



# HOUSE OF LORDS

Revised transcript of evidence taken before

## **The Select Committee on National Policy for the Built Environment**

Inquiry on

### **BUILT ENVIRONMENT**

*Evidence Session No. 19*

*Heard in Public*

*Questions 204 - 213*

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11.35 am

Witnesses: Dr Laurence Carmichael, Dr Ann Marie Connolly and Dr Matt Egan

#### USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on [www.parliamentlive.tv](http://www.parliamentlive.tv).

### Members present

Baroness O'Cathain (Chairman)  
Baroness Andrews  
Lord Clement-Jones  
Baroness Finlay of Llandaff  
Lord Freeman  
Lord Inglewood  
Baroness Parminter  
Baroness Rawlings  
Baroness Whitaker  
Lord Woolmer of Leeds  
Baroness Young of Old Scone

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### Examination of Witnesses

**Dr Laurence Carmichael**, Co-ordinator, WHO Collaborating Centre for Healthy Urban Environments, **Dr Ann Marie Connolly**, Director of Health Equity and Impact, Public Health England, and **Dr Matt Egan**, Senior Lecturer, London School of Hygiene and Tropical Medicine

**Q204 The Chairman:** Good morning and thank you very much for giving up your time and travelling here to appear before us. You are very welcome indeed to this evidence session of the Select Committee on National Policy for the Built Environment. We are coming to the end of our witnesses—we are fairly near the end, but it has been very intense. We have learned a huge amount, and I am sure we are going to learn even more today. You have in front of you a list of the interests that have been declared by members of the Committee. There is an additional one for Baroness Young, who has just been appointed Chairman of the Woodland Trust. A transcript of the meeting will be taken and published on the Committee website. You will have the opportunity to make corrections to that transcript where necessary. Could I begin by asking each of you to briefly introduce yourselves to the Committee? This is for the purpose of the transcript, so we can know where people are coming from.

**Dr Carmichael:** I am Dr Laurence Carmichael. I am the Co-ordinator of the WHO Collaborating Centre for Healthy Urban Environments at the University of the West of England, Bristol.

**Dr Connolly:** I am Ann Marie Connolly. I work with Public Health England, where I am the Deputy Director in the Health and Wellbeing Directorate. I lead on health equity, place and mental health.

**Dr Egan:** I am Matt Egan and I am a senior lecturer at the NIHR School for Public Health Research at London School of Hygiene and Tropical Medicine.

**The Chairman:** You are all very welcome. I am sure we are going to get a lot from you.

**Q205 Baroness Parminter:** We are really keen to tease out the impacts of the built environment on health. As an overview, does national policy at the moment set a proper framework for health issues to be accounted for in decisions about the built environment?

**Dr Egan:** Impacts of the built environment on health are quite varied. It can influence health by shaping people's behaviours, both in terms of physical activity and in terms of the things that they might consume. It can influence people's health directly, let us say, if we are talking about housing and problems associated with it. It can also influence people's health through what academics call psychosocial mechanisms: the way that people feel about the place that they live and how that then gives them as individuals a sense of self-esteem and well-being and influences the way the whole community works. From those mechanisms, there is a very wide range of health impacts that could possibly be determined.

**Baroness Parminter:** Could I ask a supplementary as you respond to that? Are there sufficient data to enable national policy to take those health impacts seriously?

**Dr Connolly:** I agree; they are all relevant elements of the built environment. They are mixed and quite complex, but there is strong enough evidence on issues such as making areas walkable and connected, particularly when you have mixed-use. That is about helping people to be able to walk or cycle from home to work or from home to shops, and connecting the impact on people's mental well-being to walking through better sets of green space and access to green space, and through good-quality housing. We know what makes for good-quality housing. We know that certain things that can be designed into local areas, such as helping people access staircases rather than elevators, designing streets in grid patterns rather than culs-de-sac and making the right sort of pathways so people have incidental social contact with each other, will help make connected communities.

The National Planning Policy Framework is quite strong on some of these elements. It has a health chapter that focuses primarily on healthy communities. There are potentially also strengths from the supportive elements of the other sections of the planning framework,

such as transport, housing and the design of local areas. They are all supportive, but the elements within there are implicit rather than explicit. There is some additional guidance in the national planning guidance on health that supplements it, but how that gets translated into local areas is another step.

**Dr Carmichael:** As far as the built environment and health are concerned—my colleagues have covered this—there is almost a direct impact, especially on environmental health. There is evidence that, if you are going to walk alongside a trunk road, there are pockets of air quality that are really bad for health. The advice is to avoid these pockets of really bad air quality on your commute. That is a more direct impact. Another impact of the built environment is on behaviour: trying to encourage people to walk, take active travel and benefit from a communal environment that is good for social capital and that kind of thing. The other aspect is the impact of the built environment on deprived communities. The Marmot review used ONS statistics to show that, in deprived areas, people pile up the risk factors on their health. They may live in areas that are prone to flooding, that are quite polluted near trunk roads or that have no access to really well-maintained green infrastructure. They may live in toxic streets, where you have betting shops, hot food takeaways, alcohol establishments and sub-prime lenders. There are values there—it is freedom and entrepreneurship—but we need also to provide environments that are going to encourage healthy behaviour in deprived communities.

In terms of the planning process and whether it is there to take health into account, Section 8 of the NPPF is about healthy communities. It is all good sense, but it is really a small section, so it leaves it to local authorities to develop their local plan, to try to assess the local needs in terms of health outcomes, and to try to promote the neighbourhood planning system taking on board local health needs. It does not say much more than that, really. The problem is that there is a sting in the tail, in that the NPPF mentions also this issue of viability. We know that local authorities have to deliver against housing targets. Paragraph 173 of the NPPF leaves it to local authorities to negotiate with developers; national policy does not really put too many constraints on the sustainability and health outcome principles. There is an issue. Local authorities rely on big developers to develop and to deliver their target housing.

We ran an ESRC seminar series and one of our colleagues, Margaret Douglas at Glasgow, mentioned that we have a mechanism to assess the impact of urban development on bats,

newts, flora, fauna, areas of outstanding natural beauty and trees, but we do not have this for protecting the health of our children. We do not have this holistic approach to health outcomes. We might measure air quality, but we do not measure how our children have access to green infrastructure to play.

Another thing is the monitoring system for local authorities. Back in 2010, we did some research for the National Institute for Health and Care Excellence. There were indicators that local authorities were requested to use in their annual monitoring reports, which really clearly linked with health—access to half-hourly bus services; access to green infrastructure that would get Green Flag awards—but all this has been scrapped, so we do not have the mechanism to monitor how well local authorities are developing on health at the city or the local authority level.

**Q206 Baroness Andrews:** Thank you very much for a very comprehensive start. It seems to me that we have an awful lot of evidence about the combination of factors that make for a bad environment, and we are beginning to understand some of the policy choices that would be effective in responding to those, whether it is providing more green infrastructure or whatever. My question is a big one; in a sense, you have partly answered it. How difficult is it to start from the premise that we need to build healthy communities and not simply respond to what we have at the moment? In this respect, it is such good news that Public Health England is taking such a proactive approach to this, which is the first time we have ever seen this. What are your priorities and where can you have most influence in changing attitudes towards planning for health rather than mitigating bad health, chronic conditions and disease?

**Dr Connolly:** As a starting point, our role is also to protect and improve the health of the nation. We do that in partnership with lots of other people. It is to set out the big health issues, and then to say, “What do we need to do?” with lots of other people. A key part of that is what we do in our work with local government to help promote the integration of health with planning and to join up health and planning. When the responsibilities for public health moved to local government, it was a new opportunity. Lots of local authorities are doing very good stuff, but there are many others that need to develop.

Our role is to identify all the key and pressing health issues—whether it be the rise in diabetes, the rise in obesity, the insufficient level of physical activity, or people living in poor housing—and how to join that up, but also to develop the abilities and skills of our public

health professionals to join up with the planning professionals to provide the right sort of information and data through the health and well-being boards and the joint strategic needs assessments, and to start showing leadership on this with the other parts of local government and move up the importance of health within that wider planning process. It is about the planning priorities of that local area and whether they sufficiently support the health aims of the area. That is where the challenge lies.

**Baroness Andrews:** What do you do when the CCG does not speak to the housing department? I have found hardly any evidence that they do.

**Dr Connolly:** In the last year, we have worked at national level, to start with, to develop a memorandum of understanding on housing and health. We have done that with the National Health Service, the Department of Health and DCLG, and some of the leading bodies on housing, to get some shared agreement about the areas we all need to be working on together. Our next challenge is to try to replicate that at local level, and to support the local levels to have equivalence of that—it may not be called an MoU—and to have a joined-up partnership on housing and health. It is in everybody's interests—the health service, local people, local government and the housing sector—to do so.

We have over the last few months also published, jointly with other organisations—for instance, the Chartered Institute of Environmental Health and some of the housing organisations—documents, advice, tools and guidance for local areas about how to take a much more proactive stance. Those are tools that can be used whether you are an environmental health officer, a planner, a public health professional or an NHS professional. We see that as a starting point rather than the end game, but it has not historically happened in the past, joined up with the NHS. It is about how we help support a future where that can happen.

**The Chairman:** Have you found any reluctance to follow that?

**Dr Connolly:** We have further to go in helping the NHS staff and commissioners, some of our public health professionals, who are busy with other things, and our housing professionals to find the right shared understanding of what the co-benefits might be and the language in which to speak to each other. Different professional groups have different ways of thinking about the world and use different evidence, and we are trying to lift their heads above the day job and the norm so that they ask how they can think about this differently and work differently in partnership.

**The Chairman:** They are probably all working all the hours God sends anyway, and to try to make more room for something like this is difficult.

**Q207 Baroness Young of Old Scone:** The forum for this sort of discussion should be the health and well-being boards. Perhaps you could give us your perspective on how well they are working in this area. Also, there was consternation a while ago about the fact that the public health directors, when transferred to the local authorities, were often not on the top table, whereas the director of development and the director of planning almost certainly will be. Is that a real problem?

**Dr Connolly:** The picture is pretty mixed across the country, but the public health responsibilities and teams are much more bedded down now. Certainly, the director of public health will always be on the health and well-being board, so there is a great opportunity there. It will be mixed as to how many have taken up these considerations at the health and well-being board. There are some examples of where that has taken place, such as Medway and Kirklees. There are some local authorities that have been doing this sort of work for a long time, such as Bristol, Stockport and Newham. They have already been thinking about how to join up the considerations of planning and local place, but it is not uniform. Again, it will come down to what the local priorities are.

One of the tools is about how we support local areas to incorporate some of the data and the knowledge into the joint strategic needs assessment, which informs the health and well-being board. Some areas are already doing that, or at least some elements of it—Barnet, Norfolk and so on. There are lots of good examples. We can support and facilitate that as Public Health England nationally and through our centres, but ultimately it will be down to those local areas to decide which things they wish to prioritise, and our job is to support, particularly for public health, good partnerships to enable that further.

**Baroness Rawlings:** Can I ask a quick question of Dr Carmichael on impact assessment and air quality? Where one comes into conflicting ideas, when for health reasons one wants to encourage walking and bicycling, for example, but the air is just so polluted because of stationary traffic that it is toxic, how does one deal with that? To give just one little example, right here on the embankment there is stationary traffic spewing out these toxic fumes and for the cyclists or pedestrians it is horrific. It must be in other places. How do you balance that?

**Dr Carmichael:** It is very difficult, because transport planners have different priorities to environmental health experts. It is really acting on different fronts at the same time. In a way, it may be easy to promote adaptation mechanisms while the air quality and transport issues are not dealt with. There is some research encouraging people not to use trunk roads for their commute but to use side roads to avoid heavy traffic. I know this is not a solution, but action has to be taken on different fronts. We still have to encourage people to walk and cycle, because there is an obesity epidemic.

**Baroness Rawlings:** But they will be killed by the fumes.

**Dr Carmichael:** Yes. That is why we have to make sure that there are enough green corridors and that local authorities are protecting and maintaining their green spaces and making them accessible in areas of deprivation. We know that there is far less availability of green space in areas of deprivation. There is no one solution; it has to be tackled on different fronts, at different levels.

**Dr Egan:** It seems to me that these can be framed as tensions, and they are in certain places, but in other cases we know that a way of encouraging people to be more active in their transport is to have a more pleasant environment in which to walk, including in an urban centre. In urban centres that are aesthetically poor quality or poor in other ways, you are less likely to get active travel. I agree there is a tension between these things, but they can also be framed in a way such that one aim supports the other.

**Lord Inglewood:** That all sounds to me entirely sensible, but we heard from the previous witnesses—I do not think you were here—that one of the problems in bringing brownfield sites forward for housing is the cost of all the remedial work to the polluted ground and the cost of infrastructure, set against, if the thing is to be sold, the price that is realised. How do you bring about the coming together of the resources and the aspirations to enable delivery?

**Dr Carmichael:** We need to engage with developers at an early stage. In this country, they have the master planning. It is talking to developers to make clear to them exactly what the objectives are—these aspirational solutions—and to make sure they understand, if they deliver really healthy environments with green infrastructure and walking and cycling, it probably adds value to the development itself.



**Lord Inglewood:** Certainly, if you can persuade them that what they are selling is going to be worth more if they do certain good things, that is a way to start. They are pretty cynical, hard-nosed people, these developers, are they not? They may not be persuaded.

**Dr Carmichael:** It may also be the inclusion of mechanisms such as health impact assessments, again at pre-application stage, to facilitate a discussion with the private sector. It needs to be local authorities that adopt these policies.

**Dr Connolly:** We regularly hear that sort of question, but there are, first of all, some examples of eco towns. The NHS has called for tender for people to apply to be NHS healthy towns, which is about health-promoting towns. They expected about 30 applicants and about 120 have applied for a small number of places. There is interest and enthusiasm. Secondly, we probably need to do more and better to be able to describe small changes that can be helpful. Not everything is additional expense. It may be about the layout of the area, which may just be different; it may not necessarily be more expensive. We need perhaps to promote better examples of that.

On healthy transport, Transport for London has a public health expert advising it. It has produced a report on health and transport for London and is now producing a supplementary document on how to assess areas more carefully and find the most cost-effective ways of providing healthy public transport, which is active transport and physical public transport as well.

**Q208 Lord Woolmer of Leeds:** You have answered quite a lot of the issues raised by that question, unless there is anything you want to add, which I would be very happy to hear. As a supplementary, all that we hear is that built environment professionals are under enormous pressure. There are fewer and fewer, public services are being squeezed, and they have less and less time, and yet people, including you, quite rightly want them to do more. Is there a conflict in practice between what you want to achieve and the professional resources available on the ground to make a difference? In the light of another big cut that is coming in local government, is that going to be even more difficult?

**Dr Carmichael:** Over the years, there has been a lot of regulation and legislation around sustainable development. Maybe planners and developers also see the health agenda as something on top of all this regulation around the sustainability agenda. We should try to do an audit of what in sustainable development is also good for health. Instead of putting the environment at the core of our development, it is putting people's health at the core and

finding out that a lot is already being done but maybe there are other adaptations that have to be delivered. It is not so much having more resource but the different use of the resources.

**Dr Connolly:** I do not doubt that there is pressure on resources, and we certainly hear from our colleagues that there is pressure on local planning departments. The only thing we can say is that, as our public health departments have funding for doing public health that will slowly get smaller as well, in a way that is an added incentive for the public health departments to talk more closely and to join up and be a little more efficient. We would like to have good models; if the NHS healthy towns can find some, that will be good. If you can find more default options, that is quite helpful as well. You start to learn from good models that you can do it this way more easily.

**Dr Egan:** Yes, it is about finding where planning and health interests co-align. Certainly in disadvantaged areas, that is often very likely, because a lot of disadvantages are housing disadvantages. It is the same people. It is about looking for examples of successes—even in austere times, there are examples of successes—assessing them with a reasonable degree of rigour, and using them to inform other local authorities to do likewise.

**Baroness Andrews:** Yesterday we heard about the cut in public health that has come out of the Autumn Statement. I am just wondering, Dr Connolly, whether you have any notion of the priorities that you would want to save at all costs and not cut.

**Dr Connolly:** It would be difficult for me, because every local area has very specific health issues. I would certainly want to see every area being able to promote good physical place, because that will help on lots of different problems. Physical activity and green space would probably be two key areas one would want to promote, because there are opportunities for the whole of the council's responsibilities to be able to support that.

**Q209 Lord Woolmer of Leeds:** Do you think elected representatives are equally enthused and motivated as I think you think, at least in good examples, the professionals are? In other words, do local politicians share your desire to implement these objectives?

**Dr Connolly:** As I mentioned before, it is probably variable across the country. There will be a mixture of local politicians. It may be the chair of the health and well-being board or the chair of the planning committee; they may be the two councillors. A public health person locally may wish to discuss, consider, engage and inform about the potentialities from this. As I say, we have had great examples of some councils where there are highly enthusiastic

councillors who have really embraced their health responsibilities or who want the planning function to support a good place for their local communities, but it varies.

**Lord Woolmer of Leeds:** The important thing is to enthuse the local politicians and get them engaged, rather than starting with the professionals.

**Dr Connolly:** I would say it is both. You cannot necessarily enthuse your politicians if your local chief planner or your local director of public health are not also enthused and should be given the sort of information they may require. I am not sure which would come first.

**Baroness Finlay of Llandaff:** I just want to go back to something you said earlier. You mentioned grid systems and culs-de-sac. If I heard you correctly, you were advocating a grid system rather than developments with lots of culs-de-sac. Is that correct?

**Dr Connolly:** There seems to be some evidence pointing towards a grid system allowing people a greater degree of movement between home and other services, and making them more likely to do it by walking or cycling, as opposed to the divides that some layouts can create for where they live. If you are trying to promote active travel, some elements of it seem to help.

**Baroness Finlay of Llandaff:** In some ways it seems counterintuitive for the young family, where you do not have the through traffic, and for old people, where you almost create a natural little hub community. Loneliness, we know, literally shortens people's lives.

**Dr Connolly:** It is a mix of elements that can come together. There are different models of it. In Salford, for some time, they have had "home safe" streets, where they prioritise families and people over cars. They allow children to run around in the streets, rather than cars having priority. You can redesign local areas so that there are pleasant ways to walk between areas and so it is a mixture of green but also safe areas for people of all ages to walk through. There is mixed evidence about what creates engaged and connected communities as well; it differs for different age groups.

**Baroness Finlay of Llandaff:** May I pick up on your comment about health impacts in planning applications? What would you see essentially included in those? I could see how an application could be made to sound great for one group in society and completely ignore another group. There is also some evidence that balanced living is better for people than "age communities" are. I do not want to use the word "ghetto" but I cannot think of another one at the minute.

**Dr Carmichael:** The health impact assessment is quite a democratic principle. It is not just experts or planners or healthy planners carrying out the assessment but also local residents. There must be some local evidence put into the assessment. In the States, for example, in San Francisco they used health impact assessment to avoid displacement of the local population and they changed the master planning. The problem at the moment is that the environmental impact assessment we have only looks at environmental health on large applications; it does not necessarily look at the combined effects of all small developments. It is mainly expert-driven and it does not look into physical activity and mental well-being. However, the health impact assessment does not have a methodology that is robust enough and can be integrated easily into the planning system. Developers might say, “Well, you have anecdotal evidence from the local population”. On appeal, how would that stand? It is a voluntary instrument at the moment. Some local authorities are using it to assess large developments, but it is really for large developments, maybe of 100 or 200 units.

**Baroness Finlay of Llandaff:** In that local population, would you be including people such as health visitors and district nurses—stakeholders who go across different bits of that community rather than only seeing the view from their own window?

**Dr Carmichael:** Exactly. It is like any democratic process; you need to give the voice to people who do not usually have a voice. There needs to be a really well-developed consultation mechanism. That is difficult, because people will see the health of their local area from their own perspective, as you say, so how do we validate this knowledge? More research needs to be done, but it is one area. This depends upon the European referendum, but a new European directive, the EIA directive, says we should look at human health in the environmental impact assessment. That is coming up in 2017 and could give local authorities the ability to look into a holistic approach to health outcomes, not just environmental impact.

**Q210 Baroness Andrews:** The Chairman has allowed me to pre-empt my question, which was to come later and links into Lady Finlay’s argument about how you plan for an age-friendly society, whether it is young, old or whatever. One of the things I am particularly concerned about is the failure to plan for the obvious demography of an ageing society, which comes with a lot more complex health conditions, so we have elements of prevention and then we have elements of responsiveness. That should be reflected, I would argue, in an attitude of planning that is about lifetime homes and lifetime neighbourhoods. To what

extent do you think we are more intelligent than we were, say, 10 years ago about the implications of an ageing society? How can the work done by your sorts of professionals with the planners reflect that? The healthy towns are a possibility, but what else do we have to do urgently and how do we prioritise that big set of priorities?

**Dr Carmichael:** It is thinking in terms of different scale as well. With lifetime homes and neighbourhoods, it is engaging with the young generation of planners and architects and trying to bring this mainstream into their education—into university courses, really. Then we have the issue of dementia-friendly environments. Unfortunately, one person in six over 80 has dementia, and at the moment there is no cure and it is terminal. The problem is that the legibility of the built environment for people with dementia does not favour younger generations, because you have to make sure that there is good signposting and that the colour scheme is appropriate. It does not help integration of different communities, but, when it comes to ageing, we have to encourage intergenerational environments.

I remember a place in Rotterdam where there was a big housing development but they brought the tram and the school before any housing was built, ironically, and put the old people's home around the school so the various generations could keep cohabiting. That is really important, because the last thing we want is to create ghettos, which are not very good at all in helping us integrate.

**Dr Connolly:** You are right about the need to recognise the ageing population. People are living longer, which is a good thing, but they are living longer with various levels of disability and poor health. It is something around 15 years for men and 18 years for women in not good health, so we need to look at both prevention and the longer term. There are good examples. As you say, Holland has lots of great examples of better ways of thinking about designing. The Canadians have been looking at cities that are called "8-80", which are designed for eight year-olds and for 80 year-olds. These are concepts we could help embed a bit more.

Our own CABE Design Council had a Building for Life set of criteria. There are multiple dimensions to that, but quite a lot of our existing developments do not reach those. Again, we have tools, but it is about promoting them and about how they are used in local areas so that people can think through all those elements. I do not think it is that difficult; it just needs the next step of embracing it and thinking about it.

**Dr Egan:** I have one additional point about the most disadvantaged neighbourhoods in the country, where large numbers of people do not get to be old. In that sense, concern and targeting of an ageing population should be downscaled through the ages for those populations, where in effect late 40s, 50s and early 60s is old. Whatever targeting needs to happen, it should not be standardised across the country. Also, some of the most disadvantaged neighbourhoods have quite exceptional demographics, often with very high numbers of young people. We found this in the GoWell study on regeneration in Glasgow. We think one reason why social cohesion does not work in the way that it often does in other sorts of neighbourhoods is because there are such exceptionally high numbers of young people. There is a possibility, which is worth looking into, that an ageing population might start to redress that balance, providing there is active support for making sure that those exceptional demographics do not remain in place.

**Baroness Andrews:** Sure, but it also makes the case for saying that when you are planning for health and you are planning for housing, you have to plan for the local demography. What is not clear is whether local authorities are taking into account the nature of the local demography. The argument would be, if you had a national housing policy, you would not simply be building starter homes; you would be enabling older people to move out of extra-large family homes into safer, right-sized homes, which would then free up the large family homes for families. All that has a health impact, does it not?

**The Chairman:** You also have to consider the people themselves. The people who live in these big homes do not want to move, in a lot of cases. A lot of people want to downsize, but a lot do not.

**Q211 Lord Clement-Jones:** I am very interested in the practical examples, such as “8 80 Cities”. How widespread is knowledge of those sorts of practical schemes, projects or whatever you might call them? Does there need to be much more promulgation of that kind of best practice in this context?

**Dr Connolly:** I would suggest so, and to a wide range of different professionals—clearly, the health professionals, but also planning professionals; some will know about those, because that will be part of their training, and others will not. Some architects will be aware of those and building professionals—the engineers, the builders and so on—a lot less so. It is about joining up those who know how to build and know how to design, and finding some of the incentives—

**Lord Clement-Jones:** Who is in pole position? Are you in pole position on this in terms of spreading the gospel? These are very interesting schemes and yet, it appears, not that widely known.

**Dr Carmichael:** In working with local authorities or different stakeholders or organisations, it is interesting to see that there are lots of guidelines—BREEAM and Lifetime Homes, WHO—but they are not linked up. It is really trying to pool the resource that already exists. Within our remit, we need to support the WHO Healthy Cities Network at UK level. I have suggested to them that they need to talk to NHS England and this Healthy New Towns programme. We are discussing now how we can disseminate the information. This NHS Healthy New Towns is a great opportunity. As Ann Marie mentioned, they expected only 40 applications and they got 120, so there is a cry for help.

**Lord Clement-Jones:** Yes. We are looking for practical, effective outcomes.

**Dr Carmichael:** Exactly. Looking at these various sites that were brought forward, in some of them you can see that the local authorities have integrated the partnership in terms of commissioning groups, stakeholders, local authorities, planners, designers and developers, and they do not need the help of NHS England, to be honest, but some of them do not even know what help they need. There are very different environments and integration in the country.

**Lord Inglewood:** Does health sell houses?

**Dr Connolly:** The health system or the NHS?

**Lord Inglewood:** No, not the NHS. If you build a healthy home, do you get more money for it?

**Dr Connolly:** I do not think anybody has ever sold them on that basis, so I am not quite sure, but there will be other criteria.

**Lord Inglewood:** That may be the answer.

**Q212 The Chairman:** Yes, but, on the other hand, that probably is the answer. Some of us went to Birmingham and visited a housing site that was run by Birmingham City Council. At one stage they said that they had houses for elderly people, which had gables and two storeys. I said, “What about the two storeys?”. It was pointed out that they had designed into the ground floor either a cloakroom or else a lift up where you could get into a bathroom or a shower room upstairs. I thought that was great, and then I suddenly realised

that for years people have been designing healthy interiors for elderly people, making sure that the plugs are in a place not down underneath the bed and so on.

This concept of clean air and green and walking and taking exercise for your health is really relatively new. It was 20 years ago, probably, that we all began to recognise it, whereas the housing people were there before us. I wonder just internally if we can get back to Birmingham and see what motivated that particular development. Within it, they had big blocks and social rooms and young people living in flats. It was completely multifunctional, and there were wide spaces too, which was great.

The question I was going to ask is: do local planning authorities take adequate account of health provision in their plan-making and development control functions? I suspect they do not take any, but do you think they are playing their part, or are they recognised as being a very important cornerstone to all this and that people would have to become more clued up about it?

**Dr Connolly:** As I say, the picture is very mixed across the country. There are some who have embraced this easily. It may have come from the health side, where the director of public health has engaged with the planning department for some time. There are good examples from across the country, but it is not uniform. This is also about when the opportunity arises for the right type of engagement. You can have different points of time: when the local plan is being developed, but that only gets done every five years or so and they are at different stages of cycle; when there is a major development, and, again, that sometimes happens; and when there are sometimes local Neighbourhood Plans, which brings things down very much more locally, which is an emerging theme. There are opportunities.

We worked last year and the year before with the Town and Country Planning Association, running a series of workshops across the country, bringing together different professionals, under the banner of "Reuniting Health with Planning", and then specifically on healthy weight environments. A lot of learning came out of that about how we need to do more about joint learning, being clear about language and sharing understanding, and about the nature of evidence. We as health professionals tend to use and focus on a different type of evidence base than the planning professionals or the architecture professionals. It is trying to join those up, both in undergraduate training and in postgraduate professional development. We need better shared learning and shared skills development to be able to do that well.



**The Chairman:** That is very useful. Should there be a list of points that you have to tick before you get permission to build anything anywhere?

**Dr Connolly:** It could be helpful, but you would have to use it sensibly. In Newham, they used a checklist from the Healthy Urban Development Unit in the post-Olympics development. In Stockport, they also have a set of criteria for when they think the planners should bring in the public health people when there is a specific development—some triggers to start getting health advice.

**The Chairman:** You have mentioned two specific areas. How do we get the rest of the areas throughout the country doing that too? How would that become general knowledge, so to speak?

**Dr Connolly:** It is about, as I mentioned, training and development. It is also about publicising, honouring and giving prestige to those who are doing well so that others may want to emulate that.

**Dr Carmichael:** It is about joining up the resources that are already there, because there is a lot out there—TCPA, RTPI, Public Health England, NHS England, WHO—and making sure that people showcase good urban development.

**Dr Egan:** The academic sector can help with this as well. We have an opportunity, say, within public health to work with both planners and public health to understand the different cultures of evidence they both have and find some way to help them with common ground, which the School for Public Health Research do as well.

**Q213 Baroness Finlay of Llandaff:** I am not going to ask you to answer this now, because time is going on, but it would be really helpful if you could write in and provide us with what might be an outline of the metrics to use for a health impact assessment that would drive up some of the standards of decision-making. There are pockets of good practice and there are pockets of appalling practice. The good practices will be good almost whatever you do, but it is how you get the bad practice up. On the issue that a healthy environment sells somewhere to live within a private market system, I can see that, if you have young children and you are buying somewhere, you would prefer to not be on the highest atmospherically polluted road and you would want to know a bit about it. There are energy impacts on housing now. A framework of those metrics would be helpful, as would the metrics that are used for these healthy towns. How valid the decisions are depends on the metrics.

Linked to that, what are the shortages of knowledge and understanding over health issues among those who are working to build the built environment—the professionals involved? You have already alluded to different thought processes, different priorities, and so on. It may be that that is a question you would want to add into the metrics I am asking you for.

**Dr Carmichael:** There is already a joint statement—it was made in 2012 or 2013—between the Faculty of Public Health and RTPI urging providers of training to create a shared knowledge base. On the Masters in Public Health Part II, we gave some case studies around the built environment, but that is not enough; we really need to integrate this knowledge base. In a way, we also have to train the trainers. We have our architects, our planners and our public health people, and all are set in their methodologies and approaches to problems and problem solving, with their own knowledge bases. We are almost asking people to be outside their comfort zone.

That is where we come from. In a way, we are trying to juggle different concepts: public health, based on rigorous medical evidence, and then a social science perspective or lens of the world, which might be value-laden. We have to make public health practitioners understand how the planning system works, and the other way round as well. It has to be both ways. It is not just planners understanding public health evidence. There is a lot of, not lobbying, but work to be done to translate the evidence from public health into user-friendly evidence for planning.

**The Chairman:** And having respect for each other's skills, which is very important.

**Dr Carmichael:** Yes.

**The Chairman:** Thank you very much indeed. It has been very useful. I shall be looking at more green trees in more places, and culs-de-sac versus grids. It has been really kind of you.