reuniting health with planning – a work in progress

A year on from publication of the TCPA’s *Reuniting Health with Planning* handbook, Andrew Ross looks at current progress on integrating public health and planning concerns and outlines the aims of phase 2 of the Reuniting Health with Planning project.

At a conference I attended recently, a planner was telling delegates about a visit he had made to a primary school as part of the community engagement the local authority was conducting for its Local Plan. ‘What,’ he asked the children, ‘did they most like about the area where they lived?’ Two of the pupils said: ‘The weeds in the cracks in the pavement.’ Puzzled, he quizzed them further and discovered that these weeds were the only bit of green they saw on their walk to school – no street trees, no parks, no allotments, no window boxes. The planner had a brief look around afterwards and had to concede that the kids had a point.

From a health perspective, this lack of vegetation should trigger alarm bells. We know that people experience better mental health when they have access to good-quality local green spaces; that they need spaces where they can exercise, play or walk...
the dog; and that helping people adapt to the health risks of climate change means using street trees to cool places down and permeable surfaces to reduce the risk of flooding.

But in the current economic climate, where viability takes centre stage, we risk perpetuating environments that are poor for health. A senior planner told one of the TCPA’s Reuniting Health with Planning seminars held in 2012 that elected members were resisting planning’s requirement that developers plant street trees when building new developments, arguing that the cost of maintaining the trees would be ‘unsustainable’.

Within this context, planners could be forgiven for feeling rather downcast about the added burden of taking on their share of the public health responsibilities that have now officially moved across to local government. But, as phase 1 of the TCPA’s Reuniting Health with Planning project made clear, the combination of the transfer of public health to local authorities and the publication of the National Planning Policy Framework (NPPF) has provided some places with an opportunity to consider afresh how they can use the planning system to help improve public health.

The launch of the TCPA handbook, Reuniting Health with Planning: Healthier Homes, Healthier Communities, which I wrote with the TCPA’s Michael Chang, preceded a seminar series that was attended by several hundred planners, regeneration and housing specialists, and public health practitioners. It is now a year since the research that underpinned the handbook was completed. To help inform phase 2 of the project (more on which below), I spoke again with those involved in the phase 1 case studies – at Bristol, Gateshead, Knowsley/First Ark Group, Lincolnshire/Central Lincolnshire, Luton, and Sandwell – to get an update on the observations they set out 12 months ago.

Settling structures

Understandably, in the spring of 2012, when the case study material was gathered, most places were grappling with how the changes to the health system would be implemented locally – a joke doing the rounds in the NHS was that the health reforms were so big you could see them from space.

Now that 1 April 2013 has passed, the whirlwind of change should, in theory, be over, but in practice there has as yet been little time for the reforms to bed down. Locally, there are a number of factors that have influenced how torrid this period of change has been; the arrangements for two-tier areas are especially complex.

There are four changes that are directly relevant, and each is considered briefly below:

- the move of public health to local government;
- the requirement on local authorities to set up Health and Wellbeing Boards;
- the introduction of new commissioning arrangements, to be led by Clinical Commissioning Groups (CCGs); and
- the launch of a new body – Public Health England – to oversee improvements to public health and health protection, and to address health inequalities.

In most of the case study areas links between planners and public health practitioners were already established, and these have continued to evolve. For example, in Lincolnshire, the Director of Public Health is supporting the move to the County Council by employing a health and environmental specialist full time to help the local authority engage the seven districts in this agenda. In Knowsley, the Local Plan team includes public health representation as part of any relevant officer working group. Most recently this included one on developing Knowsley Council’s approach to developer contributions.

The success of the public health move to councils hinges on the response of elected members. As one interviewee put it, ‘For local authorities to improve health it is essential that members ‘get it’ – but they don’t always.’ Elected members should be natural champions for creating environments that promote health; finding an issue that resonates locally may be one of the ways to help them understand these links better. As an aside, one of the Reuniting Health with Planning phase 2 case study organisations – Hertfordshire County Council – has created a new portfolio in its cabinet, on public health and localism.

Health and Wellbeing Boards are tasked with improving integrated working between health and social care, and with reducing health inequalities locally. Legally there are seven types of member
that must be on each Board (for example, an elected member, a representative of the local Healthwatch, and so on). Beyond this, there is some flexibility about their size and composition, although there seems to be a consensus that small, focused boards will be more effective than larger ones. None of the seven statutory members will necessarily represent the links between planning and health. However, most of the case study organisations report that there is either someone they regard as a ‘champion’ of public health and the environment on the Board, or that a subgroup has been set up to ensure that this perspective is fed into the Board’s work. For example, Luton Borough Council has a subgroup on the wider determinants of health that is chaired by the Director of Environment and Regeneration.

Only one interviewee felt that the Board was ignoring the connections between health and place, but that this was largely due to individuals being swamped by the scale of restructuring locally: there simply had not been the time or capacity – yet – to look beyond the core elements of the Board’s role.

A year ago Clinical Commissioning Groups did not exist. Now, they are specific consultation bodies in the local plan-making process. Consequently, some places are beginning to establish links between planners and public health specialists with an interest in this area and CCG representatives. In Sandwell the CCG receives a weekly notification of any relevant planning applications. The CCG lead clinician on long-term conditions has asked for a meeting with public health and planning specialists to talk about the spatial element (including housing) of managing and preventing long-term conditions. Planners at Knowsley have invited the CCG onto an officer stakeholder group to look at the local authority’s approach to developer contributions. The Central Lincolnshire Joint Planning Unit has agreed to present at a meeting of the Clinical Commissioning Groups Council, which oversees the four relevant CCGs.

The new supporting agency for public health – Public Health England – is prioritising lifestyle factors that drive the four main causes of death and disease: tobacco use, poor diet, lack of physical exercise, and alcohol and drug misuse. Its Director of Health and Wellbeing, Dr Kevin Fenton, has stressed that ‘For all these lifestyle factors, place matters… it has a huge impact.’ Locally, there is some concern about the capacity and expertise of Public Health England in this area. One case study interviewee observed that ‘they are focusing on lifestyles… but social determinants don’t appear to be in there very deeply’.

### NPPF – incorporating health aspects

Last summer the planning profession was absorbing the implications of the recently published NPPF. Now, it is the central plank of plan-making and decision-taking. The jury is out as to the impact of the NPPF, but one thing seems clear: an up-to-date Local Plan that complies with all aspects of the NPPF, including the chapter on promoting healthy communities, is crucial for being able to make and defend planning decisions.

In the past year some of the case study authorities have published policies that aim to fulfil the NPPF’s objective to promote healthier communities. Bristol has been consulting on the publication version of its development management policies. It has a number of policies that aim to reduce the causes of ill-health, improve health and reduce health inequalities by, for example, ‘enabling healthy lifestyles as the normal, easy choice’. It also requires a health impact assessment for residential developments of 100 or more units, for non-residential developments of 10,000 square metres or more, and for other developments where the proposal is likely to have a significant impact on health and wellbeing.

The Central Lincolnshire Joint Planning Unit has prepared a draft Core Strategy for three districts in the county: City of Lincoln Council, North Kesteven District Council, and West Lindsey District Council. The plan’s health and wellbeing policy includes objectives to reduce health inequalities and to support ‘healthy and active lifestyles’ by, for example, ‘promoting and safeguarding local food growing spaces’. It also requires developers of major new development proposals to undertake a health impact assessment (the strategic site allocations part of the plan includes eight sustainable urban extensions that will account for around 35% of the area’s projected housing development).

### Health and wellbeing strategies

One of the messages that the Reuniting Health with Planning handbook emphasised was the importance of finding ways to get environment and planning into the Health and Wellbeing Board’s joint health and wellbeing strategy. Sandwell was one of the first authorities to write a strategy based on the recommendations of the Marmot Review (Fair Society, Healthy Lives), published in 2010. Its strategy will be refreshed shortly and will continue to include priorities on healthy urban development and measures to address the spatial elements of health and health inequalities.

Bristol’s draft joint health and wellbeing strategy was published in February 2013. Its vision is for Bristol to be ‘a place where all who live, work or learn in the city lead healthy, safe and fulfilling lives, now and in the future’. One of its four themes is ‘a city of healthy, safe and sustainable communities and places’.

One of the drivers for change to help achieve the objectives in Knowsley’s health and wellbeing
strategy is ‘health promoting environments’. And Lincolnshire’s strategy has some links to planning – for example recognising the importance of good-quality, energy-efficient housing.

The bigger picture
Beyond the internal machinations and anxieties that the health and planning reforms have triggered, the state of flux has also provided the chance for some of the case study areas to consider the broader challenges facing planning, and how they relate to health.

There is probably no appetite among planners for another attempt at improving the planning system, and yet this will be on the agenda again at some point. Indeed, the TCPA has begun to consider the need for a new Planning Act to replace the patchwork quilt of legislation that currently guides the system.

If we were devising a planning system with health at its core, what would it look like? Rather than starting with a policy-based approach, one case study authority is considering establishing health improvement zones in areas with gaping inequalities. In this model, all departments – including planning – would be instructed to reconfigure what they offer to halt the worsening of health inequalities and improve health within the identified localities.

As noted above, there is potential for viability to trump wider health considerations. Development can provide opportunities to improve health, such as through new jobs and investment, and access to better facilities. But how often do developers win the argument on viability when their case is actually rather flimsy? Writing in the April issue of Town & Country Planning, Bob Colenutt and Martin Field contend that ‘builders are adept at using ‘viability’ arguments to drive down Section 106 obligations, particularly for affordable housing, when their overall healthy financial positions (due to advantageous land prices etc.) would equip them to meet the levels of affordable housing sought by many local planning policies’. If this is true, then perhaps one of the best skills a health-promoting planner can have is the ability to engage persuasively and sceptically in pre-applications meetings on development finance. Building a business case for considering health will continue to be a theme in phase 2 of the Reuniting Health with Planning project.
The focus on viability comes at the same time that the Northern and Midland case study authorities – Sandwell, Gateshead and Knowsley in particular – are responding to the impact of the welfare reforms and the evaporation of millions of pounds from the local economy. During the autumn seminar series that accompanied the launch of the Reuniting Health with Planning handbook, we were told that the reforms were a ‘tsunami on the horizon’. This was prescient: by spring 2013 the mainstream press had caught on to the fact that the changes to the benefits system were going to hit hard in some areas. The evidence of the detrimental impact of austerity policies on health is growing – and has most notably been set out in the recently published The Body Economic: Why Austerity Kills.6

With this in mind, two interviewees raised concerns about public health practitioners now being ‘in the local authority tent with planners’: will this compromise the ability of health officials to advocate for health policies and assess impact? As one interviewee put it, ‘A potential negative is that public health’s autonomy/independence to question a planning decision is reduced.’ In truth, few places can point to the old Primary Care Trusts objecting to planning applications or Local Plan policies on health grounds. But the reminder that public health practitioners need to advocate as well as collaborate is timely.

Phase 2 – health and planning still reuniting

Phase 1 of the TCPAs Reuniting Health with Planning project focused on policy and legislative reforms and their implications for planners and public health practitioners. The TCPA is delighted to have secured funding for a second phase, which will explore how planners and public health practitioners are taking forward the reuniting health with planning agenda using examples from the places in which they are working.

Phase 2 will develop an understanding of how planning can positively respond to local issues within the framework of the NPPF and the Public Health Outcomes Framework, through appropriate policy and development management actions in various spatial settings. This will be achieved by focusing on a number of case study areas. Four case study authorities and organisations from phase 1 – Bristol City Council, Knowsley Council/First Ark Group, Lincolnshire County Council/Central Lincolnshire Joint Planning Unit, and Sandwell Council – are joined by Hertfordshire County Council, Manchester City Council, the London Borough of Newham, and Stockport Council.8

In early May the TCPA launched phase 2 of the Reuniting Health with Planning project to an enthusiastic gathering of planning and public health representatives from these areas. It is already clear that these places are developing their own priorities in response to local circumstances. The project will use a series of practitioner roundtables to devise ways of using the planning system to help achieve better health outcomes locally. For some this will mean focusing on greenfield development; for others the challenges will be within existing urban areas, or will involve working across a diverse range of settlement types. The project will capture this learning over the coming months, and will report towards the end of 2013.

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Notes
4 Dr Kevin Fenton was speaking at an expert seminar on health and the environment organised by the University of West of England on 14 March 2013
7 See the NPPF and health wellbeing checklist (Section 4 in the Reuniting Health with Planning handbook), at www.tcpa.org.uk/data/files/Health_and_planning/TCPA_FINAL_Reuniting-health-planning_NPPF_Checklist.pdf
8 Further information on each case study area is available from the ‘Reuniting Health with Planning: Phase 2 Project’ webpage at www.tcpa.org.uk/pages/reuniting-health-with-planning-phase-2-project.html