The Bristol Health and Planning Protocol - First year evaluation

(DRAFT – 13 Aug 2013)

by the

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for the

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August 2013

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The Bristol Health and Planning Protocol
First year evaluation

The commissioning of the study and report

This study was commissioned by the Healthy Urban Team at Bristol City Council, as part of the on-going programme of Bristol City Council and NHS Bristol to bring public health expertise into decision-making for planning and managing the built environment. With public health now having been transferred from the NHS to the council, this workstream continues within the local authority. The study was carried out by the WHO Collaborating Centre for Healthy Urban Environments based at the University of the West of England, Bristol.

Acronyms & Abbreviations

BCC	Bristol City Council
CABE	Commission for Architecture and the Built Environment, now part of the Design Council
CCG	Clinical Commissioning Group
CIL	Community Infrastructure Levy
HIA	Health Impact Assessment
HUDU	NHS Healthy Urban Development Unit
NICE	National Institute for Health and Clinical Excellence
NPPF	National Planning Policy Framework
PCT	Primary Care Trust
WHO	World Health Organisation

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Summary and recommendations

The Bristol Health and Planning Protocol
First year evaluation

"Bringing public health expertise into decision-making for planning and managing the built environment"

The report documents the evaluation of the first year of 'the Bristol Protocol'. This is an agreement between NHS Bristol and Bristol City Council to receive public health consultations for selected planning applications and pre-application processes. The purpose was to support the consideration of the impact on health outcomes in the assessment and determination of planning applications.

Much of what affects our health lies outside the domain of the health sector. Whether people are healthy or not, is determined by a complex interaction of their circumstances, lifestyle factors and environment.

Traditionally the impact of developments on health and wellbeing has not been an explicit consideration within the planning system. However this is changing. There is increasing recognition that the environment is a major determinant of our health and wellbeing; and that the planning system has a major influence on the environment.

The NHS is not a statutory consultee on planning applications. To address this issue Bristol City Council and NHS Bristol signed a development management protocol in May 2011 on consultation over planning applications.

Based on audit of planning applications referred to NHS Bristol, surveys of Bristol City Council's planners, interviews and documentary analysis, this evaluation assesses how and to what extent public health colleagues in Bristol have been able to influence decisions on planning applications. The analysis also helps to determine whether there have been changes in knowledge and attitudes of development management planners about the links between health and planning.

The research covered the period 17 May 2011 to 31 August 2012. During this time, Bristol City Council received 3,896 planning applications. NHS Bristol was consulted on 54 planning applications, out of the 72 major planning applications received, and commented on 31of them. It also commented on 21 of the 30 pre-applications it was consulted on. This level of response took up 11% of the time of the Specialist Professional Planner (health improvement).

The bulk of the evaluation is based on the 20 major planning applications that were received, consulted on and determined within the evaluation period.

NHS Bristol requested Section106 contributions in 26 applications or pre-applications based on the 'HUDU model' totalling £1.48 million. This averaged about £1,470 per dwelling; ranging from just over £900 per dwelling for one/two-bed flats to about £2,500 for four-bed houses.

Planners stressed that for health to be given greater consideration in their work health would need to be highlighted in national and local planning policy and guidance whereas at present it is only in other sources of evidence. The rationale emphasised by planners in the research is that only planning policy and guidance gives strength when negotiating with developers

Some of the key messages are:

- Consideration by development management of the impact on physical activity, active travel, access to greenspace, environmental health and quality of the public realm is strong. Consideration of accidental injury and casualties was also quite strong.

- Consideration of access to safe, affordable and nutritious food, mental health and wellbeing, health inequalities and physical health (illness and disease) is much less strong.

- Awareness and discussion of health issues at pre-application meetings with developers has increased and health is raised more strongly as an issue internally when considering major developments.

- Not all relevant applications were referred to NHS Bristol and NHS comments were not always reflected in the case officer report.

- Some NHS responses were disproportionate to the proposed development and referred to standards that were not Bristol City Council policy. Others were seen as comprehensive and logical.

- NHS responses often overlap with responses from other consultees. Sometimes this is helpful as it reinforces the point and adds weight. Other times it can cause confusion where the responses on the same issue vary.

- There were two instances where NHS Bristol raised issues that no other consultee had raised and in both these cases the NHS advice was acknowledged by the planning officer.

- The weight given to health evidence was limited compared to the weight given to national and local planning policies. Where appropriate, effort should be given to changing the policies.

- So far the use of health evidence in planning decision has not been tested at appeal.

- Although public responses are uploaded onto the Planning Portal, responses from consultees, such as NHS Bristol, are not.

- Requests for Section 106 funding for health services as a result of new development had very limited success. This needs to be reviewed with the introduction of the Community Infrastructure Levy.

- Future monitoring and research should be directed at examining the actual impact on health behaviours once new developments are completed.

The findings of this evaluation have highlighted that the protocol has brought extensive health and wellbeing expertise into the development management process. This is especially welcome at a critical transition point during which the council has the opportunity to develop its public health portfolio and integrate public health strategies and outcomes within its own existing structures and policies.

The public health and planning sectors both aim to create healthy sustainable communities; however, each sector employs different approaches and methods to achieve this aim. A process of knowledge exchange and cross-sector working needs to develop to support the integration of health consideration into planning practice. The protocol has supported this process.

Analysis of the findings has led to 18 recommendations which can be used to strengthen this important connection. Some of the findings are relevant only to the specific local context and contractual basis of the protocol. However many of the findings will be of interest to other local authorities across the country, where recent organisational changes now provide both an opportunity and imperative for closer working between public health objectives and built environment planning and development processes.

In conclusion, the processes set up through the protocol do work, resources have been allocated and the referral process is in place, albeit it needs to be reinforced to ensure that public health has the opportunity to better scrutinise all applications that can potentially affect health and wellbeing.

Of course there have also been some teething problems. On the one hand public health must learn to adapt its contribution to a well-established development management system which is performance and process driven.

In particular public health needs to ensure that responses are more closely related to adopted national and local planning policies; without losing its aspirations and ethics of challenging and advocating for better and higher standards to improve the health of the population. This also means that it needs to continue to be involved in the upstream planning policy development work too.

On the other hand, planners need to better recognise the value of the robust evidence base provided by public health and better consider how to integrate this into reports, decisions and into new policies and standards.

At development management level, there are some indications that the protocol has helped raised the awareness of planners or strengthened their arguments in discussions with developers. In addition, some NHS responses have influenced the shape of future developments, particularly in the case of super-major applications.

Given the rigid procedural aspects of development planning, development planners have made some useful suggestions for the steps that must be taken next to ensure more effective integration of health into planning. This includes the need for the specialist 'healthy urban' planner to be more integrated into pre-application discussions and inform the Health Impact Assessment process.

More fundamental to population health and wellbeing: councils throughout the country need to consider and radically re-design the ways that they can integrate health into council policy, exploring the cross-cutting links between health and other priorities, in particular urban design, traffic and transport, housing quality, green and blue infrastructure, community safety and sustainability and other regulatory regimes such as licensing, food safety and trading standards.

In England, the role of the Health and Wellbeing Board and the development of Health and Wellbeing Strategies will be fundamental

The immediate priorities in all local authorities should be to set up robust systems to assess the opportunities that cross-sector collaboration can bring to improving the quality of life in urban environments and ensure that strategic links are made between a range of built environment and public health interests.

Recommendations

A. For Public Health Bristol and Bristol Planning services

Recommendation 1: The Director of Public Health to be the successor body to NHS Bristol under the protocol.
Recommendation 2: Public Health consultant and Development Management service manager to discuss ways to improve planners' consideration of health evidence and issues in the context of the NNPF – ie core planning principle to take account of and support local health and wellbeing strategies (para 17), the promotion of healthy communities (paras 69–78) and taking account of the health status and health needs of the local population (para 171).
Recommendation 3: Bristol City Council approaches other authorities about setting up a scheme of mutual support in relation to defending health in planning decisions**.**
Recommendation 4: The Director of Public Health and the Director of Planning work to ensure that the Annual Monitoring Report, Joint Strategic Needs Assessment and Director of Public Health's annual report complement each other in monitoring changes in the urban environment and the impact on health and wellbeing.
Recommendation 5: Director of Public Health and the Director of Planning explore the option for establishing a local public health responsibility deal for the built environment.

B. For Public Health Bristol

Recommendation 6: Public Health to ensure that responses are proportionate to the proposed development and related to adopted national and local planning policies as far as possible.
Recommendation 7: Director of Public Health to determine if and when representations on planning application should be explicitly considered as formal expert, objective advice on health matters to the public as well as advice to the council.
Recommendation 8: Director of Public Health monitors the number of applications sent for consultation and the number of responses and considers issues of work priorities and capacity as necessary.
Recommendation 9: Bristol's Health and Wellbeing Board, Bristol Clinical Commissioning Group and the NHS England Local Area Team engage with the planning system and decision-making about the allocation of Community Infrastructure Levy monies in relation to the need for and provision of new health care facilities.
Recommendation 10: Director of Public Health to review Bristol's health and wellbeing strategy and Joint Strategic Needs Assessment to ensure that they can be seen as planning evidence and thus effectively carry out their function of influencing planning decisions.

Recommendation 11: Director of Public Health to make representations on council planning policies and on other Council policies promoting healthy and sustainable communities, as necessary, based on the evidence in this evaluation and to determine if it is appropriate that such representations should be explicitly considered as formal expert, objective advice on health matters to the public as well as advice to the council.
Recommendation 12: Director of Public Health to continue to engage with the development of planning policy locally and nationally

C. For Bristol's Development Management Service

Recommendation 13: Development Management to review the weight given to health evidence in the light of the NPPF core planning principle to take account of and support local health and wellbeing strategies and the reference in para 171 to understand and take account of the health status and needs of the local population.
Recommendation 14: Development Management officers to consider having the impact on health and wellbeing as a key issue in reports.
Recommendation 15: Development Management Service Manager to ensure that there are robust systems in place to ensure that all relevant applications are referred to the Director of Public Health
Recommendation 16: Development Management service to publish consultee comments on the planning portal.

D. For Bristol Planning Policy

Recommendation 17: Bristol City Council to adopt development management policy DM14 on the health impacts of development as soon as possible
Recommendation 18: Bristol Planning Policy to review cycle and car parking standards and residential space standards so that they better support delivery of health outcomes.

1 Introduction

Much of what affects our health lies outside the domain of the health sector. Whether people are healthy or not, is determined by a complex interaction of their circumstances, lifestyle factors and environment. Many factors combine to affect the health of individuals and communities, such as where they live, the state of their environment, their income and education levels, their relationships and hereditary factors.

Traditionally the impact of developments on health and wellbeing has not been an explicit consideration within the planning system and the NHS has not been a statutory consultee. However this is changing. There is increasing recognition that the environment is a major determinant of our health and wellbeing; and that the planning system has a major influence on the environment.

The Marmot Review (2010) and the Health and Social Care Act (2012) have highlighted the health sector's desire to influence the planning system so as to lead to the creation of environments that support healthier lives and healthier lifestyles. The government's public health white paper "Healthy People, Healthy Lives: our strategy for public health in England" (2010**)** highlighted the influence of the environment on people's health and included the objective of *creating healthy places to grow up and grow old in*.

The vision in Bristol's draft Joint Health and Wellbeing Strategy (February 2013) is for Bristol as *"a place where all who live, work or learn in the city lead healthy, safe and fulfilling lives, now and in the future"*. One of its four themes is *"a city of healthy, safe and sustainable communities and places".*

Good planning helps to ensure that development takes place in the public interest, in economically, socially and environmentally sustainable ways. It has a major impact on how local neighbourhoods look, feel and function. It also has a role to play in helping to cut carbon emissions, protect the natural environment and deliver energy security.

Although planning is rarely sufficient on its own to change behaviour and to promote good health, it is necessary through creating an environment that supports people making healthy choices (such as for active travel, physical activity, healthy eating and drinking) and making those choices easier.

Planning operates within a statutory framework and a quasi-judicial process, with major planning decisions taken by councillors and minor ones delegated to officers. They are subject to statutory consultation processes, rights of appeal, call-ins and independent hearings by the Planning Inspectorate, so the final decision can be taken by a planning inspector or the Secretary of State for Communities and Local Government.

That Bristol City Council aspires to use physical city development to support the development of a healthier environment is evident in a number of its

policies. The Core Strategy of the Bristol Local Plan (2011) aims to deliver *"A safe and healthy city made up of thriving neighbourhoods with a high quality of life"* and has *"Better health and wellbeing"* as one of its eleven objectives.

Its quality urban design (Policy BCS21) states that development is expected *to "deliver a safe, healthy, attractive, usable, durable and well-managed built environment comprising high quality inclusive buildings and spaces that integrate green infrastructure".*

With these planning policy objectives in place, the next step was to look at how they could be put into practice through the development management process.

Despite references to health in National Planning Policy Framework (NPPF) (Department for Communities and Local Government, 2012), the NHS is not a statutory consultee on planning applications, unlike other bodies such as the Environment Agency, English Heritage and Natural England. To address this issue Bristol City Council and NHS Bristol signed a development management protocol in May 2011 on consultation over planning applications.

This report presents the evaluation of the first year of operation of a protocol between an urban municipal authority, Bristol City Council and a co-terminus health authority, NHS Bristol. The protocol was developed to support principles of health and wellbeing being considered in the assessment and determination of planning applications. The methods used to develop and then evaluate the protocol included an audit of planning applications, a survey and interviews of Bristol City Council's planners and document analysis of planning reports.

The evaluation of this initiative provides several lessons that can inform better practice. The findings include an assessment of how and to what extent the public health interests, represented by the health authority in Bristol were able to influence decisions on planning applications; the degree to which there have been changes in knowledge and attitudes of development management planners about the links between health and planning; and the impact of a changing national and local planning policy context and the reform of the health service.

Although NHS Bristol no longer exists, the public health function has now been transferred to the local authority and hence, this study is highly relevant as shedding light on an important way in which planning can be used to support public health.

2 Context

2.1 Background

A strategic collaboration between the WHO Collaborating Centre for Healthy Urban Environments, situated in the University of the West of England, Bristol City Council and NHS Bristol has ensured knowledge sharing leading to innovative approaches to urban spatial planning. Joint leadership from the Director of Public Health and the WHO Collaborating Centre has helped to establish working practices within the Bristol Partnership and within the council. Establishing a healthy city core team has been important in testing new ideas and establishing new working practices.

Sharing an office with the Director of Public Health during 2010, Marcus Grant, the deputy director of the WHO Collaborating Centre for Healthy Urban Environments noticed that the Director of Public Health was intermittently circulated with planning applications requesting his advice. These were not dealt with on a systematic basis by either party, both in terms of which applications would be sent to the Director of Public Health by the council, and in terms of how NHS Bristol would then process them.

When trying to 're-engineer' existing urban areas, incremental change to the built environment is an important factor (Davis et al. 2007). Some of this change is represented by the month in, month out, determination of planning applications; each may have impacts that are beneficial or harmful to health. But no one was monitoring these changes. The concept of using a systematic 'triage' approach for ALL planning applications was developed. Using a student placement a basic proof of concept and feasibility study was undertaken and in May 2011, a consultation protocol was agreed between Bristol City Council and NHS Bristol.

2.2 Planning and public health policy context

The government's white paper "Healthy People, healthy lives: our strategy for public health in England (DoH, 2010) highlights the influence of the environment on people's health and includes three key objectives relevant to the built environment:

- Create healthy places to grow up and grow old in
- Active travel (walking and cycling) and physical activity need to be the norm in communities
- Create an environment that supports people in making healthy choices and that makes these choices easier.

Yet until 2012, the English planning system had no statutory requirement for the local planning authority to consult with the health authority, unlike the requirements to consult, for example, the Highways Agency, Environment Agency, English Heritage and Natural England on relevant applications.
In 2012 this lack of linkage between health and spatial planning was corrected to an extent and indirectly by changes to both health and planning governance by the central government in England. A new act, the 'Localism

Act 2011, new national planning policy set out in the NPPF (2012) and a fundamental reorganisation of the health services due to the Health and Social Care Act 2012 are leading to deep policy and process changes in the relationship between planning and health at the local level. Predating, and to an extent anticipating these changes, the Bristol Protocol, the subject of this paper, provides unique insights into the development of better practice under the new arrangements.

The NPPF recognises that supporting the health, social and cultural wellbeing of communities is part of the social role of planning in delivering sustainable development and includes improving health, social and cultural wellbeing for all within the twelve core planning principles. Several phases in the new NPPF point to an expectation of closer joint working between public health and planning, an issue that is definitive to the delivery of 'healthy urban planning'. As stated in the NPPF, local planning authorities, when drawing up their development plans,

> 'Should work with public health leads and health organisations to understand and take account of the health status and needs of the local population (such as for sports, recreation and places of worship), including expected future changes, and any information about relevant barriers to improving health and wellbeing' (DCLG 2012, #171, p.41).

A judicial review of a decision by Tower Hamlets council (Regina (Copeland) v. Tower Hamlets LBC, 11 June 2010) ruled that health could be a material planning decision, in this case, childhood obesity and healthy eating.

In April 2013, in England, public health functions moved from local health authorities into local authorities, this move offers new opportunities for closer working as recognised by the Department of Health (DoH, 2010). In theory, at last, this removes an excuse for inaction by some practicing planners that population health is not a material consideration in planning decisions.

The NPPF does, though, lack precision on how to interpret healthy planning, and how to monitor achievements on the ground. This leaves ample opportunities for local authorities and communities in terms of neighbourhood plans, to develop their own processes and policies for healthy planning, a mixed blessing. It is hoped that the experience of a year of operating the Bristol Protocol can provide some valuable lessons.

2.3 Bristol context

NHS Bristol primary care trust (PCT) was formed on 1 October 2006 by combining the two PCTs that previously covered the City of Bristol (Bristol North and Bristol South and West PCTs). The new PCT covered the same area as Bristol City Council. Since this reorganisation of boundaries to provide co-terminosity, the Director of Public Health has been a joint appointment between NHS Bristol and Bristol City Council. This provided an opportunity for innovation.

Since 2007, some years in advance of public health transferring to local authorities, the Director of Public Health started to engage with a wide range of city development processes in novel ways through building what became known as the ‘Healthy Urban Team' within the council. Supported by collaboration between the WHO Collaborating Centre in Healthy Urban Environments and NHS Bristol, this team consisted of public health specialists, led by a public health consultant. It worked on a range of public health issues that require interventions in land use planning, transport planning and other policies that required a spatial or city approach, such as walking and cycling, food systems, peak oil and climate change.

The establishment of a cross-disciplinary healthy urban team has developed a knowledge sharing approach that has led to innovative approaches to urban spatial planning. This has included using inclusive and participatory health impact assessment process to alert communities and regeneration officers to the health opportunities inherent in good urban design. Other approaches included neighbourhood walkabouts and high level policy and partnership building.

Working within the Bristol Partnership, the local strategic partnership, a Healthy City Group was established in 2009, which has been important in widening stakeholder engagement and trust for testing new ideas and establishing new working practices. The Healthy City Group brought together urban designers and planners, public health workers, housing officers, people who work in neighbourhoods and communities, transport and parks and, those concerned about the environment and climate change. The goal was, to talk about what needs to be done and to initiate action to make the city a healthier place to live. The Healthy Urban Team supported this work. The aim of the Healthy City Group, as stated in its Terms of Reference was:

> “The aim of the Healthy City Group is to achieve a healthy city with healthy communities and reduced health inequalities by ensuring that health and wellbeing for all citizens is integrated into the way that the urban environment is designed, planned and managed.
>
> “In pursuance of this aim, it is essential that policy and practice follows the principle of sustainability, by which we mean meeting the needs of the present without compromising the ability of future generations to meet their needs.”

Within this agenda, the protocol is a formalised cooperation agreement between NHS Bristol and Bristol City Council planning department. Its remit is to identify planning applications likely to have an effect on health. The intention being a step towards setting up a system that captures urban change, screens it against potential health effects, and then supports beneficial health outcomes whilst mitigating foreseen adverse impacts.

The protocol helps achieve the vision in the Core Strategy of the Bristol Local Plan (Bristol City Council, 2011) of *“a safe and healthy city made up of thriving neighbourhoods with a high quality of life”* and *“a city which reduces its carbon*

emissions and addresses the challenges of climate change" and its objective of *"Better health and wellbeing"*.

> **Better health and wellbeing** - a pattern of development and urban design that promotes good health and wellbeing and provides good places and communities to live in. Bristol will have open space and green infrastructure, high quality healthcare, leisure, sport, culture and tourism facilities which are accessible by walking, cycling and public transport. This will help enable active lifestyles, improve quality of life and reduce pollution.

In particular, it helps implement one of the objectives of core strategy policy BCS21 (quality urban design) that states that development in Bristol will be expected to *"deliver a safe, healthy, attractive, usable, durable and well-managed built environment comprising of high quality inclusive buildings that integrate green infrastructure"* .

It also supports delivery of other local plan policies including:

- BCS 9 (green infrastructure)
- BCS10 (transport and access improvements)
- BCS11 (infrastructure and developer contributions)
- BCS12 (community facilities)
- BCS 13 (climate change)
- BCS 15 (sustainable design and construction)
- BCS 18 (housing type)
- BCS 23 (pollution).

The protocol will also help deliver the vision in Bristol's draft Joint Health and Wellbeing Strategy (February 2013) for Bristol to be *a "place where all who live, work or learn in the city lead healthy, safe and fulfilling lives, now and in the future",* one of its four themes in particular being *a "city of healthy, safe and sustainable communities and places".*

2.4 Development of the protocol

To be effective, a healthy planning approach needs to engage with all aspects of the planning process. Having worked with planning policy and neighbourhood planning, there was a gap in terms of the development management process. It was evident that since the NHS was not a statutory consultee, it was not being systematically consulted on planning applications that could have an impact on human health and wellbeing, either negatively or positively.

The first stage towards addressing the development management processes was to test and develop the potential effectiveness of a health triage system for planning applications. This was the subject of student placement project carried out by a Masters planning student from UWE, Bristol supervised by Marcus Grant from UWE's WHO Collaborating Centre for Healthy Urban Environments and Stephen Hewitt from Bristol City Council.

Planning applications come in an all shapes and sizes and early work assessed that an average of 370 planning applications were submitted to Bristol City Council in a month in the post-crash era (compared to an average of 450 per month during a more buoyant property market in 2007). The initial agency project research, using the wider determinants of health model, took a census of a complete months planning application and reviewed potential impact to the promotion and protection of public health through issues such as physical activity, health inequalities and diet. This preliminary research found that the nature of the proposed changes to the built or natural environment, including permissions for changes of use, in many applications could have an impact on the wider determinants of health. These fell into three broad categories, proposals that;

- would restrict healthy lifestyles
- would promote healthy lifestyles
- had not realised a potential to promote healthy lifestyles

Analysis of the findings indicated that an efficient and practicable approach would be to categorise planning applications according to development type based on an analysis of the potential to cause a risk to health. Having obtained a good understanding of the number and type of applications per month, further analysis focussed on the nature of the applications with the greatest potential health impact. That analysis informed the key features of the collaborating protocol between Bristol City Council and NHS Bristol policy (Hewitt and Richards, 2010). For ease of administration it was decided to use existing categories, such as major and super-major developments as far as possible.

It was agreed by Bristol City Council that the following categories of development would be routinely referred to NHS Bristol for consultation due to their potential impact on health:

- Major residential (10 or more dwellings) and non-residential developments involving 1,000m^2 of floor space and above
- All major transport and highway infrastructure projects
- Proposals that would result in the loss of public open space
- All applications for the establishment of A5 (hot food takeaways) uses

It was estimated that this would result in approximately 13 applications per month being referred to the NHS Bristol, of which about ten would be in the major residential category. However, the agency project did not examine the number of pre-applications nor their effects on health.

A policy report to NHS Bristol Senior Management Team by the Director of Public Health and Director of City Development in March 2011 recommended the adoption of a consultation protocol on the basis of the agency project findings, also adding that NHS Bristol should also be involved in pre-application discussions on all “super major” development proposals (100+ homes or 10,000+ sq. m of floor-space) and major developments as appropriate as this is “the key opportunity to influence the shape of schemes before they are worked up into costed planning proposals submitted for

consent and define the information required to determine the application" (Hewitt, 2011).

The protocol also states that:

> 'NHS Bristol should be involved in pre-application discussions on all 'super major' development proposals (100+ homes or 10,000+ sq. m of floor-space) and major developments as appropriate.
>
> 'NHS Bristol should hold regular surgeries (weekly or fortnightly) in the planning offices (Brunel House) that allow case officers to consult them on a range of applications and have a dialogue about particular applications.

In order for the public health team at NHS Bristol to respond within limited resources, it was assumed that a number of standard letter responses for those categories of development that pose only minor health implications would be prepared. For developments with significant health implications a detailed assessment would be required; and in a few cases a full health impact assessment (HIA) could be required.

The protocol was signed in May 2011 (see Appendix 1) and implemented from June 2011, implantation proceeded immediately. To support implementation and build capacity, NHS Bristol set up a healthy spatial planning sub-group consisting of eight officers and community health workers from neighbourhood public health teams across Bristol. Shortly afterwards, the WHO Collaborating Centre was asked to carry out the evaluation of the effectiveness of the protocol after its first year of operation. The results were to assist bringing health expertise into decision-making on planning following the reorganisation of the NHS at local level.

Recognising that urban form can affect people's health is a first step; knowing how to act on that knowledge is quite another matter. Research has demonstrated that a number of challenges face planners attempting to prioritise health in settlement planning including working across organisational and professional silos, lack of the necessary knowledge, skill gaps, resources and reactive planning regimes (Carmichael et al., 2012).

2.5 Summary of theoretical background

The body of research evidence demonstrating that the physical environment has a direct impact on health and wellbeing as well as on health inequalities is growing. For over a decade now, a number of studies have implicated the built environment as a contributor to health risk with evidence of causality for many non-communicable diseases resulting from lack of physical activity, social isolation, poor diets and high levels of mental stress (Braubach and Grant 2010, Dannenberg et al. 2011, Marmot 2010, Rao et al 2007). Incidence of resultant diseases, such as, obesity, type 2 diabetes, strokes, respiratory problems and cardiovascular morbidity is rising, as is the corresponding costs for the national health care system in the UK.

In addition, there is evidence showing that the structure of the built environment and interventions on the physical urban environment (e.g. parks and green spaces, new street layout, multi-use trails) can have an impact on healthy behaviours such as walking and cycling and increase the perception of safety and wellbeing. NICE has for instance issued guidance on the promotion and creation of physical environments that support increased levels of physical activity (NICE, 2008). This was based on evidence that interventions on the built environment such as accessibility of footpaths, accessibility of physical activity and other facilities, traffic-calming, the density of residential areas, land use mix and urban 'walkability' scores can lead to increase in self-reported walking and cycling. Traffic-calming interventions for instance may specifically enable children to benefit from physical activity through play outdoors. Multi-use trails have also been shown to leading to an increase in walking and cycling (Newby and Sloman 1996; New South Wales (NSW) Health Department, 2002; Layfield et al., 2003; Gordon et al., 2004; Handy et al., 2006).

Although a key determinant of the form of the urban environment, planning practice increasingly side-lined public health promotion during the twentieth century, with the exception of a narrow range of health protection issues broadly related to environmental health. In contrast, the discourse in planning literature, based on a mixture of empirical evidence and practice is increasingly promoting a social model of public health and explores ways in which physical development of the built environment interacts with what has become known as the wider determinants of health (Corburn 2010, Barton and Grant 2010, Barton and Grant 2006).

A key issue/challenge is how to operationalise high level policy/evidence (for example being more physically active is good for your health) at the level of a specific physical development. There are a limited number of health related guidance documents dealing with design criteria for planning and design. The health benefits are not necessarily made explicit even if the quality of the guidance is good and clearly angled towards creating healthy and more sustainable urban environments (UWE, 2011). This may be due in part to the nature of different topics, some of which are much easier to make general principles than specific requirements. It may also be due to the effectiveness of the organisations involved.

Good quality guidance includes for instance *By Design* (DETR et al 2000); *Urban Design Compendium* (Homes and Communities Agency, 2010), *Why Places Matter* (Living Streets, 2013) and *What makes an eco-town* (Bioregional and CABE 2008) which give good and usable advice on local design and built environment. *Watch Out for Health* (HUDU, 2009) is a checklist for assessing the healthy impact of planning proposals.

The Manual for Streets (DfT, 2007) provides excellent guidance on local movement and street design*; Active Design* (Sports England 2007)*; Making Space for Play (*Play England 2008)*; Planning and design for outdoor sport and play* (Fields in Trust, 2008) and *Nature Nearby* (Natural England, 2010) give very good guidance for open space and greenspace planning.

The *Code for Sustainable Homes* (DCLG, 2009) is a systematic way of assessing building design, especially in relation to energy and *The Sign of a Good Place to Live: Building for Life 12* (Building for Life Partnership, 2012) provides a framework for assessing the urban design quality of new housing developments.

Guidance and examples of best practice on healthy urban planning has been published by the Town and Country Planning Association (2012), the Spatial Planning and Health Group (2011), the Local Government Group (2011), the Royal Town Planning Institute (2009), the Kings Fund (2009), CABE (2009) and the Planning Advisory Service (2008); some of which have featured the work in Bristol.

Research furthermore identified five areas which impact critically on health but no guidance or inadequate guidance supported the operationalisation of evidence to the level of physical development including accessibility of and walkability to local facilities, access to jobs without recourse of a car, integrated strategic planning, socially inclusive environments and the still contested matter of spatial planning for social networks (UWE, 2011).

Across Europe, through the World Health Organisation (WHO) Healthy Cities programme, there has been a reciprocal, and mutually reinforcing, relationship between the developing conceptual approach and the practise in cities taking part in the programme (Barton and Grant 2012). Since 2003, this was accelerated through a 'healthy urban planning' theme within the WHO Healthy Cities programme, initiated and supported by the WHO Collaborating Centre for Healthy Urban Environments, based at the University of the West of England in Bristol.

3 Scope of the evaluation and methodology

Preliminary work for involving NHS Bristol in development management identified a number of issues (Hewitt and Richards, 2010, p.15) that have informed the scope of the evaluation. The aims of the evaluation are to answer the following questions.

Primary research question:

- Does the process set up through the protocol, to bring health expertise into planning decisions work?

In other words - to what extent do NHS Bristol comments influence Bristol City Council's decisions on planning applications?

Secondary questions:

- How do NHS Bristol comments influence Bristol City Council's decisions on planning applications?

- Have there been any changes to knowledge, attitudes and actions of development management planners concerning health and planning since the protocol has been implemented?

- What is the impact of the changing organisational and policy context on future action?

In order to address these questions, the evaluation was broken down into 11 elements as follows:

1. Categorise by type, size and location how many applications were referred to NHS Bristol for comment, and in how many pre-application discussions NHS Bristol was involved.
2. Identify if all the relevant applications in each category were sent to NHS Bristol and if not, why not?
3. Classify by category, type, size, location and number of applications NHS Bristol commented on and which ones it did not comment on and why.
4. Identify and analyse what types of comments were made.
5. Identify how NHS Bristol comments were used by Bristol City Council planners and both whether, and how, they influenced the officer's recommendation and final planning decision.
6. Assess the relationship between health comments and other comments (eg. urban design, community safety, sustainability) and the relative weight given to them by development management planners.
7. Assess if decisions influenced by the protocol led to better development. As it is unlikely to see much actual development happen in 12 months, identify methodology for long term evaluation.

8. Assess the resource and capacity implications of NHS Bristol to respond, and the quality of responses.
9. Assess knowledge before the protocol was implemented.
10. Assess knowledge after the first 12 months of the protocol.
11. Identify the factors that helped and hindered the implementation of the protocol and to what extent it has led to a cultural shift towards embedding health concerns within development management processes.

A number of methods were used to collect the information required to address these 11 elements, they included:

- A documentary analysis (of the list of applications and the comments made by NHS Bristol and the planning officers' reports)
- Before and after on-line surveys of all planners in the planning service
- Interviews with four development management planning officers

This included data extraction and analysis of NHS Bristol's comments as well as planning officers' reports for applications falling within the protocol's consultation threshold. Methods also included semi structured interviews with four team leaders/managers within BCC's development planning team and two surveys of BCC's planners using Survey Monkey. The first survey was carried out in the first few weeks of the protocol's implementation and the second a year later. Understanding was also augmented through an analysis of relevant BCC's policies.

Appendix 2 details the methodology and timeline further.

4 Findings

4.1 Introduction

This section will present the key findings. It starts by introducing the data analysed. It then looks at the capacity of NHS Bristol to respond to consultation requests and the quality of their responses, paying particular attention to the types of health outcomes identified in NHS responses, the evidence base used and the relationship between health comments and other comments. The section then describes how planners view NHS responses and use them in planning decisions. Finally, this section examines whether the protocol had an impact on the perception of development planners on the consideration of health issues and outcomes in planning decisions.

4.2 The data sets

The evaluation period covered applications received between 17th May 2011 and 31st August 2012. The following two tables summarises key figures for the data sets examined during that period. Table 1 gives information on the level of requests for consultation and responses. This first data set was used to help us identify the types of comments made by NHS Bristol, the evidence base put forward and rationale. However, no officers' reports were available if the applications had not been determined at the time of the research.

Table 1: Activity during the evaluation period (17 May – 31 August 2011)

Total number of applications received by BCC during the period. • Super major developments: 13 • New major applications: 59 • Other major developments(1): 62 • Minor applications: 1,446 • Other applications: 2,316	3,896
Total number of pre-applications received by BCC during the period. • Super major pre-applications:17 • Major pre-applications: 43 • Minor pre-applications: 225 • Other pre-applications: 101	386
Number of consultation requests from BCC. • Planning applications: 54 • Pre-applications: 30	84
Consultations average per month based on 15 months	5.6
Number of consultation responses by NHS Bristol: • Planning applications: 31 • Pre-applications: 21	52
NHS response level in percentage	62%
Staff resource required in percentage of specialist planner's time (health improvement) and based on BCC's time recording system (PROFESS)	11%
(1) Extensions of time, renewals, variations or replacement of conditions	

From the 54 planning applications consultation requests, 21 planning applications were determined during the research period - 14 were granted, six were refused and one was disposed of. Two applications were granted and one refused by the relevant area planning committee (ie by elected councillors). The other applications were either granted or refused as delegated officer decisions.

Table 2 gives a summary of responses to planning applications falling within the Protocol for which a decision was made and an officer's report was available. This second data set was used in the research to analyse, not only NHS Bristol comments, but also to what extent planners had considered these comments and integrated them into their reports.

Table 2: Summary of planning applications (excluding pre-apps) that NHS were consulted on and were determined during the evaluation period (17th May 2011to 31st August 2012)

NHS consulted but made no comments	1
NHS made comments. They were not referred to in the officer report.	5
NHS made comments. They were listed in the report. The substance of the comments was not addressed in the officer report.	3
NHS made comments. The substance of the comments was addressed in the officer report. The NHS advice was not followed.	8
NHS made comments. The substance of the comments was addressed In the officer report. The NHS advice was followed in the final recommendations and decision. These corroborate comments by other experts or Bristol policy standards.	2
NHS made comments. The substance of the comments was addressed in the officer report. The NHS advice was followed in the final recommendations and decision. These addressed new issues.	1
Total number of planning applications referred to NHS Bristol for comments and subsequently determined during the research timeframe – 14 approved and 6 refused	**20**
Total number of major planning applications received and determined during the period	115

Appendix 3 gives more details on the substance of the NHS Bristol comments for each of the applications falling within the categories identified in table 2. Appendix 3 also records the type and location (as per BCC's planning areas) of applications and pre-applications that NHS Bristol commented on, for each of the protocol categories.

As for pre-applications, NHS Bristol was included in the council's Development Team that meets monthly to co-ordinate responses to pre-applications for super major applications, which are likely to be subject to a Planning Performance Agreement.

From September 2011 a weekly list of all per-applications was sent to NHS Bristol and based on the information supplied, the specialist planner (health improvement) then would decide if or what type of response is required and whether to include a request for Section 106 contributions or request a Health Impact Assessment.

4.3 The capacity of NHS Bristol to respond and the quality of responses

The analysis of 52 NHS Bristol comments shows that NHS Bristol is concerned by the impact of the built environment on a broad range of health outcomes. The health outcomes identified in the comments analysis include:

1. Physical health
2. Mental health
3. Environmental health
4. Prevention of accidents and injuries
5. Nutrition
6. Health equity

In particular, NHS Bristol highlighted the importance of the following interventions on the built environment or planning policies and instruments to deliver healthy sustainable communities and the health outcomes they identified:

1. Measures to promote active travel, importance of sustainable transport planning
2. Accessibility to parks and green open space and amenities
3. Housing and living space standards
4. Accessibility to affordable, safe, nutritious food and policy regulating hot food takeaway outlets
5. Environmental sustainability policies including energy efficiency, renewables
6. Promotion of Health Impact Assessment
7. Policy calculating developers contributions to health services

The specialist planner confirmed that NHS Bristol consciously decided not to comment on the following issues:

1. Impact of development during construction period
2. Environmental quality (eg air and water quality, contaminated land, noise, flood risk) and remediation

4.4 Use of evidence by NHS Bristol

NHS Bristol was consulted to provide expert evidence. Analysis of NHS comments identified the following range of evidence put forward to inform arguments for alterations or to endorse applicant's proposals:

1. Research evidence from NICE (e.g. review of evidence showing how the built environment can encourage and support physical activity), CABE (e.g. Space standards), Foresight reviews, local GP evidence and local health statistics.
2. Guidance from think tanks and advocacy sources such as Sustrans and School Food Trust.
3. Application specific and local evidence such as desk-top Health Impact Assessment.
4. Standards and guidance embedded in policies, for instance Code for Sustainable Homes, BREEAM, Building for Life assessment

In addition in line with the process of development management NHS Bristol backed up its arguments for higher standards or to reject applications with references to local and planning policies including:

1. Bristol Local Plan (formerly Local Development Framework) in particular the 2011 core strategy:
2. Spatial strategic policies specific to an area of the city
3. Spatial strategic approaches to other areas of Bristol
4. Development principles
5. Development management policies
6. Bristol Local Plan saved policies (1997)
7. Supplementary Planning Document 10 (Planning a Sustainable Future for St Paul's, 2006)
8. Bristol Joint Strategic Needs Assessment (2010 update)
9. Bristol parks and green space strategy (2008)
10. Bristol weight management strategy
11. Neighbourhood strategy (eg Ashley, Easton and Lawrence Hill area green space plan 2010

NHS Bristol also made references to national policies including:

1. Government White Paper Healthy Lives, Healthy People (2010)
2. A call for action on obesity in England (2011)
3. Education Act 2011**,** Healthy schools and healthy schools plus programmes

It is difficult to evaluate the relative importance of each piece of evidence as data used to justify comments need to be targeted to specific application. However, some sources have been used more extensively than others over the evaluation period. A summary of the most used evidence and how development management planners used it is set out in Table 3. Appendix 4 gives the details of the sources identified in NHS Bristol comments during the evaluation period and the number of times each piece of evidence was used.

Table 3: Use of Evidence

Evidence	How used by Development Management
Research based evidence: NICE guidance PH8 promoting and creating built environment that encourage and support physical activity (used 5 times) CABE/South Yorkshire Space Standards (used 16 times)	Planning reports and decisions did not refer to this type of evidence. Furthermore planners interviewed emphasised the need for research evidence to be embedded in Bristol's planning policies in order to be used in planning decisions. In particular, planners referred to the South Yorkshire Space Standards that were referred quite often by NHS Bristol
Standards and guidance: Code for sustainable homes (used 13 times) Building for life assessment (used 5 times) BREEAM (used 7 times)	This type of evidence was used in planning reports and decisions by development planners and NHS comments using them also quoted.
Core strategy policies: **a. Spatial strategic approaches** BCS9 Green infrastructure (used 8 times) BCS10 Transport and access (used 12 times) **b. Development principles** BCS11 Infrastructure and developer contribution (used 26 times) BCS13 Climate change (used 7 times) BCS15 Sustainable design and construction (used 11 times) BCS18 Housing types (used 9 times) BCS21 Quality urban design (used 13 times) BCS23 Contaminated land, air pollution, noise (used 8 times)	Strategies and principles, essential for promoting healthy outcomes match the list put forward by development planners to justify their decisions. Two other policies often quoted by planners in the decisions examined with links to broader determinants of health include BCS16 (Flood risks and water management) and BCS17 (Affordable housing provisions).
Development management policies DM14 requiring Health Impact Assessment on super major development (used 8 times). NHS Bristol requested 16 HIAs at pre-app.	This has been referred by planners in their reports and decisions

4.5 Request for developers contributions based on Bristol Local Plan policy BCS11

NHS Bristol requested Section106 contributions in 26 applications or pre-applications based on a model developed by the Healthy Urban Development Unit (HUDU) in London (www.healthyurbandevelopment.nhs.uk) - the 'HUDU model'.

The HUDU model enables a full appreciation of health service requirements resulting from a new residential or mixed-use development. The original HUDU Model was launched in April 2005 and updated and improved in 2007. The Model uses the numbers, size and type of proposed dwelling units in a development, to calculate the likely resulting net population increase and consequentially:

- Amount of hospital beds or floor space required for that population in terms of acute elective, acute non-elective, intermediate care, mental health and primary care (eg GPs, dentists).
- The capital cost of providing the required space
- The revenue costs of running the necessary services before mainstream NHS funding takes account of the new population.

The details of the financial contribution per application requested by the NHS Bristol are in Appendix 5. The total amount was £6.56 million, of which £5.08 million (77.4%) was to cover the additional revenue costs and £1.48 million (22.6%) for the extra capital costs. NHS Bristol requested contributions to meet the capital cost. This averaged about £1,470 per dwelling; ranging from just over £900 per dwelling for one/two-bed flats to about £2,500 for four-bed houses.

Interviews of development management planners and the survey responses showed that NHS Bristol and Bristol City Council planning department agreed for case officers to advise applicants of the total figure but also advise them that Bristol City Council will only request the capital element of the overall figure. In case the applicant objected in principle to making a HUDU contribution, the proposed recommendation was to be discussed with a service manager. In delegated and committee reports, the HUDU issue was to be set out as part of the decision-making process. However, interviews of planners unanimously showed that the application of this policy approach was considered by Service Managers as

> "*inconsistent because it depends on how amenable applicants are to paying HUDU contributions, on a case by case basis. At this stage, unless a very good case could be made, we are not inclined to refuse schemes on this matter."*

Interviews also indicated that there needs to be some context added in terms of the economic situation, viability of development, requests from developers to re-negotiate Section 106 contributions and affordable housing provision and government pressure to approve applications to support economic growth. Bristol's Community Infrastructure Levy came into force on 1 January 2013, so the findings concerning developers' contributions need to be analysed within this new context.

4.6 The relationship between health comments and other comments

As stated above, interview with the specialist planner showed that NHS comments intentionally do not overlap with pollution control, contaminated land and remediation or major environmental health issues.

NHS Bristol comments present clear overlap and agreement with:

- Transport planning with physical health (active travel, walking, cycling) and safe environments (secured cycle parking)
- Sustainable City team: tackling global warming and promoting healthy urban principles (reduction in car emission, public transport, reduction in car parking spaces in particular in inner city locations to encourage take up of alternative modes of transport)
- City Design team: promoting good quality urban design, connectivity and creating a public realm that is legible, permeable and promotes walking and cycling.

4.7 Quality of NHS Bristol's responses as seen by development management planners

Four in depth interviews with service managers (see semi-structured interview questions in Appendix 1) have reflected on the features of the protocol. Comments gathered through the two surveys also supported and complemented the comments by service managers.

Response time from NHS Bristol is very good.

NHS Bristol comments in some cases are very relevant and reinforce the arguments of other experts or services (*it gives some gravitas to the issues* one planner interviewed commented). However, the counterargument put forward is that *NHS Bristol comments' overlap with established areas of policy/ they duplicate many of other considerations from a slightly different angle and can make it difficult to maximise their potential and take them on board.*

NHS Bristol comments can be useful to bring the health perspective to the fore and to flag up issues, raise the awareness and highlight deficiencies in policies (one interviewee commented that it *supports things we are trying to do).* They offer a different perspective: *Health Impact Assessment reminds us why we do things*, i.e. to promote health through active travel, reduction of emission.

One planner interviewed considered that the comments scoped out every issue, response format offers headings, logical development and content is thorough and was judged as the most thorough consultation response. However, as a counterargument NHS Bristol comments are *one consultee response amongst many, some of which conflict*. With resource being scarce, *officers do not have unlimited time to spend on negotiating minor changes to schemes;* several Development Management planners lament that NHS Bristol comments are *often hugely disproportionate in terms of their length,*

content and requested mitigation; another wrote that comments need to be *more timely and realistic.*

Both interviews and survey showed that several Development Management planners feel that NHS Bristol deals with technical issues which are not relevant, references from NHS Bristol on standards not adopted by Bristol City Council (e.g. space standards from other local authorities; interior layout of buildings) *are not helpful* at Development Management level as they cannot be a material consideration for the application and do not allow Bristol City Council to *negotiate with developers from a position of strength.*

One Development Management planner mentioned that although he did not quote or referred explicitly to comments in his report on transport links, he nevertheless incorporated them in his own feed back to the plan.

NHS Bristol comments might not secure a contribution from the developers but they raise the awareness of planners.

4.8 How NHS Bristol comments were used in planning decisions

Analysis of officers' reports backed up by interviews and surveys demonstrate that case officers justify their own decisions with *the letter* of planning policy in Bristol and national planning guidance rather than other sources of evidence.

In both surveys and interviews planners stressed that for health to be given greater consideration in their work, it would need to be highlighted in national and local planning policy and guidance rather than in other sources of evidence. The rationale emphasised in interviews is that only planning policy and guidance gives strength when negotiating with developers**.**

Examples include the following:

Cycle storage: Bristol policy currently requires 2 per dwelling. Any development providing only 2 is policy compliant and while planners recognise that it would be *"preferable to provide additional parking spaces"* (Luckwell Club), they are not supporting NHS Bristol request. Alternatively, case officer has commented that if the developers meet policy requirements, then "*not reasonable to insist that additional storage is provided"* (St Peter's hospice).

Car parking spaces: NHS Bristol has tended to require a reduction in car parking spaces in central locations, but if proposals do not exceed policy maximum for parking spaces, then the case officer will argue that there is no sufficient ground for refusing planning application. This is further reinforced by the lack of safety issues for instance (St Peter's hospice).

Size of residential accommodation: Space standards practice note does not apply to student accommodation. So NHS Bristol comments that recommend a certain size were not taken into account by case officers who judge *the limits as adequate* (Carlton Chambers).

Mitigation: Planners might consider the alternative proposals by developers to meet Bristol policies. For instance, lack of external open space on development flagged up by NHS Bristol as an issue, but the planners will however consider the proximity of the development to public open spaces (Carlton Chambers)

HUDU model: Local Plan policy BCS11 specifically refers to the use of Section 106 planning obligations to secure measures to mitigate the impact of development on healthcare facilities, without proposing how this is calculated.

NHS Bristol has used the HUDU model, with Bristol data as appropriate. Despite there being a real extra demand on limited health services, explicit reference in the protocol to the HUDU model and no alternative method of calculating that health need being put forward; lack of its formal adoption in Bristol means that officers were advised not to pursue requirements for health contribution based on HUDU.

NHS Bristol's *Section 106 is not based on formula set out in SPD4 and as the HUDU model is not tested nor adopted in a Bristol SPD*, it has been systematically rejected by development planners in their reports as not justifiable.

Local Plan policy: When NHS Bristol comments are backed by full reference to local policy, it is difficult to assess the weight given to them by development management planners since local policy documents will identify standards owned and implemented by different Bristol City Council departments consulted on the applications.

For example, on the Code for Sustainable Homes, the NHS Bristol requirement for at least code level 4 is usually meet, so the NHS Bristol comment does not make any difference (eg St Peter's hospice)

Reporting NHS comments: NHS Bristol comments are sometimes listed in officers' reports en bloc and not necessarily used as arguments to answer specific planning concerns.

NHS Bristol comments are not usually found on the planning portal. A notable exception is the application for a Sainsbury's superstore on the Memorial Stadium where NHS Bristol comments were uploaded onto the planning portal. Subsequently the comments were referred to by local residents, community groups and members of the Area Planning Committee during discussion of the application.

Sole comments: In at least two cases NHS Bristol made comments that no other consultee had and these did lead to changes in the proposed development. In the case of Bristol General Hospital it highlighted need for a contra-flow cycle lane on Lower Guinea Street.

In its response to the residential development at Gloucestershire Cricket Ground it showed that the proposed access meant that journeys to St Andrew's park, local shops, GPS and bus stops on Gloucester Road were long and torturous, which would discourage walking and cycling to them. NHS Bristol recommended that providing direct access through the cricket ground would overcome this, and this was accepted. The original application was for only Code for Sustainable Homes level 2. NHS Bristol recommended achieving level 4. Planners used NHS Bristol's response to secure level 3.

4.9 Knowledge at the start of the protocol implementation

Early in the evaluation (September 2011), a baseline survey of planners in all four development management planning teams (major developments, North, South and Central), city design and strategic policy was carried out, to understand the knowledge of Bristol City Council's planners in the field of healthy planning, in particular to:

- Assess the level of consideration and integration of health into planning
- Tentatively identify the importance of policy and skills to explain that level of consideration and integration of health into planning.

58 planners responded in total, of which 25 were in development management. 82% of these 25 were aware of the protocol and half had dealt with an NHS response.

Over 90% thought that planning had a role in delivering public health outcomes, the others were don't knows. 81% thought that health was integrated into Bristol's Core Strategy, compared to only 43% thinking health was integrated into the adopted 1997 Bristol Local Plan.

The consideration of health in planning decisions was patchy (see Table 4). Environmental health/quality physical activity, active travel, access to green space, housing quality and the quality of the public realm scored well, in contrast to food, mental health, physical health and health inequalities.

Table 4: Consideration of health issues by development management planners

Do you take into account evidence on the following health issues in your work?	Yes DM %	Yes non-DM %
Environmental health (eg air and water quality, noise, waste, contaminate land, odours)	90.0	70.8
Access to green open space	85.0	83.3
Active travel (walking and cycling)	85.0	79.2
Physical activity (eg play area, sport)	85.0	79.2
Quality and safeness of the public realm	85.0	75.0
Housing size and quality	85.0	66.7
Accidental injury/casualty	50.0	54.2
Health implications of global environmental issues (eg climate change, peak oil, biodiversity)	36.8	66.7

Do you take into account evidence on the following health issues in your work?	Yes DM %	Yes non-DM %
Access to local health services	36.8	62.5
Health equalities/inequalities	22.2	54.2
Physical health (illness, disease)	21.1	45.8
Mental wellbeing, mental health	16.7	58.3
Access to safe, affordable and nutritious food – to buy or to grow	16.7	50.0

No development management planners had reviewed the quality of a Health Impact Assessment or considered the outcomes of a Health Impact Assessment.

The top three things that would support planners giving greater consideration to health was national policy and guidance (95%), local planning policy (95%) and local advice and guidance (84%). Training would also help (74%), particularly lunchtime briefing, in-house half-day sessions and RTPI events.

33 non-development management planners (eg strategic policy and city design) also responded to the survey. Many of their scores were similar to the development management policies. Some of the differences were the relative consideration of health issues (see Table 4), particularly global environmental issues, access to local health services, health inequalities and mental wellbeing.

Perhaps surprising, given the concern about takeaways and childhood obesity and the increasing demand for allotments, was the low score for food from both sets of planners.

Another difference was the greater use of newspaper and professional journals articles and evidence from academic sources (conference papers, journal articles and research papers) by non-development management planners.

The first survey was carried out at a time of change for the planning system in England. In 2012, the NPPF was introduced to replace Planning Policy Statements and regional strategies abolished while core strategies and development management policies remain. The NPPF makes health a material consideration of planning decisions and states that planners should not only implement local plans but also consider other local non planning health strategies, such as obesity strategy when making their planning decisions.

For health to be given greater consideration in their work would require training to highlight health in national and local planning policy and guidance rather than other sources of evidence.

4.10 Knowledge after the first year of the protocol

A second survey of planners was carried out 12 months later. 21 planners responded, of which 13 were from development management. The survey was shorter covering more open-ended feed-back from planners on whether they think the NPPF and neighbourhood planning will help or hinder integrating health considerations into planning decisions and why; on how neighbourhood plans can best take local health issues into account.

Planners were asked if they felt the protocol is working well, if NHS Bristol comments are useful or relevant, what the issues are and how the process might be improved. These feed-back comments informed the next analytical section. One needs to be careful in drawing comparisons between the two surveys as the number of development management respondents dropped from 25 in the first survey to 13 in the second survey.

Altogether, results from the first survey on consideration of evidence covering various health issues have improved for all health aspects (except for access to safe, affordable and nutritious food where there is a small drop from 16.7% to 14.3%).

Consideration of evidence for physical activity, active travel, access to green space, environmental health and quality of the public realm remains strong (85.7% of development management planners will consider such evidence in their work). All development management planners take environmental health into account and consideration of evidence on mental health and health inequalities has strongly improved from (16.7% and 22.2% to 57.1% and 71.4% respectively).

They were generally doubtful that the references to health in the NPPF would make a greater difference, that it would be over-ridden by the priority given to economic growth and simplifying the planning process. Some were more optimistic, that it provided a stronger reference in negotiating and determining planning applications. However it would be necessary for this general guidance to be translated in to more specific development management policies. The weight given by the Planning Inspectorate in appeal decisions would be crucial.

There were a range of suggestions about how neighbourhood planning could take health into account starting with being aware of the health issues in the area to proposals to address barriers to walking and cycling, improved play facilities, access to services, safeguarding sites for health infrastructure and identifying interventions to be funded through CIL that meet local health needs. However it is too early to see how this will work out in practice.

A year on, health considerations still have little impact on final decisions (both before and after surveys show 0%). However, the protocol has helped raise awareness and discussion of health issues at pre-application meetings with developers (from 19% to 71.4%) and health is raised more strongly as an issue internally when considering major developments (from 51.1% to 71.4%).

5 Analysis and discussion

5.1 Introduction

The analysis will examine the integration of the protocol in the practice of development management by considering the issues of resources, referral process, process and substance of NHS responses, health considerations at pre-applications and early stages of the developments, transparency, developers' contribution, consideration of health evidence by development planners and statutory value of the protocol.

The analysis will then examine the protocol's value as a strategic and policy instrument, focussing in particular on the links between NHS Bristol comments and BCC policies, considering the future role of health and wellbeing strategy and Health and Wellbeing Board and the need for monitoring the effectiveness of the protocol to contribute towards the Bristol Local Plan vision.

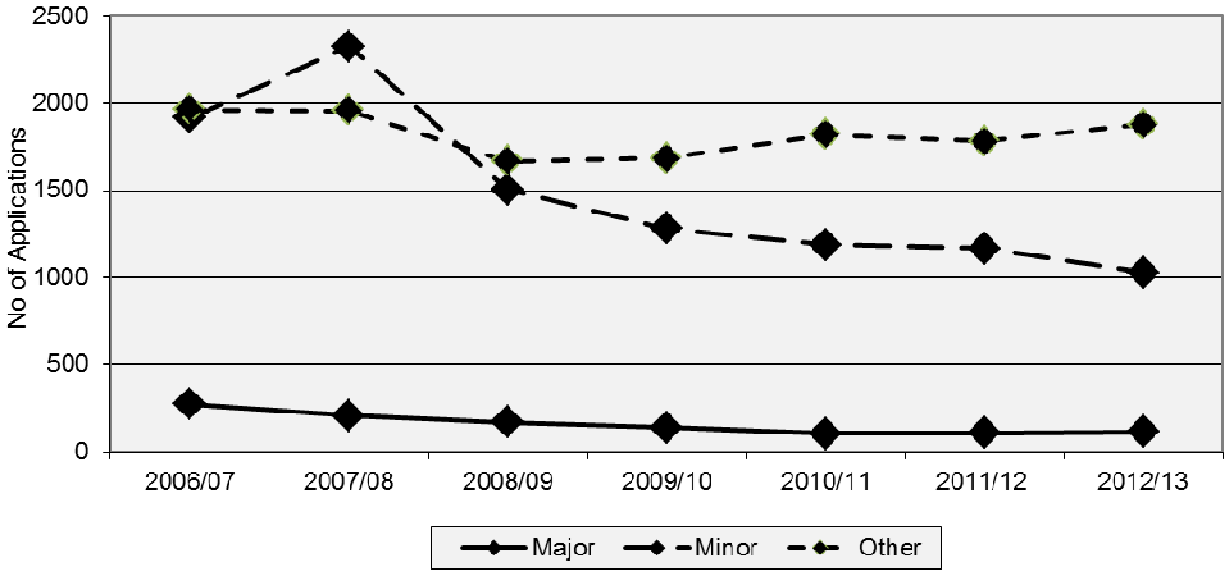
5.2 Resources

It was originally thought that NHS Bristol would need to respond to 13 consultations per month. However, over the evaluation period, NHS Bristol received an average of 5.6 consultations per month and responded to nearly two-thirds of them, equivalent to 11% of the specialist planner's time. The post-2008 economic downturn has led to a reduction in major and minor applications (table 5 and figure 1 below). A return to better economic conditions in the future will lead to an increase in planning applications with a consequential pressure on work priorities and capacity that will need to be monitored and addressed accordingly.

Table 5: Number of major planning applications received by Bristol City Council over the last few years

Year	Major	Minor	Other	Total
2006/07	273	1,916	1,964	4,153
2007/08	208	2,328	1,959	4,495
2008/09	170	1,505	1,668	3,343
2009/10	138	1,282	1,686	3,106
2010/11	105	1,189	1,819	3,113
2011/12	107	1,168	1,783	3,058
2012/13	113	1,030	1,877	3,020

Figure 1: Planning applications submitted to Bristol City Council 2006/07 to 2012/13



Recommendation 8: Director of Public Health monitors the number of applications sent for consultation and the number of responses and considers issues of work priorities and capacity as necessary.

5.3 Referral process

The economic downturn alone cannot explain the reduction in referrals in the first year of the protocol. The process to refer relevant applications to NHS Bristol is generally functioning well after a period of adaptation, however not all relevant applications do get referred.

Table 1 shows that NHS Bristol was consulted on 54 major planning applications over the 15 months period, two thirds (68%) of the 72 (59 + 13) major and super major applications received during the same period. In the evaluation period, as table 2 indicated, NHS Bristol did not comment on any proposals that would result in the loss of public open space.

Furthermore, development management officers did not use their discretion to refer minor residential applications nor any other applications. This could be due to pressures on time and resources. It could also be that no other application was deemed as affecting health or a lack of awareness of development planners about health outcomes.

Recommendation 15: Development Management Service Manager to ensure there are robust systems in place to ensure that all relevant applications are referred to the Director of Public Health.

5.4 Process and substance of NHS responses

The findings from NHS Bristol comments analysis, surveys and interviews of development planners showed that health comments reinforce other expert comments, can set higher principles, are cross-cutting, provide a robust and broad evidence base, raise broad health awareness, and can support changes in proposals.

However, a number of teething problems have hampered the use of the protocol and need to be reviewed to maximise its effectiveness to promote healthy settlements. First, the overlap with established areas of policy can be seen as positive but also a waste of resource. Second, NHS Bristol bases its comments on a broad range of evidence in an evolving field of research as well as on existing planning guidance, standards and policies. Yet planning officers rely only on the latter to justify their decisions. Third, development planners have observed that NHS comments are very thorough, but perhaps too detailed, referring to non-material issues and disproportionate sometimes in terms of length, content and requested mitigations.

NHS Bristol should be careful that relating their responses more closely to existing local and national planning policies does not unnecessarily constrain them. Being aspirational, challenging and advocating for better and higher standards to improve the health of the population is an important public health function.

Findings also show that impact on health and wellbeing is not identified as a key issue in planning officers' reports. Rather it can get covered across a range of issues (e.g. sustainability, space standards, transport), so health outcome visibility might be diluted. In some applications, NHS Bristol comments are listed in officers' reports "en bloc" but not necessarily distilled and used as argument to answer specific planning questions. Expert knowledge of the specialist planners can therefore be lost.

Recommendation 6: Public Health to ensure that responses are proportionate to the proposed development and related to adopted national and local planning policies as far as possible.

Recommendation 14: Development Management officers to consider having the impact on health and wellbeing as a key issue in reports.

5.5 Health considerations at pre-applications and early stages of the developments

Findings showed that over the evaluation period NHS Bristol requested 16 Health Impact Assessments at pre-application stage of super-major applications. Bristol's draft development management policy DM14 requires a Health Impact Assessment for residential developments of 100 or more units, non-residential developments of 10,000m^2 or when the proposal is likely to have a significant impact on health and wellbeing. However as it is not yet an adopted Bristol Local Plan policy, development management planners have not been able to insist on Health Impact Assessments.

Policy DM14: The Health Impacts of Development (March 2013)

Development should contribute to reducing the causes of ill-health, improving health and reducing health inequalities within the city through:

i. Addressing any adverse health impacts; and

ii. Providing a healthy living environment; and

iii. Promoting and enabling healthy lifestyles as the normal, easy choice; and

iv. Providing good access to health facilities and services.

Developments that will have an unacceptable impact on health and wellbeing will not be permitted.

A Health Impact Assessment will be required for residential developments of 100 or more units, non-residential developments of 10,000 m^2 or more and for other developments may be required where the proposal is likely to have a significant impact on health and wellbeing. Where significant impacts are identified, measures to mitigate the adverse impact of the development will be provided and/or secured by planning obligations.

From the first survey caries out at the beginning of the evaluation, no development management planners had reviewed the quality of a Health Impact Assessment or considered the outcomes of a Health Impact Assessment.

Development management planners surveyed have recognised that the protocol, after a year, has helped the consideration and discussion of health issues at pre-application meetings with developers: from 19% to 71.4% and health is raised more strongly as an issue internally when considering major developments (from 51.1% to 71.4%). This was confirmed in interviews.

However, the protocol does not contribute directly to an on-going dialogue with developers or with communities. NHS Bristol responses include recommendations to improve a development. Yet planners are concerned that the protocol can be a reactive tool which aims at criticising applications if not rejecting them. This can be probably exacerbated by their concern over the disproportionate nature of the requested mitigation.

The expertise of the public health planner could be deployed to help scope the Health Impact Assessment and to be fully integrated in the team negotiating with developers at pre-application stages. This would also address the issue of on-going dialogue with developers and build the protocol as a positive tool. The recurrence of health input on pre-applications would also reflect health becoming a critical policy issue.

In addition depending on the type of application, developers could also be required to demonstrate how they take into account impact of their scheme on health through their design and access statement, and Environmental Impact

Assessment and public health offers expertise in ensuring that the healthy outcomes identified in DM14 are considered by applicants.

Working further upstream would be engagement with the development industry (eg architects, surveyors, developers, house builders, land owners, funders) before the pre-app stage, so that healthy planning principles are embedded from the beginning. One possibility is to use the model of the government's Public Health Responsibility Deal, localising it (Department of Health, 2013) and extending it from the existing four sets of pledges (food, alcohol, physical activity and health at work) to a fifth set of pledges for building healthy places for people to grow up and grow old in.

The aim of the Responsibility Deal is to maximise the potential benefits of business making healthier products and using its marketing expertise to influence healthier purchasing habits. The government's view is that by working in partnership, public health, commercial, and voluntary organisations can agree practical actions to secure more progress, more quickly, with less cost than legislation. The challenge would be to transfer this to the city level.

Recommendation 17: Bristol City Council to adopt development management policy DM14 on the health impacts of development as soon as possible

Recommendation 5: Director of Public Health and the Director of Planning explore the option for establishing a local public health responsibility deal for the built environment.

5.6 Transparency

The findings regarding the Sainsbury superstore on Memorial Stadium emphasise how the planning portal can support transfer of the specialist planner's expert knowledge to local communities and stakeholders. To ensure transparency of the decision-making process, it would be good practice to upload all NHS Bristol comments, as well as all other consultee comments, on the planning portal as they can be of considerable public interest.

Another more critical issue concerning transparency is linked to the restructuring of public health structure. Abolition of NHS Bristol and the transfer of public health to the local authority and commissioning of health services to the Clinical Commissioning Group and to the NHS Commissioning Board (aka NHS England) could have an impact on transparency as public health changes from being an external consultee to an internal consultee. The Director of Public Health led on the protocol process within NHS Bristol and should keep the responsibility following the reform of the NHS.

The core purpose of the Director of Public Health is to be an independent advocacy for the health of the population and leadership for its improvement and protection. As part of their advocacy role, Directors of Public Health are expected to produce an Annual Report on the health of their population and provide the public with expert, objective advice on health matters.

Recommendation 16: Development Management service to publish consultee comments on the planning portal.

Recommendation 7: Director of Public Health to determine if and when representations on planning application should be explicitly considered as formal expert, objective advice on health matters to the public as well as advice to the council.

5.7 Developers' contribution

NHS Bristol's requests for Section 106 payments, totalling £1.48 million, towards the extra demand on health services have been systematically rejected on the grounds that they are *very large and insufficiently justified and* compared to other contributions required (e.g. education; affordable housing), they are unreasonable, in particular at a time of economic downturn. Four planners interviewed and some survey comments reject the HUDU model. Development management committee was not too interested either by it perhaps because of the introduction of the Community Infrastructure Levy (CIL) in Bristol from January 2013. Procedurally, this issue has per se disappeared with the CIL replacing formula-based Section 106 payments.

The developers' contribution to cover extra demand on health services needs now to be addressed through the Community Infrastructure Levy and the council's 123 statement of CIL expenditure. The NPPF refers to infrastructure planning stating that all local plans must have strategic policies to deliver:

The provision of health, security, community and cultural infrastructure and other local facilities (NPPF, 2012, para 156).

Local planning authorities are to work with other authorities and providers to:

Assess the quality and capacity of infrastructure for…health, social care…and its ability to meet forecast demands (NPPF, 2012, para 162)

It therefore follows that following the abolition of the PCT, the Health and Wellbeing Board, Bristol Commissioning Group, Foundation Trusts and the NHS England Local Area Team (aka NHS Commissioning Board) will need to engage with the planning system and decisions about the spending of CIL monies about the need, location and delivery of new health care facilities in phase with new housing and other developments to meet the health needs of new and existing residents.

Recommendation 9: Bristol's Health and Wellbeing Board, Bristol Commissioning Group and the NHS England Local Area Team engage with the planning system and decision-making about the allocation of Community Infrastructure Levy monies in relation to the need for and provision of new health care facilities.

5.8 Consideration of health evidence by development management planners

All in all, the findings of the before and after surveys show that the protocol has contributed to raised awareness of planners around health outcomes. However, findings from decisions and interviews also show that the consideration of health outcomes by development planners is still limited.

Several reasons explain this and will need to be addressed. First, findings show that development planners favour NHS Bristol's references to local and national planning policies rather than strong (non-planning) evidence-based research and guidance not yet adopted formally in Bristol. Case officers interviewed have stressed that they need reassurance that NHS Bristol's requirements for changes in applications or rejections have a clear hook *to the letter* of planning policy in Bristol. Yet, the NPPF states that health is now a material consideration to planning decisions, in terms of both supporting local health and wellbeing strategies (para 17) and taking account of the health status and needs of the local population (para 171). This has strong policy development implications if Bristol City Council wants to acknowledge further the importance of the built environment on health and harness new evidence into development planning.

Second, one decision (more evidence would be needed) gave anecdotal evidence that NHS Bristol comments were rejected "en bloc" as "no longer of relevance" (Redcatch) when the planning application did not meet protocol criteria anymore (i.e. number of dwellings reduced) . This application of the letter of the protocol should be reviewed as the introduction of the protocol validates the implementation of healthy planning principles whatever the size of the proposal, and use of the referral process is only limited because of pressures on staff resources.

Recommendation 2: Public Health consultant and Development Management service manager to discuss ways to improve planners' consideration of health evidence and issues in the context of the NNPF – ie core planning principle to take account of and support local health and wellbeing strategies (para 17), the promotion of healthy communities (paras 69–78) and taking account of the health status and health needs of the local population (para 171).

Recommendation 13: Development Management to review the weight given to health evidence in the light of the NPPF core planning principle to take account of and support local health and wellbeing strategies and the reference in para 171 to understand and take account of the health status and needs of the local population.

5.9 Statutory value of the protocol

It is important to stress that so far Bristol approach has not been tested at appeal – i.e. no planning application has been refused on health grounds and gone to appeal, so health policies and health evidence has not been tested in front of a planning inspector.

Although health and wellbeing is referenced in the NPPF, the research team is not aware of any planning applications being refused just on health grounds and have then gone to appeal. Health has been a consideration in a number of appeals, but has not been the sole reason.

An increasing number of authorities have healthy planning policies. It is understandable that any one local authority could be anxious to be a precedent and refuse an application on health grounds, with the risk of an award of costs and a judicial review and its consequential costs. Under the umbrella of the Local Government Association, Core Cities or the UK Healthy City Network, local authorities could agree to mutually support each other as and when a test case occurs and thus spread the risk of any claim for costs.

Recommendation 3: Bristol City Council approach other authorities about setting up a scheme of mutual support in relation to defending health in planning decisions.

5.10 Links between NHS Bristol comments and BCC policies

While NHS Bristol comments are specific to individual applications finding show that they can often be highly relevant to planning core strategy but also other council wide strategies to ensure that they consider a broad range of health outcomes (see appendix 6). Examples include the following:

NHS requirement for secure bike storage/cycle racks, increase in cycle parking and cycle parking for visitors which supports the delivery of physical health outcomes through the core strategy.

Requirements on the quality of the public realm, capacity in social, community and recreational activities, quality of built environment: increase standards required, residential space standards, tree planting/better choice of trees, better public participation supports mental wellbeing are highly relevant to the principles/objectives set in the core strategy.

For instance, detailed comments on infrastructure for walking/cycling, conditions on design of pedestrian and cycle routes, on active travel (e.g. transport of bikes on buses), increase in cycle parking, reduction in car parking are highly relevant to the Local Transport Plan and apply as a general rule to all planning applications referred to NHS Bristol.

An example is the pre-application to the North Fringe to Hengrove BRT scheme. NHS Bristol made some comments on specific urban design aspects of the scheme (e.g. design of bus stops, improve legibility, landscaping), its direct effectiveness as a mode of transport (more stops along the route) but also on the need to integrate the bus service with the entire system of public and active travel transport.

NHS Bristol's reference to level of access to nutritious/fresh food, on food growing areas/ allotments and impact on local suppliers can

inform Who Feed's Bristol and the allotment strategy.

Comments considering the impact of developments on employment and education opportunities in the area, and adverse impact on small traders and reducing in access to local shops are relevant to economic development and reference to lack and affordability of housing feeds directly into the housing strategy.

Requirements for high standards in renewable energy used on new developments feeds directly into the climate change strategy and targets fuel poverty, and its health impact.

In addition, NHS Bristol is not bound by the letter of the policy and the present intentions of the applicants but is more concerned by its spirit and the overall objective to build long-term healthy, sustainable communities.

This difference in approach between planning officers and NHS Bristol can be identified in various applications. For instance when NHS Bristol comments highlight that the layout *and design suggests that applicants may intend to have a significant A5 takeaway use* (12/01618/F) while development management officers can only base their decisions on the stated intentions of the application (i.e. A3 in that case).

Is a planning application good enough to approve or bad enough to refuse? This difference in perspectives may explain differences in approach or emphasis. Public Health tend to use the former, while Development Management given the presumption in favour of sustainable development, use the latter. A Development Management planner interviewed suggests that NHS Bristol should *lobby planning policy to improve them in future iterations if they think that Bristol City Council standards do not go far enough*.

The holistic nature of NHS Bristol assessment should inform the development of health promoting policies and support policy learning from health to planning, both at a local and national level. Two areas where this has come up most often are parking standards and residential space standards.

Recommendation 11 Director of Public Health to make representations on council planning policies and on other Council policies promoting healthy and sustainable communities, as necessary, based on the evidence in this evaluation and to determine if it is appropriate that such representations should be explicitly considered as formal expert, objective advice on health matters to the public as well as advice to the council.

Recommendation 12: Director of Public Health to continue to engage with the development of planning policy locally and nationally.

Recommendation 18: Bristol Planning Policy reviews cycle and car parking standards and residential space standards so that they better support delivery of health outcomes.

5.11 Role of health and wellbeing strategy and Health and Wellbeing Board

The protocol evaluation cannot be considered outside the broader context of transfer of the public health function from the NHS back to local authorities, and the concomitant statutory duty to improve health, as it creates an opportunity to recreate a dynamic partnership between planning and public health functions, in particular to deliver the shared aspiration of developing healthy, sustainable communities and addressing health and social inequalities.

While the primary focus of the Health and Wellbeing Board is the improvement and co-ordination of commissioning local health and social care services, there is a great opportunity for it to address the wider determinants of health through the Joint Strategic Needs Assessment for health and wellbeing (JSNA) and its health and wellbeing strategy (Tomlinson, Hewitt and Blackshaw 2013).

The health and wellbeing strategy can be the means for influencing other council policy and service decisions that have an impact on health. This includes ensuring that planning plays its role in delivering healthy, safe and sustainable communities and places and better integration with other regulatory regimes such as licencing, food safety and trading standards on issues such as health eating, childhood obesity and hot food takeaways and responsible drinking, the night-time economy and the sale of alcohol through both on- and off-licences.

To support this ambition, the Health and Wellbeing Board will need to ensure that the JSNA makes explicit the contribution that the built environment can make to the improvement of health and wellbeing and addressing health inequalities at a local authority level.

This is reflected in the planning system. One of the core planning principles in the NPPF refers to the fact that planning decisions should take account of and support local strategies to improve health, social and cultural wellbeing for all. The health and wellbeing strategy is one such strategy. The Health and Wellbeing Board must ensure that the health and wellbeing strategy is fit for that purpose.

The Health and Wellbeing Board can take on board some of the lessons that have emerged out of this evaluation of the protocol, in particular in terms of forming cross-sector partnerships with other Bristol City Council departments to influence policies and allocating health related resource to address the following issues:

- Broadening the evidence base taken into account by planners, in particular health evidence that shows a strong link between design aspects and a wide range of health outcomes
- Building of a cross-disciplinary knowledge base between NHS and planning and between experts and decision-makers, as encouraged by

the Faculty of Public Health, Royal Town Planning Institute and Spatial Planning and Health Group joint statement (January 2013)
- Addressing the issue of developers contribution to health related services
- Promoting public health involvement at pre-apps and early stages of the developments, including support for Health Impact Assessment.

The Health and Wellbeing Board could also alleviate the fear of planners interviewed that the NPPF will not help the integration of health consideration into planning decisions, mainly because of the presumption in favour of development and the lack of specific planning policies. The protocol and expert health knowledge could help ensure that health and health equity in all policies linked to the built environment is translated on the ground.

Recommendation 1: The Director of Public Health to be the successor body to NHS Bristol under the protocol.

Recommendation 10: Director of Public Health to review Bristol's health and wellbeing strategy and Joint Strategic Needs Assessment to ensure that they can effectively carry out their function of influencing planning decisions.

5.12 Future monitoring

This evaluation has only been able to look at the influence of health on the development management process. So far the planning applications looked at have not yet turned into fully constructed and occupied developments.

It is important that there are systems in place to monitor progress towards the Bristol Local Plan vision of *"A safe and healthy city made up of thriving neighbourhoods with a high quality of life"*.

Under Section 35 of the Planning and Compulsory Purchase Act 2004, local planning authorities have a duty to prepare an Annual Monitoring Report on progress in preparing and implementing their Local Plan, including monitoring new development, proposed and completed. This can be a valuable source of information on new developments in an area.

Joint Strategic Needs Assessments for health and wellbeing were first introduced in the Health and Local Government Act 2007 and required Primary Care Trusts (now the Health and Wellbeing Board) and local authorities to jointly and systematically review the health and wellbeing needs of their population. It brings detailed information on local health and wellbeing needs together in one place and looks ahead at emerging challenges and projected need in the future. The scope can include all the factors that impact on health and wellbeing of local communities, such as employment, education, housing, and environmental factors.

The Director of Public Health has a duty to provide the public with expert, objective advice on health matters and to write an annual public health report. The content and structure of the report is something to be decided locally.

These reports take many forms; some covering all conditions, others topic based or a combination

There is the opportunity for these reports to be a suite of complementary documents that can record and monitor changes to the urban environment and on the impact on the health and wellbeing of local residents and on health inequalities.

Together they could become a powerful common evidence base for planning decisions, commissioning public health and health care services and facilities. As far as possible they should use common definitions, comparable data and align geographical and temporal boundaries. The potential of using GIS to integrate data and illustrate trends should be exploited. The Annual Monitoring Report could include a chapter on health, and this could then be mirrored by an urban environment chapter in the Joint Strategic Needs Assessment.

It is generally easier to identify the impact on the determinants of health or risk factors (e.g. levels of physical activity, air quality and access to greenspace) than on health directly (e.g. cardio-vascular disease, respiratory problems, mental wellbeing). It is then a question of indicating the plausibility of the, sometimes complex, relationships (association or causal) between the risk factor and the health outcome

Recommendation 4: That the Director Of Public Health and the Director of Planning work to ensure that the Annual Monitoring Report, Joint Strategic Needs Assessment and Director of Public Health's annual report complement each other in monitoring changes in the urban environment and the impact on health and wellbeing.

6 Conclusions

The findings of this evaluation have highlighted that the protocol has brought extensive health and wellbeing expertise into the development management process. This is especially welcome at a critical transition point during which the council has the opportunity to develop its public health portfolio and integrate public health strategies and outcomes within its own existing structures and policies.

The public health and planning sectors both aim to create healthy sustainable communities; however, each sector employs different approaches and methods to achieve this common aim. A process of knowledge exchange and cross-sector working needs to develop to support the integration of health consideration into planning practice. The protocol has supported this process.

The processes set up through the protocol do work, resources have been allocated and the referral process is in place, albeit it needs to be reinforced to ensure that public health has the opportunity to better scrutinise all applications that can potentially affect health and wellbeing.

Of course there have also been some teething problems. On the one hand public health must learn to adapt its contribution to a well-established development management system which is performance and process driven.

In particular public health needs to ensure that responses are more closely related to adopted national and local planning policies; without losing its aspirations and ethics of challenging and advocating for better and higher standards to improve the health of the population. This also means that it needs to continue to be involved in the upstream planning policy development work too.

On the other hand, planners need to better recognise the value of the robust evidence base provided by public health and better consider how to integrate this into reports, decisions and into new polices and standards.

At development management level, there are some indications that the protocol has helped raised the awareness of planners or strengthened their arguments in discussions with developers. In addition, some NHS responses have influenced the shape of future developments, particularly in the case of super-major applications.

Given the rigid procedural aspects of development planning, development planners have made some useful suggestions for the steps that must be taken next to ensure more effective integration of health into planning. This includes the need for the specialist ‘healthy urban’ planner to be more integrated into pre-application discussions and inform the health impact assessment process.

More fundamental to population health and wellbeing: councils throughout the country need to consider and radically re-design the ways that they can

integrate health into council policy, exploring the cross-cutting links between health and other priorities, in particular urban design, traffic and transport, housing quality, green and blue infrastructure, community safety and sustainability and other regulatory regimes such as licensing, food safety and trading standards.

In England, the role of the Health and Wellbeing Board and the development of Health and Wellbeing Strategies will be fundamental

The immediate priorities for all local authorities should be to set up robust systems to assess the opportunities that cross-sector collaboration can bring to improving the quality of life in urban environments and ensure that strategic links are made between a range of built environment and public health interests.

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Appendix 1: Protocol between Bristol City Council and NHS Bristol for bringing health expertise into decision-making on planning (May 2011)

Contents

1. Scope of this protocol

1.1 This protocol is the first stage in the establishment of a working relationship between Bristol City Council and NHS Bristol. In this way it will be possible to ensure that the principles of health and wellbeing are properly considered when evaluating and determining certain planning applications.

2. Who is NHS Bristol?

2.1 NHS Bristol is the primary care trust for the city and is one of the main providers of NHS services in Bristol. Primary Care Trusts (PCTs) have three main functions:

1) Engaging with the local population to improve their health and wellbeing;
2) Commissioning a comprehensive and equitable range of high quality, responsive and efficient health services, within allocated resources, across all service sectors; and
3) Directly providing high quality, responsive and efficient services where this gives best value

2.2 NHS Bristol is responsible for providing and managing all of the primary care services in the Bristol local area from GPs, dentist surgeries, opticians, and pharmacists to name but a few. In addition to providing the services that are necessary for bringing those that are ill back to health, NHS Bristol also recognises that preventative measures are equally important. The interests of PCTs and local planning authorities are therefore complementary and are best pursued by working together for mutual benefit.

[NB – this will be changing following the health white paper "Equity and Excellence: liberating the NHS" (July 2010)]

2.3 At present there is no requirement for developers to consult any health organisation in Bristol, even where an application clearly has implications for public health and wellbeing. In the same way that the Environment Agency is a statutory consultee for certain developments that would impact upon the environment, Bristol City Council would like NHS Bristol to be consulted for those applications that are likely to impact upon health and health inequalities. NHS Bristol, recognising that prevention is just as important as cure, are equally keen for this to be involved in the development management process.

2.4 The main reason why NHS Bristol should be consulted is that it can bring unique information to the process and offer an interpretation that may not be available from any other source. Its broad public health responsibilities and access to, and use of, routine health and demographic data make it uniquely positioned to comment independently on the aspects of the

application which are relevant to human health and the wider determinants of health. There would appear to be scope to involve NHS Bristol in the planning application process at all stages, particularly pre-application stages when development proposals are still in the process of being formulated, Environmental and Health Impact Assessments are being undertaken and planning obligations estimated. In order to do this it will first be necessary to establish exactly how, and to what extent NHS Bristol will inform the planning application process.

2.5 The aim of NHS Bristol in engaging with the planning system is to help deliver the government's high level public health vision: “To improve and protect the nation's health and to improve the health of the poorest fastest” (proposed public health outcomes framework Dec 2010), through:

> 'adapting the environment to make healthier choices easier and to create healthy places to grow up and grow old in, that support people in making healthy choices, that makes these choices easier, that enable active ageing to become the norm rather than the exception and to address health inequalities as a priority' (“Healthy Lives, Healthy People” public health white paper November 2010)

2.6 This is put into operation through the following healthy planning goals:

- **Avoiding adverse health impacts from development - health protection**

Air quality, Water quality, Noise, Dereliction and land pollution, Waste management, Light pollution, Community severance

- **Providing a healthy living environment**

Housing (quality, space standards, affordability, mixed tenure, type, density); Good quality, safe, stimulating public realm; Accessible for all (disabled access); Parks and green open space, water features, play facilities; Community facilities (youth clubs, places of worship, pubs, arts venues); Recreation and sports facilities (indoors and outdoors); Employment opportunities (variety, skill levels, working hours); Education and learning (schools, adults, FE/HE); Walking and cycling routes (on/off road, dual use/segregated); Pubic transport network (access to stops, fares, frequency, destinations served, hours of operation, reliability, safety); Food production and distribution

- **Promoting and facilitating healthy lifestyles as the norm**

Pattern of development (mixed use), movement/connectivity and urban design quality to promote active travel, physical activity and mental wellbeing; Active travel (safe, direct routes, secure parking and facilities for walking and cycling); Physical activity (access to green open space, play, recreation and sports facilities); Healthy eating (access to affordable safe and nutritious food, space for local food growing); Safe space for social interaction and play (events, meetings, markets, performance); Internal and external circulation

arrangements of all buildings to be designed to maximise physical activity by encouraging walking and the use of stairs rather than lifts and escalators and by providing sufficient secure cycle storage.

- **Providing good access to health facilities and services**

Health centres, GP's, dentists, hospitals, pharmacies to meet current and future population needs

- **Responding to global environmental issues - climate change, peak oil, resource depletion, waste management - resilience**

Minimising carbon emissions by transport and development; Sustainable design, construction methods and building materials; sustainable/renewable energy; flood risk (storm water management/ SUDS); urban heat islands; biodiversity and nature conservation; waste disposal and recycling

- **Ensuring community and stakeholder engagement in governance, delivery, implementation and future management**

Community involvement and cohesion, neighbourhood planning, strategic links, partnership working and stakeholder involvement, monitoring arrangements, research and evaluation

Underpinning all these goals is the cross-cutting/over-arching **principle of reducing health inequalities.**

3. Pre-application discussions

3.1 Depending on the proposal, NHS Bristol may want to raise any health issues and make suggestions regarding how they could be addressed, or alternatively request that a health impact assessment be undertaken, which they themselves may wish to be involved in producing. It is expected that a health impact assessment (HIA) will be required for all super major developments. NHS Bristol will need to provide advice on the quality of the HIA produced and how it is produced, including how it influences the proposed development.

1. Early consultation and liaison on development proposals is beneficial for resolving any problems or conflicts before any formal application is submitted
2. Development Management case officers involve NHS Bristol in pre-application discussions on all 'super major' development proposals (and major developments as appropriate).
3. Development Management case officers will use their discretion on whether to involve NHS Bristol in pre-application discussions on non-major developments
4. City Council officers should also encourage developers and promoters of development to liaise with NHS Bristol at the outset of such projects
5. Pre-application discussion should include the need, scope and nature of any HIA and whether it is a free-standing HIA or whether and how it is integrated with an environmental impact assessment, if that is also required.
6. NHS Bristol will provide advice on how the quality of the HIA will be judged

Major developments are those including 10 or more dwellings, or 1,000 sq m or more of floorspace, or site area greater than 1 hectare (0.5 hectares for residential development), as defined under SI 2006/1062.

'Super major' developments are those including 100 or more dwellings, or 10,000 sq m or more of floorspace and will normally subject to a planning performance agreement.

4. Application phase

4.1 Different proposals will require NHS Bristol to undertake different levels of assessment. In some circumstances it may simply be a case of preparing a short letter of support, whereas others may require a more detailed assessment of potential health impacts along with suggestions for design interventions and regarding planning obligations.

1. Development management officers will consult NHS Bristol directly on development proposals falling within the following categories:
    - Major residential (10 or more dwellings) and non-residential developments involving 1,000m^2 of floor space and above
    - All major transport and highway infrastructure projects
    - Proposals that would result in the loss of public open space
    - All applications for the establishment of A5 (food and drink) uses

    Development Management case officers will use their discretion on whether to consult NHS Bristol on minor residential (less than 10 dwellings) and minor non-residential developments (less than 1,000m^2 of floor space) and other applications.
2. NHS Bristol will then have 21 days from receipt of any consultation to provide a written response, subject to any negotiated extension of time.
3. The onus for viewing or obtaining relevant information relating to the application via the Planning Portal will be on NHS Bristol - **http://planningonline.bristol.gov.uk/online-applications/**
4. NHS Bristol's comments will be reported in the case officer's report.
5. If the case officer is mindful to recommend approval of an application, with or without conditions, against the advice of NHS Bristol then they should discuss this with NHS Bristol prior to any determination.
6. The case officer should discuss the final decision with their line manager to ensure that appropriate weight has been given to the comments of NHS Bristol.
7. The reason for overriding the comments of NHS Bristol should be clearly justified within the case officer's report
8. Where NHS Bristol have commented on planning applications they should be informed in writing of the decision including any relevant conditions that have

been attached.

9. NHS Bristol will hold regular one-hour surgeries every week (or fortnight?) in the planning offices (Brunel House) that allow case officers to consult them on a range of applications and have a dialogue about particular applications.
10. NHS Bristol will provide guidance on the quality of an health impact assessment provided by an applicant
11. NHS Bristol will be required to provide written evidence and technical advice for planning appeals on refused planning applications or on appeals lodged against conditions imposed on a planning consent.
12. NHS Bristol will provide the City Council with the contact details of a named officer to receive all consultations.

5. Securing planning obligations

5.1 NHS Bristol is well placed to assist the local planning authority in securing planning obligations to address any negative health impacts associated with new developments. This can cover issues such as active travel, access to green open space and play facilities, community severance and disturbance and environmental quality. In addition, it is legitimate to require developers to contribute towards the funding of healthcare infrastructure (for example when a local GP surgery is currently at capacity) where development creates a burden that cannot be accommodated by existing facilities.

5.2 The planning obligations system is changing and under the Community Infrastructure Levy (CIL) Regulations (SI 2010/948) a planning obligation may only be sought, where it is:

- Necessary to make the development acceptable in planning terms;
- Directly related to the development; and
- Fairly and reasonably related in scale and kind to the development.

Councils that wish to secure contributions to support growth (such as additional healthcare infrastructure) will need to implement a CIL as the use of planning obligations to support growth will cease. It is anticipated that Bristol City Council will implement CIL from April 2012.

5.3 In the meantime, the London Healthy Urban Development Unit (HUDU) model will be used (with Bristol data where appropriate) to calculate the size of any potential planning obligation in relation to the health needs of residents of new developments. The HUDU model enables a full appreciation of health service requirements resulting from a new residential or mixed-use development. The original HUDU Model was launched in April 2005 and updated and improved in 2007. The Model uses the numbers of proposed housing units in a development, and the likely resulting population and calculates the following information:

- Amount of hospital beds or floor space required for that population in terms of acute elective, acute non-elective, intermediate care, mental health and primary care.
- The capital cost of providing the required space
- The revenue costs of running the necessary services before mainstream NHS funding takes account of the new population.

www.healthyurbandevelopment.nhs.uk/pages/hudu_model/hudu_model.html

www.hudumodel.com

- NHS Bristol needs to be involved in any negotiations that may result in a planning obligation to address any negative health impacts and/or to meet health needs of the residents of new development
- The terms of a planning obligation should be clear and agreed by all parties prior to a consent being granted
- NHS Bristol needs to show how the financial contribution or facility will be used to provide services for the population within a reasonable period of time
- The health services provided through planning obligations should directly relate mitigating a negative health impact and/or to the health needs of the residents of a new development.

6. Conclusion

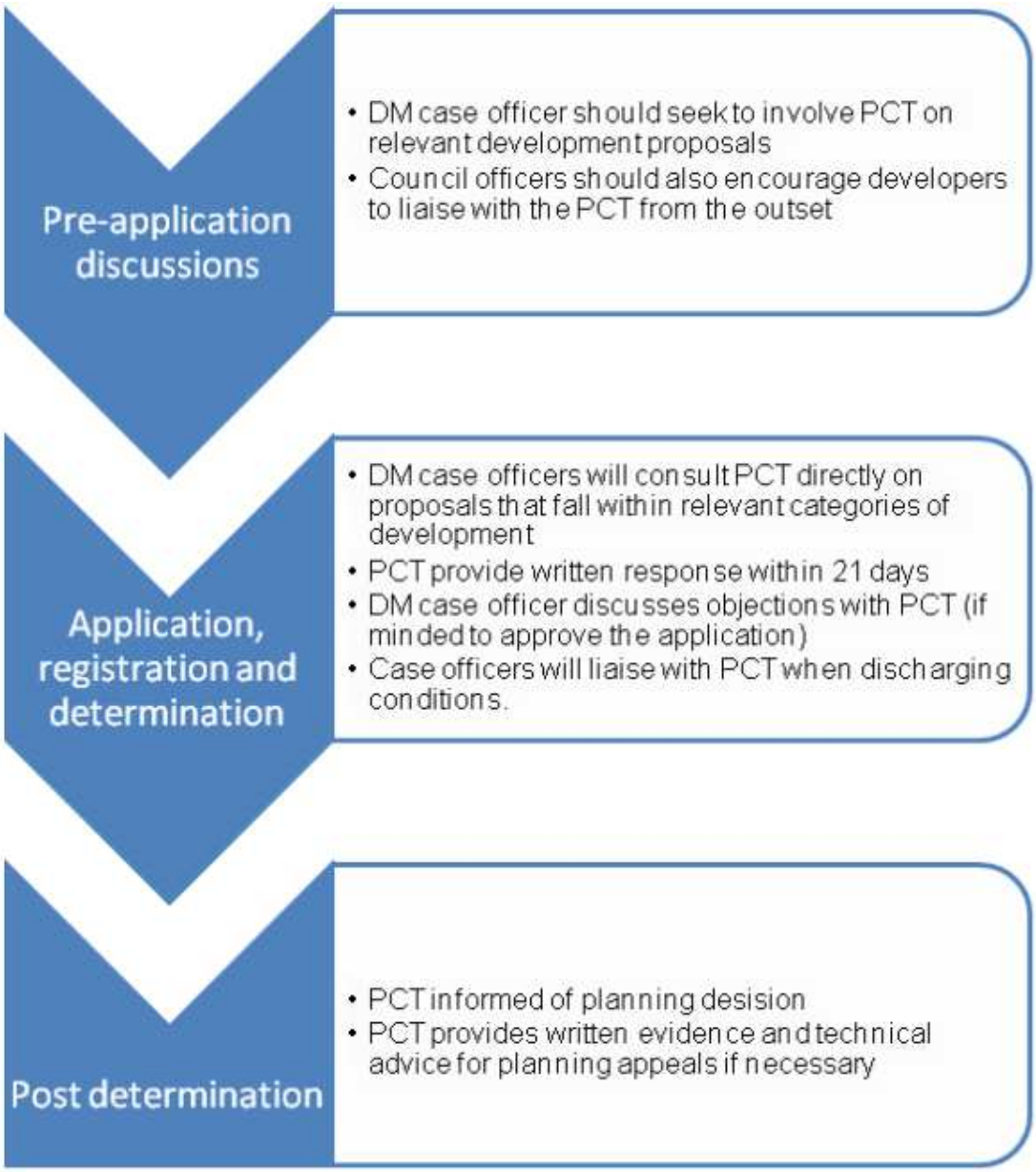
6.1 Everyone should have the opportunity to lead healthy lives. Collaborative working between Bristol City Council and NHS Bristol shows a commitment from both sides to work together to combat health inequalities in the city, recognising that spatial planning has an important role to play in improving the health of both current and future generations.

6.2 Development management is about more than the determination of planning applications. As appropriate NHS Bristol and Bristol City Council will work together over issues of implementation and enforcement.

6.3 This protocol will be reviewed in 12 months after it has been signed and can be reviewed earlier with the agreement of both parties.

Signed		
Date	Friday 6 May 2011	Friday 6 May 2011
Name	Angela Raffle	Gary Collins
Title	Public Health Consultant NHS Bristol	Development Management Manager Bristol City Council

APPENDIX – Development Management process map



Appendix 2: Research methods and timeframe

Research Brief

Evaluation of the protocol between Bristol City Council and NHS Bristol for bringing health expertise into decision-making on planning

Marcus Grant, WHO Collaborating Centre for Healthy Urban Environments
Laurence Carmichael, WHO Collaborating Centre for Healthy Urban Environments
Stephen Hewitt, Bristol City Council

Timeframe:
September 2011 to September 2012

Scope of evaluation/research questions:
The protocol between BCC and NHS Bristol is the first stage in the establishment of a working relation between BCC and NHS Bristol. Its aim is to ensure that principles of health and wellbeing are considered when evaluating and determining certain planning applications. The protocol came into operation from 1 June 2011. The WHO Collaborating centre was asked to carry out the first year evaluation of the effectiveness of the protocol for bringing health expertise into decision-making on planning in the light of experience and the reorganisation of the NHS.

Preliminary work for involving NHS Bristol in development management identified a number of issues (see Hewitt and Richards, 2010, p.15) which have informed the scope of the evaluation. The aims of the evaluation are to answer the following questions.

Primary research question: Does the process aimed at bringing health expertise into decision making on planning work?

Supplementary questions:

1. How and to what extent do NHS Bristol comments influence BCC's decisions on planning applications?
2. Has there been any changes to knowledge, attitudes of development management planners about the links between health and planning since the protocol has been implemented?
3. What is the impact of the national and local planning policy context?

The objectives are as follows:

1. Categorise by type, size and location how many applications were referred to NHS Bristol for comment, and how many pre-application discussions were NHS Bristol involved in.
2. Identify if all the relevant applications were sent to NHS Bristol and if not, why not?
3. Classify by type, size, location how many applications NHS Bristol commented on and which ones it did not comment on and why.
4. Identify what types of comments were made.
5. Identify how NHS comments were used by BCC planners and how they influenced the final planning decision? (approvals, recommendations, conditions, section 106 payments. HIAs carried out, changes to design).
6. Assess the relationship between health comments and other comments (eg urban design, community safety, sustainability) and the relative weight given to them by development management planners.
7. Assess if they led to better development? As it is unlikely to see much actual development happen in 12 months, identify methodology for long term evaluation
8. Assess the capacity of NHS Bristol to respond and the quality of responses – issues covered and not covered.
9. Assess knowledge before the protocol was implemented
10. Assess knowledge after the first 12 months of the protocol
11. Identify the factors that helped and hindered the implementation of the protocol and the mainstreaming of health into development management decisions

The research report will report on findings, conclusions, recommendations and lessons for the future. The data analysis and conclusions will bear in mind the issues raised before the protocol was implemented. The appendix identifies some of the issues to cover.

Project Team:

Marcus Grant: Deputy Director, WHO Collaborating Centre for healthy urban environments will oversee the project and be able to provide strategic advice
Laurence Carmichael: Research Fellow, WHO Collaborating Centre for healthy urban environments will be the main UWE researcher on the project
Stephen Hewitt, Specialist Professional Planner (Healthy Living/Health Improvement)
Bristol City Council will be main BCC collaborator on the project supervising the collection of data and supervising project outcomes.

Initial theoretical approach:
For a refereed publication, I would see the evaluation of the protocol as a case study of policy integration, so models of integration could be used: eg basic (Where for instance only certain health outcomes permeates decision-making in planning), project based changes (for instance through better cooperation between health and planning at local level) or holistic integration (using health map) through ideas, process, strategies at all tiers of governance. These are just ideas to be developed during the year.

Methodology - time frame/workplan:
A number of methods will be used to collect information and answer the 11 questions. We propose the following:
Lead person on each task has been identified, but drafts will be shared for comments.
SH: Stephen Hewitt
LC: Laurence Carmichael

Research question	Methodology	Timeframe
1. Categorise by type, size and location how many applications were referred to NHS Bristol for comment, and how many pre-application discussions were NHS Bristol involved in.	Data to be collected from BCC planning department (SH) Screening table 1 to design (LC) Screening table 1 to populate (SH) Data analysis (LC)	07/11 to 07/12 Data to be collected as applications come to BCC for consideration Data analysis can be on-going
2. Identify if all the relevant applications were sent to NHS Bristol and if not, why not?		
3. Classify by type, size, location how many applications NHS Bristol commented on and which ones it did not comment on and why.		
4. Identify what types of comments were made.	Data to be collected from BCC planning department, NHS Bristol Table 2: extraction table to design (LC) Extraction table 2 to populate (SH) Data analysis (LC)	07/11 to 07/12 Data to be collected as applications come to NHS Bristol for consideration Data analysis can be on-going Synthesis: 07-09/2012
5. Identify how NHS comments were used by BCC planners and how they influenced the final planning decision? (approvals, recommendations, conditions, section 106 payments. HIAs carried out, changes to design).		
6. Assess the relationship between health comments and other comments (eg urban design, community safety, sustainability) and the relative weight given to them by development management planners.		
7. Assess if they led to better development? As it is unlikely to see much actual development happen in 12 months, identify methodology for long term evaluation	Data analysis (LC/SH) Synthesis if possible and/or Suggest methodology? (LC/SH)	07-09/2012
8. Assess the capacity of NHS Bristol to respond and the quality of responses – issues covered and not covered.	NHS interviews + data analysis of table 2 (LC) Synthesis (LC)	07-09/2012
9. Assess planners' knowledge	Survey of 25-30	09/2011

Research question	Methodology	Timeframe
before the protocol was implemented	planners in all 4 teams (major developments, North, South and Central) Interviews of 4 team leaders/managers, heads of services (LC) Design and run survey (LC)	
10. Assess their knowledge after the first 12 months of the protocol	Survey of 25-30 planners in all 4 teams (major developments, North, South and Central) Interviews of 4 team leaders/managers, heads of services (LC) run survey (LC)	09/2012
1. Identify the policy factors that helped and hindered the implementation of the protocol and the mainstreaming of health into development management decisions	Document collection (SH/LC) Document analysis (LC)	06-09/2012
Conclusions, recommendations and lessons for the future?	Data analysis, synthesis (LC) Final report (LC/SH)	06-09/2012

Ethical issues

The researcher will conform to current national and EU legislation. In particular data protection legislation will be respected during the empirical stage of the research. Application for ethical review will be sought from UWE's research ethics committee. Potential participants in the survey and/or interviews will be all planners from BCC's planning department. They will be emailed and asked to take part in the survey and/or individual interview. The email will give information on the aims and objective of research and the specific purpose of survey explained. Participant consent email and information sheet is in the appendix below. Planners can decide to take part or not in the survey which is only one aspect of the research's methodology. Consent is therefore implicit when the survey is filled in. Opt-out is also implicit when a potential participant decides not to fill in survey. In addition, potential participants can opt out interview and participant consent will be gathered via their response to

email invitation to be interviewed. The survey is anonymous and should take about 20 mns to answer. The research does not carry health and safety risks for the participants or researcher as the purpose of the survey and interviews and indeed the whole research project is to collect information on existing and emerging work practice independent to the research itself.

Storage of data
Survey monkey will be used to carry out survey. Personal data gathered by researcher will not be shared with anyone and kept in a separate folder in S with restricted access limited to UWE researcher. The aim of the research is to identify the common knowledge of the planning department rather than individual knowledge, so anonymity and confidentiality should be maintained as part of the research methods as well as through storage of data.

Appendix

Background information

- Stephen Hewitt (March 2011): report to NHS Bristol management team.
- Protocol between BCC and NHS Bristol for bringing expertise intop decision making on planning (May 2011).
- Stephen Hewitt and Mark Richards (July 2010): Involving NHS Bristol in Development Management.
- Marcus Grant, Angela Raffle and Stephen Hewitt (2011): Health triage in development management UWE's Project magazine.
- Schedule of applications referred to NHS Bristol as of 13/07/2011

Issues to consider in conclusions

- Procedures set up now will need to be aware of the proposed NHS reorganisation and
  be able to evolve over the next two years as the detail of the new NHS structures
  becomes clearer (Q8/11)
- Does this level of consultation seem about right? (Q11)
- Does the City Council have the administrative capacity to carry out this consultation? (Q11)
- Can it be easily integrated into existing processes? (Q11)
- Does NHS Bristol have the capacity to respond to the number of applications? (Q8/11)
- How to ensure NHS Bristol involvement in pre-application discussions? How to organise consultation on major developments in adjoining authorities? (Q1)

- NHS Bristol to ensure it has the capacity and skills to participate in pre-application
  discussions, respond to the relevant applications and within the consultation timetable
  (normally 21 days) and to comment on any HIAs produced. (Q8)
- Is the scope of NHS Bristol responses right? Are there any health issues not included?
- Or is it too broad and covers issues already adequately picked up through the (Q 4 to 8) development management process? Should NHS Bristol response focus on a few clear issues?
- Is the range of type of responses (standard letter, surgery, detailed assessment, health impact assessment) correct?
- Who carries out a health impact assessment and when?
- How is the quality of any health impact assessment judged?
- What evidence is needed to justify Section 106 payments towards new health services required as a consequence of new development? Is the HUDU model the right approach?
- How to ensure that the various development plan documents (eg core strategy, development management policies, action area plans, supplementary planning documents) under the Bristol Development Framework have the relevant policy hooks to cover the issues NHS Bristol are likely to raise. (Q11)

Evaluation Implementation Timeline

PROTOCOL	DATE	BRISTOL EVENTS	NATIONAL EVENTS
	November 2009	Core Strategy publication version published	
UWE Agency project	April-May 2010		
	June- Sept 2010	Core Strategy examination	NHS white paper (July 2010)
	June 2010	Ideas for DM policies	
	November 2010		Public Health white paper
	December 2010		Draft public health outcomes framework
Report to NHS Bristol Senior Management Team	March 2011	Core Strategy Inspector's report Bristol Planning Protocol for super major applications	
	April 2011		
Protocol signed	May 2011		
Protocol comes into effect	June 2011	Core Strategy adopted	Consultation on how change of use is handled in the planning system SPAHG "Steps to Healthy Planning" published LGG" Plugging Health into Planning" published
	July 2011		Draft NPPF
	August 2011		
Research brief agreed Pre-apps list started to be sent to health	September 2011		
First survey of planners	October 2011		Dept of Health Call for Action on Obesity
	November 2011		Localism Act 2011 gains royal assent
	December 2011		
	January 2012		Public Health Outcomes Framework

PROTOCOL	DATE	BRISTOL EVENTS	NATIONAL EVENTS
			Draft guidance on JSNA and health and wellbeing strategies
	February 2012	Central Area Action Plan options published	
	March 2012	Draft DM policies preferred approach published Draft CIL charging schedule published	NPPF adopted
	April 2012	Wet of England planning toolkit launched	
	May 2012		
	June 2012	CIL examination	
	July 2012	Redcliffe Way and Lockleaze neighbourhood planning areas designated	TCPA "Reuniting Health with Planning" published
End of data collection of planning applications	August 2012		
Second survey of planners	September 2012		
	October 2012		
Interviews of planners	November 2012		NICE PH41 Guidance on walking and cycling
	December 2012		Consultation on review of planning practice guidance
	January 2013	CIL comes into force Lawrence Weston and Old Market neighbourhood planning areas designated	
	February 2013	Draft Health and Wellbeing Strategy published	
	March 2013	DM policies publication version published Knowle West neighbourhood planning area designated	NHS Bristol abolished
	April 2013		Growth and Infrastructure Act 2013 gains royal assent.
	May 2013		
	June 2013	Bristol announced as European Green Capital for 2015	
	July 2013	DM policies submitted to DCLG	

Research Methods and Timeframe

<table>
<tr><th>Objective</th><th>Research Methods</th><th>Timeframe</th></tr>
<tr><td>1. Categorise by type, size and location how many applications were referred to NHS Bristol for comment, and how many pre-application discussions were NHS Bristol involved in.</td><td rowspan="3">Data to be collected from Bristol City Council planning department from list of planning applications and pre-applications (SH)

Screening table 1 to design (LC)

Screening table 1 to populate (SH)
Findings to objectives 1, 2 and 3 (LC)</td><td rowspan="3">07/11 to 07/12
Data to be collected as applications come to Bristol City Council for consideration

Data analysis can be on-going</td></tr>
<tr><td>2. Identify if all the relevant applications were sent to NHS Bristol and if not, why not.</td></tr>
<tr><td>3. Classify by type, size, location how many applications NHS Bristol commented on and which ones it did not comment on and why.</td></tr>
<tr><td colspan="3">Note post analysis for objectives 1, 2 and 3:
Lists of planning applications provided us with information needed to identify criteria for referral to NHS Bristol and assess if relevant applications were referred to NHS Bristol for comment.
NHS Bristol identified list of pre-applications in which they decided to comment on in view of a desk assessment of health impact</td></tr>
<tr><td>4. Identify what types of comments were made.</td><td rowspan="3">Data to be collected from Bristol City Council planning department, NHS Bristol

Table 2: extraction table to design (LC)

Extraction table 2 to populate (SH)

Findings to objectives 4, 5 and 6 (LC)</td><td rowspan="3">07/11 to 07/12
Data to be collected as applications come to NHS Bristol for consideration.
Data analysis can be on-going
Synthesis: 07-09/2012</td></tr>
<tr><td>5. Identify how NHS Bristol comments were used by Bristol City Council planners and how they influenced the final planning decision.</td></tr>
<tr><td>6. Assess the relationship between health comments and other comments and the relative weight given to them by development management planners.</td></tr>
<tr><td colspan="3">Note post analysis for objectives 4, 5 and 6: On-line planning portal provided us with relevant information on planning application, in particular planning officer’s reports and NHS Bristol provided us with their comments on relevant applications and pre-applications.
We devised extraction forms to analyse NHS Bristol and planning officer’s reports. In particular, we were interested in extracting the following information in line with the above objectives :
Assess what health impacts were identified by NHS Bristol on each application and pre-application they considered. We identified the following categories:
Physical health, mental wellbeing, accident and injuries, health equity…
Identify the links NHS Bristol made with local and national policies
Identify whether planning officer had referred to NHS Bristol in their report and if so to what extent
Identify the link between NHS Bristol comments and other expert comments from other Bristol City Council services or consultees.</td></tr>
<tr><td>7. Assess if they led to better development? As it is unlikely to see much actual development happen in 12 months, identify methodology for long term evaluation</td><td>Synthesis if possible and/or Suggest methodology? (LC/SH)</td><td>07-09/2012</td></tr>
<tr><td>8. Assess the capacity of NHS Bristol to respond and the quality of responses – issues covered and not covered.</td><td>NHS Bristol interviews + data analysis of table 2 (LC)

Synthesis (LC)</td><td>07-09/2012</td></tr>
</table>

Objective	Research Method	Timeframe
9. Assess planners' knowledge before the protocol was implemented	Survey of 25-30 planners in all 4 teams (major developments, North, South and Central) Interviews of 4 team leaders/managers, heads of services (LC) Design and run survey (LC)	09/2011
10. Assess their knowledge after the first 12 months of the protocol	Survey of 25-30 planners in all 4 teams (major developments, North, South and Central) Interviews of 4 team leaders/managers, heads of services (LC)	09/2012
Note post analysis for objectives 8, 9, 10: we carried out two surveys. The surveys of Bristol City Council planners examined the health knowledge base that planners had when the protocol had just been introduced and compared with their knowledge base 12 months later. We also sought feedback from planners on whether they thought the protocol worked, if there were any issues with it and how the process might be improved.		
11. Identify the policy factors that helped and hindered the implementation of the protocol and the mainstreaming of health into development management decisions	Document collection (SH/LC) Document analyses (LC)	06-09/2012
Conclusions, recommendations and lessons for the future?	Data analysis, synthesis (LC) Final report (LC/SH)	06-09/2012

Planners' knowledge of health: Survey 1 (Oct 2011) Administered by SurveyMonkey

1. Which team do you work in?

2. Your length of service/professional experience in the planning field in years?

3. Before this survey, were you aware of the development management protocol between NHS Bristol and Bristol City Council?

4. Have you dealt with or seen an NHS Bristol response to a planning application or pre-application discussions?

5. Do you think planning has a role to play in delivering public health outcomes?

6. In Bristol, are health related issues integrated into planning policy and planning processes? Please tick:

- City Council Corporate plan
- Bristol Partnership Bristol 20:20 Community strategy
- Adopted Bristol Local Plan
- Bristol Core Strategy
- Draft development management policies
- Draft site allocations
- Bristol Central Area Action Plan
- Knowle West Regeneration Framework
- Community Vision for Lockleaze
- Hengrove Park master plan
- Other planning briefs and masterplans
- Any Supplementary planning documents

7. Please consider the following statements concerning the integration of health into planning and tick the relevant response for each statement

- Health impact assessment (HIA) is set out in Bristol's validation checklist for local issues
- As part of my job, I have reviewed the quality of a HIA and/or considered the outcomes of a HIA
- HIAs do not bring any added value, as all relevant health issues are already captured by other appraisal processes.
- I/ my team identify(ies) the potential health impacts of emerging planning policies and/or major developments
- Health considerations have a greater impact on final decisions compared to other considerations
- Health issues are raised and discussed at pre-application meetings with developers

- When negotiating Section 106/developers contribution for major developments we examine the possibilities of health related contribution and improvement
- Health is raised as an issue internally when considering major developments

8. Do you take into account evidence on the following health issues in your work ?

- Physical health (illness. disease
- Physical activity (eg play areas, sport)
- Active travel (walking, cycling)
- Access to green open space
- Access to safe, affordable and nutritious food – to buy or to grow
- Mental wellbeing, mental health
- Accidental injury/casualty
- Environmental health: air and water quality, noise, waste, contaminated land, odours
- Quality and safeness of the public realm
- Housing size and quality
- Health equalities/inequalities
- Access to local health services
- Health implications of global environmental issues (eg climate change, peak oil, biodiversity)

9. If you consider health in your work, what source of evidence on health issues do you find useful/not useful to inform your work?

- Case studies from other local authorities
- Legal judgements/planning appeal decisions
- Policy guidance and advice from professional bodies (eg RTPI, CABE, Sustrans)
- Guidance, advice and evidence from health bodies (eg NICE, Dept of Health, British Heart Foundation)
- South West regional policy guidance
- Existing PPGs and PPSs
- Draft National Planning Policy Framework
- Joint Strategic Needs Assessment (JSNA) for Bristol
- Newspaper and professional journal articles
- Evidence from academic sources (conference papers, journal articles and research reports)
- Health and planning websites

10. If you have ticked not useful in question 9, please tell us why in a few words:

11. What would support you to give greater consideration to health in your work?

- National policy and guidance
- Local planning policy

- Local advice and guidance
- Specific evidence
- Training
- Short but regular e-mail updates
- Responses to planning consultations by health bodies
- Articles in planning journals

12. In reference to question 11 above, tell us a bit more why you think some forms of support are more useful than others

13. If training would help increase your understanding of the relationship between health and planning, what would be the best format?

- Lunchtime briefings
- In-house half-day sessions
- In-house full-day sessions
- External conferences
- Personal study
- Day release
- Online learning (web-based)
- RTPI event
- Training leading to a qualification

14. Equalities monitoring – age, gender, ethnicity, disability, sexual orientation

Planners' knowledge of health: Survey 2 (Sept 2012) Administered by SurveyMonkey

1. Which team do you work in?

2. Your length of service/professional experience in the planning field in years?

3. Do you think the National Planning Policy Framework will help or hinder integrating
health considerations into planning decisions and why?

4. How do you think neighbourhood development plans can best take local health issues
into account?

5. The protocol between Bristol City Council and NHS Bristol for ensuring that principles of health and well-being are properly considered when evaluating and determining certain planning applications has been in use for over a year now. We hope you are aware of it and would like your feed-back on it: - Do you think it works well? - Are the comments from NHS Bristol useful/relevant? - Are there any issues with it? - How might the process be improved?

6. Please consider the following statements concerning the integration of health into planning and tick the relevant response for each statement

- Health impact assessment (HIA) is set out in Bristol's validation checklist for local issues
- As part of my job, I have reviewed the quality of a HIA and/or considered the outcomes of a HIA
- HIAs do not bring any added value, as all relevant health issues are already captured by other appraisal processes.
- I/ my team identify(ies) the potential health impacts of emerging planning policies and/or major developments
- Health considerations have a greater impact on final decisions compared to other considerations
- Health issues are raised and discussed at pre-application meetings with developers
- When negotiating Section 106/developers contribution for major developments we examine the possibilities of health related contribution and improvement
- Health is raised as an issue internally when considering major developments

7. Do you take into account evidence on the following health issues in your work ?

- Physical health (illness. disease)
- Physical activity (eg play areas, sport)
- Active travel (walking, cycling)
- Access to green open space

- Access to safe, affordable and nutritious food – to buy or to grow
- Mental wellbeing, mental health
- Accidental injury/casualty
- Environmental health: air and water quality, noise, waste, contaminated land, odours
- Quality and safeness of the public realm
- Housing size and quality
- Health equalities/inequalities
- Access to local health services
- Health implications of global environmental issues (eg climate change, peak oil, biodiversity)

8. What would support you to give greater consideration to health in your work?

- National policy and guidance
- Local planning policy
- Local advice and guidance
- Specific evidence
- Training
- Short but regular e-mail updates
- Responses to planning consultations by health bodies
- Articles in planning journals

14. Equalities monitoring – age, gender, ethnicity, disability, sexual orientation

List of questions for semi-structured interviews with development management planning officers

Wednesday 14th November 2012

Interview with Development Management planners, Bristol City Council

1. Identifying the respondents and their team:

a. Which team do you work in? Do you collaborate with other teams/with other council departments?
b. numbers in your team/ coverage/ general information on work schedule, work practice…

2. Consideration/integration of health into planning

What do you think health means in relation to planning applications, DM? HUDU or walking, cycling…

a. Are you/team aware of the development management protocol between NHS Bristol and Bristol City Council? Have you been involved in its development?
b. Has your team yet received an NHS Bristol response to a planning application you have been/are dealing with?
c. Has the protocol been discussed within your team/with other teams?
d. How is protocol viewed in the planning department?
e. Do you think planning has a role to play in delivering public health outcomes?
f. If yes, which aspects of planning relate directly to public health?
g. How are health related issues integrated into planning policy and planning processes?
h. Describe how you work if at all with Bristol NHS or any other health related organisation at local or national level. How has the relationship evolved? through institutional or work practice, formal or informal arrangements?

3. The protocol

Discuss general view of protocol?
Do you think it will change your practice? What are your views on protocol? Pros and cons?

In view of comments from NHS Bristol: have they been useful, helpful or not, added anything?

What would make the comments more useful?
To what extent DM planners have used comments with architects or developers?
Vis a vis planning committee: does it share interests in comments about health?
HIA in supermajor applications (DMP12)

In particular, discuss the following applications:

Key applications:

- 10 - Gloucestershire Cricket Club, (DM committee): HUDU model, full response (refused)
- 32: Bristol entertainment centre: request for HIA, comments made at development team meeting
- 1 Westmorland House, full response desktop spectrum HIA (pending?)
- 35 South Bristol Link: note on design principles, comments in EIA scoping report (pending?)
- 45 North Fringe to Hengrove Bus Rapid transit: note on design principles, comments on EIA scoping report, draft design comments (pending?)
- 8 The White Lion: HUDU model, short email (refused)
- 13 The Luckwell Club: support with conditions, HUDU model (granted)
- 14 St Peters Hospice: support with conditions, HUDU model (granted)
- 33 The Rising Sun: initial comments (pending?)
- 52 Graphic Packaging:: discussed by healthy city group (pending)
- 66: Diamonite Industrial Park: HUDU model, raising serious concerns (pending)
- Bristol General Hospital.

Appendix 3: Planning applications within the Protocol.

No.	**Planning applications which were determined** Details – Development Management response to NHS Bristol conditions
NHS Bristol consulted but made no comments	
1	**10/05171/F The White Lion – delegated decision - refused** Refused on ground of poor design and fails to mitigate impact of proposed development on local infrastructure.
NHS Bristol made comments but they were not referred to in the officer report	
5	**11/01328/R Former Royal Mail sorting Depot – delegated decision - granted** NHS comments not used in decision granted. But conditions include need for provisions to ensure adequate access for people with disabilities, health and safety provisions, adequate cycle parking, and environmental health issues. **11/05107/F Hawkins Street, Unity Street, Jacob Street – delegated decision - granted** NHS Bristol does not acknowledge scheme's to provide a link in an important secondary walking route. Scheme has general positive impact on health; Access to outdoor amenity space is considered relatively good despite concerns over dominance of the courtyards by car parking. Scheme will provide "adequate cycle parking". **11/04834/R West Street - delegated decision - refused** Application refused on grounds that: BCS15 climate change/sustainability of buildings BCS18 residential space standards are not met Parking: issue addressed but only car parking (i.e. lack of car parking is ok; need for cycle parking not considered). **11/02757/R Cresswick House - delegated decision - granted** Concern over cycle parking: general condition to ensure the provision and availability of adequate cycle parking will be met. **11/03785 Victoria Street – delegated decision - granted** Unilateral agreement for tree planting from developer. **Landscape team and arboriculture team:** Loss of trees outweighed by benefits of proposal, financial contribution would fund tree planting in vicinity of site
NHS Bristol made comments and they were listed in the report, but the substance of the comments were not addressed in the officer report	
3	NB: this includes also 2 applications (Bristol General Hospital and Stonebridge House) where the only reference to S. 106 contribution requirement based on HUDU model was considered but systematically rejected by development planners in the decisions on the ground that that the HUDU methodology is not adopted by Bristol City Council

No.	**Planning applications which were determined** Details – Development Management response to NHS Bristol conditions
	11/05262/F Stonebridge House – delegated decision - granted NHS comments mentioned only insofar as they cover need for developers contribution to meet additional capital cost. HUDU model: not upheld. Contribution not required on basis of type and scale of development and "weighing all other issues in the balance in this instance" Cycle storage: compromised/acceptable on numbers as not possible to further cycle storage on ground floor. Limited outside amenities: planners consider that lack of it not a problem as it is a city centre location close to public open space. So proposal is acceptable. **Transport department:** cycle parking not acceptable in application: type and numbers **12/01056/F General Hospital – committee decision – refused** NHS comments were the only ones to highlight provision of contra-flow cycle lane on Guinea Street at the General Hospital Development. Health not part of the refusal. Health comments hardly mentioned in the report and Cycle parking mentioned as part of transport issues Other issues not covered or reference to NHS comments not mentioned. **12/01602/F Leinster Av. – delegated decision - granted** NHS Bristol mentioned as a consultee but specific comments not used although covered by planning officer's report: Opening hours conflicted with Development Management9 but applicant revised opening hours to avoid school hours and to avoid nuisance to residents **Transport development management** Cycle storage should be more suitable within the store than within bin storage area
NHS Bristol made comments, and they were addressed in the officer report, but NHS Bristol advice was not followed	
8	**11/02655/F Filton Avenue take away – delegated decision - refused** Bristol City Council strategic and citywide policy health adviser; Only concerns over controlling fumes, noise, odours so it does not harm to adjacent residents were taken into account in decision to reject application based on Policy ME4 of Bristol local plan 1997, Policy BCS7, 2011, PPG 24; planning and noise; Hence not only on NHS concerns (not explicitly referred to). **11/03097/F Luckwell Club - committee decision granted** Min size for 4 beds house + 60 m rear garden mentioned by NHS Bristol: report states that proposed dwelling are of an acceptable size

No.	**Planning applications which were determined** Details – Development Management response to NHS Bristol conditions
	and all properties would be provided with a rear garden; 4 cycle storage facility per house required by NHS Bristol: sufficient according to report to have 2 cycle space per dwelling, more would be preferable but not supported by policy. Sustainability: NHS wants CSH4 rather than 3 stated in sustainability statement. Report has conditions that development has a CSH certificate but CSH 4 for most properties and only 3 for 2 of the properties, i.e. NHS requirement not upheld. **Transport development management:** Proposed cycle parking arrangements are acceptable **11/03154/F Redcatch Rd – delegated decision - granted** Comments received during course of the application by Healthy living and health improvement team; however the scheme is no longer a major application given the number of units has been reduced to 9 dwellings. Therefore the representation made is no longer of relevance. However following aspects mentioned by NHS considered by planners: minimum space standards within the core strategy met by scheme + some communal outdoor amenity space would be provided for the flats+ 3 public parks in close proximity to site Cycle storage considered adequate but cycle parking will need to be completed before occupied + kept free of obstruction **11/05254/F Carlton Chambers - delegated decision – granted** SYR standards: cramped and poor living standards mentioned by NHS Bristol: report states that space standards practice note confirms that the standards do not apply to student accommodation: …it is considered that units are of adequate size in terms of living conditions… Concern not upheld Concern over limited and inadequate amenity space; not upheld as report states that site is a city centre location close to public open space (Castle Park and Queen Square); S106 contribution for open space: upheld (SPD4) but "consistent with practice note on contributions for student accommodation" **Transport development management:** Significant Objection relating to cycle storage + mentions also security issue as cycle storage in corridor **Pollution control:** Issues over noise **12/01618/F Wells Rd – delegated decision - granted** Considers NHS comment: conditioning application for A3 use only not necessary as an A5 takeaway would require planning permission Environmental health: NHS comment not mentioned but planners considered them as part of policy S8 of Bristol Local Plan anyway.

No.	**Planning applications which were determined** Details – Development Management response to NHS Bristol conditions
	12/02473/F Dolphin School – delegated decision - granted No report, only decision: Condition is completion and maintenance of cycle provision ready before occupation of buildings **11/0305/F St George Baptiste Church – delegated decision - refused** Case officer mentioned that NHS consulted, CSH4 requires by NHS not upheld as "neither CSH or BREEAM relate to conversions and it is advised that at present Eco homes can be used" No other NHS comments mentioned specifically **11/03086/F St Peters Hospice – delegated decision - granted** Size of dwellings which seem unclear to NHS Bristol in application: report states that dwellings meet HCA size standards Reduction in car parking: discussed in report, high car parking could be reduced but still it is below the 2 car spaces per dwelling policy; Highway team satisfied that there would be no impact on highway safety so NHS requirement not upheld. Increase in cycle parking: NHS request mentioned but 1 cycle space per dwelling meets policy requirement and "it is not reasonable to insist that additional storage is provided" CSH4: sustainability statement states the development would meet CSH4, so no different to NHS requirement/ **Ward councillor:** S106 for play equipment in Redcatch park **Transport Development Management:** Ok re cycle storage as rear gardens accessible to a bike
NHS Bristol made comments, they were addressed in the officer report and the NHS Bristol advice was followed in the final recommendations and decision and they corroborate comments by other experts or Bristol policy standards	
2	**11/02824/F Oatlands Av. - delegated decision - granted** NHS Bristol comments mentioned and one key issue addressed in officer report is: Does the proposal consider health and well- being? Cycle parking: added Use of site restricted to that of Severn Project BUT comment on reduction car park: rejected as not sufficiently harmful to warrant refusal application/city transport department and planning officer. **Transport team:** pedestrian link to site + addition of cycle parking **Community building officer:** positive and as useful and beneficial than community hub identified for the site **11/03266/F Former Gas Works – committee decision- granted** BREEAM excellent is targeted by developers , travel plan provides 52

No.	**Planning applications which were determined** Details – Development Management response to NHS Bristol conditions
	cycle space and some cycle parking for visitors deemed OK Conditions include prior to start of development, must be registered with BREEAM certification body and must achieve Excellent before being occupied. Policies BCS13-15 increased requirements in terms of sustainability credentials: Climate change officer does not raise any objection to the proposal Climate change officer has no concerns on BREEAM and Transport team happy with travel plan So NHS Bristol comments do not go beyond what is sought. **Transport Assessment by Bristol City Council Transport development management :** No on-site car parking dictated by site but means developer will have to work hard on its travel plan Covered cycle store for 52 bikes as part of travel plan.
NHS Bristol made comments, they were addressed in the officer report and NHS Bristol advice was followed in the final recommendations and decision	
1	**11/02609 Gloucestershire County Cricket Club – committee decision - refused** NHS Bristol was the only consultees to identify an access issue: allowing access across the cricket ground to new flats at Gloucestershire Cricket Club development. What this proposal would not address, however, is the affordable housing need and demand 88 cycle parking spaces for employees, visitors and spectators to the ground is acceptable. The scheme proposes 164 cycle parking spaces which is above the Bristol Local Plan standard and is acceptable. Although there are no areas proposed or suitable for growing food on site, the closest allotments would be those situated to the south east of the site off Ashley Hill (known as Ashley Vale) that are approximately 1 mile away from the apartment block. The applicant provided a Code for Sustainable Homes Strategy and a BREEAM Communities assessment in accordance with the requirements of policy BCS15 of the Core Strategy. Policy BCS 14 clearly states that exceptions will be made in the case where a development is appropriate and necessary but where it is demonstrated that meeting the required standard would not be feasible or viable. **Other comments:** many Comments on urban design, scale and height and mass of building, too few parking spaces. **Sustainable city team** comments on lack of affordable housing and poor CSH2.

Type and location of applications and pre-applications commented on by NHS Bristol		
Protocol category	**Type/Size**	**Location based on planning areas**
Major residential (10 or more dwellings):	1. 14 townhouses 2. 14 houses 3. 12 flats 4. 10 apartments 5. 12 flats 6. Housing	Bristol South
	7. 12 flats	Bristol East
	8. 13 apartments 9. 18 studios and flats 10. 14 flats 11. Student accommodation + budget hotel	Bristol Inner West
	12. 11 flats	Bristol Inner East
	13. 460 bed space flats + 10 bed town houses	Bristol North West
Major residential (with other uses)	14. 183 residential units + retail 15. 250 residential units + commercial + surgery 16. 42 apartments + retail 17. 107 residential units + commercial 18. 183 flats + retail 19. 250 residential units+ commercial + surgery	Bristol Inner East
	20. 78 residential units + employment 21. Residential units + café	Bristol South
	22. 13 flats + pub 23. Residential units + employment	Bristol East
	24. 150 apartments+ commercial+ cricket ground 25. 202 residential units +commercial 26. 180 flats + retail 27. Residential units + commercial 28. Leisure use, student accommodation, hotel	Bristol Inner West
	29. 65 residential units + commercial + community 30. Student accommodation + retail	Bristol North
Major non-residential	31. Commercial floor-space	Bristol Inner West

Type and location of applications and pre-applications commented on by NHS Bristol		
Protocol category	**Type/Size**	**Location based on planning areas**
(1,000m^2 floor space)	32. Office 33. School	Bristol Inner East
	34. From B1business to D1 non-residential 35. A1 Superstore 36. School	Bristol North
	37. A1 Superstore	Bristol South
	38. Various school sites	Citywide
Major transport and highway infrastructure projects	39. South Bristol link	Bristol South
	40. North Fringe to Hengrove Metrobus (aka Bus Rapid Transit)t	Citywide
	41. Greater Bristol Bus network - Stapleton Road	Bristol Inner East
	42. Greater Bristol Bus Network - Whiteladies Road/Westbury Road	Bristol Inner & North
	43. Bus, cycling and walking link	Bristol North
Proposals that would result in the loss of public open space	No application identified	
Establishment of A5 (hot food takaway) uses	44. Mixed use including A5	Bristol Inner West
	45. A1 shop to A5 takeaway	Bristol North
	46. A5 takeaway	Bristol East
	47. from office/shop to A5 48. A1 to A3 café/restaurant	Bristol South
	49. A1 to A5 50. A1 to A5	Bristol Inner East
Use of officer' discretion for minor residential (less than 10 dwellings)	No application identified	
Use of officers' discretion for minor non-	51. Single storey – café, training rooms	Bristol South

Type and location of applications and pre-applications commented on by NHS Bristol		
Protocol category	**Type/Size**	**Location based on planning areas**
residential developments (less than 1000m^2 floor space)		
Officers' discretion for other applications	No application identified	
Use Classes: A1 Shops; A2Financial and professional services; A3 Restaurants and cafes; A4 Pubs; A5 Hot food takeaways; B1Business; B2 General Industrial; B8 Storage or distribution; C1 Hotels; C2 Residential institutions; C2A Secure residential institutions; C3 Dwelling houses; C4 Houses in multiple occupation (HMO); D1 Non-residential institution; D2 assembly and leisure		

Appendix 4: Sources of evidence

In parenthesis is the numbers of planning applications and pre-applications (out of 54 responses to consultation requests) for which NHS Bristol has used each of the following evidence:

Research-based evidence
NICE guidance backed up by systematic reviews of evidence:
PH8 on promoting and creating built environments that encourage and support physical activity (5)
PH25 on prevention of cardiovascular disease (1)
PH35 on type 2 diabetes (1)

CABE/South Yorkshire Space Standards (16)
CABE 10 criteria for successful school design (2)
CABE's resident satisfaction with space in the home (1)
GLS's housing space standards
Foresight reviews on housing as a determinant of mental health (2008) (1)
Local GP evidence on student clients (1)
Local health statistics (1)

Guidance from think tanks and advocacy sources
Temptation town research by school food trust/CACI (2)
Sustrans cycle parking information sheet FF37 (1)
Kentucky design manual (1)
Public health responsibility deal pledge on Out of Home calorie labelling (1)

Application specific and local evidence
In four planning applications NHS Bristol has carried out desk Health Impact Assessment on the Spectrum model to advice planners on design or other changes needed to offset the impact of the application on a broad range of health outcomes or to enhance its capacity to promote healthy living.

Standards and guidance
NHS Bristol refers to standards and guidance embedded in policies listed below and therefore formally adopted by Bristol City Council to shape the practice of development planning in Bristol. They include:
Code for sustainable homes (level 4 systematically applied by NHS Bristol) (13)
HCA space standards (1)
Lifetime Home Standards (2)
Building for life assessment (good/very good) (5)
Homes for all (1)
Bristol bus strategy 2003 (3)
Bristol biodiversity action plan (4)
BREEAM (good/excellent) (7)
BREEAM Communities (1)

Policy hooks
In line with the process of development management NHS Bristol backs up its arguments for higher standards or to reject applications with references to local and planning policies as well as national policies, whenever possible. Policies and strategies mentioned include the following:

National (non-planning) policies:
Policy hooks to back up NHS Bristol arguments in favour or against applications also include broader national policies including the following:
Government White Paper Healthy Lives, healthy people (2010) (2)
A call for action on obesity in England
Education Act 2011 (1)
Healthy schools and healthy schools plus programmes (1)
Climate Change Act 92008 (1)
UK low carbon transition plan (1)

Bristol Local Plan:
Spatial strategic policies:
BCS1 South Bristol (2)
BCS2 Bristol City Centre (1)
BCS3 Northern arc and inner east Bristol – Regeneration areas (1)
Spatial strategic approaches to other areas of Bristol
BCS5 Housing Provision (4)
BCS7 Centres and retailing (2)
BCS9 Green infrastructure (8)
BCS10 Transport and access improvements (e.g. Cycle parking) (12)
Development principles
BCS11 Infrastructure and developer contributions (24)
BCS12 Community infrastructure (2)
BCS13 Climate change (7)
BCS14 Sustainable energy (3)
BCS15 Sustainable design and construction (e.g. CSH assessment/renewable energy) (11)
BCS16 Flood risk and water management (2)
BCS17 Affordable housing provision (1)
BCS18 Housing Type (e.g. HSCA Space standards) (9)
BCS20 Effective and efficient use of land (2)
BCS21 Quality urban design (e.g. Staircases) (13)
BCS23 Contaminated land, air pollution, noise (8)
Development management policies
DM5 Protection of Public Houses (1)
DM9 Food and Drink Uses and the Evening Economy (e.g. forbids takeaway shops in proximity of schools) (3)
DM21 Transport Development Management (1)
DM14Health Impacts of Development (8)
Saved 1997 Bristol local plan
S08/Control of food and drink uses/PAN 17 on retail diversity (1)
Supplementary Planning Document
SPD10 Planning a Sustainable Future for St Paul's (2006) (1)

Other Bristol policies and strategies
Bristol Joint Strategic Needs Assessment 2010 update (1)
Bristol parks and green space strategy 2008 (1)
Bristol weight management strategy (1)
Bristol Food and health strategy (1)
Building a positive future for Bristol after peak oil (BP and BCC, 2009) (1)

Neighbourhood strategy:
One neighbourhood strategy has been used by NHS Bristol to back up its arguments. This is worth mentioning in particular as neighbourhood plans start to develop and offer a strategic opportunity to mainstream health in planning:
Ashley, Easton and Lawrence Hill area green space plan 2010

Appendix 5: Financial contributions requested by NHS Bristol from developers

Application number	Status at 01/09/2012	Total financial implications in £ for NHS Bristol capital + revenue	Financial contribution required in £ capital only
11/00034/P Dove Lane	Pending	1,300,000	300,000
11/02928?PREAPP Wesley College	Preapp	n/a	n/a
11/05202 White horse	Pending	75,512	14,318
12/01827/P Diamonite IP	pending	566,145	108,580
12/01058/F BGal Hospital	refused	1,160,056	280,048
11/05262/F Stonebridge house	granted	132,128	26,222
11/04834/F West St.	refused	60,111	10,934
11/02609/F Glos Cricket Club	refused	832,164	189,448
11/05254/F Carlton chambers	granted	89,215	18,131
11/03243/F bunch of grapes	withdrawn	66,412	11,736
11/03154/F Redcatch Rd	granted	54,832	11,020
11/01181/F and 11/01182/LA Westmoreland House	disposed	727,795	206,815
11/03097/F Luckwell Club	granted	174,575	35,218
11/01328/R Royal mail depot Cattle market	granted	559,145	122,955
11/0510/F Hawkins St.	granted	352,926	68,209
11/032757/R Creswicke house	granted	124,505	25,333
11/02871/F Grandby House	withdrawn	54,832	11,020
11/03605/F St George's	refused	72,152	13,803
11/03086/F St	granted	160,482	30,838

Application number	Status at 01/09/2012	Total financial implications in £ for NHS Bristol capital + revenue	Financial contribution required in £ capital only
Peter's			
11/03207/preapp New Bridewell	preapp	n/a	n/a
11/04917/preapp Rising Sun	preapp	n/a	n/a
12/00410/preapp Novers Hill	preapp	n/a	n/a
12/00850/preapp Whapping Wharf	preapp	n/a	n/a
11/05261/preapp former Brooks laundry	preapp	n/a	n/a
11/05391 preapp	preapp	n/a	n/a
11/05214/preapp Filwood park	preapp	n/a	n/a
		6,562,987	1,484,628

Appendix 6: Scope of NHS Bristol comments

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
Physical activity/health	Infrastructure for walking/cycling, conditions on design of pedestrian and cycle routes Active travel: BRT vehicles to take bikes Secure bike storage/cycle racks Increase in cycle parking, cycle parking for visitors Reduction in car park spaces More stops en route Encourage staircase use by good design/location	Local Transport Plan Climate change framework Bristol Local Plan core strategy Bristol Bus Strategy 2003 Bristol parks and green space strategy 2008	NICE guidance: PH8 on promoting and creating built environments that encourage and support physical activity PH25 on prevention of cardiovascular disease PH35 on type 2 diabetes Sustrans cycle parking information sheet FF37 Local evidence: Spectrum workshop Bristol bus strategy 2003 Bristol Local Plan core strategy: Spatial strategic policies: BCS1 South Bristol BCS2 Bristol City Centre BCS3 Northern arc and inner east Bristol – Regeneration areas BCS10 Transport and access improvements (e.g. Cycle parking)

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
			BCS12 Community infrastructure BCS21 Quality urban design (e.g. Staircases) DM14 Health impacts of development DM23 Transport development management Bristol parks and green space strategy 2008 Government White Paper Healthy Lives, healthy people (2010) A call for action on obesity in England
Mental wellbeing	Access to work, services, leisure, social networks, increase connectivity to help social capital Access to public open space On-site external amenity space Employment and education opportunities Alter route to serve local facilities better	Economic development Housing strategy Climate change framework Bristol Local Plan core strategy Bristol biodiversity action plan	CABE's resident satisfaction with space in the home; South Yorkshire Space Standards GLS's housing space standards HCA space standards Code for sustainable homes (level 4 systematically applied by NHS Bristol) Lifetime Home Standards Building for life

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
	(400m) Adverse impact on small traders and reducing in access to local shops Loss of jobs Lack of housing, affordable housing Quality of the public realm: capacity in social, community and recreational activities Quality of built environment: increase standards required Residential space standards Tree planting/better choice of trees Better public participation Use of renewable energy Ensure permeability and connectivity (avoid gated		assessment (good/very good) Homes for all Foresight reviews on housing as a determinant of mental health (2008) CABE 10 criteria for successful school design Kentucky school design manual Local GP evidence on student clients Local health statistics Local evidence from Spectrum workshop Bristol biodiversity action plan BREEAM (good/excellent) BREEAM Communities Bristol Local Plan core strategy: Spatial strategic policies: BCS1 South Bristol BCS2 Bristol City Centre BCS3 Northern arc and inner east Bristol – Regeneration areas BCS5 Housing

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
	communities) building housing in industrial estate		Provision BCS7 Centres and retailing BCS12 Community infrastructure BCS13 Climate change BCS14 Sustainable energy BCS15 Sustainable design and construction BCS 17/Affordable housing provision BCS18 Housing Type BCS21 Quality urban design DM6 Protection of Public Houses DM14 Health impacts of development Bristol parks and green space strategy 2008
Environmental health/quality	Air pollution, noise and vibration carbon emission Water quality Biodiversity Asphalting road	Air quality management plan Local Transport Plan Bristol Bus Strategy 2003	Sustrans cycle parking information sheet FF37 Local evidence from Spectrum workshop Bristol bus strategy 2003

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
	Use of resources Car free development Good access to green space Fast food outlets: opening hours, noise, fume, odour control, waste disposal, litter	Climate change framework Biodiversity plan Bristol Local Plan core strategy	Bristol biodiversity action plan Bristol Local Plan core strategy Spatial strategic policies: BCS1 South Bristol BCS2 Bristol City Centre BCS3 Northern arc and inner east Bristol – Regeneration areas BCS9 Green infrastructure BCS13 Climate change BCS14 Sustainable energy BCS15 Sustainable design and construction BCS16 Flood risk and water management BCS20 Effective and efficient use of land BCS21 Quality urban design (e.g. Staircases) DM14 Health impacts of development DM23 Transport development management

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
			Bristol parks and green space strategy 2008
Prevention of injury /accident:	Road safety/ danger reduction Traffic management Rerouting or traffic calming home-zone Place management approach for local shopping Cycle friendly road junction 20 mph limit Limited vehicle access P and R enhanced	Local Transport Plan Bristol Bus Strategy 2003 Retail strategy Bristol Local Plan core strategy	Sustrans cycle parking information sheet FF37 Local evidence from Spectrum workshop Bristol bus strategy 2003 Bristol Local Plan core strategy: Spatial strategic policies: BCS1 South Bristol BCS2 Bristol City Centre BCS3 Northern arc and inner east Bristol – Regeneration areas BCS7 Centres and retailing BCS10 Transport and access improvements BCS16Flood risk and water management BCS21 Quality urban design DM14 Health impacts of development DM23 Transport development

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
			management PAN 17 on retail diversity
Nutrition	Food security Access to nutritious/fresh food Food growing areas/ allotments Impact on local suppliers	Who feeds Bristol? Allotment strategy Bristol weight management strategy Bristol Local Plan core strategy	Temptation town research by School Food Trust/CACI Public health responsibility deal pledge on Out of Home calorie labelling Local evidence from Spectrum workshop DM10 Food and Drink Uses and the Evening Economy DM14 Health impacts of development 1997 Bristol Local Plan saved policy S8 Control of food and drink uses Bristol weight management strategy Government White Paper Healthy Lives, healthy people (2010) A call for action on obesity in England Education Act 2011 Healthy schools and healthy schools plus programmes

Scope Health outcome	Individual applications: scope of comments	Council strategies NHS comments relate to:	Evidence from NHS Bristol
Health equality	To different groups: pensioners, children Healthcare provisions	Bristol biodiversity action plan Bristol Local Plan core strategy	Local evidence from Spectrum workshop Bristol biodiversity action plan BCS9 Green infrastructure BCS11 Infrastructure and developer contributions DM14 Health impacts of development

Appendix 7 – Results from the two surveys of planners

All planners' knowledge of health 1 (Oct 2011)

1. Which team do you work in?

	Response Percent	Response Count
Development Management - Inner	10.3%	6
Development Management – North	8.6%	5
Development Management – South and East	10.3%	6
Development Management – Major Schemes	3.4%	2
Development Management - Enforcement	10.3%	6
Strategic Planning and Policy	22.4%	13
City Design	**25.9%**	**15**
Planning Administration	0.0%	0
Other	8.6%	5
If you chose other: please specify		5
answered question	**58**	
skipped question	**1**	

2. Your length of service/professional experience in the planning field in years?

length of experience/service in years

	1	2	3	4	5	6	7
Development management	2.6% (1)	10.5% (4)	5.3% (2)	5.3% (2)	13.2% (5)	13.2% (5)	2.6% (
Local and strategic planning/policy	0.0% (0)	13.6% (3)	13.6% (3)	18.2% (4)	13.6% (3)	4.5% (1)	0.0% (
Urban design	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	14.3% (1)	0.0% (0)	0.0% (
Regeneration	0.0% (0)	0.0% (0)	14.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (
Other	0.0% (0)	0.0% (0)	0.0% (0)	9.1% (1)	0.0% (0)	0.0% (0)	9.1% (

3. Before this survey, were you aware of the development management protocol between NHS Bristol and Bristol City Council?

	Response Percent	Response Count
Yes	**76.0%**	**38**
No	24.0%	12
	answered question	**50**
	skipped question	**9**

4. Have you dealt with or seen an NHS Bristol response to a planning application or pre-application discussions?

	Response Percent	Response Count
Yes	40.0%	20
No	**60.0%**	**30**
	answered question	**50**
	skipped question	**9**

5. Do you think planning has a role to play in delivering public health outcomes?

	Response Percent	Response Count
Yes	**94.0%**	**47**
No	0.0%	0
Don't know	6.0%	3
	answered question	**50**
	skipped question	**9**

6. In Bristol, are health related issues integrated into planning policy and planning processes? Please tick:

	Yes	No	Don't know	Response Count
City Council Corporate plan	**56.3% (27)**	4.2% (2)	39.6% (19)	48
Bristol Partnership Bristol 20:20 Community strategy	41.7% (20)	2.1% (1)	**56.3% (27)**	48
Adopted Bristol Local Plan	**41.7% (20)**	37.5% (18)	20.8% (10)	48
Bristol Core Strategy	**87.5% (42)**	6.3% (3)	6.3% (3)	48
Draft development management policies	**59.6% (28)**	4.3% (2)	36.2% (17)	47
Draft site allocations	27.1% (13)	6.3% (3)	**66.7% (32)**	48
Bristol Central Area Action Plan	33.3% (16)	2.1% (1)	**64.6% (31)**	48
Knowle West Regeneration Framework	30.6% (15)	2.0% (1)	**67.3% (33)**	49
Community Vision for Lockleaze	28.6% (14)	4.1% (2)	**67.3% (33)**	49
Hengrove Park master plan	12.2% (6)	6.1% (3)	**81.6% (40)**	49
Other planning briefs and masterplans	19.1% (9)	0.0% (0)	**80.9% (38)**	47
Any Supplementary planning documents	27.1% (13)	12.5% (6)	**60.4% (29)**	48
			answered question	**49**
			skipped question	**10**

7. Please consider the following statements concerning the integration of health into planning and tick the relevant response for each statement

	Yes	No	Don't know	Does not apply	Response Count
Health impact assessment (HIA) is set out in Bristol's validation checklist for local issues	16.7% (8)	18.8% (9)	**64.6% (31)**	0.0% (0)	48
As part of my job, I have reviewed the quality of a HIA and/or considered the outcomes of a HIA	6.3% (3)	**83.3% (40)**	2.1% (1)	8.3% (4)	48
HIAs do not bring any added value, as all relevant health issues are already captured by other appraisal processes.	10.4% (5)	41.7% (20)	**47.9% (23)**	0.0% (0)	48
I/ my team identify(ies) the potential health impacts of emerging planning policies and/or major developments	**52.1% (25)**	25.0% (12)	12.5% (6)	10.4% (5)	48
Health considerations have a greater impact on final decisions compared to other considerations	0.0% (0)	**83.0% (39)**	17.0% (8)	0.0% (0)	47
Health issues are raised and discussed at pre-application meetings with developers	27.1% (13)	27.1% (13)	**41.7% (20)**	4.2% (2)	48
When negotiating Section 106/developers contribution for major developments we examine the possibilities of health related contribution and improvement	**41.7% (20)**	6.3% (3)	**41.7% (20)**	10.4% (5)	48
Health is raised as an issue internally when considering major developments	**56.3% (27)**	12.5% (6)	31.3% (15)	0.0% (0)	48
				answered question	**48**
				skipped question	**11**

8. Do you take into account evidence on the following health issues in your work ?

	I consider evidence on this aspect of health	I do not consider evidence on this aspect of health	Response Count
Physical health (illness. disease)	34.9% (15)	**65.1% (28)**	43
Physical activity (eg play areas, sport)	**81.8% (36)**	18.2% (8)	44
Active travel (walking, cycling)	**81.8% (36)**	18.2% (8)	44
Access to green open space	**84.1% (37)**	15.9% (7)	44
Access to safe, affordable and nutritious food – to buy or to grow	35.7% (15)	**64.3% (27)**	42
Mental well being, mental health	40.5% (17)	**59.5% (25)**	42
Accidental injury/casualty	**52.4% (22)**	47.6% (20)	42
Environmental health: air and water quality, noise, waste, contaminated land, odours	**79.5% (35)**	20.5% (9)	44
Quality and safeness of the public realm	**79.5% (35)**	20.5% (9)	44
Housing size and quality	**75.0% (33)**	25.0% (11)	44
Health equalities/inequalities	40.5% (17)	**59.5% (25)**	42
Access to local health services	**51.2% (22)**	48.8% (21)	43
Health implications of global environmental issues (eg climate change, peak oil, biodiversity)	**53.5% (23)**	46.5% (20)	43
		answered question	**44**
		skipped question	**15**

9. If you consider health in your work, what source of evidence on health issues do you find useful/not useful to inform your work?

	Useful	Not useful	Don't know/not used	Response Count
Case studies from other local authorities	34.1% (15)	0.0% (0)	**65.9% (29)**	44
Legal judgements/planning appeal decisions	**52.3% (23)**	0.0% (0)	47.7% (21)	44
Policy guidance and advice from professional bodies (eg RTPI, CABE, Sustrans)	**65.9% (29)**	2.3% (1)	31.8% (14)	44
Guidance, advice and evidence from health bodies (eg NICE, Dept of Health, British Heart Foundation)	**50.0% (22)**	4.5% (2)	45.5% (20)	44
South West regional policy guidance	14.0% (6)	18.6% (8)	**67.4% (29)**	43
Existing PPGs and PPSs	**53.5% (23)**	11.6% (5)	34.9% (15)	43
Draft National Planning Policy Framework	27.3% (12)	20.5% (9)	**52.3% (23)**	44
Joint Strategic Needs Assessment (JSNA) for Bristol	20.5% (9)	0.0% (0)	**79.5% (35)**	44
Newspaper and professional journal articles	29.5% (13)	6.8% (3)	**63.6% (28)**	44
Evidence from academic sources (conference papers, journal articles and research reports)	29.5% (13)	4.5% (2)	**65.9% (29)**	44
Health and planning websites	34.1% (15)	2.3% (1)	**63.6% (28)**	44

Others: please state which other sources of evidence you find useful or would be useful to inform your decision: 6

answered question	**44**
skipped question	**15**

10. If you have ticked not useful in question 9, please tell us why in a few words:

	Response Count
	10
answered question	**10**
skipped question	**49**

11. What would support you to give greater consideration to health in your work?

	Yes	No	Don't know	Response Count
National policy and guidance	**86.0% (37)**	4.7% (2)	9.3% (4)	43
Local planning policy	**85.7% (36)**	4.8% (2)	9.5% (4)	42
Local advice and guidance	**82.9% (34)**	7.3% (3)	9.8% (4)	41
Specific evidence	**74.4% (32)**	9.3% (4)	16.3% (7)	43
Training	**69.8% (30)**	16.3% (7)	14.0% (6)	43
Short but regular e-mail updates	**45.2% (19)**	33.3% (14)	21.4% (9)	42
Responses to planning consultations by health bodies	**68.3% (28)**	14.6% (6)	17.1% (7)	41
Articles in planning journals	**50.0% (21)**	26.2% (11)	23.8% (10)	42
			answered question	**43**
			skipped question	**16**

12. In reference to question 11 above, tell us a bit more why you think some forms of support are more useful than others

	Response Count
	25
answered question	**25**
skipped question	**34**

13. If training would help increase your understanding of the relationship between health and planning, what would be the best format?

	Yes	No	Response Count
Lunchtime briefings	**86.5% (32)**	13.5% (5)	37
In-house half-day sessions	**68.4% (26)**	31.6% (12)	38
In-house full-day sessions	31.3% (10)	**68.8% (22)**	32
External conferences	31.0% (9)	**69.0% (20)**	29
Personal study	25.0% (8)	**75.0% (24)**	32
Day release	17.2% (5)	**82.8% (24)**	29
Online learning (web-based)	39.4% (13)	**60.6% (20)**	33
RTPI event	41.9% (13)	**58.1% (18)**	31
Training leading to a qualification	16.7% (5)	**83.3% (25)**	30
		Other (please specify)	4
		answered question	**43**
		skipped question	**16**

14. How would you describe yourself?

Age

	18 – 30	31-45	46-60	Over 60	Prefer s
Please choose from drop-down menus	14.0% (6)	**53.5% (23)**	23.3% (10)	0.0% (0)	9.3

Gender

	Female	Male	Prefer not to s
Please choose from drop-down menus	32.6% (14)	**58.1% (25)**	9.3% (4)

Transgender

	Yes	No	Prefer not to s
Please choose from drop-down menus	0.0% (0)	**87.5% (28)**	12.5% (4)

Ethnicity

	White British background	Other White background	Black and minority ethnic background	Prefer not
Please choose from drop-down menus	**90.5% (38)**	0.0% (0)	0.0% (0)	9.5%

Do you have a religion or belief?

	Yes	No	Prefer not to s
Please choose from drop-down menus	31.0% (13)	**54.8% (23)**	14.3% (6)

Are you disabled?

	Yes	No	prefer not to s
Please choose from drop-down menus	0.0% (0)	**90.2% (37)**	9.8% (4)

Sexual orientation

	lesbian	gay	bisexual	heterosexual	Prefe s
Please choose from drop-down menus	0.0% (0)	0.0% (0)	0.0% (0)	**82.9% (34)**	17.1
					answered
					skipped

Page 1, Q1. Which team do you work in?		
1	sustainable city	Oct 20, 2011 1:19 PM
2	NHS Bristol public health	Oct 20, 2011 9:58 AM
3	Service Development	Oct 5, 2011 11:39 AM
4	Head of Service	Oct 5, 2011 9:16 AM
5	Transport	Oct 5, 2011 9:09 AM

Page 1, Q2. Your length of service/professional experience in the planning field in years?		
1	I am a planning compliance officer	Dec 8, 2011 1:55 PM
2	Landscape design advice to planners	Nov 1, 2011 3:12 PM
3	Public Art	Nov 1, 2011 2:03 PM
4	public health, with two years experience in public health aspects of planning	Oct 20, 2011 9:58 AM
5	Enforcement 10 years	Oct 5, 2011 3:06 PM
6	I work in the research and monitoring team which provides evidence on which to guide the policies	Oct 5, 2011 10:21 AM
7	Corporate policy; recycling; economic development; neighbourhood management	Oct 5, 2011 9:32 AM
8	A number of the above - 27yrs	Oct 5, 2011 9:16 AM
9	Transport	Oct 5, 2011 9:09 AM
10	Urban Design	Oct 5, 2011 9:04 AM

Page 3, Q9. If you consider health in your work, what source of evidence on health issues do you find useful/not useful to inform your work?		
1	Not relevant to my job.	Dec 16, 2011 11:03 AM
2	Professional Journal articles important. Newspaper articles dependent upon the reliability of the source!	Oct 6, 2011 3:12 PM
3	The Council's Health Improvement advisor would be the first stop for planners in seeking advice on this matter. There is simply not enough time for us to trawl through journal articles etc. and therefore we must rely on Stephen Hewitt to give a response advising us on this issue.	Oct 6, 2011 8:04 AM
4	Building Research Establishment Reports	Oct 5, 2011 10:21 AM
5	Conference, workshops and other training events; TV programmes like recent "Secret Life of Buildings".	Oct 5, 2011 9:41 AM
6	Unfortunately in DM there is absolutely no time to look beyond adopted local development plan/guidance and national guidance (PPGs/PPSs). If health would like us to rely on take on board such sources they will need to provide them to us with their comments.	Oct 5, 2011 9:26 AM

Page 3, Q10. If you have ticked not useful in question 9, please tell us why in a few words:		
1	The weight attached to S West Regional policy guidance is low, given that the RPG's are to be abolished. No great weight can be accorded to the draft planning policy framework, given its (early) stage of consultation.	Dec 9, 2011 3:22 PM
2	No significant national policy focus on health issues and planning.	Nov 8, 2011 4:25 PM
3	Health matters not clearly addressed/outlined in documents.	Nov 8, 2011 1:21 PM
4	We need to have evidence based on planning policy. I would also question how useful and what weight we could give to newspaper articles.	Nov 1, 2011 3:44 PM
5	Some of the docs listed are of only limited use- the draft NPPF and national planning policy make only brief mention of health as a general issue to be considered.	Oct 6, 2011 8:04 AM
6	not maintained and up to date, no statutory basis, repeats what stated with more weight elsewhere	Oct 5, 2011 12:34 PM
7	Haven't noticed much reference to health issues in the DNPPF Not aware of health issues evidence in existing PPGs or PPSs	Oct 5, 2011 11:00 AM
8	Not a material consideration in assessing works to a listed building according to current legislation ie the Planning (Listed Buildings and Conservation Areas) Act 1990.	Oct 5, 2011 9:48 AM
9	Draft NPPF does not appear to tackle health issues at all. Existing PPGs/Ss may tackle health issues in their own, primary way (eg tackling contamination and air pollution) but not necessarily under the banner of health.	Oct 5, 2011 9:26 AM
10	I have a limited amount of time and my primary focus is transport although often good transport and good health go hand in hand. I don't often go back to the original sources but tend to depend on existing policies.	Oct 5, 2011 9:17 AM

Page 3, Q12. In reference to question 11 above, tell us a bit more why you think some forms of support are more useful than others

1	None of this is really relevant to my job.	Dec 16, 2011 11:03 AM
2	Specific support in adopted policy would lend weight to the issue above, for example articles in planning journals. e-mails - too many already. We don't need this if it is embedded in policy and specific training is given instead.	Dec 9, 2011 3:22 PM
3	National Policy and Guidance would set the framework for consideration and would be likely to have the greatest impact. Local policy and guidance would be similarly effective. In terms or practical application - email updates, training and articles in planning journals would increase understanding of best practice.	Dec 8, 2011 11:13 AM
4	Forms of support that provide specific detailed evidence rather than opinion would be useful.	Nov 8, 2011 4:25 PM
5	Local policy advice and guidance would be the most useful as this would directly inform decisions.	Nov 8, 2011 1:21 PM
6	Those with statutory status would have support through the appeal process - local policy should be in line with national policy guidance.	Nov 1, 2011 4:36 PM
7	Ease of access to information is a priority. For this reason Local Planning Policy support accessed via the web pages, with updates, would probably be the most useful. Short e -mails often get ignored.	Nov 1, 2011 3:26 PM
8	I've ticked them all because thanks to Stephen Hewitt's influence and our link with the WHO Centre I am able to access and do receive training, regular updates, evidence, articles, etc. And thanks to public health engagement with planners in Bristol since Paul Scott's first attachment, we do have some mentions of health in local planning policy and guidance.	Oct 20, 2011 11:12 AM
9	Clear guidance at both local and national levels (and clear guidance on where to find it) should allow for consistent decision making.	Oct 7, 2011 8:26 AM
10	The greatest support inevitably comes from the most authoritative and influential sources. This is magnified the further up the policy chain you go, with the best, most authoritative being at national (or even EU level). Of still further significance in compelling delivery of health benefits is when funding is associated with, or stem from policy, and reflected in government funding regimes.	Oct 6, 2011 3:12 PM
11	All forms of support would be useful, but journal articles, updates and consultation responses are not likely to be as useful as planning policy and advice/guidance national and/or local, which has the added weight of being formally adopted/approved.	Oct 6, 2011 11:41 AM
12	All would be useful but in realistically we would not have time to attend regular training, look at detailed evidence or responses to consultations or articles. It would be useful if there were a one-stop-shop where we could find such information when we have time to look in order to update our own knowledge on this subject- maybe a website where we can access all of the information in one go.	Oct 6, 2011 8:04 AM
13	It's important to keep up to date with current thinking, so more immediate research findings and specific training can be more helpful when creating places for the long term future National Planning Guidance would give sufficient weight to health-based decisions in determining development.	Oct 5, 2011 11:00 AM

Page 3, Q12. In reference to question 11 above, tell us a bit more why you think some forms of support are more useful than others

14	National and local policy guidance would be most useful in decision making as they have weight with professionals e.g. in planning appeals. Others such as articles in planning journals are very useful as back-up information but don't necessarily have any legal weight to them.	Oct 5, 2011 10:21 AM
15	Email updates would be particularly useful - as much research can be in conflict, need further testing or need incorporating into policy which takes time to emerge. It is useful to know general trends and guidance and separate this from direct policy or strategy.	Oct 5, 2011 10:17 AM
16	To consider the impacts of health would require a change in the parent legislation concerning Listed Buildings and Conservation Areas.	Oct 5, 2011 9:48 AM
17	Need for more evidence about how specific developments (as against the environment in general) impact on health - that will stand-up/has been tested at planning appeal. Health experts giving evidence at planning inquiries/local plan hearings	Oct 5, 2011 9:41 AM
18	adopted policy and guidance is the most helpful as it give a proper hook to negotiate with developers as with room standards, sustainability Currently without any founded structure I have been asked for contributions as a resu7lt of development. I feel that to ask for planning contributions is essentially asking to top up the NHS which is unfounded. It is better to make sure the development is of a high quality and adaptable which we strive to do already	Oct 5, 2011 9:31 AM
19	Ultimately to apply any agenda, it needs ot be set out in either legislation or policy before it can be actively applied beyond simple encouragement and certainly for gaining legal obligations which have to have a foundation in law/policy.	Oct 5, 2011 9:30 AM
20	Policy guidance and requirements are more important to me than training. Once we have the teeth we need to be trained how best to bite with them. Until then, more training would be not be an effective use of our time (we first need more training on other higher priority issues)	Oct 5, 2011 9:26 AM
21	They are all useful but most beneficial when it relates directly to the issues you are dealing with and is within current parameters of control & influence.	Oct 5, 2011 9:25 AM
22	Planning decisions have to taken in accordance with adopted policy. Therefore national and local planning policy is the best way to allow consideration to be given to health issues.	Oct 5, 2011 9:24 AM
23	It would be useful to see guidance and evidence that provided a clearly demonstrated relationship between urban design and health. Whilst health may be considered under planning, it often isn't made clear how physical design can contribute to better health.	Oct 5, 2011 9:23 AM
24	Policy tends to hold the most sway. At the back of my mind is could I defend this at appeal. On a marginal case where the transport is poor it might be that adding the health angle could swing the decision.	Oct 5, 2011 9:17 AM
25	If guidance is enshrined in national and local policy then progress is made.	Oct 5, 2011 9:10 AM

Page 3, Q13. If training would help increase your understanding of the relationship between health and planning, what would be the best format?		
1	the blanks are 'maybe's	Oct 20, 2011 11:12 AM
2	Realistically, it needs to be recognised that prioritisation of training will depend on: 1) Available budget at a time when budgets are significantly at risk, 2) Available time in relation to work commitments, and 3) Relevance to particular service area; i.e. training designed to fit the immediate needs of the particular work group, and not 'sheep dip' approach.	Oct 6, 2011 3:12 PM
3	a mix of the above depending on the level of knowledge and expertise required	Oct 6, 2011 11:41 AM
4	Any training would need to be incredibly focused and avoid review of general national planning policy which only mentions health really generally. Instead It should be focused on the reality of dealing with planning applications giving examples and should give detail regarding contributions/ obligations. It should be arranged to ensure that most officers can attend, especially ensuring attendance by management.	Oct 6, 2011 :04 AM

All planners' knowledge of health 2 (Oct 2012)

SurveyMonkey

1. Which team do you work in?

	Response Percent	Response Count
Development Management Inner	**19.0%**	**4**
Development Management – North	4.8%	1
Development Management – South and East	9.5%	2
Development Management – Major Schemes	9.5%	2
Development Management - Enforcement	**19.0%**	**4**
Strategic Planning and Policy	14.3%	3
City Design	**19.0%**	**4**
Planning Administration	0.0%	0
Other	4.8%	1
	If you chose other: please specify	1
	answered question	**21**
	skipped question	**2**

2. Your length of service/professional experience in the planning field in years?

length of experience/service in years

	1	2	3	4	5	6	7
Development management	0.0% (0)	0.0% (0)	6.3% (1)	0.0% (0)	**18.8% (3)**	0.0% (0)	**18.8%**
Local and strategic planning/policy	10.0% (1)	**30.0% (3)**	0.0% (0)	**30.0% (3)**	10.0% (1)	0.0% (0)	0.0%
Urban design	0.0% (0)	0.0% (0)	0.0% (0)	**25.0% (1)**	**25.0% (1)**	0.0% (0)	0.0%
Regeneration	0.0% (0)	0.0% (0)	25.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0%
Other	0.0% (0)	0.0% (0)	0.0% (0)	**20.0% (1)**	0.0% (0)	**20.0% (1)**	**20.0%**

3. Do you think the National Planning Policy Framework will help or hinder integrating health considerations into planning decisions and why?

	Response Count
	10
answered question	**10**
skipped question	**13**

4. How do you think neighbourhood development plans can best take local health issues into account?

	Response Count
	10
answered question	**10**
skipped question	**13**

5. The protocol between Bristol City Council and NHS Bristol for ensuring that principles of health and well-being are properly considered when evaluating and determining certain planning applications has been in use for over a year now. We hope you are aware of it and would like your feed-back on it: - Do you think it works well? - Are the comments from NHS Bristol useful/relevant? - Are there any issues with it? - How might the process be improved?

	Response Count
	10
answered question	10
skipped question	13

6. Please consider the following statements concerning the integration of health into planning and tick the relevant response for each statement

	Yes	No	Don't know	Does not apply	Response Count
Health impact assessment (HIA) is set out in Bristol's validation checklist for local issues	20.0% (2)	30.0% (3)	**50.0% (5)**	0.0% (0)	10
As part of my job, I have reviewed the quality of a HIA and/or considered the outcomes of a HIA	0.0% (0)	**70.0% (7)**	0.0% (0)	30.0% (3)	10
HIAs do not bring any added value, as all relevant health issues are already captured by other appraisal processes.	11.1% (1)	**44.4% (4)**	33.3% (3)	11.1% (1)	9
I/ my team identify(ies) the potential health impacts of emerging planning policies and/or major developments	**60.0% (6)**	20.0% (2)	10.0% (1)	10.0% (1)	10
Health considerations have a greater impact on final decisions compared to other considerations	0.0% (0)	**80.0% (8)**	10.0% (1)	10.0% (1)	10
Health issues are raised and discussed at pre-application meetings with developers	**50.0% (5)**	10.0% (1)	20.0% (2)	20.0% (2)	10
When negotiating Section 106/developers contribution for major developments we examine the possibilities of health related contribution and improvement	**50.0% (5)**	0.0% (0)	30.0% (3)	20.0% (2)	10
Health is raised as an issue internally when considering major developments	**50.0% (5)**	0.0% (0)	30.0% (3)	20.0% (2)	10
				answered question	**10**
				skipped question	**13**

7. Do you take into account evidence on the following health issues in your work ?

	I consider evidence on this aspect of health	I do not consider evidence on this aspect of health	Response Count
Physical health (illness. disease)	30.0% (3)	**70.0% (7)**	10
Physical activity (eg play areas, sport)	**90.0% (9)**	10.0% (1)	10
Active travel (walking, cycling)	**90.0% (9)**	10.0% (1)	10
Access to green open space	**90.0% (9)**	10.0% (1)	10
Access to safe, affordable and nutritious food – to buy or to grow	20.0% (2)	**80.0% (8)**	10
Mental well being, mental health	**50.0% (5)**	**50.0% (5)**	10
Accidental injury/casualty	**60.0% (6)**	40.0% (4)	10
Environmental health: air and water quality, noise, waste, contaminated land, odours	**100.0% (10)**	0.0% (0)	10
Quality and safeness of the public realm	**90.0% (9)**	10.0% (1)	10
Housing size and quality	**90.0% (9)**	10.0% (1)	10
Health equalities/inequalities	**50.0% (5)**	**50.0% (5)**	10
Access to local health services	**70.0% (7)**	30.0% (3)	10
Health implications of global environmental issues (eg climate change, peak oil, biodiversity)	**60.0% (6)**	40.0% (4)	10
		answered question	**10**
		skipped question	**13**

8. What would support you to give greater consideration to health in your work?

	Yes	No	Don't know	Response Count
National policy and guidance	**80.0% (8)**	10.0% (1)	10.0% (1)	10
Local planning policy	**80.0% (8)**	20.0% (2)	0.0% (0)	10
Local advice and guidance	**70.0% (7)**	30.0% (3)	0.0% (0)	10
Specific evidence	**66.7% (6)**	11.1% (1)	22.2% (2)	9
Training	**80.0% (8)**	0.0% (0)	20.0% (2)	10
Short but regular e-mail updates	**44.4% (4)**	22.2% (2)	33.3% (3)	9
Responses to planning consultations by health bodies	**88.9% (8)**	0.0% (0)	11.1% (1)	9
Articles in planning journals	**50.0% (5)**	**50.0% (5)**	0.0% (0)	10
			answered question	**10**
			skipped question	**13**

9. How would you describe yourself?

Age

	18 – 30	31-45	46-60	Over 60	Prefer s
Please choose from drop-down menus	33.3% (3)	**44.4% (4)**	22.2% (2)	0.0% (0)	0.0

Gender

	Female	Male	Prefer not to s
Please choose from drop-down menus	33.3% (3)	**66.7% (6)**	0.0% (0)

Transgender

	Yes	No	Prefer not to s
Please choose from drop-down menus	0.0% (0)	**87.5% (7)**	12.5% (1)

Ethnicity

	White British background	Other White background	Black and minority ethnic background	Prefer not
Please choose from drop-down menus	**88.9% (8)**	0.0% (0)	0.0% (0)	11.1%

Do you have a religion or belief?

	Yes	No	Prefer not to s
Please choose from drop-down menus	33.3% (3)	**55.6% (5)**	11.1% (1)

Are you disabled?

	Yes	No	prefer not to s
Please choose from drop-down menus	0.0% (0)	**100.0% (9)**	0.0% (0)

Sexual orientation

	lesbian	gay	bisexual	heterosexual	Prefe s
Please choose from drop-down menus	0.0% (0)	12.5% (1)	0.0% (0)	**62.5% (5)**	25.0
					answered
					skipped

Page 1, Q1. Which team do you work in?		
1	city transport	Sep 24, 2012 1:33 PM

Page 1, Q2. Your length of service/professional experience in the planning field in years?		
1	Private Sector Planning	Oct 15, 2012 10:27 PM
2	Research & Monitoring	Oct 15, 2012 4:18 PM
3	Landscape Architect	Sep 25, 2012 6:06 PM
4	transport planning	Sep 24, 2012 1:33 PM
5	Conservation of Historic Environment 24 yrs	Sep 24, 2012 9:59 AM
6	Private Practice	Sep 24, 2012 9:12 AM

Page 2, Q3. Do you think the National Planning Policy Framework will help or hinder integrating health considerations into planning decisions and why?

1	no difference	Oct 16, 2012 1:56 PM
2	It will hinder integration, because the NPPF is about simplifying and speeding up planning processes the priority being on delivering economic growth and a comprehensive planning approach is considered too burdensome, onerous and unresponsive to the requirements of development. A comprehensive approach however is necessary if health is to be truly integrated into planning processes	Oct 16, 2012 12:05 PM
3	I'm not sure	Sep 26, 2012 10:41 AM
4	Hinder in that developers will argue the presumption in favour of sustainable development in scheme where the LPA may wish to secure improvements in health terms. The NPPF is not particularly strong in terms of health but just reiterates previous planning guidance about open space etc. through the Healthy Communities section. There is no specific about health. BCC local policies (some of them draft) are stronger in this respect.	Sep 24, 2012 1:40 PM
5	Likely to make it harder - the bar has been raised in terms of waht are acceptable transport impacts	Sep 24, 2012 1:35 PM
6	Given the current thrust of government policy, it will make it harder as even the quality of life aspects on a small scale are being eroded (possible 6m extensions)	Sep 24, 2012 9:23 AM
7	No opinion either way.	Sep 24, 2012 9:04 AM
8	It will help as the health is incorporated in part into the definition of sustainable development which is the primary focus of the document. This provides a stronger point of reference in negotiating and determining applications.	Sep 24, 2012 8:54 AM
9	The NPPF includes health within the definition of sustainable development and contains a section on promoting healthy communities that will likely be helpful by giving the issue prominence in national planning policy and drawing different strands of health together under one heading. Among the core planning principles is a requirement for planning to take account of and support local strategies to improve health, which could include safeguarding sites for development to address health infrastructure needs and would also be helpful.	Sep 24, 2012 8:36 AM
10	The NPPF makes a lot of good noises about sustainable communities to include adequate provision of open space and community facilities, all are important if healthy travel/leisure options are to made available. It will be necessary to translate this guidance into more specific DM policies, (currently being drafted), to interpret this guidance. It will then be up to the inspectorate to give guidance through appeal decisions on what weight should be given to these items and the need for 'growth', given this is the overall message coming out of the government at the moment.	Sep 24, 2012 8:35 AM

Page 2, Q4. How do you think neighbourhood development plans can best take local health issues into account?		
1	don't know	Oct 16, 2012 1:56 PM
2	neighbourhood plans need to reflect Local Plan policies but reflect particular local characteristics, aspirations and circumstances. Local people do have the potential to ensure their local policies address health matters and planning applications make them more appropriate	Oct 16, 2012 12:05 PM
3	Identifying any particular local health needs or problems which the planning system can seek to address - eg poor walking environment/strategic barriers to walking & cycling; concentration of health problems; poor access to/shortage of health facilities	Sep 26, 2012 10:41 AM
4	They should identify specific goals where CIL money would be spent as Neighbourhood Partnerships will have some control over this. They should look at movement mainly and barriers to walking specifically, access to services etc.	Sep 24, 2012 1:40 PM
5	yes	Sep 24, 2012 1:35 PM
6	Unless neighbourhoods are fully aware of all health issues as well as the need to weigh all the differing considerations of the planning process up, then all this will achieve is raising expectations unrealistically.	Sep 24, 2012 9:23 AM
7	Using up-to-date and reliable data, on health inequalities/issues, from the very start of the plan making process to feed into the aims of the plan. This can also be fed into designing early consultation documents to see if the plan is on the right track.	Sep 24, 2012 9:04 AM
8	I don't know. There is yet to be a neighbourhood plan and given the neighbourhood level focus (whatever that means outside of a rural parish council setting) is likely to be a unique set of circumstances. Individual aspects could be encouraged such as removing rat runs, improving play facilities, etc but it very much depends on the locality. In addition, I think its highly unlikely that many neighbourhood plans will come into place given the time/cost for the level of outcome.	Sep 24, 2012 8:54 AM
9	Neighbourhood Development Plans could identify sites to be safeguarded to meet local health infrastructure needs. In proposing new development, Neighbourhood Development Plans could identify planning requirements to contribute to public health.	Sep 24, 2012 8:36 AM
10	Neighbourhood Plans can give strength to arguments in relation to the above matters but can also extend to look at service provision and matters outside of the planning system.	Sep 24, 2012 8:35 AM

Page 2, Q5. The protocol between Bristol City Council and NHS Bristol for ensuring that principles of health and wellbeing are properly considered when evaluating and determining certain planning applications has been in use for over a year now. We hope you are aware of it and would like your feed-back on ...

1	They are relevant but most overlap with established areas of policy. Struggling to find a clear additional point of value in some cases	Oct 16, 2012 1:56 PM
2	Unfortunately my work is not directly involved with planning applications, so i am not able to answer these questions.	Oct 16, 2012 12:05 PM
3	Comments can be useful, but the fact that they duplicate many of our other considerations from a slightly different angle can make it difficult to maximise their potential and take them on board - sadly the consequence in my opinion is likely to be (in the majority of cases) - "comments from NHS Bristol also support this analysis/view". I find the reference to and use of different space standards (Sheffield?) within comments completely unhelpful. We have our own space standards, and space standards from elsewhere are, in my view, not a material consideration. Furthermore I don't think that officers should be expected to deal with these comments within reports (ie I feel that this is wasting officer time). If NHS Bristol doesn't think our own standards go far enough, then their approach should be to lobby planning policy to improve them in future iterations, and not to ignore our adopted policy standards and seek to apply different ones which no stakeholders in Bristol have had the opportunity to comment on.	Sep 26, 2012 10:41 AM
4	The resource is limited given the amount of applications that the NHS ask to be consulted on, it is usual to not receive a response on all schemes. I have personally not received any responses given that I work mainly on minor schemes, where we would only consult them regarding changes of use to A5/ loss of open space etc. There comments are probably useful from what Ive heard from other comments experiences, but not always relevant referring to internal signing within buildings etc. to encourage use of stairs rather than lifts etc. when this is not a planning matter. They need to be more focused on realistic outcomes and improvements to schemes. They are simply one consultee response amongst many, some of which conflict. In addition, with fewer resources officers do not have unlimited time to spend on negotiating minor changes to schemes, which may have other implications in terms of other planning issues. Their work feeding into strategic policy is probably more consistent but needs to be followed up through commenting on application. I understand that there are issues in terms of the sums being requested for health contributions being very large and insufficiently justified, however this will change under the CIL regime coming in from 1st Jan 2013 in Bristol I understand. I think that it is positive but perhaps there needs to be better feedback from officers regarding what is relevant and realistic in order to get the best out of this resource, rather than spending time writing very lengthy comments on issues that officers cannot necessarily consider. A focus at an early stage on the really key applications.	Sep 24, 2012 1:40 PM
5	Yes, It seems to work well.	Sep 24, 2012 1:35 PM
6	any comments need to be more timely and realistic	Sep 24, 2012 9:23 AM
7	Have not encountered it yet.	Sep 24, 2012 9:04 AM
8	Comments are received but are often hugely disproportionate in terms of their length (in terms of the level of detail), content (in terms of the range of issues covered) and requested mitigation. I have concerns about whether it is a best use of Angela's time as a result. One example from a recent comment I've received have been requests for a travel plan on a minimal	

Sep 24, 2012 8:54 AM

Page 2, Q5. The protocol between Bristol City Council and NHS Bristol for ensuring that principles of health and wellbeing are properly considered when evaluating and determining certain planning applications has been in use for over a year now. We hope you are aware of it and would like your feed-back on ...

	scheme for a change of use from an A1 to an A2 use (which according to our development plan policies generates no change in movement demand), which is well below the DfT and CLG guidance on the scope for a travel plan and without any objections from the Council's own highways team. Consultees who regularly make requests considerably beyond what is reasonable run the risk of being ignored as a result. Please note that in relation to the question below HIA assessments do not apply to minor developments that make up my caseload.	
9	I am not aware of the protocol.	Sep 24, 2012 8:36 AM
10	The main problem re comments is that they tend to overlap with those from other departments and as there is no adopted policy basis for the equational approach to contributions it is very difficult to negotiate with developers from a position of strength, at best we get less than requested, the amounts being requested are high and added to those that are based on adopted policy are difficult to sustain in the current economic times.	Sep 24, 2012 8:35 AM