town & country planning

● **reuniting health with planning**

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Material should be submitted to the Editor, preferably by e-
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● **we create:** ideas, knowledge, publications, campaigns, and independent policies

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inside stories

TCPA welcomes Lyons Housing Review's support for new Garden Cities

The TCPA has responded to the launch of the Lyons Housing Review in October by welcoming its conclusion that Garden Cities should form part of the portfolio of solutions to the nation's housing shortage, and by supporting the recommendation that a new generation of Garden Cities should be promoted immediately by central government. The TCPA further commended the report for placing the housing crisis at the top of the agenda, and for emphasising the quality, as well as the quantity, of new homes.

Led by Sir Michael Lyons, the Lyons Housing Review was established by the Labour Party in November 2013 to provide an independent view on the changes to housing and planning policies that would be needed to enable the country to build 200,000 homes a year by the end of the next parliament.

Sir Michael appointed an expert panel, which included TCPA Chief Executive Kate Henderson, alongside people from a range of perspectives and backgrounds, to provide independent advice and consider evidence and develop recommendations for publication.

Commenting on the publication of the Review, Kate Henderson said: 'The Lyons Review has rightly placed the housing crisis and the need to deliver more homes at the top of the political agenda. The TCPA strongly supports the recommendation that a new generation of Garden Cities should be promoted immediately by an incoming Government.

'For the first time in a generation we are now in the position of having cross-party political support for Garden Cities. The Lyons Review sets out the important next steps of how to deliver them, including a recommendation to update the New Towns Act. It is time to seize this opportunity and deliver the homes and communities the nation needs.

'The Lyons Review has also been right to focus on the quality of new homes as well as the quantity. We particularly welcome recognition in the report for space standards, high-quality design and zero carbon standards.'

inside stories

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TCPA Chief Executive signs cross-party letter on housing

TCPA Chief Executive Kate Henderson joined politicians from the three main political parties, council leaders, leading architects and planners, and heads of NGOs, development companies and housing associations in signing a joint letter calling for a national consensus on solutions to the housing crisis. The letter, which was published in the *Times* on 20 October, argued that good planning is part of the solution to meeting the nation's housing need, stating that: 'Good planning goes beyond the cycle of elections, and cross-party support... is vital for high-quality developments to be delivered. For too long planning has been marked by division.'

The letter appealed for a national consensus on building homes based on three interlocking objectives:
● comprehensively planned redevelopment of brownfield sites within an urban context (for example the docks in London, Salford and Bristol);
● the expansion of existing towns and settlements where the addition would improve the overall level of amenity for the existing population rather than detract from it (the letter argued that this would not be achieved by merely adding numerous housing estates on the edge of a town: it would require a proper provision of additional services and support for existing transport networks to prevent them becoming even more crowded); and
● new planned settlements based on Garden City principles, where new social and physical infrastructure ensures that they will be sustainable and provide a good quality of life.

The text of the letter can be found on the TCPA website, at www.tcpa.org.uk/ resources.php?action=resource&id=1228

TCPA forges links with China

The TCPA and the British Embassy in Beijing have successfully organised a series of workshops on low-carbon urbanisation in China. A team of UK planners, including the TCPA's Head of European Affairs, Diane Smith, gave presentations on UK planning and approaches to low-carbon new development and urban regeneration in Shenyang during British Week in October, and in Beijing to a government-affiliated research institution, before finally running a workshop for Chinese mayors with the National Academy for the Mayors of China. The sessions were well received, and the TCPA aims to establish a working relationship with counterparts in China to facilitate a two-way knowledge exchange on sustainable development, including how the Garden City principles can be applied in a Chinese context.

Working relationships with Chinese counterparts were further enhanced by a series of tours to the UK for Chinese urban professionals. The first tour, for a delegation from Zengcheng in October, involved presentations on the TCPA and its programme of projects and its Garden Cities campaign, and presentations on innovative approaches to environmental management and green infrastructure from the Greater London Authority, BACA Architects and Land Use Consultants. The delegation also benefited from educational site visits to the Royal Docks, the Olympic Park and the Old Ford Water Treatment Plant. A delegation from Wuhan province followed in November, and further two-day tours are planned for early December.

TCPA to undertake work on a climate change adaptation plan for Jersey

The TCPA has been commissioned by the States of Jersey's Department of the Environment to undertake phase 1 of its Climate Change Adaptation Action Plan. Following the adoption of its Energy Plan in May 2014, Jersey's Department of the Environment recognises that the development of a Climate Change Adaptation Action Plan is a key next step. Phase 1 of the work will involve the TCPA facilitating a series of stakeholder sessions to ensure internal and external stakeholder commitment to the process; completing a SWOT analysis and a risk and vulnerabilities assessment (drawing on the much-acclaimed TCPA-led GRaBS – Green and Blue Space Adaptation for Urban Areas and Eco Towns – project); and providing mentoring support. The project is due to be completed by the end of January 2015.

notes from the dark side

Tom Pain on the conversion to homes of a former office block in Bournville, and the contrasts between planning today and the aspirations of the utopian tradition

osborneville and problems of overripe mangos

Above

Franklin House, in Bournville

It is that time of year when the cat moves from its high-pressure summer lifestyle of sleeping 22 hours a day to its winter mode of being conscious just long enough to eat and offer a few brief swipes at the current Labour leadership. It is true that the autumnal mists seem to reflect a bewildering political situation in which everyone is doing equally badly. The publication of the Lyons Review report could have been a golden moment for Labour to set a strong agenda, but in fact it seemed to slip through their hands, as if they lacked the self-confidence to make housing the core issue for the next election.

Despite the clear case for self-financing new settlements made in relation to Garden Cities, made even through the Wolfson competition, Labour seemed derailed when asked how it was to pay for growth. And of course there is a sense of being slightly becalmed as we build up to the Autumn Statement on 3 December, when George Osborne will no doubt move to make town planning a criminal offence.

Hard to be angry about anything? Well, yes; until my attention was drawn to a case in Birmingham. It relates to the conversion of a former Cadbury office block in Bournville. The facts are that Franklin House, built in the 1960s, was sold by Cadbury's owners in 2008. An application for conversion to 73 flats was rejected in 2012 partly on the grounds that the new residents might object to the noise from the remaining parts of a factory. There was also strong local opposition. The *Birmingham Post* now reports that the site, inside the Bournville estate Conservation Area, will now go ahead, using the Government's new permitted development rights to create 96 flats.[1] The block, shown above, is a very fine example of the 1960s architectural movement known as 'industrial dull'.

For a moment, let's forget about local democracy by assuming that all the 600 local objections were unfounded. Let's forget about the growing trend

for new residents in converted office blocks to successfully object to music venues and industrial premises on noise grounds – which, incidentally, led Cadbury to sustain its objection. Let's just think about Bournville, that paragon of industrial philanthropy. Let's think about the 1901 Garden City Association conference in Bournville that did so much to launch the Garden Cities and the planning movements. The deeds to the Bournville Village Trust established in 1900 to administer the estate stated:

'The object is declared to be the amelioration of the condition of the working class and labouring population in and around Birmingham, and elsewhere in Great Britain, by the provision of improved dwellings with gardens and open spaces to be enjoyed therewith.'

Let's look at one of the consequence of that commitment – classic Bournville homes, as illustrated on the next page. A comparison of this image with the image of Franklin House speaks for itself: two conceptions of how to house people separated by a century. It hard to know how we could fall this far. I suppose the new private residents of Franklin House (there is, of course, no way of enforcing the provision of any affordable homes in the new block) will benefit from the rich

notes from the dark side

Above

Classic Bournville homes

legacy of green space in Bournville. For their sake I hope so, because they will get no private gardens at all. Neither will the local authority get any contribution for transport improvements or schools or anything else, because no planning permission is required.

All ideas must be contested if they are to evolve, and perhaps there should be no sacred spaces; but to do this in Bournville is like walking into St Paul's Cathedral and finding it sponsored by Wonga.

Is there nothing of our past achievement that we are willing to defend? No principle we will not surrender in the face of the current physical and moral colonisation? You could argue that the Government has already stolen our future by deregulating democracy; it has stolen our language by making democratic town planning sound like a form of abuse. The last act is to steal and degrade our past; and yet collectively we do nothing.

Of course, planners do care about this, otherwise I wouldn't have heard about the Franklin House conversion; but trying to get the planning profession as whole to respond is like murdering a dead sheep with an overripe mango. The Franklin House episode is totemic, but in the same week that I heard of it two sets of planning academics told me that the British utopian tradition no longer features in any depth in the modern planning course. My

God, it's like trying to understand medicine with no knowledge of anatomy: 90% of our future – and 100% of the moral compass we have so obviously lost – depends on knowing the practical experience of the past.

The cat has opened a disapproving eye and suggested that readers might wish, if they have time, to look at Electoral Commission website[2] and gently trawl through the party donations from property interests over the last five years. Could it really be as brutally simple as that?

● **Tom Pain** *is a believer in the power of planning to build better futures. The views expressed are personal.*

Notes

1 G. Brown: 'Former Cadbury HQ to become £16 m apartment complex'. *Birmingham Post*, 9 Oct. 2014. www.birminghampost.co.uk/business/business-news/former-cadbury-hq-become-16m-7905503

2 See https://pefonline.electoralcommission.org.uk/Search/CommonReturnsSearch.aspx?type=advDonationSearch

off the fence

David Lock on the Lyons Housing Review and the potential for cross-party agreement and action on housing after the general election

lyons at last – a path for all parties?

The Leader of the Opposition, Ed Miliband of the Labour Party, established a Housing Commission in September 2013 to advise on 'creating a step change' in the building of new homes, and asked Sir Michael Lyons to be Chairman. One Commissioner was Kate Henderson, Chief Executive of the TCPA, and evidence was submitted by the Association itself and by many of us in the membership.[1]

Sir Michael has pursued a distinguished career in local government, including as Chief Executive in Wolverhampton, Nottinghamshire and Birmingham, and then as head of the INLOGOV policy organisation for five years. He then took the high-profile role of Chair of the BBC Trust and – here's the easily overlooked bit – wrote an insightful, readable and quietly smouldering report on the role, function and funding of local government.[2]

Sir Michael Lyons' Housing Review was published on 16 October.[3] It does not disappoint. The conclusions follow an inexorable logic and, while it provides Labour with a robust policy platform, it actually sets out a way forward for all political parties. About time too – housing the people is a deadly serious business, and the boring 'yah-boo' of party politics on this subject has wasted decades, to the shame of us all and to the acute pain and distress of many hundreds of thousands.

Early chapters recite the familiar problems, but there are up-to-date statistics and good graphs and maps to furnish many a PowerPoint presentation. The observations include:

- too few planners with budgets that are too small to do their work;
- too many local authorities too slothful or uncaring to make plans;
- a housebuilding industry that has eaten itself to a core of mega-companies who hugely dominate the market and turn out a product that meets a need but often offends the eye and rarely makes places;
- tenure choices that have shrunk to a handful;

- salted-away public land banks;
- over-complicated planning and design processes (considering the ordinariness that is the fruit);
- houses and jobs in disconnected places far apart; and
- the whole lot regulated by relatively well-off politicians harassed by baying NIMBYs who have nice houses already and just don't get it.

The Commission tries so hard, after such a depressing *tour d'horizon*, to see glimmers of hope. But, for example, the essay on the joyful potential of Neighbourhood Plans is frankly unconvincing. It is curious that one of the historically most intransigent anti-housing districts in England – South Oxfordshire – should now be home to the over-publicised Neighbourhood Plan at Thame for coming up with space for 775 homes when only 600 were sought, and likewise that for Woodcote, where 70+% opposition was turned into 96% in favour, for 76 houses (yes, 76!); but the argument is not persuasive, especially as the reportage is silent on the costs and time taken, and the sustainability of such community effort is not considered. But then Broughton Astley in Harborough needed to find at least 400 homes and found 500. Well done! Only another several million needed. Perhaps this essay was ironic!

And so to some of the meat of it:

- Strategic Housing Market Assessments need to be standardised in their assumptions, and a new Housing Observatory would provide key data and forecasts.
- Local plan sloth must be tackled – only 57% of authorities have an adopted plan today, and 21% have not even bothered to publish a draft. The Planning Inspectorate (PINS) will be called in to produce a plan if there is still inaction.
- Delivery against plans is to be fiercely monitored, with penalties for slippage (a bigger buffer on the housing number, for example), or a New Homes Corporation will be called in (see below).
- Groups of local authorities sharing a Strategic Housing Market Area will be 'encouraged' to make a Strategic Housing Market Plan (SHMP), agreeing ways that each will estimate need and 'resolve' what are called 'cross'-border tensions'. Where this doesn't work, the Secretary of State should step in (or be called in by a whistle-blower,

such as one of the local authorities, or PINS, or the Local Enterprise Partnership), require an SHMP as a statutory exercise and, if necessary, get PINS to do it.

● Strategic plans (including SHMPs) would be plan-making on one cycle, with 'light touch' local planning documents in a following cycle. The Planning Officers Society is credited with this thinking. (Why aren't they doing this in their day jobs? 21% of planning authorities have had no plan since 2004!)

● 'Use it or lose it' – a ghastly coinage – means the life of a planning permission would be reduced from three years to two (the rule would apply to phases in very large developments), with council tax payable on unbuilt dwellings where a site is not started in five years, and Compulsory Purchase Orders (CPOs) to be used where inactivity continues, with the authority either selecting a development partner or calling in its local New Homes Corporation (see below, again).

● Housing Growth Areas could be designated in which landowners must pool their land, and then sell or take an equity stake (enjoying uplift in due course) – a sort of compulsory collaboration in a CPO-free environment.

This is mostly very sound. Left hanging in this summary list, though, is the idea of New Homes Corporations (NHCs). These are a distant echo of New Town Development Corporations which might distil some of that extraordinary experience: an NHC would be the servant of the local authorities in Strategic Housing Market Areas who ask for it to be brought into being to deliver their collective plan. An NHC would be created by the Secretary of State and given a ten-year service contract, renewable if well performed. Its task would be to focus planning and CPO powers on delivery; and pool public land stocks and any available funding. NHCs would particularly target stalled sites, and the task would be to widen the range of housebuilders and variety of tenures, including loads of self-build, and also co-operative and co-ownership schemes. On sites over 500 homes, the Commission also wants them to have development control powers.

The idea of these delivery agents working over a whole strategic housing market to deliver properly allocated sites is fresh and could work well. A wise, pragmatic feature is that not everywhere needs one, or would want one.

There are other ideas in the report, too. Lyons says that London will need to overspill, and this requires a clear steer from central government on how much housing must overspill. Another idea,

that a proportion of new homes must be made available for a period to locals first, will be popular among those who think that their local problems are caused by in-migration. I recall that when this was tried in London Docklands it created a market for local rent books or other identity information so that outsiders could cheat and pose as locals. Human ingenuity knows no bounds.

The report has its holes. There is a discussion about the way some planning authorities are 'running at a loss' and need to be able to raise fees for planning applications and services to 'recover their costs'. Stalwart readers of this column will know that it is one of the last refuges of those who remain of the view that planning is a public service and that the concept of earning fees from the public to cover its costs is an abomination. Further, if you want to play that game, then the present methods by which costs are identified and fees calculated is worthy of *Alice in Wonderland*. So no support here for Lyons on that line of argument!

It is also an error, made first by the Coalition Government, to think that PINS is a body that could make plans where the local authority will not. PINS is not resourced in any way to do such work; it would contaminate its carefully constructed image of semi-judicial independence; and who will examine the Examiner? This won't work.

But these are marginalia. The need for change is set out very clearly. The approach outlined is correct. There is no need for another re-design of the whole planning system right now.

Ed Miliband may have commissioned this report, and Labour may put most of these recommendations into its manifesto, but the housing problem is not a party problem, and neither are the solutions. The clever person will seek cross-party agreement after the general election in May 2105 so that they can just get on with it.

● **David Lock CBE** *is Strategic Planning Adviser at planning and urban design consultancy David Lock Associates, and a Vice-President and Trustee of the TCPA. The views expressed are personal. His special contribution in evidence to the Lyons Review is acknowledged in the report.*

Notes

1 D. Lock: 'Don't overlook the Lyons Review'. *Town & Country Planning*, 2014, Vol. 83, May, 206-8

2 M. Lyons: *Lyons Inquiry into Local Government. Place-Shaping: A Shared Ambition for the Future of Local Government*. TSO, Mar. 2007. www.lyonsinquiry.org.uk/

3 *Mobilising across the Nation to Build the Homes our Children Need*. Lyons Housing Review: Independent Review of Housing for the Labour Party. Oct 2014. www.yourbritain.org.uk/agenda-2015/policy-review/the-lyons-housing-review

back to the future?

Guest Editors Andrew Ross and Carl Petrokofsky introduce the Special Issue on Reuniting Health with Planning

This Special Issue of *Town & Country Planning* taps into the current momentum around attempts to better understand both the influence of the built and natural environments on our health and the role of spatial planning in shaping places that help us to maintain good health. For readers who are new to this agenda, a good place to start is the TCPA's Reuniting Health with Planning programme,[1] which has published an introductory handbook and a range of other resources to help planners and public health practitioners work more closely together. Michael Chang, Policy Officer at the TCPA, provides, within this issue, a brief overview of the ongoing work of the programme.

Planners, allied to their public health colleagues, were spectacularly successful in improving the health of the population over the course of the late 19th century and the early decades of the 20th. Planning transformed the lives of millions of people in the UK who previously would have died an early death from an infectious disease due to, or exacerbated by, poor housing, sanitation or food, or lack of access to good medical care. However, in recent decades the planning profession – like many

others – has overlooked the contribution it could make to solving the new health challenges of the 21st century: the rise of the so-called non-communicable or 'lifestyle' diseases.

It has become increasingly clear that a number of current public health priorities, such as cardiovascular diseases, stroke, respiratory diseases, and mental and physical health, have a significant spatial dimension. Air pollution, a lack of good-quality green spaces, isolated neighbourhoods and poor access, and unsafe environments – to name a few – are all recognised as factors that have an impact on our health. There is a great opportunity now for planning and public health professionals to combine – as they did over 100 years ago – to help to address these new public health challenges in ways that improve and enhance the public realm.

It would be wrong to say that the links between public health and planning were severed completely during the latter stages of the 20th century. A few directors of NHS public health teams and of council planning departments – such as those at Stockport, Liverpool, Luton and Bristol – as well as the activities of London's Healthy Urban Development

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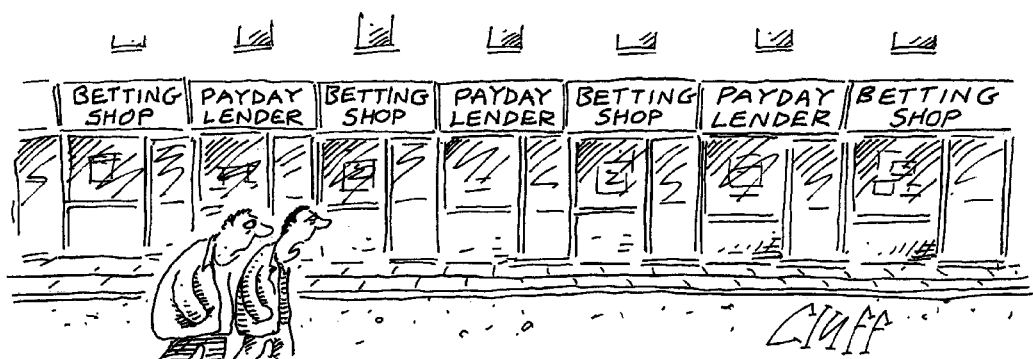
IT'S GOOD TO SEE THE HIGH STREET COMING BACK TO LIFE

"AT LEAST WE STOPPED THEM SELLING OFF **ALL** THE PLAYING FIELD".
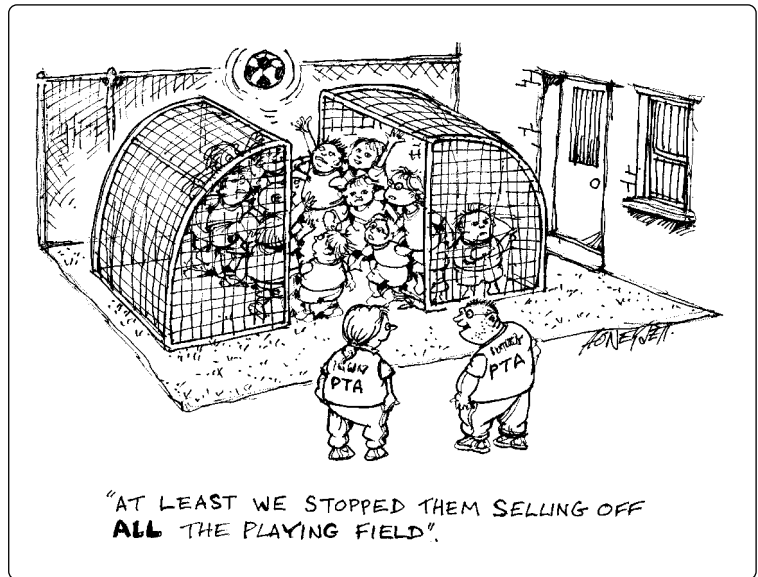
Unit (HUDU) and the Spatial Planning and Health Group (SPAHG), continued to foster the connections throughout the 2000s. This included joint-funding specialist planning and health posts. But the transfer of public health teams to local authorities in April 2013 has reunited public health practitioners with the wider levers of change that are located in local government, such as housing, education, regeneration, planning, transport, environmental health, and parks and leisure. This has created an appetite for exploring how the built environment professions can help to improve the public's health. The commitment of both the Royal Town Planning Institute (RTPI) and Public Health England (PHE) to this integrated agenda, as set out within this issue, is welcome.

For planners, the health guidance written into the National Planning Policy Framework and Planning Practice Guidance raises opportunities and challenges; these are thoughtfully considered by Tim Townshend in his overview of the potential and limitations of planning in creating healthier places. He particularly challenges the inconsistent role of the Planning Inspectorate regarding planning's part in improving health. A relevant evidence base would help, and Hugo Crombie describes how the National Institute for Health and Care Excellence (NICE) is developing its understanding of what counts as useable health evidence in the planning system.

Four articles develop this theme by topic: Jessica Allen reviews the evidence relating to health inequalities and the built environment; Adrian Davis looks at transport; Rachel Penny focuses on green infrastructure; and Nick Bundle reports on one local authority's experience of developing an evidence base on healthy eating. There are always calls for better data, but there is also the challenge of how public health teams can work with planners to find ways to make existing evidence relevant to policy- and decision-making (see, for example, the excellent article on developing useful health evidence published in the August issue of *Town & Country Planning*[2]).

There is still room for planning and public health together to develop approaches to evaluation, so that we can determine how new developments and redesigns are impacting on health and wellbeing, especially by linking to existing assessment and monitoring regimes. Paul Johnson describes the practicalities of undertaking Health Impact Assessment and the linkage with the updated EU Environmental Impact Assessment Directive.

Clearly, though, enabling a healthy environment needs more than a good evidence base. Hugh Barton reviews good practice from mainland Europe and asks why it seems so difficult to replicate the conditions of, say, Freiburg or Stockholm in many of the UK's cities and towns.

We are delighted to have two of the pioneering joint post-holders write for this issue: Cath Taylor from Knowsley Council and Angie Jukes from Stockport Council share their experience, not least on the importance of their role in working across professional boundaries and breaking down organisational silos.

One of the ways that planning can help to improve health and wellbeing is by involving local people meaningfully in the design of their own areas. Louise Dredge reports on a number of examples of constructive participation: the challenge for planners, supported by public health practitioners, is to require this quality of engagement for as much new development as possible.

Of course, we will not always enjoy good health, and planning has a crucial role in providing accessible and appropriate healthcare facilities. The

"OF COURSE I HAVE TO DRIVE HIM TO SCHOOL IN A PEOPLE CARRIER, HE WON'T FIT INTO ANYTHING ELSE"
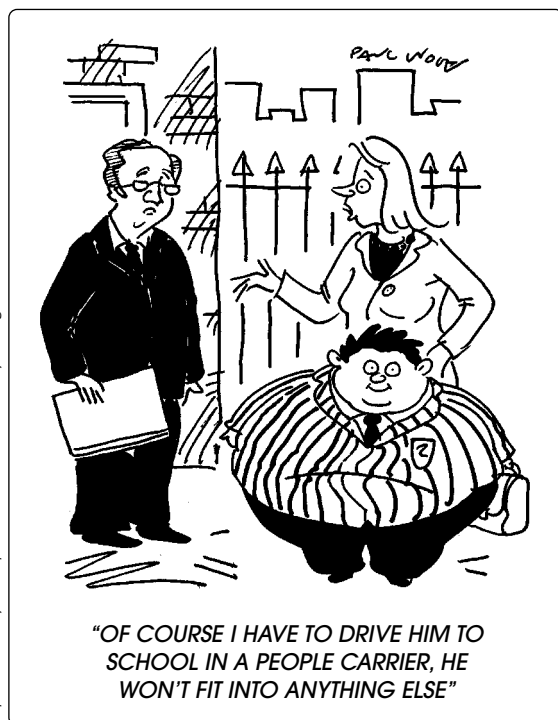
stakeholders that need to be involved in decision-making related to such provision have changed considerably since the Health and Social Care Act 2012 took effect in April 2013. Vernon Herbert and Malcolm Souch succinctly describe the revised approach.

Overall, this Special Issue captures the wide range of current thinking on how to create healthier environments. It is crucial that this period of momentum and good will does not crumble under the challenges that lie ahead. These include the ongoing pressures on the public purse and on the planning system to secure economic viability without necessarily giving proper consideration to the long-term effects of development outcomes on health and wellbeing. As a result of our participation in numerous local authority workshops around England, we are all too aware of how constraining a short-term focus is on achieving long-term healthier places, especially in areas with high levels of health inequalities.

We need to demonstrate the cost-effectiveness of enabling healthier environments in places where people currently experience poor health. One of the most effective ways of achieving this would be to deliver some demonstrable changes to real places; we hope that future issues on this topic will be able to report on development examples from these shores to match Hugh Barton's inspiring tales from mainland Europe. In the meantime, organisations such as the TCPA and its wide range of partners will need to continue to underline the long-term costs of

short-term thinking, and the economic, social and environmental gains that accrue from requiring development that helps everyone to achieve better health and wellbeing.

Finally, we have already acknowledged the influence of those individuals within local authorities who have been at the vanguard of integrating health and planning in practice. One of the most energetic of these was Stephen Hewitt, Public Health Manager (Spatial Planning and the Environment) at Bristol City Council. We were very sad to learn, as this issue went to press, that Stephen died from cancer following a short illness. For the last four years of his life Stephen worked jointly across the Public Health Team and the Planning Directorate of Bristol City Council, influencing Bristol's Core Strategy and development management policies for the benefit of health. He saw his post as a prototype for re-establishing the relationship between town planning and public health, in effect reaffirming their joint origins in the 19th century. He was rather special and will be greatly missed, and we send our condolences and best wishes to his family, friends and colleagues.

● **Andrew Ross** *is a writer and researcher on planning and public health at Final Draft Consultancy, and is co-author of the TCPA's Reuniting Health with Planning series of publications.* **Carl Petrokofsky** *is Specialist in Public Health in the Health Equity and Place Division at Public Health England. They gratefully acknowledge the kind permission of Private Eye magazine to reproduce a few humorous perspectives on health and planning. The views expressed are personal.*

Notes

1 Information on, and produced by, the Reuniting Health with Planning programme is available from the 'Health and Planning' pages of the TCPA website, at www.tcpa.org.uk/pages/health.html

2 W. Anderson, M. Egan, A. Pinto and L. Mountford: 'Planning for public health – building the local evidence base'. *Town & Country Planning*, 2014, Vol. 83, Aug., 341-7

promoting healthy places

Planning, at all levels, can play a crucial role in creating environments that enhance people's health and wellbeing, but collaborative and inclusive processes for multi-sectoral co-operation are required to produce new ways to integrate planning and health, says Janet Askew, RTPI Vice-President 2014

Janet Askew

Above

Rieselfeld in Freiburg, Germany – well planned and well connected neighbourhoods can promote a better quality of life and opportunity for all

The relationship between planning and health has always been important. In its centenary year in 2014, the Royal Town Planning Institute (RTPI) has been looking back at its roots in the early 20th century, when living conditions were overcrowded and unhealthy. Early philanthropists recognised this, building model villages where the population was provided for from cradle to grave, locating factory,

home and community facilities adjacent to each other. These principles have been revived, and as part of its centenary 'Planning Horizons' series of papers the RTPI has recently published *Promoting Healthy Cities: Why Planning is Critical to a Healthy Urban Future*.[1]

Drawing on UK and international examples, the paper recognises that well planned cities, urban and rural areas can promote a better quality of life and opportunity for all. Planning in the broadest sense, at all levels, can play a crucial role in creating environments that enhance people's health and wellbeing.

Conditions such as obesity, chronic heart disease, stress and mental health are intricately linked to the environments in which people live and work, and many reflect social and economic inequality. Transport, green space, pollution, housing quality, access to food, community participation and social isolation have significant implications for health. In developed and developing countries, many policies are encouraging location decisions which result in sprawling communities with poor connections and inadequate access to services, exacerbating inequality, social exclusion and poor health. And climate change may be the biggest health threat facing all societies across the world, especially with its impact on safe drinking water, sufficient food and secure shelter.

The possibility of a wider and more integrated urban and rural health agenda is undermined by institutional division between planning and public health, and is fragmented further between other services, such as housing and education, in the public and private sectors. Collaborative and inclusive processes are needed for multi-sectoral co-operation which can result in new ways to integrate planning and health.[2] This is a key proposal of the RTPI, following the recommendations of the Marmot Review[3] and the 2010 Public Health White Paper, *Healthier Lives, Healthier People*.[4] Scotland has an implementation plan, *Good Places, Better Health*,[5] which encourages a 'system-based' rationale for action to reduce health inequalities and create links with other government strategies related to this domain.

Other recommendations from the RTPI relate to better governance to develop appropriate systems for the promotion of healthy urban environments. This might mean granting more powers to city governments to tackle the integration of health into built environment policies. A multi-disciplinary approach is vital, along with better education of both planners and public health professionals. In 2013, the Faculty of Public Health and the Royal Town Planning Institute, along with the Spatial Planning and Health Group (SPAHG), urged providers of education and training for planning and public health professionals to emphasise the importance of

acquiring at least a basic mutual understanding of the role of the built and natural environments as determinants of health.

In addition, other built environment actors such as builders, developers, designers, architects and engineers also need to be engaged early on regarding health issues, for example in the design and implementation of housing space standards, and on the economic as well as social and individual benefits that can result from pro-health decisions. Community engagement in planning and public health is crucial in policy-making.

The RTPI suggests that there is a need for better evidence and data to give decision-makers a clearer picture to create the conditions for health issues to be incorporated into development decisions. Good design is also essential – well designed neighbourhoods that incorporate natural systems and green infrastructure have been shown to provide long-term and sustained health benefits for local communities, resulting in the design of places with character and good urban form.[2] A 10% increase in green space in cities could help to keep temperatures at present levels into the 2050s, despite climate change.[6]

The RTPI is committed to the revival of the early principles upon which the planning profession was built, to create innovative and beautiful places in which to live. Built environment and health professionals all over the world are urged to work together to create places that are sustainable and healthy for future generations.

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Notes

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now is the time for a renewed focus on health and planning

Local leadership of planning and public health provides an opportunity to address the wider determinants of health that are shaped by the context and circumstances of people's lives, says Kevin Fenton, National Director of Health and Wellbeing at Public Health England

Health and planning have a proud tradition of working together to improve the lives and health of local communities. We need this partnership now more than ever as we confront today's challenges of climate change, the rise in chronic diseases, an ageing population, and increased pressures on resources and infrastructure.

Our starting point at Public Health England (PHE) is a shared aspiration that the places where people live, work and play should promote wellbeing, support communities and help to reduce inequalities. This aspiration is grounded in both theory and evidence.

The theory is based on the powerful idea that people's health is shaped by the context and circumstances of their lives – the wider determinants of health. Many of these determinants are intertwined with planning, both directly because planning determines the built environment of houses, streets, and public spaces, and also indirectly because planning influences local economies, transport, natural habitats, and the use of natural resources.

We also have evidence that the places in which we live can have wide-ranging impacts on our health. We know, for instance, that cold homes are a risk to health and that green spaces are associated with improvements in health and lower levels of health inequalities. We know that environments that encourage physical activity as part of everyday life (more walking and cycling) make a useful contribution

to tackling obesity and that people who live and work close to lots of takeaway food outlets are more likely to be obese.

People need healthy places to lead healthy lives. This is not a new agenda, but what we have now is an opportunity to drive it forward with renewed impact. That is because we now have local leadership of planning and public health. With the return of public health to local government, different parts of the system are aligned around a common set of incentives to promote wellbeing. For instance, planning, housing and transport have roles across many public health outcomes that are measured and monitored in the new system as set out in the Public Health Outcomes Framework[1] (such as fuel poverty, utilisation of green spaces, and air pollution).

In principle, that should make it easier to integrate approaches to planning and health: take these words from a local authority's Joint Strategic Needs Assessment, which sets out its ambition to 'design a healthy city with green space and less congestion and pollution to improve people's health and wellbeing'.

And that is what we are starting to see in practice. All across the country, there is renewed confidence in the ability and power of local communities to take action to make their environments better to live in – whether through urban trees in Birmingham, restrictions on fast-food premises near schools in St Helens, or cycle lanes in London. There is also

interest in developing new tools and new resources so that health issues can be more salient and relevant to planning, whether through Health Impact Assessments for large-scale planning applications or by working on better evidence of economic impact and returns on investment.

PHE exists to support this local leadership with relevant data and evidence of effective interventions. PHE's Healthy People, Healthy Places programme addresses health, wellbeing and inequalities in the planning and development of the built environment through the evidence it disseminates and the networks and partnerships it helps to create.

These partnerships are key because we will only capitalise on the opportunity the new system affords us if we encourage new ways of working and collaborating – for instance, by ensuring that public health directorates are consulted on major planning applications and by bringing together stakeholders and professionals from different backgrounds (take the West of England Health and Transport Forum as just one example). Builders, developers, architects and engineers have to be part of the conversation about how we design health and sustainability into our housing and our public spaces.

There are many challenges. First, health leaders have to make the economic case as well as the health case for urban design that promotes physical and mental wellbeing. Local authorities face constraints on budgets and difficult trade-offs – between the need to see more housing delivered and the need to preserve more open space; between the shorter-term financial viability assessments of new developments and the longer-term returns (both economic and social) of health-promoting places.

Second, making the argument relies on being able to collect and assess the kind of data and evidence that is relevant to local leaders and helps them to evaluate the impact that major planning decisions have on health. This is a complex task. It requires combining data on ill-health with data on how this varies with living conditions. It requires new ways of integrating spatial data with existing planning policy, so that decision-makers have an effective way of considering other key areas – such as transport, water management, health, and landscape – as they develop their vision of urban development.

Third, we have to take on new research questions: what, for instance, does it mean to have an environment that promotes healthy weight, rather than an obesogenic one? How can we ensure that urban design is inclusive, so that we end up with more, not less connectivity? How can we embed physical activity in the way we design our transport systems?

Our cities can be great engines for healthy development; they connect people to jobs, education, services, and a wealth of opportunities. But they have to be planned with people's health and wellbeing in mind. Our towns, villages and rural communities too face specific challenges to ensure that they can develop and thrive in the 21st century and provide places supportive of healthy lifestyles and integrated social communities. This takes vision and determination, over long periods of time. The starting point is a shared ambition to make the places we live in as conducive to wellbeing as they can be. With the new public health and planning system in place, we are in a better position than ever before to deliver on this ambition.

● *Professor Kevin Fenton is National Director of Health and Wellbeing at Public Health England.*

Note
1   See the Public Health Outcomes Framework webpages at www.phoutcomes.info/

Public Health England

Public Health England (PHE) exists to protect and improve the nation's health and wellbeing and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health. PHE has an ambition: for people of this country to live as well as possible, for as long as possible. It also believes that efforts to promote health and wellbeing, and tackle ill-health, will only be successful through working with people, places and communities. It is an approach that recognises the power of individuals to change their lifestyles, especially if they get the right support at the right time, but which also recognises that our health is shaped by where and how we live: by our jobs, families, homes, and the places in which we live.

PHE recognises that the built and natural environments are major determinants of health. The impact of the quality of buildings, the design and accessibility of housing, and the access we have to clean air and green space are fundamental to our health and wellbeing. To support its work in this area PHE launched its Healthy People, Healthy Places programme last year. PHE's vision is a future in which everyone – wherever they live – is able to live, work and play in a place that promotes health and wellbeing, sustains the development of supportive and active communities, and helps to reduce health inequalities. In short... *healthy places to grow up and grow old in.*

Public Health England

reuniting health with planning – the mission continues

Michael Chang provides an update on the TCPA's Reuniting Health with Planning programme

The TCPA's Reuniting Health with Planning programme (see Box 1) produced its first major outcome in the form of the *Reuniting Health with Planning* handbook,[1] published in 2012, with a major report from the second phase of the programme, *Planning Healthier Places*,[2] following in 2013. The latest phase of the programme is focused on harnessing the benefits of integration and collaboration, building on the momentum of the 2012 reforms to planning, public health and social care in England. Project work carried out with English local authorities has continued through the Planning Healthy-Weight Environments project – 'phase 3' of the Reuniting Health with Planning programme – and, in a continuation of 'phase 2' work, through bespoke roundtables with individual councils. And 2014 has also seen the programme's reach extend beyond England to Northern Ireland and Scotland.

The Planning Healthy-Weight Environments project

Stories on the 21st century obesity crisis are now commonplace within mainstream and specialist media, touching on the various contributing factors, the negative social and economic impacts, and the sort of public policy interventions required in response. Planning has a role to play in helping to create new and rectify existing environments so that people are given opportunities to become more active through walking and cycling; to participate in physical recreational activity; to enjoy access to open space; to buy fresh food and even grow their own; and to use spaces and places free from the

> **Box 1**
> **The Reuniting Health with Planning programme**
>
> The TCPA has been leading a series of projects aimed at reuniting the public health and planning professions in work to create healthier, happier communities and places. Details of the various projects undertaken to date and of the latest work and developments in the Reuniting Health with Planning programme are available from the 'Health and Planning' pages of the TCPA website, at **www.tcpa.org.uk/pages/health.html**
>
> Anyone seeking further information or interested in discussing opportunities to commission the TCPA to help plan and independently facilitate a workshop on key planning and health priorities is invited to contact Michael Chang, on **Michael.Chang@tcpa.org.uk**, or call on 0207 930 8903.

fear of crime. Policies that impact, for good or ill, on the public health potential of places are being developed as local authorities update and bring forward their new local plans, and as decisions on new developments are made up and down the country.

The Planning Healthy-Weight Environments project is supported by Public Health England under its 2014/15 programme of work on obesity and healthy places, as well as by a number of other

organisations and local authorities.[3] It aims to determine how to create and reshape places with spatial characteristics that help to provide people with opportunities to maintain a healthy weight. The project focuses on particular types and scales of development; factors that planners/built environment/ health professionals can influence; and identifying who these professional need to collaborate with to bring about healthy-weight environments.

As part of this project, seven workshops were held with local authorities across England, focusing on what these councils can do to effect change. A report on the outputs of the Planning Healthy-Weight Environments project is being published in December 2014.[4] There is scope for the findings and advice to be applied across the other nations of the UK.

Bespoke health and planning roundtables

The TCPA offers an independent package of support to local authorities through the Reuniting Health with Planning programme. In April 2014, the TCPA and Andrew Ross held a roundtable with Sefton Council[5] to improve capacity-building in order to address specific local issues through better integration between the public health and planning functions. Sefton Council, which was in the process of preparing its Local Plan, focused on two particular issues – a healthy high street, and housing an ageing population – and outcomes from the discussions

were fed directly into public health's contribution to developing both an evidence base and policy proposals for the forthcoming plan. Ryan Swiers, Senior Public Health Practitioner at Sefton Council, found that the workshop produced 'tangible outcomes':

'These include a revised policy included in the draft local plan and a greater understanding of the interfaces between the disciplines of public health and planning within the authority, which led to a subsequent workshop and ongoing collaboration. Planning is now seen as central to key areas of public health as a means of delivering a sense of healthy places in which the very fabric of the environment is supportive and conducive to leading a healthy, happy life.'

A fresh start for a healthier Belfast

In early 2014, Belfast Healthy Cities commissioned the TCPA and Andrew Ross to work on a Reuniting Planning and Health capacity-building project. Belfast is a leading member of the World Health Organization (WHO) European Healthy Cities Network, working on core themes that include healthy urban environments and design. Its role is to work with institutions and organisations to facilitate change and to develop tools, strategies and ways of working which demonstrate the benefits of planning for a healthier city and which these bodies can integrate into their own practice to improve the population's health.
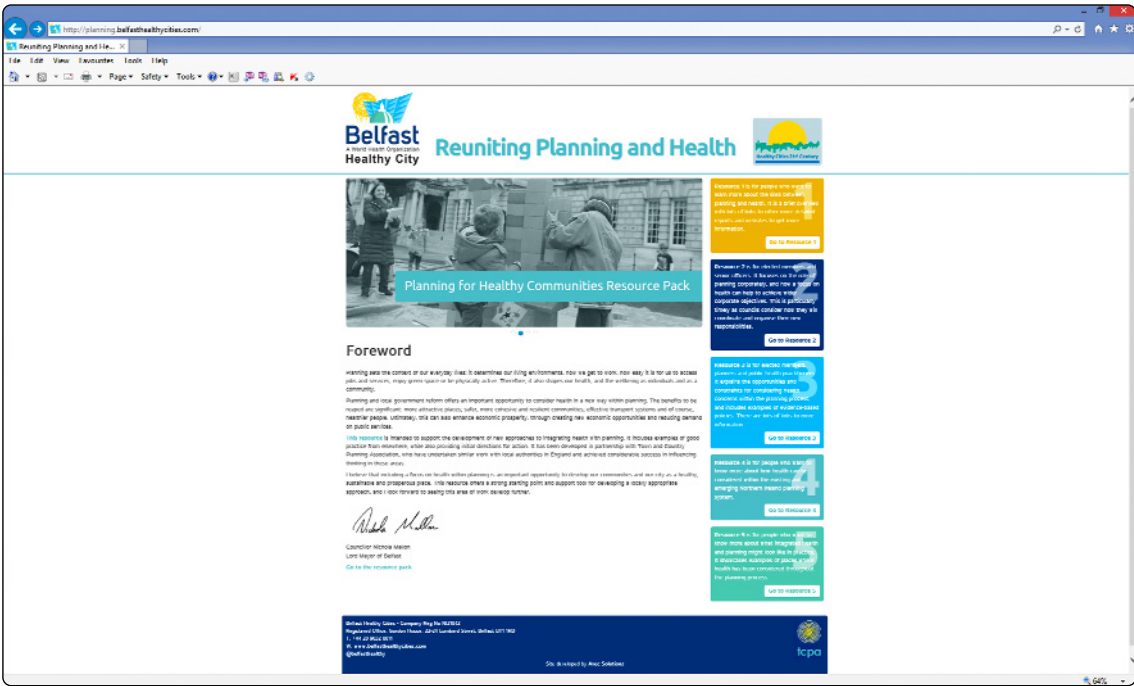
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The Belfast Healthy Cities Reuniting Planning and Health capacity-building project aims to explain how better integration between health and spatial planning can help to create healthier places in which to live

The project ran during a time of a significant and historic transition, as Northern Ireland's councils prepared to take on planning responsibilities, for the first time in decades, from April 2015. With Belfast City Council working to establish its new structures, Belfast Healthy Cities saw this as a perfect opportunity to embed public health objectives and delivery at the heart of the new planning system and within its wider corporate organisation.

There were two parts to the project. First, two roundtables were held in Belfast in March 2014 with senior officers from the Department of the Environment (DoE), the Northern Ireland Housing Executive (NIHE), Belfast City Council and representatives from a host of relevant local organisations. The roundtables aimed to identify current health and planning concerns that could be used as the basis for informing future debate, commissioning specific local projects, and making local links and building working relationships.

Secondly, the TCPA developed a series of stand-alone online resources in collaboration with Belfast Healthy Cities members, including Belfast City Council, the DoE and the NIHE, to help users to focus on the topics in which they are most interested.[6] The resources were launched by Belfast Healthy Cities at the Reuniting Planning and Health: Tackling Disadvantage Conference held on 14 November in Belfast.

Jonna Monaghan, Health and Wellbeing Manager at Belfast Healthy Cities, notes that the resource 'offers a strong basis for informing future development and collaborative approaches, and further capacity-building is already being planned'.

Supporting the planning and health agenda in Scotland

In spring 2014, the Planning Exchange Foundation commissioned the TCPA to identify the opportunities and gaps in current guidance and practice in the interaction between planning and health in Scotland, and to suggest how knowledge gained from the Reuniting Health with Planning programme could be shared in a Scottish context. While momentum for change has been generated in England by the integration of the public health function into local authorities, in Scotland public health is the responsibility of the NHS, while planning responsibilities sit with local councils.

The overall conclusion of the commissioned scoping study[7] was that although there are examples of centrally initiated projects aimed at integrating planning and public health, there is scope for renewed and sustained effort to engage public health functions in understanding the importance of the wider social and environmental determinants of health, and to target 'upstream' interventions. And planners should be helped to understand the wider purposes of planning beyond land use control, perhaps through the development of practical guidance to support national planning policy or community planning processes.

Continuing the work

Significant momentum has developed on the planning and health agenda, and there is a real commitment from local authorities to implement policy priorities to improve the health and wellbeing of their communities. Collaboration and integration presents both challenges and opportunities, but there is increasing recognition that this is now the way to operate – to create health-promoting environments and to make the best of what we already have in place. Professionals from across the UK and Europe have shown increasing interest in the TCPA's work and the unique approach taken in delivery, as recently recognised when the Reuniting Health with Planning programme was presented as a case study in collaboration at the WHO Healthy Cities Conference in Athens. The TCPA aims to build on this momentum in 2015 and extend the programme's reach to those areas which need support in the process of reuniting health with planning so as to deliver local objectives.

● *Michael Chang* is *Planning Policy Officer at the TCPA, and is the co-author of the TCPA's Reuniting Health with Planning and Planning Healthier Places reports.*

Notes

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2   A. Ross, with M. Chang: *Planning Healthier Places – Report from the Reuniting Health with Planning Project.* TCPA, Nov. 2013. www.tcpa.org.uk/pages/reuniting-health-with-planning-phase-2-project.html

3   Information on the Planning Healthy-Weight Environments project, including workshop materials, is available at www.tcpa.org.uk/pages/planning-out-obesity-2014.html

4   A. Ross, with M. Chang: *Planning Healthy-Weight Environments. A TCPA Reuniting Health with Planning Project.* TCPA, Dec. 2014. www.tcpa.org.uk/pages/planning-out-obesity-2014.html

5   Details of the Sefton Council workshop are available at www.tcpa.org.uk/pages/health-and-planning-with-local-authorities-2014.html

6   Details of the Belfast Healthy Cities Reuniting Planning and Health capacity-building project and associated resources are available at http://planning.belfasthealthycities.com/ (see also www.tcpa.org.uk/pages/belfast-reuniting-planning-and-health-2014.html)

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time for some blue-sky thinking?

Tim Townshend looks at the potential and limitations of the current planning system in meeting the NPPF's call to create healthier places

Andrew Ross

Above

'The core purpose of planning is to provide places for human flourishing...'; but many of our existing motor vehicle dominated environments are far from health-promoting

There is a growing body of evidence that implicates the built environment in a number of contemporary health crises. Research has shown that the places in which people live may provide a setting beneficial to health and wellbeing and enable healthy lifestyle choices. Conversely, some places have a deleterious effect on wellbeing, by providing barriers to healthy lifestyle choices, or by providing a plentiful supply of shops and services that have known links to negative health and wellbeing outcomes.

Improving the built environment is, therefore, arguably part of the solution to improved public health and wellbeing. Moreover, in England and Wales the National Planning Policy Framework (NPPF) calls for planning to promote healthy communities. This

short article discusses the potential and limitations of the current planning system in meeting the NPPF's call to create healthier places.

Unhealthy uses and restrictive policies

The proliferation and/or clustering of unhealthy uses has been highlighted in *Town & Country Planning* recently.[1] Many of our shopping streets, particularly those in poorer neighbourhoods that were once lined with grocers, butchers and bakers, have become dominated by fast-food outlets, betting and sub-prime financial services – among other potentially unhealthy uses such as tanning salons. There is a rapidly growing research base which links availability and access to these services

with consumption/use and, furthermore, to negative health outcomes. For example, while links have been notoriously difficult to establish, there is now good UK-based evidence that the proliferation of fast-food restaurants has had a detrimental impact on young people's dietary behaviour and is linked to obesity levels in older children.[2,3]

Proximity and access have been linked to other potentially unhealthy uses, for example gambling. Here, international research has suggested that gambling facilities often locate in more deprived areas of cities. Close proximity is linked to use, to problematic gambling, and by the same token to mental and physical health issues, since it is often linked to other addictive behaviour such as drug and alcohol abuse.[4,5] Likewise, research has established links between sub-prime financial services, use and mental health issues.

Some local authorities have been developing restrictive policies to try to tackle the impact of unhealthy shops and services. For example, the London Borough of Barking and Dagenham's Supplementary Planning Guidance (SPG) on takeaways has been in place since 2010.[6] Such policies take four approaches:
● allowing outlets only in certain locations;
● restricting concentrations and clustering;
● restricting proximity to other uses (for example children's centres, schools, parks, etc.); and
● clamping down on 'back door' applications (for example refusing A3 restaurant applications which are thinly disguised A5 takeaways).

Evidence of the effectiveness of these policies is, however, mixed – particularly in relation to appeals. For example, a Planning Inspector overturned Islington Council's decision to refuse the conversion of a former public house to a takeaway restaurant, despite its proximity (130 metres) to a primary school. While noting that the borough had a high rate of childhood obesity, the Inspector reasoned that primary school children using the takeaway would be accompanied by an adult who would be able to 'guide food choices'. In another case the decision to refuse permission for a takeaway within a 400 metre exclusion zone around a school was also overturned. In this case the Inspector noted that there were already a number of existing hot-food outlets on routes around the school and was not convinced that this particular location would attract pupils from the identified school.[7]

These and similar cases underline the importance of the Planning Inspectorate (PINS) in the system; PINS's apparent lack of support for health-related planning policies is causing huge frustration among planning practitioners.

There are also other problems with these policies – for example, in relation to food outlets, dietetics experts have pointed out that many 'sit-down'

restaurants actually serve food that is as nutritionally poor as that served by many takeaway outlets. Other research has highlighted that children's consumption of sweets, fizzy drinks and salty snacks, which can be obtained from any corner store, can be as problematic as takeaway food.

In relation to other potentially 'unhealthy' uses, the debate about whether betting shops should have a use class of their own has been rumbling away since first proposed by the Portas Review. This would allow for the control of clustering and/or (co-)location. However, as discussed in *Town & Country Planning* recently,[8] the issue is far from straightforward, and refusing applications on the grounds of impact on local health may be difficult to uphold at appeal.

So while restrictive policies are helpful and send out the right messages, the Use Classes Order is really too blunt an instrument to tackle the problem: granting planning permission for food premises that reach certain nutritional standards, or financial services that sign up to certain codes of conduct, would be too complex and probably impossible to monitor.

One potential for restrictive policies is addressing cumulative impact – in other words the clustering or concentration of different uses that together may provide unhealthy environments. However, the evidence base on this is even less developed than those addressing specific uses in isolation, and more evidence is needed.[1]

Proactive planning

More proactively, planning should seek, where possible, to promote environments that support healthy behaviour. One avenue that appears to have much promise is encouraging active travel (walking and cycling) as part of people's everyday routines, since exercise is key to physical and mental health and currently only a fraction of UK adults meet exercise guidelines. There have been a raft of studies (mostly in the USA and Australia) that have associated certain built environment features with active travel – higher residential density, mixed land use, high levels of street connectivity, a safe and attractive public realm, and access to green space or the presence of vegetation.[9]

Unfortunately, translating this knowledge into policy that can be used to guide development is not necessarily straightforward, and the research base, though large, has many gaps and uncertainties. For example, how much green space is enough, what mix of uses is ideal, or just how connected street networks have to be to encourage more walking are all factors that are either unknowns or disputed. Moreover, although mixed land uses may promote active travel, if too many of the unhealthy uses outlined above are present this may counteract healthy outcomes.

What we do know, however, somewhat depressingly, is that particularly in our suburban areas more recent development (that developed over the last 20-30 years) is *more* car dependent and promotes less walking than older development.[10] Acting on what evidence we have is crucial, and therefore promoting a highly-connected, high-quality public realm, ensuring sensible amounts of usable green space are included in developments, and promoting facilities for cycling are all important.

There is potential here for the greater use of Health Impact Assessment (HIA) – this has been shown to have a positive impact on outcomes when used early in the planning process, and, although full HIA will only be used for major projects, more light-touch versions might be developed for smaller-scale development.[11] Another potential way forward is the use of the Community Infrastructure Levy (CIL) to directly address local health issues – for example through the provision of green space where it is lacking.

What needs to change?

While the evidence base is admittedly imperfect, the built environment generally lasts over decades and therefore impacts on the lives of generations of communities. The planning profession therefore needs to act now.

Location is an important factor in the built environment-health equation. The new public health responsibility for local authorities presents an opportunity for planners and public health organisations to focus on local health priorities. It also provides an opportunity to identity suitable natural experiments which will vastly improve the evidence base – this is desperately needed.

Where local health and wellbeing objectives are identified, policies to address them need to be built in to core documentation. The existing SPGs on issues such as hot-food takeaways are an encouraging start, but much more can be achieved.

More generally, the professional bodies should encourage the positioning of health and wellbeing at the centre of planning by, for example, acknowledging developments that achieve improved health and wellbeing objectives – much in the same way as environmentally sustainable developments are given high profiles.

Some in the profession might argue that tackling obesity, gambling addiction or poor mental health induced by indebtedness are problems beyond the scope of planning, and that planning policies will always be ineffective in addressing them. However, this line of argument misses the point. The core purpose of planning is to provide places for human flourishing. This will not happen if the places we build constrain the lives of people, provide barriers to healthy living, and/or expose communities to the deleterious effects of unhealthy shops and services.

Of course human health and wellbeing has to be balanced against other aspects of sustainability. However, contemporary unhealthy lifestyles are leading to earlier mortality and shorter lives with often debilitating illness – planning and planners have to face up to their responsibility to address these issues.

● *Dr Tim G Townshend* is Head of the School of Architecture, Planning and Landscape at Newcastle University. The views expressed are personal.

Notes

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lies, damned lies and… a qualitative evidence review?

Hugo Crombie considers how to go about increasing our understanding of 'what works' in improving public health in the 21st century

The history of public health is inextricably linked with our understanding of the influence of places, and the environment in which we live, on health. Its UK origins lie in attempts to address the crowded squalor of cities in the 19th century caused by industrialisation and urbanisation. One of the earliest pioneers of public health and the science of epidemiology was Dr John Snow. He identified a link between cases of cholera and the use of a particular well in Soho. Despite a very incomplete understanding of the cause of cholera (the germ theory of disease was yet to be developed), he successfully petitioned to have the well's pump handle removed, preventing its use and the further spread of the disease among the community.

Snow's pioneering work showed how inner-city overcrowding, lack of safe water and food and inadequate sanitation led to disease and epidemics spreading rapidly through communities. In response, advances in housing, hygiene, water and sewerage systems led to dramatic changes in the health of the population and reduced deaths from infectious diseases. Infectious diseases became less of a scourge, and attention turned to personal prevention and treatment of disease with new drugs such as insulin and antibiotics.

Today's public health movement is very different. Many of the health concerns of countries in the developed world, such as the UK, are related to behavioural factors. Coronary heart disease, diabetes, stroke and cancers are linked with a range of factors, in particular smoking, diet, physical inactivity and alcohol. *The Lancet's* analysis of the Global Burden of Disease Study (2010) in 2013[1] found that the contribution of individual risk factors to the burden of illness and disease in the UK was highest for tobacco (12%). This was followed by

high body-mass (9%) and then physical inactivity, alcohol and poor diet (5% each). While all these factors relate directly to the individual, they are also influenced by wider societal and economic considerations.

To illustrate the impact of external factors and socio-economic considerations on a person's health, public health specialists often refer to a socio-ecological model proposed by Dahlgren and Whitehead, and adapted more recently by Hugh Barton and Marcus Grant at the University of the West of England (see Fig. 1). This model places the individual at the centre, together with personal influencing factors, such as genetic inheritance and age. Outside of these 'inherent' factors the model shows a range of factors that can influence health – both directly and as a result of individual behaviour.

What does NICE say?

Since NICE – the National Institute for Health and Care Excellence – took on its public health remit in 2005, it has published a number of guidelines which look at the external influences on individual behaviour and how they might be modified to improve health. Some of these guidelines (such as *Physical Activity and the Environment*[2]) are focused directly on how places can influence behaviour known to have an impact on health. Others (such as *Walking and Cycling*[3]) take a wider view on influencing specific behaviour. NICE has also produced guidelines that look at risk factors for diseases such as obesity and cardiovascular disease.

Other NICE guidance has looked at how features of the built environment influence road injuries (*Preventing Unintentional Road Injuries among Under-15s*[4]). This has a wider impact as the risk of injury is a significant influence on people's decisions
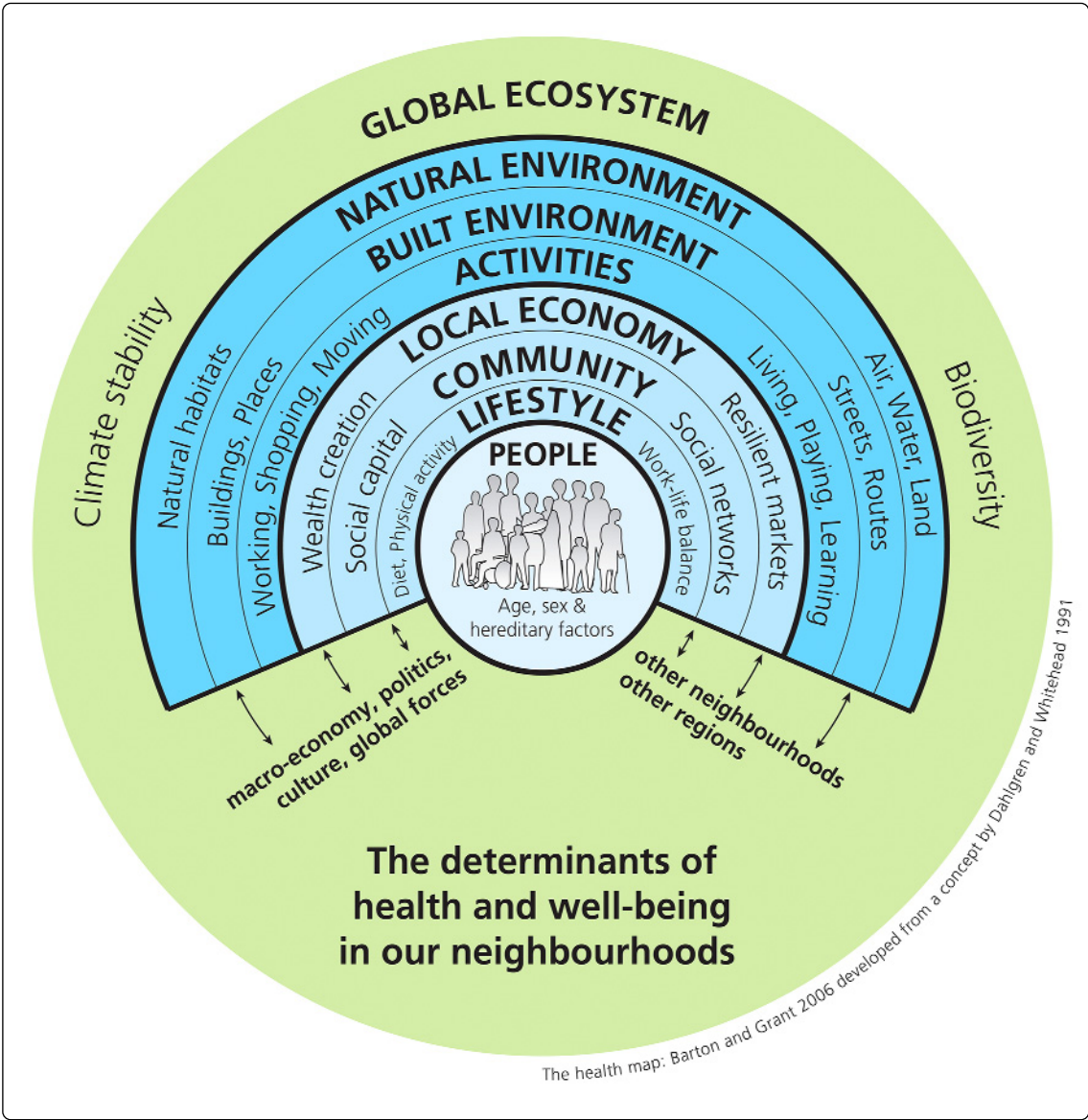
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Fig. 1 The health map – an individual's neighbourhood includes a number of factors that will influence their health and wellbeing

Source: H. Barton and M. Grant: 'A health map for the local human habitat'. *Journal for the Royal Society for the Promotion of Health*, 2006, Vol.126 (6), 252-3. Developed from 'The main determinants of health' model, formulated by G. Dahlgren and M. Whitehead (1991) – see G. Dahlgren and M. Whitehead: *European Strategies for Tackling Social Inequities in Health: Levelling Up Part 2.* World Health Organization Europe Region, 2007. www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf

on whether to walk or cycle. NICE has also begun work on guidance that looks at excess winter deaths and the impact of housing on cold and ill-health.

These guidelines all analyse the evidence of effective interventions to improve individual health and make recommendations for policy-makers, service providers and public health practitioners to take action. These actions vary from considering the impact of local policies (such as decisions on urban planning which enable people to get around in more 'active' ways such as walking or cycling) to the design of working and living spaces that can encourage healthy living and physical activity.

NICE is also exploring the possibility of future work on air pollution and the importance of green spaces for health. Public health topics that NICE intends to develop are included in the Quality Standards Topic Library.[5]

The complexity of developing evidence-based guidance

While the role of NICE is to develop guidelines on the prevention of ill-health and the promotion of health based on the best available evidence, this can sometimes be misunderstood to mean a reliance exclusively on randomised controlled trials (RCTs). RCTs are used to minimise bias and to identify the impact of an intervention on a specific outcome. However, in many circumstances they may not exist to support a particular intervention and may not be appropriate. Where a small effect is seen across a very large population, the size of an RCT may make it effectively impossible to carry out. Similarly, where the intervention involves, for instance, the redesign of an urban neighbourhood, an RCT design may not be possible.

Interventions may also be put in place for reasons other than to achieve a potential health benefit, and so may be evaluated from a different perspective. For instance, data on travel patterns might include walking and cycling, which is likely to provide important information for any assessment of the physical activity of a population. However, from a

'Although interventions might have a small impact on an individual level, they can deliver significant change at population level. The problem is that the interventions may have a weak evidence base in conventional terms. Therefore other ways of assessing their value need to be considered'

transport or urban planning perspective the key issue might be the modal share between different forms of transport (car or cycle, for instance). An evaluation would then need to be devised to see how that modal share changes and the change in the numbers of journeys by foot or by bike. From a public health perspective we would want to know how this has changed an individual's level of physical activity – so we would need to know who changed their travel behaviour and what were the possible unintended consequences. For example, has changing from driving to work to cycling stopped that person doing other exercise – or has it encouraged them to cycle more in other areas of their life, such as for shopping trips or recreationally?

Although interventions might have a small impact on an individual level, they can deliver significant change at population level. The problem is that the interventions may have a weak evidence base in conventional terms. Therefore other ways of assessing their value need to be considered. Evidence about the theoretical link between the intervention and its outcome, as well as knowledge derived from natural experiments, observations and experience, will need to be brought together to identify the likely effect of a proposed intervention. If a positive effect is the likely outcome, the key question for NICE is whether it is cost effective and a good use of public money.

Key to how NICE makes decisions are transparency and openness about our process, and a willingness to incorporate new developments in the evidence and review the impact on population health. Working with organisations like the TCPA and Public Health England is very important in ensuring we capture all relevant evidence and take new developments into account.

● *Hugo Crombie is an Analyst at the Centre for Public Health, National Institute for Health and Care Excellence (NICE). The views expressed are personal.*

Notes

1 C.J.L. Murray *et al.*: 'UK health performance: findings of the Global Burden of Disease Study 2010'. *The Lancet*, 2013, Vol. 381 (9,871), 997-1020. doi:10.1016/S0140-6736(13)60355-4. www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60355-4/fulltext#article_upsell

2 *Physical Activity and the Environment*. NICE Guideline PH8. National Institute for Health and Care Excellence (NICE), Jan. 2008. www.nice.org.uk/guidance/ph8

3 *Walking and Cycling*. NICE Guideline PH41. National Institute for Health and Care Excellence (NICE), Nov. 2012. www.nice.org.uk/guidance/ph41

4 *Preventing Unintentional Road Injuries among Under-15s*. NICE Guideline PH31. National Institute for Health and Care Excellence (NICE), Nov. 2010. www.nice.org.uk/guidance/ph31

5 Available at www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards-/Quality-standards-topic-library

planning – a powerful tool for reducing health inequalities

Health inequalities are an important and significant challenge which cannot successfully be addressed by the healthcare sector alone – planners have a unique and powerful contribution to make in co-ordinating actions across relevant sectors and professions to improve public health and reduce inequalities, says Jessica Allen

The most recent health data, from 2010-12, shows that average life expectancy continues to increase in England. For women, life expectancy at birth is 83, an increase of 0.5 years compared with 2008-10 data. For men, life expectancy at birth has risen to 79.2, an increase of 0.7 years on the 2008-10 figures.[1] However, widespread health inequalities persist. On average, the estimated difference in life expectancy between the most and least deprived areas in England is 6.8 years for females and 9.2 years for men.

But inequalities in life expectancy and health are not just confined to differences between the most and least deprived in society: they exist for everyone, to some extent – at least for all those below the very top of the socio-economic distribution. There are 36 local authority areas with a male life expectancy gap of 10 years or more, and eight local authority areas with a gap of 10 years or more for females. Fig. 1, which presents the latest data by Index of Multiple Deprivation decile, shows clear inequalities in life expectancy across the whole population, related to levels of area deprivation.

Healthy life expectancy – i.e how long one can expect to live in good health – also shows clear inequalities across the whole population. The 2010-12 figures showed that, on average, women expect to live until 64.1 years of age in good health,

with substantial local variation. In Manchester women can only expect to have 55.5 years in good health, compared with 71 years in Wokingham. Men can, on average, expect to live in good health until 63.4 years, an increase of 0.1 years from 2009-11. But again, there is substantial local variation: in Tower Hamlets men can expect to live to just 52.5 years in good health, compared with 70 years in Richmond upon Thames. For men, there is an estimated 17.5-year gap between the area with the best healthy life expectancy and the area with the worst, and for women a 15.5-year gap.

Clearly, health inequalities remain a significant and pressing challenge in England. Reducing them is a complex and challenging task which cannot be achieved by the healthcare sector alone. In fact, evidence shows that most of the reasons for poor health and health inequalities lie outside the remit and ambit of the healthcare sector. The social determinants of health – the conditions which influence our daily lives – include income, social protection, environmental conditions, education, gender equity, housing, quality of neighbourhoods, and community, political and cultural conditions. Such factors and their impacts have been considered in the Marmot Review[2] and in many other evidence reports.
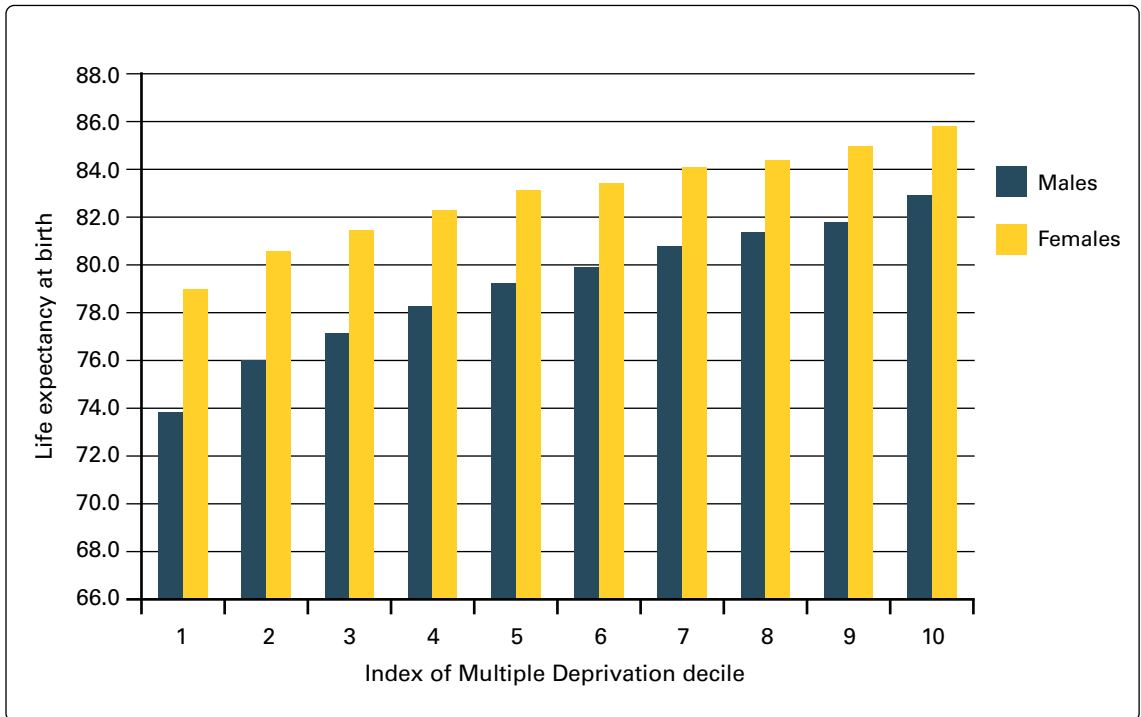
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Fig. 1 Life expectancy at birth 2010-12, by Index of Multiple Deprivation decile
1 = the most-deprived 10% of areas; 10 = the least-deprived 10%
Source: Office for National Statistics annual death extracts, 2014

In order to reduce health inequalities locally, action must be taken across a range of sectors, including public health, social care, housing, education, children's services, and planning. Effective planning for healthy places can make significant and unique contributions to improving health and reducing health inequalities, and there are some excellent examples of where this has been done effectively.[3]

As the causes of health inequalities lie in wide social and economic spheres, they do not fit neatly into one sector, or into one area of professional responsibility. Action must therefore be multi-faceted, involving close collaboration across various professions and sectors. Planners have an important role in co-ordinating actions across relevant sectors and professions, such as education, housing, transport and health, and in ensuring that health equity is embedded throughout local systems.

Since 2010, the UCL Institute of Health Equity (directed by Michael Marmot) has been working to embed social determinants of health approaches to reduce health inequalities in England and in other regions of the world. There have been encouraging developments, and many local authorities have prioritised the 'Marmot' approach – in fact more than three-quarters of English local authorities have

Joint Health and Wellbeing Strategies based on Marmot principles.

However, there are many challenges in prioritising and implementing effective social determinants programmes, including:
● financial pressures;
● the drive for short-term measurable outcomes;
● professional, organisational and budgetary silos;
● the pervasive notion that health is largely driven by healthcare and individual behaviour, rather than seeing behaviour as shaped by social determinants; and
● the nature of evidence on social determinants.

The remainder of this article briefly considers the role of good-quality evidence in ensuring that a social determinants approach is prioritised and in ensuring that action is effective and based on best practice. There are perceived issues related to the availability and appropriateness of evidence on social determinants which are often put forward as a reason for not taking action. Despite these perceptions, there is a strong evidence base and sound evidence about what to do and how to take effective action in tackling health inequalities through action on the social determinants of health. Certainly there is sufficient information to make the

case, even in a cost-constrained system, and certainly enough to drive and shape appropriate actions:

● *First, evidence about how planning can produce healthy places and improve health equity:* A number of important reviews have synthesised the evidence on how planning systems can shape and influence places to become healthy in the broadest sense.[4,5] This would include, for instance, assessing plans for a new housing development to determine whether the design would enable or impede residents in increasing their physical activity levels, or widening their social networks; both of the examples would be supportive of a social determinants approach to tackling health inequalities.

● *Secondly, evidence about potential impact:* Such evidence is important, but it must also be practical for use by practitioners and professionals in their day-to-day roles. Evidence based on tried-and-tested approaches is particularly helpful and allows transfer of knowledge and practical experience. This type of evidence, while useful, is often lost and not widely shared or disseminated – often due to time and/or financial pressures, which may preclude recording and evaluation of activities at local level. Some of this evidence has been summarised in a report by the Marmot Review team looking specifically at urban planning,[5] and in a further report on interventions to improve use and access to natural spaces.[6]

● *Thirdly, making the cost case:* This type of evidence is always important, but increasingly so for local areas which are increasingly resource constrained and are having to assess the impacts of decommissioning existing services rather than commissioning new approaches. Health equity impact assessments would be helpful, particularly in combination with approaches which assess long-term health returns on investment, as well as overall impacts. Some important evidence on the return on investment in planning for health and health equity is already emerging.[7] Planning the built environment involves a number of organisational and professional sectors, and there are cost benefits to working jointly across sectors, bringing mutual benefits – so-called 'win-wins' – to all the sectors involved.

Planning is an important social determinant of health and can make a unique and powerful contribution to improving public health and reducing health inequalities. But public health evidence in the form which planners need is not always readily available – and there are gaps, particularly in practical examples and in evidence on cost benefits, both of which are of significance in securing prioritisation for action. While there is sufficient evidence to act on reducing health inequalities, a

greater evidence base needs to be built by researchers and public health agencies, in collaboration with planners and local authorities.

● *Dr Jessica Allen is Deputy Director of the UCL Institute of Health Equity. The views expressed are personal.*

Notes

1 *Marmot Indicators 2014*. UCL Institute of Health Equity, Sept. 2014. www.instituteofhealthequity.org/projects/marmot-indicators-2014

2 *Fair Society, Healthy Lives. The Marmot Review*. Strategic Review of Health Inequalities in England Post-2010. The Marmot Review, Feb. 2010. www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

3 *Healthy Urban Planning Checklist*. NHS London Healthy Urban Development Unit, Jun. 2013. www.tcpa.org.uk/data/files/Health_and_planning/Health_Phase_2/Healthy_Urban_Planning_Checklist.pdf

4 A. Ross, with M. Chang: *Reuniting Health with Planning – Healthier Homes, Healthier Communities*. TCPA, Jul. 2012. www.tcpa.org.uk/data/files/TCPA_FINAL_Reuniting-health-planning.pdf

5 I. Geddes, J. Allen, M. Allen and L. Morrisey (Marmot Review Team): *The Marmot Review: Implications for Spatial Planning*. UCL Institute of Health Equity, Apr. 2011. www.instituteofhealthequity.org/projects/nice-spatial-planning-and-health

6 J. Allen and R. Balfour: *Natural Solutions for Tackling Health Inequalities*. UCL Institute of Health Equity, Sept. 2014. www.instituteofhealthequity.org/projects/natural-solutions-to-tackling-health-inequalities

7 D. Buck: *Understanding the Economics of Investments in the Social Determinants of Health*. Health Equity Briefing 9. UCL Institute of Health Equity, Sept. 2014. www.instituteofhealthequity.org/projects/understanding-the-economics-of-investments-in-the-social-determinants-of-health

public health evidence to support transport planning

Adrian Davis considers ways – and the benefits – of providing evidence on the public health impacts of transport planning policy and decision-making
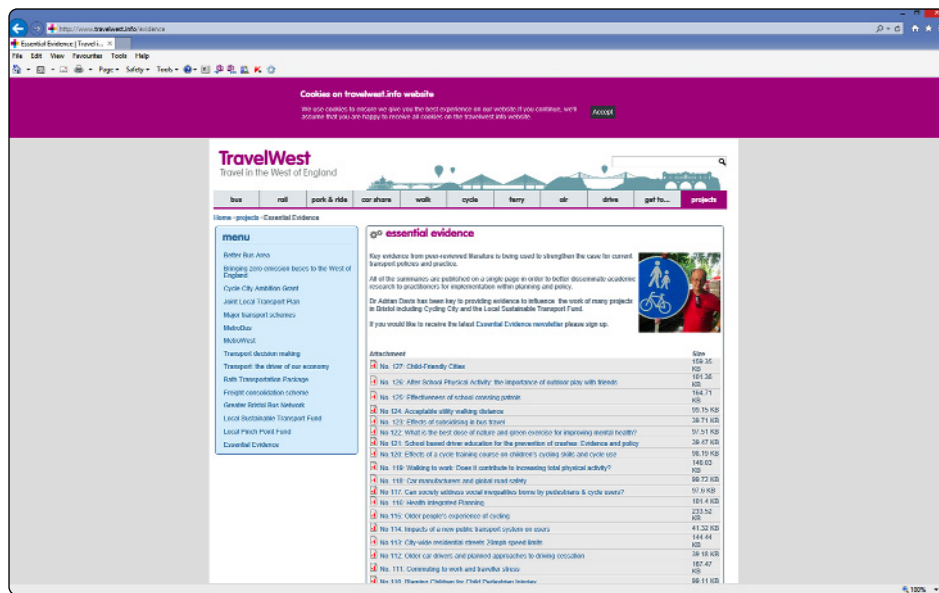
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'Essential evidence', available from the TravelWest website, at www.travelwest.info/ evidence – evidence-based public policy can be supported by using peer-reviewed evidence

One of the central offers from public health professionals as they rejoined local government in April 2013 was their proficiency in evidence-based practice and policy, drawing on methodologically robust peer-reviewed studies. Eighteen months into a new relationship with local government colleagues, many public health teams will still be assessing how 'evidence', as public health practitioners understand this term, can be used to guide non-public-health team work, if such an offer is welcomed.

Evidence-based public policy (EBPP) is a relatively new approach – many commentators remind us that the rise of evidence-based policy and practice was first attributed to medicine, and that evidence-based medicine became 'fashionable coinage' during the 1990s.[1,2] Adherence to the mantra of evidence-based policy and practice has now spread across most, if not all, areas of European public policy.[3] In the UK, its application was significantly bolstered by the Labour Government of 1997-2010, at least in rhetoric, and

not least in the broader ambition to achieve social progress through the application of reason.

The challenge regarding evidence – and it is a significant challenge – is that there is still a diverse pre-existing stock of 'evidence' drawn on by professions which arguably does not measure up well with the ambitions of those who pioneered EBPP. As Rychetnik and Wise note:[4]

'... concepts of evidence vary among professionals, disciplinary and social groups: for example, scientists have traditionally adopted different standards of evidence to lawyers. Since the advent of evidence based medicine in the early 1990s, health professionals, managers and consumers have been debating (and negotiating) what is considered as valuable and credible evidence to support decisions about health services, public health, health promotion and health policy.'

A recent snap-shot survey of a small number of built environment and public health professionals, as indicated by their institution, suggested that 'evidence' is sought and gained from diverse sources (see Fig. 1), most of which are not peer-reviewed.[5] Earlier research surveying transport planners also reported

From where do you currently seek evidence in support of your work?

■ Academic journals
■ Journals and newsletters from professional bodies

Professionals, by institution membership
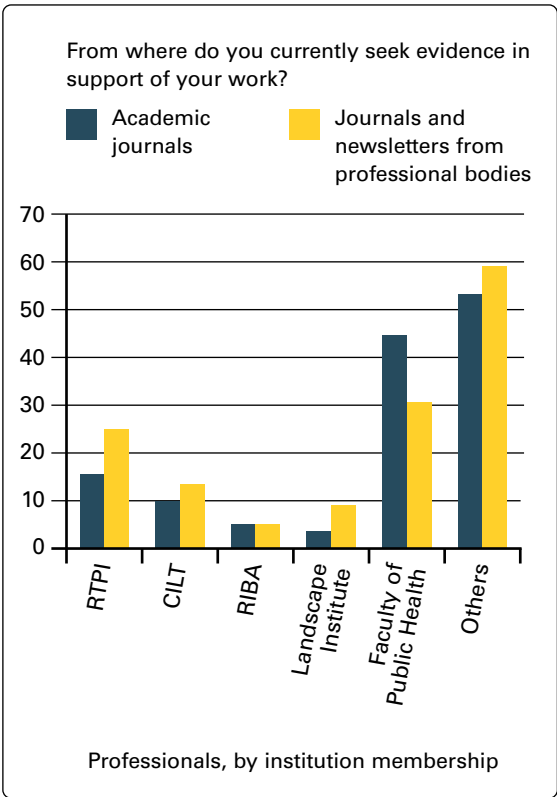
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Fig. 1 Snapshot survey of built environment and public health professionals on the frequency of use of sources of evidence to support their work

that knowledge was accessed largely through trade magazines and non-peer-reviewed journal articles.[6] But if we consider evidence as requiring strict methodological rules to reduce bias (for example author and study design bias), then local authority transport planning often falls short of the mark, although, here, as a profession planners are far from being alone. So, while, to some, evidence is understood as a central pillar of public policy decision-making, for others evidence may be considered more of a second-order consideration once the policy direction has been decided. As a World Health Organization report on governance has noted, evidence and expert advice are only one element of the co-production equation.[7]

More broadly, and as repeatedly and cogently argued in peer-reviewed literature, evidence is socially constructed.[8,9] Within academia and the urban development and management professions we may distinguish competing epistemologies as a cause, but ultimately, in wider society, the conflict over what is considered legitimate evidence is also based on differing ontological positions. This provides a pragmatic starting point since it gives rise to questions that need answering if public health and transport planning are to work in concert. What is accepted as evidence? How much is evidence valued? And how does this differ between these professions? Differences can often create barriers to successful collaboration.

My own first-hand experience comes as a public health specialist in transport planning embedded into Bristol City Council's transport policy team since 2008. My approach has partly been to translate bite-sized amounts of peer-reviewed evidence, often with the aim of strengthening the case for work that is already being progressed as a result of identifying health benefits, including the quantification and distribution of such benefits. One of the most visible manifestations of my translational work is the Essential Evidence on a Page series:[10] since 2009 I have been selecting topical transport issues or concepts, identifying robust peer-reviewed papers, and then distilling key findings into a one-page, de-jargonised format. To my initial surprise, the series has proved popular and is now subscribed to (free of charge) by over 1,000 people, over half of whom are from outside Bristol (the original target audience being the Council's transport and urban environment planners).

Another example of a public health evidence-based approach in Bristol is provided by the selection of local road safety measures by lay people. As part of localism, more power and a greater budget has been devolved to lay people involved in planning and managing their neighbourhoods. Bristol City Council's Traffic Choices website[11] provides research evidence, in lay language, on the effectiveness of different types of road safety interventions (such as

road crossings – Puffin and Zebra, for example), their advantages, the restrictions upon them, and rough costs. The aims of the website are to facilitate better-informed discussions with Council staff, to speed up scheme identification through prior learning via the website, and to help manage public expectations of what can be achieved through specific interventions. Other highway authorities are approaching Bristol City Council with a view to partnering with Bristol to develop their own versions of Traffic Choices.

I remain acutely aware that peer-reviewed evidence has no particular standing within local authority transport departments, which are subject to many pressures to implement particular interventions, irrespective of what any peer-reviewed evidence demonstrates. Politics and power take the lead in determining what and how evidence is used. It is nonetheless vitally important to provide robust evidence, given limited budgets, of just what the most effective interventions are, both for population health and for key transport objectives. This can be highly effective not only in winning funding bids, but ultimately in saving the local authority money.

A coda: My role as a Visiting Professor at the University of the West of England is noted below the signature on my Bristol City Council emails. Only recently have some of my Council transport planning colleagues told me that they had understood this to mean that I am a professor who is visiting them in the City Council. I much prefer this interpretation as it supports my attempts to be a conduit for knowledge exchange. It reminds me of Wulf Daseking, former Director of City Planning for Freiburg, who, speaking at the 2014 Academy of Urbanism Congress as part of Bristol's Festival of Ideas, said:[12]

'What is the point of universities that are just castles in the sky? The University people must have contact every single week with their City Hall.'

● **Dr Adrian Davis** *is Public Health and Transport Consultant at Bristol City Council. The views expressed are personal.*

Notes

1   C. Pope: 'Resisting evidence: the study of evidence-based medicine as a contemporary social movement'. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine*, 2003, Vol. 7 (3), 267-82

2   W. Parsons: 'From muddling through to muddling up – evidence based policy making and the modernisation of British Government'. *Public Policy & Administration*, 2002, Vol. 17 (3), 43-60

3   C. Autant-Bernard, M. Fadairo and N. Massard: 'Knowledge diffusion and innovation policies within the European regions: challenges based on recent empirical evidence'. *Research Policy*, 2013, Vol. 42 (1), 196-210

4   L. Rychetnik and M. Wise: 'Advocating evidence-based health promotion: reflections and a way forward'. *Health Promotion International*, 2004, Vol. 19 (2), 247-57

5   A. Davis, H. Lease and M. Grant: *Scoping Study for a 'Healthier Places Responsive Service'*. University of the West of England, for Public Health England, 2014

6   H. McClintock: 'Practitioners' take-up of professional guidance and research findings: planning for cycling and walking in the UK'. *Planning Practice & Research*, 2001, Vol. 16 (2), 193-203

7   *Governance for Health in the 21st Century: A Study Conducted for the WHO Regional Office for Europe.* 61st Session. WHO Regional Committee for Europe. World Health Organization, 2011. www.euro.who.int/__data/assets/pdf_file/0010/148951/RC61_InfDoc6.pdf

8   N. Krieger: 'The making of public health data: paradigms, politics, and policy'. *Journal of Public Health Policy*, 1992, Vol. 13 (4), 412-27

9   J.J. Chan and J.E. Chan: 'Medicine in the millennium: the challenge of postmodernism'. *Medical Journal of Australia*, 2000, Vol. 17, 332-4

10 Documents in the Essential Evidence on a Page series are available at www.travelwest.info/evidence

11 The Traffic Choices website is at www.trafficchoices.co.uk

12 W. Daseking: 'Learning from Freiburg – towards a greener urbanism'. *eg Magazine*, 2014, Vol. 19 (6), 12-15. www.globaltolocal.com/eg19_6.pdf

public health evidence to support green infrastructure planning

Rachel Penny outlines sources of evidence for planners and health professionals on the health benefits of green infrastructure, together with sources of tools and good practice examples

Green infrastructure is defined in the National Planning Policy Framework as 'a network of multi-functional green space, urban and rural, which is capable of delivering a wide range of environmental and quality of life benefits for local communities'.[1] These networks of green places, features and links provide a broad range of services, almost all of which have implications for people's and communities' health and wellbeing. Green infrastructure helps in:

- adapting to and mitigating climate change and extreme events, through, for example, flood attenuation, urban cooling, and locking up carbon;
- reducing air, water and noise pollution;
- providing spaces for play, exercise and relaxation, bringing health and social benefits;
- increasing community cohesion – boosting social interaction, civic pride and a sense of belonging;
- providing economic benefits – through tourism and leisure uses, by reducing ill-health and its costs to the health service, and by increasing property values and inward investment;
- delivering networks for walking and cycling, greening transport corridors, and connecting home, school, work and leisure;
- delivering high-quality and distinctive places which reflect local landscape character and design;

- enhancing habitats and increasing ecological connectivity, providing opportunities for people to connect with nature and learn in the natural environment; and
- providing spaces for local food production and for people to connect through growing and farming.

Effective networks of green infrastructure in liveable, healthy towns, cities and villages do not happen by accident, but need careful planning, management and investment. Here, planners and health professionals have key roles to play within collaborative partnerships. The rewards of such collaborations will be great, as evidence shows that investment in green infrastructure and the natural environment delivers multiple benefits to society, often at lower cost and delivering higher savings than other interventions.

The benefits and services provided by green infrastructure are now widely understood and backed by good evidence. Practitioners' focus can now turn to *using* this evidence – taking advantage of recent work to synthesise, signpost and demonstrate the application of that evidence in decision-making, rather than asking for more. Accordingly, some authoritative summaries of

Will Cousins

Above

The health benefits of high-quality green infrastructure are now well documented – practitioners' focus can now turn to using this evidence

evidence for planners, health professionals and others are set out below:

● The National Ecosystem Assessment Follow-On (NEAFO) was launched in June 2014 and builds on the work of the National Ecosystem Assessment in 2011. Chapters 23, 16 and 10 of the initial National Ecosystem Assessment report are particularly useful (see http://uknea.unep-wcmc.org).

● The Parliamentary Office for Science and Technology's POSTNote 448 summarises research evidence on the effectiveness of (urban) green infrastructure and challenges to its implementation (see www.parliament.uk/briefing-papers/POST-PN-448/urban-green-infrastructure).

● UCL Institute of Health Equity's September 2014 Local Action on Health Inequalities series of evidence reports, commissioned by Public Health England (PHE), set out practical, local actions to tackle health inequalities by addressing the social determinants of health. They include evidence, practical points and case studies on approaches and actions (such as improving access to green spaces) that can be taken by local authorities (see www.instituteofhealthequity.org/projects/local-action-on-health-inequalities-series-overview).

● Furthermore, in October 2014 the UCL Institute of Health Equity published *Natural Solutions to Tackling Health Inequalities*, commissioned by the National Outdoors for All Working Group, which includes Natural England (see www.instituteofhealthequity.org/projects/natural-solutions-to-tackling-health-inequalities).

● The *Microeconomic Evidence for the Benefits of Investment in the Environment 2* (MEBIE 2) report assesses the evidence for investment in the natural environment across a wide range of themes, including economic growth, benefits for human health and wellbeing, social cohesion, and resilience to climate change. Launched by Natural England in June 2014, the evidence set out meets central government standards for decision-making (see http://publications.naturalengland.org.uk/publication/6692039286587392).

● The TCPA's publications and resources on health and planning (at www.tcpa.org.uk/pages/health.html) and the Spatial Planning and Health Group resources (at www.spahg.org.uk/) are useful sources of evidence.

The goal of integrated decision-making in spatial planning and public health is greatly advanced when

planners and public health and environment professionals share evidence and collaborate on each other's plans, strategies and case work. Local authorities in Bristol, Liverpool, Stockport and elsewhere follow protocols to improve the quality of inputs from public health into development management and forward planning.

In Liverpool, health commissioners have helped to pay for spatial and data analysis to feed into green infrastructure planning, Local Plan evidence and planning policies (see www.merseyforest.org.uk/our-work/liverpool-green-infrastructure-strategy/). This was followed up by the substantial Natural Choices for Health and Wellbeing programme of health delivery projects (see www.merseyforest.org.uk/our-work/natural-choices-for-health-and-wellbeing/). And collaboration between planning, public health, leisure and green infrastructure colleagues at Central Bedfordshire Council has led to the production of a detailed Leisure Strategy, which will be adopted as Technical Guidance under the Development Strategy (see www.centralbedfordshire.gov.uk/leisure/sports-clubs-andcentres/leisure-strategy.aspx). This includes detailed local standards for green infrastructure provision for health under the Community Infrastructure Levy (CIL) or section 106 agreements, based on sound spatial and other evidence and extensive residents' surveys.

'Investment in high-quality, well planned and managed green infrastructure is now an essential part of infrastructure planning for healthy, liveable communities. Let's collaborate across our different sectors and move from policy to delivery '

Other examples of good practice are the inclusion of Health Impact Assessments (HIAs) as part of a suite of environmental, sustainability, equality etc. assessments of the impacts of an authority's policies and plans (see Public Health England's HIA Gateway, at www.hiagateway.org.uk, for resources and best practice examples).

Planners can find data on the health of their local populations through a series of useful tools giving information on how to research the health challenges and statistics for their area:

- **Health profile data:** Public Health England's Health Profiles for 2014 are available for every local authority area in England – an invaluable resource from the previous Public Health Observatories, now part of PHE (see www.apho.org.uk/default.aspx?RID=49802).

- **Local health:** A recent addition, also from PHE, is health data given in even greater detail in the Local Health mapping tool (see www.localhealth.org.uk/#v=map4;l=en). Indicator data is available for all wards, middle level super output areas (MSOA Census) and Clinical Commissioning Group areas, along with data for upper- and lower-tier local authorities in England.

- **Health and Wellbeing Board priorities across England:** The Local Government Association's (LGA's) interactive map of Health and Wellbeing Board priorities across England allows users to search the priorities of Health and Wellbeing Boards across England, as well as view Joint Health and Wellbeing Strategies and Joint Strategic Needs Assessments for each area. Users can also explore data reports containing key measures at local authority and ward levels (see www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56/10180/6111055/ARTICLE). Other LGA tools and support for health and wellbeing can be found at the LGA's 'Health and wellbeing systems' webpages (see www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56).

Public health professionals and commissioners should collaborate with planners, green space and environment managers and their communities in determining the best approaches to use in tackling local health challenges.

In the face of the looming health and health funding challenge, evidence shows that natural environment and nature-based programmes and therapies are efficacious and cost-effective ways to help tackle some health conditions, develop resilience and contribute to wellbeing. There should be a greater focus on the natural environment in Joint Health and Wellbeing Strategies and in decisions on commissioning. Use of the environment for health and exercise can be monitored via Indicator 1.16 in the Public Health Outcomes Framework, which measures the percentage of people using outdoor places for health/exercise reasons (see the Department of Health's interactive Public Health Outcomes Framework webtool at www.phoutcomes.info/ and search under the 'Wider determinants of health' section). Indicator 1.16 is also included as one of the suite of 15 Marmot (health inequality) indicators, launched in September 2014 (see www.instituteofhealthequity.org/projects/marmot-indicators-2014).

Birmingham City Council is one authority where green infrastructure is well embedded within its public health investment and programmes – through its Active Parks initiative, for example. Innovative work on commissioning therapies such as care farming, walking for health, ecotherapy and green exercise is being established in Cornwall, North West/Mersey Forest and elsewhere, but there is

more to be done to scale up from small commissioning pilots.

Other useful online tools available to demonstrate the economic value of green infrastructure and its contribution to health and wellbeing include the following:

● **Green Infrastructure – Valuation Tools Assessment:** Natural England's *Green Infrastructure – Valuation Tools Assessment* draws together a number of the most widely used economic valuation tools and assesses them against research standards for natural science and economics (see http://publications.naturalengland.org.uk/ publication/6264318517575680?category=39013).

● **Tools to help better planning of walking and cycling:** The National Institute for Health and Care Excellence (NICE) Pathways tool is an online resource for health, social care, planning and other professionals that brings together all related NICE guidance and associated products in a set of interactive topic-based diagrams (see http://pathways.nice.org.uk/ – 'Walking and cycling'). Also useful is the well regarded World Health Organization/Europe Health Economic Assessment Tool (HEAT) for walking and cycling, updated in August 2014 (see www.heatwalkingcycling.org/).

● **Improving the Public's Health – A Resource for Local Authorities:** The King's Fund's *Improving the Public's Health – A Resource for Local Authorities* brings together a wide range of evidence-based interventions on 'what works' in improving public health and reducing health inequalities (see www.kingsfund.org.uk/ publications/improving-publics-health). Aimed at Health and Wellbeing Boards and local authority departments, it presents the business case in nine key areas, including access to green and open spaces and leisure (directly available at www.kingsfund.org.uk/sites/files/kf/field/field_ publication_file/ improving-the-publics-health-kingsfund-dec13.pdf). It also signposts resources, evidence and case studies.

Investment in high-quality, well planned and managed green infrastructure is now an essential part of infrastructure planning for healthy, liveable communities. Let's collaborate across our different sectors and move from policy to delivery!

● *Rachel Penny is Senior Specialist (Health and Accessible Natural Environment) at Natural England. The views expressed are personal.*

Note

1 *National Planning Policy Framework.* Department for Communities and Local Government, Mar. 2012. Annex 2: Glossary. www.gov.uk/government/uploads/system/ uploads/attachment_data/file/6077/2116950.pdf

public health evidence to support planning for healthier eating

Nick Bundle outlines the findings of a review of evidence on public health and the 'food environment'

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Hot-food takeaways in Medway – research suggests that low-cost, high-energy food options such as these are contributing to the obesity problem

Efforts to tackle ill-health tend to focus on causes such as infectious diseases and unhealthy lifestyles, but achieving lasting improvements in the health of populations also requires a shift upstream to tackle the *causes of causes*. It is popular to blame the current obesity crisis on poorly informed individuals who make the wrong choices about food and physical activity. This view ignores those upstream factors, beyond an individual's control, which limit our ability to live healthily. The 2007 Foresight report, *Tackling Obesities: Future Choices*, attempted to map out the drivers of obesity according to the best evidence at the time, pointing to the 'food environment' as a key determinant of our food access and food choices.[1]

Public health is an evidence-based discipline, with much effort spent on the conduct and critique of research, but evidence is only of practical use if it

can be presented in a form that is useful to other professionals. Efforts were made by the public health team in Medway to do this. A desk review of evidence on obesity and the environment was carried out in late 2012,[2] leading to the development of close ties with the planning team and the backing of elected members. This article summarises findings and lessons from the process.

Food access through planning

Plausible mechanisms by which the planning system might influence the food environment were identified from Foresight's evidence-based map of obesity drivers. First, the control of unhealthy food and drink, such as through restrictions on hot-food takeaways, as covered comprehensively elsewhere.[3-5] Secondly, increasing the availability of healthy food and drink. Distribution of retail premises and supermarkets can impact local food availability, as can ensuring space for farmers' markets. Thirdly, increasing the opportunities for local food production, which can be affected by redevelopment of allotments and agricultural land.

The food environment, health and behaviour

International comparisons suggest that countries with higher densities of fast-food outlets have higher levels of obesity.[6, 7] However, reviews of studies conducted at smaller scales report conflicting findings on the fast-food/obesity association.[8, 9] Fast-food takeaways do tend to cluster around schools, and although it is not clear whether this itself increases consumption,[10] studies following children over time have found that those children who do consume fast food are more likely to become obese.[11]

There is good evidence that poverty and area deprivation act as barriers to purchasing fresh or unfamiliar foods.[12] More deprived groups have the highest levels of obesity[13] and are more likely to consume foods that are processed or high in fat or sugar.[14] More deprived neighbourhoods in the UK also have higher concentrations of fast-food outlets.[4] Targeting efforts in more deprived areas is therefore likely to have a proportionately greater impact on food access and obesity and so help tackle health inequalities.[12]

Overall, culture and habits may have a much stronger influence on eating patterns than spatial planning.[15] Community engagement is therefore very important to ensure that any proposed changes reflect the priorities, concerns and cultural differences of the affected population

What type of evidence?

As shown, academic evidence linking the built environment to diet and health is suggestive, but not conclusive, and questions about causality are likely to remain since controlled clinical trials in this

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Allotments – linking healthy weight to sustainable environments by providing opportunities for local food production

area are unfeasible. The work in Medway revealed that other types of evidence are also important, and can have a different value, depending on professional perspective.

Planning colleagues in Medway felt that existing public health policy could add more weight to planning considerations than an uncertain academic evidence base. This is because the process associated with policy-making adds robustness, and aligning decisions with existing policy demonstrates a willingness to balance potentially competing interests, such as health and economic growth.[16, 17] Locally, Medway's Joint Health and Wellbeing Strategy commits to shaping the environment to make healthier choices easier. The national 'call to action on obesity' links healthy weight to sustainable environments, such as food growing in allotments.[18] Relevant guidance from the National Institute for Health and Care Excellence (NICE) promotes partnership with planners as part of a multi-stakeholder approach to tackling obesity.[19]

'Practice-based' evidence, in the form of case studies from areas that have already attempted similar work, also turned out to be valuable. Good practice has emerged only recently, and there have been very few attempts to formally evaluate its impact on obesity. Sitting near the bottom of an established 'hierarchy of evidence', case studies can be overlooked by public health professionals. However, best practice examples were found to be a compelling way to demonstrate how the planning system can contribute to a healthier local environment. They also helped to identify where partnerships between public health and planning had succeeded. Accordingly, a policy review exercise initially conducted in Luton helped to inform how the evidence gathered in Medway could be put to use.

Putting evidence into practice

Evidence identified from the desk review was used to inform a joint review of local planning policies. The aim was to identify opportunities to promote access to food and physical activity through existing policy. The first output was a guidance note for planners on hot-food takeaways, adopted by Medway Council in July 2014, following public consultation.[20] This forms part of, and has helped to inform, a broader local obesity agenda, which also uses evidence from Foresight as the basis for local action.[21, 22]

Although it is unlikely to significantly impact local obesity rates, planning guidance on takeaways sends the right message. It was also felt to be a 'quick win', paving the way for more substantive work to embed public health within the new Local Plan. Additional evidence reviews will be required to inform this, but with an established process, partnerships, political support and appointment of staff to drive the process, firm steps have already been taken in the right direction. Sharing evidence in the right form can be a catalyst for successful partnerships and joint agendas on complex problems. Moving forward, partners should commit to performing well designed impact evaluations. Local interventions could then generate robust new knowledge, justifying investment decisions and making the search for good evidence that little bit easier.

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Notes

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3   *Using the Planning System to Control Hot Food Takeaways. A Good Practice Guide.* NHS London Healthy Urban Development Unit, Feb. 2013. www.healthyurbandevelopment.nhs.uk/wp-content/uploads/2013/12/HUDU-Control-of-Hot-Food-Takeaways-Feb-2013-Final.pdf

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8   L.K. Fraser, K.L. Edwards, J. Cade and G.P. Clarke: 'The geography of fast food outlets: a review'. *International Journal of Environmental Research & Public Health*, 2010, Vol. 7 (5), 2,290-308. doi:10.3390/ijerph7052290

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health impact assessment – where next?

Paul Johnson looks at the developing practice of Health Impact Assessment and at the current and anticipated future interaction with the EU Directive on Environmental Impact Assessment – and poses questions over the paucity of relevant guidance on health assessment for major developments

This Special Issue of *Town & Country Planning* is testament to the burgeoning interest in developing healthier places and ensuring that new developments, as well as policies and plans, contribute to positive health outcomes for affected communities. From the perspective of an environmental and planning consultancy practice, there is significant interest in the relationship between strategic plan production, the planning, design and implementation of urban and infrastructure developments, and the assessment techniques used to communicate environmental and health impacts to stakeholders and decision-makers.

EIA and HIA – integrated or confused?

Environmental Impact Assessment (EIA) and Health Impact Assessment (HIA) are used to support new development applications. However, the legislative status and best practice guidance for EIA and HIA differ greatly. Unlike HIA, the EIA process is long established in statute, case law and practice. Both are often produced in parallel, with overlapping reports made publicly available for decision-makers. Differences in the reporting of complex community health matters can lead to confusion and misunderstanding as to the nature and purpose of the two documents.

Health Impact Assessment

HIA is undertaken to predict the health implications for populations of implementing a plan, policy, programme or project, and in so doing to aid decision-makers. HIA should aim to enhance the potential positive aspects of a plan, policy, programme or project while avoiding or minimising any negative

impacts, with particular emphasis on disadvantaged sections of the communities affected.

In the UK, the HIA Gateway website,[1] maintained by Public Health England, provides an excellent resource for practitioners and those interested in HIA. Various guidance documents from the Department of Health, Health Scotland, the Wales Health Impact Assessment Support Unit, the National Mental Wellbeing Impact Assessment Collaborative and several regional Public Health Observatories and universities provide useful assistance in undertaking HIA.

However, there is no formally prescribed methodology for undertaking HIA for a major or indeed minor project. HIAs can be undertaken by anyone; there is no registration of qualified practitioners and no formal way of reviewing the quality of a published HIA. Into this space have stepped private consultants, often environmental/planning consultancies, but also specialist HIA practitioners. Different types of HIA can be produced, but most development proposal HIAs are 'prospective' (predicting future impacts) and are either 'rapid' or 'comprehensive', depending on the scale and nature of the proposed development.

HIA follows a similar process to EIA in that it involves screening, scoping, collection of an evidence base, community profiling, the use of consultation and steering groups, assessment, reporting, and provision of recommendations. Increasingly, HIA is used earlier in the project planning process to influence design and obtain better health outcomes. A mixture of qualitative and quantitative methods and data are used to obtain a holistic view of the

effects on communities. Where EIA is also being undertaken, this provides information on air quality, noise and socio-economic impacts, etc., all of which are often reflected in the HIA process.

An HIA, when undertaken in concert with EIA, is normally submitted as 'supporting documentation' to the formal Environmental Statement and its Non-Technical Summary required by legislation. This makes the HIA report something of a 'Cinderella' document – it may or may not be taken into account in the development consenting process. It is unclear as to the weight a local authority will place on the findings of an HIA submitted as part of a suite of application documents. Best practice is developing as published HIAs are made available on the HIA Gateway for other HIA practitioners to review and incorporate lessons learned in future projects.

EIA – changes are afoot

In contrast to HIA, EIA is enshrined in European and UK legislation via the EU EIA Directive. The EIA process has developed over time using guidance issued by central government and latterly by various institutes. EIA is mandatory for certain major developments and is undertaken routinely for many other major project categories listed in the EU Directive. The Institute of Environmental Management and Assessment (IEMA) takes the lead in registering EIA practitioners and awarding Quality Marks to registered organisations[2] such as Arup. The current

'The revised EU EIA Directive provides an opportunity for an integrated impact assessment to be undertaken, incorporating HIA... However, the mechanisms for dealing more comprehensively with health in EIA have not been tested'

EIA Directive requires that an EIA considers the likely significant effects of development proposals on the environment, and includes effects on 'human beings' in its list of matters to be addressed. This is usually undertaken through reference to standards to protect human health – on air quality, water quality, ground contamination, and noise and vibration, for example.

The IEMA *State of Environmental Impact Assessment Practice in the UK* report[3] found that of 100 randomly selected UK Environmental Statements submitted in 2010, 13% had a chapter on population/human beings and only 6% had a dedicated public health chapter. This compares with over 80% having chapters on ecology, noise, water, landscape, transport, heritage and soil.

The newly revised EU EIA Directive (2014/52/EU)[4] includes requirements to consider the direct and indirect significant effects of projects on 'population and human health' and the interaction with other factors listed, such as biodiversity, climate, and the landscape. It also requires consideration of the risks to human health due, for example, to accidents or disasters. There is as yet no guidance on how this would be undertaken, but it can be anticipated that all future EIAs will have sections specifically highlighting human health aspects.

What does this mean for HIA in the future?

The revised EU EIA Directive provides an opportunity for an integrated impact assessment to be undertaken, incorporating HIA within the EIA process. Provided this is undertaken thoroughly, then the EIA may be an adequate vehicle for consideration of the effects of projects on human health. However, the mechanisms for dealing more comprehensively with health in EIA have not been tested through practitioners' best practice, public consultation, the decision-making processes, or the courts.

Intense public scrutiny requires EIA to be objective, definitive and quantitative about impacts, mitigation and residual effects. HIA is much more of a subjective and qualitative process and currently does not lend itself well to specific predicted outcomes or levels of significance in terms of community health impacts. It may be that in the same way that Transport Assessment informs the findings of an EIA, then HIA may still be undertaken separately and the HIA findings used within the formal EIA documents.

Of course there will remain many smaller projects and plans for which EIA is not necessary but HIA is still required by the relevant authority. But questions still remain over who should undertake HIA, the appropriateness of available methodologies, the reporting of findings, and the weight applied by decision-makers to predicted health outcomes.

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Notes

1   The HIA Gateway website is at www.apho.org.uk/default.aspx?QN=P_HIA

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healthier places for real – how they did it, and the challenges for the UK

Hugh Barton examines the factors behind successful healthy places in continental Western Europe, and the currently missing ingredients needed to produce comparable UK examples

How do we know that a place is 'healthy'? It is notoriously difficult to prove that the physical environment in a particular neighbourhood or town results *directly* in better health – although evidence abounds about the links between place and health. We can establish that self-reported happiness (which impinges on health) is related not only to income, work status and family relationships, but also to the quality of place and services.[1] We also know the kind of places which give people healthy options, and lead to what we know from extensive research is healthy behaviour.[2,3]

The characteristics of a healthy urban environment are clean air and water, contact with nature, a wide choice of good-quality affordable housing, safe and convenient active travel networks, a full range of accessible local facilities, varied and safe opportunities for outside play, convivial meeting places free from excessive noise, and – overriding all of these – a location that gives excellent access to a wide range of jobs, high-level facilities and wider social networks without necessary recourse to the car.

In Britain in the last 20 years many new or renewed places have achieved some of these characteristics. *The Planner* recently identified two exemplars: East Village in London's Olympic Park,

and Govan in Glasgow.[4] Each person reading this article could name their own favourites. Such developments in Britain are typically inner-city renewal projects, comprising only small parts of a town or city-region that as a whole compromises health. Major new suburban extensions (and occasional new settlements) fail to achieve the kind of healthy travel behaviour or the level of housing choice achieved by the best European examples. No town or city in the British Isles begins to compete.[5] This article asks: what is it that makes the difference?

European best practice

Peter Hall has tackled this question in his book *Good Cities, Better Lives*.[5] His focus on 'urbanism' accords in practice with a focus on health and wellbeing. He studied cities and towns in Germany, France, the Netherlands, Sweden and Denmark, many of which have at some time been members of the World Health Organization (WHO) Healthy Cities network.

Malmö, at the southern tip of Sweden, has the impressive new quarters of Augustenborg and Bo01. Across the Øresund bridge, Copenhagen has transformed the feeling of the city for pedestrians

and cyclists, altering the behaviour of residents – so that 37% of journeys to work are now made by bike. In the Netherlands, Vathorst and Houten are new settlements within the orbit of existing cities and demonstrate most of the healthy place characteristics.

The WHO European Healthy Cities network had a Healthy Urban Planning Action Group during the 2000s. One of the places leading the way was the medium-sized town of Kuopio in Finland. Kuopio invented an appraisal tool and strategy based on progressively extending the 'walking fabric' and the 'transit fabric' of the city, eating away at the still dominant 'car fabric'.

In contrast to these examples, the technical and political commitment they demonstrate is difficult to replicate in Britain, for reasons that will be explained shortly.

The two cities that impressed Hall most, achieving superb-quality neighbourhoods within the context of coherent long-term sustainability strategies, were Stockholm in Sweden and Freiburg in South West Germany. Freiburg has not explicitly stressed health as its goal – rather it has aimed at liveability, quality of life and environmental sustainability, becoming known as the green capital of Germany, if not Europe. It is a place of pilgrimage for planners and city leaders from across the world.

'In Freiburg things which in Britain seem almost impossible to achieve – such as a first-class public transport service, diversity of housing provision, 'free-range' children, and community renewable energy schemes – are commonplace'

In 2008 and 2009 I joined the throng, leading a mixed group of chief public health officers and planners from South West England. What moved all the people who went was that the principles of healthy urban planning are here made visible. Things which in Britain seem almost impossible to achieve – such as a first-class public transport service, diversity of housing provision, 'free-range' children, and community renewable energy schemes – are commonplace. The way in which decisions are taken also impressed. Renewal and new-build schemes are planned collaboratively, with the planning authority setting a very clear framework within which local people and businesses have freedom to innovate. In the economic, social and environmental spheres there are remarkable

partnerships, building consensus and reinforcement between policy areas.[6]

The quality of place – and of community – is tangible. The new neighbourhood of Vauban, oriented around an extension of the tram system, provides all the features listed in the first paragraphs of this article. The housing is custom-built, with great variety in detail, but conforming to a simple masterplan. Some was designed by housing co-operatives (*Baugruppen*). The streets are almost car-free, offering a superb, friendly environment for children and adults. Nature permeates the neighbourhood. Parts of the development are net exporters of energy (incorporating solar cells made in the city).

Older Freiburg citizens remember when the city was following a track similar to most other European cities: increasingly car dependent with a growing traffic problem and air pollution.[7] But consistent policy innovation and political commitment has enabled dramatic changes in behaviour. The tram system has been extended to give excellent city-wide accessibility. While ridership has mushroomed to 75 million passengers per year, the level of subsidy has decreased. Fares now account for almost 90% of running costs – the highest of any city in Europe.[5] Car dependence has decreased, with the proportion of car trips falling from 38% to 30% between 1982 and 1999. Car ownership has also fallen, so it is now way below the German average, and, despite a buoyant economy, transport carbon dioxide emissions have fallen too.[8]

In Britain new suburbs, even those attractively designed, are largely car dependent, and car vehicle ownership is almost universal. By contrast, car ownership in Vauban is a mere 150 vehicles per thousand population, or about one third of households.[8] Car use is down to around a tenth of trips. There are 'sticks and carrots' involved in this transformation. Car owners have to accept communal parking in multi-storey car parks, and pay heavily for the privilege. But the essential reason is that the quality of non-car options is so good, and the car-free residential environments so friendly, that most people find that cars are an unnecessary expense. The health benefits are not only in terms of active travel (increased physical activity), street-based social networks and improved air quality, but also in the form of household disposable income. The spatial strategy is creating an equitable environment that actively combats health inequalities.

Neighbourhood quality, housing diversity and affordability are key goals. The planners recognised that the conventional processes of the land and housing market would fail to deliver. So the city bought development land, built the infrastructure and then sold plots, ensuring that no single developer could dominate an area and opening up

Janet Askew

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Allotments at Freiburg – the city has not explicitly stressed health as its goal, aiming rather at liveability, quality of life and environmental sustainability, but the principles of healthy urban planning are here made visible

options for individual families, community groups, social providers and small builders. A design guide, worked out with future residents, shaped built form, green space and circulation patterns, creating an enviable environment for all. Because everyone walks and cycles, social networks and local facilities flourish. As visitors from South West England, we fell in love with the place.

What makes it possible?

Nicholas Falk believes that the key factors that make all this possible are to do with land ownership and investment banks.[9] Taking the land question first, the lesson not only from Freiburg, but from examples across Europe, is that healthy, human-scale development is only achieved when local authorities have the power both to buy well located land without legal or financial penalties, and to set a clear spatial context for private sector and community investment. The British New Town and Urban Development Corporations showed one way to do this. But it does not have to rely on a non-democratic appointed body. If local authorities could buy potential development land at existing-use value plus generous compensation, then, when the plots are sold or leased on, a communal surplus is created which can be invested up-front in social and physical infrastructure.

State investment banks can provide the bridging loan. The *Beyond Eco-towns* report, based on study of four European countries, concluded that the existence of state banks, able to support local authorities with low-interest loans, was a critical factor in making attractive places and keeping house prices affordable.[10] The British people currently own several banks(!), which could in theory provide an opportunity. In Germany, however, the distinctive feature is *local* banks. Instead of breeding giant companies, the rules encourage provincial banks that are dedicated to the support of local businesses and municipalities.

Finance, though, is not enough. What is different about Freiburg, Copenhagen, Stockholm, Utrecht and the rest is long-term strategic thinking. A city's political and professional leaders have to lead, and accept their responsibility to set a logical long-term course which is likely to deliver their aspirations. Freiburg has been pursuing a consistent strategy since the 1970s. Planning, transport, economic, green space and housing policies have been largely taken out of party politics, but remain within the orbit of the city. In England, central government is forever changing the rules, and undermining local strategies, to suit its rhetoric. When strategy is a political football, then everyone is the loser. The creation of long-term spatial strategies relies on the autonomous power of local authorities to plan across sectors and agencies.

Critical to effective strategy is the ability to integrate land use, transport and economic

development. Policies promoting public transport, walking and cycling rely on settlement structures that keep distances short, routes safe and direct, and destinations close to public transport stops. This applies in particular to commercial and institutional development. In Freiburg every major trip generator is sited within easy walking distance of a tram stop. Out-of-town retail centres and car-reliant office parks are not allowed. Far from undermining economic vitality, the resulting uncongested, walkable city has thrived.

Freiburg won agreement through open discussion and the evidence of progressive success, enlisting support from all sectors. The planning department in particular has seen its task as understanding the interests of residents and businesses, facilitating participation in both the city plan and local development areas. Consistency has been achieved because of strong political goals, cross-party support, and clear technical requirements in the realisation of those goals. Building trust and mutual understanding was vital for implementation, and sowed the seeds of community cohesion.

The consistency of strategy, and the collaborative decision-making process, depend on continuity and quality of staff. Planning departments need real authority and a willingness to take a positive lead to achieve stated political goals. Staff need staying power and real competence across all aspects of the profession, including spatial strategy, urban design, market analysis, community engagement and implementation skills; plus evidence-based knowledge about what works, and how behaviour is affected by place. Freiburg was immensely fortunate in having not only an outstanding architect–planner leading the department over many years, but one visionary and charismatic mayor for 20 years.

Transferability

Transferability no doubt depends on context. It is obvious that most prerequisites are not currently being reproduced in Britain. The tradition of highly centralised government, and disjointed incremental decision-making, mitigates against integrated strategies. Yet some policies have proved remarkably robust: green belts, national parks, building and area conservation, for example. If planning for health and wellbeing became ingrained in official thinking, perhaps motivated by the need to cap growth in demand for the NHS, then it could provide a rationale currently missing.

The WHO Health Cities programme gives insight to this. It becomes clear that a health perspective can give precision to otherwise woolly social, economic and environmental goals. Promoting health, wellbeing and quality of life can be a powerful political and professional ambition which appeals to the population at large. In some European cities where the commitment to spatial planning was marginal – including Belfast in the 1990s – healthy planning built alliances for stronger, more deliberate policies.[11] In many Scandinavian cities the powerful logic of planning healthy urban environments has driven forward coherent spatial strategies in the same way that quality of life and sustainability did in Freiburg.

There are moves afoot in Britain. The Department of Health, the RTPI, the TCPA, the RIBA, the Landscape Institute and many others are promoting health-integrated planning. Even the much-maligned National Planning Policy Framework highlights the importance of health. In Britain cities like Plymouth and Glasgow are trying to push ahead. The All London Green Grid is a vision beginning to happen. If government were to examine and implement the principle of subsidiarity, then Britain could have a Freiburg yet.

● **Hugh Barton** is Emeritus Professor of Planning, Health and Sustainability at the WHO Collaborating Centre at the University of the West of England. The views expressed are personal.

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healthier places for real

A response by **Deirdra Armsby**

How can we continue to ignore the central appeal of Hugh Barton's article – that we must improve the prognosis of our cities and towns? The existing health deficit must be repaired, and not recreated.

The elements of healthy places are well known: the need for job-creating developments and better-quality housing within highly accessible environments will come as no surprise to urban planners and politicians. However, badging that position as aimed specifically at securing healthy places is not a common narrative.

Shrinking public investment means that success is measured along similar lines to private investment outcomes. This leaves little space to count the cost of failure to create places (including the conversion of existing places) which enable healthy living, working and moving. This mismatch between the instruction to fix our unhealthy environments and a lack of means to administer the remedies must be tackled at a strategic level. The success of cities such as Freiburg is characterised by long-term visions, enabling public investment unfettered by pure monetary payback, and bringing people along with them. The finite supply of land in many cities will, over time, increasingly do the job of pricing out car use at levels we have seen historically (but let's not forget, for places without comprehensive public transport networks, the potential role of the electric car – charging-point infrastructure is building up). Walking and cycling dominated environments must become the norm, and we have the expertise to achieve that.

With the resources and expertise of public health departments, local authorities are now better placed to lead on pushing healthy places higher up the agenda. Shifting the thinking of decision-makers to long-term goals is never easy, but it must start with a simplified message that has broad appeal. Having a healthy place in which to live and work is surely common ground and brings public and private economic rewards, if it has to be judged on that basis. If planners and other built environment professionals feel that there is a lack of progress, we must find a way of energising the ambition. Some old-fashioned 'champions' are needed nationally and locally to increase the pace of change. The NPPF does reference health, but financial viability is at the heart of its message; this is inhibiting the nature and pace of change. Perhaps the evidence base to lever healthy places higher up the agenda lies in defining the cost of failure as well as costing wellbeing. A healthy place – what's not to like?

● *Deirdra Armsby is Head of Planning and Regeneration at Newham Council. The views expressed are personal.*

A response by **Paul Gregory**

It is difficult to know whether – and prove that – a development improves the health of its customers. However, as a social housing developer we at 'Johnnie' Johnson Housing Trust have always aspired to provide high-quality, affordable accommodation that actively encourages people to engage in a healthy lifestyle. Convenient access to local shops, schools and transportation routes are factors that are integral to the development process and are encouraged by the Homes and Communities Agency and our strategic partners. During the initial design stages we work carefully to ensure that the development:

● is located within close proximity to shops, offices, doctors' surgeries and post offices;
● is located close to major transportation routes and rail networks;
● is located with convenient access to schools and nursery premises;
● is conveniently located for access to nearby parks and outdoor leisure facilities;
● makes provision for the production of local food – i.e. allotments, gardens or planting beds (depending on availability); and
● includes provision for cycle storage.

Most social landlords are taking this approach as part of their development strategy. However, to forge real changes across the community, a collaborative approach is required with the local authority in taking the lead in producing a masterplan, particularly where considerable levels of economic investment have been have been targeted to encourage home ownership and commercial enterprise. Robust planning policy from both central government and local planning authorities could be one of the key drivers in encouraging developers to actively engage and invest in the process both at feasibility and completion stages.

Moreover, the engagement of a collective pool of local representatives from both the social and private sectors could help in shaping the backbone of a masterplan and in implementing the infrastructure to support and encourage people to live, work and thrive in such an environment. In addition to encouraging a healthy lifestyle through design, it is also important to reinforce the lifestyle message and educate through literature, scheme hand-over packs, local gym membership discounts, and so on.

● *Paul Gregory is with 'Johnnie' Johnson Housing Trust. The views expressed are personal.*

towards healthier environments –
integrating public health and planning at knowsley

Cath Taylor reports on the experience of bringing public health and planning together at Knowsley Council

Above

A new play area opened at McGoldrick Park, Huyton in 2013

Knowsley Council has a well established history of joint working that existed long before the transfer of public health responsibilities to the local authority. From 2001 onwards, the Council and the former Primary Care Trust (PCT) made a number of joint appointments at assistant director level. As in other areas, these tended to focus on health and social care, where the remit of each organisation clearly overlapped and partnership working created

quantifiable benefits and savings, visible to each service.

More recently, increased understanding of the wider determinants of health – the impact of 'the causes of the causes' – has prompted closer joint working between public health and other parts of the local authority; in particular, those able to influence the form and function of built environments, including planning, housing, regeneration, and green space.

This presents numerous opportunities but also some different challenges compared with previous joint working.

Knowsley Council started to consider these issues around 2009, and in April 2010 I was appointed as Health and Regeneration Officer, funded solely by the former PCT. Initially based in the Council's Department of Regeneration, Economy and Skills, the purpose of the post was to work across both organisations to promote health and wellbeing through planning and regeneration activity, and to ensure that health was considered within all strategy- and policy-making.

At the time, this area of work was much less familiar to both organisations, and encouraging discussion across different professional backgrounds and negotiating the technical jargon associated with each was difficult. In addition, robust evidence to prove the case for joint working was (and to some extent still is) somewhat limited. The impact of living near high-quality green space or a shopping parade selling fresh food is presumed, but is difficult to identify as having a direct positive effect on things such as mental health or levels of obesity.

Having been in post for over four years, I have been fortunate to be involved in an ever-increasing range of work, and have been supported throughout by the current Director of Public Health for Knowsley, Matt Ashton. I have sat within several different departments across the Council, which, along with my background as a qualified planner, has helped me to establish positive working relationships with many teams, and to understand where opportunities and challenges lie.

A wide-ranging brief

Major pieces of work to date have included a Health Impact Assessment (HIA) of the emerging Core Strategy, which ensures that the Local Plan contributes to public health outcomes, including the promotion of physical activity, the availability of healthier food, and the use of HIAs within planning for new developments. A new strategic objective was also added, recognising the importance of the Core Strategy in creating health-promoting environments. This creates a policy 'hook' allowing development of future planning policy around health-related issues as this field of work expands.

The Council's planning team is currently developing a Non-Retail Uses Supplementary Planning Document which covers proliferation of hot-food takeaways but will hopefully be expanded to cover any changes to the Use Classes Order in relation to betting shops, as suggested by a recent Department for Communities and Local Government consultation. The latter is considered to be a significant issue in Knowsley, as the fourth-most indebted local authority area in England,[1] and the public health team recently led a piece of research by Liverpool Public Health Observatory into the local impact of fixed-odds betting terminals.[2]

Work so far has not just been planning related, but has also included environmental health, licensing and other service areas, reflected in my current title as Principal Health Promoting Environments Officer.

Working with asset management, we have developed a new shop management policy to ensure that there are no new lettings to sun-bed shops, off-licenses or betting shops within council-owned units, and that takeaways are limited to one per parade. Rent relief is also offered for traditional businesses such as greengrocers, and healthy workforce initiatives are promoted to support local businesses and achieve positive health outcomes in workforce health, access to healthier food, and community cohesion.

Healthy Homes scheme

More recent work has focused on the outcome of an evidence review I was asked to conduct in 2012, in anticipation of the transfer of public health responsibilities. This looked at areas of local authority work which would have the greatest potential impact on health outcomes. In particular, housing was identified as a gap where no previous joint working had taken place.

As a result, one of the first major initiatives embarked on by public health within the Council has been the development of a £1 million Healthy Homes scheme, which takes a holistic approach to improving housing conditions and the health and wellbeing of residents over the next two years. Developing this has been my main task for the past year, and, with the initiative now under way, my focus has moved to ensuring that a robust evaluation framework is in place. It is hoped that this will provide demonstrable outcomes to illustrate how prevention, a key principle of public health, can reduce the long-term costs of providing social care, healthcare and other services such as fire and policing. This will be important to illustrate the value of public health interventions in a local authority context, through quantifiable savings as opposed to more process-driven outcomes.

Interestingly, many of the resultant savings from the Healthy Homes scheme may not be directly felt by the Council, but by partner agencies. A particular challenge therefore remains over future funding for initiatives such as this; however, our current focus lies in demonstrating that the model is effective.

Lessons

Given that more authorities are opting for this kind of post, what are the lessons from experience at Knowsley? There are four key points:
- *Make the right contacts in different departments:* This is helped greatly by working flexibly and physically sitting, at least part of the time, with different teams you want to engage with.
- *Undertake an evidence review to understand the areas you can influence to have most impact:* This should be informed by national

Above

New homes in Parkside Close, Huyton – one of many new housing developments in the borough

evidence of what works, but also by local health and other data, and factors such as political and officer willingness to engage.

● **Try to build capacity in other teams:** Public health issues should be considered by everyone working within a local authority and ought to overlap hugely with the council's corporate objectives. Use these overlaps as opportunities to make connections and get others involved for mutual gain.

● **Do not expect to find someone who has both a built environment and a public health background:** Training will be key to build up expertise in both areas.

Future work

In line with our evidence review we intend to adopt a more systematic approach to conducting HIAs. While Knowsley has undertaken a number of HIAs to date, these have largely been in relation to new PCT buildings as a requirement of funding. However, as the Council looks to release land for future housing developments, we will be working with the development team to undertake HIAs on the largest sites, and we see this as an ideal opportunity to ensure that new developments make a positive contribution to the health and wellbeing of local communities.

However, HIA is just one aspect of this role – which is so much wider than planning and development, covering all aspects of local authority activity. The breadth of this remit has allowed me to get involved in a range of diverse and challenging projects. I have been given the support and freedom to develop new projects where I find relevant links, and to work flexibly, sitting temporarily within the teams with which I am currently working. And while the sheer size of the role is a major challenge in terms of my own personal capacity, it is reflective of the influence which the Council's work has on the health of the local population and the breadth of future opportunities to align priorities.

● **Cath Taylor** *is Principal Health Promoting Environments Officer at Knowsley Council. The views expressed are personal.*

Notes

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better together –
embedding health into all stages of the planning process at stockport

Angie Jukes reports on the experience of bringing public health and planning together at Stockport Council

Above

Stockport Council's BREEAM 'Excellent' building reflects sustainable design ideals, including health benefits

Public health professionals have long had a tradition of understanding the benefits of sustainable plans and development. As many planners and health professionals are finding out, health colleagues can be useful contributors to the development of local plans and the built environment. In return, public health benefits from a built environment that contributes to preventing ill-health.

Check mail box
- Development management identifies the need for public health comments, and issues request via email
- Daily check of healthy planning email box by senior public health officers
- Access case data online
- Public health team identify lead officer to co-ordinate response

Is it compliant with policy?
- Access case data online
- Check Core Strategy health-relevant policies checklist for compliance
- Yes – 'No comments required' response sent to planning case officer
- No – Responses provided by relevant team members to lead officer
- Lead officer co-ordinates draft response in memo format

Senior officer check
- Lead officer sends draft response to senior public health officers for comment with deadline
- Any case requiring it should result in public health team discussion, taking account of time limitations
- Comments returned to lead officer by deadline

Respond
- Lead officer co-ordinates amendments where required/stores response
- Lead officer submits memo to planning case officer via email

Above

Fig. 1 Embedding the prevention of ill-health into major planning applications to Stockport Council – process map

In April 2008 I was appointed to a post advising on health and environment issues within the planning policy team at Stockport Council. More recently, the function of this team has been merged with the Council's transport policy remit, and it is now positioned to work closely with the Council's development management, regeneration, housing strategy, planning enforcement, conservation/heritage and economic development teams. My role is co-funded by the Director of Public Health, and key elements of my work are undertaken as part of the public health team.

Key achievements of my role include helping to deliver:
- a Health Impact Assessment (HIA) of the Local Plan (Stockport Core Strategy) before it was adopted;
- an adopted policy on hot-food takeaways (justified in part with data on childhood obesity); and
- a local relief road to be delivered to CEEQUAL standards (the sustainability assessment rating scheme adopted by the civil engineering profession), building on work set out in the Local Plan HIA.

However, there are a wider set of benefits from my post that relate to how officers undertake their work, and the influence that facilitating joint working can have.

Public health as a consultee on major planning applications

In 2013 Stockport Council worked to prepare designated members of the public health team to comment appropriately and usefully on all major[1] planning applications. Stockport's Director of Public Health saw this as an essential way of further embedding the prevention of ill-health into the planning activities of the Council as the local

planning authority, alongside work to ensure that local planning policies reflect health considerations.

In order to enable the public health team to develop the skills to take full advantage of this opportunity, I prepared a process document, a spreadsheet of relevant planning policies, and training slides, with input from the lead officers for development management and planning policy. A two-hour training session was delivered to nominated team members from public health and the process began. The development management and planning policy leads attended a public health team meeting to discuss any queries or issues regarding the process. It was established that the process would be reviewed for any issues that might arise. That review is due to be undertaken shortly.

A process map summarising Stockport Council's process is shown in Fig. 1.

Joint evidence and monitoring

Joint Strategic Needs Assessments (JSNAs) are prepared by public health teams in local authorities, alongside the work of the Health and Wellbeing Boards in every area, informed by a wealth of statistical analysis. Monitoring of these documents should dovetail with the local plan monitoring undertaken by local planning authorities.

We are discussing this at the moment at Stockport Council, along the lines of referencing issues highlighted in the annual Authority's Monitoring Report (AMR) within health documents. This monitoring work could be used by the private sector to inform the preparation of planning applications, from concept to delivery. This would result in an application that delivers against policies, as much as it is feasible and viable to do so, and can thus move swiftly through the application process, reducing inefficiencies and costs. Stockport has long focused on the fact that introducing sustainable design and construction at the earliest concept stages will deliver cost benefits, countering the usual perception of additional costs when sustainability is bolted on to projects at a later stage of design.

There are wide-ranging benefits to planning in terms of incorporating public health considerations. First, the achievement of a robust local plan is more likely through the inclusion of health evidence. In addition, the Sustainability Appraisal process is strengthened by public health input and the inclusion of health information. This is especially true of social considerations, but environmental and economic aspects can also benefit. For example, in order to fully incorporate cycling as a workable commuter option, a development needs not only cycle routes and parking but also showers and clothes-drying/ storage facilities.

An application for a development that takes account of health issues is more likely to be acceptable to locals and neighbours. Furthermore,

without consideration of the health aspects of a development, there is more likelihood that the scheme will not deliver what is needed in a community.

It is also important to monitor such developments to inform any assessment of public health benefits linked to planning outcomes. Annual monitoring undertaken by local planning authorities should include contextual information on health. For example, life expectancy and healthy life expectancy,[2] obesity levels and sports uptake are included in Stockport's AMR.[3] Public health professionals are understandably cautious regarding causality relationships between issues such as affordable housing and health conditions, but without well structured and informed annual monitoring, such concerns will never be addressed. It is therefore important that public health professionals inform planning monitoring; and, indeed, in these days of public sector capacity demands, discussions on data-sharing and analysis are extremely useful.

Towards demonstrating the public health benefits and costs of development

Colleagues at Stockport Council are currently in discussion to assess where we can go next in terms of preparing viability evidence regarding non-compliance with planning policies resulting in additional health budget costs over subsequent decades. Taking part will be both planning policy representatives and public health team members, led by Stockport's Director of Public Health. The initial focus will be on areas of policy that directly benefit ill-health prevention, such as open space and sustainable transport, but could also include matters such as affordable housing. Further steps will be dependent on resources, capacity and information availability.

In addition, this discussion will inform potential inclusion of an HIA policy in any future planning policy review, possibly building it into the Environmental Impact Assessment requirements. If this happens, it will be vital to provide guidance and support to the development sector on the appropriate level and content of such an assessment. There will be a need to monitor the quality and effectiveness of such an approach to ensure benefits for all.

● *Angie Jukes provides health and environment advice to the planning teams at Stockport Council. The views expressed are personal.*

Notes

1 Ten or more dwellings; more than 1,000 square metres of non-residential development

2 A situation in which longevity is matched by independence and good health

3 Stockport Council's Authority's Monitoring Reports are available at http://stockport-consult.limehouse.co.uk/ portal/pp/zzz_adopteddocuments/aaa_ldsamrsci/amr_1/

'crap places kill people' –

how local involvement in place-making aids health and wellbeing

Louise Dredge looks at how participation in the processes of making and improving our surroundings can improve individuals' health and help to deliver healthy places

In October 2012, The Glass-House Community Led Design, a national charity supporting and promoting public participation and leadership in the design of the built environment, hosted the first debate of its annual debate series in a chilly Edinburgh market space with the question: 'How can great places create value for local people?' Rev. Christopher Rowe, a Church of Scotland Minister and resident of Milton, one of Glasgow's most impoverished neighbourhoods, made the stark and powerful statement that 'crap places kill people' as he spoke about his perspective on how places affect people's lives. Rowe's claim was not a hollow one – he spoke of male life expectancy statistics that separated Milton from another neighbourhood only three miles away by 20 years (Milton's average was 68 years, while in Bearsden it stood at 87). While the physical spaces that people live in and interact with are only one factor in the quality of people's lives, they have an undeniable effect.

People and place are inextricably bound. While our places shape us, by our activity and often our passivity we also shape our places. Good design can lead to places that are better used, more easily managed, and more economically, socially, culturally and environmentally sustainable. Encouragingly, recent years have seen a greater awareness of 'healthy environments'; of supporting and creating places that help people to live healthier, more active lives. But what can the process of participation in

place-making (the process through which we make, create and improve our places) do for our health and the health of our places?

Over the past 15 years, we at The Glass-House have supported communities across the UK to lead or participate in a huge range of place-based projects involving open spaces, community buildings, housing, and neighbourhood level change. There are endless examples of projects that demonstrate not only the positive health effects of local involvement in place-making, but also the value that participation in these processes can have on personal health and wellbeing. Our experiences reveal three important points:
- that people are a key resource in affecting positive changes in place;
- that a participatory design process supports health and wellbeing; and
- that small changes can have a big impact.

People are a key resource in shaping healthy places

The work of The Glass-House is grounded in the principle that local people should be at the heart of changes to their places, as both users of and experts on them.

Community-led and neighbourhood planning are significant mechanisms for putting forward recommendations for the development of places, based on issues of daily experience and interaction

Above

Adults experiencing playful environments during a Glass-House 'Spaces by Design' course

with place. Through collaborative, hands-on mapping and exploration of the local area, The Glass-House helped two villages in West Sussex (Kirdford and Loxwood) to identify key issues around movement and transport and how these could be addressed in community-led plans. The potential impact of simple improvements to public realm infrastructure to make villages more accessible and safe, and to support healthier living in a rural context, is significant for rural communities. The erosion of rural public transport services leads to an increasing reliance on private car ownership. This often leads to a poor pedestrian experience and affects the perception of the safety and accessibility of these places, encouraging even more car use.

The Glass-House has supported many locally led projects to improve under-used or neglected open spaces, in order to help communities unlock their potential and provide a resource for the area that has significant positive effects on community health and wellbeing. Open green spaces provide a vital health resource to communities across the UK. Studies such as CABE Space's *Community Green*[1] have demonstrated the value of green spaces in tackling health inequalities in places. In this study, half of the people interviewed said that they would take more exercise if the quality of their local green space was better; 60% said that if their local green space was more pleasant and they began to use it

more, they would expect their physical health to improve; and almost half thought it could improve their mental health and improve their relationships.

One open space project supported by The Glass-House is Myatt's Fields Park in Lambeth, South London. It began in 2000, when a group of local mothers decided to take action to renovate their local park and started to engage other local residents and the local authority, the London Borough of Lambeth, to support their cause. With help from The Glass-House, the project galvanised support, interest and participation from local people, involving schools and individual families in the process through workshops and a fun open day that highlighted the progress of the project and provided opportunities for input into the plans. After over ten years of dedicated work, the park is now a thriving community hub, with food-growing facilities and activities, a local café, a children's centre, and leisure spaces – resources and activities that have developed through consistent local engagement and participation.

Participation benefits health and wellbeing

As well as bringing communities together and building a sense of community, participation in a place-making project can be a transformative experience for the individuals involved. Empowering individuals to effect change in their place affects other aspects of their life. One of the most powerful

examples of this is a very personal anecdote from a man involved in a tenant-led project (the Pioneer Gardeners Tenant Involvement Project, or PG TIPS) to create a gathering space for young people on his housing estate in Greater Manchester. As told by Glass-House Chief Executive, Sophia de Sousa:

'Before taking part in the project, he was unemployed and living on his own, feeling extremely isolated. He told me that he had spent most of his days sitting alone in his flat watching television, with little interaction with others. One of his neighbours convinced him to take part in the project and this, he told me, 'changed his life'. He spoke of the importance of being part of a group that achieved something, and that working with others towards that outcome had increased his confidence and helped him interact socially with others. He also really enjoyed working with young people, and following the project he trained in youth work and became actively involved in working with young people on his estate.'

This is the story of one man, but it illustrates the impact that participation in place-making can have on the social interaction, confidence and employability of those involved – factors that play a key role in our wellbeing.

Small changes can have a big impact

In Play England's study of literature on play,[2] Lester and Russell have documented a wealth of research on the role of play in children's lives and how it supports many aspects of their health and wellbeing, from developing their emotional engagement, for example, to helping them to be active and tackling obesity.

However, our places often present many obstacles to opportunities for play. By inviting users (i.e. children) into these conversations, we can find simple solutions. Our work with LS14 Trust, a Leeds development trust based on the Seacroft Estate, was one of these occasions. A walkabout with members of the community revealed that a large hill that dominated the estate was a point of grief for many, but for others a source of delight (or held potential for delight).

A young girl spoke of her joy of playfully rolling down the hill with her friends, but pointed out that a large cluster of stinging nettles at the bottom presented both an obstacle and a danger. Through a bigger process of looking at the public realm with residents and how it could be improved to provide a more pleasant place in which to live, it was revealed that the simple act of removing the nettles from the bottom of the hill would make a huge difference to the environment for play for children on the estate. The nettles were subsequently removed, to the delight of lots of local children, and to the benefit of their wellbeing.

Valuing participation

The examples shared above demonstrate the value of participation in improving health and wellbeing not just through improvements to place, but through active involvement in the processes of change. For all of us, this starts with an awareness of place and its effect on how we live our lives, and at The Glass-House we are passionate about supporting and promoting this, not only through live projects, but also through advocacy and awareness-raising activities such as debates, workshops and campaigns. The case for the value of empowering people to participate in place-making continues to grow, with more and more organisations and agencies supporting such practice, and research actively capturing and assessing its impact.[3]

We hope to see more participation that leads to more sustainable, more attractive and healthier places, and we will continue to work to support and promote these opportunities. The words of long-time local place champion and friend of The Glass-House, Jane Hearn, working in community development in South East London, express the inherent potential of such a vision:

'There is a great untapped potential in the community to create environments they want to live and stay in, that will impact on their own health and wellbeing and those of their families, friends and neighbours. If you aren't aware of your surroundings and what shapes them, how can you be inspired to change them?'

● **Louise Dredge** *is Outreach and Impact Manager at The Glass-House Community Led Design. This article includes a contribution by* **Sophia de Sousa***, Chief Executive, The Glass-House Community Led Design. The Glass-House Community Led Design is a national charity supporting and promoting public participation and leadership in the design of the built environment – see www.theglasshouse.org.uk*

Notes

1 *Community Green: Using Local Spaces to Tackle Inequality and Improve Health*. Research Summary. CABE Space. Commission for Architecture and the Built Environment, 2010. http://webarchive.nationalarchives.gov.uk/20110118095356/http://www.cabe.org.uk/publications/community-green

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3 The Glass-House has developed a strategic partnership with the Design Group at the Open University to support future research into design practices that empower people and support great place-making. To date, we have worked collaboratively on ten research projects to explore the value of community-led or collaborative design in place, including Valuing Community Led Design (2012-13) and Scaling up Co-Design Research and Practice (2013-14)

planning for health infrastructure – re-engaging with the NHS

Vernon Herbert and **Malcolm Souch** outline the issues facing NHS estate planning and emphasise the need for NHS organisations and local authorities to work together to undertake health infrastructure planning

The National Planning Policy Framework (NPPF) and the related Planning Practice Guidance require local planning authorities to ensure that health infrastructure is considered in local plans and when determining planning applications. However, changes to the NHS, particularly the abolition of Primary Care Trusts (PCTs), and changes to the planning system, with the introduction of the Community Infrastructure Levy, are both having an impact on the way in which the planning sector and the new NHS organisations need to engage with each other.

Issues facing NHS estate planning

There are several key issues and challenges affecting the planning of healthcare infrastructure:

- changing models of care and the need to ensure that the estate is an enabler of change;
- the need to make best use of existing assets, including greater utilisation of the estate and the release of surplus assets where appropriate;
- limited financial resources and the need for efficiency savings;
- ensuring that the estate is fit for purpose, can operate more flexibly and meets modern standards;
- accommodating additional service capacity to address population growth and change;
- capitalising on opportunities for partnership working to achieve broader health and wellbeing objectives and make better use of public sector assets; and

- co-ordinating to best effect the different interests in the health estate, the use and ownership of which is spread across a variety of organisations.

The planning system has an important role in helping to deliver new or improved premises and in supporting the rationalisation or disposal of surplus estate. It is therefore vital that NHS organisations are engaged with local authorities – particularly given their responsibilities for public health as well as planning.

Knowing who to talk to

The abolition of PCTs means that health infrastructure planning now involves a number of different NHS organisations and requires a collaborative process.

NHS England Local Area Teams have responsibility for commissioning primary care services and managing GP contracts, including premises costs. This new responsibility, along with the regulatory role of the Care Quality Commission in ensuring clean, safe premises, is stimulating a renewed focus on primary care estate issues.

There can be wide variations in the size of GP practices – from single-handed GPs to practices with as many as 20 or more full-time-equivalent GPs offering a range of other services. Many practices still operate from converted residential premises or shops, while others are co-located in more modern,

purpose-built health centres offering a range of healthcare services to their local communities, perhaps involving different service providers, as well as integrated health and social care services.

Clinical Commissioning Groups have responsibility for commissioning a range of hospital services, including urgent and emergency care, inpatient and outpatient services, and community health services. They do not hold assets, but aim to ensure that the estate enables the delivery of services and supports changing models of care, including moving care out of hospitals closer to home.

NHS Property Services (NHSPS) owns and manages around 70% of the former Primary Care and Strategic Health Authority estate (some 4,000 properties). Its sister company *Community Health Partnerships* is responsible as head tenant for the overall management of Local Improvement Finance Trust (LIFT) buildings across England (around 300 properties). Both organisations support commissioners and providers in developing strategic estate plans which will result in better-used and refurbished buildings, new premises and the disposal of unneeded estate.

NHS Trusts provide healthcare services and are responsible for much of the acute/specialist hospital and mental health estate. Many of these organisations have acquired Foundation Trust status, and have also grown and diversified over time through a combination of mergers between Trusts and the taking on of new services.

Therefore, no single organisation has complete responsibility for the health estate and its planning. This can sometimes be a source of frustration to local authorities and other organisations because there is seemingly no single point of contact for NHS health estate issues. This means new ways of engaging are required.

The need for a collaborative approach on strategic estate planning is recognised within the NHS alongside the need to work with local authority partners to maximise opportunities to integrate health and social care and make better use of public assets more generally.

Across the health service, there is a newly emerging framework of five-year commissioning strategies, along with a growing focus on the task of developing new models of care and assessing the health infrastructure implications of change.

On the planning side, local planning authorities will need to ensure that their Statement of Community Involvement and planning consultation database is up to date with contacts in the new NHS organisations. The local authority Director of Public Health, NHS Property Services and HUDU in London should be able to help co-ordinate responses to local plans and planning applications on behalf of NHS England Local Area Teams and the local CCG.

Health infrastructure planning as a shared activity

The introduction of the Community Infrastructure Levy (CIL) is another opportunity to join up health and wider infrastructure planning. CIL places a greater emphasis on infrastructure planning and the need to identify when and where future investment in health infrastructure is required. Local authority planners and public health officers have an important role in helping NHS organisations to develop their commissioning and estate plans by providing data on housing supply, population projections and health needs, including information from the Joint Strategic Needs Assessment.

Infrastructure planning is an iterative process. Local authorities can assist NHS estate planning by monitoring housing development and population growth to identify when and where investment in premises is needed. Significant growth in a locality may trigger the need for investment or require the timing of planned provision to be reviewed. It is also important that site opportunities for new premises secured by section 106 agreements are kept under review. Some local authorities have established infrastructure planning groups to share information and identify projects and priorities for CIL. It is important that NHS organisations are represented on these groups. In some parts of the country, there are section 106 health contributions which need to be allocated towards projects. An established process to draw down section 106 funds may help NHS organisations bid for CIL funding.

Aligning the CIL process with NHS estate planning

NHS organisations need to be engaged at key stages in the CIL process:
- They need to provide evidence of health infrastructure requirements and costs when the CIL charging schedule is being prepared. The local authority's infrastructure list (known as the Regulation 123 list) will need to include health or health projects as a recipient of CIL.
- They will be expected to provide information on health infrastructure requirements needed to support growth in an area, usually over a 10-15 year period. Details of health projects should be provided, where known, including costs and sources of funding. It is recognised that projects may not have been identified, particularly in the longer term beyond the timeframe for commissioning or estate strategies – in which case, the HUDU (NHS London Healthy Urban Development Unit) planning contributions model[1] can be used to provide a broad estimate of requirements and costs resulting from housing and population growth.

The prioritisation and allocation of CIL funds is at the discretion of the local authority, as charging

authority. While there is no prescribed approach to allocating funds, it is likely that most local authorities will use their capital programmes to allocate CIL funds. The capital programme will include projects identified in the local infrastructure plan, but which will require immediate CIL funding to proceed.

The NHS will need to bid for CIL funds against potentially growing and competing demands for social infrastructure generally. As such, corporate support for a project is vital, and the Health and Wellbeing Board will have an important role in supporting health-related projects.

The CIL process should be aligned as far as possible with NHS estate planning and the NHS business case approval process for capital investment in primary care premises. The first stage of the NHS business case process is the production of a Project Initiation Document (PID), which must be approved before a business case is developed. Where the need for investment has been demonstrated in a PID, the project and estimated costs can be identified in the local authority infrastructure plan and on the CIL infrastructure (Regulation 123) list. The outline business case will identify a preferred option and costs, and could be used as evidence to support a bid for CIL funds where needed to help meet a funding gap.

Re-engaging with the NHS

The split of responsibilities under the new NHS organisational arrangements between commissioners, providers and support services (including the estate) means that infrastructure planning has to involve a more explicitly collaborative approach within and between the NHS and its partners.

Key elements include:
- Understand the new NHS organisations and the issues facing NHS estate planning. (Local authorities)
- Find out who to talk to and update planning consultation databases. (Local authorities)
- Understand the scale of change needed and agree a co-ordinated view on health estate needs and priorities. (NHS organisations)
- Seek to align the CIL process with NHS estate planning and the business case process.
- Undertake healthcare infrastructure planning together.

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Note

1 Details of the HUDU planning contributions model are available at www.healthyurbandevelopment.nhs.uk/our-services/delivering-healthy-urban-development/hudu-model/

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going local

David Boyle on what the Home Office's difficulties in appointing someone to lead the historical child abuse inquiry tell us about our over-centralised system of government

in search of a solicitor from redditch

It is quite possible that by the time this edition of *Town & Country Planning* is published, the inquiry into historical child abuse, which is supposed to investigate the rumours surrounding an establishment cover-up of various kinds, will be going ahead as planned. As I write, this looks uncertain.

Two things strike me as the second of the people appointed to lead the inquiry has had to resign. The first is the staggering incompetence of the Home Office. All they needed to do was to find someone to lead the inquiry who was not friendly with one or other of the various people whose names have become entangled – for their sake, as much as anything else. It should hardly have been that difficult. But the second is that, actually, it does seem to have been a difficult task.

I listened yesterday to an edition of the *Today* programme in which the historian Juliet Gardiner talked about 'the establishment'. It is difficult to find members of this august body who don't move in interlocking circles, she said. What they really need – as she put it, whether being satirical or serious – is 'a solicitor from Redditch'. And here we get to the nitty-gritty; and it explains something about way that the UK has always been over-centralised – because the establishment tends to live in London, with perhaps the occasional weekend retreat in the Home Counties and maybe a summer house in Italy.

The devolution of power to Scotland and Wales has tackled that problem to some extent. There are now Scottish and Welsh establishments in a way that there were not before. But other countries have a class of people in *each city* who can stand alongside anyone in the nation in their stature, intelligence and objectivity. You might almost believe, from the coverage and the flailing arms of the Home Office, that we in the UK do not.

We have people running cities, or the shadowy figures that run hospitals. We have professors at regional universities. So why can't we find a 'solicitor from Redditch' to lead the child abuse inquiry? Perhaps that is the key question here, and there are two obvious possible answers.

The first is that nobody in the political establishment – or in the locked lists in the filing cabinets of Whitehall where they keep the names of the sound pairs of hands – knows about them or their records, so they never get to lead government inquiries. The other possibility is that these super-solicitors in what used to be called, rather revealingly, 'the provinces', don't actually exist at all – because, we have to assume, they have long since found themselves forced into the aura of London to further their career.

Both are possibilities, and both have elements of truth about them. Both lead to the kind of indefensible snobbery with which London regards the rest of the nation. Both have fuelled the UKIP revolt by those who have been left behind. I remember the ridicule

'The ignorance of UK talent beyond the centre – probably beyond the M25 – is a serious weakness for the nation as a whole and a serious consequence of an over-centralised system of government'

that the architect James Stirling once heaped, in my hearing, on the idea of an art gallery in Rotherham. Metropolitan disdain runs deep here.

Whatever the answer is, it seems to me that the ignorance of UK talent beyond the centre – probably beyond the M25 – is a serious weakness for the nation as a whole and a serious consequence of an over-centralised system of government. It means we miss out on their talents, just as the inquiry has.

It seems to me that a major devolution of power is now likely in a way that it was not after the last election. All three main parties – all five main parties – seem now committed to it. But they all

want to achieve different and somewhat conflicting objectives, and we all know what happens when Whitehall gets involved in localism.

The English way is to adopt a gradual, tentative approach, rather than the 'Big Bang Localism' which Simon Jenkins advocated back in 2006; but, as we know, tentative localism is often so tentative that it is just centralisation by another name. The back-door localism which is known as City Deals will soon cover the whole country and also provides a potential route.

'These two approaches seem to point towards a major possible shift. Whether this will be as big as the two most effective pieces of devolution since the Second World War – the expansion of higher education and the devolution of home rule power to the nations – will remain to be seen'

These two approaches, allowing local variation at the same time as laying down new objectives, seem to point towards a major possible shift. Whether this will be as big as the two most effective pieces of devolution since the Second World War – the expansion of higher education and the devolution of home rule power to the nations – will remain to be seen. But the complete horlicks the Home Office has made of appointing anyone to run the historical abuse inquiry is a sign that, in the end, it is the culture of centralisation, rather than its administration, that really matters and most needs to be tackled.

If and when that Redditch solicitor is appointed to run a government review, we will know that something has really changed.

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making places

Peter Roberts on devolution in the UK and gaps and inconsistencies in the current constitutional arrangements – and their importance for spatial planning and development

the new territorial governance revisited

In 2000 the TCPA published a paper, written by me, entitled *The New Territorial Governance: Planning, Developing and Managing the United Kingdom in an Era of Devolution*.[1] This paper took stock of progress under the New Labour devolution project and looked forward to the possible consequences of its full implementation. Given the result of the recent Scottish referendum on independence, and subsequent events which have included the re-awakening of the arguments surrounding the so-called 'West Lothian question', it now seems appropriate to revisit my earlier contribution.

As the 2000 paper explained, the devolution project had (and still has) deep roots, and these roots have strengthened considerably over the past 15 years, especially in the Celtic nations and London. Elsewhere progress has been more erratic: forwards, sideways, backwards and virtually eliminated. More importantly, the devolution project as a whole still suffers from a lack of certainty about the rules of engagement and progression, and from an aura of grudging concessions to troublesome territories beyond the M25.

In short, the positive attitudes and rapid progress of the 1990s and early 2000s have been replaced by a much more defensive and stultifying approach. This is all the more surprising given the circumstances in which the pre-1997 devolution and strategic planning debate took place, including the announcement in 1993 of Government Offices for the Regions – an important innovation that John Gummer described as bringing 'a new localism to improved government services' and which was intended to 'bring services closer to the people they serve, simplify the Government machine and improve value for money'.[2]

Now, while recognising that one government's innovation may be cursed by the next, the surprising thing is that the general pattern of evolution of the regional management-cum-devolution project was broadly positive from the late 1980s until 2010. Since then, there has been a sharp dichotomy, with a growing maturity of devolution in Wales, Scotland and Northern Ireland and (to a lesser extent) London, on the one hand, and the virtual disappearance of regional planning, management and governance on the other. Although I have examined the causes and consequences of the latter point in earlier contributions to this journal,[3] the reality is that the debate has now moved on and requires further discussion.

The Scottish referendum on independence shone a spotlight on a number of important matters and revealed some serious gaps and inconsistencies in the current constitutional arrangements. While the West Lothian question may be portrayed as the principal issue that needs to be addressed, such a discussion can equally be seen as a diversionary tactic designed to slow the progress of devolution in the Celtic nations and avoid the need for any real decision before May 2015.

Chief among the matters highlighted during the period prior to the referendum vote in Scotland were the limits and restrictions placed upon the devolved administrations as a consequence of the original legislation. In Scotland the major focus of attention in the campaign was the unsatisfactory nature of the existing economic and fiscal mandate, and the absence of powers over key aspects of policy, such as housing benefits and other welfare payments. The response to the challenge of independence was a 'vow' made by the leaders of the three main Westminster parties that, in effect, offered Scotland enhanced devolution, the so-called 'devo max'. This package proved sufficient to avert a 'yes' majority.

However, the failure of the Scottish referendum to usher in independence has left a legacy of constitutional confusion. This was not unexpected and has led to renewed calls from the three Celtic nations for rapid progress to be made on enhancing their constitutional mandates, and from English cities, counties and regions for a new devolved settlement to be agreed and implemented as soon as possible.

Now, much of this discontent and constitutional confusion is a consequence of the fudged devolution settlements of the late 1990s. As Linda Colley has argued, the New Labour Government 'pursued 'ad hoc' measures in Wales, Northern Ireland and Scotland but declined to adopt a systematic federalism that might properly have

embraced England as well'.[4] Most importantly, and returning to a theme introduced earlier, there was no attempt in 1997 or subsequently to set rules of engagement and progression for either the devolved governments in the Celtic nations and in London, or for the other English regions.

The above situation is one of the many consequences of the 'unwritten' British constitution and the conventions of governance which have accumulated through accretion rather than conscious choice. In the present circumstances, the real priorities are to deliver the items contained in the 'vow' to Scotland and the other enhancements to the devolution settlement that are already in train for Wales and Northern Ireland, and then to pause and put in place an independent constitutional commission, preferably chaired by an outsider, to examine both the best arrangements for England and the overall arrangements for the United Kingdom.

One of the key tasks of such a commission would be to provide the missing rules of engagement and progression, which have proved to be so helpful in the French regionalisation process and in determining the arrangements for the autonomous communities in Spain. Linda Colley has, for example, suggested that the end result may be some form of federal arrangement.

All of these issues are of considerable importance for policy-makers and practitioners because they provide the platform upon which spatial planning and development proposals are constructed. In the wake of the Scottish referendum calls have emerged for (greater) devolution to the North of England,[5] the English counties[6] and the English cities and city-regions.[7] A key driver in this debate is the growing awareness of the chasm between the

capacity for action which exists in the one English region – London – that has gained devolved powers and the capacity of the rest. In one sense it would be more sensible to focus attention on how to bridge this divide within England, rather than to bother with the West Lothian question.

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Notes

1   P. Roberts: *The New Territorial Governance: Planning, Developing and Managing the United Kingdom in an Era of Devolution.* Tomorrow Series Paper. TCPA, 2000

2   'John Gummer announces measures to bring a new localism to improved government services'. Press Release 731. Department of the Environment, 4 Nov. 1993

3   See, for example, P. Roberts: 'Geography matters'. *Town & Country Planning*, 2014, Vol. 83, Mar., 146-7

4   L. Colley: 'Scottish independence: the catalogue of errors that has brought the UK to the brink'. *The Guardian*, 16 Sept. 2014. www.theguardian.com/ politics/2014/sep/16/scottish-independence-catalogue-errors-union-uk

5   C. Blackhurst: 'It's not because I'm sentimental about the North that I believe it needs devolved powers '. *The Independent*, 2 Oct. 2014. www.independent.co.uk/ voices/comment/its-not-because-im-sentimental-about-the-north-that-i-believe-it-needs-devolved-powers-9770978.html

6   P. Hetherington: 'Whatever Scotland decides, English counties want greater devolution'. *The Guardian*, 17 Sept. 2014. www.theguardian.com/society/2014/sep/17/scotland-independence-referendum-england-counties-devolution

7   E. Rigby and K. Stacey: 'Smaller cities join push for devolved tax and spending powers'. *Financial Times*, 23 Sept. 2014

detroit – endgame or new beginning?

Above

Downtown Detroit, with the Quicken headquarters draped in the 'Opportunity made in Detroit' banner

The recent judgement on the bankruptcy of Detroit marks a critical moment in the history of this great, but deeply flawed American city. With the judge's ruling, a complex settlement between the city, its creditors, the State of Michigan and several other players will come into force. The pensions of 32,000 city retirees are secured, albeit with a 4% reduction and little prospect of future cost-of-living increases. For people whose average pension is only $19,000 per year, that is a bleak prospect. They agreed only reluctantly, facing a worse alternative. The magnificent collection of the Detroit Institute of Art appears to be safe from the threat of sale to the highest bidder.

The overall deal hinged on pledges by foundations of $360 million, matched by state funds and other sources for a total of $816 million, which was unprecedented in urban bankruptcies. Creditors and bondholders will receive only modest payments; some will hold out and sue. Nonetheless, the city can move out of receivership and begin the even more difficult task of turning itself around.

That job will not be easy. Once home to a population of close to 2 million people, Detroit now has about 700,000, the vast majority of whom are African-American and poor. Physically, much of the city is a wasteland. One-third of the houses are vacant. Of 380,000 properties in the city, 114,000 have been razed, and a further 80,000 are considered blighted. Crime levels are high, and police and fire response times are lamentably slow, due to savage cuts in personnel and failing equipment that is long past time for replacement. Perhaps one-third of streetlights are functioning. The education system is ineffectual and failing the city's children.

The city is ringed by hostile suburbs that generally want nothing to do with it, apart from funding

cultural facilities that their inhabitants use. Racism, both in housing and at work, is a terrible legacy. Above all, the city's economic base has been so eroded that the tax base is simply insufficient. Both manufacturing and retail businesses simply abandoned the city. By one estimate, only 70,000 people now both live and work in the city. The majority work outside, so the city gains nothing in property taxes from their employers. Although there is some in-commuting, the tax base generated is inadequate.

'What is happening is often admirable, but the underlying weakness of the city's fiscal system is a continuing threat that bankruptcy has not entirely solved... The heart wishes Detroit a great future, but the head remains sceptical'

In short, the new Mayor, Mike Duggan, has a formidable task ahead. Elected in 2013, he is the first white Mayor since 1974. He came to power in an odd way, having moved back to the city from a suburb too recently to file for the primary election. Nonetheless, he won nomination on a write-in vote, and then won the election handily with 55% of the vote. His platform, not surprisingly, focused on economic development, crime reduction, and financial stability. Nonetheless, he brings energy and commitment, together with significant support from the Republican Governor of Michigan, Rick Snyder, and from the residual business power structure, especially in the automobile industry that still has headquarters in downtown Detroit.

Duggan's first steps have been to address services. Reportedly, emergency response times decreased by 50% in the first six months of 2014, and 6,000 streetlights were installed. Rather than focus on demolition, he has offered incentives for the purchase and fix-up of houses, and is encouraging legal immigrants to come to Detroit.

Nonetheless, it is clear that turning Detroit around will take much more than public policy. There must be private investment and new people. Much attention in the media and policy circles has focused on Dan Gilbert, the charismatic billionaire founder of Quicken, the powerful online mortgage company that is headquartered in downtown Detroit with

some 12,000 employees. Gilbert is the prophet of the new Detroit, advocating for its revival as a dynamic urban centre. Putting his money behind the vision, he has bought or acquired long-term leases on over 60 buildings, many of them architectural gems. With other investors, he is building a light rail line from the Midtown area to Downtown, as well as supporting entrepreneurial development in a variety of ways.

Others have followed. Investors have bought single-family houses in viable but threatened neighbourhoods, fixing them up for sale or rental, the latter especially useful in the wake of the Great Recession, in which foreclosures in Detroit were massive. Still others have attempted to bring back neighbourhood-shopping areas or start new information technology firms. There are some inspiring stories here, but also failures, mainly due to lack of market scale.

Still others have followed different paths. Artists have occupied houses and abandoned buildings. Squatters in abandoned houses are resisting eviction. A number of urban agriculture groups started farms on abandoned land. Using goats to clear weeds, they have come into conflict with Mayor Duggan, leading to incidents in which the city has rounded up and slaughtered the goats. Others have been planting forests. There is room for a lot of experimentation.

Altogether, it is difficult to say whether Detroit will turn out to be a dramatic story of urban recovery, or simply a wounded city that limps along. What is happening is often admirable, but the underlying weakness of the city's fiscal system is a continuing threat that bankruptcy has not entirely solved. If some recovery occurs, municipal unions will push hard for their share, even as the pension system remains underfunded. The heart wishes Detroit a great future, but the head remains sceptical.

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