.

Further considerations and recommendations

5.2.47 Section B(2) aims to promote development of a new food store (convenience store) and ensure there are facilities within walk/cycle distance of Bletchley Station. With regard to a recent mapping of food deserts within the needs assessment, the policy seeks to address access to healthy foods. To support this, it would be desirable to promote development of a convenience store (e.g. Tesco) that offers a higher proportion of healthy food options than other convenience stores, acknowledging that this is dependent on market forces. This approach could be supported by asking developers to adopt a healthy food ethos, like the Healthier Catering Commitment (31). Such an approach could be better supported within the strategic policies (e.g. PFHP4) which would then apply to sites everywhere. Otherwise, MK Development Partnerships, who own the Brunel Centre/Sainsbury sites, would have more control over who the landowner is and therefore might have more ability to emphasise a healthy eating approach for the development. Emphasising the need to deliver access to healthy foods is supported by paragraph 96 of the NPPF.

5.2.48 Section B(2iii) makes reference to a ‘health hub’ which is interpreted as meaning healthcare. It is suggested this is clarified in the text so that it is ‘**healthcare** hubs’.

5.3 High Quality Homes

5.3.1 This section considers the strategic policy GS2 and the policies HQH1 to HQH10.

Regulation 18 HIA Summary

5.3.2 Table 3-2 of the Reg18 HIA identifies the potential for the MKCP policies related to *Homes* to contribute to the HWBS priorities and shows that these policies are relevant to different population groups in MK, including people considered to be vulnerable (see Table 6-6).

Regulation 19 Policy Assessment

GS2 Strategy for Homes

How does this policy affect health?

5.3.3 The focus of the policy is on access, adaptability and affordability of homes. Access to high-quality affordable housing that is adaptable to needs across the lifespan, also known as lifetime homes, is a determinant of health and wellbeing (32). The quality, affordability, and stability of housing, as well as the broader living environment, are fundamental determinants of health. Safe, secure, and well-maintained homes all contribute to physical and mental wellbeing, while poor housing conditions and neighbourhood deprivation are linked to a range of adverse health outcomes (33–35).

5.3.4 Growth is focussed into strategic allocations, largely within CMK and several strategic city extensions. There is also some smaller regeneration planned for Wolverton and Central Bletchley, and some growth focussed along MRT routes within the existing urban area.

5.3.5 The policies as a whole have a focus on sustainable development—using growth to improve infrastructure for communities—and reflecting housing need. This includes social housing provision and how to address people's access to rented or affordable home ownership, and accessibility standards (HQH1) and how to make sure people can stay in their homes for longer (rather than building more care homes).

5.3.6 It is anticipated that the housing figures will change in the Reg19 policy but broadly the policy will remain the same as in the Reg18 plan.

Who is most affected by this policy?

5.3.7 This policy will primarily affect people who are not currently able to afford to rent or buy homes, enabling people to stay in MK.

5.3.8 The policy has a focus on the needs of older people, but also seeks to address the needs of other people, as set out in HQH3. The policy aims to make sure there are appropriate design aspects for the right homes in the right places. There is the potential that, as a growing city, there will be people moving into the city who will benefit from more affordable housing, or affordable housing will attract people to MK which will contribute to the city's growth strategy.

5.3.9 The policy will also support 'concealed households' (when households are living with someone else) to move into their own accommodation.

5.3.10 Existing residents who do not need housing will not benefit as much directly. However, the focus on growth would ideally bring benefits to all MK residents through, for example, expansion of the MRT. There is some risk of some populations missing out where there will not be new development (e.g. villages). Some areas will be based on neighbourhood plans rather than allocations, and then there is a risk that neighbourhood planners do not come forward to deliver.

Further considerations and recommendations

5.3.11 Strategic policies and Bletchley policies (areas of high-density growth) are not included in the homes site policies. It will be important to ensure that those allocations are aligned with the goals of the housing policies.

5.3.12 The recommendations set out in the Reg18 HIA for GS2 should be considered to strengthen the health benefits of this policy.

HQH1 Healthy Homes

How does this policy affect health?

5.3.13 The provision of new homes within new and existing developments is key to reaching the policy goal of people friendly healthy places.

Who is most affected by this policy?

5.3.14 The policy applies to the development of new homes and will therefore mostly affect new residents, however new housing has broader impacts to the community as a whole (e.g. through housing affordability) and many also affect existing residents.

Further considerations and recommendations

5.3.15 No updates from the Reg18 HIA.

HQH2 Affordable homes

How does this policy affect health?

5.3.16 As described under GS2.

Who is most affected by this policy?

5.3.17 This new policy will reflect an updated housing mix aimed at maximising affordable homes. The new policy focuses on social rent, affordable rent, and shared ownership. Greater provision of affordable homes is likely to support low to moderate income individuals and families including first time home buyers, and more vulnerable groups such as the elderly and people receiving social benefits.

Further considerations and recommendations

5.3.18 No updates from the Reg18 HIA.

HQH3 Supported and specialist homes

How does this policy affect health?

5.3.19 As described in GS2 assessment.

Who is most affected by this policy?

5.3.20 This policy is most relevant to people in need of specialist or supported homes, such as elderly populations and people in need of support services including those with low socio-economic status.

Further considerations and recommendations

5.3.21 Further evidence is forthcoming to identify what the need is and the types of supported housing required. The current focus is on housing for older people. The policy will need to set out other types of need and how they are provided.

5.3.22 The percentage allocation of social housing on the site is currently under review.

5.3.23 There is a need to better articulate what is meant by the types of needs for people in temporary accommodation. The Adult Service team are looking at this. It is recommended that consideration be given to further articulating what is meant by 'support services or amenities' for people in temporary accommodation. Ideally this should apply to public transport, employment opportunities, education, etc., not just support services.

HQH4 Supporting regeneration and renewal

5.3.24 The Reg19 policy wording is being changed to reflect a preference for reuse or refurbishment of existing buildings where appropriate. This goal of prioritising refurbishment helps to both preserve the local character and also mitigate climate change by preserving the embedded carbon within existing structures.

How does this policy affect health?

5.3.25 The policy promotes health through support for regeneration proposals that address key health determinants, such as: affordable homes, open space, active travel, green and blue infrastructure, and healthy food environments.

Who is most affected by this policy?

5.3.26 Regeneration projects are focused on areas of high deprivation, including poor quality housing and economic deprivation. The aim of the policy is therefore to provide regeneration and renewal of estates in areas of populations with high need.

Further considerations and recommendations

5.3.27 It will be important to ensure communities are not disempowered through the process of development, as oftentimes the community can feel that they are being developed upon without having input into that development. Through Reg18 consultation, it was expressed that people were concerned, particularly in areas where regeneration is likely to happen, that developers will come in with plans without consulting with the local communities. Development needs to happen in a way that respects local character, identity and meets the desired needs of the community, rather than perceived needs. Ideally this would be achieved through developers holding pre-application consultation workshops with the community to identify their needs/preferences. However, this is constrained by the lack of a legal requirement for them to do so. The challenge of this is therefore how to ensure regeneration proposals meet local need if there is no requirement for developers to consider community preferences. One solution is to require developers to demonstrate community input, for example: "Proposals for regeneration will be permitted where they demonstrate that they have had consideration for social and community planning". It might also be useful to have language that requires the developer to demonstrate how community consultation or social planning have been considered within the design. For example: "Proposals will be supported where they have demonstrated that the input from public consultations have been integrated into the design". This would align with a recommendation provided in PFHP1 about ensuring that developers demonstrate how the results of the HIA, which can provide input from the community, have been considered in the design. Developing specific wording to target social or community planning is under consideration for Reg19.

5.3.28 As the food environment is already discussed by PFHP4, it is suggested to amend A(6) to align with that policy, for example: “Contribute to an improvement in the food environment through **approaches set out in PFHP4”.** This can help to ensure that there is coherence between the two policies.

5.3.29 The recommendations set out in the Reg18 HIA for HQH4 should be considered to strengthen the health benefits of this policy.

HQH5 Homes for co-living

5.3.30 No updates from the Reg18 HIA.

HQH6 Houses in multiple occupation

5.3.31 The policy sets requirements for amenity and what Council would expect to see in houses of multiple occupation (HMOs), such as provision of refuse and recycling, cycling storage and parking, and drying areas. These amenity standards can help to ensure high-quality living standards for occupants.

5.3.32 The SPD for HMOs is available but there is discussion around how to take some of the standards from this into the Plan. The Reg19 policy will also include a numeric requirement for how to calculate over-concentration of HMOs in an area. The calculation from the SPD is for no more than 35% of total number of properties in a 100-meter radius of the application property. There is also a requirement for any one property to not be situated between two HMOs (to protect the character of an area and mix of tenures). There is a plan to offer an appendix on how some of these things are assessed.

How does this policy affect health?

5.3.33 In addition to amenity standards, which support high quality living environments, this policy also focuses on appropriate provisions for quality of living. For example, cycle parking is part of the people friendly travel ambition. Preventing mould is part of the logic around having designated drying areas. It is these ‘micro level of prevention’ policies that support the building blocks for health.

Who is most affected by this policy?

5.3.34 Young people are likely to benefit the most from this policy as they are the largest occupants of HMOs. HMOs can also support affordable housing, therefore this policy may impact lower income groups. There is also a large proportion of single households that would benefit from this policy. The policy also supports the overall housing policy in that it helps to supply another type of housing tenure. All of this helps to support youth mobility and housing affordability.

Further considerations and recommendations

5.3.35 Even though the policy is focused on HMO density, the supporting text could set out the expectation that both internal and external amenity standards are met. While the SPD does set out standards for suitable and adequate provision of outdoor space, the Council is putting together an amenity standard for housing where all homes would have to meet these standards. It might be useful to either reference this in the supporting text or put this directly in the policy. The Council also has an amenities policy for HMOs – these are licensing requirements but it might also be helpful to refer to this in the supporting text, for

example:
"We would encourage applicants to refer to those amenity standards as legal requirements and also as the Council's expectations".

5.3.36 There is an expectation that this type of development would fall under the other policies (e.g. PFHP). HQH5, section A(1) ensures co-living homes are accessible by bike, walking, and public transport and it might also be useful to add something similar to HQH6. The policy has requirements to support active travel (e.g. provision of cycle parking), therefore it would make sense that HMOs should be within a distance from most amenities that can be reached through modes of active travel. This will be especially important if the majority of occupants for this housing tenure are likely to be young people who are less likely to own a car.

HQH7 Pitches for Gypsies and Travellers

How does this policy affect health?

5.3.37 Provision of pitches for Gypsies and Travellers is essential for meeting the housing needs of a minority population group.

5.3.38 The needs assessment is still forthcoming so it is not yet clear how many pitches are needed or how to provide for them (i.e. could be extensions or more likely to be new sites). Strategic allocations, if required based on the needs assessment, will have different site requirements.

5.3.39 The Reg18 HIA recommendations will be included in the revised policy.

Who is most affected by this policy?

5.3.40 The policy is relevant to Gypsies and Travellers.

Further considerations and recommendations

5.3.41 The recommendations set out in the Reg18 HIA for HQH7 should be considered to strengthen the health benefits of this policy.

HQH8 Accommodation for boat dwellers

5.3.42 No updates from the Reg18 HIA.

HQH9 Exception sites

5.3.43 No updates from the Reg18 HIA.

HQH10 Amenity for Homes

How does this policy affect health?

5.3.44 This is a new policy added for Reg19. The policy includes the amenity standards that had originally been set out in Policy HQH1. Section A of the policy requires a standard of amenity in line with design guidance and principles set out in the PFHP chapter. This is a welcomed addition and reflects the importance of home amenity for health.

5.3.45 The supporting text emphasises that design principles need to support quality of life and create flexibility to accommodate changes in circumstances. This supports the ageing population in MK and need for adaptable homes across the lifespan.

Who is most affected by this policy?

5.3.46 The policy applies to the development of new homes as well as the protection of amenity within existing developments. The amenity standards for new homes will be part of this policy, including national space standards, daylight, sunlight, etc.

Further considerations and recommendations

5.3.47 None.

5.4 People Friendly and Healthy Places

5.4.1 This section considers strategic policy GS4 and the policies PFHP1, PFHP2, and PFHP5 to PFHP7.

Regulation 18 HIA Summary

5.4.2 Table 3-4 of the Reg18 HIA identifies the potential for the MKCP policies related to *Healthy Places* to contribute to the HWBS priorities and shows that these policies are relevant to different population groups in MK, including people considered to be vulnerable (see Table 6-6).

Regulation 19 Policy Assessment

GS4 Strategy for People Friendly and Healthy Places

How does this policy affect health?

5.4.3 Policy GS4 is important for health. It is a strategic policy which sets out key strategies for development proposals to promote good physical and mental health. The policy explicitly places the promotion of public health as one of the strategic drivers of the MKCP.

Who is most affected by this policy?

5.4.4 Development proposals informed by this policy have the potential to affect people living, working, visiting and passing though MK.

Further considerations and recommendations

5.4.5 Regarding Figure 7, it is suggested to change this to ‘access to health**care**, social care & social infrastructure’ which is more specific than ‘access to health’ and is consistent with other policies in the MKCP.

5.4.6 The recommendations set out in the Reg18 HIA for GS4 should be considered to strengthen the health benefits of this policy.

PFHP1 Delivering Healthier Places

How does this policy affect health?

5.4.7 This policy sets out the requirements for producing a health impact assessment alongside development proposals. This has the potential to mitigate potential health harms and improve health and wellbeing benefits of developments.

5.4.8 The policy also sets out restrictions for development of adult gaming centres/betting shop, pay-day loan shops and shisha premises. As these types of development often have disproportionate impacts on areas of deprivation, this policy is likely to be influential in reducing health inequalities.

Who is most affected by this policy?

5.4.9 While the requirement for HIAs on development proposals is relevant to the general population, the emphasis on certain types of development (Use Class C2) involving more vulnerable populations, is important for reducing health inequalities. Similarly, section E is focused on limiting development proposals that may be harmful when overconcentrated in areas of deprivation, or near schools. This is important for reducing negative impacts on school-aged children and people living in high deprivation areas.

Further considerations and recommendations

5.4.10 Section B now requires that the development proposal uses an HIA to demonstrate how it has a positive impact on health. Section D also states that development proposals should demonstrate how the design of the scheme has been informed by the conclusions of a HIA. This can help to ensure that applicants undertake HIA earlier in the planning process, providing more opportunities for the HIA findings to feed into the design process and contribute towards healthier approaches.

5.4.11 In paragraph 5 of the supporting text, reference is now made to the Council's current guidance for HIA which more clearly connects the policy with the relevant SPD. It also states that the HIA should be undertaken by a competent expert, as set out by IEMA guidelines. The addition of this text should help to ensure that HIAs submitted for development proposals meet standards for how and by whom the HIA is conducted.

5.4.12 Listing the HIA threshold requirements in the policy rather than the planning validation helps to make it more visible and should hopefully highlight to applicants the need to conduct the HIA earlier in the design and planning process. Section B(1) sets out minimum land requirements (5 hectares) for employment land or sites to require an HIA. It is suggested to expand criteria for an HIA of employment land to sqm in addition to hectares, as large-scale development could be less than 5 hectares, for example, with vertical design.

5.4.13 It is noted that the policy does not distinguish between rapid or comprehensive HIA, and this is also not documented within the SPD. The HIA process set out by the SPD, particularly section 3 – Appraisal, is aligned with a comprehensive approach by, for example, requiring magnitude and probability of an impact, stakeholder and community engagement, and consideration of cumulative impacts. However, paragraph 2.11 of the SPD states that 'for some development proposals, [the screening/scoping template] may also be able to form the bases of the assessment and report itself..' indicating that a rapid approach would also be acceptable. The SPD does not clarify for which development proposals a rapid approach may be appropriate. This could be set out in PFHP1 by stating thresholds for rapid or comprehensive HIA or requiring a proportionate approach. For example: "The HIA should be proportionate to the size of the development proposal: an

HIA accompanying a development for 100 dwellings would not be expected to be in as great a depth as one for 1,000 dwellings."

5.4.14 Section B(6) has been revised for a requirement for waste development to include re-designed projects, not just for new or expanded ones. This is supported.

5.4.15 The policy has been revised to not overemphasize shisha premises compared to payday loans or betting shops. This is important because, although the health impact is less direct than using shisha, payday loans and betting shops are related to income deprivation and poverty which profoundly affect health.

5.4.16 With regard to the limitation of development of shisha premises near schools, the rationale for this approach is supported by evidence that reducing the visibility of a harmful activity can reduce enticement for the activity (36). It should be considered whether this is the same goal for betting shops and, therefore, if the same restrictions should apply (i.e. not being located within 400m of schools).

5.4.17 The recommendations set out in the Reg18 HIA for PFHP1 should be considered to strengthen the health benefits of this policy.

PFHP2 Provision and Protection of Community Amenities

How does this policy affect health?

5.4.18 This policy emphasises the need to provide and protect community amenities as part of creating people-friendly healthy places. Community amenities play a vital role in providing health-supporting amenities that promote physical health, mental health and community wellbeing.

Who is most affected by this policy?

5.4.19 Community amenities are an important asset to all populations, however, there are some groups who rely on these more than others. For example, having access to public transport and opportunities for active travel is particularly important for populations without access to a car, including young people, older people, people with limited or impaired mobility, and people on low incomes. Providing community amenities that are accessible to both general and vulnerable populations is critical for ensuring that they promote health equitably.

Further considerations and recommendations

5.4.20 Regarding the Loss of Community Amenities, section B(3) allows for 'proposals for alternative community amenity where it has been demonstrated that there is a greater local need'. It will be important that 'local need' is defined in partnership with the community. It should be considered whether this could be demonstrated through consideration of the health and wellbeing needs of the community (for example through an HIA required as part of PFHP1) or through some other approach, such as community engagement.

5.4.21 The supporting text of the policy focuses on access to community amenities. Whilst access is essential, it is important to acknowledge that amenities are only useful to the community if they meet the current needs of that community. Therefore, provision of community amenities needs to take into consideration just not their accessibility but also whether they are appropriate, available, and acceptable to the community. This ties in closely to section B(2) which states that alternative provision must be suitable in terms of 'quality, function and accessibility'. Making it explicit that the alternative must also be acceptable to the

community would strengthen this. It would also be worthwhile to reflect this in the supporting text above Table 3. Paragraph 47 talks about 'ensuring new development contains the appropriate range of community amenities in the right locations, delivered in a timely manner'. It would help to add that it should also be ensured that these amenities are acceptable, appropriate and available to the communities who want to use them. For example, accessibility to open space is important, however, if that open space is not designed to be appropriate and acceptable to the needs of the local community - such as providing seating, wayfinding, play structures, etc. - then it will not be used. Therefore, it will be important to demonstrate how new development provides community amenities that are accessible and also appropriate and acceptable to communities.

5.4.22 With regard to access to amenities set out in Table 3, it will be important to consider how they are used by the community, which can be more than just their prescribed function. For example, although many communities would assign low importance to hairdressers and barbers, they are often places of cultural and social importance to Black and other minority ethnic populations. For example, barber shops have been used in Black communities as a space to congregate and socialise and have been the site of public health interventions (37). This relates to the point above that determining how a proposal meets the requirement for supporting community amenities is more than just accessibility and should really depend on what is considered an important amenity to that community. This emphasises the need for community engagement as part of any development of community amenities.

PFHP5 Designing People Friendly Places

How does this policy affect health?

5.4.23 Urban design principles can be very supportive of health generally. Design principles support the need for the built environment to be compact enough to promote active travel and create safe, attractive routes. Walkable communities that link to the urban design and mix of uses can promote physical health and mental wellbeing.

5.4.24 This policy lays out the design principles to be followed to achieve people friendly healthy places. The reference to the Sport England Active Design guidance is a welcomed addition. The Sport England guidance set out 10 principles which are supported by the policy and can help to support health throughout the MKCP.

5.4.25 The supporting text highlights the importance of the policy in using design principles to promote health.

5.4.26 The supporting text aligns with the NPPF in supporting the use of the Building for a Healthy Life (BHL) as a suitable assessment tool. The BHL, alongside the HIA required through PFHP1, would provide a narrative for the design review process on how health principles are achieved through the design of the proposal. Paragraph 26 of the supporting text states that "the planning authority will also use an independent design review process…to ensure that the design is people friendly and healthy…" Emphasising that the review process is intended to ensure health is important and supports other policies such as GS4.

5.4.27 The new MK Design Code set out in the chapter also places emphasis on creating people friendly healthy places and notes that health and movement were themes particularly supported though public engagement on the design code. Having a design code that prioritises active travel and integrated, sustainable transport is also supportive of health.

Who is most affected by this policy?

5.4.28 Urban design is key for enabling people with dementia to journey outside their homes and this is supported by section 17 of the policy.

5.4.29 The emphasis on using urban design to create connected, walkable routes and promote ease of movement is important for many populations groups that do not have access to a car, including young people, older people, people with low socio-economic status and some people with limited or impaired mobility.

Further considerations and recommendations

5.4.30 The recommendations set out in the Reg18 HIA for PFHP5 should be considered to strengthen the health benefits of this policy.

PFHP6 Designing Healthy Streets

How does this policy affect health?

5.4.31 As stated in the supporting text to the policy, “Healthy Streets is an evidence-based approach to improving health and reducing inequalities through active travel”. The focus of the policy is on promoting healthy, inclusive environments.

Who is most affected by this policy?

5.4.32 While the policy will be relevant to all street users, section 2 of the policy notes that streets need to meet the needs of the most vulnerable users. Children, people with a disability, and elderly people are population groups that are more vulnerable to road accidents and may have additional needs in using streets, such as requiring additional time at pedestrian crossings. Section 9 of the policy notes the need to promote pedestrian and cycle safety and section 10 requires provision of shade and shelter, rest areas, seating and places to play. These are noted as being beneficial to all users but particularly to those vulnerable populations.

Further considerations and recommendations

5.4.33 Whilst the policy lists several key provisions that are needed to enable street use by elderly people or people with a disability, such as those set out in section 10, one notable omission is the provision of public toilets. Public toilets are an essential amenity of walkable environments and the lack of public toilets can be a barrier for many street users including people with babies, people with incontinence, pregnant people, and people with certain medical conditions (38). Adding a reference in the policy to having ‘public conveniences in appropriate locations’ could support this.

5.4.34 The recommendations set out in the Reg18 HIA for PFHP6 should be considered to strengthen the health benefits of this policy.

PFHP7 Well-designed buildings and spaces

How does this policy affect health?

5.4.35 This policy helps to ensure new buildings are well-designed to support MK to be a place for everyone. The supporting text of the policy emphasises the importance of this to health

by stating "…with a focus on people friendly and healthy places supported by infrastructure that makes for a thriving and sustainable place". Well-designed buildings can support physical health and contribute to the character of a place, impacting upon mental wellbeing as well.

Who is most affected by this policy?

5.4.36 This policy is relevant to people living in or using buildings in new developments. Given that buildings contribute to positive character of a location, this can also affect people living in the vicinity. Section A(7) of the policy also draws specific attention to design that supports the needs of people with dementia and related illness.

Further considerations and recommendations

5.4.37 The recommendations set out in the Reg18 HIA for PFHP7 should be considered to strengthen the health benefits of this policy.

5.4.38 It is noted that further iterations of the draft Reg19 HIA resulted in the creation of two additional separate policies: PFHP8 Tall buildings outside CMK, and PFHP9 Amenity for healthy buildings and spaces.

5.4.39 With regard to PFHP8, supporting tall buildings in locations within a short distance of mass rapid transport hubs is important for supporting walkability and active travel. The policies relating directly to tall buildings, PFHP8 and CMK3 (Central Milton Keynes Skyline Strategy) must be considered alongside all the PFHP policies (which include the design related policies PFHP 5,6,7 and 9). This will ensure that healthy placemaking standards are applied to tall buildings. To further support section C(6) regarding safety, consideration could be had for the London Planning Advice note on preventing suicides in high rise buildings and structures (39). This would also support section A(8) of PFHP9 which requires design measures to reduce risk of falling and opportunity for suicide.

5.5 Retail

5.5.1 This section considers policies GS5, PFHP3 and PFHP4.

Regulation 18 HIA Summary

5.5.2 Table 3-5 of the HIA identifies the potential for the MKCP policies related to *Retail* to contribute to the HWBS priorities and shows that these policies are relevant to different population groups in MK, including people considered to be vulnerable (see Table 6-8).

Regulation 19 Policy Assessment

GS5 Our Retail Hierarchy

How does this policy affect health?

5.5.3 This policy is required by the Government to define a hierarchy of town centres and retail. Having access to retail, particularly convenience shopping such as groceries, is essential for promoting health.

Who is most affected by this policy?

5.5.4 Accessing retail and health-supporting goods is an issue in particular for rural communities. Reduced rural shops can also lead to increased isolation. The policy lists district centres as delivering local shopping to rural hinterlands and it will be important to continue to consider the needs of this population group as part of the policy.

Further considerations and recommendations

5.5.5 Section 4 of the policy (Local Centres) is the only retail hierarchy that seeks to provide reduced car dependence. A focus on non-car access for all retail types should be considered. Paragraph 115(a) of the NPPF states that, with respect to development proposals, sustainable transport modes should be prioritised. There may already be opportunities for sustainable transport for retail development within existing town centres, however the supporting text of the policy could strengthen this to emphasise the need for walkability and access to all types of retail within the hierarchy. This could correspond to PFHP2 section C(1) or could state in the policy: 'all retail areas will be connected by public transport and be located near active travel routes'. The supporting text could also cross-refer to Table 3 which states the catchment distances to community amenities.

PFHP3 New Local Centres

How does this policy affect health?

5.5.6 The aim of this policy is to support local shops within 800m of new housing (as set out in GS4, Table 3). The focus is on new local centres within strategic allocations. This helps to achieve the health benefits of community amenities as presented in the discussion of PFHP2.

5.5.7 Section B aims to connect the need for convenience store development to where there is a lack of provision. This relates to the MK needs assessment of food deserts and will be important for ensuring greater access to healthy and affordable foods.

Who is most affected by this policy?

5.5.8 Having access to affordable healthy food is a key factor in promoting health and wellbeing for all people, but especially for young children. Childhood obesity has life-long health impacts (40). Ensuring that all communities have access to healthy foods, including in some residential areas that are too small to drive commercial demand for this, and in areas designated as food deserts, is critical for reducing health inequalities.

Further considerations and recommendations

5.5.9 The new policy states "development proposals for a general convenience store to address lack of provision and support the criteria for policy GS4 will be supported". It is suggested this could also reference PFHP4 with regard to delivering a healthier food environment.

PFHP4 Delivering a healthier food environment

How does this policy affect health?

5.5.10 This policy sets out approaches for delivering healthier food environments. This includes protection and provision of food growing, reducing areas within food deserts and restricting hot food takeaways.

Who is most affected by this policy?

5.5.11 As stated in the assessment of Policy PFHP3, access to healthy foods is critical for all people, but is particularly important for children. As discussed in section 4, 36% of children in year 6 are overweight (including obesity). People with low socio-economic status are also more likely to live in food deserts and to have higher levels of overweight and obesity. One study in the UK found that people with the least amount of education, living the furthest from a supermarket, were 3.4 times more likely to be obese (41). Vulnerable groups, particularly those with a lower income, may be more affected by nutritional quality, affordability, and accessibility of local food options.

Further considerations and recommendations

5.5.12 The new policy has expanded the criteria to limit hot food takeaways within 400m of schools, further education facilities, youth or community centres, leisure centres or parks. This reflects more of the types of places children congregate and is a supported change to the policy.

5.5.13 It should be considered having this policy apply to fast food, not just hot food takeaways. The NPPF introduces the concepts of ‘fast food outlet’ and ‘places where children congregate’. It would be useful if these were defined or at least referenced by the policy. The UK Office for Health Improvement and Disparities is now tracking fast food outlet density at the population level (42) indicating that this is a concern nationally. This data show that as of 2024 in MK there were 125 fast food outlets per 100,000 people, which is higher than the England average (116 per 100,000).

5.5.14 The NPPF (paragraph 97) states: “…in locations where there is evidence that a concentration of such uses is having an adverse impact on local health, pollution or anti-social-behaviour.” HIA would be a good way to evidence that impact, therefore it may be useful to include this type of development within the requirement for HIA in PFHP1.

5.5.15 Supporting healthier retail, which would support policy CB1, could be achieved through some additions to the policy or the supporting text, such as: “To ensure faster delivery of a healthy food environment, the local planning authority will work proactively and positively with promoters, delivery partners and statutory bodies to plan for required facilities and resolve key planning issues before applications are submitted. Significant weight should be placed on the importance of new, expanded or upgraded facilities that deliver affordable healthy food and drink options when considering proposals for development. This may include community growing areas, allotments and orchards, as well as healthy food and drink shops or restaurants/cafes. Whilst it is recognised that planning conditions and processes offer limited mechanisms to secure the types of food and drink sold, development promoters and landowners are able to secure legal requirements outside of the planning system that may effectively govern these factors. The securing of such covenants cannot be required, but where it is undertaken, it will be given significant weight in terms of the public health planning response recommendation. Less committal measures, such as adopting a healthy food ethos or committing to schemes like the Healthier Catering Commitment (31) will also be supported as positive”.

5.5.16 The recommendations set out in the Reg18 HIA for PFHP4 should be considered to strengthen the health benefits of this policy.

5.6 Growth and the countryside

5.6.1 This section considers the strategic policy GS6.

Regulation 18 HIA Summary

5.6.2 Table 3-6 of the HIA identifies the potential for the MKCP policies related to *Growth and the countryside* to contribute to the HWBS priorities and shows that these policies are relevant to different population groups in MK, including people considered to be vulnerable (see Table 6-9).

5.6.3 The evidence and recommendations provided in the Reg18 HIA inform this assessment and should be considered as part of the recommendations provided below.

Regulation 19 Policy Assessment

GS6 Open Countryside

How does this policy affect health?

5.6.4 Having access to community infrastructure, including employment, housing, healthcare, social care, blue and green infrastructure, and recreation is as important for people living in rural settings as it is for urban dwellers. Policy GS6 helps to support this by setting criteria for development proposals within Open Countryside.

5.6.5 With regard to section B(1), the policy has been revised to: '…meet the need for a rural worker' without specifying farms. This is a welcomed changed as this policy could impact upon other rural businesses and workers, including healthcare workers. This section has also been revised to remove the requirement 'to live permanently' as temporary accommodation may be more suitable in some instances. This is also supportive of rural healthcare workers who may be working on a temporary basis.

5.6.6 The policy should be revised to include an additional requirement for rural workers' dwellings. This is an important addition as access to housing is a key consideration for rural workers, including healthcare workers.

Who is most affected by this policy?

5.6.7 Protection of rural landscapes and enhancements to open spaces is important for people living in open countryside but is also relevant to people who use the countryside for these features, for example, people visiting the countryside for exercise and leisure. This provides both physical health and mental wellbeing benefits to people living and visiting open countryside.

5.6.8 People who work in rural settings are also likely to be impacted by this policy. Having access to job opportunities, and nearby housing, is important for allowing people to remain in their community and also supports provision of essential infrastructure to rural communities (e.g. healthcare).

Further considerations and recommendations

5.6.9 Consideration should be given to section B(2), which supports development of certain types of infrastructure, to include healthcare and social care infrastructure, which can be demonstrated as requiring a location within the Open Countryside. This would support access to essential infrastructure for people living in rural areas.

5.7 Energy

5.7.1 This section considers the strategic policy GS7.

Regulation 18 HIA Summary

5.7.2 Table 3-7 of the HIA identifies the potential for the MKCP policies related to *Energy* to contribute to the HWBS priorities and shows that these policies are relevant to different population groups in MK, including people considered to be vulnerable (see Table 6-9).

5.7.3 The evidence and recommendations provided in the Reg18 HIA inform this assessment and should be considered as part of the recommendations provided below.

Regulation 19 Policy Assessment

GS7 Wind Turbine and Solar PV Spatial Strategy

How does this policy affect health?

5.7.4 Renewable energy developments including wind and solar are important strategies for mitigating climate change effects. Climate change is associated with increased natural hazards which impact on health (e.g. heat waves).

5.7.5 The Reg18 HIA included recommendations around community engagement and wider community benefits that have been integrated into the revised policy. The revised policy will include that development proposals will be supported by appropriate levels of community engagement and suitable benefits for local people in line with the national guidance. It will also set the expectation that details of this will be provided in the statement of community involvement as part of the planning application. Health and mental wellbeing impacts can arise from the development process and community engagement is a supported approach to mitigating those effects (43).

5.7.6 Some changes have been made to the revised policy including requiring restoration plans following operational phase, and consideration for adverse cumulative impacts. These are supported changes that can help to ensure long-term and cumulative health impacts are mitigated or avoided.

Who is most affected by this policy?

5.7.7 As identified in the Reg18 HIA, this policy supports priority AW6 of the HWBS. Though not in the original scope, this policy can also be viewed as supporting priority AW7 of the HWBS: ‘Respond in a positive and proactive way to the needs of our ageing population’. As older populations can be more susceptible to extreme weather events like heat, having strategies in place that support climate change mitigation like the ones supported in GS7 can help to avoid health harms and support the needs of an ageing population.

5.7.8 Some people who live in the countryside may desire unobstructed views and may resist development, even if it is renewable. Visual impacts and residential amenity can impact

community identity affecting health and wellbeing. Ensuring that there are other community benefits (as supported by government guidance) is important for minimising potential negative effects on rural residents.

Further considerations and recommendations

5.7.9 Wind and solar developments can have health and wellbeing effects. These can include public health and health inequalities considerations in relation to: affecting use of outdoor space and routes for leisure and physical activity; influencing availably of land for local healthy food markets; affecting community identity; affecting mental health in relation to understanding of risk, including about electromagnetic fields; providing opportunities for local green jobs and investment; and reducing health effects of climate change. In some instances, these will be considered within EIA consenting processes that should include impacts on human health, following the 2022 guidance of the Institute of Environmental Management and Assessment (IEMA), also known as the Institute of Sustainability and Environmental Professionals. For the largest EIAs (nationally significant infrastructure projects) relevant policy is set out in the overarching National Policy Statement (NPS) for energy (EN-1), NPS for renewable energy infrastructure (EN-3) and NPS for electricity networks infrastructure (EN-5). Proposals not considered part of EIA (e.g. due to the size of the scheme) should consider potential for significant population health effects where relevant through an assessment process such as a HIA. Setting out this expectation within the supporting text of the policy would help to achieve this.

5.7.10 Regarding reference in the policy to looking at community engagement and providing suitable benefits for local people in line with the national guidance on community engagement benefits, this should apply to both wind and solar developments.

5.7.11 The recommendations set out in the Reg18 HIA for GS7 should be considered to strengthen the health benefits of this policy.

5.8 Climate and environmental action

5.8.1 This section considers the policies within the climate and environmental action (CEA) chapter, including CEA1 – CEA15. This chapter had been originally scoped out of the Reg18 HIA, however, given the connection between environmental and human health, and the intended alignment with PFHP policies, it was decided to include CEA policies within the Reg19 HIA.

Regulation 19 Policy Assessment

How do these policies affect health?

5.8.2 The CEA chapter sets out a range of policies relating to sustainable and climate resilient buildings, water efficiency, reducing and mitigating environmental pollution, protecting open space and biodiversity, and flood and water management. The chapter aims to add planning weight to proposals that improve energy efficiency or internal comfort and reduce environmental impacts.

5.8.3 These policies can help to prevent direct risks to human health, such as through air quality, increased heat or flood risk, and can also support the building blocks required to promote health, such as through open space and green and blue infrastructure.

5.8.4 With regards to the building standards policies (CEA1 – CEA4), the aim is to ensure that the health benefits of good design are recognised. Policy CEA3 Resilient Design includes

new standards for internal air quality, overheating risk, internal environment and energy efficiency.

5.8.5 Policy CEA2 Green Roofs and Walls can help to improve urban environments which lead to health benefits from improved air quality and green space.

5.8.6 Policy CEA4 Retrofitting has benefits to health in terms of the quality of buildings and ensuring healthy internal environments.

5.8.7 Policy CEA5 Water Efficiency indirectly affects health in terms of reducing strain on the environment for water consumption.

5.8.8 Policy CEA6 Low and Zero Carbon Energy Provision sets out clear links between environmental pollution and health protection.

5.8.9 Policy CEA7 Mitigating Wider Environmental Pollution addresses multiple sources of pollution including ground, air, odour, noise, light and water and requires development proposals to ensure pollution does not have unacceptable impacts on human health.

5.8.10 Policy CEA8 Provision and Protection of Accessible Open space supports the provision, management and maintenance of open spaces which has direct links to both physical health and mental wellbeing.

5.8.11 Policies CEA9 Biodiversity and Habitats Network and CEA10 Protection and Enhancement of Environmental Infrastructure Network, Priority Species and Priority Habitats indirectly support health through the benefits of natural biodiversity for human populations.

5.8.12 Policy CEA11 Urban Greening, Trees and Woodland contributes to human health through protection of green cover in urban areas and the protection of woodland which can help to reduce heat and improve air quality.

5.8.13 Policy CEA12 Conserving and Enhancing Landscape Character/ Special Landscape Areas supports the protection of areas which are of value to people for recreation and relaxation, which has both physical and mental wellbeing impacts.

5.8.14 Policies CEA13 – CEA15 on Flood and Water Management help to reduce the potential risks to humans, and to provide multiple benefits (including for health) of multi-functional drainage systems.

Who is most affected by these policies?

5.8.15 Policies that protect the physical environment and support adaptation and resilience for climate change effect everyone. Whilst everyone may benefit from the policies, vulnerable populations are likely to benefit the most. Elderly people, young people, people with certain chronic health conditions, people working in certain occupations, and Gypsy and Traveller populations are particularly susceptible to the risks of climate change exacerbating natural hazards, such as heat and flooding. New standards including urban greening, tree canopy cover and green roofs and walls will help to reduce urban heat effects. Indoor air quality policies set requirements for developers to go beyond minimum standards which may also more greatly affect vulnerable populations.

Further considerations and recommendations

5.8.16 Paragraph 234 of the supporting text for Sustainable Buildings states that indoor air quality is an important health matter for enjoyment and wellbeing. It would be beneficial to also highlight that it is more than just a comfort issue but also a health risk for overheating for vulnerable populations.

5.8.17 CEA6, Section A supports development proposals where it can be demonstrated there will not be significant adverse social, economic, or environmental impacts. It should also include avoidance of significant adverse health impacts.

5.8.18 CEA7, Section D states that development proposals will be refused when they produce unacceptable impacts to human health and/or the natural environment through air pollution. Section E requires major development proposals to demonstrate the avoidance of any negative effects through assessment of air quality impacts. It would be beneficial to include that impacts to human health should be assessed according to best practice for health in EIA: “The current endpoints of EIA analysis are expected changes in, for example, air quality or noise levels. From a public health perspective, these are changes in determinants of health, not changes in health outcomes. The consideration of significant effects on population and human health requires a statement on the way in which any change can be expected to manifest itself e.g. a change in respiratory health, or in mental wellbeing. The endpoint of EIA population and human health analysis should, where possible, describe the predicted health and well-being outcomes” (44).

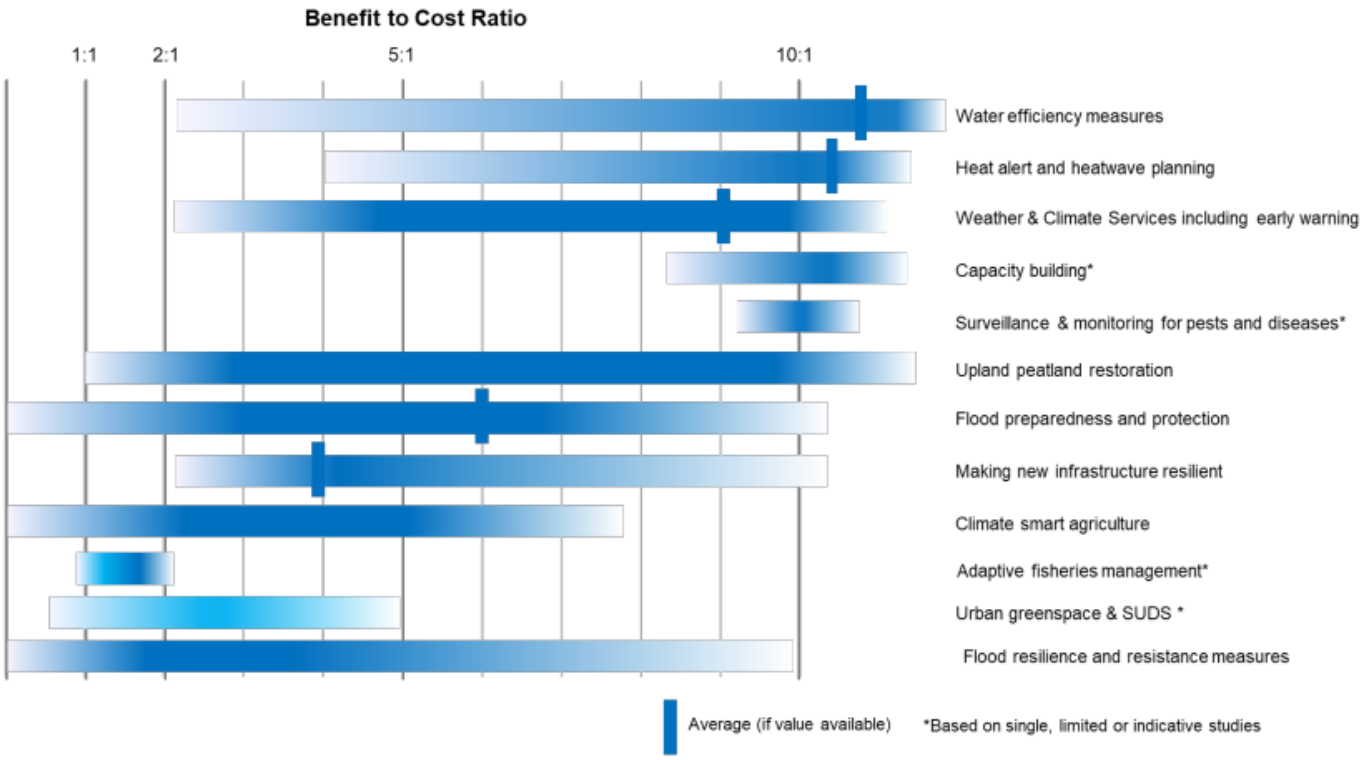
5.8.19 CEA8, Section A states that development proposals must maintain and enhance the quality and connectivity of access networks. It is not clear what is meant by ‘access networks’ and the definition of this term could be added to the glossary. Additionally, if the intention is for open spaces to be accessible, then it would help to make it clear that the priority is for *accessibility* as well as quality and connectivity.

5.8.20 As the aim of the Chapter is to reduce climate change and environmental impacts, there are further considerations that could strengthen the MKCP approach to climate change and to emphasise the impact of this on public health:

- A key distinction should be made between reducing climate change (e.g. emissions) and enhancing climate change adaptation. Policies should distinguish between actions that reduce climate impacts, such as more energy efficient buildings that contribute to net zero targets, and adaptation strategies that support health in a changing climate. For example, climate resilient buildings might include compatibility for window insect screens or elevated foundations. Including climate adaptation as part of the goal of the chapter would help to strengthen this approach.
- The Chapter should emphasise that adaptation strategies should promote public health. For example, the introductory text of the Chapter could say “The Plan seeks to respond to climate change and support adaptation in ways that deliver public health benefits.” This should also be emphasised in the PFHP chapter, as notably, there is no mention of climate change within that chapter.
- Policy CEA 11F emphasises enhancement and protection of woodlands and landscape. Increased wildfire risk should be considered as part of this and strategies should be incorporated to help to reduce risk. This is also applicable to protection of agricultural land.
- Many of the CEA policies are supportive of cost-effective strategies for climate change adaptation (see Figure 3) (45). Some of the more cost-effective strategies include water efficiency measures, flood preparedness and protection, and making new infrastructure resilient. One of the most cost-effective strategies is a joined up early warning system for temperature, flooding and storms. Implementation of this type of approach should be considered as part of development (e.g. using smart home technologies) and as part of MKCC’s climate adaptation strategies.

5.8.21 The Sustainability Strategy 2025-2050 is also in the process of being drafted and there is an opportunity to ensure that the policies in this Chapter are supported by actions identified in the Strategy. For example, there are many policies in the MKCP that support increased access to and use of open space for recreational purposes. According to the Met Office Climate Report for Milton Keynes (1), in the recent past (2001-2020) there were on average 28 summer days (daily max temperature above 25ºC) which could rise to 32 days in the event of 1.5ºC global warming level. This is associated with increased risk of hospitalisation or death for vulnerable people, transport disruption and increased water demand. It should be considered if there are additional strategies that could be set out in

Figure 3 Benefit to Cost ratios for Adaptation for Selected CCRA3 risks (45)



the Sustainability Strategy to support the use of open spaces in a warming climate (e.g. free public water stations, information about suncream use or preventing mosquitos). Additionally, other climate adaptation strategies should be considered such as providing cooling spaces within public buildings or community spaces.

5.9 Movement and access (transport)

5.9.1 This section considers the strategic policy GS10.

Regulation 18 HIA Summary

5.9.2 Table 3-8 of the HIA identifies the potential for the MKCP policies related to *Movement and Access (transport)* to contribute to the HWBS priorities and shows that these policies are relevant to different population groups in MK, including people considered to be vulnerable (see Table 6-9).

5.9.3 The evidence and recommendations provided in the Reg18 HIA inform this assessment and should be considered as part of the recommendations provided below.

Regulation 19 Policy Assessment

GS10 Movement and Access

How does this policy affect health?

5.9.4 Regular physical activity and opportunities for active travel, such as walking and cycling, play a vital role in preventing chronic diseases and supporting mental health. The built

environment, transport infrastructure, and local amenities all influence how easily people can incorporate movement into their daily lives (46–49).

5.9.5 Mobility reflects how quickly and easily one can get to where one needs to go. Faster and easier travel leads to more free time and more access to health-promoting goods and services. This can improve health by increasing social cohesion and allowing more time for health-promoting activities. Accessibility to a range of routine destinations also ensures that people have access to what is needed to live healthy lives (50).

5.9.6 This policy promotes movement and access through public transport and active travel means. This includes safe, suitable and convenient access for all users. Having access to active travel opportunities is beneficial for physical health. Having a movement network that enables access to essential infrastructure, such as jobs, groceries and education, without the need for a car, can also reduce stress and social isolation. However, these health and mental wellbeing benefits are only achieved when routes include 'safe, suitable and convenient access for all users' as set out in section A(1) of the policy. This may require added amenities such as places to rest, lighting, etc.

Who is most affected by this policy?

5.9.7 Some populations are more likely to have reduced access to a car. This can include people with low socio-economic status and elderly people. Having access to public transport and active travel networks can reduce stress of these population groups when they know how to access these alternatives (e.g. if they cannot access a car or if something happens to their car). However, indirect public transport routes, such as those necessitating the need to transfer, can lengthen journey time, increase costs and add stress to daily commutes. Long commute times can negatively impact social connection, which can affect stress, lifespan and access to emotional and physical resources (51).

5.9.8 In older populations, being able to travel without a car can lessen social isolation, as people feel they can get to the places they want to go. However, this needs to be supported by dementia friendly neighbourhoods that support safety, confidence and independence (52).

Further considerations and recommendations

5.9.9 Though referenced frequently throughout the MKCP, public transport measures are not explicitly defined in the Plan. It may be useful to add a definition of this to the glossary.

5.9.10 Section A(4) could include provision of on-site cycle parking as well.

5.9.11 As part of section C, Redways are required to be extended alongside grid roads. Bus stops are connected to Redways (majority of bus stops are on grid roads) and any new extensions would require these same connections. It would be beneficial for the policy to establish that in an area of new extensions, it would be required to provide pedestrian access to bus stops and Redways.

5.9.12 Section A(1) expresses the need to make routes suitable for all users. Section D supports this by requiring routes that are direct, safe, well lit, convenient and attractive. It would be helpful to include some of the measures that would support this approach, such as provision of wayfinding, seating, lighting, etc. This would help to ensure that routes can be used by all demographics of people (e.g. old, young populations).

5.9.13 As discussed in the Reg18 HIA, public consultation has raised concerns around safety on the Redways. A preference for overpasses vs underpasses (as far as practicable), and other measures that enhance perceptions of safety, could be included in the policy or the supporting text. It may be that a separate policy is required on how underpasses are designed (i.e., lightning, safety features) and where this is particularly an issue—geographically and demographically—as the fear of using Redways and going through

underpasses is also demographically driven. The limitation of this approach, however, is that these measures would only apply to new development. Therefore, it could be explored how under S106 it would be possible to contribute to upgrades to existing underpasses as part of infrastructure delivery.

5.9.14 An underlying tension in the policy relates to grid roads and the relationship to active travel. The current policy states that grid roads should be expanded, however, providing more roads that make car use easier may not be consistent with support of active travel. New grid road infrastructure will be required to support the MRT and careful language is needed on how these extend into city extensions (e.g. not a requirement for extension and only done if necessary). It will be important for GS10 in particular, and the MKCP as a whole, to balance extending routes while not prioritising this over active transport, and providing better access to active transport hubs within these extensions. It could support the policy to include first mile/last mile requirements of active travel. This could address how to get people to the proposed transport hubs from the different locations and how this is integrated into development requirements within extensions. This might better align with placemaking principles part of GS4.

5.9.15 The recommendations set out in the Reg18 HIA for GS10 should be considered to strengthen the health benefits of this policy.

5.10 Conclusion

5.10.1 This Health Impact Assessment (HIA) has been undertaken as part of the Regulation 19 consultation and the Council will take account of it in addition to the Reg18 HIA when finalising the MKCP.

5.10.2 In considering the potential health impacts of the MKCP the HIA examines what impact the MKCP is likely to have on health and wellbeing in Milton Keynes; who it will affect the most; and what can be done to strengthen the MKCP.

5.10.3 Overall the MKCP strongly supports approaches that can improve physical health, mental wellbeing, and reduce health inequalities. The emphasis on People Friendly Healthy Places as an overriding theme serves to tie the policies together and demonstrate the importance of many of the policies in supporting health.

5.10.4 In addition to the recommendations presented in the assessment (Section 5), the following overarching considerations are offered to strengthen the health and wellbeing outcomes of the MKCP:

a) The Plan sets out to ‘deliver the right infrastructure at the right time and in the right places’. This approach is necessary for ensuring communities have access to needed infrastructure in early stages of development, however, MK has an ageing population and infrastructure that is built now may not be best suited to the needs of communities in the future. The expectation for management and maintenance of certain infrastructure may help to mitigate this issue. Providing new infrastructure that is accessible and appropriate to multiple users in the first instance, can also help to ensure that it remains appropriate to communities over time.

b) There is a strong emphasis on developing infrastructure that is most likely to benefit urban populations. It will be important to consider the needs of rural communities, including access to essential amenities, throughout the MKCP.

c) The Plan should strengthen approaches to serve the needs of diverse populations. This could include improvement of public amenities such as provision of wayfinding on routes, and shade and rest areas near open spaces. These approaches support more population groups, e.g. elderly people, to engage in the public realm.

d) Whilst the Plan considers key provisions that are needed to enable street use by elderly people or people with a disability, one notable omission is the provision of public toilets. Public toilets are an essential amenity of walkable environments and the lack of public toilets can be a barrier for many street users. Consideration should be given to how this can be addressed through provision of public amenities or contributions to social infrastructure.

e) While the Plan has a strong emphasis on ensuring access to public amenities and infrastructure, it is important to also consider whether these offerings are also appropriate, available and acceptable to the communities who want to use them. For example, accessibility to open space is important, however, if that open space is not designed to be appropriate and acceptable to the needs of the local community - such as providing seating, wayfinding, play structures, etc. - then it will not be used. Therefore, it may be necessary to demonstrate how new development provides amenities that are accessible and also appropriate and acceptable to communities.

f) It will be important to ensure that communities are provided with opportunities to engage in aspects of planning and development. With regard to regeneration, it will be necessary to ensure developers consult with communities to deliver amenities that are needed by the community. Development needs to happen in a way that respects local character, identity and meets the desired needs of the community, rather than perceived needs. This might require developers to demonstrate community input and how community consultation and social planning have been considered within the design. Ensuring there are community benefits in places where communities are likely to bare some level of burden (for example, with regard to renewable energy infrastructure in the countryside) will also be important for protecting wellbeing and avoiding unintended or disproportionate impacts.

g) The MKCP strongly supports the expansion of active travel routes, including Redways, and public transport such as the MRT. This is greatly supported as a mechanism to support physical health and mental wellbeing, and can help to reduce inequalities when these options are accessible to a range of users. However, indirect public transport routes, such as those necessitating the need to transfer, can lengthen journey time, increase costs and add stress to journeys. Consideration will need to be given to how expansion of grid roads, which make car use easier, is balanced with active travel goals and the design of public transport routes which can make this option less attractive.

h) Milton Keynes will experience climate changes over the next 25 years. It is currently projected that global warming levels will reach 1.5ºC by 2050 which would lead to more summer days, more hot summer days, fewer frost days, and more cooling degree days in Milton Keynes (1). This has clear health consequences including higher risk for heat-related hospital admissions and death, transport disruption, increased water demand and increased energy demand for cooling. In addition to extreme heat, the MKCC administrative area is also most vulnerable to flooding (including from rivers and surface water) (2). The Climate and Environmental Action chapter sets out approaches to help mitigate some of these actions. A distinction should be made between strategies that reduce climate change (e.g. GHG emissions) and those that enhance climate change adaptation and further consideration could be given to ensuring the MKCP achieves needs strategies. It should also more clearly link climate adaptation to public health benefits in both the CEA policies and the PFHP policies. This could also be further emphasised in the draft Sustainability Strategy 2025-2050.

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