# Getting Research into Practice (GRIP) Supporting development of local healthy planning practices

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# Executive summary

**Introduction**

The Getting Research Into Practice 2 (GRIP2) project has two aims. First, to facilitate the implementation of health evidence set out in key Public Health England (PHE) publications by directly engaging with local and regional policy makers, and practitioners across place-making professions and communities. Second, to provide evidence-informed resources to assist local authorities in developing planning policies to improve health and wellbeing.

Locations were selected from 39 Expressions of Interest to take part in the research and develop local resources. Four workshops were then held in each of the selected locations, both, to understand how health evidence could be used in the development of planning policies, each with a different focus:

- **Worcestershire**: template Technical Research Paper on Planning for Ageing Well that could form the evidence base for new Supplementary Planning Documents (SPDs) in the county.
- **Hull**: template SPD on Healthy Places to address considerable health inequalities.
- **North Yorkshire, York and East Riding (YNYER)**: framework for planning for health.
- **Gloucestershire**: template to integrate health into neighbourhood plans.

These locations were also selected in consideration of a range of factors including geography, authority type, topical focus and because they had not received previous capacity building support from PHE or the Town and Country Planning Association (TCPA) to integrate health and planning policy. The discussions at the workshops were used to develop national guidance on Getting Research into Practice: How to use public health evidence to plan healthier places, which includes these local resources and is aligned to the requirements set out in the National Planning Policy Framework (NPPF). This research report focuses on the reporting the findings from the workshops.

**Key findings**

Across the four locations examined there is a genuine recognition of the ongoing need to develop places that improve health and wellbeing outcomes and reduce health inequalities. The research conducted in this project confirmed that integration and partnership working across the professions is key, and highlighted areas of good practice that already exist.

It also highlighted areas where barriers remain, related to a lack of leadership, experience, financial resources and capacity in local authorities, in particular, to develop a shared vision for planning for health between professions. However,

participants were positive that these barriers could be overcome. Enabling factors to achieving better integration of health into planning policy include increasing communication and joint working between planning and public health teams, learning from best practices and successes in other locations, making better use of the powers available to planners and including a range of voices and contributions in the local planning process.

There is an opportunity and an appetite to more effectively translate health evidence into local planning policy by improving stakeholders' understanding of the typologies, strengths, limitations and sources of the available evidence, as well as appreciating the full range of opportunities for its use in local planning policy.

The effective use of health evidence in practice, in turn, can further strengthen the case for healthy places at the local level, encouraging buy in from politicians and local communities.

**Recommendations**

The findings presented above indicate that there is scope and an appetite to better integrate evidence from public health into planning policy and practice. The use of workshops as a key engagement mechanism helped to initiate and strengthen these local appetites for better integration. There is agreement from those in local authorities that opportunities are being missed to maximise the use of health evidence and strengthen planning policy.

It is worth noting here that these locations had not already benefitted from support via PHE's healthy planning or the TCPA's reuniting health and planning initiatives. Therefore, these implications can be read as suggestions for new activities in some areas or encouragement to continue with good practice.

Key recommendations are:

All those involved in the planning and development process must understand the importance of planning in tackling poor health and health inequalities, including central and local government planning policymakers, and those working in development management, private developers and their consultants.

Public Health England and public health teams could provide tailored evidence with specific objectives and audiences in mind; this will allow planning policies and decisions to be locally evidenced.

To maximise the use of public health evidence in planning policy, planning policy and public health teams, with their partners in health and social care, and wider built environment professions such as transport and housing, could work together to:

- Develop a shared understanding of the role of planning in improving population health and reducing health inequalities.
- Make best use of public health evidence to help planners use their powers more effectively.
- Draw from a broad range of evidence, including that generated by communities.

In addition, public health teams in local authorities could:

- Prioritise introducing planning officers to health inequalities, and their relationship with the built environment, through interprofessional learning.
- Support the creation of an effective evidence base which can be applied within a planning context.
- Support planners in monitoring and evaluating planning policies, sharing tools, resources and methods.

Finally, planning teams could:

- Clearly explain the contribution planning can make to improving health and reducing health inequalities and how this can be realised in their policies.
- Use public health evidence to help them achieve their policy objectives.

The guidance document Getting Research into Practice: How to use public health evidence to plan healthier places, which includes the four template planning documents, provides a resource to facilitate these recommendations.

# Glossary

| | |
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| Active 30:30 | Initiative developed to "help schools reduce sedentary behaviour and increase physical activity in young people outside of timetabled curriculum PE" (1). |
| Category C2 | Use class in planning legislation defined as "Use for the provision of residential accommodation and care to people in need of care (other than a use within a class C3 (dwelling house). Use as a hospital or nursing home. Use as a residential school, college and training centre which includes "residential institutions" or C3 which is "dwelling houses" (2). |
| Category C3 | Dwelling house defined as: "C3(a) those living together as a single household – a family; C3(b) those living together as a single household and receiving care; C3(c) those living together as a single household who do not fall within C4 definitions of a house in multiple occupancy" (2). |
| CCG | Clinical Commissioning Group.<br>CCGs are "clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area" (3). |
| CIL | Community Infrastructure Levy.<br>The CIL is a "planning charge, introduced by the Planning Act 2008, as a tool for local authorities in England and Wales to help deliver infrastructure to support the development of their area" (4). |
| Fingertips | A suite of health and wellbeing indicators produced by PHE. |
| GRIP | Getting Research into Practice.<br>GRIP is an initiative from PHE aims to "help local authority public health and planning teams to influence the planning process in an evidenced-based way by ensuring that improvements in health and wellbeing underpin all local plans and the design of local development projects" (5). |
| Healthwatch | "Independent national champion for people who use health and social care services" (6). |
| HSCA | Health and Social Care Act 2012 (7). |
| JSNA | Joint Strategic Needs Assessment.<br>Produced by local Health and Wellbeing Boards, JSNAs "analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas" (8). |
| NDP | Neighbourhood Development Plan.<br>A NPD contains "policies for the development and use of land" in a designated neighbourhood planning area. It is produced by a parish |

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|---|---|
| | or town council, neighbourhood forum or community organisation and "forms part of the development plan and sits alongside the local plan prepared by the local planning authority" (9). |
| NPPF | National Planning Policy Framework.<br>The NPPF "sets out government's planning policies for England and how these are expected to be applied" (10). |
| NVivo | Computer-based software that supports qualitative data analysis in a variety of disciplines from sociology, psychology to business and marketing research (11). |
| Section 106 agreements | Planning Obligations, also known as "Section 106 agreements", are "private agreements made between local authorities and developers and can be attached to a planning permission to make acceptable development which would otherwise be unacceptable in planning terms" (12). |
| SHAPE | Strategic Health Asset Planning and Evaluation.<br>SHAPE is a "web-enabled, evidence-based application that informs and supports the strategic planning of services and assets across a whole health economy" (13). |
| SPD | Supplementary Planning Document.<br>SPDs "add further detail to the policies in the Local Plan. They can be used to provide further guidance for development on specific sites, or on particular issues, such as design. Supplementary planning documents are capable of being a material consideration in planning decisions but are not part of the development plan" (14). |
| YNYER | York, North Yorkshire and East Riding Local Economic Partnership. |

# Introduction and background

In 2017, Public Health England (PHE) published *Spatial Planning for Health* (15), which illustrated the linkages, and strength of evidence, between the built environment and health to inform public health practitioners and planners.

*Spatial Planning for Health* presented the evidence base, primarily from a review of the academic literature, for the relationship between a range of health outcomes and the built environment grouped into five themes: Neighbourhood design; Transport; Housing; Healthier food; and Natural and sustainable environments. It identifies a series of planning principles under each theme, followed by the physical features in the built environment that would achieve these principles along with their likely impact (e.g. increased physical activity) and corresponding health outcomes.

Following the publication of *Spatial Planning for Health*, PHE commissioned further research project: *Getting Research into Practice* (GRIP). This sought to explore the use of the principles set out in *Spatial Planning for Health*, and the challenges of applying these in local planning policy and decision making. As part of this research a survey was completed by 162 public health and planning professionals in local authorities, followed by 6 in-depth semi-structured interviews with 12 paired professionals. The report, published in November 2019 (5), found that:

- Although most respondents were aware of Spatial Planning for Health, awareness was greater amongst public health professionals.
- Around half of those aware of the resource has used it, the majority finding it useful, for example as a reference document for highlighting the importance of the built environment as a wider determinant of health.
- Respondents felt that the resource could be improved by providing guidance on how the evidence can be applied locally, data and metrics, and additional case studies, as well as simplifying the structure for a non-public health audience.
- There remains a lack of integration between planning and public health in many areas, with barriers including differences in the interpretation and use of evidence and a lack of resources and capacity to implement the evidence base.

These findings informed the basis of this second phase of *Getting Research into Practice* (GRIP2).

# Purpose of GRIP2 project

The GRIP2 project aims to facilitate the implementation of the evidence set out in *Spatial Planning for Health* and other relevant Public Health England publications by directly engaging with local and regional policy makers and practitioners across

place-making professions and communities. The project also aims to provide evidence-informed resources to assist local authorities in developing planning policies to improve health and wellbeing.

This research sought to answer three questions:

1. What are the barriers faced by place-making professionals in the four case study locations in England when interpreting and using health evidence in planning policies and tools?
2. How can planners and public health professionals work collaboratively to integrate health evidence into planning policies and tools?
3. How can public health evidence be used effectively to provide a suite of planning resources that enable planners to develop robust policies?

The project received ethical approval from UWE's Faculty of Environment and Technology Research Ethics Committee (Reference: FET.19.09.010).

The findings are presented in two reports. This report focusses on questions 1 and 2, presenting the barriers and enablers to more effective integration of public health and planning. A second report, Getting Research into Practice: How to use public health evidence to plan healthier places, focusses on question 3 and presents recommendations for local authorities and the four practice-based resources as templates for integrating health evidence into planning policy developed in collaboration with professionals.

## Intended audience

The intended audience for this report is primarily PHE, and planning and public health practitioners working in local authorities. However, national stakeholders with an interest in healthy placemaking may also find the recommendations useful, for example, other government departments and agencies such as Ministry for Housing, Communities and Local Government (MHCLG) and the Planning Inspectorate, Local Government Association, Association of the Directors of Public Health (ADPH), Highways England, and the Royal Town Planning Institute (RTPI). Those who need practical guidance on integrating health into planning policy should refer to the guidance in Getting Research into Practice: How to use public health evidence to plan healthier places.

# Research methods and limitations

## Selecting the locations

The first task in the research was to identify suitable locations from which to develop local resources. To achieve this an Expression of Interest call was issued to all local authorities via Public Health England Centres and Directors of Public Health. See Annex A for the Expression of Interest. Only local authorities that had not already benefitted from support via PHE's healthy planning or the TCPA's reuniting health and planning initiatives were eligible to apply. Interested local authorities were invited to submit a one-page response detailing:

- What area(s) of planning they were likely to explore;
- How they would seek to maximise involvement and partnership working with the planning team and other relevant stakeholder groups;
- How they intended to apply the PHE evidence publications;
- Which public health and inequalities issue(s) they intended to address though planning;
- Whether they were able to commit to co-planning and hosting a planning healthy places workshop with relevant professionals/ stakeholders to take place by end of November 2019 with the support of your Director of Public Health and the Head of Planning?

In total 39 applications were received. These were reviewed by the project team and representatives from PHE's Centres and scored against the following criteria:

- Clarity of planning areas to explore in terms of evidence themes and the types of planning document or resource they were seeking to produce;
- Potential local impact on health and wellbeing, and health inequalities;
- Scope of maximising collaboration with planners and other relevant stakeholder groups;
- Scalability and innovation of proposal.

The scores for each application were summarised and ranked and the four locations selected from these to ensure a reasonable geographic coverage across England and a variety of health priorities and planning documents. A summary of the approach taken is presented in Figure 1.

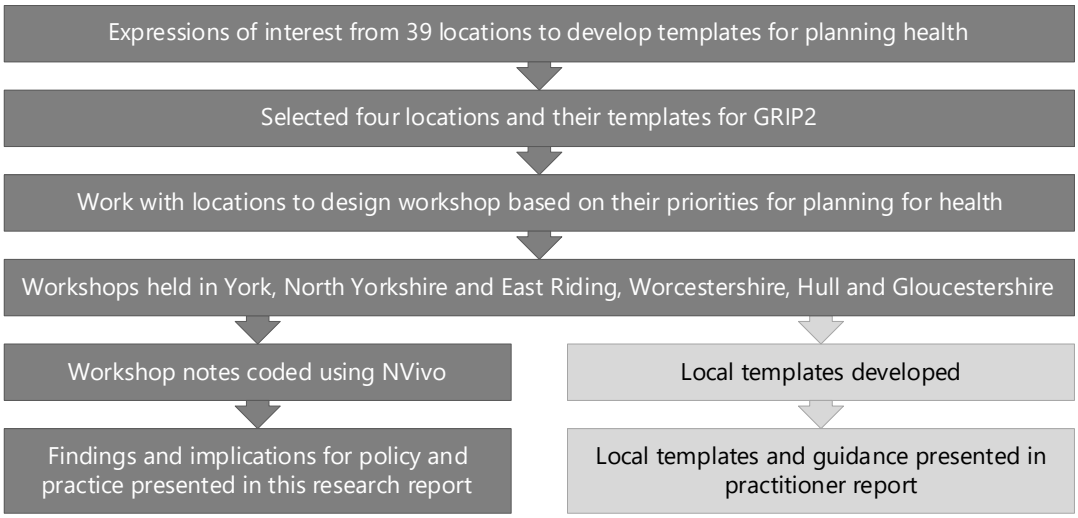


**Figure 1. Summary of the approach taken in GRIP2**

# Getting health evidence into planning policies

After the four locations were selected the project team worked with the lead applicants in each location to design the workshops around their priorities and the planning document they aimed to produce (Table 1). These then also helped to inform the practical resource developed in conjunction with the TCPA and published together with this report.

The leads from each location, who were working in public health and/or planning, then issued invitations to key representatives in their areas. The invitees were chosen to ensure engagement from planning and public health, the range of relevant local authorities or county councils, as well as other locally identified stakeholders and elected members. The four workshops took place in November 2019. The project team developed, with the locations, a series of short 'scene setting' presentations followed by short interactive workshops. Although there was some variation between the events, these sessions generally included:

- An introduction to the project, the format for the day and an icebreaker;
- A summary of health evidence from the area, followed by a workshop on the extent to which this evidence is used in planning and how it can be used more effectively in planning policy;
- A summary of existing good practice tailored to the local focus, followed by a discussion about what the local resource should include;
- A summary of existing approaches, such as the Principle of Healthy Placemaking, followed by a discussion on the future actions to develop the resource.

**Table 1. Summary of selected locations for GRIP2**

| Location | Resource overview |
|---|---|
| Worcestershire | Recognising their ageing population and building on the success of their Technical Research Paper (16) on Planning for Health, Worcestershire County Council's workshop was designed around developing a template Technical Research Paper on Planning for Ageing Well that could form the evidence base for new Supplementary Planning Documents (SPDs) in the county. |
| Hull | Recognising their considerable health inequalities this workshop was designed to enable Hull City Council to use the evidence from *Spatial Planning for Health* to develop a new SPD on Healthy Places. |
| North Yorkshire, York and East Riding (YNYER) | Recognising the significant health inequalities across urban and coastal towns and the rural hinterland, the initial focus of this workshop was a template Design Guide and SPD on Planning for Health that could be linked to the local Industrial Strategy, but during the workshop it was felt that a framework for this Local Economic Partnership was more appropriate given the different local authority contexts. |
| Gloucestershire | Building on the local planning and health framework and emerging neighbourhood plans, Gloucestershire County Council's workshop focussed on integrating health and wellbeing into Neighbourhood Development Plans (NDPs). |

Workshops were held in local venues and lasted five hours. There were around 30 participants in each workshop representing a range of stakeholders related to planning or public health (see Annex A).

## Data collection and analysis

One or two researchers took written notes to record the content of each session and discussion to capture what was being said by delegates in each workshop. The notes did not capture any personal information; therefore, all reported views and opinions are anonymous. The written notes were then analysed using the qualitative data analysis software NVivo (Version 12).

NVivo is a computer-based software that supports qualitative data analysis in a variety of disciplines from sociology, psychology to business and marketing research. It allows researchers to organise and manage a wide range of research material, including not only the data collected and/or generated, but also all the literature and contextual information gathered for the research project. In doing so, it allows to interrogate and gather insights from the data more efficiently and effectively.

In the context of this project, NVivo has been used to organise, manage and analyse typed-up notes and observations made during the four workshops, together with any other background documentation on the specific local authority involved, their objectives for participation in this project, and any literatures concerning the topic under investigation. The typed-up notes, which summarise the content of each workshop session and discussions, constitute our qualitative data. NVivo has allowed and simplified the identification of key concepts and themes that emerged during the workshops and stored the corresponding text in a thematic coding structure, which has been interrogated (using query tools in NVivo) according to the project's research questions.

The coding structure has been developed consistently across all materials to ensure reliability of data analysis and interpretation.

## Methodological considerations and limitations

First, although the workshops followed a similar format in terms of structure of the day and sessions involved, each had a slightly different focus which was dependent on the specific objective set by the participating local authority. Although this was deliberate as the context of each workshop was different, it does mean that comparisons across the four different workshops (and local authorities) in terms of emerging themes and issues need to consider such difference in overall aims.

Second, the knowledge base of delegates was different across the four locations and this affected the focus and depth of the discussions.

Third, even within the same workshop, inevitable differences in how participants' discussions were facilitated and recorded by each researcher will need to be accounted for when interpreting patterns in the data. NVivo itself is a tool which needs the input of the researcher at each stage of the data analysis process. To avoid biases in the interpretation of the text, the coding strategy and structure has been agreed, and has been continually revised, by the whole team.

Finally, although the workshops sought to ensure a representative spread of stakeholders there were some disciplines that were underrepresented in several workshops, most notably transport planners and elected members.

## Workshop evaluation

Participants at the workshops were invited to complete a short survey at the end of each workshop in order to evaluate if, and how, the workshop met their expectations and its usefulness in terms of integrating health into planning policy.

A total of 70 participants completed the workshop evaluation form across the four locations. Of these 24 (35%) participants identified themselves as strategic/policy planners, while 20 (29%) said they were working in public health roles. The remainder of the participants came from a variety of roles including: development (n=3) and community sectors (n=3), elected members (n=3), transport (n=2), design and architecture (n=2), sport and physical activity, housing, nutrition and diet, health commissioning (all n=1), and 'other' (n=8). The evaluation of the workshops as part of the process towards integrating health into planning policy are summarised in the Results and Discussion section later in this report. The remainder of the evaluation of the workshops as an event are presented in Annex A.

# Results and discussion

The results are grouped into key themes emerging from the qualitative analysis of written notes summarising round table discussions and plenary sessions. These key themes are:

- The use of health-related evidence in the development of planning policy;
- Barriers and challenges to getting health-related evidence into planning policy;
- Enabling factors to getting health-related evidence into planning policy;
- Format, design and content of the local resources.

In presenting the results, we highlight the themes and sub-themes that emerged across most or all locations and those that were specific to one location.

Finally, a summary of the evaluation of the workshops is presented.

## The use of health-related evidence in the development of planning policy

In line with the findings from the GRIP project (5), there was general agreement across participants in the four locations that health evidence could be developed and used more effectively in planning policy. Building on this, workshop participants discussed in detail the **objectives of using health evidence**, i.e. what the different authorities were seeking to achieve through the use of evidence. The following aims were mentioned across more than one location:

- To effect change in planning policy, influence development design and decisions making.
- To enable the monitoring and evaluation of health outcomes or the impact of interventions, for example public green gyms (mentioned in Hull and YNYER). However, it was noted that monitoring cannot always provide the answers in

terms of health outcomes – "*some things are difficult to evaluate and can't always be attributed to particular policy interventions or decisions*" (Hull).

A second set of comments was made on the **types of evidence** people were referring to when talking about health-related evidence:

- Delegates acknowledged that evidence can be expressed in different forms, for example "*hard and soft evidence*" (Gloucestershire); and evidence from/about the local community, e.g. "*grassroot evidence*" (Worcestershire), "*lived experiences*" (Hull).
- Evidence from Health Impact Assessments (HIAs) should be used in local policy and be mandatory for planning applications, where appropriate. It is necessary to specify what role the evidence from HIA should play and in which planning applications (Hull). It was suggested that the impact of HIA recommendations on local health is evaluated (Worcestershire).

Other more specific comments on the issues reported above were mentioned in each location, and these are presented in Annex B.

A third set of comments concerned the **characteristics and attributes of the evidence**. The GRIP project (5) highlighted the differences in the interpretation and use of evidence across public health and built environment disciplines, and the need to build on the evidence provided in *Spatial Planning for Health* (15) to ensure that health evidence is applicable to planning policy and development management. In this research, workshop participants across the four locations expressed the two primary needs and aspirations in this respect. Other aspects concerning the language and interpretation of evidence were also considered and these are addressed in the section on the local resources.

The evidence needs to be spatially specific, relevant at the "*ward level*" (Worcestershire), and "*show areas of need and health inequalities*". Granular evidence was seen important in two respects. First, it can support effective policy and application in planning decision making. Second, it can enable its effective consideration in planning contribution negotiations ('S106 Agreements') and the Community Infrastructure Levy (CIL). The CIL is a planning levy that local authorities can choose to charge on new developments in their area. Spatially-specific health evidence, for example, would enable local authorities to better direct CIL contributions to areas in need (Hull). World Health Organization data was considered "*too generic*" and concerns were expressed about evidence resulting from the Joint Strategic Needs Assessment (JSNA), which cannot be "*drilled down to your actual neighbourhood*" (Gloucestershire). The importance of using local health evidence in planning policy was also a key recommendation from research examining planning as an enabler of health (17).

The evidence needs to be up to date, robust and trustworthy. Delegates discussed two points in this respect. First, the need for effective understanding of the use of evidence in planning decision-making to enable its successful use within the development management context. Second, the use of best practice. For example, public health professionals in Hull expressed the need to understand what evidence carries weight in the planning world and influences decisions more effectively. Participants suggested that evidence needs to be presented in a "*much more punchy manner*" to influence developers (Hull) and framed in a way that will persuade elected members to act, e.g. refer to cost saving benefit in their budget (Worcestershire). Others argued that evidence should be framed in terms of positives, e.g. "*what we have and works well, rather than negatives*", and in a way that is relevant to and easily understood by lay people (Gloucestershire).

## Barriers to getting health evidence into planning

Turning to the second theme, the qualitative analysis of workshop discussions has identified seven sets of factors that were represented as challenges/barriers to including health evidence in planning documents in each of the four locations. These challenges focus on the terminology, types of evidence, disciplinary traditions, understanding of planning process, stakeholders, resources and national policy, and each one is discussed in turn.

### Challenges related to the terminology around 'health', e.g. how health is framed and understood by the lay public and professionals working in different sectors.

A general comment emerging from all the workshops was that people, including place-making professionals, do not always realise they are talking about health. In Gloucestershire participants expressed concern that the term 'health' may be a barrier to intervention; "*Health is not familiar in a planning context*", where it is perceived as synonymous of healthcare and the provision of health services. They suggested that the concept of 'wellbeing' (which includes issues such as social isolation, green and open spaces etc.) might be understood better than health. At the same time, it was noted that the term 'health' may be perceived as more authoritative than 'wellbeing'.

## Challenges related to what is considered health evidence, where it can be found, how it is expressed, how spatially specific it is, how it can be interpreted and made relevant locally, whether people/professionals are aware of it and willing to use it.

Delegates had varying degrees of knowledge and awareness of the available existing health evidence resources, with some admitting not to be aware of such resources. A number of delegates raised concerns over the sheer amount of public health evidence available, the need to distil it down into an essential evidence base, and to make it available, usable, easily accessible and interpretable, especially when those wishing to use it are non-experts and may not possess the skills to interpret and use the evidence, e.g. those involved in the production of an NPD (Gloucestershire).

Planners in Worcestershire were sceptical whether health evidence is sufficiently robust to push for higher standards in residential development, e.g. Lifetime Homes. Participants acknowledged that PHE evidence (e.g. local health profiles, SHAPE atlas, fingertips) is available, but not in the local JSNA website. Not all planners attending the workshops were aware of these resources.

Although some developers were perceived as reluctant to use health evidence in their decision-making, it was acknowledged that the reality may be more nuanced. For example, developers of C2 housing (e.g. retirement villages) demonstrate good knowledge of what to provide for older people, but often this is not translated into C3 housing (i.e. housing not specifically developed for older people). Redressing this would help keep people in their own homes when they are older (Worcestershire).

## Challenges related to public health and planning being separate professions with different vocabulary, ways of working, policy development processes and gaps in understanding each other's responsibilities and areas of influence.

As was a key finding in GRIP (5), participants across the four locations recognised that planning and health are largely separate policy domains. They provided examples of the challenges this brings highlighting three areas of disconnect: language and communication, organisational and structural, and documentation. In turn, these challenges can affect the provision of appropriate evidence and the effective use of the evidence provided. It is necessary to recognise that these locations were specifically chosen because they have not received support from PHE or TCPA in the past, so are likely to feel these barriers more acutely than areas that have already developed or begun to develop policies on planning for health. For example, at the workshops areas of existing good practice were highlighted through

looking at example policies (e.g. Torbay, Gateshead, South Worcestershire), guidance (e.g. Putting Health in Place, Designing for Ageing Communities) and tools (e.g. Lifetime Homes standard).

Despite progress elsewhere, in YNYER, concerns were raised that the Sub-Regional Health and Well-Being Strategy "*doesn't have enough planning hooks*" and the JSNA "*is not written in planning language*". Similarly, participants in Hull indicated that whilst the air quality management area policy mentions environmental impact e.g. emissions, it does not discuss health impacts e.g. asthma.

The lack of shared language between the two disciplines was identified as a challenge: "*There is still a big disconnect between the worlds – public health commissioners are not equipped with the knowledge or language*". This is despite public health teams being transferred to local authorities following the Health and Social Care Act (HSCA), 2012, and health being a recurrent theme in the National Planning Policy Framework (NPPF) (10).

The lack of shared education and knowledge between public health and planning professions was identified as a challenge. For example, it was also mentioned that the lack of health content in planning degrees "*means that data/evidence needs to be presented in a lay fashion for planners, e.g. based on traffic lights*" (Worcestershire). Likewise, some public health professionals lack planning knowledge: "*At the moment, public health is sent the details of all planning applications but they don't know the most effective way to respond to them, and it is difficult to know what to prioritise*" (Hull).

Other additional challenges concerned the different, and often disjointed, levels of governance within local authorities, the tendency to work in silos, and different working practices in the public health and planning domains.

## Challenges related to maximising opportunities in the planning process to integrate health and planning.

In different ways, each workshop highlighted areas where the opportunities for planning to deliver better health outcomes were being missed or where the complexity of the planning system was not always well understood by other stakeholders. For example, it was suggested in the Hull workshop that there are opportunities for the Planning Inspectorate to better reflect and implement current thinking or emphasis around health in decision making, a factor also reported in GRIP (5).

Planning for active travel was seen as a priority across the four locations. In the Worcestershire workshop, however, it was felt that the planning system could be

more effective in promoting such measures: "*It's very difficult when you've got different land owners, developers don't like each other and won't connect their sites*".

Participants also reported that the 'planning process' can be a barrier to incorporating health evidence, for example in the case of Neighbourhood Plans discussed in Gloucestershire. "*It tends to make people process-driven, to meet deadlines and requirements. This can stifle creativity and the ability to develop exciting initiatives that might be good for communities*". Others complained about lengthy and bureaucratic processes: "*The planning process is so bureaucratic. It took us three years to get a meeting with planners*". This may reflect that in some cases the most appropriate time for a meeting may be at a particular point in the process of plan preparation or determining a planning application.

A common thread in most discussions across the four locations was the need to understand and communicate what planning can and can't do, for example the difference between planning system and building regulations, licensing, highways regulations, legislation concerning housing, and environmental health controls. Understanding the limits of planning policy and the nature of planning decision-making in the UK would help professionals, policy makers and lay people understand what can realistically be achieved, in terms of health outcomes, by the specific policy document under consideration in each location.

## Challenges related to the stakeholders/communities involved in producing planning policies/documents.

Translating the available health evidence into planning was seen as dependent upon the stakeholders, practitioners and communities involved in the development of planning policies. In Gloucestershire, for example, where the focus was on the production of NDPs, participants wondered whether the "*people who are developing NDPs have the right skill set to interpret the evidence, they may not be fully experienced in how to create a plan or effectively engage with the community*".

Another concern was around the socio-demographic characteristics of those involved in developing NDPs who were perceived not to represent the diversity in local communities. It was suggested that inclusion of representatives of a range of social groups reflecting the local populations should be facilitated, for example people in poor health who may be disengaged from the NDP development process and unable to make their voices heard.

There emerged concerns that "*one person with a strong view can determine what gets into policy*" hence the need to have robust evidence to inform policy-making. Public engagement was seen an essential part of NDP development and one that requires a shared vision on why health is important in planning. Participants were concerned

about how to "*ask questions to the public in a way that is relevant to them. The public are going to ask: what does this mean for me?*".

Further concerns about the perceived lack of interest in getting health into planning among other professionals who were not involved, by their own choice, in these conversations. The following quote provides an extreme but telling example: "*One of my highways colleagues was not remotely interested in attending and they are key decision makers. They are not seeing the link that the decisions they have made may have had negative health outcomes*". Similar perceptions of lack of engagement were expressed towards the regional planning board in YNYER and the lack of health content in the draft Spatial Planning Framework. In addition, some participants highlighted that it is critical to involve developers in the process to ensure their early buy in to the vision for the area.

## Challenges related to the financial resources required to produce, deliver, monitor and evaluate what the planning policy/document proposes.

Resourcing the delivery of healthy developments and other measures was seen as "*a real challenge*" across the four locations. In contrast to GRIP which mainly focused on a lack of resources for policy development and monitoring, our participants also focussed on the cost of delivering healthy places. They felt that hard and soft solutions that provide health benefits, such as physical infrastructure for housing and mobility, and active travel plans, would be more expensive to finance and, as a result, meet obstacles in their delivery. Planners in Hull indicated that land use planning has been trying to promote active travel, which is associated with positive health outcomes, for years. Barriers they cited include, resourcing active travel infrastructure (not just the capital costs but also maintenance and monitoring of health outcomes) and ensuring compliance in its delivery. Claims from developers on the viability of their schemes were mentioned as key barriers to achieving health outcomes through planning, in Hull and Worcestershire in particular. Financial resources were also considered important in ensuring the effective monitoring and evaluation of the health outcomes of interventions, which would contribute in turn to making a stronger case for such interventions if a positive impact on public health was identified.

## Challenges related to national policy/regulation/legislation and how this affects local planning policies/documents and interventions.

This last set of barriers concerns the perceived lack of mandatory national standards. Although the NPPF has relatively strong policies on ensuring healthy places in new

development, there is no set of specific requirements for what this should include (e.g. walking distances to greenspaces and other amenities). This means that local authority planners and developers are unsure of what exactly they need to provide, and therefore opportunities are missed. The lack of certainty of what is expected has been also raised as an issue in the delivery of green infrastructure (18).

Participants in Gloucestershire suggested that "*healthy developments have to be mandatory*" and "*there needs to be a culture change at the top, at a national level. If the evidence is there why isn't the government changing its policies?*" Examples cited during the workshop discussions included developers charging for the management of green spaces and planning obligations ("Section 106 agreements") being used in a "*piecemeal fashion*".

# Enabling factors to getting health evidence into planning policy

Considering the third theme, participants in the workshops identified enabling factors or opportunities when discussing how to include health evidence in planning documents in each of the four locations. The factors identified as enablers have been grouped into three categories and are presented as follows.

## Understanding, using and enhancing standards/regulation.

Participants across the four locations discussed ways in which existing standards and regulation, both within the remit of planning and in other areas (e.g. licensing), could be better applied and enforced. In Worcestershire, an accreditation from Public Health England was suggested as an enabler, others examples of the Live Well Accreditation (used in Essex), Building with Nature and Lifetime Homes were also suggested.

Regulations and controls over other areas of local government, such as licensing and procurement, were perceived as important enablers to improving health outcomes (e.g. reducing obesity). Examples mentioned by participants included conditions on opening hours for hot food takeaways, controls over concentrations of betting shops, payday lenders and casinos: "*Licensing is critical, it needs to work alongside and in addition to planning to ensure robustness in approach*" (Hull). Participants suggested that regulation should require all new developments to be planned with space to grow food, but the challenges of rural locations were highlighted in this context: "*Many rural communities are becoming food deserts despite being very close to where fresh food is actually produced*" (YNYER). There is, in the absence of national mandatory standards, perhaps an opportunity for local authorities to set expectations on the use of accreditation systems in new developments in their areas

and ensure that these work synergistically with regulations from other areas as planning can only ever solve part of the problem.

Making the most of the CIL was also mentioned as an opportunity. In Hull, participants suggested that it could be spent on improving open spaces in areas of need, as *"recent changes to CIL regulations make it more flexible*".

## Learning from best practice/successes

Evaluating the outcomes of planning policy interventions wherever possible (e.g. active travel plans, community gardens, public gyms etc.) and the robustness of the health evidence itself, as well as learning from past experience, were seen as key enablers to translating evidence into planning. Participants in Hull suggested that an independent organisation could be in charge of the monitoring and evaluation task. Linking local authorities' Authority Monitoring Report (AMR) with health data was also seen as a potentially useful tool to monitor the outcome of interventions. AMRs are an important part of local authority reporting on planning. Although, there are inevitably challenges around attributing causality.

Wider examples of using health evidence in planning policy from elsewhere were considered particularly helpful, and these are provided in the accompanying Getting Research into Practice: How to use public health evidence to plan healthier places. Planners attending the Worcestershire workshop, for instance, requested examples of "*strong policies with evidence that allowed [planners] to push for higher standards*". It was suggested that "*once you've got a policy in one area of Worcestershire it's easier to get it in other areas. There are good policies for access to the natural environment, walkability. And strong evidence. The South Worcestershire Design Policy seems to do well, is not challenged by inspectors*".

## Helpful ways of working

From a policy process perspective, effective working practices emerged among the key enabling factors. The inclusion of "*subject matter experts*" (Worcestershire) and "*partnership working*" were considered contributors to successful policy implementation and achievement of positive health outcomes (Hull). In Gloucestershire, it was considered helpful to involve local organisations such as residents' associations "*to make sure that the views of left-out communities are included in the development of Neighbourhood Plans*". However, it should be noted that those involved in residents' groups are often also not typical of the areas they represent (19). Other stakeholders to include in the policy process were mentioned, for example parish councils, developers and "*community builders*". Examples of good practice noted at the workshops included running joint CPD courses with planning

and public health teams, and ensuring the public health team were on the consultation list for planning applications.

Timing of involvement of multiple stakeholders with different interests is important. The message from Gloucestershire was that early engagement is particularly helpful to allow people to make (and feel they are making) a significant contribution to policy before any decisions are taken.

### Developing a shared vision

The importance of developing a shared vision across health and planning was a key finding of both GRIP (5) and research examining enablers for integrating health into planning (17). It is also highlighted as one of ten principles for *Putting Health into Place* (20). The evaluation of the workshops found that participants valued these as a first step towards developing this shared vision, and addressing some of the barriers identified above and in GRIP.

## Local resources

The fourth and last theme discussed at the workshops concerns the format, design and content of the local resources to be developed, and what type of guidance was needed, for each of the four local authorities. Sub-themes have been identified and organised from the workshop notes using NVivo. Although most of these sub-themes emerged across the four locations, there are differences in the way workshops were conducted (depending on the specific focus of the resource to be developed) which have produced distinctive results in each of the localities. Moreover, although the focus was on the content of the local resource, or guidance, rather than the final policy document supported by such guidance, participants often talked about the specific document or strategy and the priorities this should include. More details about the distinctive content of the resources in each local authority are presented in Annex B. The sub-themes are summarised as follows:

- *Audience:* the resource should provide guidance on how to best engage with the audience of the policy document under consideration. Participants were aware this heterogeneous audience could include policy makers, elected members, developers, consultants, professionals from different backgrounds, interest groups and local communities.
- *Design and presentation style:* the resource should provide guidance on how to produce an engaging and clear policy document, to make sure those who read it interpret it correctly. Participants suggested that clear visual representations, such as maps and infographics, are preferable to text, and that the language used should be simple to understand but rigorous and authoritative. Participants

discussed what structure the resource should have, e.g. headings, but this varied quite considerably across the four locations. The content should include examples of best/worst practice.

- *Built environment as a wider determinant of health:* the resource should provide some standard introductory text to explain the importance of integrating health into planning, and why it is important that places are planned, designed and delivery to enable healthy lifestyles for all.
- *Evidence:* the resource should provide guidance on how to find, present, interpret and use the evidence on the links between planning and public health. Participants broadly agreed that evidence should be presented in a way that is relevant/meaningful to the audience, resonates with the local authority's priorities and aspirations, and creates a compelling case for action by decision-makers. Evidence and data should be up to date, i.e. linked to external 'live' sources which are constantly updated, and areas of uncertainty should be acknowledged.
- *Links to other resources/tools/policies:* the resource should provide guidance on signposts to other documents and strategies relevant to achieving public health outcomes. Participants in each area provided examples that were relevant in their respective contexts.
- *Spatial specificity:* the resource should provide guidance on how to account for disparities in health outcomes, needs and priorities within each local authority. There was broad agreement that each location experienced significant geographical variations in terms of health outcomes.
- *Monitoring and evaluation:* the resource should provide guidance on how to effectively monitor and evaluate the health outcomes of the proposed interventions, including ensuring adequate resourcing for these important tasks.
- *Public engagement and communication:* the resource should provide guidance on public engagement in the planning policy process and a consistent framework for consultation. There was significant variation across the locations in the level of existing public engagement, but a propensity for more and better engagement emerged in all the workshop discussions which brought up this theme.
- *Proposed solutions/interventions:* participants in all locations discussed the solutions and interventions they would like to see included in the resource and, most importantly, in the specific planning policy document under consideration. Such solutions ranged from physical infrastructure e.g. housing, transport and connectivity, green infrastructure, public gyms, to marketing and communication interventions, such as travel planning and promotion of active travel.

# Key learning from the workshop

The following sections present a summary of what participants found particularly beneficial in the workshops to help those wishing to start the process of integrating health into planning policy. Additional results are presented in Annex A.

The majority of participants indicated that their understanding of the role of planning and public health had improved as a result of the workshop. As one participant explained they had gained *"Knowledge of evidence, understanding of future opportunities for collaboration, capacity"* (YNYER). Some participants said they had become more aware of relevant resources and case studies that could inform their practice while others said they had made useful contacts during the workshop. For example, a participant from Worcestershire highlighted the value in *"Access to large area of evidence base that I wasn't previously aware of"* and another from Hull found benefit in the *"Examples of good practice- opportunity to influence local plan 2022"*.

## Impact of the workshop on practice

Participants particularly highlighted that the workshop would have an impact on planning practice in terms of policy making, for example by providing a *"Good grounding for developing policies and wider knowledge relating to who should be inputting into policy development"* (Worcestershire). In addition, they also commented that the workshop provided content that would aid them in assessing planning applications *"… in terms of planning policy and development management of how we respond to applications"* (Worcestershire). Participants also found that the workshops provided an opportunity for collaboration and to *"Engage more with colleagues in planning but also other areas across LA, i.e. Highways" (*YNYER).

## Next steps for implementation

Several ideas were identified as next steps for implementation of knowledge gained during the workshops. These included the anticipated local resources, such as SPDs and technical research papers, but participants also commented on the relevance to their local plan development and to improve partnership working across teams. For example, one participant said their next steps would be to *"Read through relevant evidence and decide how to integrate into local plans and/or SPD"* (YNYER) and another said *"Communication + working in partnership to deliver more impactful work"* (Gloucestershire).

# Implications for policy and practice

The findings presented above indicate that there is scope and an appetite to better integrate evidence from public health into planning policy and practice. The use of workshops as a key engagement mechanism helped to initiate and strengthen these local appetites for better integration. There is agreement from those in local authorities that opportunities are being missed to maximise the use of health evidence and strengthen planning policy. The implications for policymakers and practitioners stemming from the workshops are presented below. It is worth noting here that these locations had not already benefitted from support via PHE's healthy planning or the TCPA's reuniting health and planning initiatives. Therefore, these implications can be read as suggestions for new activities in some areas or encouragement to continue with good practice.

**All those involved in the planning and development process must understand the importance of planning in tackling poor health and health inequalities**, including central and local government planning policymakers, and those working in development management, private developers and their consultants. There is variation in understanding and practices in many parts of the process, which is hampering progress in some areas. Three examples were highlighted:

- Disparities in practice amongst planning inspectors concerning the potential, scope, and ability to integrate enhanced health and wellbeing derived requirements into the planning policy context, particularly with regards the Development Plan creation, examination, and adoption process, is causing uncertainty and a lack of confidence in authorities about how to ensure health is integrated into their policies;
- Elected members should be supported to better understand the relationship between planning and the built environment, and health and wellbeing outcomes;
- Stakeholders in different areas of local authorities should be supported to better understand the contribution they can make, for example those involved in highways planning.

**There is a role for public health teams in local authorities to enhance planning officers' knowledge concerning health inequalities, and their relationship with the built environment**. Although the roots of planning are in improving health, planners have not always approached planning policy and decision-making in the context of health inequalities in the manner now expected. There is a role for public health teams to strengthen planners' understanding of health inequalities, for example, through joint CPD, particularly the priorities in their locations, and how

planning policies and decision could help reduce these inequalities or, if they are not considered, make them worse.

**Planning policy teams could articulate the contribution planning can make to improving health and reducing health inequalities.** There is a lack of awareness of the wider determinants of health amongst both professional and community groups, so policymakers need to set this out prominently in relevant policies. It may also be that the word 'health' is unhelpful, and that alternative terms, such as wellbeing, may be more readily understood, particularly for Neighbourhood Planning Groups or during consultation activities.

**Planning policy teams could develop their understanding of how public health evidence can help them achieve their policy objectives.** There are multiple opportunities to make better use of public health evidence in planning and public health teams can support planners to maximise these. These opportunities include:

- To improve the built environment through better policy and design guidance, so that it can contribute positively to health and tackling health inequalities;
- To provide a greater understanding of localised health outcomes to better target interventions and maximise the benefits from new development, funding and developer contributions;
- To enable monitoring and evaluation of policies, guidance and new places to demonstrate the effectiveness of healthy planning in improving health outcomes;
- To demonstrate the cost effectiveness of healthy places and their long-term maintenance to counter arguments regarding the viability of development.

**Public Health England and public health teams could provide tailored evidence with specific objectives and audiences in mind to enable planning decisions to be locally evidenced**. Health evidence can be presented to decision makers more effectively, for example, by presenting the consequences of doing nothing to enable healthy planning, the cost savings to other areas of local government, and providing positive examples from other authorities. Public health teams can work with planners to ensure that evidence they produce is more usable for planners, and help with interpreting the evidence. Evidence presented at ward or authority level may hide pockets of health inequalities; reducing the ability to target interventions to where they are most need. Similarly, comparisons with national data are not helpful as there are poor health outcomes at the national level, so using this as a benchmark provides an inaccurately positive picture. Critically, health evidence must be specific and precise to support and underpin planning decision making and the effective application of planning policy.

**Planning policy teams could seek the views of a wide range of stakeholders when interpreting and using evidence.** There is a need to recognise that different

stakeholders interpret evidence in different ways, and this can bias the ways in which evidence is used. Often planning and public health professionals represent a subset of the population and there is a need to ensure that the voices of all the community are represented, particularly those from marginalised groups who may suffer the greatest health inequalities.

**Planning policy and public health teams could draw from a broad range of evidence, including that generated by community groups.** Linked to the above, there is a tendency to value quantitative evidence from national datasets more than locally generated data from grassroots organisations. Publications and research documents (e.g. *Spatial Planning for Health*) are very valuable, but it's vital that they are supplemented with qualitative and locally generated evidence that presents the lived experiences of local people, particularly the least healthy and most marginalised.

**Public health and planning professionals can work together to develop a shared understanding of the role of planning in improving population health and reducing health inequalities.** Differences in the use of evidence, language and practices of the different disciplines need to be recognised and overcome. This is particularly important in understanding how public health evidence can facilitate better planning outcomes, but also in recognising the limits of the planning system and what it can and can't achieve. This will allow scarce resources to be targeted where they can make the greatest difference. The workshops were an effective way of facilitating this shared understanding, and Gloucestershire shared positive experiences of running joint Continuing Professional Development (CPD) sessions for planners and public health professionals, which could also bring in some of the other stakeholders (e.g. elected members, highways, neighbourhood planning groups).

**Public health evidence can help planners use their powers more effectively.** The use of local standards (e.g. Live Well Accreditation) or accreditation systems (e.g. Lifetime Homes, Building with Nature) was seen as key to delivering healthy places, and planners have the powers to require these into their local policies. Local public health evidence that sets out the health priorities for the area, and evidence of the relationship between built environment interventions and health outcomes, such as that provided in *Spatial Planning for Health*, can provide the necessary weight for such standards.

**Public health teams should support planners in monitoring and evaluating planning policies.** Evaluating the effectiveness of policies and interventions in the built environment is often neglected, but often existing evidence can support this. It is crucial that this is prioritised and robust monitoring and evaluation takes place to

test what works and allow other locations to learn from front runners, and target resources effectively.

# Conclusions

Building on the findings from the GRIP1 project, this follow-on research provides localised narratives of the opportunities, barriers and enablers of using health evidence in planning policy. We found that there is an appetite across planning and public health teams to make better use of the local health evidence base. Despite this, and a strong policy steer nationally, there remain a number of barriers. Many of these barriers relate to a lack of resources and capacity in local authorities. This includes resources to find the time and space to develop a shared vision for planning for health, which the workshops we report on here can initiate, and resources to prioritise new planning policy focused on health when there are multiple priorities for new policy development.

But we also find that the right 'hooks' into planning policy are being found, and that there is a genuine recognition of the ongoing need to develop places that improve health and wellbeing outcomes and reduce health inequalities. The effective use of health evidence was seen as a key mechanism to making the case for healthy places at the local level, encouraging buy in from politicians and local communities. Opportunities to learn from successes in other locations, and making better use of the powers available to planners were also seen as crucial in ensuring health is prioritised in planning policy.

A suite of implications from policymakers and practitioners in planning and public health teams also provide suggested ways forward for those in national and local government. These should be considered alongside the guidance and resources provided in the Practitioner Report.

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# Annex A: Expression of Interest

Public Health England (PHE) Healthy Places team is working with the University of the West of England (UWE) and the Town and Country Planning Association (TCPA) to deliver a project to provide you in local authorities with much needed capacity building and national expertise to implementing healthy places through town planning. It is part of the Getting Research into Practice (GRIP) initiative which found various practical challenges which need to be overcome in applying public health evidence in planning practice. The focus would be translating issues set out in PHE evidence publications, specifically Spatial Planning and Health, Air Quality and Green Spaces.

Through working with national experts in UWE and the TCPA, the outcomes of your involvement would be the co-production of local workshops and resources which are directly translatable into practice by other local areas. These would establish and develop resources to enable the translation of research and evidence into practice on the ground through the local plan-making and the planning applications process, and to meet requirements in the Planning Practice Guidance (PPG) on Health and Wellbeing and the National Planning Policy Framework (NPPF).

**Areas of planning to explore**
We are interested in focusing on local plan-making (supporting bringing forward relevant health and wellbeing policies), guidance (planning for health checklists or supplementary planning documents) and planning applications (development management of proposals for housing or mixed use). We emphasise the focus to be based on the PHE evidence publications listed above.

**What is on offer**
We recognise time and expertise constraints in local authorities. We can offer capacity building and expertise from the UWE, TCPA and PHE Healthy Places team to independently facilitate a workshop and co-produce a local planning for health resource to assist with your on-going commitment to reducing health inequalities and improving health outcomes through the local planning system.

**Expression of interest questions**
Please provide a submission, no more than 1 side of A4, by 19th August 2019:

- What are the area(s) of planning you are likely to explore?
- How will you seek to maximise involvement and partnership working with the planning team and other relevant stakeholder groups?
- How do you intend to apply the PHE evidence publications?
- Which public health and inequalities issue(s) do you plan to address though planning?
- Are you able to commit to co-planning and hosting a planning healthy places workshop with relevant professionals/ stakeholders to take place by end of November 2019 with the support of your Director of Public Health and the Head of Planning?

**Eligibility**
We are seeking to work with those local authorities which have not benefited from previous work on planning for health with PHE or TCPA Reuniting Health with Planning initiative of projects, and also to reflect the different local authority arrangements (unitary, two-tier, strategic planning etc).

**Timescales**
Following receipt of submissions, up to 4 local authority areas will be selected to be part of the project. The selection process will take place in late August/ early September and local authorities will be notified immediately after selection for a further phone conversation with UWE/TCPA. We would wish planning for the workshops to be underway shortly after notification.

# Annex B: Workshop evaluation

A total of 70 participants completed the workshop evaluation form for all four sites (Table A1). About 35% of participants identified themselves as strategic/policy planners, while nearly 30% said they were working in public health roles.

**Table A1. Number of participants in each location completing the feedback.**

| Respondent characteristics | Number of respondents | Percentage |
|---|---|---|
| Workshop location | | |
| Hull | 22 | 31% |
| Gloucestershire | 18 | 26% |
| York, North Yorkshire and East Riding | 17 | 24% |
| Worcestershire | 13 | 19% |
| Role | | |
| Strategic/ policy planner | 24 | 35% |
| Public health | 20 | 29% |
| Others | 8 | 12% |
| Development management | 3 | 4% |
| Community | 3 | 4% |
| Local Councillor | 3 | 4% |
| Transport | 2 | 3% |
| Design and architecture | 2 | 3% |
| Sport and physical activity | 1 | 1% |
| Housing | 1 | 1% |
| Nutrition and diet | 1 | 1% |
| Healthcare commissioner | 1 | 1% |

## Overall evaluation of the workshops

The majority of participants (96%) indicated that the overall content and structure of the workshops were good. Over 70% of respondents affirmed that the aims and objectives of the workshop were met very well and that their expectations of the day were met very well (Figure A1).

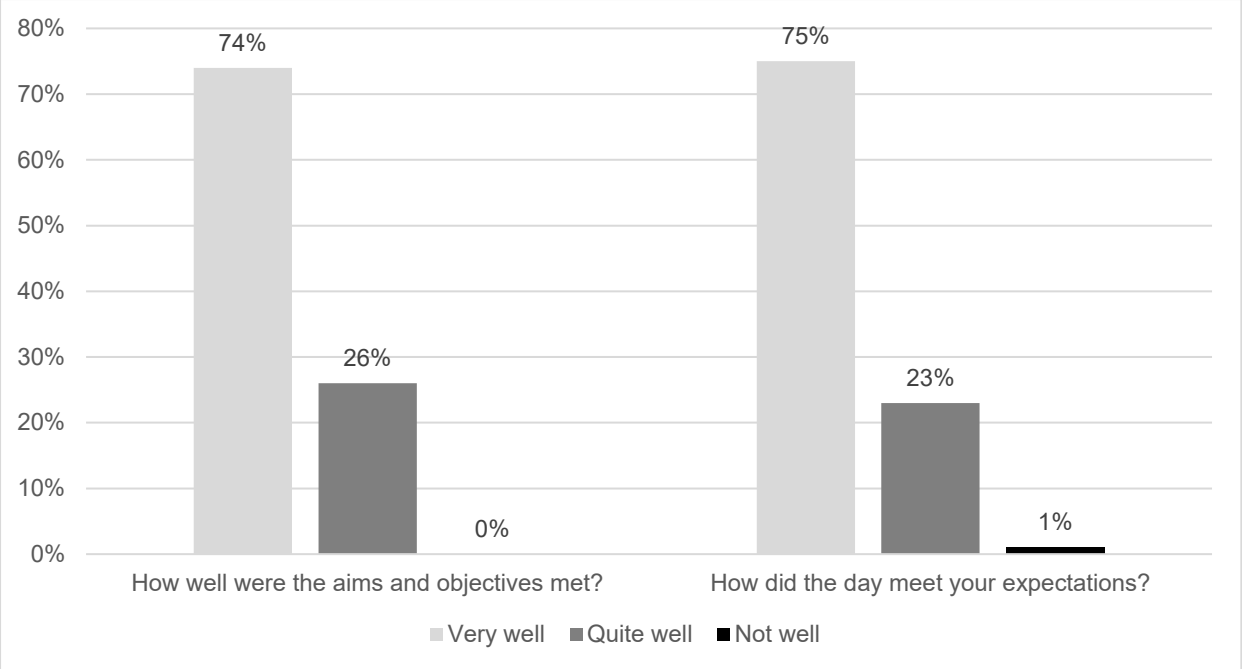


**Figure A1. Overall evaluation of the workshop.**

## What participants hoped to gain from the workshop

Networking opportunities, a better understanding of planning and public health in relation to improving health and wellbeing, and examples of best practices were most commonly cited as what participants hoped to gain from the workshop. For example, highlighting that they wanted a *"Better understanding of how public health and planning can work together to implement healthy planning"* (YNYER) and *"A better understanding of how planning can deliver health benefits"* (Hull).

These narratives also emerged from the ice-breaker session at the beginning of each workshop. Participants from the four locations, many of whom had never taken part in a multi-disciplinary gathering of this kind, expressed their desire to understand the roles of professionals in the planning and health policy domains; how they can work together towards better health outcomes and evidence-based planning policies; to gain inspiration from the work of others; to avoid duplication of efforts; and to learn from each other's experiences, both positive and negative. For example, participants welcomed the opportunity to *"Share best practice and learn from others"* (Worcestershire) and for *"Good networking + increasing my knowledge base"* (Gloucestershire).

## Further evaluation of the workshops

The majority of the participants felt that the content of the workshops was relevant and practical (97%), and nearly all the participants (97%) indicated that they would

recommend future workshops to others. Most respondents (77%) also agreed that they learnt examples of practical application from the workshop and 79% indicated that the learning would enable them to make a difference in reducing health inequalities. Further details of participants evaluation of the workshop can be seen in Table A2.

**Table A2. Further evaluation of the workshop.**

| About the workshop | Agree (%) | Neutral (%) | Disagree (%) |
|---|---|---|---|
| The content were relevant and practical. | 91% | 9% | |
| I would recommend future workshops to others. | 97% | 3% | |
| I learnt from examples of practical application. | 77% | 22% | 1% |
| I believe this learning will make a difference to efforts to reduce health inequalities. | 79% | 21% | |
| I was able to contribute my knowledge and experience to discussions. | 96% | 4% | |
| I will be able to apply the knowledge I gained in my work and share this with my colleagues or stakeholders. | 91% | 9% | |
| I made contacts with whom I can work collaboratively. | 81% | 19% | |

Participants were asked to indicate the aspects of the workshop they found particularly useful, and nearly all aspects (presentations, networking, round table discussions) were mentioned. However, the round table discussions were repeatedly mentioned among participants across all four workshops sites as they highlighted opportunities for collaborative working. The networking/ice-breaker session at the start of the session was also repeatedly mentioned as one of the useful aspects of the workshop.

Other stakeholder groups which participants of the workshops wished were in attendance include developers, highways, Clinical Commissioning Groups and elected members/local politicians.

# Annex C: Full results relating to specific local resources

## The use of health-related evidence in the development of planning policy

In addition to the general aims presented in the Results and Discussion, there were a number of specific aims in each location, as follows.

In Worcestershire:

- To influence design guide detail and to support the development of local standards.

In Hull:

- To demonstrate that healthy lifestyles/choices (e.g. healthy eating) are cost effective;
- To understand which geographical areas are most in need of interventions;
- To be able to provide a robust challenge to claims by developers that developments will not be viable if particular features are included in a scheme.

In Gloucestershire:

- To use Planning Obligations ("Section 106 agreements") and CIL contributions more effectively.
- Other specific comments concerning the types of evidence were also made in each location, as follows.
-

In Worcestershire:

- Suggestions that evidence from the JSNA should be used more in planning.
- More evidence on issues affecting the older population (transport modes, trip length and patterns, mobility scooters' range, charging requirements etc.) is needed.

In Hull:

- Success stories and examples of failures can also be considered evidence to be used in planning policy.
- The public health team in Hull has a new mapping software able to generate spatial evidence of health problems in the local authority. This can be made available to planners.

In Gloucestershire:

- NDPs can be regarded as evidence because they can be used to effect change in planning policy.

## Local resources

What follows is a detailed and complete list of issues that were mentioned by participants in the workshops when discussing the format, design and content of the local resources to be developed for each of the four local authorities.

### North Yorkshire, York and East Riding

Workshop participants identified the following **aspirations** for the local resource:

- To gather more health evidence that can be used in support of local plan examination.
- To include health as a key component of shortlisted SPDs which currently do not mention health but have strong links to it, e.g. green infrastructure and climate change.
- To include public health in the Statement of Common Ground that councils prepare in support of their local plans.
- To explore the role of a potential sub-regional spatial plan.
- To develop a high-level document that bridges the work of the Health and Well Being Board and local plans.
- To consider best practice from elsewhere. Healthy Planning Principles from Darlington/Hertfordshire were mentioned and favoured by all participants, who would like to see that replicated for YNYER.
- To reflect the geography of the area and the distinctive needs of each district. There was disagreement on whether a policy guided by general core principles would be applicable, and accepted, in all areas within the local authority.
- To ensure that the SPD would be interpreted correctly and offer developers clear shared expectations of what they should provide.
- To adopt and apply a shared set of principles to all places to get good health outcomes.

Concerning the **themes and solutions** that could be included in the resource, participants mentioned the following:

- Food environment
- Play (not just playgrounds)
- Ageing population
- Climate change adaptation

- Flooding
- Coastal erosion
- Street trees
- Access, transport and connectivity.

## Hull

Participants in the Hull workshop highlighted the following **considerations** concerning the local resource.

- *Possible title:* 'Healthier places, healthier people'.
- *Audience for the SPD:* in order to shape the design and content of the SPD there needs to be more clarity about who the audience is, e.g. policy makers, developers, but also local communities.
- *Design and presentation style of the SPD:* clear visual representations of the links between planning and public health should be provided, showing the overlaps and correlations, with the aid of maps and infographics. A clear and succinct executive summary would be beneficial. There was no consensus of whether placing key health data right at the beginning of the document, rather than in an appendix, would be preferable. Participants also discussed the benefits of strengths of language and the use of 'must' or 'could' or 'should'. However, this would be dependent on the strength of language used in the relevant local plan policy.
- *Evidence:* participants indicated that health evidence needs to be presented in a "*much punchier manner*" so that it informs planning applications and decision making, e.g. by developers or councillors. This should include evidence about healthy life expectancy and health inequalities across the area.
- *Links to other resources/tools/policies:* participants indicated that the SPD could provide signposts to other documents and processes relevant to achieving public health outcomes, e.g. licensing, building control. This might provide clarity on 'planning's reach'. The SPD also needs to be aligned to other policies e.g. the Climate Change Action Plan and policies on green infrastructure.
- *Spatial specificity:* the SPD could have different priorities for different areas, e.g. those that are most severely affected by childhood obesity and other health priorities.
- *Monitoring:* the SPD needs to recommend solutions, such as travel plans, which are then monitored and evaluated to capture the health benefits. Participants expressed concern over the apparent lack of resources for adequate monitoring.
- *Public engagement:* the current SPD doesn't include much about public engagement. Suggestions included co-production processes, i.e. "*doing planning not for the public, but with the public*", learning from the example set by public

health professionals who have good connections to the community, e.g. patient groups, and working with professionals from other policy domains, e.g. the Fairness Commission.

Concerning the **themes and solutions** that could be included in the resource, participants mentioned the following:

- Improving the physical environment – creating accessible paths, strengthening key vistas, green spaces for different community groups, parkour areas, public green gyms, benches etc.
- Healthy eating and residents' growing space.
- Adopting a combined approach – physical infrastructure matched by education initiatives, community champions, financial viability and other aspects to ensure behavioural change.
- Supporting active travel e.g. walking and cycling, including travel plans and infrastructure maintenance, to improve accessibility to life opportunities.
- Stealth health initiatives to support behaviour change, e.g. nudges, marketing and communications.
- Initiatives targeted at school children, such as: The Daily Mile, Active30:30, Change4Life.

## Worcestershire

Participants in the Worcestershire workshop highlighted the following **considerations** concerning the local resource.

- *Aim:* to inform an SPD and other planning policies by providing robust evidence and explaining the planning process, and the reach and limits of planning.
- *Audience:* whilst the primary audience for this resource is the planning profession, it should be read and understood by the Health and Wellbeing Board, the development industry, the Clinical Commissioning Group (to support planning future work), the Sustainability and Transformation Partnership Board, and potentially also local third sector organisations, e.g. Age UK.
- *Design and presentation style:* the inclusion of a stakeholder map would be useful to understand who does what in different policy domains. It should include photographs and examples of best/worst practice. The resource should start with a section illustrating the 'context', e.g. the challenges of ageing well in the county and the policy drivers, from the perspective of planning and health disciplines.
- *Evidence and data:* Evidence and data reported in the resource need to be signposted to live documents (actual data sources), so that it is always up to date. The 'evidence' section of the resource should address questions such as "*What is ageing well? What is dementia?*" and provide an explanation of the built and

natural environment as wider determinants of health, as well as the meaning of dementia-friendly environments. Data on affordable housing, demographics of new sites and data on adaptable housing should also be provided, and this must account for future health demand, future tenure profiles and demographic trends. Evidence on social isolation, connectedness and planning (i.e. space, number of rooms for older adults) could also be included. This may lead to a review of the space standard.

- *Monitoring and evaluation:* all the proposed measures in the policy document need to be financially deliverable and their health impacts need to be measured.

Concerning the **themes and solutions** that could be included in the resource, participants mentioned the following:

- The development of new planning policy should include the needs of local older people. At the workshop an older persons' representative highlighted a number of key features that would support ageing well in Worcestershire:
    - Safe housing, no stairs.
    - Accessibility in the home, doors that are wide enough etc.
    - Integral pull-down bed in lounge if property has to be one bedroom.
    - Thermal comfort.
    - Being able to see nice things (flowers, greenery).
    - Security, lighting especially at the back of the property.
    - Being close to other older people, but also not just older people.
    - To be able to get to things and have things to do.
    - Online access.
    - Ability to travel to amenities and services further afield.
- Creating community hubs for older people, providing a safe space for socialization and activities.
- Supporting access to fresh and healthy food.
- Supporting the use of digital health.
- Supporting care at home / closer to home and the need to step down and extra care housing. Supporting people in their home can be integrated into planning policies, considering shopping and cleaning needs.
- Integrating social housing for older people into the planning policies. There also needs to be more affordable C2 housing, with public transport connections to other places.
- Exploring potential to develop a Worcestershire Lifetime Homes / neighbourhood standards – identifying the core elements that are essential and supported by evidence and cost-effectiveness.
- Improving transport infrastructure in and around homes and recognising the issues with cul-de-sac. Providing: accessible storage and charging facilities for

bikes/e-bikes and electric mobility scooters; walking and cycling infrastructure (including handrails and special wayfinding) that is safe for older people; pedestrianised areas in new developments. Promoting walking groups.

## Gloucestershire

Participants in the Gloucestershire workshop highlighted the following **considerations** concerning the local resource.

- *Audience:* The resource needs to acknowledge the needs of different audiences, e.g. council officers, elected members, consultants acting on behalf of developers and local authorities, and local communities.
- *Design and presentation style:* The resource needs to be effective at communicating with the public and contain simple, short, clear messages in plain English. Diagrammatic information is best, with infographics presenting evidence starting with the people, and then going on to the planning principles, e.g. "*30% of our community suffers from type 2 diabetes, therefore we need to do X*". The evidence could also provide the cost of not doing something e.g. "*cost to NHS of carrying on as we are*". The guiding principles should fit in a one-page A4. The language used should be authoritative but also engaging so that people want to read it, feel included and connected, and understand how issues can affect them personally (e.g. health, sustainability etc.). Participants in this workshop debated whether it would be better to use the term 'wellbeing' rather than 'health' to improve public understanding. The guidance should clarify how to use the concept of 'health' in NDPs.
- *Evidence and data:* The resource should provide a "*How to*" guide with worked examples of how to find, interpret and use health-related evidence, as well as guidance on how to cope with uncertainty in the evidence, especially future changes or where data are dated.
- *Links to other resources/tools/policies:* The resource should add value to or link with existing guidance, e.g. the Gloucestershire Health and Wellbeing Strategy - what could this mean for your neighbourhood? Integrated Locality Partnerships were suggested as potentially helpful in providing resources for neighbourhoods.
- *Public engagement and communication in the NDP development process:* The guidance should provide a consistent framework for consultation, on how to pose questions to the community, what kind of questions to ask and how to word them, how to frame the issues in a way that lay people can understand and that relate to them. The consultation itself provides evidence from the community being engaged. The guidance should also clarify the process, objectives, scope and limitations of NDPs, i.e. what NDPs can/cannot achieve in terms of solutions (for example, public transport provision and active travel infrastructure), and

associated health outcomes. NDPs have considerable influence on developments but they are not just about housing.

- *Content of the local resource:* the resource should explicitly list the general principles to follow when developing NDPs, for example starting with people and what matters to them, making connections between health and built environment, then presenting the evidence and addressing the question "why should health and wellbeing be included in your NDP?". NDPs should include best practice, bad examples and lessons learned, at local, national and international level. NDPs could include the following headings: 1. Understand your community (evidence about people): e.g. who lives in your community; Do we know who our more vulnerable are? What are their needs? 2. Understand your physical environment (evidence about place) 3. Understand what you've got that is positive (people and place). 4. Plan to address the gaps.

Concerning the **themes and solutions** that could be included in the resource, participants mentioned the following:

- Planning: planning for community cohesion and mixed housing, where people of different backgrounds and ages live in the same place and interact with each other. Focus on the quality of planning and new homes, but also improving the existing housing stock. Include the need for affordable housing, especially for young people and dementia-friendly planning.
- Sustainable development and green infrastructure: appropriate and safe infrastructure that supports new housing, and serves the communities, such as roads and all the additional elements that improve quality of life for the community, such as pocket parks, allotments, green initiatives, community spaces.
- Community engagement: engaging communities in planning, we need to dilute confrontation and support a collaborative non-confrontational approach to finding solutions.
- Transport connectivity through sustainable transport options.
- Addressing health inequalities and designing for social sustainability.