Better Health Outcomes Through Spatial Planning
A report for Cheshire West and Chester Council

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Background
The approach to health and spatial planning in England has undergone significant change in the in recent years, and this is on-going. Upper tier local authorities such as CWAC have assumed public health responsibilities, and statutory Health and Wellbeing Boards have been charged with coordinating the local health system to improve health outcomes and reduce inequalities. National planning policy has been radically revised and has given planning authorities clear obligations in respect of health and local communities. Chester West and Chester is developing innovative approaches to health and wellbeing and has published its draft Local Plan in recent months.

Purpose
We were asked by the Director of Public Health for CWAC to undertake a review of the ways in which health considerations can best be integrated with spatial planning policy and practice as the Borough moves forwards. Given the above dynamic and challenging background this is very opportune. Spatial planning for the purpose of this exercise is defined to include transport planning. It must be stressed that the report is not a broad critique of planning policy nor does it look in depth at corporate policy and practice. However, it has been necessary to consider policy towards health and wellbeing in a holistic way and consequently some recommendations stray beyond the strictly planning arena. It is hoped that they are seen as positive and relevant across the Council

Method
The review comprised a study of the policy background nationally and locally and a detailed analysis of current planning policy and implementation. This was supported by face-to-face interviews with groups of key staff and some elected Members in the Council. A context is provided by a brief examination of current practice elsewhere in the UK and of the broad evidence for the relationship between planning and the environment. The review was carried out between September and October 2013 and thus reflects the situation at that time but has been up-dated in minor ways in June 2014.
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STRATEGIC INTRODUCTION

A Paradigm Shift

The analysis in this report and the options it identifies revolve around three key aspects of policy formulation and delivery in Cheshire West and Chester Council (CWAC):-

- Strategies and the need to strengthen and align them
- Processes and the need to secure and sustain effective communications
- Structures and the need to establish clear lines of responsibility for the delivery of ‘health in all’.

However the opportunity, and the point of this report, is to suggest that, despite much progress and the existing visions and aims, there is a need for a **paradigm shift**. The health of the population is a powerful organizing principle that goes beyond the NHS and health services and indeed the remit of the Health and Wellbeing Board. It links closely for instance to sustainability and to economic growth through capability and productivity. There is no doubt that if asked people invariably place health as a high if not the highest priority in their lives.

The focus of this report is on the scope to address health more effectively through spatial planning. The options and processes that we have suggested will assist in achieving this but it is clear that the challenge is enormous and in some respects growing. These pressures are already acknowledged within the Council and nationally. They include an ageing population, growing obesity and persistent and pernicious inequality. The suggestions in this report are based on the understanding that the way in which we manage our environment in its widest sense is critical to health and more specifically to mental well being, social cohesion and healthy life expectancy. Whilst strategies are crucial – to stimulate and accommodate appropriate growth – the management of the resulting urban and rural environment requires creative innovative and careful design and all stakeholders need to be fully engaged in this. Key outcomes include better quality affordable housing, more cycling walking and physical activity, increased biodiversity, better urban spaces and neighbourhoods with convivial appealing public spaces. In these ways in parallel with improved health and social services, health-oriented design can be transformative.

There is no one blueprint, one ‘right answer’ as to how planning can most effectively contribute to health and wellbeing, or what structures and mechanisms are best in any given situation. This is particularly true at the moment, when both the planning and the health systems are subject to substantial organisational change. However, the following suggestions and options have been arrived at from the review of current practice and in the light of discussions with some of the key players in CWAC. It is hoped therefore that they will be seen as relevant to the challenges facing the Council and as reflecting its distinctive vision, priorities and innovative ways of working. They are designed to ‘add value’ to the Councils corporate approach to the challenges of accommodating growth, addressing demographic change, reducing health inequalities, and achieving the co-benefits that integrated working can produce.
Underpinning the approach is the need to:

- Prioritise healthy developments.
- Align strategies and develop systems, approaches and relationships that bring planning and health closer together.
- Review and develop the approach over time.

Achieving progress will be challenging, but with sustained ambition a paradigm shift that will make a very significant contribution to the Council’s vision is possible. The following options, which are derived from the analysis of the local evidence, the wider context and examples of good practice elsewhere are suggested as potentially key steps in delivering this paradigm shift.
SUGGESTED OPTIONS FOR ENHANCING CWAC’S PERFORMANCE IN HEALTH AND PLANNING

1 **Raise the profile and priority of health within the Council**
   - Consider joining a network of like-minded local authorities such as the UK ‘Healthy Cities’ network.
   - Consider requiring those proposing major council policies to undertake a review of likely health and health inequalities impacts as part of the policy’s justification.
   - Develop a communications strategy to promulgate ‘Health is Everyone’s Business’ throughout the council.

2 **Public Health**
   - Take early steps to identify and promulgate the key public health priorities in relation to planning and transport.
   - Prioritise joint working with planning and transport to develop the ISNA as part of a common evidence base.
   - Devise and agree a protocol with planning and transport to establish and maintain communications and allocate responsibility for health-related evaluations, and to identify a contact point(s) for planning and transport.
   - Invest in communicating and explaining the various corporate structures, and in supporting staff to understand roles, responsibilities and relationships.
   - Develop joint education and training with planning and transport to raise mutual understanding of each other’s priorities, language and methods of working.

3 **Health and Wellbeing Board**
   - Ensure that the remit and work of the committee explicitly covers the determinants of health as well as the commissioning of health and social care services and takes steps to align outcomes across the Council.
   - Engage the planning and transport departments in the work of the Board on a regular basis and ensure that they are consultees in the Local Plan process.
   - Consider forming a Strategic Environment, Health and Wellbeing group to advise the Board on addressing the determinants of health and health inequalities including new infrastructure.

4 **Health and Wellbeing Strategy**
   - Ensure that the Health and Wellbeing Strategy comprehensively addresses the social determinants of health and has objectives that fully acknowledge the overall role that planning and transport has in improving health and wellbeing and reducing health inequalities.
Within the above, ensure that the HWBS identifies and addresses locally identified health needs and opportunities that are amenable to planning intervention.

Where possible, identify the spatial dimension to the issues identified above.

Include indicators that can measure the outcomes from the above policies. These can be drawn from the Public Health Outcomes Framework, particularly Objective 1 ‘Improving the wider determinants of health’, and from the Local Plan Sustainability Appraisal.

5  **The Local Plan - implementation**

The strategic part of the Local Plan is now in the final stages approaching adoption. Part 2 of the Local Plan will include more site allocations (beyond the strategic sites) and the development management policies that consist largely of detailed criteria to be applied in support of the strategic policies.

- Ensure that there is strict conformity between the health-related principles and guidelines contained in part 1.
- Ensure that the scope of part 2 policies encompasses the key factors in the built environment that influence health.
- Ensure that part 2 policies make explicit reference to health wherever appropriate and contain or make clear reference to performance standards (in for instance an SPD and Design Guide as suggested below) calculated to lead to health protection and improvement.
- Unless done under part 1, set appropriate thresholds for undertaking the assessment of the health impacts of developments and explicitly identify the health checklist and/or HIA as appropriate methods.

6  **Supplementary planning guidance**

- Prepare an SPD to include:
  - Key elements of healthy sustainable environments (covering the issues described in section ‘Environmental influences on health’)
  - Guidance on how the health impact of proposals should be assessed, for instance through the use of the checklist (see appendix 1) or of HIA
  - Approach to mitigation and enhancement measures
  - Criteria that developments will be expected to meet, for example ‘Building for Life’ Diamond status.

- Ensure that other SPDs, for example Design Guides, and other development plan documents, for example Area Action Plans, contain policies that promote specific and holistic health policy within the relevant area.

7  **Development Management**

- Ensure that the health policies in the NPPF, the Health and Wellbeing guidance in the ‘Planning Practice Guidance’ and the Local Plan and supporting documents, are considered throughout the planning application process and communicated as early as possible to applicants.
Consult with Public Health within the terms of the agreed protocol for advice on health impacts, mitigations and enhancements on large scale major developments as defined above.

Consult with the health service commissioners* at the earliest possible stage in the case of proposals that are likely to give rise to increase in the demand on health and social care services (*NHS England, the Clinical Commissioning Groups, independent GPs and NHS Property Services as appropriate)

At the earliest opportunity define and agree a protocol with the bodies in 3 above to ensure rapid and reliable communications in the case of major applications with implications for health and social care services.

Adopt a Rapid Healthy Planning Checklist (see Appendix 1) to enable officers to gain a quick health overview of development proposals, and enable them to raise issues with developers and/or members as appropriate.

8 Information systems and intelligence

Ensure that the capacity for undertaking necessary analysis and data management is adequately resourced, fully integrated internally and externally and that it is readily accessible to all sections of the Council, and externally as appropriate.

Develop the Integrated Strategic Needs Assessment (ISNA) as a tool to support the spatial planning as well as the health and wellbeing agenda and ensure that wherever possible the analysis identifies ‘actionable insights’ that are directly relevant to spatial planning.

Ensure that the ISNA has a spatial dimension that can help planners to identify specific areas of need.

Provide summarised ‘headlines’ and ‘actionable insights’ that describe ‘place’ and can help Localities teams to define evidence-based policies.

Develop the ISNA Steering Group as an integrative mechanism for coordinating the approach to information management and presentation, and ensure that Planning is represented.

Monitor the influence of planning on health and wellbeing outcomes by undertaking well-designed evaluations of selected interventions as a means of developing the evidence base for the effectiveness of spatial interventions on health and wellbeing.

Localities

Ensure that Planning and Transport Planning are embedded within the Council’s Localities management and delivery structure.

Success factors and indicative outcomes

The boxes below suggest the success factors and outcomes that would indicate significant progress towards the integration of health transport and planning resulting from adopting the above options.
**Success factors**

1. Adoption of an explicit health policy
2. Spatially structured evidence with actionable insights
3. Prioritised outcomes
4. Systematic appraisal of health implications of policies and development
5. Use of s 106/CIL for health (and social care) services and infrastructure
6. Strategy alignment
7. Shared objectives - health, transport, planning
8. Joint working on applications and projects
9. An adopted health appraisal framework
10. Agreed evidence-based standards for health optimization
11. Sustained, reliable horizontal communications
12. Manageable robust indicators
13. High level of awareness of health/planning issues amongst staff
14. Widespread professional development in understanding of health planning connections
15. Driven pervasive culture of integrating health planning and transport

**Outcomes**

1. Reduction in Healthy Life Expectancy gap – the slope of inequality
2. Increased levels of physical activity
3. Improvement in IMD scores
4. Reduction in road injuries
5. Increase in housing satisfaction
6. Increase in quality of open space
7. Increase in walking to school
8. Increase in cycling
9. Increase in proportion of new housing achieving Building for Life ‘Diamond’ award
10. Improvement in air quality
11. Increase in numbers reporting mental wellbeing
12. Increased proportion of decent Homes
13. Increased biodiversity
14. Increased accessibility measured to open space, social infrastructure, schools and local services.
15. Reduction in noise complaints/increase in tranquillity
16. Increase in proportion of warm homes

*These suggested outcomes have spatial, social and age dimensions according to the data available*
3 THE BASELINE

3a The Local Planning and Transport Policy Context

Introduction
This section forms part of the background policy baseline assessment for health and planning project being undertaken for CWAC Council. Its purpose is to describe and to analyse the current local policy context for the way in which health is addressed through spatial planning, including transport. Aims, objectives and policies that can be described as health-related are summarised and critically described. The aim is not to conduct a comprehensive appraisal of the policy framework which would require a much greater in depth understanding of the local context but to critically review the framework using experience and good practice in order to identify potential for strengthening the policies and the process of implementation.

Policy Background
CWAC became a unitary authority in April 2009. As a planning authority it comprised the amalgamation of three local planning authorities (LPA); Chester City, Ellesmere Port and Neston, and Vale Royal and took on the planning functions of the former County Council.

Each predecessor LPA had a local plan. There was also a Cheshire Structure Plan and the NW Regional Spatial Strategy and a number of policies have been ‘saved’. Health did not figure significantly in the previous policy framework.

- In Chester there was an objective of creating a healthy environment for residents also described as “a greener more attractive place to work, live etc”. In site-specific terms, the Countess of Chester ‘health park’ was a significant land use.

- Ellesmere Port and Neston local plan contains no specific references to health

- Vale Royal LP had a specific objective, ‘to promote development that improves health’. The role of walking in promoting healthier lifestyles was acknowledged and cycling was encouraged for the same reason.

The LPAs had a number of Supplementary Planning Documents but none that deal specifically with health as such. Chester had a Safe and Healthy Environment SPD, which dealt with community safety.

Summary-legacy planning policy
Whilst two of the plans made reference to health either directly or in the context of their respective Sustainable Community Strategies, health is addressed in an implicit or indirect way. There are no health-specific policies and no health-specific indicators or targets. There is one reference to the South Cheshire Health Authority in the Chester Plan.

While the predecessor plans did contain policies that could be said to be health-supportive (e.g. walking, cycling, green space etc), health per se was not defined in any operational way
that enabled it to be integrated into the plans. The lack of monitoring criteria – indicators and targets underlines this.

**CWAC – Towards the Local Plan**
The Core Strategy, now titled the Local Plan, has been through a number of consultative stages following the creation of the Council. The Local Plan and all supporting documents were submitted to the Secretary of State in December 2013, and the Secretary of State has appointed an Inspector to determine whether the plan is ‘sound’. This note looks at the later stages from the ‘preferred policy directions’ published in 2012.

**The evidence base**
The evidence base is what might be expected of a local plan. It contains no specific health evidence such as the ISNA but there are numerous references to health, which appear to reflect local health strategies. Health is also referred to for instance, in the open space audit as explained below:

**Open space audit**
The open space audit makes specific reference to the role of open space in health in general, citing the 2010 Health White paper, Healthy Lives Healthy People and drawing on CABE reports specifically in relation to deprived and ethnically diverse areas. It summarise CABE conclusions about the factors that encourage the use of open space. Specific reference is made to allotments and health. Stress is placed on the value of networks or interconnectivity of open space in facilitating walking and hence delivering health objectives. A brief appendix includes health and child development as some of the wider benefits of open space but this is simply a list and is not evidenced. The report does not attempt to provide a health baseline nor does it contain suggested health indicators. However it does refer to ‘pockets of deprivation’ in the borough in particular the Blacon and Overleigh Wards and states that access to open space is likely to be most important there. It points to a deficit in parks in Blacon and in open space generally in Frodsham, Helsby, Weaver and Abbey. These observations are followed by a comparative list of quality and quantity of open space in the borough. (81) which highlight Blacon and Eddisbury as being wards with particular needs. There is no evidence of an attempt to quantify these relationships and for instance to measure actual accessibility. However maps are missing from the on line version and they may contain such analysis.

**The Local Development Scheme (LDS)**
The recently published LDS makes reference to the revision of the SCS to incorporate the requirement to produce a health and well being strategy (see below). There is reference to a joint consultation on the local plan, the transport plan and the sustainable community strategy in 2009 in recognition of the links between them.

**Annual Monitoring Report**
The latest AMR 2012 contains a generic list of indicators including business, housing environmental quality transport minerals and waste. These do not contain specific health indicators. However there is also a list of ‘significant effect indicators drawn from the SA scoping report. These include the number of people in the most deprived areas in the
borough, the number in fuel poverty, and air quality together with others such as housing which can be said to be indirectly related to health.

There is as yet no attempt to quantify progress or baseline against these health indicators. Some work has been done as might have been expected in the SA but this is incomplete and is dealt with below.

**Sustainability Appraisal (SA)**

There have been a number of iterations of the Sustainability Appraisal (SA) as the local plan has progressed. The latest is the SA scoping 2012 up-date. Population and human health is dealt with in Chapter 10. This states that the assessment will contain a health impact assessment (as well as an equalities impact assessment) although the nature of this is not specified.

The SA deals with a number of health-related issues. Air quality is stated to have significant implications for health including respiratory and cardiovascular conditions and particularly for vulnerable people such as the elderly and children and those with asthma, and it states that it is often the case that those living in deprived areas suffer the worst air pollution although this is not evidenced.

The SA contains a long and possibly comprehensive list of policy context. This may be seen as necessary for completeness but if they are used as part of the SA process the multitude of criteria and standards continued in these reports policies and strategies are not made explicit.

The SA points out that deprivation can lead to social problems and exclusion including health. It points to secondary indicates of deprivation such as smoking, binge drinking and obesity although this relationship is not evidenced.

It points out that CWAC has some of the worst areas of deprivation in the country. 30 of the area’s LSOAs are in the worst 20% nationally (2010), Lache Park in Overleigh being the lowest ranked in the borough.

The SA observes that health and wellbeing can be improved by access to green space either for recreation or physical activity although it reflects that it is difficult to quantify this relationship.

The baseline and trend tables in the SA contain some specific and indirect health data. However this is sometimes quite dated; ‘those with a limiting illness’ is drawn from the 1991 census. While it is not directly evidenced that data has been drawn from the published public health reports or health profiles for the borough, the 2012 report does state that the baseline has drawn on the JSNA.

Reference is made to the implications of an ageing population but it is based on generic assumptions.

Fuel poverty is identified as a significant variable but there is no data on the baseline and the national target of eliminating it by 2016 is replicated.

The objectives against which the local plan policies are evaluated are set out on p 69 et seq. The specific health objective is expressed as:

“Improve health and social inclusion whilst reducing inequality and valuing diversity and equality”. It can be observed that this, whilst laudable in sentiment (albeit being somewhat circular in argument) is very high level. There are a number of questions by which the policies are interrogated in order to judge their effectiveness against this objective

- Will it improve the health or access to health facilities particularly in those areas identified as in need?
• Will it reduce the poverty gap?
• Will it improve social inclusion and access to services?
• Will it result in a reduction in the number of LSOAs in urban and rural areas in the bottom 20%?

The indicators include:
• Households in fuel poverty
• The IMD for CWAC and the numbers of LSOAs in the bottom 20%
• Reduction in KSI (community safety)

There are 19 SA objectives including in addition to health, climate change, ecology, flooding risk, air quality, environment and landscape, housing, crime and safety employment land, sustainable growth, urban and rural regeneration and town centre vitality and viability and shops and services. As above these do have indirect implications for health. It is not clear to what extent health implications have been identified in a cross-cutting sense. This may be the intention of the HIA.

**Observations on the Sustainability Appraisal**

The application of the above framework to the ‘preferred policy directions’ of 2012 suggests that the impact on health objectives (as set out above) will be, ‘positive or very positive’. The narrative on each policy in relation to the health objectives also reflects this positive overall assessment. However the assessment in each case is not supported by explicit evidence or data but takes the form of an assertion. For instance PD16 health and well being is judged perhaps unsurprisingly as having a positive effect “ as it contains a range of measures to support the health and wellbeing of residents (including) the provision of new health facilities in areas of recognised need, supports opportunities for culture sport and recreation creating safe and accessible environments and considers the requirements of different groups of the community and aims to reduce poverty and deprivation and promotes access to greenspace”

The potential effect of these policy ingredients may well be positive but it is hard to judge from the text whether and what criteria have been used to test either the direct or indirect health effects or the distributional effects of the policy or its chances of success or how that success might be judged.

A basic weakness of the generic SA approach is that it is to a significant extent self-referential. In other words the mere inclusion of a health objective in the policy is seen to meet the previously defined health objective of the SA. At one level this is self-evident but cannot be taken as an objective and robust assessment of the likely effects of any given policy. This would require some assessment of the baseline, an understanding of the linkages or pathways between the policy and the health condition and some way of measuring an anticipated health outcome. As stated above it may be that the proposed HIA will undertake such an objective and rigorous assessment. As such the SA can be taken as some indication that the policies will be broadly benign in respect of health but no more than that.

The SA does in the mitigation and enhancement section (14.33) and the following conclusions recognise some of these potential weaknesses, and for instance identifies some ways in which PD 16 could be strengthened. It points out that the ‘areas of need’ have not been identified and could be more locally specific and address in particular ’protecting the
labour market in the post recession period’. It points out that whilst fuel poverty is identified as an issue none of the policies address it specifically. The SA also identifies the fact that the cross over between policies could be better addressed and points as an example to health and wellbeing and sustainable development.

The Local Transport Plan (LTP)

The LTP forms a crucial part of the spatial planning framework. Several references are made to the integration of the local plan, the corporate strategies and the LTP.

Health figures prominently in the LTP. The main dimensions are road safety, access to services including healthcare, improved air quality and active transport, which is acknowledged to encourage more physical activity and hence healthier lifestyles and better health. “There is a clear recognition that the steady decline in physical activity especially the falls in the levels of walking and cycling is having a negative effect on our health”. 7.2.1. These assertions not supported by specific evidence or reference to published studies.

A number of policy proposals or interventions are listed to support the above assessment. These include safer routes to schools travel plans, Cycle Demonstration Town and promoting cycling on the PROW and green infrastructure. Reference is made to the need to sustain working with the health sector, which is said to be a feature of the LSP.

Public consultation clearly supported the above approach. Reference was also made to the difficulty of accessing ‘centralised’ healthcare facilities and the mobility needs of an ageing population. It is not specific about which particular healthcare facilities but may be reflecting a generic problem of a dispersed rural population. A strategic assessment of accessibility has been completed that highlighted the priority that should be given to accessing employment and training opportunities and also access to health services. The steps proposed include ensuring developments are in accessible locations and improving local bus services and physical accessibility including removing barriers.

Transport is also seen as having a role in improving the quality of life through improving access to leisure by which is meant green and open space and the countryside. Examples include improving town centre school and health centre access in deprived areas such as Ellesmere Port and linking this with the promotion of active lifestyles.

Noise is identified as having a significant impact on the quality of life and there are proposal to target particular hot spots in the highway network and to assess residential applications in regeneration areas and close to roads for noise levels.

Health Assessment of the LTP

One of the background documents for the LTP 3 is a policy and plans review and then an HIA. The policies review identified the following health policy indications:

- Increasing exercise
- Do more on tackling inequalities
- Improve access to community services
- Provide more support to those with long-term needs
Promoting walking and cycling  
Modal switch from the car will have positive impacts on health  
Open space and greening transport corridors will enhance human health community cohesion and wellbeing.  
Noise is an important issue that affects human health

The report notes that the proportion of commuters walking and cycling is relatively low at 15% - although this rises to 20% in Chester and falls to 8 % in the rural west.

The SEA adopted zones of influence and identified one for health in relation to obesity and heart disease by promoting active travel (21).

The scoring of the LTP used ‘headline’ objectives. Health was expressed as encourage healthier lifestyles. Encouraging walking and cycling was scored as positive but the package was scored as negative in relation to a lack of improved access to services specifically health and the encouragement of the use of private cars.

The HIA described as a health impact study comprised a high level health check, as it was not considered appropriate that that stage to conduct a full HIA. This was because of the high level nature of the LTP. Reference was also made to the need to subject the local plan and LTP to a common framework and a compatibility assessment with the PCT health strategy is mentioned. The impact study utilised a revised version of the HUDU core strategy health check. 

The finding of this suggested that the plan scores
- Policy 70%
- Evidence 77%
- Policy framework 77%
- Implementation – could not be scored until implementation plan is available

The study suggested a list of possible indicators including road safety, noise active lifestyle and air quality but did not attempt at the time to quantify these.

The review of the Healthcare Strategy 2010-16 suggested a number of health strategy actions that were directly relevant to the LTP such as reducing overweight and obesity figure. It also identified issues in the LTP that were not reflected in the healthcare strategy specifically road safety and access to healthcare facilities and improved air quality and improved community safety. It then identified a number of synergies with the SCS. It finally carried out a compatibility review with the then emerging core strategy.

The Study concludes by making some recommendations on taking the health aspects further:
- More details of expenditure plans monitoring and evaluation
- Consideration of plan options
- Details of SMART health related monitoring
- Joint working with the spatial team
- Reconstruct the relationship with the health bodies
THE DRAFT LOCAL PLAN August 2013
The draft local plan follows on from the preferred policy directions of 2012. A comparison of the two from a health-related policy perspective suggests that there have not been significant changes. The Plan was submitted to the Secretary of State in December 2013

Corporate context
The refreshed Sustainable Community Strategy, Altogether Better, is cited as part of the corporate context. The Health and Wellbeing Strategy also called an interim partnership plan was refreshed from the sustainable community strategy in 2012 and developed alongside the local plan and LTP. Altogether Better is predicated on a holistic view of health and well being:-

“Our wellbeing is affected by a wide range of influences outside of what happens in our health and social care services. The social, economic and environmental fabric of our community helps to determine our sense of wellbeing”

The HWB adopted as its vision:
“To enable everyone to lead a healthy life and increase the sense of wellbeing within our community”.

The strategy draws on the key policy objectives set out in the Marmot review including support all to have a healthy standard of living and strengthen ill health provision and create sustainable places and communities.

It states that poverty and low living standards are powerful determinants of ill health and health inequalities and points to the widening health gap in the borough, as life expectancy is not growing as quickly in deprived areas as elsewhere. It identifies coronary heart disease as the main cause of the gap and puts that down to differences in lifestyle.

The aim of creating sustainable places and communities is expressed as encouraging communities to take action collectively and enabling them to meet most of their needs locally. It involves improving health through increased walking and cycling, improved air quality and an accessible resilient built environment using fewer resources. Housing quality and affordability and the need to develop new models to enable elderly people to stay independent in their homes are seen particular challenges. Low carbon transport, energy efficiency, enhanced access to green space; reduced KSI and increased affordable housing are identified as key challenges.

The report identifies a number of pathways, linking ‘root causes’ to symptoms and lists some community assets. In the model illustrated jobs, access and connectivity, quality places in which to socialise and a supply of suitable homes are seen as key wider determinants.

The Altogether Better programme forms a pilot in the Governments whole place community budgets. The aim of that initiative is to explore the potential for cost saving through changes in service delivery and thorough ways of joint working in health and social care and other areas.
The Local Plan Vision
The Vision for the plan includes “opportunities for healthier lifestyles will be delivered through the provision of sport recreation and social facilities”.

Strategic Objectives
There are 3 strategic objectives with particular reference to health:

SO8
Create stronger, safer and healthier communities by enabling access to leisure, recreational and community facilities and promoting walking and cycling

SO11
Ensure new development does not create an unacceptable impact either individually or cumulatively on the amenity and health of residents

SO13
Manage expand and improve green infrastructure and waterways network recognizing their importance in delivering local environmental social, economic and health benefits.

Strategic Policies
What follows are those policies that make explicit reference to health.

Strategic policy 1 is entitled sustainable development and is presumably meant to express and apply the principles, the golden thread, contained in the NPPF.
It contains generalized high level statements encompassing the main dimensions of sustainable development as ‘defined’ by the NPPF and which include “ ...promoting healthy inclusive communities”.

Strategic policy 10 Transport and accessibility, states that development and infrastructure should, contribute to safer and secure transport in and promote forms of transport that are beneficial to health”
The policy explanation states that reducing distances and promoting cycling and walking will ‘promote healthy communities’.

Chapter 7 deals with social issues and states that, “Ensuring the long-term health social and well-being of our communities is an essential role of the planning system Reducing health inequalities is one of the key priorities of the SCS. The local plan seeks to enable the delivery of improved healthcare and leisure opportunities and facilities across the borough.”

Strategic policy SOC 5
The overall approach to health and well being is set out in SOC 5 which expresses support for proposals that:

- Provide new or improved healthcare facilities especially in areas of recognised need.
- Support improved links to healthcare in rural areas..
- Promote safe and accessible environments with good access by walking cycling and public transport.
Support opportunities to widen and strengthen cultural sport recreational and leisure offer.
Consider the specific requirements of different groups.
Work to reduce poverty and deprivation particularly in areas of recognised need.

It states that development that gives raise to significant adverse impact on health and quality of life will not be allowed.

In explanation the plan states that health and wellbeing is a prime concern of the Council and that promoting health and wellbeing is a key thread in the plan. It repeats the SCS which states that ‘ our wellbeing is affected by the nature of our physical environment; living in poor housing in a neighbourhood with a lack of access to green spaces impacts negatively on our physical and mental wellbeing. Poor housing conditions including homelessness and overcrowding are a risk to a range of health conditions such as accidents and poor mental health. Living in cold conditions and fuel poverty can contribute to excess winter mortality amongst older people’.

It states that health and well being is closely linked to deprivation with areas of significant deprivation having residents with poorer health and health and wellbeing. The Council will work to improve education and employment across these areas and across the borough and will help deliver physical improvements to the neighbourhoods themselves. Rural areas in particular are identified as needing improved access to services and facilities. Fuel poverty is recognised as a wide problem but particularly in rural areas and increased energy efficiency will be supported. The JSNA is cited as identifying several issues:

The lower life expectancy for women
• The slower rate of improvement of life expectancy in deprived areas
• 16% of children in poverty
• 35000 households in fuel poverty
• Significant expected increases in those aged 64 and older.

The strategic review of leisure facilities found that they are generally of poor quality. The open space audit, the green infrastructure Framework and the playing pitches strategy set standards and seek to improve access.

The plan also identifies the role of green infrastructure in providing ‘vital socio-economic and cultural benefits that underpin individual and community health and wellbeing (and). address health inequalities and create a high quality of life’ and notes the synergies with other plan policies.

There are several other policies that have already been referenced elsewhere in this note that have health implications. SOC 6 open space is one example where the link between open space health and deprivation has been made elsewhere. However, neither the policy itself nor the explanation however makes this link explicitly.

**Monitoring and indicators for health**

The monitoring of health policy SOC5 has two components:

1. The delivery of new or improved health facilities
Indicator –

- The provision of new health facilities

2 The reduction in poverty and deprivation.

Indicators- 

- The number of deprived areas in the worst 5% nationally
- The number of people in fuel poverty
- Total amount of open space per 1000
- Number of sites awarded Green Flag Status

‘Health facilities’ are not defined in the text. It should also be noted that number of indicators are used to monitor multiple different policies for instance: The amount of green space /1000.

It is immediately obvious that this set of indicators does not measure health outcomes directly. It is also valid to question the precision of the indicators. As has been explained mere provision of open space is not a sound indicator of its health impacts and at the LA level is even less so. Fuel poverty can be said to be a proxy for a health outcome, namely excess winter deaths. The use of areas (presumably this means wards) in the worst 5% nationally would, if changes could be effectively tracked, give and indication of the incidence of ‘poverty and deprivation’ but this would still leave several wards in the worst 10%.

The local plan and health: some issues

A starting point for addressing health through the local plan is the NPPF and the Planning Practice Guidance. Although the scope of the Local Plan goes a considerable way to meeting the guidance on health in the NPPF the supporting text does not fully replicate the health imperatives that it contains. Specific weaknesses are the failure already referred to identify the areas of need and to integrate the health strategy. The following suggestions will go some way to addressing these issues.

As has been observed the local plan contains a number of health-related policies, that is, policies that can be assumed to have health implications. The whole range of policies is appraised in the SA published in 2012.

SO1 seeking to give effect to the presumption in favour of sustainable development in the NPPF provides an overall health aim of “promoting healthy inclusive communities”.

SOC 5 Can be interpreted as an integrated health policy that provides the framework for delivering this aim and the plans health objectives. It is phrased as a ‘supportive’ policy; that is, worded in such a way to be interpreted on the whole as positive

It deals with

- Health facilities
- Links to healthcare
- Walking and cycling (as a means of promoting physical activity)
• Sporting and recreational opportunities (again to support increased physical activity but also mental wellbeing)
• Poverty and deprivation.

The policy ends with a negative statement to the effect that developments with a significant adverse effect on health will not be allowed.

The generic nature of the policy – its ‘strategic’ wording may be viewed as both strength and a weakness. The strength is that it is open to wide interpretation some of the potential weaknesses are dealt with below.

SP 10 is about transport and accessibility but repeats the health objectives as contained in SOC 5.

Other policies support elements of SOC 5 such as SOC 6 open space, ENV 3 green infrastructure and STRAT 11, infrastructure.

The unique elements of SOC 5 which are not contained in other policies are thus:
Its reference to poverty and deprivation and the prohibition of developments judged to have significant adverse health impacts. The policy may thus be judged to be repetitive. This illustrates one aspect of the difficulty in framing robust ‘cross cutting’ policies and goes some way to explaining the general tendency for topic based policies in local plans.

The second related question is to what extent SOC 5 can be implemented within its own terms. The supportive phrasing, which is generally encouraged and expected by the NPPF, does not make clear whether developments that do not meet the generalized aims of the policy will be supported. A case in point would be a proposal that removed health facilities through for instance the closure of secondary care facilities or some other reconfiguration. Secondly the criterion of alleviating poverty and deprivation is highly unspecific. It is difficult on the face of it see how such a policy can be unambiguously interpreted.

It is also worth considering what the policy leaves out. There is no mention of housing, its quantity, location or quality.

Some of these issues arise from the strategic nature of the policy. The local plan will eventually comprise two parts and it will be important to ensure that any understandable and to an extent necessary ambiguities in part 1 are resolved in part 2. It might be suggested that part 2 sets the standards that enable part I polices to be applied clearly, predictably and consistently.

Other issues that arise from the treatment of health in the process as a whole are explored below.

Summary: health in the local plan process – strengths and weaknesses
Health outcomes can be seen as a consistent ingredient of the spatial planning framework. Both the emerging local plan and the LTP contain specific policies to promote health. The LTP lists specific actions or interventions that are aimed primarily at facilitating the improvement of health either by encouraging physical activity or through reducing the burden of air pollution, noise and road accidents.

However the policy documents and their supporting documents lack a coherent, strong and local evidence base. The health baseline is nowhere fully described or up to data, there are
no precise health indicators and targets are generic and quite often out of date such as some baselines in the SA. Given this it will be difficult therefore to judge what the effect of the policies actually is, that is, what contribution they can be making to health improvement.

The SA points out that one of the weaknesses of the local plan is that the ‘areas of need’ that are at the heart of the health policy (SO 5) are not defined. Thus it is not clear what the spatial dimensions of the policy are meant to be or how the distributional effects may emerge. This may be an issue of the balance between strategic and what might be called tactical policies which are due to be developed in part 2 of the local plan. It may point to a fundamental weakness in the current national planning system, which encourages a generic policy approach.

Whilst there are a number of ‘cross-cutting’ references the degree of integration of strategy and policy strands is relatively weak. In part this stems from the lack of a common evidence base as referred to above. There is evidence but generally speaking this is generic. It is probably also the case that the changes in the planning and transport but particularly the health sector have militated against more integrated working in the recent past despite references to the joint working within the LSP. It is also accepted that some aspects of joint working are often more apparent at the operational level than at the strategic level.

There is a lack of evidence of intelligent mapping of the data and of spatial analysis undertaken within a common spatial framework. There is extensive evidence in the Annual Public Health Reports of the distribution of health conditions and the highways section has carried out accessibility analysis but it is not clear that there has been integrated working within this spatial framework. This might provide some insights that would for instance inform transport interventions and assist in defining the ‘areas of need’ referred to the local plan policy SOC 5.

The policy framework lacks a coherent theory or set of organising principles. It is based rather on generic understanding or assumptions about health and its determinants. The social determinants of health model which underpinned the Marmot Review of Health Inequalities and is now at the heart of Government’s Public Health Strategy states that health status is determined by a person’s social, economic and environmental circumstances as well as their personal characteristics. There is no doubt that the concept of health reflected in the combined strategies goes beyond the strictly bio-medical and beyond mere reference to ‘healthcare’ which is quite typical of planning strategies in the recent past. As reflected in the strategies the concept of health is thus made up primarily of:

- Health protection- road safety, noise and air quality
- Promoting healthier lifestyles including access to green space
- Improving access to health services.

There is recognition of the pattern of deprivation and of the need to reduce levels of deprivation but no clear explanation of the links between deprivation and health. There is no clear expression of what the pathways are between the determinants in Cheshire West and Chester and the pattern of health status, the prevalence of certain health conditions that lead to premature mortality or poor health outcomes/morbidity and the inequality that results. There is thus a weak explanation of how specified interventions might be expected
to impact on health. This is exacerbated by the necessarily strategic nature of the policies. Whilst acknowledging the brief and incomplete Health Impact Study in the LTP process, the only means of assessment appears to be the sustainability appraisal. But as explained elsewhere this does not and in its current format cannot provide an objective assessment of the likely health effects. It lacks both the evidence and the critical framework.

**Health Impact Assessment; some observations**

As mentioned above reference is made in the SA of the intention to carry out an HIA. (In addition a ‘health impact study’ was carried out on the LTP).

The techniques of Health Impact Assessment can provide one route to achieving some of the above suggestions aimed at strengthening the policy framework. HIA seeks to anticipate the impacts of strategies or interventions and to identify how strategies and polices can be improved to maximise their positive health benefits and minimise their negative impacts. HIA can be more or less holistic and more or less quantitative depending on the issue, circumstances and resources available. HIA is not a substitute for sound and effective policymaking but is best seen as a tool for tracking the consequences intended and unintended of any policy or intervention.

It can be argued that HIA in policy appraisal is quite different to its use in project appraisal. Projects that come forward for a very wide range of purposes may well have implications for health, which the designers and promoters have not even contemplated. HIA can thus be powerful in tracing such impacts and enabling them to be addressed.

Where policies are devised that seek to promote or optimise health the role of HIA is more problematic or ambiguous. It is self-evident that such as policy should be devised in relation to the evidence and a clear concept of what it is seeking to achieve. That being the case it can be argued that applying HIA as a distinct process is somewhat superfluous. It also raises questions of timing and applying HIA retrospectively to such a policy seems on the face of it to beg the question of what the policy was about in the first place. In other words HIA might best be seen as a step towards policy design rather than a post-hoc process.

HIA has significant resource implications, requires significant amounts of data and may impact on crucial timescales in policy or project development. The decision not to proceed with an HIA on the LTP appears to have been taken on these grounds. The responsibility for carrying out HIA and for assessing its findings must be clearly identified. These considerations must be fully addressed before HIA is adopted as routine otherwise the risk of delay and confusion is high.

Assessment of the impact on human health is also a mandatory component part of both SEA and EIA as described in the relevant Directives. However, and paradoxically, health impact assessment is not prescribed as part of SA although it is typically included. It can thus be argued that SEA and EIA when carried out objectively and thoroughly can deliver some if not all of the outputs of a specific HIA. Whether this is the case will depend on the specific circumstances.
The CWAC Draft Local Plan Part 1

It is acknowledged that the strategic policies of the Local Plan, Part 1 are at a very advanced stage. The analysis so far does not suggest that there are fundamental weaknesses in the health aspects of the plan that would demand radical revision. Some of the above suggestions could, it is suggested, be incorporated into the Local Plan as it moves towards Adoption and others, such as the identification of key evidence and the associated actionable insights, be developed over time.

Future planning policy

Part 2 of the Plan will contain additional site allocations and the development management policies. The above strategic policy changes will enable these policies to integrate health related outcomes more fully than otherwise would have been the case. The tools and techniques described elsewhere should be used in order to achieve this outcome.

Even with strengthened strategic and focussed development management policies there is a strong case for developing supplementary planning guidance in order to give effect to the strategic aims and to Council priorities in health. Suggestions are made elsewhere as to what tools and guidance will be necessary if this step is seen as appropriate.
Health issues in planning applications 2012-13

Introduction
The purpose of the health and planning project is to review the way CWAC council addresses health issues in the pursuit of its planning responsibilities. This section deals with aspects of the way in which health issues have been taken into account or reflected in the development management process in 2012-13.

Method
A number of major residential planning applications dealt with in the last twelve months, 2012-13, have been reviewed in order to gain some insight into what extent and the ways in which health considerations have been identified and dealt with in the CWAC development management process. The information has been gained from the database of planning applications and has relied heavily on the relevant officers reports published on the website. Needless to say, in view of this it constitutes only one albeit the most public aspect and cannot throw light for instance, on any informal discussions.

The applications
These are listed in the table page 27-29 below.

Analysis and commentary
As might be expected the above applications which amount to a significant quantum of development (almost 4000 units) exhibit a wide range of contexts and considerations and the point of this review is not in any way to ‘judge’ the individual decisions. The aim is to ascertain how health considerations have been approached.

All of the applications were considered within the policy context at the time. This includes the NPPF, which was published in March 2012 except for those outline applications decided some time ago such as Winnington. The local policy context comprised the constituent local plans and up to a certain point, the RSS. The very limited scope of health policy in these existing local plans is explored in the accompanying baseline report. Needless to say this paucity of health specific policy goes some way to explaining the fact that health issues are rarely explicit in the consideration of applications as expressed in officer reports. Reference is made in some applications to the emerging local plan in the shape of the Preferred Policy Directions, published in June 2012, but explicitly little weight was given to that document.

The NPPF was a consistent contextual reference although nowhere was the full scope of the health imperatives in the NPPF fully reflected (see 4a for a full text). In most cases health was considered in the context of distinct policy topics. Air quality and noise for instance were consistently expressed as having health connotations. Links were regularly made between health and open space either for play or sports, usually by quoting the NPPF as above, but the discussion was overwhelmingly conducted in terms and within the parameters of the play and open space polices, that is, quantity and quality. Health per se and the differential impacts on the host community are not discussed. Nevertheless, open space provision was a very significant not to say determining factor in a number of applications.
Education provision was regularly discussed in some depth and a number of the accompanying s 106 agreements secured educational contributions. There was no evidence that other community infrastructure was considered to a significant extent. Health facilities are identified as an issue in a few cases, in most cases by the local parish council or residents, but the issue was never resolved. In the case of the largest applications, Winnington and Chapel Street Wincham health facilities were not considered. One report contained a specific comment to the effect that current policy prevents requests for health infrastructure. This is not in fact the case. The NPPF could be used to justify such developer obligations for instance.

Transport
The health implications of transport were not referred to explicitly. In general transport consideration rarely played a significant part in the analysis of the issues. In a few cases the issues of sustainable transport and the need to encourage safe environments, walking and cycling was referred to.

Overview
The reports on the above applications were almost without exception extensive, systematic and thorough. The main policy considerations that come through the discussions are the housing supply imperative on the one hand and the housing growth objectives of the Council although the latter was less prominent overall.

Open space provision was as suggested above a significant factor in a number of the applications and received detailed and thorough consideration involving the Play team.

However, health was at best an implicit consideration. In the case of air quality and noise health is recognised as a justification and is pursued again indirectly through the medium of standards.

Conclusion
As the policies do not reflect a holistic and integrated concept of health the result is that the application process cannot be said to deal systematically with health considerations. There is no discussion of the health context in any of the locations so that any consideration of the impact on health is necessarily generic. There is no evidence of any input on health conditions from what would at that time and prior to April 2013 have been the Primary Care Trust or indeed from the environmental health division. To a large extent this also extends to the consideration of the adequacy and possible provision of health infrastructure as referred to above.

The result of this approach is that health is addressed only in an indirect way – the possible outcome of policies directed at land use issues for instance open space and green infrastructure.

Whether the outcome would have been materially different had explicit health evaluative criteria been applied whether through the HIA process or some other mechanism, is of course an open question. However what is clear is that the appraisal process taken as a
whole cannot be relied upon to arrive a definitive or even tentative conclusion as to the health effects individually, or even less so cumulatively, of the applications that were considered.
### Annotated list of selected major applications received by CWAC 2012-13

<table>
<thead>
<tr>
<th>Number</th>
<th>Location</th>
<th>Description</th>
<th>Units</th>
<th>Decision</th>
<th>References to health noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/02247/out</td>
<td>Saighton camp, Huntington Chester</td>
<td>Redevelopment</td>
<td>295</td>
<td>Approval</td>
<td>Passing reference to health and safety</td>
</tr>
<tr>
<td>13/01638/ful</td>
<td>Ellesmere Port</td>
<td>Recycling and anaerobic digestion</td>
<td>n/a</td>
<td>Approval</td>
<td>HSE input</td>
</tr>
<tr>
<td>11/01968/OUT</td>
<td>Wincham, Northwich</td>
<td>Residential and commercial</td>
<td>950</td>
<td>Approval</td>
<td>No health reference. Reference to sustainability benefits. Issue of relocation of scrap yard and noise. Acceptance that deficit in pitches can be made up off site within 20mins drive time. S106 education highways and env improvements</td>
</tr>
<tr>
<td>13/02118/ful</td>
<td>Tarporley</td>
<td>Residential</td>
<td>100</td>
<td>Approve</td>
<td>Generic quotes re health from NPPF. Reference made in objection to inadequacy of local health provision. Affordable housing segregated. No open space in west of site. S 106 education</td>
</tr>
<tr>
<td>13/02449/OUT</td>
<td>Rudheath, Northwich</td>
<td>Residential</td>
<td>74</td>
<td>Approve</td>
<td>Generic quotes from NPPF re health- 5-year supply and ‘sustainability’ considerations uppermost.</td>
</tr>
<tr>
<td>13/01213/OUT</td>
<td>Malpas</td>
<td>Residential</td>
<td>140</td>
<td>Approve</td>
<td>Generic quotes from NPPF re health. Concern expressed at adequacy of local health provision. Evidence from GPs as to surgery at capacity. States that there is no justification for requiring a financial contribution”.</td>
</tr>
<tr>
<td>12/04804/OUT</td>
<td>Winsford</td>
<td>Redevelopment</td>
<td>161</td>
<td></td>
<td>No health reference or response.</td>
</tr>
<tr>
<td>13/01365/EXT</td>
<td>Ellesmere Port</td>
<td>Renewal residential</td>
<td>500</td>
<td></td>
<td>S 106 education and highways.</td>
</tr>
<tr>
<td>13/00283/OUT</td>
<td>Fardon, Chester</td>
<td>Residential</td>
<td>105</td>
<td></td>
<td>S 106 education and highways.</td>
</tr>
<tr>
<td>12/02091/OUT</td>
<td>Little Sutton, Ellesmere Port</td>
<td>Residential</td>
<td>2000</td>
<td>Approve</td>
<td>Correspondence re inadequacy of GP surgeries from CCG. No confirmation of health requirement at time of report publication.</td>
</tr>
<tr>
<td>12/01837/REM</td>
<td>Northwich</td>
<td>Urban village</td>
<td>1200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference</td>
<td>Location</td>
<td>Type</td>
<td>Size</td>
<td>Decision</td>
<td>Notes</td>
</tr>
<tr>
<td>-----------</td>
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<td>------</td>
<td>----------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>12/01754/OUT</td>
<td>Saighton Camp Huntington</td>
<td>Residential</td>
<td>295**</td>
<td>No health input.</td>
<td></td>
</tr>
<tr>
<td>11/05737/8/REM (08/02000/OUT)</td>
<td>Saighton Camp Huntington</td>
<td>Residential RM</td>
<td>349</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/01837/rem 06-0740-oum</td>
<td>Winnington</td>
<td>Urban village</td>
<td>1200</td>
<td>Reference to possible GP surgery. No contact with PCT.</td>
<td></td>
</tr>
<tr>
<td>10/02062/OUT</td>
<td>Rossmore Rd Ellesmere Port</td>
<td>Residential</td>
<td>300</td>
<td>Refusal</td>
<td>Reference to health related policies in the Preferred Directions (PD16) Reference to lack of adopted LP policies in relation to social infrastructure. No input from PCT. Noise an issue – reference to PD 16 and NPPF. Subsequent appeal did not raise health issues.</td>
</tr>
<tr>
<td>12/05370/FUL</td>
<td>Cable drive Helsby</td>
<td>Residential with care home</td>
<td>146</td>
<td>No assessment of health impacts of the development or the “extra care” element.</td>
<td></td>
</tr>
<tr>
<td>12/04928/OUT</td>
<td>Lostock Gralam Northwich</td>
<td>Residential</td>
<td>146</td>
<td>Approved contrary</td>
<td>EHO objection due to noise.</td>
</tr>
<tr>
<td>12/05430/OUT</td>
<td>Tilston Road</td>
<td>Residential</td>
<td>60</td>
<td>No decision</td>
<td>No reference to health or health infrastructure. Reference to impact on education.</td>
</tr>
<tr>
<td>12/05668/OUT</td>
<td>Winsford</td>
<td>Residential</td>
<td>148</td>
<td>Approve</td>
<td>No reference to health; no health input. Relatively large addition to Moulton.</td>
</tr>
<tr>
<td>12/04120/REM</td>
<td>Tarporley Rd Tarvin</td>
<td>Residential</td>
<td>130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/00424/OUT 120</td>
<td>Sutton Way Ellesmere Port</td>
<td>Residential</td>
<td>120</td>
<td>Approve</td>
<td>Loss of designated open space seen as acceptable. Changes to layout to provide for safer cycling.</td>
</tr>
<tr>
<td>12/04925/FUL</td>
<td>Blacon, Chester</td>
<td>Redevelopmen nt</td>
<td>90 (63 net) inc new health centre</td>
<td>Approve</td>
<td>No input from PCT.</td>
</tr>
<tr>
<td>Reference</td>
<td>Location</td>
<td>Use</td>
<td>No.</td>
<td>Decision</td>
<td>Notes</td>
</tr>
<tr>
<td>-----------</td>
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<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>11/05098/OUT</td>
<td>Marston, Northwich</td>
<td>Park homes</td>
<td>59</td>
<td>Approve</td>
<td>No reference to impact on health infrastructure.</td>
</tr>
<tr>
<td>13/02129/REM</td>
<td>Chapel St Frodsham</td>
<td>Residential</td>
<td>60</td>
<td>Approve</td>
<td>No input from PCT. Reference to noise and contamination.</td>
</tr>
<tr>
<td>11/05439/OUT</td>
<td>Chester health Park</td>
<td>Residential and care</td>
<td>55 + care home</td>
<td>Refuse</td>
<td>Reference to contact with PCT. Open space provision seen to be inadequate.</td>
</tr>
<tr>
<td>12/04229/OUT</td>
<td>Clifton Drive Chester</td>
<td>Residential</td>
<td>142</td>
<td>Refuse</td>
<td>Input from Sport England reference pitches. Reference to open space assessment and its health objectives. to PD 1 open space and health, PD 16 and NPPF and open space and health. Refused on pitches loss.</td>
</tr>
<tr>
<td>13/00283/OUT</td>
<td>Churton Rd Fardon</td>
<td>Residential</td>
<td>105</td>
<td>Refuse contrary</td>
<td>Reference by PC to impact on local services. PCT consulting with GP. Reference to NPPF and healthy communities.</td>
</tr>
<tr>
<td>11/01968/OUT</td>
<td>S Chapel St, Wincham</td>
<td>Residential and commercial</td>
<td>1050</td>
<td>PCT input but no requirement made. Applicant states that there are 4 GPs within 2.5 miles and nearest is 0.8 miles. Reference to noise and hazardous impacts of nearby commercial activity. Reference to inadequacy of open space. Recommended with s 106 for education, highways and env improvements.</td>
<td></td>
</tr>
<tr>
<td>12/00982/REM</td>
<td>Lostock Gralam</td>
<td>Residential</td>
<td>119</td>
<td>REM</td>
<td></td>
</tr>
<tr>
<td>10/01794/OUT</td>
<td>Hooton Ellesmere Port</td>
<td>Redevelopment residential and care</td>
<td>265 + care home</td>
<td>Approve</td>
<td>Reference to impact on local services, contamination and Green Belt. Lack of medical services not seen as a problem</td>
</tr>
<tr>
<td>11/03802/OUT</td>
<td>Lostock Gralam</td>
<td>Residential RM</td>
<td>119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/04895/FUL</td>
<td>Chartenhall Dr Chester</td>
<td>Residential</td>
<td>200</td>
<td>Education s 106</td>
<td></td>
</tr>
</tbody>
</table>
Health policy background

Introduction
This section comprises a brief summary of the background to health policy, relevant to spatial planning, in CWAC as it has evolved since the establishment of the Shadow Health and Wellbeing Board (HWB) in early 2103. This is not say that this marked the beginning of health related policy as the Council had an Interim Joint DPH and worked closely with the PCT prior to this. It must also be stressed that the period since April 2013 when the formal assumption of public health responsibility took place the work of the department and of the HWB has been necessarily concerned with the establishment of the department and of priority tasks such as commissioning of public health services and refreshing the Health and Wellbeing Strategy.

Planning related issues at the Health and Wellbeing Board
The HWB has received a number of reports that reflect spatial planning issues. These include, consultation on the Sustainability Strategy for the Health, public health and social care system, the impact of new housing development in rural areas on health services and the NICE public health guidance. CWAC policy was systematically reviewed for compliance with the NICE guidance on cycling and walking. This process involved a range of departments including planning and transport and its conclusion was overall positive. However the process was seen as cumbersome and time consuming and may not offer a practical basis for future joint working.

The HWB has very recently adopted terms of reference for the HWS and has initiated a refresh drawing on the DH guidance on Joint Strategic Needs Assessments and Health and Wellbeing Strategies published in 2012. The aims of the HWS are reported elsewhere in this report. These do not refer to planning specifically but to promoting the integration and partnership working with “other local services’.

The HWS framework does not specifically refer to spatial planning which reflects the statutory advice and current practice. HWS tend to focus understandably on commissioning and on health public health and social care. The degrees to which this approach adopted the social determinants of health model, “going beyond the minimum statutory duties” as a report to the HWB puts it, will determine to a large extent the extent to which other services and spatial planning in particular will be seen as offering a contribution to health outcomes that the HWB has adopted.

The exploration of these wider synergies may be pursued through the Health and Wellbeing networked, which meets in parallel with the Statutory Board. The Network has a wider membership, although this does not include any planning or transport interests.

Conclusion
The immediate conclusion from this brief and desk based review is that the HWB has not adopted a holistic view of the potential relationship between planning and health and wellbeing. This may be because of a combination of the urgent primary tasks facing the Board and the continued narrow interpretation of the role of the HWB in statutory guidance and current practice. Our recommendations will hopefully facilitate the HWB’s aims of
integration and collaborative working and offer a route to overcoming this limited perspective and of achieving the potential co-benefits.
Interviews with CWAC staff

Introduction
On 2nd and 3rd October 2013 interviews were carried out with a number of staff in public health, planning (policy and development management), transport and in some corporate areas, as well as with some key local authority members. We spoke with a relatively small number of staff, and we cannot be sure that they are completely representative of the views of whole of the relevant departments, but they did give us very valuable insight, both into the current situation, and into how things could be developed in the future.

Quotes

“The challenge is to link areas of opportunity to areas of need”

“Health needs to be core business”

“We need to change hearts and minds”

“I was not aware that public health had moved into the council”

“What is needed most? ‘Support From The Top’”

The interviews.
The interviews focused around understanding the organisation and processes currently in place; health and planning and how they currently interact; the priority currently given to health; and barriers and opportunities for change. A summary of the main responses is given below:

Overview of CWAC
The Council staff we met were very positive about the work of CWAC, its aspirations and its approach. CWAC was seen as a dynamic and innovative organisation, if at times a confusing one! The council’s structure and approach is developing rapidly, with the arrival of public health as a local authority responsibility being just one of the changes that are happening.

The authority itself is relatively new in its present form. It is in the early stages of developing a flexible locality based approach to addressing local needs. It is pioneering ‘Altogether Better’, one of four national whole place Community Budget pilot areas that are testing new, radical and local approaches to delivering public services. This programme aims to tackle the root causes of longstanding problems, promoting early intervention and deploying resources in the most effective way, working with a range of partners in the public, private, voluntary and community sectors. The Council is also establishing a Locality Commissioning approach, bringing together considerations of individual and family life-chances, place management and place and economic development at the local level.
Health and wellbeing issues facing CWAC

There is quite a widespread understanding of health issues and the determinants of health. Most commonly mentioned challenges were:

- Health inequalities, pockets of multiple deprivation and the difference between the affluent and the deprived areas.
- Ageing population
- Rural and remote areas
- Obesity, particularly child obesity
- Drugs & alcohol
- Road traffic accidents

Council priorities and policies

Corporate focus
There was general agreement that the councils overall objectives are:

- Economic Growth
- Housing growth
- More effective services through breaking down silos and creating more flexible and holistic approaches
  - thus reducing demand

The council is developing several new approaches to addressing the challenges that it faces, including commissioning via four localities. This is at a very early stage. It was unclear at this stage how these localities relate to for example the areas used by development management.

The ‘Altogether Better’ approach is tightly focused. This is clearly a strength, but it does mean that it does not align very well with planning, concentrating as it does on small areas with high need.

Health as a corporate priority
There was less consensus as to the extent to which public health is a council priority. If it is, it is implicit rather than explicit. It was noted the Director of Public Health is not a member of the Senior Management Team, which could indicate that Public Health is not considered a top priority, and could limit the influence that public health can have on the Council agenda.

The view was expressed that there was a better understanding of the priority of public health at senior level. There was not an understanding throughout the organisation that ‘health is everyone’s business’.

Several respondents considered that a key priority to move health up the agenda throughout the organisation was demonstrating unambiguous support from the top - member and senior management level.
It was noted that CCGs appear to have developed good corporate links with CWAC – which means that when people think of ‘Health’ they often think of CCGs first.

**Planning and transport planning practice**

It was not felt that the health effects of transport policies were traced and monitored. In the case of both transport and planning, health was seen as a by-product rather than a main driver.

Public health had not had a significant input into the Local Plan.

Development management is driven by national policies and requirements.

Planners and transport didn’t always know what public health could offer, (or where to get it.). They were also more generally unclear about the new health and NHS architecture, and who is responsible for what where.

It was unclear as to whether ‘Health’ issues, either relating to health services, or to wider determinants, were considered in Section 106 negotiations.

The idea of simple tools such as guidelines or checklists for use in development management was supported.

Overall it was felt that health in the wider sense is not fully integrated into planning and transport. ‘Health’ does not feature strongly as part of the planning decision making process.

(It was reported that Transport has little money to spend, and that the current emphasis is on basic maintenance).

**Impact of Public Health moving to local authority**

The move of public health into the local authority has widespread support. It is widely considered that the arrival of public health is starting to make an impact, and to raise the profile of the area.

The concept of a ring-fenced public health budget is arousing some ‘interest’ among other departments.

However planning and Transport were not clear who was responsible for their areas within public health, or who to contact in what circumstances.

**Relationships and Communications**

Public health is at the early stages of establishing itself within the local authority, and the authority as a whole is beginning to take on board its new public health responsibilities.

Links between public health, planning and transport are just beginning to develop, but as noted above a number of respondents still reported that they often did not know who to call for advice or professional input.

Even though the staff involved are aware of health and wellbeing issues, it is not normal for planners, particularly those in development management or transport, to get public health
advice, for example on proposed developments. It would be normal to get advice from Education, or the Green Space team or Environmental Health in appropriate circumstances.

A number of informants found the new health landscape baffling, were confused about the roles of various the bodies such as the Clinical Commissioning Groups, Public Health England, NHS England, NHS Property Services, as well as where Public Health in the local authority fits in. This means that planners and transport planners were unclear about where to look for advice on health or health provision, and had sometimes found health unresponsive in the past.

Public Health priorities
There was less clarity about public health priorities. There was an impression from some informants that ‘everything is a priority’, which did not give them enough of an action focus.

There was a widespread view that a brief statement of public health priorities and objectives in relation to the spatial environment (2 sides), widely promulgated and supported, would go a long way towards bringing the potential for health improvement into focus.
This would need to be corporately endorsed, and supported by a communication strategy.

It was noted that the format of the Annual Director of Public Health Report was changing, and that it could be part of an initiative to spread the public health message more widely.

The Health and Wellbeing Board and HWB Strategy
Some informants saw the Health and Wellbeing Board, and its Strategy as key to identifying and implementing public health policies. The current HWBS was seen as very high level, and not very action orientated. There were hopes that the ‘refresh’ of the strategy currently being carried out would provide a clearer steer, and help to integrate health more clearly into all of the council’s policies and actions.

It was noted that the ‘Altogether Better’ programme had a Strategic Board, and that maybe a Strategic Board for Health and Wellbeing and Health Inequalities could be considered.

Information and intelligence
It was considered that intelligence has not always driven action, and that evaluation of initiatives or policies was not always done.
There was widespread support for the current policy of linking public health analysis capacity with the Council’s existing intelligence unit. The two groups were felt to have complementary skills. Some informants thought that it was worth considering bringing together some of the other intelligence functions within the council, to support the holistic approach being driven by ‘Altogether Better’.

The new localities are waiting for information to help them shape their priorities and policies. Analysts are currently working on a ‘dashboard’ system, which will start to address these issues. However there are capacity issues to providing more comprehensive or accessible area analysis.
Joint / Integrated Strategic Needs Assessment

There was general agreement that the ISNA was a useful tool, but that it did not really describing ‘place’. It had very much a ‘health’ focus. Up to now it has only been used to a limited extent by planning or transport.

Some respondents felt that it was too big and unwieldy, which made it difficult to find what was useful or needed.

It needed to be supplemented by some much briefer headlines

There was a general feeling that the ISNA was at a transitional stage, and has the potential to be a very useful tool. It is being developed towards being an ‘Integrated Strategic Needs Assessment, which it will bring together information and intelligence covering the whole range of the council’s responsibilities.

It was considered that the ISNA Steering Group could be a key integration and communication mechanism if the right people are involved.

Tools and techniques

Within the developing local plan, the Sustainability Appraisal does consider health issues. The impact of planning and transport policies on health is not systematically assessed. Assessment techniques such as ‘Building for Life’ are not used to assess proposed developments. Health Impact Assessment is not normally used to assess policies.

It was suggested that a Health and Wellbeing impact statement could be appended to all Council reports, as is now the case for equalities assessment.

Barriers and improvements

Even though there is widespread support for the energy and innovation of the council’s approach, there is a feeling that there is some confusion about where responsibilities lie, and who to talk to on any given issue.

There may be some governance issues, for example between the Health and Wellbeing Board and the Altogether Better Board. It is not fully clear to all yet how the four new localities currently being established will link with planning, or how the Regeneration Boards fit in.

The Altogether Better programme, which is central to the Council’s approach, does not have strong links with planning, or with the current locality structures.

The incentive structures are not always lined up, for example a transport initiative might reduce health costs transport would not share the benefit.
There was little response to questions about examples of good practice or healthy planning, or what guidance would be useful.

*We would like to thank everyone who gave his or her time to talk to us.*
3. SYNOPTIC REVIEW AND ANALYSIS

Introduction

The following summary of the findings from the review of policy and practice in Cheshire West and Chester leads to a series of options that form the Strategic Introduction to this report and which represent our recommendations as to the steps the Council may wish to consider in enhancing its performance in improving health through spatial planning.

Review of policy background and the local plan (see sections 3a and b)

CWAC is currently going through the process of revising the planning policies of its former constituent authorities (Cheshire County, Chester, Ellesmere Port and Neston, and Vale Royal) and of producing its Local Plan as required by the National Planning Policy Framework (NPPF).

This review shows that the existing local plans (which are those of the 4 former authorities that combined to create CWAC) contain no health specific aims or policies although they contain some policies with potentially positive health implications. Collectively therefore they perform relatively weakly against the imperatives in the NPPF in respect of health.

The Draft Local Plan, (published in its final draft form in July 2013 and now the subject of the independent examination process in June 2014) in its vision and aims reflects the priority the Council is giving to health and wellbeing and to an extent the requirements of the NPPF. It includes a policy, SOC 5 that seeks to promote some aspects of health and to prevent development that is prejudicial to health and wellbeing. There is no question therefore that the Plan is setting out to promote health in the community and this is a definite strength. However, the health implications of the draft plan have not been fully appraised and the effectiveness of policy SOC5 can be questioned. Health does not run as strongly and consistently through the plan as it might and there are some important gaps. The monitoring framework and associated indicators are relatively weak in respect of health.

Suggestions are made as to how these gaps and relative weaknesses can be addressed. The resulting plan would meet soundness tests, facilitate more effective integration with health priorities, policies and programmes and provide a strong platform on which to develop effective development management policies. More relevant indicators will enable health related policies to be effectively monitored and refined.

Development management practice and major applications (see section 4c)

A review has been undertaken of a sample of major residential applications decided by CWAC in 2012-13. The analysis shows that health considerations have rarely emerged as critical in the consideration of the applications. This conclusion is equally relevant to both health conditions and to the provision of health facilities and services. In large part this is due to the lack of health focus in the existing local plan policies, which currently take precedence over the emerging policies in the draft CWAC Local Plan. There are no examples of the imperatives in the NPPF being used in the absence of local plan policies to justify
health-oriented decisions. However, it is also the case that issues with health implications such as pollution, contamination, noise and open space have been significant factors in some decisions. These decisions have drawn on the expertise of the HSE, the Environmental Health team and the open space team. On the other hand, until recently neither Public Health, nor NHS health bodies, and in particular the former Primary Care Trusts have, with very few exceptions, been closely engaged in addressing the implications of major residential proposals for health or for health services. One result has been a lack of developer’s financial contributions for enhancing health services to meet the needs of new populations.

Health policy in CWAC (see section 4c)
The annual reports of the Director of Public Health in the three years up to 2013 and the first iteration of the Joint Strategic Needs Assessment (JSNA but known in CW&C as the ISNA)\(^2\) provided a context for the emergence of the Local Plan. The Preferred Directions version of 2012 clearly reflected the health priorities and contained the first draft of SOC 5, which has carried forwards into the Draft Local Plan.

At the same time the Shadow Health and Wellbeing Board began operating and became a formal body in April 2013. As explained briefly elsewhere this process coincided with the Altogether Better project under the Government’s Community Budgets initiative. It is not the purpose of this report to analyse corporate processes as a whole but the point should be made that this period was one of significant change.

Health and Wellbeing Strategy
The first Health and Wellbeing Strategy was initiated by the Shadow Board, and a new draft Health and Wellbeing Strategy 2014 – 2019 is currently out for consultation. (May - July 2014).

The draft H&WS focuses on four priority areas, ‘Starting Well’, ‘Substance Misuse’, ‘Mental Health and Wellbeing’, and ‘Ageing Well’. The focus is on partnership working and on personal responsibility and empowerment. There is little discussion of the wider determinants of health, and no mention of planning and the spatial environment except in the context of substance misuse.

The initial focus of the HWB has been on child and adult services and on overseeing the commissioning of public health services. The composition of the Board necessarily reflects this orientation. There is weak evidence so far of the influence of the wider determinants of health model. Planning had figured on the agenda but only in respect of the potential impact of new housing on services in rural areas. There is no evidence that the Board has concerned itself with the Local Plan. However, the HWB is supported by a wider health Partnership and it has been suggested that it deals with topics such as housing, physical activity and access to health services. The Partnership has a diverse membership including for instance Groundwork (an environmental charity) and the Local Enterprise Partnership but does not include any planning or transport representatives.

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\(^2\) The JSNA is now known locally as the Integrated Strategic Needs Assessment (ISNA)
The terms of reference of the HWB reflect the above observations and state that the primary focus will be the improvement and coordination of commissioning related to the NHS, social care and related children’s and public health services. However this is to be pursued within a context of ‘a wider influence on policy decisions which impact on health’.

Aligning strategies
This report makes the case that spatial planning and transport, in the context of the social determinant of health, have a significant influence on health outcomes. Given the ‘influencing ‘model adopted by the HWB it will be important to take steps to maximise the common understanding between the Board and the planning function, both within and external to the Council, so that the strategies can be effectively aligned and the synergies that we have sought to highlight, and which are implicit and explicit in the Local Plan can be secured. Suggestions have been made in the course of the review that a ‘health appraisal’ be included in all committee reports as is the case in equality and diversity issues. Whilst this will have the effect of ‘flagging’ health issues it has also been argued that this approach tends to tick–box and fails to deal in depth with health (or indeed other) implications. The process also implies monitoring and review which may impose an unsustainable bureaucratic burden. However consideration could be given to this.

The report has suggested corporate measures to increase the awareness of role of health issues in spatial planning. These may be viewed as generic in nature. Hence capacity building within the HWB and joint development and collaboration between staff should be adopted as the HWB evolves and established itself. An immediate and straightforward example would be a presentation of the Local Plan to the HWB. This would draw member’s attention to the synergies and linkages and may also throw up new and potentially profitable areas for collaboration. The principle of ‘embedding’ health in this way will maximise the chance of synergy and co-benefits whilst minimizing the need to add to workloads and bureaucracy in the form of formal reports.

The use of a checklist approach, as is used elsewhere, elsewhere and of Health Impact Assessment (HIA) should also be considered in appropriate situations outside the sphere of spatial planning. As stressed elsewhere this will have resource implications that will need to be carefully considered.

Diagnostic interviews (see section 4d)

The interviews with a range of key staff who might be expected to have an influence and role in the health planning agenda suggest that there is generally a relatively strong recognition of the overall priority given to health by the Council. However, there is somewhat paradoxically a lack of confidence about what the actual health priorities are. There is a strong and coherent recognition of the health implications of transport and spatial planning in parts of the planning department and transport but it is not possible to determine how widespread this is and is perhaps relatively weakest in development management. Similarly since public health is in transitional stage it is not possible to be

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3 See for example Thetford Healthy Planning Checklist: http://www.breckland.gov.uk/sites/default/files/Uploads/planning_building_control/Healthy%20checklist%20August%202011.pdf
definitive about its level of awareness of planning issues. There is a relatively strong general feeling that the organisation is still in flux, and hence a lack of a clear understanding of roles and responsibilities. This extends to the external ‘health landscape’. There is a relatively high awareness of the integration of public health and a high expectation that it will be very beneficial. It is not clear that evidence and communications on health issues are yet as strong and consistent.

**Gaps and opportunities for health in planning in CWAC**

Drawing on the topic based baseline review and the above synopsis the following section attempts to pin point the gaps in the approach to health through planning which in turn suggests where and what steps might be taken to strengthen the integration of health and planning.

There is a relatively high level of awareness and understanding of the health implications of development. However there are gaps and hence opportunities. The organisation appears still to be evolving so that there is a lack of clear and stable understanding of the overall structure and of roles and responsibilities. The integration of public health however beneficial in the long run will inevitably exacerbate this issue in the short run. This leads to barriers to effective and timely communication. Investment in communicating and explaining the structure and in supporting staff to understand roles and responsibilities might be effective in helping to overcome these challenges.

Maximizing the opportunity that the integration of public health will bring requires effective, sustained and consistent communication and the raising of shared understanding through joint development and collaboration. The development of a shared evidence base will greatly assist. It is crucial that complex evidence is distilled wherever possible into *actionable insights*. The danger otherwise is that large data sets will not be used as effectively as they might to inform policy. We are aware that the JSNA, which the Council terms the ISNA, is being revised in part with a view to making it more readily accessible. This can only be a good thing so long as the point made above about ‘actionable insights’ is kept uppermost. This imperative is two-way – planning and transport data sets for instance may offer insights to public health and there should be steps taken to ensure that this happens. The monitoring process in planning is typically strong in parts, particularly in relation to housing which is a critical indicator. However, we have noted that the health indicators are not fit for purpose and it is suggested that these are revised perhaps to be more in line with the public health outcomes. The evaluation of planning interventions is also often generically weak whether at a strategy or a project level.

The opportunity should be taken if at all possible to develop the means of evaluating health-oriented interventions in parallel with the annual ‘strategic’ monitoring. We note that the spatial dimension has the potential to be an integrating mechanism in planning for health. Planning interventions take place in specific locations and population health is typically analysed at different spatial scales. However it is not clear that the spatial aspects of health policy are clearly enough articulated and that the means of manipulating data in a spatial environment is sufficiently well developed in CWAC. We understand that there are skilled analysts and specialists in GIS and this capacity should be used to the greatest extent
possible to ensure that there is a common spatial framework that provides a contact for policy making and interventions in CWAC. There is a great deal of innovative practice and research nationally in this field that could be drawn upon.

The Local Plan
It must be stressed yet again that the purpose of this review is not to criticise or critique planning policy as a whole. This review is aimed at optimising the potential effectiveness of planning policy in relation to health.

The draft Local Plan (2013) goes a considerable way to providing the policy framework for addressing health issues both in principle and through a number of specific policies, directly in the case of SOC 5 and indirectly in others. This approach, of incorporating a ‘cross-cutting health policy (SOC 5) together with topic based policies that enshrine health objectives is strongly endorsed in principle. However, a review of the policies suggests that there are several area where they can be strengthened and these are set out in detail in section 3a. This process starts with the recognition of the central importance of the social determinants of health. The key is to make health outcomes explicit, to ensure that the impacts of development on health are properly identified and mitigated and that the opportunities for health protection and improvement are taken. Planning interventions also have the potential, if properly designed, to help in addressing health inequalities. Understanding and optimising the spatial implications of planning policies is key to progress in this area.

Ensuring that these criteria are met at this stage will contribute to the soundness of the plan when it comes to be examined and will maximise the chances of the aims and objectives in relation to health can be secured on the ground.

The Local Plan is at a very opportune stage and is one part of a local development plan that could mark a paradigm shift as we have termed it in the approach to health and wellbeing in CWAC.

The emerging local plan policy would if amended and strengthened as suggested give far greater focus to the health implications of development. It is important that this focus is carried through into the process of development management at the earliest opportunity. The evidence suggests that his has not happened in any significant way in the past. There will be an urgent need to raise awareness and understanding of the objectives and support given to enable the decision making process to incorporate health objectives. This will extend both ‘vertically’ to elected members and higher management and ‘horizontally’ between area teams, planning policy, public health and other key players across the authority. The support should be planned and adequately resourced (including time) from the outset. This is as much a ‘cultural’ issues as it is technical or procedural.

The reorientation that will be needed to fully embed health in the spatial planning process would be greatly assisted if the same process were continued and wherever necessary intensified corporately. We have commented that the authority gives a strong emphasis on health and well being and that there is a relatively high level of awareness and understanding of its importance to strategic performance. The Altogether Better programme exemplifies the link between better services and the urgent need to meet the
financial challenges facing local government in general and CWAC in particular. The forthcoming ‘health premium’ will be another driver to this process. This project has hopefully identified the synergies between spatial planning and public health. If these can be secured they will contribute significantly to making progress towards the public health outcomes that will determine the scale of the health premium. We have noted that the perception of additional and ring fenced public health funding is already stimulating the exploration of cross sectoral or joint funding. The extent to which this can be used internally to drive collaboration is not a matter that we can comment on but is an obvious avenue to be explored.

Engagement of ‘Health’ with Development Management

The above suggestions are formulated in the context of a holist concept of health that has underpinned this whole project. However, it is worth highlighting one specific weakness identified in the assessment of the development management process, which is the lack of effective and sustained engagement of the NHS in the consideration of the implications of development on health services. It is quite clear that very significant housing sites have been determined without a systematic and authoritative assessment of the impacts on ‘health services’, or on whether they will be healthy environments in which to live. Whilst it is not possible to state that this has had or will have detrimental impacts without further information, it is clear that given the scale of population growth envisaged and the degree of change expected in the organisation of local health services this situation is not sustainable and indeed fails the requirement for infrastructure planning explicitly set out in the NPPF. There is an urgent need to establish effective and reliable communications with the NHS bodies responsible for commissioning and providing health care and to agree a robust methodology for aligning new development and the necessary health services in space and in time. Whether this entails developer contributions through s 106 and or the Community Infrastructure Levy (CIL) will be determined by the circumstances at the time. It is widely acknowledged that the organisational landscape in the NHS is still in flux and this makes definitive arrangements very difficult.

One option may be to convene a working group at high level, possibly under the HWB, in order to determine the most effective channels of communication and to agree how the methodology might be commissioned and to clarify the financial implications. There is little doubt that the constraints on NHS funding on the other hand and the issue of development viability on the other will make this a difficult process but is one that seems to us to be urgently needed.
APPENDIX I CURRENT PRACTICE

Current practice in health and planning in England, with some examples of current practice in addressing health through spatial planning

Introduction
This section examines a number of examples of policy and guidance developed by local planning authorities in England. It is not a comprehensive study of the various ways in which planning authorities individually are tackling health issues. Such a study is beyond the resources available to the review.

The definition of health
Health in this note and throughout the project is defined in a holistic way and draws on the World Health Organisation definition as “A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” We can also add that it is not merely the presence absence or adequacy of healthcare facilities and services.

Planning policy tools for health aims
Health objectives can be pursued through spatial planning in a number of ways
- Through strategic policies in the local plan
- Through development management policies in the local plan
- Through supplementary planning documents (SPDs)
- Through other development plan documents (DPDs)
- Through neighbourhood plans.

In principle health oriented policies like all planning policies have to be compliant with national policy, the NPPF and to have been found sound before they can be assumed to carry significant weight.

Current practice- introduction
As suggested above, it is very difficult to arrive at a definitive statement as to what current practice in local authorities comprises. There are over 300 local planning authorities and they are at widely differing stages in the planning process that was instituted by the NPPF in 2012. Some are still reliant on pre 2004 local plans; some have local development frameworks or at least core strategies dating from the period prior to 2012. Both the pre and post 2004 plans have diminishing weight because of the changes to national policy brought in by the NPPF. Some have or will be undertaking reviews of their pre NPPF plans to test their compatibility with the NPPF. The remaining local authorities, probably still a minority have local plans and possibly some other DPDs adopted since the NPPF and which are NPPF-compliant.

This note looks at:
- The overall treatment of health in the examination of local plans since the NPPF, and at an example where health was a relatively significant issue at the examination
- An example of a Development Plan Document (DPD) that makes explicit reference to health
- 3 SPDs that address health issues in a holistic way

**Local Plans and health in Examinations in Public since March 2012**

A review of the Inspectors’ reports into 24 local plans adopted the 12 months after March 2012 suggests that consideration of health policies if it takes place at all almost always addresses to one degree or another the adequacy of the policies for and the provision of, health infrastructure. The holistic concept of health has only figured in one examination, that of the London Borough of Haringey. This is not to say that health has not been included as an objective or indeed as a policy, simply to observe that Inspectors have only once singled it out as a ‘matter’ for consideration in arriving at the judgement as to whether the plan is sound or not.

**Local Plan and health the example of LB Haringey**

The Inspectors examination of the Haringey Local Plan concentrated almost entirely on it provision for health infrastructure. He did not examine or discuss the broader health objectives

Health inequalities are indentified as a key challenge. At the outset the fact that the promotion of health and well-being cuts across many issues is acknowledged (1.4.15) Policy SP 1 Managing Growth, aims to create healthy and sustainable communities.

These are explicit and clearly expressed in the Strategic Policies Document. SP14 states that the Council will seek to improve health and wellbeing by:
- Working with NHS Haringey
- Identifying appropriate sites for health infrastructure
- Protect existing and support new health infrastructure
- Prioritise interventions in those areas of the Borough where health inequalities are greatest
- Support the integration of facilities and services

The contribution of local plan policies to health promotion and reducing health inequalities is identified as:
- Integrating housing types
- Encouraging physical activity and good mental health through the provision of open space and walking and cycling, improving road safety, providing jobs and lessening impacts from noise and air pollution.

There follows an extended discussion of these influences covering the role of the built environment in encouraging physical activity, the value of well designed housing, access to social infrastructure, reducing car use, improving air quality, improving access to employment ensuring planning decisions do not exacerbate health inequalities, facilitating healthy food and reducing obesity.
The policy justification also includes a very extensive discussion of the need for health infrastructure in a spatial framework. The message in the Haringey Plan is thus clear and addresses health in an explicitly holistic way. However whilst there is evidence supplied as to health conditions the pathways through which planning interventions can be expected to make a significant impact on health status and inequalities and how progress will be monitored are not clearly explained. It has to be borne in mind that this document comprises the strategic policies setting the direction of travel and that delivery of SP 14 will to a large extent rely as in many other local plans on the individual topic based policies.

This brief review has looked only at the health specific policy SP 14. There are other policies that support this objective. These include transport, air quality, and design, open space. The evidence base for these strategic policies is extensive and includes a number of health reports including the PCTs strategy. However there is no health specific evidence base and despite the inclusion of maps of health facilities and the incidence of childhood obesity, no spatial analysis of health conditions and land use issues.

**Development Plan Documents and health**

One example of a health oriented DPD is the *Thetford Area Action Plan (TAAP)* adopted by Breckland Council in 2012. (See Appendix).

Thetford was one of the Healthy Town Pilots initiated and funded by Government in 2009 and there was strong collaboration between the planning authority and NHS Norfolk, which was responsible for the Healthy Towns Project, which led to a strong health theme in the TAAP.

This plan is primarily aimed at providing for the very significant growth in Thetford – over 5000 houses in a proposed sustainable urban extension (SUE).

Improving health is an explicit aim and the vision stated that: “Thetford will be known as a town where healthy lifestyles are at the heart of what people communities and businesses do” The policies in the TAAP were designed to make a significant contribution to a healthier Thetford.

The TAAP contains a specific and holistic health policy as follows:

**TH8 Healthy Lifestyles**

All net new development (excluding minor household applications) will be expected:

- To demonstrate that appropriate steps have been taken through its design and construction and implementation to avoid or mitigate potential negative effects on the health of the population;
- To facilitate enhanced health and well-being through the provision of conditions supportive of good physical and mental health (such as enabling physical activity);
- To reduce, where possible, disparities in health between different parts of Thetford by addressing detrimental environmental social and economic conditions.

Developers will be expected to complete and submit the following with planning applications:

i. Health Impact Assessment for large and complex proposals;
ii. A Healthy Urban Planning Checklist for development of 5 dwellings/1,000m² non residential or more.
There is also a policy on the provision of new health facilities in the SUE and extensive discussion of how this will be approached.

The policies are supported by a summary of local health evidence and are partly justified by a brief assessment of the way in which they align with the recommendations of the Marmot Review of health Inequalities.

**Examination of the TAAP**
The TAAP was found to be sound. However, and somewhat ironically, as is generally the case with recent local plans (see above), health issues, with the exception of the provision of health facilities did not figure at all in the Inspectors identification of matters relevant to the plan’s soundness.

The Healthy Urban Planning Checklist.
The draft checklist is included at the end of this section. It is not known whether and to what extent either this or HIA has been used in subsequent development management.

**Supplementary Planning Documents and health**

**The nature of SPDs**
The NPPF defines SPDs as documents that add further detail to local plan policies and states, somewhat restrictively it might be said, (153) that they “should be used where they can help applicants make successful applications or aid infrastructure delivery and should not be used to add unnecessarily to the financial burdens on development”. SPDs must not conflict with the Local Plan policies and can be a material consideration but are not part of the development plan. They do not have to be subject to Examination. Whilst quite widely used in the past their status is thus somewhat ambiguous.

**Examples**
There would appear to be 3 SPDs currently that attempt to deal with health as a holistic concept. These have been published by South Cambridge, Stoke on Trent and Dudley. Somewhat paradoxically none of these SPDs are tied to holistic health policies and the ‘parent’ core strategies were adopted prior to 2012. Each adopts a different approach to seeking to pursue health objectives.

Health does figure in other SPDs. The most common topic is that of hot food takeaways. According to a report commissioned by Medway Council earlier this year 21 local planning authorities had polices on the issue and 15 of them had published SPDs. There have been a small number, including Dudley and Stoke Councils, since then. This note does not address them.

**South Cambridgeshire Supplementary Planning Document (SPD)**
This SPD adopted in 2011 supports the application of HIA in the consideration of planning applications. Whilst the focus is on setting out the generic HIA process there is extensive
discussion of the wider determinants of health and hence it can be argued that the document promotes a holistic concept of health.

There is no substantive and holistic health policy within the core strategy and the SPD amplifies a development management DPD that is concerned only with the provision of health facilities. However, links are made to other corporate documents produced for instance by the Improving Health partnership and justification is drawn from them although the SPD does not contain an assessment or description of the health evidence in S Cambs. The appendix contains other examples of health impact checklists.

**Dudley Council 2013, Planning for Health**
The purpose of this SPD is explicitly holistic and described as:

- To offer guidance for addressing the affect of the built and natural Environment on health as part of a strategic approach to tackling the Borough’s health inequalities and promoting healthy lifestyle options.
- To present the social aspects of planning and demonstrate concisely how social, environmental and economic conditions influence health and health inequalities.
- To clarify the importance of accessibility, its role in creating healthy, sustainable communities and how it helps impart better quality of life.
- To provide supporting information and guidance on planning for health for decision-makers and developers in line with that which is set out in the emerging Development Strategy for Dudley Borough.
- To be an important material consideration in the determination of planning applications by providing checklists against which to assess development proposals.
- To impose distance restrictions on the creation of new takeaways in proximity to schools and youth amenities and to reduce the clustering and over proliferation of hot food takeaways across the Borough.
- To explore the possibility of seeking developer contributions via the most appropriate means from any new takeaways towards initiatives to tackle obesity and encouraging hot food takeaway owners to improve the nutritional value of the food they sell.

The SPD amplifies the Black Country Core Strategy, which was adopted in 2009. However, the Core Strategy does not contain a holistic health policy. It explicitly refers to health in the Vision. “create a network of cohesive healthy communities etc” and Spatial Objective 8 contains a reference to “delivering a network of community services including health that will result in an increase in..health and well-being”.

Policy HOU5 refers to education and healthcare facilities.

There are as might be expected other health related policies such as transport, open space and recreation but health is not explicit in them.

The Core Strategy also refers to the Sustainable Community Strategy that has a health and wellbeing theme and puts stress on the role of the JSNA for both planning and health professionals.
The SPD contains a section on the links between health and planning. It cites the Marmot Review, summarizes the health conditions in Dudley and points to other more detailed evidence.

The guidance is contained in the 4th section. This is structured around 6 themes as follows:

- Healthy sustainable development
- Location and accessibility of healthcare and community facilities
- Planning for active lifestyles
- Designing for safety and wellbeing
- Life stages, equality and inclusion
- Over proliferation of Hot Food Takeaways

The guidance itself is generic and is split into that on strategic planning decisions and is followed by a checklist or flow chart to be used in considering specific development proposals.

**Stoke Council SPD: healthy urban planning, March 2012**

This SPD is explicitly holistic in nature and acknowledges that planning shapes the physical environment and that the environment has a significant impact on health and wellbeing.

It refers to Stoke’s status as one of the members of the UK Healthy City movement, which is managed by a partnership of the City Council and the PCT.

The SPD was published just before the NPPF and relies on the pre-existing planning policy statements for its justification.

The Core Strategy has a strategic aim that includes “the delivery of the best of healthy urban living”.

The only policy with an explicit health context is Design Quality CSP1 that requires development to contribute positively to healthy lifestyles.

The second part of the SPD comprises a ‘healthy urban planning checklist’. This states that new development should contribute positively to healthy lifestyles and is based on 5 principles

- Partnership and Inclusion
- Healthy Neighbourhoods
- Planning for Active Lifestyles
- Protecting the Environment
- Design for Safety and Well-Being

There are then a series of checklists containing generic criteria relevant to the above themes and linked to policies and references.

The third section is focused on HIA, which is ‘encouraged’ for development plan policies, large scale major development, neighbourhood plans and major regeneration projects. It then sets out the generic HIA process and cites a small number of case studies of the application of HIA in Stoke.
Summary
As stated in the introduction it is very difficult to summarize the totality of local planning policies. The above survey of key aspects suggests the following.

Health has been an explicit imperative of planning policy guidance to one degree or another for some time but in particular since the publication of Planning Policy Statement 1 in 2004. The NPPF published in 2012 clarified and to a degree codified this guidance. The introductory paragraph above distills the key requirements. However it is clear from the review of recent local plan examinations that health is still not in practice seen as a prime or essential concern of spatial planning, for instance a criterion for soundness, or if it is the emphasis is very much on ensuring the provision of health infrastructure. This lack of focus on health should be taken into account in developing local policies.

This is not to say that specific policies in the various local plans do not incorporate to one degree or another health objectives and that to a degree they meet the criteria in the NPPF. This reflects a distinct policy choice as between a cross cutting health policy – chosen by Haringey and Breckland for instance and a sectoral or topic based approach which would appear to be the overwhelming choice at local level. This is not either/or, as any cross cutting policy would necessarily be accompanied by topic-based policies. The question to be considered therefore is what a cross cutting policy adds to the planning policy framework.

The three SPD authorities have chosen a slightly different route, which is not to adopt a holistic health policy but to develop the health approach based on high-level aims in the local plan through the medium of extensive guidance. Each of these contains an appraisal framework whose aim is to both guide and test planning policies and proposed developments as to their likely health impacts. This is the precise role of HIA and each of the examples chosen in this brief review incorporate HIA to one degree or another. In the case of South Cambridgeshire it constitutes the core of the health approach.

The case of Breckland and the Thetford AAP illustrates how health might be approach at a more localized level as distinct from the strategic policies in the core strategy. However it too draws on HIA and a bespoke healthy urban planning checklist.

What these examples lack, on the available evidence, is a strong robust and comprehensive local evidence base to justify the policy design and to explain how the polices are likely to be effective and what the indicators will be used to measure progress. Most of the evidence as to pathways and outcomes is highly generic.

The review of plans at recent Examinations may suggest that this is not an issue because Inspectors are not critically examining health or health related polices, unless they are raised by those objecting to or commenting on the plans. However the crucial test is further down stream when appeals are considered and the basis of health related reasons for refusal of planning applications are subjected to more scrutiny. The experience of hot food takeaway refusals tends to support the view that the case has not yet been made at least in the eyes of Inspectors who have not generally given health-specific aspects of takeaway policies strong endorsement. Furthermore and perhaps more important in the long run is the need to justify health related policies and build confidence that they will in fact deliver significant health
improvement and reduce health inequalities. Some of the evidence for this has and hopefully will continue to emerge from academic research but local authorities, particular Unitary authorities where public health functions and analytical capacity are now embedded, have a crucial role in building the evidence base and hence the policy justification.
APPENDIX II: NHS Norfolk and Breckland 2012 Healthy Urban Planning Checklist

Thetford Healthy Planning Checklist
Planning and health: issues and linkages

A Healthy Planning Checklist for Thetford

The application of healthy urban planning principles at the town level is, it is suggested, best approached through careful strategy making, explicit objectives and the use of appraisal techniques. The following checklist is designed to assist in securing the above objectives by applying criteria at the neighbourhood and dwelling levels that will amplify the strategic health oriented policies in the national planning policies, Core Strategy and TAAP.

The Thetford Healthy Planning Checklist is aimed at assisting developers, planners, architects, health professionals and others to consider in a systematic and comprehensive way to what extent any development proposal, ranging in scope from a neighbourhood or Masterplan to a single dwelling will foster better health and reduce inequalities.

PLANNING AND HEALTH – THE LINKS

<table>
<thead>
<tr>
<th>Healthy spatial planning aim</th>
<th>Health implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of sufficient accessible land and buildings to provide for a diverse, viable and rewarding employment</td>
<td>Rewarding stable employment is strongly conducive to better health; unemployment and poverty are strongly associated with poor health.</td>
</tr>
<tr>
<td>Provision of high quality and accessible social infrastructure including schools, social and healthcare facilities and cultural and community facilities</td>
<td>Equitable and ready access to services is supportive of good health. Access to health services mitigates the impact of acute and chronic disease. Access to good education and higher attainment is linked to better health</td>
</tr>
<tr>
<td>Provision of an accessible transport infrastructure and system that supports the maximum use of walking, cycling and public transport and gives it priority over the private car</td>
<td>Active transport, walking and cycling on it own or as part of a journey increases physical activity levels, which are linked to circulatory diseases, diabetes and obesity. Car use diminishes and discourages physical activity and is a major contributor to negative health impacts.</td>
</tr>
<tr>
<td>Provision of accessible formal and informal green space and landscaping and vegetation and the maintenance and encouragement of the highest possible biodiversity so that all can benefit from its visual and physical enjoyment</td>
<td>Use of greenspace supports physical activity and access to it is strongly linked to better mental health</td>
</tr>
<tr>
<td>Provision of accessible facilities and opportunities for play and informal activity</td>
<td>Play is crucial to the physical and mental and social development of children and young people.</td>
</tr>
<tr>
<td>Provision of accessible affordable high quality facilities for sport and recreation</td>
<td>Sport is directly linked to higher levels of physical activity which is linked to chronic and acute disorders and to improved mental health and is a source of community development</td>
</tr>
<tr>
<td>Levels of air and noise and light pollution that are within specified limits that do not separately or cumulatively harm or endanger health</td>
<td>Respiratory diseases are exacerbated by air borne pollutants and leads to chronic and acute episodes and in cases reduced life expectancy. Noise is linked to mental health</td>
</tr>
<tr>
<td>Provision of sufficient housing of uniformly good quality and with high levels of environmental performance that is flexible in</td>
<td>Poor housing conditions are linked to respiratory diseases, some infectious disease, excess winter deaths and falls.</td>
</tr>
</tbody>
</table>
To meet changing housing needs, provision of affordable housing options for all the community is essential. Exclusion from the housing market is linked to poor health and to reduced mental health. A high standard of design and local distinctiveness of buildings, spaces and the public realm that affords the opportunity for meeting assembly and passive enjoyment in equitable temperatures. A stimulating external environment is linked to higher levels of satisfaction and mental health.

A route system that ensures pedestrians and cyclists are prioritised and protected that is highly permeable and where vehicle speeds are the lowest practically achievable. More active travel increases physical activity. Road accidents are a significant cause of injury and death and are disproportionately linked to deprived, young and older people.

High accessibility to a range of diverse shops and facilities to meet the maximum possible range of needs including fresh and good quality food. Access to daily necessities encourages active travel and better mental health. Access to fresh food is linked to better quality diet and reduced levels of obesity.

Sufficient, accessible, varied opportunities to grow food. Food growing is linked to improved diet and to higher levels of physical activity.

Provision of reliable and high quality communications, water and energy services. Good access is necessary to maintain levels of hygiene and enable contact with services and personal networks to be maintained which is supportive of physical and mental health.

### Using the Checklist

Policy TH7 of the TAAP states that the Checklist needs to be completed by developers/promoters of schemes of 5 dwellings or more and 1,000m² non residential or more. The Checklist must accompany planning applications for such schemes.

The checklist is constructed as a series of positive potential judgments that could be arrived at in relation to many aspects of a proposal that have been shown to be strongly linked to good health outcomes, from the masterplan down in some cases to the dwelling. The idealised outcome is for the proposal to perform strongly against all the criteria. Those appraising the proposal are asked to score the development on that criterion on a scale from strongly negative (it fails to match the criterion) to strongly positive (it is judged to be very close or better than the criterion). The 3rd column is to be used to briefly justify the judgment reached, as this will enable others to validate or audit the process. The final column is to be used to specify what more needs to be done either to enable a weak proposal to meet the criterion more effectively or in some cases to seek more information where that is inadequate or missing.

There is, as with all appraisals, a high degree of judgment required. However, the checklist does not require a technical knowledge of public health or health conditions. It should be possible for any competent person reasonably familiar with spatial planning and related concepts to arrive at a view based on the description supplied.

There may, on occasion, be some overlap between the application of this checklist and other appraisal systems such as sustainability appraisal and environmental impact appraisal. However it is suggested that the checklist meets a need not currently fully met and will complement other appraisals.

Not all criteria will apply to all proposals; this requires the judgment of the user. They are encouraged to apply as inclusive an approach as possible.

Finally this table applies only to the town of Thetford. There are many issues arising from its geographical context that will nevertheless contribute or not to health, for instance, access to the wider countryside, accessibility to regional centres and communications generally. There are also key issues, in particular climate change, that will have health impacts but where the policy framework is necessarily wider than the town. It is not intended in any way to diminish the significance of these policy considerations.
### 1: EMPLOYMENT

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A range of employment opportunities are available within the neighbourhood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training opportunities will be made available to meet the local needs as the neighbourhood develops or changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Residents will be able to access a good range of employment and training opportunities outside the neighbourhood by sustainable transport</td>
</tr>
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<td></td>
<td></td>
<td>Walking cycling and public transport are practical options to reach employment opportunities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employment sites and buildings will minimise waste, maximise recycling and optimise energy efficiency and use of renewables.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employment sites and buildings will offer covered cycle parking in convenient locations, under surveillance and related facilities such as lockers and showers.</td>
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</tbody>
</table>

### 2: HOUSING

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Affordable housing options will be available to all sections of the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Affordable housing is seamlessly integrated in the whole site</td>
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<td></td>
<td></td>
<td>The housing mix will provide options for all sections of the community avoiding segregation</td>
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<tr>
<td></td>
<td></td>
<td>The houses provided meet high standards of urban design</td>
</tr>
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<td></td>
<td></td>
<td>The housing performance will allow residents to minimise energy costs</td>
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<tr>
<td></td>
<td></td>
<td>The option of increasing renewable energy sources will be increasingly available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Well oriented practically useful garden space is provided</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Where garden space is impractical effectively managed communal garden space will be provided</td>
</tr>
</tbody>
</table>
Where communal or garden space is impractical private outdoor space on balconies or roof gardens will be provided

All the dwellings be accessible to mobility impaired people

The dwellings will provide options for private and quiet space for occupants

The dwellings will be designed to lifetime home standards

The dwellings will facilitate electronic networking

The dwellings will offer water minimisation and recycling options

Privacy in the dwellings will be assured

Noise transmission will be minimised and the external noise environment optimised

The building design will permit safe easy cycle storage

<table>
<thead>
<tr>
<th>Scoring:</th>
<th>No Health Benefit</th>
<th>Neutral</th>
<th>Greater Health Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### 3: TRANSPORT

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>The layout be highly permeable with continuous footways or shared surfaces</td>
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<tr>
<td>All modes will be attractive options for all residents</td>
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<tr>
<td>For those without access to a private car the alternative movement options will be safe and accessible</td>
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<tr>
<td>Public transport of adequate frequency will be available throughout</td>
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</tr>
<tr>
<td>Effective plans to increase patronage on public transport will be implemented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking routes are direct and offer access to main destinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking routes are effectively overlooked and likely to be well used as a result of density and layout</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cycling and walking routes are designed so as not to be severed by main roads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking and cycling routes are designed to be compatible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roads are designed to maintain appropriate traffic speeds in</td>
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<td></td>
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</tbody>
</table>
residential frontages.
Pedestrians and cyclists are given priority at junctions
Walking and cycling routes to schools and nurseries are segregated or safe
Walking and cycling routes are linked safely to the town path network, green infrastructure and the wider rural setting

<table>
<thead>
<tr>
<th>4: GREENSPACE AND GREEN INFRASTRUCTURE</th>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All residents have good visibility to green space and landscape</td>
<td></td>
<td></td>
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<tr>
<td>The green space is connected and provides a viable network, linked to public realm and paths</td>
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<tr>
<td>The green space is accessible to all residents, be it existing or new.</td>
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</tr>
<tr>
<td>The greenspace provides for the needs of the social demographic and ethnic mix of the locality</td>
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<tr>
<td>There are fully sustainable means of supervising/maintaining the greenspace</td>
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<tr>
<td>Activities within the green space are sustainably managed to avoid conflict but offer strong attractions</td>
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<tr>
<td>All children and young people have diverse options for supervised formal and unsupervised informal play including wild space</td>
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</tr>
<tr>
<td>Formal play spaces are under informal or formal surveillance</td>
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</tr>
<tr>
<td>Schools and other social infrastructure sites offer access to greenspace, managed or otherwise</td>
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</tr>
<tr>
<td>The green infrastructure is managed to optimise biodiversity</td>
<td></td>
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</tr>
<tr>
<td>The green infrastructure is used effectively to reduce ambient temperatures and provide shading in public spaces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunities to introduce sustainable drainage methods and to integrate drainage areas with greenspace have been taken into account</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scoring:</td>
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</tr>
<tr>
<td>No Health Benefit</td>
<td>Neutral</td>
<td>Greater Health Benefit</td>
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<tr>
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<td>2</td>
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</tbody>
</table>

### 5: SPORT AND RECREATION

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

Sports and recreation facilities are accessible to all residents.
Diverse options for sport and recreation are provided for, meeting a range of needs locally and town wide as appropriate to the activity.
Schools and other appropriate social infrastructure offer access to sports or recreational facilities.

### 6: FOOD GROWING

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

Allotments, community gardens and orchards provided for all residents within a walkable distance.
Support is made available for marketing and distribution of locally produced food.
Advice and support is given to using local food.

### 7: TOWN CENTRE AND RETAILING

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
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<tbody>
<tr>
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</table>

The town centre is accessible for all residents and visitors.
Pedestrians are prioritised within the town centre.
Opportunities to increase the permeability of the town centre will be taken.
Scope for significant change, spatial and uses, within the town centre is provided for.
Most daily needs can be met in the town centre with diverse choice.
Fresh food is available daily within the town centre.
All residents are within walking distance of daily needs: shopping and services.
Opportunities to diversify small or local centres with services or other uses will be taken.
### 8: ENVIRONMENTAL QUALITY

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air quality levels everywhere are such as to not damage health or exacerbate chronic symptoms</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>Noise levels will be monitored and managed to minimise annoyance</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>Increases in noise levels or reductions in air quality problems will be avoided</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>Water courses free of significant pollution and have sustainable flows</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>All houses are protected from flooding</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>The construction process is managed to prevent noise, dust, air ground water pollution</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
</tbody>
</table>

### 9: URBAN DESIGN

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The context of the proposal has been fully analysed and the principles of urban design are identified, visualised, explained and justified</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>There are detailed plans for the public realm and streets showing horizontal surfaces and landscaping and greenspace</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>Boundary treatments ensure sites are integrated with their context, and contribute to green infrastructure</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>All uses proposed are compatible and effectively integrated</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>Historic buildings and places will be effectively maintained and enhanced</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
</tbody>
</table>

### 10: SOCIAL INFRASTRUCTURE

<table>
<thead>
<tr>
<th>Score</th>
<th>Basis for judgment</th>
<th>Mitigating any negatives and maximising any positives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transparent methodologies have been used for forecasting demand for social infrastructure</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>A range of options for models of service provision and location of</td>
<td>Mitigating any negatives and maximising any positives.</td>
<td></td>
</tr>
<tr>
<td>facilities have been fully explored and evaluated</td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standards are set for accessibility to services and robust reliable methods used to calculate it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The demand arising from the development will be within the capacity of accessible social infrastructure at all stages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All opportunities to integrate, co-locate or relate different services have been explored and adopted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliable funding streams are identified for necessary social infrastructure</td>
<td></td>
<td></td>
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</tbody>
</table>
### APPENDIX III
Health and Planning IN CWAC – a review of current practice

#### DIAGNOSTIC INTERVIEWS
The interviews were HELD 2\textsuperscript{nd} and 3\textsuperscript{rd} of October 2013.

#### INTERVIEW SCHEDULE

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Topic</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wed</td>
<td>11.00</td>
<td>Health/corporate policy</td>
<td>Sarah Clein</td>
<td>Health-localities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Filip Previc</td>
<td>Policy Manager</td>
</tr>
<tr>
<td></td>
<td>12.00</td>
<td>Health</td>
<td>Jill Oakley</td>
<td>Public health Analyst</td>
</tr>
<tr>
<td></td>
<td>13.00</td>
<td>Health</td>
<td>Caryn Cox</td>
<td>DPH</td>
</tr>
<tr>
<td>Wed</td>
<td>2.30</td>
<td>Highways</td>
<td>Jamie Mathews</td>
<td>Transport Strategy Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dave Thomas</td>
<td>Transport Planning and Policy Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Richard Flood</td>
<td>Area Highways Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kieran Collins</td>
<td>Area Highways Manager</td>
</tr>
<tr>
<td></td>
<td>3.15</td>
<td></td>
<td>Cllr Riley</td>
<td>Localities Lead</td>
</tr>
<tr>
<td></td>
<td>4.00</td>
<td></td>
<td>Laurence Ainsworth</td>
<td>HoS Transformation</td>
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<td>Jeremy Owens</td>
<td>Spatial Planning Manager</td>
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<td>Duncan McCorquodale</td>
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<td>Planning Performance Manager</td>
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<td>Nial Cassellden</td>
<td>Area Planning Manager</td>
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LIST OF QUESTIONS

MEMBER LEVEL

Common
C1 Could you briefly explain your role?
C2 What do you believe are the main health issues facing CWAC?
C3 Do you think that the council and senior management give the right priority to improving health and wellbeing? Has this changed recently?
C4 What are the most important changes we can make to the local environment to improve people’s health and wellbeing?
C5 Is there a specific change to policy or working practice that you would like to see to help the council to improve health and well-being?
C6 Is there an example in CWAC of a healthy development, either built or which is being designed now?

Role Specific

M0 In what ways has the restructuring of public health and the HWB changed the approach to health issues in CWAC?
M1 Has the HWB considered the role of planning in promoting health and wellbeing?
M2 Do you feel members have sufficient advice on health impacts when making planning decisions? Please give an example of where health was an important consideration.
M3 Do you think the role of the environment and of planning decisions in health is fully understood on all Council bodies? Is there a mechanism for ensuring that health objectives are embedded across the authority, and between people with different responsibilities?
M4 Which are the most important partners for the Council in looking to improve health and reduce inequalities?
M5 What if any do you think are the barriers, to health being fully taken into account in planning?
DIRECTOR/HEADS OF SERVICE

Common
C0  Could you briefly explain your role?
C1  What do you believe are the main health issues facing CWAC
C2  Do you think that the council and senior management give the right priority to improving health and wellbeing? Has this changed recently?
C3  What changes can we make to the local environment to improve people’s health and well being?
C4  What are the barriers to delivering better health through spatial planning?

Role Specific
1. Does the Authority have explicit health and wellbeing policies and objectives that apply to all council functions?
2. In what ways has the restructuring of public health and the HWB affected the way in which you work?
3. What statutory duties drive your consideration of health in your strategies, policies and decisions?
4. What types of evidence do you use to identify health issues and solutions? Can you give a specific example where such evidence has been used?
5. How do you ensure that health objectives are embedded across your directorate and between people with different responsibilities? Is there a mechanism for ensuring that health objectives are embedded across the authority, and between people with different responsibilities?
6. What use do you make of external guidance and best practice?
7. What internal links and external partnerships do you use and how do they improve your decisions, in regards to health? Please specify your contacts.
8. What if any do you think are the barriers, to health being fully taken into account in planning?
POLICY/LOCALITIES

C1  Could you briefly explain your role?
C2  What do you believe are the main health issues facing CWAC?
C3  Do you think that the council and senior management give the right priority to improving health and wellbeing? Has this changed recently?
C4  What are the most important changes can we make to the local environment to improve people’s health and well-being?
C5  is there a specific change to policy or working practice that you would like to see to help the council to improve health and well being

1. What would you describe the Council’s role in improving health and wellbeing?
2. How would you describe the level of awareness in the Council of the need to improve health and wellbeing and what needs to be done?
3. Would you say the Council’s structure and organisation is well aligned to addressing health and wellbeing?
4. Can you give us an example of a policy or project that you have been involved in that aims to improve health wellbeing?
5. Which are the most important working relationships in the Council and externally in making progress on health and well being? Can you give examples of these being used?
6. How important relatively would you say spatial planning (or planning and transport) is in addressing health and wellbeing?
7. What evidence do you draw on in developing policies relevant to health and well being? Do you feel this is adequate?

SPATIAL PLANNING

Common

C1  What do you believe are the main health issues facing CWAC
C2  What are the most important changes can we make to the local environment to improve people’s health and well being?
C3  Do you think that the council and senior management give the right priority to improving health and wellbeing? Has this changed recently?
C3  is there a specific change you would like to see to help the council to improve health and well being
C4  is there an example in CWAC of a healthy development, either built or which is being designed now?
Role Specific

1. Do you think planning has a significant role in protecting and improving health and in tackling inequalities?
2. Does the Authority have explicit health and wellbeing policies and objectives that apply to all council functions?
3. Do you have robust indicators that will show how far health/planning integration is having an effect?
4. What types of evidence do you use to identify health issues and solutions and where do you access this information? Please give a specific example.
5. Are you aware of the JSNA? How much have you used it? Does it have the information that you need?
6. What national policies, guidance and best practice are you aware of, and which do you find most useful and least useful?
7. What are the Council’s main health-related priorities and how are they reflected in strategies and policies?
8. Which are the most significant current planning policies in relation to health?
9. How do you think the Local Plan will affect health policies and the way you work on health issues?
10. How do you and your team identify the potential health impacts of emerging planning policies and/or major developments? Please give an example (s). Do you ever refer to the SA? Are you aware of HIA?
11. Are you aware of the restructuring of public health? How has it changed the way in which you are working?
12. Which working relationships within the Council and external do you draw on to influence your policies and decisions in relation to health? How often do you use these? Please be specific.
13. How confident would you say you are in assessing or interpreting health impacts of policies and developments?
14. What health related data, skills and expertise do you have access to and are these sufficient?
15. Would you say that the production of supplementary planning guidance on health issues would be helpful. Is it a priority?
16. What if any do you think are the barriers, to health being fully taken into account in planning?

DEVELOPMENT MANAGEMENT

Common

C1 What do you believe are the main health issues facing CWAC?
C2 Do you think that the council and senior management give the right priority to improving health and wellbeing? Has this changed recently?

C3 What are the most important changes can we make to the local environment to improve people’s health and well-being?

C4 is there a specific change you would like to see to help the council to improve health and well being

C5 is there an example in CWAC of a healthy development, either built or which is being designed now?

**Role Specific**

1. What are the Council’s main health-related priorities and which planning policies would you say are most significant in relation to health?
2. Are you aware of the policies in the emerging Local Plan. What effect will these have on the ways you address health issues?
3. Would you agree that planning should take health issues and impacts into account? Please give examples of how that has been done in your experience.
4. How are the health implications of development proposals assessed? When does this take place exactly? Have you come across HIA?
5. At what stages of the development process do you raise health issues with developers? (eg pre-app discussions, in determining an application, reserved matters?)
6. In practice is there a threshold over which health implications of development would be subject to detailed assessment?
7. Have you had experience of an EIA that addressed health issues. Be specific.
8. What guidance and best practice in relation to planning and health are you aware of?
9. What are the Sec 106 or CIL contributions to health that you require when negotiating with developers?
10. Which health related data, skills and expertise, within the Council or externally do you draw on. How often does this happen? Please be specific. Are there problems in doing this?
11. Would you say that guidelines or a checklist to assist in identifying health impacts would be useful?
12. Would you say that the production of supplementary planning guidance on health issues would be helpful.
13. What if any do you think are the barriers, to health being fully taken into account in planning?
Transport

C1 What do you believe are the main health issues facing CWAC?
C2 What are the most important changes can we make to the local environment and transportation to improve people’s health and well being?
C3 Is there a specific change you would like to see to help transport planning to improve health and well being?
C4 Is there an example in CWAC of a healthy development, either built or which is being designed now?

Role specific

1. Do you think transport planning has important implications for health? Please give examples.
2. Which are the most significant current transport policies in relation to health?
3. Which are the most important Council policies other than transport?
4. Do you think these policies are having a significant effect? Can you give examples of where health has been an important factor in a transport related policy or decision.
5. Are you aware of the restructuring of public health? Has it made a difference to the way you work?
6. Which are the most important working relationships within the Council and externally in making sure health considerations are reflected in policies and decisions of development? How often do you use them? Be specific. Are these working consistently well?
7. What improvements or changes would you like to see in transport policy, infrastructure provision and development management and working relationships that would improve and protect health?
8. What if any do you think are the barriers, to health being fully taken into account in transport planning?

Public health

C1 What do you believe are the main health issues facing CWAC?
C2 Do you think that the council and senior management give the right priority to improving health and wellbeing? Has this changed recently?
C3 What are the most important changes can we make to the local environment and transportation to improve people’s health and well being?
C4 Is there a specific change you would like to see to help transport and planning to improve health and well being?
C5 Is there an example in CWAC of a healthy development, either built or which is being designed now?

Role specific

8. What do you think are the most important influences the environment and planning and transport have on health?
9. Do you think the Public Health section prioritises these issues effectively? Which staff are involved? Please give examples of working practice.
10. How has the restructuring of public health affected your ways of working and relationships within and external to the Council?
11. Has the responsibility for dealing with planning and transport been clearly allocated?
12. Are public health staff called upon to make comments on planning or transport policy or on proposed developments or work with colleagues in those sections? Be specific with whom.
13. Who would you go to in the planning and transport sections if you wished to discuss health related issues?
14. Have you heard of the National Planning policy Framework? Please describe it.
15. Which public health policies would you say are most relevant to influencing planning decisions?
16. What evidence and guidance do you think are most important for influencing planning and transport decisions? Do you think you have this evidence? Which guidance do you find helpful?
17. How has your relationship with planning and transport colleagues changed since April 2013?
18. What if any do you think are the barriers, to health being fully taken into account in planning?
19. Which indicators would you say will be most important in judging how effective spatial planning policies are in improving health and wellbeing.
APPENDIX IV  ENVIRONMENTAL INFLUENCES ON HEALTH

This appendix examines key health or health-related outcomes, and suggests some of the important influences which might be described as ‘environmental’ in the widest sense of the word. They comprise a significant part of the social determinants of health. They are also highly congruent with the scope of spatial planning. The linkages are set out in a matrix that suggest their relative significance. Whilst these rankings do draw on the evidence it must be stressed that they are at this stage to an extent subjective and it is hoped that they can be refined in due course. The following sections set out in summary for the evidence and suggest key planning policies and interventions that can be expected to make a positive impact on the health outcomes. A set of key references to the evidence base is provided although this should not be taken as by any means comprehensive given the range of evidence now available globally.

Environment and health matrix

1) Physical health and healthy lifestyles
The ability to lead an active and healthy lifestyle is influenced by where we live, work and play. For example we are more likely to use active travel if the places that we want to go to are within walking and cycling distance, and the routes are safe, pleasant and direct. We are more likely to eat healthy food if it is available locally. We are more likely to have active leisure if there are facilities available nearby.

2) Mental health and wellbeing
Green space has a positive impact on health and wellbeing and has a marked stress reduction effect.
Belonging to a local community is health promoting, and is particularly important for certain groups; for example older people who can become isolated and depressed, parents with young children who benefit from supportive networks. Buildings and parks alone do not create communities, but they can provide the settings and opportunities within which they can get established and flourish.

3) Unintentional injury
The safety of the area has a direct influence on health. This is perhaps most obvious in the case of the dangers of motorised transport, but there are also risks associated with water, and with the design and construction of homes.

4) Environmental hazards
The aspect of health that traditionally has had the most attention. Air quality, water quality, contaminated land, noise, all have a health impact, and the design and management of the spatial environment is a key determinant of the level of exposure.

5) Equity
There are very substantial health inequalities between different areas, measured most starkly by variations in life expectancy. The Marmot report demonstrated that there is a strong link between the quality of the environment and health; almost invariably the places with the poorest health have a lower quality environment, poorer quality housing, with more pollution, less access to services, less green space etc.
The figure below shows how environmental influences in the built and natural environment have the potential to influence the different dimensions of health:

<table>
<thead>
<tr>
<th>Environmental influences</th>
<th>Physical health and healthy lifestyles</th>
<th>Mental health and wellbeing</th>
<th>Unintentional injury</th>
<th>Environmental health</th>
<th>Equity</th>
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<tr>
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Key: XXX: Strong influence  XX: Some influence  X: Little influence
The following pages consider each of the environmental influences in turn, say why each is an issue and give pointers as to where more evidence may be found. Each section concludes with some suggestions for good practice.

**Built Environment and Urban Design**

**Why is it an issue?**

The form and design of urban environments constrains or enables the extent to which people can build exercise into everyday life. There is little doubt that there has been a significant reduction in the amount of physical activity in daily life. Only a minority of the population approach the government’s recommended levels of 150 minutes of moderately intensive activity per week. People will not be physically active in environments that are unpleasant, unsafe, traffic dominated, or where there is nowhere to go to within a reasonable distance.

It is difficult to overstate the importance exercise to overall health and wellbeing. The former Chief Medical Officer for England noted that:

“*If a medicine were discovered today that could reduce the risk of chronic disease to the same extent as does regular physical activity, it would be regarded as a wonder drug … The benefits of regular physical activity to health, longevity, well-being and protection from serious illness…easily surpass the effectiveness of any drugs or other medical treatment. The challenge for everyone, young and old alike, is to build these benefits into their daily lives.*”

(Other aspects of the influence of urban design on health, for example open space, are discussed below)

**Where is the evidence?**

The National Institute for Health and Clinical Excellence (NICE) has made a number of evidence based recommendations to planners and designers concerning helping people to become active.

The University of New South Wales has done a systematic evidence review of Healthy Built Environments

A huge international study led by the Medical Research Council confirmed that regular physical activity can in part offset genetic susceptibility to obesity.

A very recent review in BMC public health indicates that physical activity appears to have a positive long-term influence on all selected diseases. This includes Alzheimers Disease, suggesting that regular physical activity may be an important and potent factor preventing cognitive decline and dementia in healthy older people.

**Things to look for:**

- Mixed uses, compact layouts, with short trip distances. These layouts increase the possibilities of active travel, walking and cycling.
  - Ensure that there is a neighbourhood centre with at least a convenience store (top-up store) and public transport stop within 5 minutes walk / 400m of homes.
A street network with high connectivity. Grid type networks decrease actual distances between origins and destinations, which encourages active travel. Cul de sacs with circuitous routes to destinations encourage car use.

- Lay out footpaths and cycle paths so that they provide the most direct routes to centres and facilities.

A varied and attractive environment, with greenery, seating and safe routes to schools.

- Apply the ‘Building for Life’ question 5: ‘Does the scheme create a place with a locally inspired or otherwise distinctive character?’

Streets that are overlooked by housing, with ‘active frontages’

Streets that are safe for children, using ‘home zone’ or similar principles

Try to avoid:

- Environments that are car dominated
- Housing areas that are isolated from services and employment

**Open and Green Space**

**Why is it an issue?**
Open and green space promotes physical activity; provide respite from stress and is positive for mental health; promotes social interaction and community; protect from environmental stressors. Children are more at risk of traffic related injuries where there are no play areas, or where play areas are poorly protected.

**Where is the evidence?**
‘Populations exposed to greener environments also enjoy lower levels of income deprivation related health inequality. Physical environments which promote good health may be important in the fight to reduce socio-economic health inequalities.’

‘The percentage of green space inside a one kilometre and a three kilometre radius had a significant relation to perceived general health. The relation was generally present at all degrees of urbanity. The overall relation is somewhat stronger for lower socioeconomic groups. Elderly, youth, and secondary educated people in large cities seem to benefit more from presence of green areas in their living environment than other groups in large cities.’

A systematic evidence review found that most studies reported findings that generally supported the view that green spaces have a beneficial health effect, although establishing the causal relationship is difficult, as the relationship is complex.

**Things to look for:**

- A network of open spaces:
  - Amenity spaces within 400M
  - Multi functional parks within 800M

- Provision for children’s play:
  - Toddler playspaces close to home (200m)
  - Older kids playspaces within 400m

- Provision for circular walks/jogs/cycle rides
Provision for sports and organised games

Try to avoid

- Open spaces that are only accessible by car, or difficult to get to by walking or cycling
- Spaces with no defined purpose

**Housing**

**Why is it an issue?**

Housing quality is an important health determinant. Poor housing, which is damp, cold, overcrowded, noisy and physically dangerous is linked with respiratory disease, cardiovascular disease, ischemic heart disease, infectious diseases and home injuries. Poor housing is a major contributor to health inequalities. It will exacerbate the situation of those with disabilities or long term health problems. Children’s educational development is adversely affected by poor housing.

**Where is the evidence?**

The World Health Organisation has a full and a summary report on the health effects of inadequate housing. It quantifies the impact of a range of housing issues on health. These include dampness, inadequate heating, home injuries, noise, and the impact on mental health. A systematic evidence review found that: “Best available evidence indicates that housing which is an appropriate size for the householders and is affordable to heat is linked to improved health and may promote improved social relationships within and beyond the household. In addition, there is some suggestion that provision of adequate, affordable warmth may reduce absences from school or work.”

**Things to look for**

- Good quality housing, both ‘market’ and ‘affordable’, with excellent energy efficiency.
  - Achieving BREEAM ‘Code for Sustainable Homes’, category 1 – ‘Energy Efficiency…’for new homes, especially at level 6, should ensure that homes are adequately warm, dry and economical to heat.

- A range of dwelling types and sizes, that meets local housing needs.
  - Including affordable housing
  - Ensure that affordable housing is ‘tenure blind’

- Houses that provide enough space for families
  - For example, using the GLA Essential Gross Internal Area standards

- Housing that can adapt to changing needs and circumstances
  - Homes to ‘Lifetime Homes’ standards, particularly criteria 2-16

- Housing with adequate sound insulation and daylight
  - Code for Sustainable Homes ‘Health and Wellbeing – Sound Insulation’- achieve 4 credits
  - Code for Sustainable Homes ‘Health and Wellbeing – Daylighting’ - achieve – 3 credits

- Housing with good indoor air quality
  - Design guidance should encourage the use of low VOC building materials, and proper ventilation.
Try to avoid

- Housing that is too small for modern family life
- Housing schemes that segregate different tenures
- Locating affordable housing in the least favourable areas of a development

**Services and facilities**

**Why is it an issue?**
All groups benefit from good local services. Particular groups have particular needs, as older people and those with disabilities need good access to health services, young families need access to schools etc. Poorer and more deprived areas often have poor access to health services. Communities most at risk of ill health tend to experience the least satisfactory access to the full range of preventative services. Good local services can help to foster community.

**Where is the evidence?**
Ben Cave et al provide a summary of the evidence on access to health services, social care and education. 

**Things to look for**

- Local services clustered within the locality, and well located in relation to walking, cycling and public transport routes.
  - ‘Local Services’ include local shops, schools, pharmacies, health facilities, post office, café, public transport.
- Health and care facilities built in to new developments, with a health facility within 800m of residential dwellings.
  - An ageing population requires a range of supportive services, which includes health care and less formal social support.
- Primary schools within walking distance of new developments, e.g. 400 – 600 m, accessible by safe walking and cycling routes
  - Secondary schools accessible by safe walking and cycling routes
- Places where people can meet, such as a community centre or hall.
  - Such a centre allows supportive activities, such as playgroups and luncheon clubs, to develop.

Try to avoid:

- Isolated developments without access to services
- Services that are severed from residential areas by roads or other barriers
Transport Systems and Access

Why is it an issue?

Good access to employment, education and services, are all health promoting. Effective transport helps to maintain social networks and enhance community. Poor transport systems that do not balance the need for access with quality of life can be bad for health. The lack of affordable access to transport is a significant factor in health inequalities, and falls disproportionately on women, children, older people and those with disabilities. 25% of households do not have a car.

Road traffic carries with it air and noise pollution, and danger of injury or death. A motorized environment can sever communities, and is hostile to walking and cycling.

Active travel, primarily walking and cycling, has a number of positive health benefits.

Where is the evidence?

The Transport and Health Study Group have produced a report that examines the evidence, and makes a number of radical proposals for change. The BMA's report Healthy Transport = Healthy Lives considers the need to prioritise health in transport planning and policy decisions. It aims to highlight the benefits to health of developing a sustainable transport environment where active travel and public forms of transport represent realistic, efficient and safe alternatives to travelling by car. Active travel, such as walking and cycling, are sustainable and have a number of health benefits: “These include improved mental health, a reduced risk of premature death, and prevention of chronic diseases such as coronary heart disease, stroke, type 2 diabetes, osteoporosis, depression, dementia, and cancer. Walking and cycling are also effective ways of integrating, and increasing, levels of physical activity into everyday life for the majority of the population, at little personal or societal cost.”

NICE Public Health Guidance 41 sets out how people can be encouraged to increase the amount they walk or cycle for travel or recreation purposes.

Things to look for

- Transport systems that give the whole population sustainable and affordable access to services such as shops, health facilities, employment and education.
  - Public transport options to access employment and education.
  - Access to public transport within 400m of homes
- Design of urban environments to give priority to pedestrians and cyclists.
  - A comprehensive network of walking and cycleways. Off road cycle paths encourage non-cyclists to try cycling
  - Cycle parking provision at destinations and transport nodes, and within dwelling design.
  - Traffic calming and shared space approaches to residential areas
  - 20mph limits in residential areas
- Roads that do not constitute severance barriers to communities.
  - Having to cross busy roads make it more likely that people will drive. People who live on busy roads have less social contacts than those on quiet roads

Try to avoid

- Designing residential areas around the road system
Isolated developments, residential, retail employment or leisure, that are only accessible by car

Social cohesion, governance and cultural issues

Why is it an issue?
A sense of community identity and belonging is important for health and wellbeing. It is particularly important for groups such as families with young children or older people, who can become isolated, and benefit from social support. Planning and design policies cannot by themselves create ‘communities’, but they can encourage or discourage the formation of social cohesion and social capital.
Participation in itself can be health promoting. People are most likely to take control of their health if they feel they can influence other aspects of their lives. Socially isolated individuals in less cohesive communities are more likely to experience poor health than those from more cohesive neighbourhoods.

Where is the evidence?
The NSW Review referred to above has a substantial evidence review of: ‘The Built Environment and Connecting and Strengthening Communities’

Things to look for

- Active involvement of those potentially affected by proposed developments
- Integration of dwelling types and tenures
  - Places that exclude or segregate certain groups will tend to increase health inequalities.
- Social infrastructure
  - Well-designed places available where people and voluntary groups can gather and use, for example shared places of worship, community centres, sports facilities, community spaces.
  - Is there community involvement in the design and management of such places?
- Design that permits and encourages informal social contacts
  - For example small green spaces with seats
  - Safe areas around houses, public transport stops etc that allow casual encounters
- Art integrated into large developments
  - Culture provides employment, encourages learning and inspires people to creative, active and healthy lifestyles.

Try to avoid:

- Developments processes that have minimal or tokenistic public involvement
- Developments that do not provide places for people to get together

Employment and economy

Why is it an issue?
Having a good job can increase income, status and feelings of making a contribution to society, all of which are health promoting. Differences in income and employment are one of
the major factors in health inequalities. Unemployment and low-grade insecure jobs can be
damaging to physical and mental health. Some regeneration schemes create jobs for
incomers without significantly benefitting the existing local population.

Where is the evidence?
The Health Development Agency (later part of NICE) carried out an evidence review into the
relationship between worklessness and health. They concluded that the evidence supports a
strong association between increased mortality and unemployment at an aggregate level. The evidence also suggests that: “…there is a strong association between unemployment and increased measures of psychological and psychiatric morbidity … Upon re-employment, there appears to be a reversal of these effects. While the direction of causality is difficult to determine, unemployment is considered to be a significant cause of psychological distress in itself.”

The Marmot Review concluded that being in good employment is protective of health. However, jobs need to be sustainable and offer a minimum level of quality. Conversely, unemployment contributes to poor health.

Things to look for

- Employment, housing and social facilities located to allow easy access between them
  - Is sustainable access to jobs (walking, cycling, public transport) built in?

- Jobs created targeted to benefit the whole working population, including the unemployed and existing residents as well as in migrants.
  - Is there evidence that profiles of local communities have been studied and taken into account?

- Employment use proposals that encourage well-paid, secure jobs.
  - Training routes so that local people and marginal groups can obtain them.

- Local agreements to ensure that ensure local employment and or training is connected with major developments.

Try to avoid:
- Developments that displace local people
- Developments that are inaccessible to those most in need

Healthy Food

Why is it an issue?
Poor diet and lack of access to good food impacts disproportionately on people with lower
incomes. The increased consumption of energy dense foods, allied with a reduction of the
levels of exercise in everyday life are major contributors to rising levels of obesity, and the
associated health risks.

Where is the evidence?
The NSW Review referred to above has a substantial evidence review of: ‘The Built Environment and Providing Healthy Food Options’ It argues that there is convincing evidence that regulation of land use around schools can assist in reducing child and adolescent access to unhealthy food options. It also argues that farmer’s markets and community gardens facilitate community interaction and physical activity. They are an extremely valuable element of a healthy built environment.
Things to look for

- Control of fast food takeaways within 400m of schools
- Provision for allotments and community growing schemes
- Availability/accessibility of shops selling fresh food

Try to avoid

- A concentration of Hot Food Takeaways, particularly around schools.

Environmental issues

Land and Land contamination

Why is it an issue?

There are well established risks to human health from exposure to contaminated land, both from metals and from organic contaminants.

Where is the evidence?

The Environment Agency has detailed information on a Contaminated Land Exposure Assessment (CLEA) model. Contaminated land Soil Guideline Values (SGV) and supporting technical guidance are intended to assist professionals in the assessment of long-term risk to health from human exposure to chemical contamination in soil.

There are different SGV according to land-use (residential, allotments, commercial) because people use land differently and this affects who and how people may be exposed to soil contamination. SGV are 'trigger values' for screening-out low risk areas of land contamination. They give an indication of representative average levels of chemicals in soil below which the long-term health risks are likely to be minimal.¹⁰⁹

Things to look for

- A CLEA assessment or equivalent on brownfield sites.

Water

Why is it an issue?

Flooding has become the most frequently occurring major disaster, and incidence appears to be increasing. ‘Non point source’ water pollution is a threat to water supplies, (as are poorly managed construction sites.) The highest incidence of water borne diseases such as gastroenteritis occurs after heavy rainfall onto hard surfaces.

Flooding can have significant effects on health and wellbeing that can extend over a considerable time. There can also be feelings of isolation and loss of control. Women and those with low incomes tend to suffer particularly from the disruption caused by flooding. Flooding can cut people off from necessary medical supplies or services.
Where is the evidence?
The Health Protection Agency undertook a literature review on the effects of flooding on mental health.\textsuperscript{xvi} The HPA found that there is a growing body of evidence that suggests that floods can have profound effects on people’s wellbeing, psychosocial resilience, relationships and mental health, often over extended periods of time. While the HPA makes a number of recommendations about how to deal with the consequences floods once they have happened, planners can play a part by building in flood avoidance or flood resilience.

Things to look for

- Good quality sustainable urban drainage schemes (SUDS), well integrated into the landscaping.
  - \textit{Slowing the run-off of rainwater via tanks, ponds and swales}
  - \textit{Reducing the amount of hard impermeable surface covering}
- Flood resilient construction in areas of flood risk
- An assessment of future flood risks in the light of increasing climate instability and rising sea levels

Try to avoid

- Building on flood risk areas without resilience precautions
- Ignoring the consequences of climate change

Air Quality

Why is it an issue?
The UK Government’s Committee on the Medical Effects of Air Pollution (COMEAP) estimated that air pollution:

- Has short and long term damaging effects on health
- Can worsen the condition of those with lung or heart disease
- May reduce average life expectancy.

Road transport is the biggest single source of gas pollutants such as carbon monoxide and butadiene. Particulates are also generated by traffic, but additionally by other sources such as construction sites. Most people in the UK spend more time indoors than outdoors, so indoor air quality is also important.

Where is the evidence?
The Department of Health commissioned a quantitative systematic review of short term associations between ambient air pollution and mortality and morbidity.\textsuperscript{xvii} This concluded that: ‘Taken as a whole, the large body of evidence from time series studies shows very consistent positive associations between measures of ambient air pollution and a wide range of mortality and morbidity outcomes.’

The Committee on the Medical Effects of Air pollutants is an expert Committee that provides advice to government departments and agencies, via the Department of Health’s Chief Medical Officer, on all matters concerning the effects of air pollutants on health. Its reports are available on its website.\textsuperscript{xviii}

The World Health Organization has very recently published a review of air pollution and cancer, noting that the disease burden due to air pollution is substantial. \textsuperscript{xix}
Things to look for

- Placing of sensitive receptors (such as housing or schools) away from busy roads
- Placing polluting uses away from residential areas
- Routing heavy goods vehicles away from residential areas
- Construction sites that work to ‘good neighbour’ policies such as ‘Considerate Constructors’
- Housing with good ventilation, and construction methods that minimise the use of volatile organic compounds (VOCs)

Try to avoid

- Housing placed close to busy roads
- Inefficient industrial uses that generate fumes and particulates

Noise

Why is it an issue?
The WHO has categorised possible health effects of noise under the following headings: Annoyance; Mental Health; Cardiovascular and Physiological Effects; Performance; Night-time Effects; Noise and Children; Foetal Effects. The WHO Guidelines study concluded: “The potential health effects of community noise include hearing impairment; startle and defence reactions; aural pain; ear discomfort speech interference; sleep disturbance; cardiovascular effects; performance reduction; and annoyance responses. These health effects, in turn, can lead to social handicap; reduced productivity; decreased performance in learning; absenteeism in the workplace and school; increased drug use; and accidents. In addition to health effects of community noise, other impacts are important such as loss of property value.”

Where is the evidence?
The WHO Guidelinesxxiv referred to above contain evidence based recommendations on noise levels in different environments.
The Health Protection Agency reviewed available evidence relating to the effects of environmental noise on health. xxv They concluded that exposure to environmental noise has been shown to be linked with impairment of cognitive performance amongst children exposed to raised sound levels. More generally: “In terms of well-being we have little doubt that a significant number of people are adversely affected by exposure to environmental noise. If it is accepted that health should be defined in such as way as to include well-being then these people can be said to suffer damage to their health as a result of exposure to environmental noise. There is increasing evidence that environmental noise, from both aircraft and road traffic, is associated with raised blood pressure and with a small increase in the risk of coronary heart disease.”
The Civil Aviation Authority has published an overview of literature in the field of noise and health. xxvi It looks at transportation noise in general, particularly aircraft noise. PPG 24, even though now withdrawn as part of then NPPF process, nevertheless contains useful guidance for planners on noise levels. xxvii It defines Noise Exposure Categories (NEC) and recommends the circumstances under which planning permission should be refused, or there should be a presumption against permitting the development on noise grounds.
Things to look for

- Measurement of actual or anticipated noise levels in proposed developments
  - Measured against Noise Exposure Categories
- Mitigation measures to produce defined noise reduction in areas where noise is likely to be an issue.
- Urban design that screens noise sources and places less sensitive uses nearer to any noise sources.
- Noise generating uses located away from sensitive receptors, particularly residential areas and schools
- Identify and protect areas of tranquillity.

Try to avoid

- Placing residential areas close to noise sources, particularly night time noise.
- Placing ‘affordable housing’ in areas disproportionately subject to noise of poor air quality.
- Locating schools in areas that are subject to daytime noise.

Radiation

Why is it an issue?
We are all exposed to a number of different sources of radiation throughout our lives. These include electro magnetic radiation from electronic devices, mobile phones and high tension power lines, as well as possible exposure to radon, a radio-active gas that is known to be carcinogenic. While there is little evidence that non-ionizing radiation at the levels normally found in the environment does cause health problems, the issue does cause public anxiety. There is also public concern about Extremely Low Frequency electro- magnetic fields (ELF EMF) of the kind produced by high-tension Power lines. Again there is little evidence to suggest a link between exposure to such fields and childhood leukaemia, as has been suggested. (Kite flying and fishing near such lines is extremely dangerous!) However people on the whole find the noise sometimes produced by HT lines disturbing, and a view of power pylons, and such a view tends to reduce feelings of wellbeing. (and such a view will tend to depress residential land values).

Where is the evidence?
The most widely used guidelines on exposure to non-ionizing radiation are those produced by the International Commission on Non-Ionizing Radiation Protection.\footnote{xxviii} (The NPPF states that local planning authorities should not determine health safeguards in relation to telecommunications equipment if the proposal meets International Commission guidelines for public exposure.) Public Health England recommends the use of these guidelines.\footnote{xxix} The National Grid have produced design guidelines on dealing with developments adjacent to power lines.\footnote{xxx}
The Health Protection Agency recommends that radon levels should be reduced in homes where the average is more than 200 becquerels per cubic metre. and has produced an indicative Atlas of radon levels in England and Wales.\footnote{xxxi}

Things to look for:

- In applications for telecommunication equipment, a report on the outcome of consultations with organisations with an interest in the proposed development, in particular where a mast is to be installed near a school or college.
- Landscape design that takes account of the National Grid design guidelines (above)
Proposals for radon protection measures in areas of radon exposure

Try to avoid:
- Schools adjacent to power lines
- Urban design that provides housing in close proximity to HT lines
- Urban design which gives direct views of pylons
- Landscape design which gives opportunities for kite flying etc. near to pylons

Ecology and biodiversity

Why is it an issue
A flourishing and diverse ecosystem is part of a healthy and sustainable community. The positive effects of contact with on health and wellbeing is well evidenced. It has been proposed that it has:
- Restorative effects – reducing fatigue 'recharging'
- Cognitive effects – enhanced self-esteem, sense of peace
- Behavioural effects- encourages play, exploration, adventure

“People depend on biodiversity in their daily lives, in ways that are not always apparent or appreciated. Human health ultimately depends upon ecosystem products and services (such as availability of fresh water, food and fuel sources) which are requisite for good human health and productive livelihoods. Biodiversity loss can have significant direct human health impacts if ecosystem services are no longer adequate to meet social needs. Indirectly, changes in ecosystem services affect livelihoods, income, local migration and, on occasion, may even cause political conflict.

Where is the evidence?
There is a substantial literature on biodiversity, although much of it does not focus on human health. A good brief introduction to this aspect is given in: ‘How Our Health Depends on Biodiversity’, published by Harvard Medical School Center for Health and the Urban Environment.

Things to look for:
- A coherent linked ecological networks
- Agreement of a 'Long-term Landscape and Ecological Monitoring and Management Plan' with the Local Authority

Try to avoid:
- Loss of diversity without credible mitigation measures

Safety and security

Why is it an issue?
Crime
Crime and fear of crime are a major influence on quality of life and wellbeing. Physical injury from crime is a public health issue in itself, and in some areas is a major cause of casualties, particularly among young people. Fear of crime is destructive of community, and can restrict the lives particularly of older people. Good urban design can reduce the opportunities for opportunistic crime, and ensuring that areas are overlooked is one of the best ways of increasing security.

Safety and unintentional injury
Falls are a major cause of hospitalisation and premature mortality especially in elderly population. Careful design and maintenance of the external environment will reduce the number of falls. Careful design of housing will reduce the potential for falls in the home. There is evidence that suggests that more than half of falls are outside the home.\textsuperscript{xxxv}

Road traffic injuries and deaths

The rate of road traffic injuries and deaths has declined for a number of years, and Britain has among the world’s safest roads. Nevertheless 1745 people were killed on the roads in 2012, and 23,039 seriously injured. While injury rates have generally been declining, the number of cyclists killed and injured has been increasing for the last eight years. Most accidents occur on built-up roads. (Speed limits under 40mph)

Road injuries are a significant cause of death in younger and older people. Children from deprived areas are at greater risk.

Where is the evidence?
Local information on reported crime is now widely available – see for instance the Office for National Statistics Neighbourhood Statistics.\textsuperscript{xxxvi}

‘Secured by Design’ is the leading national initiative supporting the principles of ‘Designing Out Crime’. It is a valuable but care must be taken to ensure that designs do not become too defensive or impermeable. Design can only go so far, and providing adequate leisure and community facilities or activities, particularly for young people, and particularly in high crime areas, is an important part of an overall approach.

The Department for Transport publishes a range of statistics and information on road traffic injuries and deaths.\textsuperscript{xxxvii}

The Manual for Streets provides detailed design guidance on streets and roads in urban areas:

“MfS demonstrates the benefits that flow from good design and assigns a higher priority to pedestrians and cyclists, setting out an approach to residential streets that recognises their role in creating places that work for all members of the community.”\textsuperscript{xxxviii}

Manual for Streets 2 gives guidance and case studies on how the philosophies set out in the Manual for Streets can be extended beyond residential streets to encompass both urban and rural situations.\textsuperscript{xlix}

NICE has published guidance on ‘Preventing unintentional road injuries among under-15s’, which focuses on 20 mph zones and engineering measures to reduce speed or make routes safer. It notes that those from lower socio-economic routes are more at risk. “The largest factor resulting in this difference in death rate is exposure to danger rather than behaviour. People from lower socioeconomic groups are more likely, for example, to live in neighbourhoods with on-street parking, high-speed traffic and few or no off-street play areas.”\textsuperscript{xl}

Things to look for:

- Community involvement in meeting the needs of all groups needs to be an important part of reducing the fear of crime.
- Adopted ‘Secured by Design’ principles, but avoid excessive restriction on movement round the area.
- Urban Design that provides for natural surveillance of public areas.
- A coherent approach to leisure and community facilities to meet locally assessed needs.
- Within new developments, streets designed on ‘Manual for streets’ principles.
- ‘Home Zone’ principles have been considered for residential areas.
- There are safe routes to schools and local centres.
- 20mph limits are in place in residential areas.
Try to avoid

- Urban design that has areas that are not overlooked, or spaces with no clear function.
- Residential areas designed primarily for traffic circulation.

**Climate stability and sustainability**

*Why is it an issue?*
Climate instability and rising sea levels have huge long-term population health implications. The predicted effects of climate change, such as more frequent extreme weather episodes, will have a detrimental impact on the health and wellbeing of the population. Design can make a significant contribution to reducing the risk. Consumption of non-renewable energy resources by transport and buildings should be minimised, and developments should aim to be as ‘carbon neutral’ as possible.

Any strategy to deal with the implications of climate change needs to consider both mitigation, reducing the emission of greenhouse gases, and adaptation, dealing with the consequences of climate instability.

Planning has a part to play, both in contributing to both of these strands.

*Where is the evidence?*
A ‘Lancet’ commission ‘Managing the impact of Climate Change’ looked at the issue globally and concluded that: “Climate change is the biggest global health threat of the 21st century.”

More recently the Health Protection Agency produced ‘Health Effects of Climate Change in the UK 2012 - Current evidence, recommendations and research gaps.’

It concluded that planning was a key adaptation strategy in reducing flood risk, but that only limited progress was being made. Protection of healthcare facilities from the effects of flooding was a key issue.

*Things to look for:*
- Design the orientation and building depth to maximise passive heating/cooling
- Promoting reuse and recycling of building materials
- Implement grey water recycling and rainwater capture
- Implementing the Code for Sustainable Homes BREEAM level 4 from rising to Level 6
- A robust approach to dealing with flood risk
- Maintenance and enhancement of tree and green cover

Try to avoid

- Reduction of tree and vegetation cover
- Optimism about flood risk
- Accepting that any mitigation strategies are unaffordable
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