# Links Between Health Issues and the Development of Strategic Plans

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# Contents

## Abstract

The number of strategic plan (SP) making processes in England has increased over the past decade. SPs can potentially affect public health, both positively and negatively. However, it is currently unclear whether health issues are effectively linked with the development of SPs. It is within this context that this report has been prepared; it explores current evidence with regard to SP making in England in six sections. First, an introduction is provided, which outlines the overall objectives of the report and describes the methodology. This is followed by a summary of experiences with integration in strategic planning in England over the past 50 years. Next, what health means in the context of strategic planning is explored before SP making experiences in England are analysed, focusing on 8 of 18 completed SPs (another 15 SPs are currently under preparation). Results from a December 2019 London SP workshop, organised by the Planning Advisory Service (PAS) are summarised, at which representatives of 6 emerging SPs were present, as well as representatives of two published SPs. Finally, recommendations on how to approach health in SP making given.


## 1 Introduction

The National Planning Policy Framework (NPPF) from 2012 (Gov.uk., 2012a) is the first UK national planning policy to specifically mention the need to promote healthy communities. Furthermore, the reorganisation of public health functions (also in 2012) gave local authorities responsibility for the health of their local populations (Gov.uk, 2012b). 'Directors of Public Health' (DoPH) as well as public health teams were placed within local government, and new 'Health and Wellbeing Boards' were set up to provide integrated guidance over local population health. This brought public health under the same local authority as urban planners in unitary authorities and supported closer working. Co-operation with the health sector is, therefore, an important issue in strategic planning.

A 'duty to co-operate' was introduced into the English planning system in 2011 as a replacement for the strategic planning guidance that had been lost with the abolition of Regional Development Agencies (RDAs). This 'duty' requires local planning authorities to co-operate with other public bodies (including neighbouring authorities) on cross boundary, strategic matters. What exactly it means to co-operate in practice, however, is interpreted in different ways (TCPA, 2018). This is due to co-operation encompassing a broad umbrella of approaches, ranging from consulting to forming partnerships. Planning inspectors and the courts have been unable to provide a commonly agreed definition on the requirement. However, organisations such as the Planning Advisory Service (PAS, working with the Local Government Association - LGA) have been active in championing new approaches to working and fostering co-operation. For example, the '*Doing Your Duty*' report from 2014[1] sought to highlight and disseminate the emerging lessons from practice. Furthermore, '*A Simple Guide to Strategic Planning and The Duty to Co-operate*' (last updated in 2016[2]) and '*Local Plan Route Mapper: Navigating plan preparation efficiently to arrive at a quality plan'* (PAS, 2019: 23) presents a series of discussion points for planners to consider. Most efforts

[1] https://www.local.gov.uk/sites/default/files/documents/doing-your-duty-practice--1a3.pdf
[2] https://www.local.gov.uk/sites/default/files/documents/simple-guide-strategic-pl-557.pdf

are, however, primarily directed at co-operation between local planning authorities rather than with non-planning organisations in the health sector. The legislative Duty to Co-operate begins during the scoping stage of Local Plan (LP) making (i.e. at an early stage). PAS, following on from the National Planning Policy Framework (NPPF) paragraph 35 (c) advises to capture the engagement (proc ss and outcomes) between authorities on cross boundary matters. As it will provide an essential audit trail of decision making, the initial matter for an inspector is often to explore engagement within the independent examination. This ultimately provides a basis for informing an authority's Statement(s) of Common Ground (SCG) ibid (2019: 23).

In 2018, Central Government made significant revisions to the 2012 NPPF, including putting renewed focus on the strategic planning dimension (Riddell, 2019). This has required local authorities to work together to produce joint or aligned plans and strategies (see paragraph 17 of the NPPF). In 2019, PAS produced advice and a template to assist local authorities in compiling their SCG. Individual statements must be made publicly accessible and need to be transparent in outlining agreements and disagreements. They also need to highlight where effective cooperation is or is not occurring, including any jointly commissioned work to address cross boundary issues.

The SCG provides evidence that agreement has been sought by relevant strategic authorities. They can also be used to inform financial agreements such as the Community Infrastructure Levy and the Infrastructure Funding Statement. Finally, the SCG is important in forecasting contributions for planned developments (MHCLG, 2019)

*Aims and objectives of this report*

This report aims to enable a better understanding of how health is considered in SP making and how current practice can be improved, thereby helping planning authorities to make more informed decisions when engaging with SP making. Integration of environmental and transport aspects into SP making are covered in two related PAS reports.

In this report, key opportunities for local planning authorities in their pursuit to achieve improved linkages between SPs and health issues are explored and outlined. This is done in order to support effective strategic planning practice.

The following objectives are pursued:

1. To reflect on the current landscape and the opportunities available for effective integration of SP making and health issues.
2. To consider and reflect on emerging practice from SPs currently being developed.
3. To explore approaches, methods, and tools that can help health-led SPs to be based on more collaborative approaches and thus be strengthened through engagement with bodies representing various interests.
4. To give recommendations for improvements that could be made to ensure that the linkages between SPs and health bodies are improved and strengthened, including areas for possible focus.

*Methodology*

Three main methods were applied to meet the objectives outlined above:

- A targeted literature review was undertaken on (a) the integration of different issues in strategic planning, as well as the development of strategic planning over time; and (b) the connections between health and strategic planning.
- A strategic planning workshop was held with 30 (mainly local authority) participants in London in December 2019, representing a range of strategic planning exercises.
- An analysis of a selected number of SP case studies was carried out.

Whilst the literature review provided the basis for designing the underlying framework of research, the workshop and the analysis of the case studies allowed for an investigation of concrete practices and their effectiveness as well as contextual conditions that support the effective integration of health.

Eight strategic plans were analysed with regards to the following basic questions that came out of the discussions held by the project team:

- What specific documents were/are produced with regards to health and wellbeing?
- What were/are the key health policies in the SP and what are the key messages?
- What is the specific health approach in the associated impact assessments (IAs)?
- What are the impacts on health and is equal weight given to different integration aspects?
- Who is responsible for the preparation of SPs as well as the IAs relevant to health?
- What is the approach taken to the assessment of health effects?
- Other observations.

# 2 Experiences with integration in strategic planning in England – an overview of the past 50 years

The need for an integrated, joined up approach to planning harks back to the very origins of town and country planning in the UK where the modern system was conceived as a way of resolving public health concerns amid Victorian squalor around the turn of the 20$^{th}$ century. By controlling the quality of the built environment, some pioneers hoped to improve sanitation and subsequently the quality and longevity of life (Cullingworth & Nadin, 2006). This was overtaken in the 1960s by a more quantitative, technical approach to strategic planning which sought to model a range of variables to predict future needs and requirements that must be provided for (Taylor, 2010; Mitchell and Rapkin, 1954). However, these approaches became increasingly discredited in the UK during the 1980s as central government abandoned metropolitan governance and the predict and provide mantra was rejected for being unsustainable and insufficiently receptive to the wider interests of the environment and society (Vigar et al., 2000).

The emergence of sustainable development in the 1990s reawakened an interest in integration through delicately balancing social, economic and environmental needs.

Sustainability-led approaches required the managing of resources through objectives-led planning. This allowed different parties to come together and work towards a common aim.

From 1997, the UK 'New Labour' government promoted an integrated and joint-up policy agenda across government (Geddes et al., 2007). Within urban planning, this took the form of a spatial approach which, while proving to be somewhat ill-defined (Morphet, 2011; Harris & Hooper, 2004), went beyond a traditional, purely land use regulatory based approach and instead encompassed the functioning and making of places (Office of the Deputy Prime Minister, 2005). This agenda attempted to inject strategy back into urban planning and borrowed heavily from similar moves in the rest of Europe for a more spatial approach to policy making which promoted structural innovation and supported sustained economic growth (Schön 2005).

The need for integration increased following the fragmentation and deregulation of public services created by the 2010 Conservative and Liberal coalition government. A vacuum developed that presented a certain freedom for planning actors to engage in their work by adopting new approaches and pursuing strategic agendas which were more appropriate to their areas (Smith, 2014; Tewdwr-Jones, 2011). These efforts have resulted in the emergence of joint plans in metropolitan areas as local authorities came together to win devolution deals from central government and take on responsibility for the planning and delivery of their local public services.

*What is Integration?*

Integration in planning is usually represented as a process by which different parties or partners (including e.g. planning and health) come together to achieve some form of alignment in their strategies (Kidd, 2007). This may be through achieving synergy; a collective effort at addressing a complex problem (being aware that not all parties will necessarily want to compromise). However, integration is not necessarily a linear process with clearly defined beginning and end points. Rather, it may be an ongoing process which is subsequently shaped by institutional memories (Healey, 2006) as well as the individual actions (Smith, 2014) of the parties involved. In this context, integration may happen:

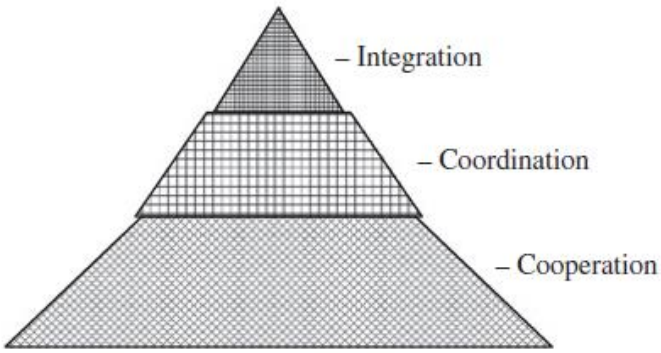
(a) across administrative, sectoral, and other boundaries;
(b) between different policies, plans, and programmes of one administration and/or sector; and
(c) between the aims and objectives of different parties or partners contributing to the same policy, plan or programme.

With regards to the question as to what makes for effective integration, Alexander & Faludi (1989) suggested that this is associated with the extent to which it is used and referred to. In this respect, the core test for effective integration is whether the objectives of one sector, policy, plan or programme are used and referenced in another (Fischer et al., 2013).

Is there a common understanding of what integration means in planning practice and is there one agreed way to integrate? To answer this question, Stead, Geerlings and Meijers (2004) established a hierarchal view of integration based around a pyramid (Fig 1). Here,

integration is presented as the pinnacle in a topology of different interpretations, with co-ordination and co-operation lying beneath. Each layer has a specific definition to describe differential outcomes. For instance, co-operation will result in more efficient sectoral policies, co-ordination leads to adjusted and more efficient sectoral policies, while only integration at the top produces joint new policies. The implication for planning practice is that what is often commonly referenced as integration may in fact be comprised of co-ordination, or even co-operation.

*Figure 1: Hierarchical View of Integration*




Source: Smith (2009), p28; adapted from Stead, Geerlings and Meijers (2004)

*Examples of different forms of integration*

The focus of this report is on linking/integrating health. In SP making, four aspects can be distinguished, including:

1. substantive integration between the aims and objectives of different topics, including health;
2. procedural and methodological integration between strategic plan and health policy production processes;
3. administrative integration across governance boundaries (planning and health); and
4. sectoral integration across different sectoral traditions and languages and e.g. associated policy and planning approaches.

Substantive integration concerns the development of consistent aims and objectives in strategic plans and associated policies (Fischer, 1999; Knox, 2003). Here, we can differentiate between broad strategic components that set a general direction of travel, and detailed aspects describing specific duties. It is entirely possible for policies to be strategically aligned, but misaligned at a detailed level due to levels of ambiguity (Fischer et al., 2013).

Procedural and methodological integration involves aligning the inputs of different sectors and partners in the strategic plans' production processes. Ideally, these inputs happen throughout production and in parallel, so that ideas, resources, and data can be shared. Similarly, plan production processes can share methods and techniques to enable comparable and exchangeable results in e.g. balance sheets and matrices (Ravetz, 2000).

The administrative aspects of integration recognise the wider context of decision making and ensure joined up decisions do not remain in joined up silos. In particular, the administrative aspects require due adherence to wider cross cutting synergies across government at different levels to meet wider priorities and ensure that all parties work in the same general direction (Cabinet Office, 2000).

Finally, sectoral aspects of integration pertain to how different sectors work alongside each other. Factors impacting this can include the compatibility of the respective professional cultures and their values (Harris & Hooper, 2004). An attempt to influence different cultures and values is represented, for example, by the 'health in all policies (HiAP)' initiative. Generally speaking, having partners work in different sectors can create communication problems both, in terms of distance between bases of operation (Cabinet Office, 2000), and also in the language and terms of reference used, particularly with regard to technical features (OECD, 1996).

*Current efforts of integration through strategic planning*

Local authority planners having to work out for themselves the mechanisms and processes of planning has been a major issue since the election of the coalition government in 2010. Whilst local authority officers were previously guided by a plethora of guidance notes and strategy documentation, in the new system they are expected to act on their recognisance and embrace new approaches to developing strategy (Smith, 2014). In this regard, the role of the individual planning officer is increasingly important in working around barriers, embracing challenges and, above all, making the system work (Smith, 2014). It follows that there is a need for more insight into how individual planners rise to the challenge of strategic planning, and disseminate the lessons learned from current practice. Given that planning practice is a highly contextual subject matter, these lessons ought to be in the form of a repertoire of approaches and techniques which officers might wish to employ, experiment with, and adapt in pursuing partnership and approaches to co-operation.

Over the past decade, some local authorities have been more pro-active at adopting joint strategic policies than others. For example, local authorities around Nottingham began working on an 'aligned' strategic plan in 2008, which was adopted in 2014 (Gregory, 2019). More recent efforts are introduced later in this report.

The 2018 revisions to the NPPF resulted in a renewed focus on the strategic planning dimension (Riddell, 2019) requiring local authorities to work together to produce either joint (or aligned) strategies, spatial frameworks, or spatial development strategies in combined authorities with elected mayors, i.e. Greater London, West of England, West Midlands, Cambridgeshire and Peterborough, Greater Manchester, Liverpool City Region, Sheffield City Region, Tees Valley and North of Tyne (see paragraph 17 of the NPPF). The way in which these plans and strategies are prepared is left to local planning authorities to determine with comprehensive advice from PAS (see, for example the Local Plan Route Map and Toolkit, PAS, 2019).

# 3 How are health issues currently integrated in strategic planning?

England has a long history of considering health within town and country planning. The industrial revolution of the 19th century increased the urban population, leading to overcrowding and unsanitary living conditions. The lack of basic public infrastructure and widespread poverty contributed to outbreaks of cholera, typhoid, scarlet fever and smallpox. Social reformers such as Edwin Chadwick in the *General Report on the Sanitary Conditions of the Labouring Classes of Great Britain* (1842), Friedrich Engels in the *Condition of the Working Class in England* (1845) were the first to demonstrate the relationship between the urban environment and health outcomes (Fawcett, 2019). John Snow is considered to be not only the founder of epidemiology but also of geographic information systems (GIS), as he was the first to map, through applying clinical statistics to street maps, the outbreak of disease in his research into the Broad Street cholera outbreak of 1854.

The works of these pioneers went on to shape the first wave of public health legislation such as the Public Health Act (1875) which charged local authorities with responsibility for public health and sanitation, the construction of sewage systems, and building codes for housing standards, land use, and natural light requirements [Fawcett, 2019: 7-9]. By the turn of the twentieth century, planning theorists such as Benjamin Richardson in *Hygeia, A City of Health* (1876) and Ebenezer Howard in *To-Morrow: A Peaceful Path to Real Reform* (1898) began to conceptualise the development of urban spaces with a key objective to maximise people's health. Howard built on this in his Garden City Movement, calling for a balance between health, the environment and the economy. These were pioneering ideas that have shaped English urban planning to this day (Barton, 2016 in Fawcett, 2019). The consideration of health in planning continued to be integrated strategically as the disciplines of planning and public health were established.

After the Second World War, the Town and Country Planning Act (1947) was the key piece of legislation which introduced the planning system we still have today (development plans, development control, and land use classes), whilst the National Health Service Act (1946) established the National Health Service (hospitals, primary care and community services free at the point of access). These developments effectively meant that the disciplines of planning and public health fragmented into two distinct professions with public health focusing on clinical needs. This led to a loss of collaboration (Fawcett, 2019: 15). By the 1980s, the neo-liberal economic agenda of the Conservative Thatcher government resulted in a planning system directed towards land-use regulation and economic growth where health considerations were narrowed to the provision of healthcare services, sanitation and minimum space standards (Fawcett, 2019: 13). Today, there is a realignment of the two professions as, increasingly, health and its wider determinants are considered essential in meeting current and future planning needs.

As mentioned earlier, the NPPF from 2012 (Gov.uk., 2012a) was the first national planning policy to specifically mention the need to promote healthy communities. Furthermore, based on the Health and Social Care Act (2012) local authorities have become responsible for the health of their local populations (Gov.uk, 2012b). 'Directors of Public Health' (DoPH) as well as public health teams were placed within local government and new 'Health and Wellbeing Boards' were set up to provide integrated guidance over local populations'

health. DoPH may be shared between neighbouring local authorities and the incumbent is a statutory member of the Health and Wellbeing Board. The DoPH is a central agent in ensuring Health and Wellbeing is integrated in services across a geographic area. This brought public health under the same local authority as urban planners in unitary authorities and supported closer working in two tier areas. Co-operation with the health sector is an important issue in strategic planning.

*What does health mean and what does it include?*

Definitions of health differ and are ambiguous, contested, and controversial. In the context of strategic planning, the definitions from the United Nations World Health Organisation (WHO) for health, mental health, Healthy Urban Planning (HUP) and Health in All Policies (HiAP) are of particular importance. Furthermore, in England, definitions from the Department of Health and Social Care (DHSC) for wellbeing, mental wellbeing, public health, and health inequalities are widely used. Subsequently, definitions are introduced. The Constitution of the United Nations World Health Organisation (WHO, 1948; see also Quickley et al, 2006) defines **health** as follows:

'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'[3]

The DHSC (2013) defines **wellbeing** as follows:

'Wellbeing comprises an individual's experience of their life; and a comparison of life circumstances with social norms and values. Wellbeing exists in two dimensions: Subjective wellbeing asks people directly how they think and feel about their own wellbeing and includes aspects such as life satisfaction (evaluation), positive affect (hedonic), and a judgement on whether their life is meaningful (eudemonic). Objective wellbeing is based on assumptions about basic human needs and rights, including aspects such as adequate food, physical health, education, safety etc. Objective wellbeing can be measured through self-report (e.g., asking people how they view their health), or through more objective measures (e.g. mortality rates and life expectancy).'[4]

The Department of Health (2010; in Cave et al., 2013, p.6) defines **public health** as:

'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society and has three domains of practice:

- health protection – biophysical: infectious diseases, air quality, noise, chemicals
- health improvement – inequalities, lifestyles, family/community, risk factors

[3] https://www.who.int/about/who-we-are/constitution
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/225525/DH_wellbeing_health.PDF

- improving services – service planning, efficiencies, equity, clinical effectiveness'

**Healthy Urban Planning (HUP)**, **Health in All Policies (HiAP)** and **Health Impact Assessment** (**HIA)** are symbiotic and each is integral to the others (Simos et al., 2015). Supporting a potential paradigmatic shift in urban planning, WHO has taken a lead in advocating the concepts of HUP and HiAP. The ecosystems approach is also of importance. It originated with Hancock and Duhl (1988) who presented a checklist of parameters for building health capacities processes within a city. The latter built on the WHO Alma-Ata Declaration (1978) and the Ottawa Charter for Health Promotion (1986) which encouraged the health sector to offer not only curative but preventative solutions to health needs and multi-agency working for healthy public policy, ensuring a 'golden thread' of health (Fawcett, 2019: 118).

*Health and Planning Regulatory Framework*

The NPPF (2012) makes reference to health at various points. Connections are made, in particular with regards to sustainable development (para 7), the improvement of health, social and cultural well-being (para 17), the promotion of healthy communities' (section 8; paras 69-78), and the health status and needs of the local population' (HUDU, 2012: 4).

The Health and Social Care Act (2012) aims to improve integration across health services. This act assigned the lead on the Joint Strategic Needs Assessment (JSNA) and Health Wellbeing Strategies (HWB) to Public Health England (PHE). It also established that PHE should encourage multi agency integrated working. The Act also established a duty for local authorities to improve the health of people in their areas (Section 12 Health and Social Care Act 2012)

The Ministry of Housing, Communities and Local Government (MHCLG) published its revised Planning Practice Guidance (PPG) on Healthy and Safe Communities in 2019. This guidance splits the health considerations in two, (1) creating environments that support healthy living, and (2) facilities for healthcare services. The latter remains the responsibility of the National Health Service and local commissioning groups. Furthermore, the role of the Director of Public Health and public health practitioners in planning decisions via the use of JSNA and HWS is reemphasised. It recommends that local authorities consult with DoPH when undertaking their Local Plan (LP) making process as well at pre-application consultation where a proposal may have significant impacts on health. Although significance is not defined, the use of HIA is promoted as a tool to assist in the mitigation of impacts.

Responsive to a local area, JSNA are assessments of the current and future health and care needs of a given community. These are not just clinical needs, but 'wider issues that affect health such as employment, crime, community safety, transport, planning or housing'. Furthermore, they aim at ensuring that 'mental health receives equal treatment to physical health' (DoH, 2013: 6-7).

Health and Wellbeing Boards have the statutory responsibility to carry out the recommendations of the JSNA and joint HWS, reviewing both on locally agreed timescales. The boards provide a local forum for collaborative working between commissioners, key stakeholders, elected members, wider partners, the voluntary sector, and communities to

address the wider determinants of health and health inequalities (DoH, 2011: 15). The JSNA and HWS are initiating steps towards a HiAP approach in England.

The Public Health Outcomes Framework is a tool updated quarterly with a vision to 'improve and protect the nation's health and improve the health of the poorest first' (PHE, 2019a). PHE collates and monitors official statistics with two high level outcomes; increasing healthy life expectancy, and reducing differences in life expectancy and healthy life expectancy.

The Directors of Public Health and their teams (Public Health and Planning Teams) are situated within local authorities across England, frequently at unitary or county council levels, and have responsibility for policy led planning for their local planning authorities. Project level planning through development control will occur at borough, district or city council level. However, there is a misalignment of spatial planning and health; in England there are 330 Local Planning Authorities with 151 Health and Wellbeing boards in unitary authorities, 195 clinical commissioning groups and 44 sustainability and transformational partnerships (Chang, 2019: 29).

The DHSC published its *Advancing our Health: prevention in the 2020*s Green Paper in 2019. It promotes preventative approaches to key areas of national health concern. It states that alongside PHE's annual Health Profile of the nation reports and the launch of the Health Index (a high-level indicator to be tracked alongside GDP), the quality and coverage of HIAs should improve non-health policies across government departments. Currently 25 local planning authorities have supplementary planning guidance on the use of HIAs**.** These define triggers for use of an HIA in project situations, for example, based on the number of new development units or floorspace.

*How does health currently get considered in planning? – the role played by impact assessments*

Health gets considered in planning through various mechanisms. Importantly, plans (including most SPs) are based on various socio-economic, bio-physical, and health objectives and policies. Associated with this are policies that are established in core strategies (guiding development over the next 15 years) and that are at the heart of many SPs.

The NPPF (2012) recommends the use of HIA for large planning applications and consultation with public health teams. Some local authorities have already started using HIA as part of their healthy planning tools. It is also increasingly used in plan making.

To undertake an HIA requires a multidisciplinary approach ('public health, social and political sciences, environmental health, urban planning, epidemiology and statistics') (O'Mullane and Guliš, 2014: 89). An HIA can vary in timing and scale, and be undertaken prospectively, concurrently or retrospectively. It can be rapid (1-6 weeks duration), intermediate (more than 3 months) or comprehensive (between 6 months to a year), depending on time and resources available.

To date, health has not been integrated into planning procedures through HIA, but mainly through other impact assessment (IA) tools. These include, in plan making: sustainability appraisal (SA), which is usually integrated with strategic environmental assessment (SEA); and in project development planning: environmental impact assessment (EIA). These tools are subsequently briefly introduced.

*Strategic environmental assessment (SEA), sustainability appraisal (SA) and environmental impact assessment (EIA)*

The EU Directive Strategic Environmental Assessment (SEA Directive 2001/42/EC) was transposed into UK law in 2004. Within English LP making it was concurrently applied within an overall framework of Sustainability Appraisal (SA) (Fischer, 2014: 37). The SEA Directive itself states that an assessment of human health effects should be included. In English Planning, SEA is usually integrated with a sustainability appraisal (SA). In order to be compliant with SEA, SA is structured into social, economic, and environmental sustainability outcomes with an implicit understanding they are the wider health determinants. Furthermore, specific health and wellbeing objectives are used (Bond & Pope, 2014: 48).

Aligned to the SA is the duty of local authorities - in response to the Equalities Act (2010) - to undertake an Equalities Impact Assessment (EqIA) of their individual LPs and policies. EqIA ensures that decision making does not discriminate against anyone based on protected characteristics: age, disability, gender (including reassignment), marriage and civil partnerships, pregnancy and maternity, race, religion and faith, sex and sexual orientation.

Environmental Impact Assessment (EIA Directive 2014/52/EU) has been adopted to support project level developments through the development control process. In 2017, it was amended to include impacts on population and human health in terms of likely significant effects and health outcomes. To consider health in EIA, Cave et al., (2019) advised that population and health may be covered differently in EIA and HIA (which was confirmed by Fischer et al., 2018), but that health needs to be assessed in different IAs (Fischer et al., 2018: 10). Provision of health evidence (quantitative statistics, peer review articles, scientific guidance, expert opinion and consultation exercises) in IA is an opportunity for the disciplines of public health and planning to collaborate [Fischer et al., 2018: 11).

These impact assessments are vital instruments in ensuring health impacts arising not just from the biophysical environment such as air, water, sanitation, biodiversity and climate change resilience are considered, but also psychosocial health and wellbeing within the context of the wider determinants of health (Fischer, 2014: 32). All IAs follow a similar process, consisting of screening (is IA necessary?), scoping (what issues and alternatives should IA potentially cover?), impact assessment and reporting, decision-making, and monitoring and evaluation. Furthermore, IAs usually include opportunities for consultation with statutory and non-statutory bodies as well as public participation (further discussed below).

# 4 Reviewing English strategic plan making experiences with regards to the integration of health

To date, 34 SP making processes have been, or are currently being, conducted in England. These fall under four main categories:

- Statutory joined or aligned local plans (JLPs)
- Statutory spatial development strategies (SDSs)
- Statutory joint strategic plans (JSPs)
- Non-statutory strategic planning and growth frameworks (SPGFs)

Table 1 provides an overview of those 34 strategic plans (SPs) in terms of being complete with documentation readily available (through the preparation authority's website), and under preparation.

The eight SPs used for further review are shaded. These were chosen based on the following criteria:

- Representation of all four categories; there was only one completed SP in each of the SDSs and JSPs categories. Three from each of the two other categories were picked (JLPs and SPGFs)
- Usable documentation on councils' websites, in particular with regards to information on health.

*Table 1: preparation status of 34 SPs in England*

| | Complete | Under preparation |
|---|---|---|
| Statutory joint or Aligned LPs | 1 North Devon and Torridge JLP 2018 | |
| | 2 South East Lincolnshire JLP 2019 | |
| | 3 North Northamptonshire JLP 2016 | |
| | 4 West Northamptonshire JCSLP 2014 | |
| | 5 Glo'ster, Tewksbury & Ch'ham JCS 2017 | |
| | 6 South Worcestershire Dev. Plan, 2016 | |
| | 7 Newcastle and Gateshead CS 2015 | |
| | 8 Greater Nottingham aligned CS 2014 | |
| | 9 Central Lincolnshire JLP 2017 | |
| | 10 Plymouth JLP 2019 | |
| | | 11 North Essex JLP |
| | | 12 Greater Norwich JLP |
| | | 13 N'castle under Lyme & Stoke Trent JLP |
| | | 14 Black Country JCS |
| | | 15 Greater M'chester Spatial Framework |
| | | 16 Central Lancashire JLP |
| Statutory SDSs | 17 The London Plan 2019 | |
| | | 18 Greater Liverpool SDS |
| Statutory Joint Strategic Plans | 19 West of England JSP** | |
| | | 20 Oxfordshire JSP |
| | | 21 South Essex JSP |
| | | 22 South West Hertfordshire JSP |
| | | 23 Greater Exeter JSP |
| Non-statutory Strategic Planning and growth frameworks | 24 P'ship f S Hampshire Pos. State. 2016 | |
| | 25 Somerset Growth Plan 2017 | |
| | 26 Surrey 2050 Place Ambition | |
| | 27 C W Sussex & G Brighton Spat. St. 2016 | |
| | 28 Suffolk Strat. Plan. Framework 2019 | |
| | 29 Leicester & L'shre Str. Growth Pl. 2018 | |
| | 30 Staff'hire Strategic Infrastr. Plan 2019 | |
| | | 31 Cambridge. & Peterb. Strategic State. |
| | | 32 Heathrow Strat. Planning Framework |
| | | 33 Norfolk Strategic Planning Framework |

analysed in subsequent analysis

* Documentation not available

** suggested it should be withdrawn by the Inspector for being insufficiently robust, consistent or objective (The Planner, 2019)

*Table 2: Analysis of eight SPs*

| | **Central Lincolnshire joint local plan 2012-2036 (3 councils); 2017** | **Plymouth joint local plan 2014-2034 (3 councils); 2019 (interactive)** | **West of England Joint Spatial Plan; 2017** | **Leicester and Leicestershire strategic growth plan 2050, 2018** |
|---|---|---|---|---|
| **What specific documents are produced with regards to health and well-being** | Joint Health and Well-being Strategy (mentioning Green space); Joint Strategic Needs Assessment; Guidance on preparing HIAs<br>Health in IIA | Equalities impact assessment<br>Health in SEA/SA | Equalities impact assessment<br>Health in SA | Equalities and human rights impact assessment<br>Health in SA |
| **Key health and well-being policies in the SP and key message** | Policy LP 9: Expectation that development proposals promote, support and enhance physical and mental health and wellbeing, and thus contribute to reducing health inequalities:<br>- Developer contributions to enhance health facilities<br>- Fit for purpose HIA for more than 25 dwellings or above 0.5 ha<br>- Role of allotments, gardens, orchards and food markets (healthy food) | 160 policies (on interactive LP), of which about half focus on individual development sites: various (explicit) health related policies:<br>- Transport for growth and healthy and sustainable communities<br>- Protecting health and amenity<br>- Air, water, noise, soil, land, light.<br>- Sport and recreation<br>- Playing pitches<br>- Community food growing and allotments<br>- Hot food takeaways<br>- Green and play spaces | 4 strategic priorities:<br>- Meeting housing needs in a sustainable way<br>- Inclusive economic growth and accessibility<br>- Spatial concentration of development<br>- Protecting high quality natural, built and historic<br>- Environment<br>7 main policies:<br>1 Housing<br>2 the spatial strategy<br>3 affordable housing targets<br>4 employment land requirements<br>5 place shaping principles<br>6 strategic infrastructure requirements<br>7 strategic development locations site requirements (with 12 sub-policies) | The overall vision states that: 'Growth will contribute to people's health, happiness and well-being…'<br>4 priorities: 1 create conditions for investment and growth (balance need for new housing & jobs with protection of environment and built heritage); 2 achieve a step change in the way that growth is delivered (focusing on strategic locations and less on non-strategic sites); 3 secure essential infrastructure that is needed to make this happen; 4 deliver high quality development<br>Document includes statements of intent; e.g.: Address lack of essential infrastructure, including healthcare facilities; need to focus on health and well-being |
| **Health approach in IA** | Health objectives of IIA:<br>- Health inequalities<br>- Mental and emotional health | SEA/SA health objectives:<br>- Health and well-being;<br>- Improve health and reduce inequalities | Health objectives in SA:<br>Theme 1: Improve the health, safety and wellbeing of all; | There is a 'sustainability appraisal statement' of 13 pages for the final plan |

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| | - Healthy lifestyles (e.g. green space)<br>- Accessibility to health and welfare system<br>- Mix of land uses (e.g. avoid integration of hot food takeaways)<br>- Fresh, affordable and healthy food<br>- Road safety;<br>In addition, objectives for pollution and economic, biophysical and social health determinants | (walking, cycling, access, noise, social inclusion;<br>- Open land, recreation, crime, anti-social behaviour, good housing quality, education and skills, jobs, reduce need to travel and car usage | 1a. Achieve reasonable access to public open space<br>1b. Minimise impacts on air quality and locate sensitive development away from areas of poor air quality;<br>1c. Achieve reasonable access to healthcare facilities | A full SA report was prepared for the draft plan (development of growth options also prepared). This included a health objective:<br>2.Maintain and improve levels of health, whilst reducing health inequalities |
| **Impacts on health / equal weight to integration aspects** | With regards to specific health objectives, the impacts of 57 LP objectives are positive overall; Economic impacts more positive than environmental impacts, though | Positive impacts with regards to housing, negative health impacts from increased noise and emissions and loss of green space | Overall positive impacts on 'health' (apart from a few specific strategic locations; but consistently negative impacts on environmental aspects<br>Economic impacts found to be more positive than environmental impacts | Overall, negative environmental impacts of development options; health overall more positive, but also various negatives are depicted. |
| **Prepared by?** | All internal | All internal | SP internal, SA by consultancy | SP internal, SA by consultancy |
| **Approach to assessment** | Options for each policy are assessed based on scoring systems (including ++ to --) | Alternatives for growth, spatial distribution, preferred strategy and alternatives for each policy are assessed (scoring system) | Assessment of 4 strategic priorities, based on scoring system (including ++ to --) | 6 development options and a hybrid option are assessed, using +++; ++; +; o; -; --; --- appraisal |
| **Observations** | 'Pseudo' options assessed in IIA (e.g. 'to have no policy'; don't include a settlement hierarchy') | A bit unclear what the outcomes of the assessment actually are. | It's odd to have a ++; +; o; -; -- assessment on the basis of development sites that are not geographically defined; whilst this is said to be a 'strategic approach', it is not clear what the evaluation is based on. | The appraisal provides most of the evidence for the local plan. development sites are not geographically defined; but a possible range of impacts are shown, depending on specific location, and for each option the impact can be between e.g. +++ and --- (some of the appraisal becomes uncertain as a consequence) |

| | **The London Plan 2019** | **Gloucester, Tewksbury and Cheltenham joint core strategy 2017** | **Partnership for South Hampshire Position Statement (PUSH) 2016** | **Coastal West Sussex and Greater Brighton strategic statement 2016** |
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| **What specific documents are produced with regards to health and well-being** | SA/SEA; London Health Inequalities Strategy; Locally-led Garden Villages; Improving Culture, Arts and Sporting Opportunities through planning; Healthy Streets Approach; MoU on healthy public realm around schools | SA/SEA and EqIA; health is a part of both assessments. | SA/SEA<br><br>No specific documents on health are prepared | SA/SEA<br><br>No specific documents on health are prepared |
| **Key health and well-being policies in the SP and key message** | Commitment to HiAP; Devolved powers to tackle climate change and health inequalities under Section 41 (4) of the Greater London Act Act;<br>Health is one of the 6 Good Growth Principles in LP with a key aim to create a Healthy City with a specific Health Inequalities Strategy and a Healthy Streets Approach;<br>Wider determinants; active lives and healthy choices; use of HIAs; healthcare provision; Air Quality; Green Spaces; Food and Fuel poverty | 3 Ambitions are formulated; one of this is to have a 'Healthy, safe and inclusive community', there are 9 strategic objectives, one of which is to promote healthy communities by<br>- Provision of green infrastructure<br>- Reducing inequalities<br>- Healthy lifestyles from community, sport & leisure, open spaces, sustainable transport<br>- Environmental quality and air quality | 4 development concepts:<br>1. small dispersed settlements<br>2. prioritise brownfield development<br>3. single economic region<br>4. development of new town<br>Implicit approach to considering health by delivering wider green and social infrastructure<br>Healthcare facilities and health and wellbeing to arise from green infrastructure | 6 strategic objectives; none are specific to health; the statement mentions health twice:<br>1. high quality environment improves health and wellbeing<br>2. investing in community facilities<br>Policy on Healthy and Balanced communities and Healthy City (not discussed in any detail in the SA/SEA) |
| **Health approach in IA** | HIA Rapid HUDU, DoH HIA Toolkit, HIA SPD and Dahlgren & Whitehead model followed; Overall Health Objective:<br>'To improve the mental and physical health and wellbeing of Londoners and to reduce health inequalities across the City and between Communities' | Set of target indicators set and health as part of the EqIA; no specific mentioning of wider determinants or HIA; no mentioning of JSNAs / HWS; no mentioning of consulting with public health practitioners | Target health inequalities; increase demands on healthcare facilities; cities have wards high in Index in Multiple Deprivation; improve health and wellbeing for residents and workers; reduce poverty and social exclusion. Mainly implicit consideration of health | New affordable homes are said to mean health benefits and reduction in deprivation. Transport plan improves safety, security and health (an SA integrated with an HIA was undertaken for the West Sussex Transport Plan; but here, health is not integrated |
| **Impacts on health / equal weight to** | Focus is on options to improve the health and wellbeing for Londoners ('Creating a Healthy City'); recognises | Reduce inequalities and participation in decision making is said to have positive impact; so are healthy lifestyles; green spaces; | Overall health and wellbeing impacts have neutral contribution in terms of significance; the SP is housing led and no integrated | Impacts not clearly assessed |

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| **integration aspects** | wellbeing in terms of both, provision of healthcare and the environment<br>Three Options: Prevention; Cure; and a spatially targeted approach; the preferred option is a combination of all three approaches | access to local health facilities; vacant/ second homes are an issue and negative impact predicted on some environmental determinants of health | approach to assessment is followed | |
| **Prepared by?** | SP internal (no PH personnel in topic working groups); IIA by consultancy | SP internal<br>IIA by consultancy | SP internal; SA by consultancy | All internal |
| **Approach to assessment** | IIA = SA/SEA/HIA/EqIA and Community Safety IA assessed with regards to:<br>- ++;+;0;-;--;?;NA<br>- Short/med/long<br>- Direct/indirect<br>- Temporary/permanent<br>  - local/ greater/ wider region/ global<br>  - cumulative | IIA = SA/SEA/EqIA (EqIA includes HIA); assessed wit regards to: x;--;-;+;++;?;0 – where x is absolute constraints;<br>SA assessment focusing on housing allocations | SA/SEA using: ++;+;0;-;--;+/-/<br>Baseline and key issues with comprehensive maps | Appraisal of each local area within region referring to each local SA, e.g. draft local plan for Arun<br>Outline each policy in line with strategic objectives & description of the baseline and do-nothing scenario, including proposed mitigation; none specific to health |
| **Observations** | IA impact outcomes on one page per objective. Only significant impact is related to noise when supporting pubs and night-time economy. No mentioning of any construction impacts, IIA consultation - too late in the process, Advise from PHE/NHS to use HIAs. authority advises to use JSNAs and HWS for health care facilities provision only | SA of site allocations for housing delivery<br>IA is logical when describing why options taken forwards or rejected | Informative maps in SA; list of health and wellbeing references in SA appendix not really referred to in the appraisal; health is not explicitly integrated into the SA; also, there is no EqIA and no mentioning of JSNA/HWS or working with public health personnel; consultancy are an engineering / law firm | Very limited consideration of health. Articles of memorandum, ways of joint working and other important information all available in an appendix |

*Summary of findings*

The findings of this research are summarised in this section with regards to the seven main analytical questions.

Q1: What specific documents were/are produced with regards to health and well-being?

As explained earlier, authorities have various choices with regards to producing documents that specifically focus on health when engaging in SP making. For only one SP was a joint Health and Wellbeing Strategy (HWS) and a joint Strategic Needs Assessment (JSNA) prepared. As LAs have a statutory duty to prepare these, it is not a surprise that the joint HWS and JSNA were associated with a joint LP (Central Lincolnshire). For six SPs, equality impact assessments (EqIAs) were prepared. The two exceptions were non-statutory SPGFs. The only other non-statutory SP (Leicester and Leicester Strategic Growth Plan) involved the preparation of an Equalities and Human Rights IA. The London Plan also involved the preparation of a Health Inequalities Strategy. For three SPs, IIAs were prepared that by definition involve HIAs. Unsurprisingly, as it is a statutory duty all eight SPs included the preparation of SEA inclusive SAs. Health was explicitly covered in six of them and implicitly in two non-statutory SPs. The London Plan included a range of documents, specifically targeting health and well-being. These included: locally-led garden villages, documents on improving culture, arts and sporting opportunities through planning healthy streets and healthy public realms around schools.

Q2: What were/are the key health policies in the SPs and what are the key messages?

All SPs include the formulation of strategic priorities, ambitions and/or objectives that are explicitly related to health. In this context, all SPs connect with housing, jobs, and highquality environments for better health and wellbeing. This includes both aspects of physical and mental health and well-being. Next to green infrastructure and environmental (e.g. air and water) quality, healthy food aspects (locally grown food and hot food takeaways) feature in about half of the SPs. Two of the SPs formulate provisions for the need to conduct HIAs in project development. This includes the London Plan, which makes reference to a range of toolkits and guidelines (including, for example, the Healthy Urban Development Unit's (HUDU) rapid HIA, and the Department of Health's (DoH) HIA toolkit) and also devises an HIA supplementary planning document (SPD). Furthermore, it includes the Central Lincolnshire joint SP, which comes with guidance on preparing HIAs, setting specific thresholds, for example that a fit for purpose HIA be conducted for developments of more than 25 dwellings or developments above 0.5 ha. The need for enhanced health facilities is reflected in the policies of all SPs. Those SPs that come with an EqIA include policies on reducing inequalities. The London Plan provides the most comprehensive approach of all SPs in terms of the inclusion of health policies and the key aim of creating a healthy city.

Q3: What is the specific approach to considering health in the associated IAs?

Those SPs that came with IIAs all include SEA inclusive SA, HIA and EqIA. The London Plan also includes a 'community safety IA'. All IAs are objectives-led, meaning impacts are assessed with regards to defined IA objectives. Whilst most include explicit health objectives, some are bolted onto other objectives, or are more implicit. For example, the non-statutory Coastal West Sussex and Greater Brighton Strategic Statement suggests that new affordable homes come with health benefits and lead to a reduction in deprivation. However, the Coastal West Sussex and Greater Brighton Spatial Strategy along with the non-statutory SP (Partnership for South Hampshire Position Statement) were the only SPs that did not explicitly integrate health in their IAs. Overall, health objectives are frequently connected with certain target indicators, for example, with regards to reducing inequalities.

Q4: What are the impacts on health, and is equal weight given to different integration aspects?

All seven SPs that cover health explicitly (i.e. all apart from the non-statutory West Sussex and Greater Brighton Strategic Statement) are said to result in positive health benefits. Whilst overall very positive impacts are said to occur with regards to economic health determinants (and to a slightly lesser extent also social determinants), negative impacts of SPs were consistently predicted with regards to environmental health determinants. This was particularly pronounced in those SPs that focused on new major housing developments, and here particularly with regards to increased emissions and noise, as well as loss of green spaces. Furthermore, in this context, negative impacts were predicted in connection with less sustainable forms of travel that residents in housing developments in more rural locations would have to rely on.

Q5: Who is responsible for the preparation of the SP and the IAs relevant to health?

The preparation of all the SPs was led by public authorities. There was, however, substantial involvement of the private sector in the preparation of the IA documents, with five of the eight SPs having their IAs prepared by consultancies. Public health experts appear to only have been involved in the preparation of HIAs, but not in SAs/SEAs.

Q6: What is the approach taken to the assessment of health effects?

All SPs have options of development policies assessed. In this context, they rely on matrices with scoring systems (from e.g. ++ to --). Furthermore, some also have strategic growth priorities assessed upfront. These are not usually formulated as options, but as statements of development ambitions/intent, e.g. 'meeting housing needs sustainably' or 'inclusive economic growth'. Whilst the assessment of alternatives and options is supposed to help plan makers to pick the best one, in practice, HIAs work more towards optimising given options and, in this context, an assessment may aim, for instance, to change policy formulations or add to them. As a consequence, at times, the outcomes of IAs remain somewhat blurred as no clear recommendations are provided with regards to choosing a preferred option.

Other observations

SPs have similar approaches with regard to how they consider health. However, there are also differences. All of them formulate development objectives; most of the SPs explicitly include some on health. In others, health is more implicit. Furthermore, there is a tendency to not assess options and/or alternatives with regards to, for instance, different sites or different policies, but instead consider policies themselves to be options. As a consequence, results from IAs are usually somewhat unclear and recommendations for the SP can be vague. Finally, there are also examples where health and wellbeing references are provided at the end of the document that are, however, not used anywhere in the IA.

One important observation refers to the most commonly used method in IA, namely the matrix scoring approach. Whilst this can provide some good indications of potential effects where there exists certainty of a specific impact (for example, a clear location), the use of this method in situations of uncertainty is questionable. In two SPs (Leicester/Leicestershire and West of England) a more strategic approach was chosen without having site specific information. However, even here a matrix scoring approach was applied. This means that the impacts of proposed development were assessed without having knowledge of where exactly they might happen. Depending on where impacts occur and what mitigation measures are used, effects can vary between very negative or very positive. This suggests that in the absence of clear site boundaries, the focus of IA should be less on assessing impacts and more on pro-actively advising how development should happen in order to enhance positive outcomes and avoid negative effects.

One observation of particular concern is that in SEA/SA there is no mention of any consultations with public health practitioners. Furthermore, there was no evidence that consultancies were using public health experts in the preparation of documentation.

# 5 Opinions of strategic planners on links between health and strategic plan (SP) making

This section summarises information obtained during a workshop with 30 strategic planners, which took place in London in December 2019. Here, strategic planners offered feedback on the progress of their SPs that were at various stages within the preparation process. Representatives of SPs from Oxfordshire, Greater London, South Essex, West of England, Greater Manchester, Coventry and Warwickshire, Greater Liverpool, South West Hertfordshire, and Greater Exeter were present. Of these, only Greater London and the West of England had published SPs. All other SPs were still under preparation (see Table 1 above).

Participants were divided along the lines of three parallel topic areas:

- Environment,
- Transport, and
- Health.

A world café participation technique was used to organise discussion. Three key questions on health were posed in two group sessions, with a series of prompts helping to guide discussion:

(1) How is health and wellbeing considered in strategic plan making?

- What health determinants are considered in strategic plan making?
- Through what tools or means are health concerns considered in SP making (e.g. SA/SEA or HIA)?
- What is the main vehicle for integrating health into strategic planning? Is it through objectives, targets or baseline data? Through health stakeholders? Something else?
- Is there compatibility of overall aims and objectives? Are health objectives aligned with other objectives?
- Is there consistency with regards to the methodological approach of considering health and other aspects?

(2) How are health practitioners included in joint working?

- What health stakeholders contribute and in what way?
- Do health and other stakeholders speak the same language?
- Do health representatives and those representing other aspects (e.g. planning) work together well?
- Is there joint responsibility for different issues?
- Is there sufficient/appropriate funding?
- Is the timing of the consideration of health and other issues aligned?

(3) How is health and wellbeing integrated into strategic planning?

- Are different elements of integration considered, for example horizontal (e.g. between different sector) and vertical (e.g. between different administrative levels)?
- Is there cooperation, coordination, or full integration?
- Is equal weight given to different integration aspects?
- What enablers and barriers are there for the integration of health in SP making?
- Are there any indications of implementation issues?
- Does the consideration of health add value to the strategic plan making process?

Key findings from the discussions are subsequently summarised in bullet point style with reference to the three overall themes.

(1) Health Considerations:

- Some participants were of the opinion that the Health and Wellbeing Strategy (HWS) should pull all relevant health aspects together and that health was not about planning decisions that are made or written.
- Some participants said that health and health inequalities were set out elsewhere.
- Participants thought that there was a need for national requirements for HIA and for making better links with SA/SEA.
- HIA was not considered to be strategic decision-making tool; participants suggested that it currently had more influence at the project level.

- Participants also said that it was difficult to retrofit existing places and that the consideration of health was easier in new strategic sites.
- Participants were unsure as to how to measure targets and on how to link up with LPs
- Participants said that it was often unclear what the direct impacts on health were and how they could be measured. In this context, they felt that there was a particular urgent need to discuss what 'good growth' was/meant.
- Participants observed that there was more discussion around health and wellbeing linked to climate change at the SP level than elsewhere.
- Some participants suggested that health and wellbeing were being used when arguing about the benefits of building on the Green Belt; one authority was said to have had the term Green Belt removed in housing site allocations, replacing it with 'Health and Wellbeing'.
- It was suggested that SA/SEA was not a genuine part of the SP making process and neither was health and wellbeing. However, one participant also stated that when in doubt, they usually refer to the evidence provided by the SA.
- Participants suggested that one of the lessons learned from the West of England SP failed examination (caused, amongst a range of things by an inadequate consideration of alternatives) was that SA/SEA should be treated as a genuine part of the SP making process.
- Participants observed that JSNAs and HWSs were not being fed into the LPs via the SA/SEA.
- It was also observed that previously agreed principles from Health and Wellbeing Boards were changing due to local electoral cycles and that planners in many authorities were under-resourced. In this context, health and well-being were not considered to be part of the day job.
- Finally, participants stated that no stakeholder mapping was undertaken which led to the duplication of work.

(2) Joint Working:

- Participants asked the questions as to how we could move away from tick boxing in IA [this connects with the matrix approach used in IAs, discussed earlier in this report].
- As an example of a current deficiencies in joint working, the issue of schools were cited; children were not going to the closest schools and this meant that there were fewer opportunities to walk and cycle to school.
- Participants suggested that links between councils still needed strengthening.
- It was also suggested that collaboratively working with the NHS was difficult due to differing funding and timescale frameworks.
- There was a lack of understanding as to the role of Directors of Public Health.
- Participants suggested that NHS Estates Plan were not integrated with planning and that, as a consequence, section 106 (legal agreements between an applicant seeking planning permission and the local planning authority, used to mitigate negative impact) funds were not taken up. There was also no health involvement in negotiating contributions; this was contributing to focusing on health and wellbeing as clinical needs and through the siting of health care facilities. Wider determinants of health were neglected and silo working continued.

- It was suggested that it was rare to find an external consultant who had expertise in health; usually assessments revolved around biophysical elements, including, for example, noise and acoustics and engineers as well as environmental scientists. Health expertise was usually internal to a council or came from the NHS (who have increasing budgetary constraints).
- It was suggested that, politically, there was little understanding of health and wellbeing in planning, and that capacity building of elected members was needed.
- It was also suggested that there was a need to triple lock long term strategic decisions to avoid short term election cycles.
- Finally, participants felt that differences between the LP and the SP were still not fully understood.

(3) Integration:

- With regards to integration, it was suggested that in IIA, HIA was equal to other elements, which was positive for the standing of health in SPs.
- It was suggested that there was a need to move away from a SP being an election battleground rather than a visioning document; there was political distrust in the process overall.
- Climate change and health issues were said to be offering a focus on cross boundary working. However, housing numbers in Green Belt locations were still increasing.
- Integration was said to be hindered by inconsistent objectives. For example, in transport strategies, new housing was assessed and judged by driving times; this was said to negatively affect climate strategies and health.
- In the case of Greater Liverpool, the spatial development strategy was said to be aligned to the Metro Mayor's Manifesto within which climate, environment, and health were overriding issues; this was thought to result in an overall positive effect on the consideration of health in the resulting SP.
- Finally, it was said that health and wellbeing were themes to be considered at different levels. These included strategic, local, and neighbourhood levels; there was confusion about what should be considered where, and there were also associated problems with evidence gathering.

To summarise, challenges with regards to the better consideration of health in SP making were seen to revolve around a lack of adequate resources (both planning and health). Furthermore, there is still resistance on the part of practitioners to engage with the other discipline, mainly because of different traditions and, associated with this, difficulties in understanding. One aspect which was mentioned a few times by those working in strategic planning was the length (sometimes as short as a year) of election cycles. Achieving successful integration of strategic planning and health was said to take time and this required commitment beyond current election cycles.

It was also suggested that there were inconsistencies between the objectives of different sectors represented in a SP. For example, driving times by residents of new housing developments were a key element in transport impact assessments, but were often in conflict with climate change objectives. Furthermore, there was confusion due to the different levels at which health needed to be considered, in particular in the presence of

only one set of health data that needed to be used at, for example, neighbourhood, local and strategic plan levels.

At the end of this section, several general observations are made that underline the problems currently found when attempting to improve the integration of health and strategic planning. To start with, it was obvious that strategic planners were somewhat reluctant to join the health session at the London workshop, with many more joining the transport and environment discussion sessions. Participants needed some gentle persuasion to join the health discussion table.

It was interesting that strategic planners tended to view health through the lens of the Department of Health and Social Care and the NHS rather than, for example, either the Ministry of Housing, Communities and Local Government, or Public Health England. Moreover, during discussion, it became clear that there was a lack of understanding of key health terms and what health meant for the built environment (including, for example, with regard to wider determinants of health, health inequalities, mental health and wellbeing). When discussing progress overall, participants from just two of the nine SPs mentioned health and wellbeing as an important issue. Finally, with regards to being able to deal with health issues in strategic planning, and when discussing team capacity, it became clear that this was varied in different SP making situations, ranging from one member of staff part-time to seven full-time members of staff. There currently appears to be a limited number of experienced strategic planners in the country. At the same time, uncertainty in funding streams, (such as with regards to how each local authority is going to contribute), has led to, recruitment into planning generally and SP teams specifically being difficult.

# 6 Conclusions and recommendations

In this report, links between the development of strategic plans (SPs) and the consideration of health in England were explored. In this context, reasons for the importance of strategic planning and for the value of an adequate integration of health in SPs were discussed. The starting point was that there is currently no clear understanding of how well and how effectively health is considered within SPs and therefore an evaluation of current SP documents was provided. Furthermore, opinions of those involved in SP making exercises were sought.

There are statutory and non-statutory SPs. Statutory SPs include joint or aligned local plans (JLPs), spatial development strategies (SDSs) and joint strategic plans (JSPs). There is no standardised approach to non-statutory SPs, which consist of a range of strategic plans and growth frameworks (SPGFs).

Joint LPs are not dissimilar to other (non-joint or non-aligned) LPs, as they have to meet the same statutory requirements. There are, however, some differences with JSPs and in particular with SDSs. However, currently there is only one completed example for each of these, namely the West of England JSP (which was asked to withdraw as it was not found sound by the Planning Inspector in 2019), and the London Plan. The main documents of both these SPs were reviewed in this report. SPGFs can divert more substantially from their

statutory counterparts, one reason being that there is more scope for them to develop a distinct methodology and approach.

In all the SPs that were reviewed in this report (including 3 joint LPs, 3 SPFGs as well as one SDS, and one JSP) health was reflected through policy objectives, and in some SPs also through additional, higher level, strategic priorities. Health objectives in most SPs are explicit, apart from those that are non-statutory, where health may be covered more implicitly. With regards to establishing the health implications of SPs, a range of impact assessment (IA) tools are currently used. Whilst all eight examined SPs included Strategic Environmental Assessment (SEA) inclusive Sustainability Appraisal (SAs), six also came with an Equalities Impact Assessment (EqIA), which is formally required for all statutory SPs. Health Impact Assessment (HIA), finally, was produced for only one SP in the context of Integrated Impact Assessment (IIA). Whilst the SEA Directive asks for human health to be considered, traditionally, the focus in SEAs has tended to be on environmental determinants of health (e.g. air, water and soil pollution), leaving most social and behavioural determinants unaddressed. Whilst SAs tend to have a strong focus on economic benefits arising from plans (Therivel and Fischer, 2012), EqIAs do address some social determinants of health. HIA, finally, should provide for a comprehensive assessment of the whole range of (economic, social and environmental) determinants of health.

Whilst some of the SP practitioners coming together during a dedicated SP workshop in London in December 2019 suggested that IA tools were insufficiently integrated with SPs, there were also suggestions that planners, when in doubt, routinely refer to the evidence provided by the (SEA inclusive) SA. In this context, an important lesson from the West of England SP failed examination was that SA/SEA should be treated as a genuine part of and running in parallel to the SP making process (with one of the reasons cited for withdrawal being an inadequate justification of strategic housing options).

With regards to inputs from health stakeholders, despite the National Planning Policy Framework (NPPF) asking for health considerations to take centre stage in planning, practice is currently still underdeveloped and some strategic planners from the practitioners workshop are of the opinion that health and health inequalities should be covered elsewhere. However, this is clearly not in line with what the NPPF is suggesting; raising awareness of what should be delivered is crucial. It is clear, though, that at this point in time strategic planners are less comfortable engaging with health than they are with, for instance, transport or environmental issues.

Overall, there are indications that whilst public health practitioners continue to have a poor understanding of (strategic) planning processes, planners still do not understand the relevance of their actions on public health well. This is not helped by what many planners suggest is currently a considerable lack of funding in planning departments in many local authorities. In this context, it is somewhat concerning that when being explicitly considered, health and wellbeing are at times used to justify controversial developments, for example, housing in the Green Belt. In this context, one authority was reported to have removed the term Green Belt in housing site allocations altogether, citing reasons of health and wellbeing benefits.

HIA is currently not widely used in SP making. Considering the requirements of the NPPF, this is surprising, as only HIA is currently able to comprehensively deal with health issues in a pro-active and problem driven manner. It is also equipped to generate transparency with regards to potential trade-offs that may occur between different health determinants, including those that are of an economic, social, and environmental nature. Currently, and most notably in the context of new housing developments, negative impacts of SPs are consistently established in SEA/SA with regards to environmental aspects, while positive impacts are usually anticipated for economic and, to a lesser extent, social aspects. However, in the interest of sustainable development, win-win-win solutions for all aspects should be sought and HIA is well placed to contribute to this, as it is not restricted by the impact-led approach present in other IA tools, including SEA and SA.

With regards to making suggestions for what may be needed to improve the integration of health and SP making, there is clearly a demand for the development of situation specific guidance. In this context, there is a particular need for encouraging IA tools which make concrete suggestions for the development of health initiatives in SPs. Considering the reluctance of planners to engage with health issues, a culture change will be required; it will take some time to materialise. In this context, training and capacity building will be of crucial importance.

There is a particular need for supporting those assessing the impacts of SPs with regards to choosing suitable methods to assess health implications. To some extent, these are currently picked not based on the need of a specific SP situation, but rather on what is routinely used in LP related assessments. However, depending on, for example, the level of “strategicness”, suitable methods differ. Thus, an assessor looking to specify for instance, damage in sq. m. of specific ecosystems from development in impact matrices in the absence of exact locations has probably picked the wrong method.

Finally, there are some generic issues that need to be addressed. These are, however, not restricted to health. For example, differences between SPs and LPs appear to remain poorly understood. Further, strategic planners also suggest that they need guidance on how development that leads to a subordination of environmental health determinants to economic prerogatives should be approached. In this context, a good question asked is what good growth actually looks like. It will be difficult for strategic planners to answer these questions without support. This can potentially be provided by PAS; in particular through providing guidance and capacity building.

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## Glossary

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| DHSC | Department of Health and Social Care |
| DoH | Department of Health |
| DoPH | Directors of Public Health |
| EIA | Environmental Impact Assessment |
| EqIA | Equality Impact Assessment |
| HIA | Health Impact Assessment |
| HiAP | Health in All Policies |
| HUDU | Healthy Urban Development Unit |
| HUP | Healthy Urban Planning |
| HWB | Health and Wellbeing Strategies |
| IA | Impact Assessment |
| JLP | Joint Local Plan |
| JSNA | Joint Strategic Needs Assessment |
| JSP | Joint Spatial Plan |
| LP | Local Plan |
| NPPF | National Planning Policy Framework |
| PHE | Public Health England |
| SCG | Statement of Common Ground |
| SA | Sustainability Appraisal |
| SDS | Spatial Development Strategy |
| SEA | Strategic Environmental Assessment |
| SP | Strategic Plan |
| SPGF | Strategic Planning and Growth Framework |