Joining up health and planning: how Joint Strategic Needs Assessment (JSNA) can inform health and wellbeing strategies and spatial planning

Abstract

There has been a welcome joining up of the rhetoric around health, the environment and land use or spatial planning in both the English public health white paper and the National Planning Policy Framework. However, this paper highlights a real concern that this is not being followed through into practical guidance needed by local authorities (LAs), health bodies and developers about how to deliver this at the local level.

The role of Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategies (HWSs) have the potential to provide a strong basis for integrated local policies for health improvement, to address the wider determinants of health and to reduce inequities. However, the draft JSNA guidance from the Department of Health falls short of providing a robust, comprehensive and practical guide to meeting these very significant challenges.

The paper identifies some examples of good practice. It recommends that action should be taken to raise the standards of all JSNAs to meet the new challenges and that HWSs should be aligned spatially and temporally with local plans and other LA strategies. HWSs should also identify spatially targeted interventions that can be delivered through spatial planning or transport planning. Steps need to be taken to ensure that district councils are brought into the process.

INTRODUCTION

In England (but not in Scotland, Wales and Northern Ireland), both the National Health Service (NHS) and the spatial (or land use) planning system have been subject to major reforms by the UK coalition government through the 2010 NHS white paper, the Health and Social Care Act 2012, the Localism Act 2011, the National Planning Policy Framework (NPPF) and the current Growth and Infrastructure Act 2013.

The Health and Social Care Act 2012 (see Box 1) introduced a new set of duties focusing upon public health. New bodies are being established such as the Health and Wellbeing Boards (HWB), Clinical Commissioning Groups (CCGs), HealthWatch and the NHS Commissioning Board (NHS CB). Public health services are reverting to local authorities (LAs) and Public Health England (PHE) is being established.

In parallel, the NPPF requires spatial planning to give consideration to public health issues alongside the LA duty on public health. Proposed changes to the Environmental Impact Assessment (EIA) Directive, due to come into effect in 2014, would also see the mandatory consideration of health for EIA development to complement the current requirement under the Strategic Environmental Assessment Directive.
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The Health and Social Care Act 2012 sets out the powers and duties of Boards, in sections 176 to 183. They are to:

- Undertake a joint strategic needs assessment – under the provisions of section 116 of the Local Government and Public Involvement in Health Act 2007.
- Develop a joint Health and Wellbeing Strategy between the Council, the GP Commissioners and the NHS Commissioning Board.
- Encourage integrated working between providers, including the use of pooled budgets and other financial arrangements under section 75 of the NHS Act 2006.

And – in the case of Board members who are also commissioners – to:

- Have regard to the JSNA and the Health and Wellbeing Strategy when making commissioning decisions.

The JSNA required primary care trusts (PCTs) and LAs to jointly and systematically review the health and wellbeing needs of their population, leading to agreed commissioning priorities that would improve health and wellbeing outcomes and reduce health inequalities. The scope includes all factors that impact on the health and wellbeing of local communities, such as employment, education, housing and environmental factors.

Prior to the current reform, the Director of Public Health (DPH), with the Directors of Adult Social Services and Children’s Services, led the JSNA process. This ensured that there was a link between the upper-tier LA and the PCT. With the abolition of the PCT and the DPH joining LAs, alongside the Directors of Adult Social Services and Children’s Services, the issue now is how to ensure strong links with the commissioners and providers of local health care services, both primary and acute, as well as with other LA services such as spatial and transport planning.

The coalition government’s structure for the leadership and delivery of health and social care services at the local level is through HWB and CCGs. The HWB is required to produce a local HWS that is informed by the JSNA and underpins joint working. The HWS provides the framework for the local commissioning of acute health services by the CCG, for the LA commissioning of social care and for primary care services commissioned by NHS CB.

The JSNA must consider all the current and future health and social care needs that are capable of being met, or affected to a significant extent, by any of the functions, including land use or spatial planning, of the LA, CCG or NHS CB.

Crucially, neither in the 2007 or 2012 guidance has the role of JSNA been firmly placed in the context of the wider determinants of the health model that makes it clear that health outcomes are a result of the social, economic and environmental circumstances, as well as personal attributes. It is essential that the JSNA and HWS go beyond coordination and prioritisation of the commissioning of health and social care services and address these wider determinants of health and well-being.

HEALTH AND WELL-BEING STRATEGY

The statutory responsibilities of HWB and CCGs under the 2012 Act need to interact with their other statutory obligations and with other stakeholders. This is a complex and difficult task on which the draft guidance does not give any real help or pointers, leaving it to local discretion and being dependent on existing relationships.

There is considerable experience of multi-agency working in the Local Strategic Partnerships and Local Area Agreements processes, including a number of non-statutory health and wellbeing strategies being produced, such as in Bristol. While a rigid template or ‘one size fits all’ would be inappropriate, the draft guidance could usefully have drawn on the good practice that exists and addressed the generic aspects of strategy formulation.

Strategy is about initiating and guiding change from one state to another. This involves setting priorities and making strategic choices informed by understanding or expectation of efficacy – which interventions will be the most effective within the available resources.

The draft guidance fails to address the generic aspects of strategy that will underpin any HWS. Choice in this context is highly political, given the status of the HWB as a formal committee of the LA and that the HWB is inextricably linked to the new NHS structures through the CCG, NHS CB and indirectly
to PHE. This complex organisational landscape with its statutory relationships, in the context of diminishing resources, will be enormously challenging to steer effectively. Indeed, the need to ensure that strategic choices are based on the best empirical evidence is more pressing, considering the need for value for money. The draft guidance throws no light on any of these challenges or opportunities.

The scope of the HWS and the relationships between the HWS and the CCG commissioning plans, the NHS mandate and the various outcome frameworks is a complex system. It would have been helpful to have how these relationships will work explained, in light of past efforts at joint working.

THE ROLE OF JSNA
Theoretically the scope of the JSNA is extremely wide. In reality the focus, with a few exceptions, has been health and social care, helping to enhance integration between health care, social care and children’s services. JSNA has always been merely a means to deliver strategic planning for health and wellbeing. However, under the 2007 Act the ends were not specified or mandated and it omitted a requirement for partners to act on the JSNA in a coordinated or collaborative way. The requirement that an HWS must take into account the findings of the JSNA has now rectified this:

The JSNA and joint health and wellbeing strategy can be the foundations upon which health and wellbeing, such as housing and education. JSNAs and joint health and wellbeing strategies will enable commissioners to plan and commission integrated services that meet the needs of their whole local community, in particular for the most vulnerable individuals and the groups with the worst health outcomes.

The challenge of fitting the ‘needs’-based assessment into a ‘demand’-based service model remains at the heart of the new system. In a climate where both LAs and the NHS face sustained reductions in resources, the challenge of delivering change has been exacerbated by stressing the link between needs assessment, strategy design and implementation. The Health and Social Care Act 2012 (section 116a) states that the HWB must ‘prepare a strategy for meeting the needs included in the assessment by the exercise of functions of the authority, the National Health Service Commissioning Board or the clinical commissioning groups’(‘a joint health and wellbeing strategy’).

While the relationship between needs and demands is explicit, what is missing in the draft guidance is how to coordinate and balance ‘upstream’ public health interventions (often by agencies outside the NHS) on the wider determinants of health with the day-to-day demands for health services.

Although the JSNA appears to have a key role within the new health system, that role has not been systematically evaluated. The review of the JSNA by I&DeA made no claims to scientific rigour, but did deliver optimistic conclusions. The examples described were based on over 100 interviews and four case studies where there was strong partnership working. They showed how the JSNA preparation had become systematic, quite well resourced and, with some caveats, embedded in the multi-agency service planning landscape. Also, some councils like Cambridgeshire have explicitly extended the JSNA role to district councils. However, how widespread such positive experiences are is open to question.

A systematic evaluation is needed to explore the extent to which the use of JSNA has led to concrete results; for example, whether there has been a match between priorities, resource allocations and outcomes to meet the needs identified by the JSNA. Some evidence suggests that the degree of change is still modest. The delivery of health and social care does not reflect a high degree of integration as witnessed by the House of Commons Health Select Committee report that states:

In the context of integrated service provision and integrated commissioning, the degree of alignment between these frameworks (NHS and social care outcomes frameworks) looks disappointing. We are particularly concerned that the Government merely “hopes” that national alignment “will cascade down to local level”.

It recommended that the government move swiftly to ‘adopt a single outcomes framework for health and social care for elderly people and that it will abandon the attempt to create artificial distinctions between health, social care and social housing.’

JSNA, PLANNING AND THE WIDER DETERMINANTS OF HEALTH
The government’s public health white paper highlighted the influence of the environment on people’s health and included the goals of creating healthy places to grow up and grow old in (para 3.4); active travel (walking and cycling) and physical activity becoming the norm in communities (para 3.32); and creating an environment that supports people in making healthy choices, and that makes these choices easier (para 3.62). This is reflected in the NPPF’s promotion of healthy communities (paras 69–78) and support of local HWSs (para 17).

This joining up of the rhetoric across government departments is welcome. However, this has not been reflected in the draft guidance on HWS and JSNA, which is silent about how this can be done practically and locally through HWS and the spatial planning system. One attempt to fill this vacuum has been the Reuniting Health with Planning project, led by the Town and Country Planning Association (TCPA) and supported by members of SPAHG.

Similarly, the Marmot Review’s work on reducing health inequalities identified creating and developing healthy and sustainable places and communities as one of its six policy objectives and recommended fully integrating the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality (recommendation 2.2).

The Marmot Review produced a specific briefing on the implications for
spatial planning. It identified the following elements as having a significant impact on health, as well as relating to socio-economic status: pollution; green and open space; transport; food; housing; community participation and social isolation. The briefing concluded that planning will need to consistently take into account the spatial distribution of environmental disadvantages and assess how they impact on the communities that are exposed to them. It is vital that planners, developers and design professionals are aware of the health equity impact of their work and proactively address environmental disadvantage through their practice.

The draft guidance is silent on the crucial issue of health inequities. If reduction in health inequity is to be the principal aim of public health policy it is essential that practice and progress is driven through a wide variety of means and not simply left to local priorities. For example, the role and resources available through the Institute of Health Equity, which, building on the work of the Marmot Review, is developing a new approach to interventions to improve public health through the wider determinants of health, should be widely publicised and used to inform JSNA and HWS.

Climate change and resource depletion were also omitted from the draft guidance. This is despite the efforts of the NHS Sustainable Development Unit to raise these issues within the NHS and the targets set out in the Climate Change Act 2008 to reduce UK greenhouse gas emissions by at least 80% by 2050, relative to the 1990 baseline.

The emphasis of the new NHS on services per se weakens these wider relationships. The social, economic and environmental context is not simply the result of the delivery of health services, but also the actions of councils, other public, private and voluntary sector organisations, market forces and global environmental pressures that have a profound influence on the wider determinants. If the wider determinants of health were explicitly recognised and operationalised in the spending priorities of NHS budgets, it would result in a more balanced strategic approach, even if the inertia present in services is very hard to shift in the short to medium term.

**JSNA AND SPATIAL PLANNING**

The extent of alignment between health and spatial (or land use) planning is difficult to evaluate objectively despite examples of good practice mainly through joint working, as in the Healthy Urban Development Unit that works with PCTs and planning departments in Greater London; Sandwell’s Healthy Urban Development Unit that coordinates and integrates spatial planning and efforts to reduce health inequalities; and the embedding of the PCT-funded Healthy Urban Team within Bristol City Council. SPAHG has published guidance for planning and health professionals to work together, based on evidence gathered for the former National Institute for Health and Clinical Excellence (NICE) Spatial Planning and Health Programme Development Group. NICE is developing a public health briefing for local government on spatial planning that is due for publication in May 2013.

Evidence for the embedded and ongoing use of JSNA and consequent real integration in spatial planning policies is harder to find. Health is rarely seen in the evidence base for local plans (previously known as local development frameworks), even in those areas where JSNAs seem to be well used.

One complication is the variations in local government structure across the country. In single-authority settings such as the London boroughs and unitary authorities there is one LA covering all LA services including social care, children’s services, housing, transport and spatial planning and public health (since April 2013) so that it is easier to coordinate LA responsibilities.

In two-tier counties, while public health, social care, children’s services and transport planning lie with the county council, the majority of spatial planning functions (and related functions such as housing, parks and green open space, economic development, community safety, licensing and environmental health) lie with district councils. This makes it much more complicated to bring spatial planning, health, social care and other local public services together. Nevertheless, the case for recognising and exploiting the spatial planning function in pursuing health and wellbeing has been strongly made. For example, the TCPA and Hyde Housing have developed guidance on how JSNA and spatial planning should be linked.

Some councils have made the policy link between health and planning explicit. In Cambridgeshire, for example, the scale of growth and creation of several new communities has become a focus for exploring the links between public health and planning. The policy implications are expressed both as creating conditions for healthier communities – green space and physical activity for instance – and aligning health care investment with community growth.

As currently written, the draft guidance fails to recognise and develop this crucial inter-relationship. The JSNA, however sophisticated in assembling the data, needs to go further by presenting ‘actionable insights’ – what does the data suggest should be done, when and where and for whom? This should then be taken forward through the HWS. The guidance is silent about this most important element of the new system.

The key must be to arrive at interventions that are calculated to ameliorate or improve health and minimise inequities in a cost-effective way. This ought therefore to be based upon a reflection of short-term health care interventions, medium-term social care and children’s service inventions and longer-term public health interventions driven by spatial and transport planning, regeneration, community development and other services. In this process, health services would be one of the means of health improvement and not the sole focus.

**THE NEW PUBLIC HEALTH REGIME AND SPATIAL PLANNING**

Driving the new public health regime is the Public Health Outcomes Framework published in January 2012. Delivering its two high-level outcomes of increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities and supporting health indicators – such
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as utilisation of green space for exercise/health reasons; proportion of physically active and inactive adults; and air pollution — will need concerted action by a range of partners, not just by public health.

The move of public health back into local government will consolidate the joint appointment of the DPH at upper-tier county level. However, this will still require significant rebalancing of relationships and responsibilities with that of chief executives and LA reporting structures. Challenges exist in drawing together the upper-tier health and the lower-tier planning functions, which the draft guidance ignores.

The new commissioning arrangements by general practitioners (GPs) will be through CCGs, whose boundaries do not necessarily align with LA boundaries, and will be supported by Commissioning Support Units. Primary care services, including GPs, will be commissioned by NHS CB, which is setting up four regional offices and 27 local area teams across England. A third of these local area teams will lead on specialised commissioning.

PHE and LAs will undertake the commissioning of public health services, although NHS CB will commission, on behalf of PHE, many of the public health services delivered by the NHS, with some likely to be commissioned on a larger geography than individual teams (such as screening programmes) and others possibly at individual local area team level (such as public health and under-fives). The degree of complexity that this introduces into linking public health and spatial planning makes it even more difficult to focus on the wider determinants of health, which provides the common agenda between spatial planners and public health.

The extent to which PHE will be in a position to seek or engage with the spatial planning agenda either in relation to nationally significant projects, in providing technical support, or as a consultee in relation to EIA development proposals, is not clear. Practice and experience within strategic health authorities and in the Department of Health thus far suggest that this agenda will have a very low priority. The recently published operating framework for PHE does nothing to contradict this.

Even if PHE wants to engage with spatial planning, the reality is likely to be that, like any reorganisation, it as brings together its constituent bodies (such as the Health Protection Agency, the public health observatories and the National Treatment Agency for Substance Misuse), it is likely to be a while before the sum is greater than its parts and PHE is able to take on this wider agenda.

In the absence of central support (in line with the localism agenda), local public health staff need to engage with EIA development projects and work with the planning community (public and private). They need to suggest targeted specific evidence-based measures, rather than just generalised requests for health impact assessments.

THE ANNUAL PUBLIC HEALTH REPORT OF THE DIRECTOR OF PUBLIC HEALTH

The Annual Public Health Report (APHR), which is an independent statement of local public health, remains statutory for Directors of Public Health. These reports take many forms — some covering all conditions, others topic based, or a combination. There is an obvious overlap between the scope, and to a degree, the purpose of the APHR and the JSNA, so that the APHR is evolving to fill gaps not covered in the JSNA. In Brighton and Hove, the APHR for 2010 took a new method of analysis:

This year the focus is on community resilience. There are a number of reasons for adopting this approach: the current financial climate with cuts in public funding and a requirement to do more with less; a Coalition Government policy of “localism”; the “Big Society” initiative; and an emerging realisation that in order to tackle local public health problems more effectively, we need to engage more effectively with local populations and harness the assets that exist therein. So, rather than expressing public health issues in the usual terms of population needs, this report describes both the public health vulnerabilities and assets that exist within Brighton & Hove, and suggests how the assets might be employed to address some of the vulnerabilities. In that sense it is a much more solution-focused report.

The importance of the wider determinants of the health model in public health, together with an interest in spatial distribution of population health conditions and indicators, can provide a common agenda for spatial planners and public health professionals.

Public health analyses have the potential to add to the spatial planning evidence base in a way that can operationalise the link between social, cultural, economic and environmental factors with issues of population health status. The JSNA may equally draw on both evidence bases for mapping and quantification of needs.

The draft guidance does not attempt to explore this potentially rich interaction.

THE DUTY TO COOPERATE AND JOINT WORKING BY LOCAL AUTHORITIES

The upper-tier councils and HWBs have the freedom to cooperate with adjoining areas to address issues of common concern. At the same time planning authorities, both upper-tier councils and district councils, have a duty to cooperate with adjacent planning authorities to address substantive planning issues that have wider-than-local impact or implications, such as housing market assessments, green belt and major infrastructure. The duty to cooperate also covered PCTs.

Some councils already have strong sub-regional frameworks, for example the Association of Greater Manchester Authorities and the Greater Manchester Combined Authority, while in many other areas Local Enterprise Partnerships are starting to provide a framework for cooperation. It is quite clear that the wider determinants operate at this sub-regional scale, especially in conurbations, and consequently, JSNAs need a degree of consistency in format, scope and indicators if they are to have a role to play both in informing such supra-local frameworks.
and in how PHE, the sub-national arm of NHS CB, will align or interact with such bodies.

Authorities with similar characteristics or facing similar issues are also coming together to share knowledge and exchange good practice in national networks such as the UK Healthy Cities Network and Core Cities Group.

The draft guidance has nothing to say about the relationship between HWS and LAs or about what the duty to cooperate means for HWBs and CCGs.

**THE NEW SPATIAL PLANNING REGIME AND HEALTH**

The government published the NPPF in March 2012, superseding the existing 27 or so topic-based planning policy statements (there was no specific health planning policy statement). The aim of this change is to simplify the English planning regime.

At the same time (except in London), the government is in the process of abolishing the regional tier of planning policy, which was until now also statutory. This means that the principal planning policy vehicle, notwithstanding the duty to cooperate, will be the local plan covering each of the English planning authority areas (district and unitary councils outside London, of which there are over 300). London boroughs will produce local plans within the strategic context of the Mayor’s London Plan. The Localism Act 2011 also gave new powers for local communities to prepare neighbourhood development plans.

The guiding principle of the NPPF is to contribute to the achievement of sustainable development. Health is acknowledged and is an integral component of sustainable development. The government uses Resolution 42/187 of the UN General Assembly definition of sustainable development and the UK Sustainable Development Strategy: Securing the Future’s five principles of: (1) living within environmental limits; (2) achieving a sustainable economy; (3) ensuring a strong healthy and just society; (4) promoting good governance and (5) using sound science responsibly. The NPPF (para 7) sets out the social role of planning in delivering sustainable development as:

- Supporting strong, vibrant and healthy communities, by providing the supply of housing required to meet the needs of present and future generations; and by creating a good quality built environment, with accessible local services that reflect the community’s needs and support its health, social and cultural wellbeing.

The NPPF (para 17) states that one of the 12 core planning principles that should underpin all plan-making and development management is to ‘Account of and support local strategies to improve health, social and cultural wellbeing for all and deliver sufficient community and cultural facilities and infrastructure to meet local needs.’

It makes it clear that planners must address health and promote healthy communities. Paragraph 69 states: ‘The planning system can play an important role in facilitating social interaction and creating healthy, inclusive communities. Local planning authorities should create a shared vision with communities of the residential environment and facilities they wish to see.’

The NPPF (para 171) also encourages interaction between the health and planning sectors:

- Local planning authorities should work with public health leads and health organisations to understand and take account of the health status and needs of the local population, including expected future changes, and any information about relevant barriers to improving health and wellbeing.

Therefore it follows that there is, in effect, reciprocal duties on local planning authorities, HWBs and CCGs to take steps to ensure that their strategies are aligned in these respects.

In addition, the NPPF (para 156) states that all local plans must have strategic policies to deliver: ‘The provision of health, security, community and cultural infrastructure and other local facilities.’

Local planning authorities are to work with other authorities and providers to: ‘Assess the quality and capacity of infrastructure for… health, social care... and its ability to meet forecast demands’ (para 162).

Thus, the HWBs, and LAs (as social care providers and regulators) together with CCGs, foundation trusts and NHS CB, will also be under a de facto duty to cooperate with local planning authorities to identify the need for, and the sources of funding, location and delivery of new health care facilities in conjunction with new housing and other developments to meet the health needs of new and existing residents.

The draft guidance on JSNAs and HWS makes no reference to these NPPF obligations, which are material to the pursuit of health and well-being, the quality and accessibility of local health services, the reduction of inequalities and in securing the optimum configuration of health care facilities and services. The location of new health facilities can also promote wide planning objectives such as regenerating local centres and economic development, and thus some of the wider determinants of health.

The reconfiguration of health care facilities and services may in many situations be practically impossible without a corresponding spatial planning policy. The risks to the HWS and to commissioning plans are therefore potentially very significant.

Local planning authorities continue to have a duty to prepare an Annual Monitoring Report on progress in preparing and implementing their local plan, including monitoring new development, proposed and completed. This can be a valuable source of information on new developments in an area that if successfully coordinated with JSNA data should help inform planning for new health facilities.

At the end of 2012, the government consulted on the recommendations of the Taylor Review into streamlining government planning practice guidance. Over 200 documents were reviewed and it found that the existing guidance was unwieldy in its current form. The review recommended that in future guidance should be shorter, while retaining the key elements, and more accessible, web based, clear, up to date, coherent and easily usable, not just by planners and
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developers, but by the public too. It recommended some areas for new guidance. Unfortunately the review did not take the opportunity to recommend new guidance on the role of planning in supporting and promoting health and well-being. This is despite the NPPF’s raising the role of planning in promoting health and delivering health infrastructure (as highlighted above), and the changing health landscape as the reform of the NHS is implemented (since 1st April 2013).

It is suggested that national planning guidance is required on the appropriate public health leads and health organisations that local planning authorities should work with; the relationship between JSNA, HWS, local and neighbourhood plans; the coverage of health in strategic environmental assessment, EIA and sustainability appraisal and the use of health impact assessments when an EIA is not required; the application of section 106 and Community Infrastructure Levy to health facilities and public health; the spatial and transport planning contributions to health inequalities and obesity; and the relationship with licensing, pollution control and health protection regimes.33

THE WAY FORWARD: CONCLUSIONS AND SUGGESTIONS

There has been a welcome joining up of the rhetoric around health, the environment and spatial planning in both the public health white paper and the NPPF. However, there is real concern that this will not be followed through into the practical guidance needed by LAs and others about how to do this at the local level through the JSNA and HWS process or through the Taylor Review of government planning practice guidance. There is a role for national guidance in explaining complex regulatory and policy requirements, as in the case of health and spatial planning, which in this instance is not currently being met.

The forthcoming changes to local health and wellbeing organisations and processes will be far reaching. The JSNA must provide the common foundation for integrated local policies for health improvement and the reduction of inequities, but the draft JSNA guidance falls far short of providing a robust, comprehensive and practical guide to meeting these very significant challenges. This paper has attempted to sketch out its generic and structural deficiencies, to point out the gaps in the guidance in relation to function and services of the organisations involved, and to show how spatial planning can have a crucial role in addressing the wider determinants of health.

Practice has developed in some localities so that it is well placed to meet the requirements of the HWS. The essential task is to ensure that the standard of all JSNAs is raised to meet good practice and to aspire to best practice. This will demand resources and the wider adoption of innovative analytical techniques – in particular, spatial analysis.

Despite the existence of good practice, there is still a need for the JSNA to be developed so that it both draws on evidence from non-health and social care functions and informs those related strategies such as local plans and those for transport, regeneration, housing and climate change. The HWS needs to be aligned spatially and temporally with these strategies.

To better support the spatial planning system, the JSNA should lead to identified, spatially targeted interventions in the HWS that can be delivered through the spatial planning or transport planning systems. These could become a schedule of costed short-term, medium- and longer-term interventions.

The strategy-making process of the HWB needs to be fit for purpose and adopt established good practice. There is a wealth of guidance and substantial evidence of the success factors in effective strategy making in a multidisciplinary context. However, the challenges of achieving high performance should not be underestimated. Good national guidance has a role in helping that process.

The organisational landscape will be fragmented and the key challenge is to align strategies, service and investment plans within a framework provided by the wider determinants of health model. HWSs need to be evidence based (largely fulfilled by high-quality JSNAs) and developed through robust and proven strategy processes.

Steps need to be taken to ensure that district councils are brought into the process and their input needs to be integrated across the important range of functions that they deliver, for instance, spatial planning, housing, parks and green open space, licensing and environmental health. National guidance has a key role in explaining the complex regulatory and policy arena that spans across the spatial and transport planning, public health, environmental health and pollution control regimes.

An important step for increasing alignment between health and spatial planning (alongside other policy areas) is in commissioning research and identifying good practice in addressing the wider determinants of health. In this way the current lack of understanding about effective interventions of preventative health actions and promotion of good health and well-being may be addressed.

In the current absence of robust guidance from the government, a starting point for this work is through groups such as SPAHG, the TCPA and the UK Healthy Cities Network.

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ETHICAL APPROVAL

Not required.
Notes

i Background information on Local Enterprise Partnerships is available online at: https://www.gov.uk/government/publications/local-enterprise-partnerships-and-enterprise-zones/supporting-pages/local-enterprise-partnerships

ii Section 106 planning obligation – a legally enforceable obligation entered into under section 106 of the Town and Country Planning Act 1990 to mitigate the impacts of a development proposal. Sometimes called ‘section 106 agreement’. More information is available online at: http://www.planningportal.gov.uk/planning/applications/decisionmaking/conditionsandobligations

iii Community Infrastructure Levy – a levy allowing LAs to raise funds from owners or developers of land undertaking new building projects in their area. More information is available online at: http://www.planningportal.gov.uk/planning/applications/howtoapply/whattosubmit/cil

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Five-year workplace wellness intervention in the NHS

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Keywords
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Aims: Poor health and well-being has been observed among NHS staff and has become a key focus in current public health policy. The objective of this study was to deliver and evaluate a five-year employee wellness programme aimed at improving the health and well-being of employees in a large NHS workplace.

Method: A theory-driven multi-level ecological workplace wellness intervention was delivered including health campaigns, provision of facilities and health-promotion activities to encourage employees to make healthy lifestyle choices and sustained behaviour changes. An employee questionnaire survey was distributed at baseline (n = 1,452) and at five years (n = 1,134), including measures of physical activity, BMI, diet, self-efficacy, social support, perceived general health and mood, smoking behaviours, self-reported sickness absence, perceived work performance and job satisfaction.

Results: Samples were comparable at baseline and follow-up. At five years, significantly more respondents actively travelled (by walking or cycling both to work and for non-work trips) and more were active while at work. Significantly more respondents met current recommendations for physical activity at five years than at baseline. Fewer employers reported ‘lack of time’ as a barrier to being physically active following the intervention. Significantly lower sickness absence, greater job satisfaction and greater organisational commitment was reported at five years than at baseline.

Conclusions: Improvements in health behaviours, reductions in sickness absence and improvements in job satisfaction and organisational commitment were observed following five years of a workplace wellness intervention for NHS employees. These findings suggest that health-promoting programmes should be embedded within NHS infrastructure.

INTRODUCTION
Globally, and in the UK, the workplace has been identified as a priority setting for workplace health promotion1–4 and the number of organisations offering wellness programmes is on the increase. Worksites not only provide longitudinal access to a large number of people but have prospect for multi-level ‘ecological’ interventions directed at individual, organisational and environmental determinants of health behaviours.5–7 The evidence suggests that a well-implemented multi-component health-promotion programme can not only improve the health status of participants but can also improve work-related outcomes such as productivity and sickness absence rates.8 This creates a sound argument for the financial

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