Worcestershire County Council

Planning for Health in Worcestershire Technical Research Paper

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Foreword

The origins of the Planning system in England can be traced back to the desire to tackle the unsanitary living conditions that arose during the industrial revolution. Subsequently, planning became separated from public health and the two systems developed separately. Reforms in 2012 resulted in public health once again becoming a local government function, making it a great time to reaffirm the links between planning and health. We are now exploring the new ways that planning and public health can work together to reduce health inequities, encourage development of healthy living environments, and reduce the economic burden of ill health.

The Strategic Planning team within the Business, Environment and Communities Directorate at Worcestershire County Council is working in partnership with the council's Adult Services and Health Directorate and with Worcester City Council to rebuild the links between Planning and Health.

The purpose of this paper is to start the process of change in Worcestershire, by providing a summary of the significant issues and challenges surrounding health within the county and considering how these might be tackled jointly through the planning system and Public Health. This paper focuses on prevention of illness, rather than addressing the consequences of its development. We hope that this paper will be used to inform future planning policy and decision-making across the county, and to guide the work of the local Health and Wellbeing Board. The paper is also intended to raise the profile and forge stronger links between planning and public health, as we work together to address some of the issues detailed in this paper.

We hope you find this a useful and interesting read at the start of this exciting new stage of joint working, as we move forward to address and reduce the health inequalities that exist in the county and help to make Worcestershire's population healthy.

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Executive Summary

This is one of a series of technical research papers prepared by Worcestershire County Council's Business, Environment and Community directorate. This paper has been produced in partnership with the council's Adult Services and Health directorate and Worcester City Council to look at ways of reaffirming and re-connecting Planning and Health. The purpose of this paper is to start the process of change in Worcestershire, by providing a summary of the significant health issues and challenges and how these might be addressed jointly through the planning system and public health. This paper focuses of the prevention of illness, rather than the consequences of its development, as prevention will bring the biggest gains for the population's health and it is through prevention that the planning system can have the greatest impact. In recognition of the fact that local authorities together with public health have powers to shape the environment in which people live, and that it is this above all else that determines people's health outcomes, the Health and Social Care Act 2012 gave upper tier local authorities new duties for improving the population's health.

Nationally we are living longer, but living longer with a disability/non-communicable disease. With the ageing population expected to grow, the Marmot Review (2010) found that the more affluent live longer than the less affluent and that the later years of the more affluent are spent in better health. Today most people now die from non-communicable diseases in old age, and the causes of premature death are linked to avoidable behaviours, such as smoking, drinking too much alcohol, physical inactivity and eating too much food high in fat, salt and sugar. There is greater awareness now of the close links between mental and physical health and we know that if people's mental health is improved, they are more likely to take part in physical activity which brings with it a reduction in the prevalence of coronary heart disease, diabetes, and obesity.

The 'social determinants of health' is an expression given to the number of elements which impact on an individual's health. These factors include where they were born, live and work, their age and any systems/legislation put in place to deal with health related issues, i.e. the social, economic and environmental factors. It is this complex set of causal factors which combine to create the environment in which people live. Policies which change any one of these factors will have an impact on health, and the most significant impact will be evident when a whole system approach to change can be delivered.

An 'inequality in health' is a term to describe the differences in health status between individuals or groups, as measured by (for example) life expectancy, mortality or disease. Health inequalities are preventable differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. The Marmot Review (2010) calculated that nationally, inequality in health accounted for productivity losses of £31–33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year and additional NHS healthcare costs associated with inequality in excess of £5.5 billion per year.

In Worcestershire the population is generally healthy, meeting or exceeding national averages. The proportion of the population in older age groups is increasing rapidly, resulting in new challenges such as the need for appropriate housing, care, and health services. There is a high health burden from conditions which are linked to behaviours such as smoking, sedentary lifestyles, drinking too much alcohol, and eating too many foods that are high in fat, salt and sugar. There are growing concerns about the projected ill-health from these behaviours. Mental ill-health issues in the county are evident although not above national averages. Life expectancy varies significantly across the county and spatial variation is evident too in the prevalence of the main disease groups. As an example, Malvern Hills and Wyre Forest districts have a higher percentage of estimated population than the national average of people with Coronary Heart Disease (CHD).

There were found to be a vast array of challenges and issues to be addressed when tackling this work, and for each challenge this paper attempts to show, through the use of case studies, how it can be overcome. The challenges are summarised as:

- Health-related challenges and issues;
- Challenge of fostering behavioural changes;
- Economic issues;
- Challenges of processes involving planning and health;
- Climate Change;
- Improving health through the environment; and
- The challenge of defining a healthy urban environment.

Further work to promote and raise the profile of public health and plan-making/development management needs to be undertaken after the launch of this paper. This is, we hope, only the start of the work to reduce health inequities.

Introduction

This paper seeks to re-establish the links between planning and health in order to reduce the health inequalities that exist in our community and in turn reduce the economic burden on local authorities and health services. The paper will be used by local authorities as an evidence base and to highlight examples of best practice to inform plan-making. It will also inform the work of the local Health and Wellbeing Board, focusing on prevention of illness, rather than addressing the consequences of its development. This paper will achieve this by tackling the planning-related components that make up what have been termed the 'social determinants' of health.

Status

This is one of a series of technical research papers prepared by Worcestershire County Council's Strategic Planning section. This paper has been prepared in partnership with the council's Adult Services and Health Directorate and Worcester City Council to assist with plan-making across the county. It is not a statutory document; it is a technical research paper and does not negate the need to read other relevant documents, many of which are listed in Appendix 1.

The audience for this paper is everyone who is involved in plan-making and development management in Worcestershire, as well as adjoining authorities that share cross-boundary health issues. This will include colleagues from:

- WCC planning team and elected members;
- District council planning teams and elected members;
- Town council officers and members;
- Parish council officer and members;
- Clinical Commissioning Groups;
- NHS England Area Team;
- Worcestershire Regulatory Services;
- Worcestershire Local Enterprise Partnership.

The purpose of this paper is to start the process of change in Worcestershire, by providing a summary of the significant issues and challenges surrounding health within Worcestershire. It identifies the key determinants of health and how these impact on the population of Worcestershire, and uses case studies as examples of what can be done to improve/prevent further decline in the health of Worcestershire residents. Public health and planning colleagues have worked together to:

- summarise the national and local policy background;
- summarise the national and local health profile;

- summarise the evidence around health and planning; and
- suggest next steps.

It is intended that this work will be used to inform future planning policy and decision-making across the county. The paper is intended to act as a background technical report and does not itself represent County Council policy.

Scope

Health impacts on many aspects of people's day-to-day lives. It is not just about falling ill, but also wellbeing and preventing illness; it goes beyond the care of a person who has become ill, and requires the application of best practice in a range of areas, including:

- planning for better built and natural environments and living conditions, to prevent people becoming ill in the first place;
- ensuring that there are facilities in place and means of getting to those facilities for those who do become ill; and
- Providing a healthy environment for those people who do fall ill to recuperate in.

The paper is structured as follows:

- Chapter 1 gives a brief introduction;
- Chapter 2 provides the national policy and evidence context;
- Chapter 3 describes the key health-related issues and challenges we face in Worcestershire within the ambit of spatial and health planning;
- Chapter 4 responds to the issues and challenges by setting out options for how they might be addressed in plan-making decisions;
- Chapter 5 sets out next steps.

Chapter 1: Background and historical context

1.1 This next section examines the historic and current reforms in planning and health care that have led us to the system we have in place today.

Historical Reforms

1.2 Once again, the wider public health[1] agenda has become a local government key function, planned, supported and enabled through local Health and Wellbeing Boards. Historically planning has been intrinsically linked to public health, from the need to tackle the health of the population in the 19th century as a result of the industrial revolution, in particular overcrowding in urban areas, to the planning system we have in place today in which planning policy related to health is addressed through the National Planning Policy Framework (NPPF) and its associated Planning Practice Guidance (PPG).

1.3 These links can be further demonstrated by looking back historically where interventions were implemented through planning, to achieve public health outcomes. Chadwick's[2] work in public health to address unsanitary conditions (sewage contaminating water supplies and the spread of cholera and other infectious diseases during the industrial revolution) helped bring about change to sewage systems and help the provision of safe drinking water, significantly improving health at a population level. The original boundaries of district councils were based on those of urban sanitary authorities, and the principle of elected individuals being democratically accountable for the health of local people was maintained into the early 20th century and survived the creation of the National Health Service in 1948[3].

1.4 The National Health Service Reorganisation Act 1973 saw the public health functions of local authorities transferred to the NHS.

1.5 Over the last 70 years and into the 21st Century there has been improved quality of housing and the development of garden cities and new towns which incorporate access to open space. They all help with positive changes in the profile of ill-health and premature mortality caused by chronic conditions which are often related to lifestyle choices and unhealthy environments. Legislation including the Clean Air Act 1956 and the Water Resources Act 1963 (which sought to manage water quality and supply) helped to improve the quality of the environment in which people lived. Waste management and noise control reform have also contributed to this improvement.

1 Public health, as defined by the Faculty of Public Health, is "the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals." (http://www.fph.org.uk/what_is_public_health)

2 Edwin Chadwick was a social reformer during the eighteenth century, noted for his work on Poor Laws, Public Health and improvement of sanitary conditions.

3 CLG (2013) report 'Eighth Report The role of local authorities in health issues' http://www.publications.parliament.uk/pa/cm201213/cmselect/cmcomloc/694/69402.htm

Current Reforms

1.6 This section of the paper looks at the current health and planning reforms which shape the system we work within today.

1.7 The modern public health profession has three elements:

- Health improvement - focuses on structural determinants of health, health promotion and ill-health prevention, and utilises a social model of health[4].
- Health protection – focussed on communicable disease and programmes based on medical work such as screening and immunisation.
- Health services public health- involves analysis of the effectiveness of health care interventions.

1.8 Three pieces of recent reform have created a new framework for bringing together health and planning considerations at the local level, with new opportunities to improve population health:

- In April 2013, the Health and Social Act 2012 gave upper tier local authorities new duties for improving population health. This is in recognition of the fact that local authorities together with public health have powers to shape the environment in which people live, and that it is this above all else that determines people's health outcomes. Reducing avoidable ill-health and narrowing the gap between those living in the richest areas and those in the poorest may be achieved through working together.
- In March 2012, the National Planning Policy Framework (NPPF) brought together revised guidance for local authority planners, including a specific requirement to promote healthy communities, and to draw on evidence of health and well-being need. To accompany this in March 2014 the Department for Communities and Local Government (DCLG) launched the Planning Practice Guidance web-based resource, which has a dedicated section on health and wellbeing, further detail of which can be found via this link http://planningguidance.planningportal.gov.uk/about/.
- In 2011, the Localism Act gave more power to local areas, including making provision for neighbourhood planning. This creates new opportunities for local flexibilities to meet local needs and for local communities to influence the local environment.

1.9 Taken together, these reforms create a new landscape of planning for health, and new opportunities to embed health considerations within the planning process. This is of key relevance for Worcestershire County Council, which has the following four corporate priorities:

- Open for Business
- Children and Families
- The Environment
- Health and Well Being

1.10 Outcomes in each of these areas can be improved if every opportunity is taken to maximise the health benefit of planning considerations.

1.11 Maximising these opportunities will be challenging, especially within a complex two-tier county, requiring a change to existing ways of working. In April 2013, a new public health team was created in the County Council, including health intelligence, health and well-being, and emergency planning functions. This team will work with planners at County and District levels to take these new opportunities to integrate heath into planning. Producing and disseminating this paper is part of this process.

4 A social model of health seeks to achieve improvements in health and wellbeing by directing efforts to addressing the social, economic and environmental determinants of health.

Chapter 2: National policy context and health evidence

2.1 This section looks at the national policy landscape in place today, before going on to examine the major changes in the nation's health that have helped shape national policy.

National policy context

2.2 Over the last two decades, government policies have highlighted and aimed to tackle the clear and growing evidence of a rising tide of avoidable ill-health and the continued health gap between rich and poor. In general, policy has sought to:

- bring a shift from treatment to prevention;
- support individuals to make informed, healthy, choices; and
- build a new, whole population based approach to health improvement which involves far more partners than the NHS alone.

2.3 These policies have drawn from evidence presented in some key national background research and reports which are summarised below (further details on these, including a diagram detailing how these fed in to this paper and other health and planning policies and legislation can be found in Appendix 2):

2.4 **The first Wanless Report**[5] (Securing Our Future Health, Taking a Long-term View) assessed the resources required to provide high-quality health services in the future. It illustrated the considerable difference between expected costs depending on the engagement of people with their own health. It found that resources were needed in the short term to improve access to services and in the long term, including investment in renewing Healthcare premises. It went on to say that health inequality improvements would only be made if people were fully engaged following widespread access to information, and public health would dramatically improve with a reduction in risk factors such as smoking and obesity as people actively took ownership of their health.

2.5 **The second Wanless Report**[6] (Securing Good Health for the Whole Population, Department of Health) focused particularly on prevention and the wider determinants of health in England and on the cost-effectiveness of action that can be taken to improve the health of the whole population and to reduce health inequalities. It found that targets set by government on reducing health inequalities were unachievable. Recommendations were made across a range of areas including research and legislation to try and maintain the balance between individual responsibility and state intervention. It suggested that an annual report on the state of people's health and health determinants be made available nationally and at local authority level to improve understanding.

5 WANLESS, 2002 The first Wanless Report, Securing Our Future Health, Taking a Long-term View

6 WANLESS, 2004 The second Wanless Report, Securing Good Health for the Whole Population, http://webarchive.nationalarchives.gov.uk/20130107105354/ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076134.pdf

2.6 **The White Paper on Public Health**[7] was steered by the Wanless report and drew attention to the causes of ill health and the need to reduce inequalities. It aimed to inform and encourage individuals to choose a healthy lifestyle and help shape the commercial and cultural environment to enable people to do this. New funding streams became available from the Department of Health which made interventions such as new food labelling based on the traffic light system, restrictions on television advertising to children, improved school sports and smoke free places legislation possible. The key theme is to empower people to make informed choices about their health and tailor support to those who find it most challenging to make these choices.

2.7 **The Marmot Review**[8] (Fair Society, Healthy Lives) revealed that health inequalities persist in the UK despite efforts that have been made. The review also reported that the gap between rich and poor had widened. The review recommended that fairness and social justice should lie at the heart of all policies for the future, since the cost of continued health inequalities is too high for the economy to sustain.

2.8 Action across 6 areas was recommended:

1. Give every child the best start in life;
2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives;
3. Create fair employment and good work for all;
4. Ensure a healthy standard of living for all;
5. Create and develop healthy and sustainable places and communities;
6. Strengthen the role and impact of ill health prevention.

2.9 The fifth area of action 'creating and developing healthy and sustainable places and communities' is of particular relevance here as this is where planning and health come together. The concept of 'social capital' (where the links between individuals and their communities help buffer against the risk of poor health through social support) is vital for physical and mental wellbeing. This can be built in at a local level through policy makers involving those in the community in the policies that will affect them and investing differently to make these places sustainable.

2.10 Improving access to active travel[9] opportunities across the social gradient, increasing access to green space for all, improving the energy efficiency of housing and enhancing the local food environment are examples of recommendations which will involve planners and public health specialists.

2.11 **The Public Health White Paper**[10] responded to Marmot with an approach to empower individuals to make healthy choices and give communities tools to address their own needs. Local authorities had new statutory duties and had the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area. As a result, public health teams have now been moved into local authorities to support delivery of this new public health duty in order to take steps to improve population health.

2.12 Innovation at a local level can enable communities to reduce inequalities and improve health at key stages in people's lives. Examples from the White Paper involving planning, include designing communities for active ageing and sustainability, making active ageing the norm rather than the exception, building more Lifetime Homes, protecting green spaces, and launching physical activity initiatives, including a £135 million Lottery investment in a Mass Participation and Community Sport legacy programme. A priority from the White Paper is to protect and promote community ownership of green spaces and improve access to land so that people can grow their own food.

7 HOUSE OF COMMONS, 2004 The White Paper on Public Health 2004
8 Marmot M et. al, 2010 The Marmot Review, Fair Society Healthy Lives
9 Travelling by foot or bicycle rather than car or public transport.
10 Department of Health, 2010 Healthy Lives, Healthy People: Our strategy for public health in England

2.13 **The 2012 National Planning Policy Framework (NPPF)** is the government's overarching planning framework which brings together health and planning. This gives new emphasis to health, and sets out the government's requirements for the planning system as far as it is relevant, proportionate and necessary to do so. In 2014 the government launched its National Planning Practice Guidance (PPG). This new web-based resource states that health, wellbeing and health infrastructure must be considered in local and neighbourhood plans. Decision-making should promote physical activity, consider health infrastructure implications of proposed development, promote access to health food, and consider pollution and other hazards which might impact on human health.

2.14 **The Localism Act 2011** gives new freedoms to local areas and includes provision for neighbourhood planning. Neighbourhood Plans enable some decisions about housing to be taken locally and enable greater statutory support for communities to take positive action to improve health and wellbeing by identifying new facilities that are required or improving the design of new buildings. They enable residents, employees and businesses to come together at a forum and debate how new communities should look, with support and technical advice from local planning authorities. These Neighbourhood Plans must conform with strategic elements of the Local Plan, including health infrastructure, which guarantees the involvement of health bodies by those preparing plans. Communities can also develop neighbourhood development orders and community right to build orders. Further detail on this and other planning and health legislation that governs the way we work can be found in Appendix 2.

2.15 The Localism Act also introduced powers to revoke Regional Strategies. In May 2013 the Secretary of State exercised those powers to revoke both the West Midlands Regional Spatial Strategy and the approved Worcestershire Structure Plan. Through the Localism Act and related legislation, these former mechanisms for cross-boundary planning have been replaced by a 'Duty to Co-operate' where there are strategic cross-boundary issues to consider during plan-making, including strategic health and infrastructure matters.

National health evidence

2.16 As shown above, the national policy landscape has changed as a result of the significant strengthening of the evidence of major change in the nation's health. This next section looks at the nation's health.

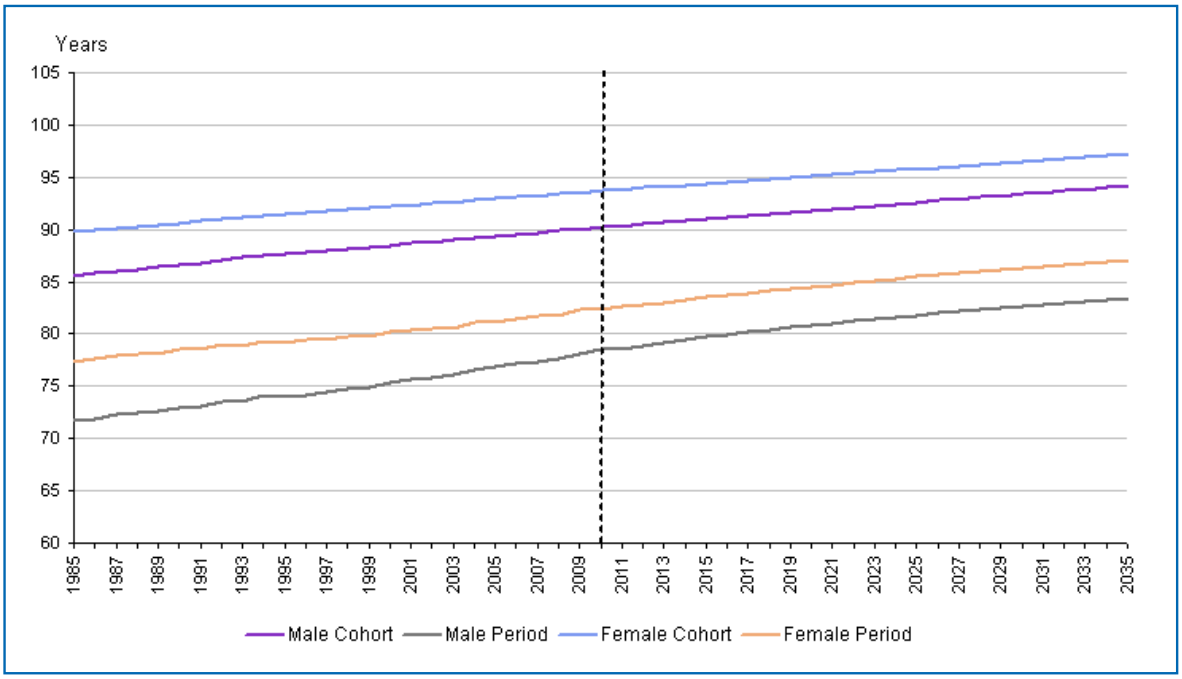
2.17 This evidence can be considered under six key points, which are discussed in more detail below:

- Increased life expectancy
- A change in the main causes of premature death
- Greater awareness of the links between physical and mental health, and the high prevalence of mental health problems
- Increased understanding about the spatial distribution of good health
- Increased understanding about the explanation for this spatial variation
- Increased concern about the economic costs of poor health.

2.18 **Increased life expectancy**. In the mid-nineteenth century, 4 in 5 deaths were before the age of 65. Today, more than 4 in 5 deaths are after the age of 65; life expectancy is higher than ever before, and this trend is projected to continue[11]. Figure 1.1 below shows that life expectancy has increased for both males and females since 1985 and will continue to do so into the future. Females continue to live longer than males with a similar gap in years between life expectancies. The ageing population will increase over the next 10 to 20 years as a result of 'baby boomers' (1946 to the early/mid 1960s) who are now reaching old age, with consequences from more older people living longer; notably their needs for appropriate housing, care, and health services.

11 Department of Health, November 2010, No Health without Mental Health: A Cross Government Mental Health Strategy for People of All Ages

Figure 1.1 Period and Cohort expectation of life at birth, 1985-2035, UK[12]



2.19 **The main causes of death and premature death have changed too**. Now only 2% of England's population dies from infectious disease, when in the past this was higher. Most people now die from non-communicable diseases in old age (circulatory, accounting for 34% of deaths, cancers 27%, and respiratory diseases, 14%)[13]. Due to improvements in public health, health issues have changed; whilst people are living longer, some are living longer with a disability/non-communicable disease, which places new types of burdens on health care. Much of the burden of disease and causation of premature death is now linked to avoidable behaviours, such as smoking, drinking too much alcohol, physical inactivity and eating too much food high in fat, salt and sugar (poor diet).

2.20 **There is greater awareness now of the close links between mental and physical health**, and the high prevalence of mental health problems. At any one time, roughly one in six of us is experiencing a mental health problem[14]; one in four experience a mental health problem in any one year; one in ten children aged 5-14 years has a mental health problem at any given time; and almost half of all adults will experience a depressive episode at some stage in their life[15]. Mental well-being is closely connected with physical well-being and we know that if mental health of individuals is improved, it brings with it a reduction in prevalence rates for coronary heart disease, diabetes, and obesity.

2.21 **There is increased understanding about the spatial distribution of good health**. Where you live is a significant predictor of health and life expectancy. Data collected on life expectancy demonstrated that, in England, people living in the poorest communities will die on average seven years before people living in the richest neighbourhoods. Not only do they die sooner, but people living in the poorest communities in England spend more of their lives living with a disability. The average difference between rich and poor for disability-free living is seventeen years[16]. The Marmot Review goes on to say that reducing health inequalities is a matter of fairness and social justice and this is what we should be aiming for. However, this should not just focus on the most disadvantaged, as this will not reduce health inequalities sufficiently, but with a scale and intensity which is proportionate to the level of disadvantage. This is called proportionate universalism.

12 Based on historical rates from 1985 to 2010 and assumed calendar year mortality rates from the 2010-based principal projections, ONS, http://www.ons.gov.uk/ons/rel/lifetables/period-and-cohort-life-expectancy-tables/2010-based/p-and-c-le.html

13 Department of Health, November 2010, as above

14 Public Health Observatories, 2013, Community Mental Health Profiles 2013, Worcestershire, Copyright © 2012-13, NEPHO. Delivered by the Public Health Observatories in England in partnership with the Department of Health.

15 http://www.mentalhealth.org.uk/help-information/mental-health-statistics/

16 Marmot Review, 2010, as above

2.22 In England the life expectancy of urban populations is lower than that of rural populations. Areas in one study were defined according to settlement type and density. Within these urban and rural populations the density of development affects life expectancy; those in less dense areas were found to have better life expectancy for both sexes. When thinking about deprivation, life expectancy was highest in urban males with low deprivation, but lowest in those who were most deprived. In the rural setting, there was less variation in life expectancy between the most and least deprived groups[17]. However, people living in rural areas are not without their own health-related issues; ease of access to health care, for example, is often reduced in rural areas.

2.23 Data has shown an increase in the numbers of elderly people living alone as well as an increase in single-parent households, which will have health implications, not least on ease of access to health care[18]. This information helps us plan services to help reduce these inequalities in life expectancy, for example through improving access to services.

2.24 Figure 1.2 below shows the life expectancy and disability-free life expectancy at birth depending on level of deprivation, measured by neighbourhood income. It reveals that there is a large gap in both life expectancy and disability-free life expectancy; the more affluent live longer and the less affluent live shorter lives. This demonstrates the health inequalities which can be apparent at birth depending on the relative deprivation of the area in which you were born. This is backed up by the Marmot Review (2010) that drew attention to the evidence that social factors such as experiences in early childhood, housing, education, income and the built environment are predictors of ill health. The Review went on to say that tackling and improving these social factors can have substantial impacts on a population's health, and in turn reduce unfair and avoidable health inequalities. This resulted in one of the Marmot Review's six policy objectives to 'give every child the best start in life'.

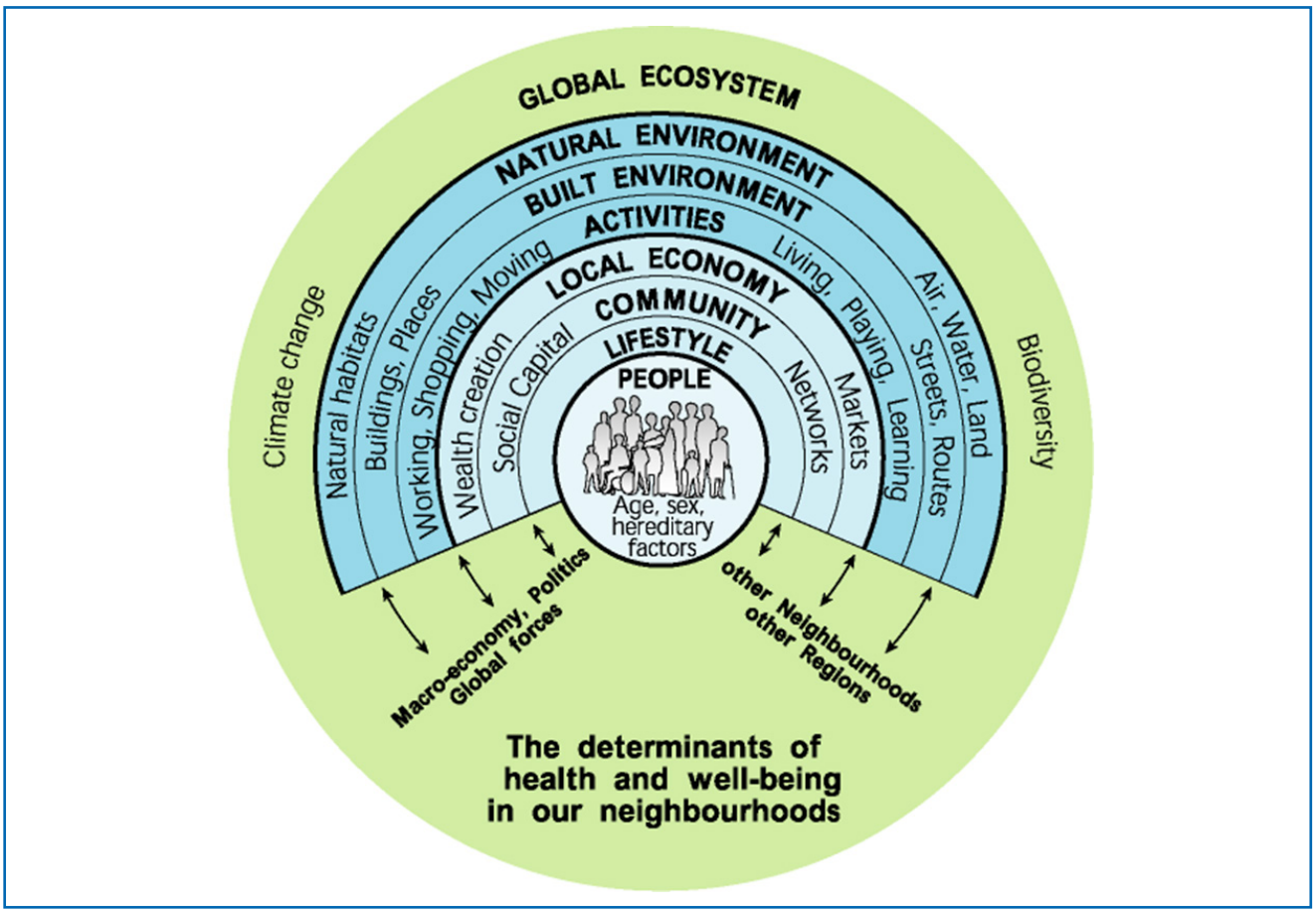
Figure 1.2 Life expectancy and disability-free life expectancy (DFLE) at birth, person by neighbourhood income level, England, 1999-2003[19]

17 ONS Health Statistics Quarterly, 46, Summer 2010m http://www.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/no--46--summer-2010/index.html
18 Rodrick and Fudge, 2009, Healthy Cities in a global and regional context, Health Promotional International, Volume 24
19 Office for National Statistics, http://www.ons.gov.uk/ons/index.html

2.25 **The Social Determinants of Health**. There is greater understanding too about the explanation for this spatial variation which is increasingly being understood as a complex set of causal factors, combining to create the environment in which people live. Policies which change any one of these factors will have an impact on health, and the most significant impact will be evident when a whole system approach to change can be delivered.

2.26 The social, economic and environmental conditions that influence the health of individuals or populations is shown in Figure 1.3 below. This details the social determinants of health.

Figure 1.3 Settlement Health Map[20]



2.27 The 'social determinants of health' is an expression given to the number of elements which impact on an individual's health. These factors include where they were born, live and work, their age and any systems/ legislation put in place to deal with health related issues, i.e. the social, economic and environmental factors.

2.28 Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health. The Marmot review highlighted that reducing health inequalities is a matter of fairness and social justice.

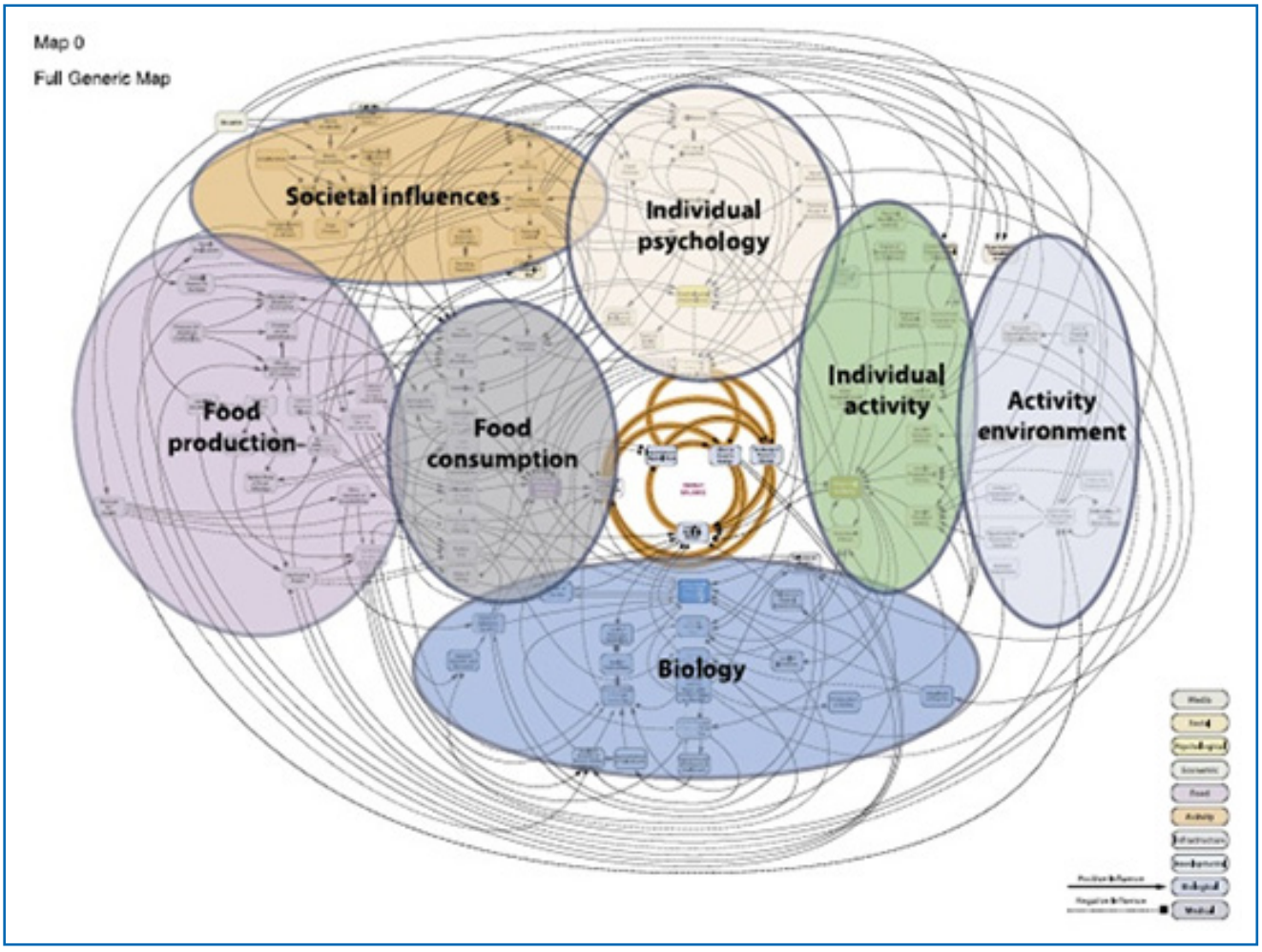
2.29 It has been found that people from lower social economic groups have little control over the following social determinants: housing, education, financial security and the built environment. They are cumulative effects; people from such social groups tend to have lower standards of education, so have less chance of getting a well-paid job, so their housing and built environment choices are reduced, and as a result, it is found that people from this group suffer with poorer health.

20 Barton and Grant, 2006, A health map for the local human habitat, Journal of the Royal Society for the Promotion of Health

2.30 Figure 1.3 demonstrates the vast array of factors that impact on a person's health (often known as 'the causes of the causes' of ill health). These can be illustrated at a very basic level using the example of premature death from coronary heart disease: the immediate cause of the disease may have been shown as obesity, but obesity is caused by eating too much of the wrong sort of food, by not exercising enough, and by a basic imbalance of calories in and calories out. However, the causes lying behind these behaviours are complex: access to unhealthy foods; lack of information about what constitutes healthy food; lack of understanding about physical exercise health benefits; lack of access to open space; lack of aspiration for good health; use of high-fat food as a stress reliever; and so on. Some of these are linked to features of the individual, and some to the environment in which they live. All are amenable to change.

2.31 The complexity of the 'causes of the causes' of obesity is shown in one of the key reports on obesity, The Foresight Report, Figure 1.4 below:

Figure 1.4 Causes of obesity[21]



2.32 **Cost to business**. There are increasing concerns about the economic costs of poor health. The rising costs of health care are putting increasing pressure on the national finances. Some of these costs are indirect. Healthy people are more likely to be in work which is good for the economy; the Department of Health[22] states that it is these people who are more likely to play an active role in society and to contribute to the economy through their families, local communities and workplaces. Conversely, poor health puts a huge strain on the economy and NHS as well as on individuals and those looking after them[23].

21 Foresight et el, 2007, The Foresight Report Tackling Obesities: Future Choices – Project report, 2nd edition
22 Department of Health, November 2010, as above
23 Department of Health, November 2010, as above

2.33 Nationally, the costs to business of working age ill health have been calculated as over £100 billion, and every employee nationally had an average of 6.5 days sickness in 2010[24]. Ill-health also costs business in terms of lost productivity resulting from people attending work when their health is less than optimum, producing the problem of 'presenteeism', when performance is low due to poor health. Marmot (2010) also points out that more than three-quarters of the population do not have disability-free life expectancy as far as the age of 68. State pension age is increasing; by 2018 both men and women will have to reach 65 before they can claim. This will go up to 66 by 2020 and is set to further increase over time. If people are to work to this age, they need to be healthy both mentally and physically.

2.34 The Marmot Review (2010) calculated that nationally, inequality in illnesses accounts for productivity losses of £31–33 billion per year, lost taxes and higher welfare payments in the range of £20–32 billion per year and additional NHS healthcare costs associated with inequality in excess of £5.5 billion per year. It has been estimated that the cost of mental health problems alone to the economy in England is £105 billion, with treatment costs expected to double in the next 20 years[25].

2.35 **Obesity**. The cost of treating the obesity epidemic and its associated illness alone was recorded as £2 billion per year in 2010, and if nothing is done to tackle the problem, this cost is predicted to rise to nearly £5 billion per year in 2025[26]. It is estimated that the cost of treating the growing number of people in the county who are obese is £80million a year[27].

2.36 **Smoking**. The cost to the NHS of dealing with smoking-related disease was estimated at £5.2 billion per year in 2010[28]. Estimated costs to the government for provision of smoking cessation services and medicinal aids to cessation were £88.2million and £66.4 million respectively[29].

2.37 **Drug Dependency**. The UK spends £1.2 billion per year on drug strategies, including enforcement and treatment. These are direct costs and do not take into account the cost of the criminal justice system including courts, police and prisons, which could top £4 billion. The wider social and economic costs of drug related crime is estimated at £16 billion per year. Research for the Drug Treatment Outcome Report Study commissioned by the Home Office and published in 2009, suggests a saving of £2.50 per £1 spent on drug treatment[30].

2.38 **Conclusions**. The examples above give some flavour of the cost associated with treating ill health, but there are obviously many more costs for other illness not mentioned above. However, it does demonstrate the costs associated with ill health and the need to reduce these costs through preventing illness in the first place by tackling the 'cause of the cause' of ill health. As Marmot (2010) states, "doing nothing is not an economic option".

24 CBI 2011, Absence and workplace survey
25 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766
26 Marmot, 2010, as above
27 Worcestershire County Council, January 2013, Worcestershire Future Fit - Corporate Plan 2013-2017
28 Allender, 2009 The burden of smoking-related ill health in the UK. Tobacco Control
29 Health and social care information centre, 2012
30 BMA, Drugs of Dependence – in Depth

Chapter 3: Health in Worcestershire

3.1 In this section we consider the key facts of the population's health in Worcestershire. These come from health indicators which are set nationally and the formulated Joint Strategic Needs Assessments (JSNAs) for Worcestershire which are updated regularly.

3.2 The following key points are made:

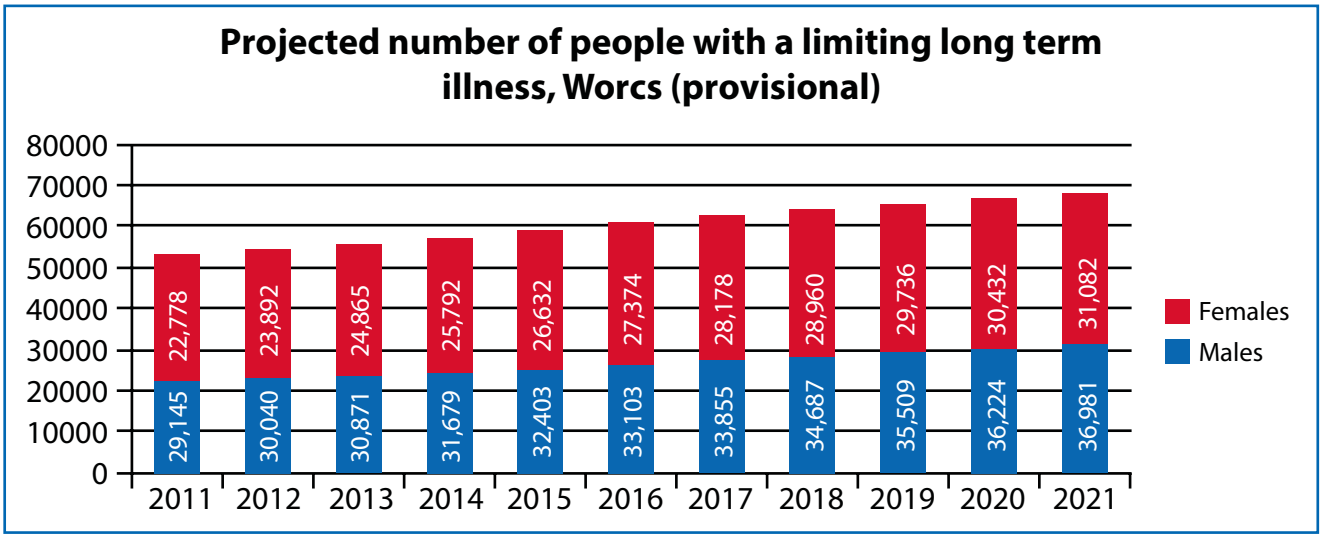
- The population is generally healthy and is either as healthy or healthier than the national average;
- The proportion of the population in older age groups is increasing rapidly, so that new challenges are developing;
- There is a high health burden from conditions which are linked to behaviours such as smoking, being physically sedentary, drinking too much alcohol, and eating too many foods that are high in fat, salt and sugar. There are growing concerns about the projected ill-health from these behaviours;
- Mental ill-health in the county is evident;
- Life expectancy varies significantly across the county;
- Spatial variation is evident too in the prevalence of the main disease groups.

3.3 **The population is generally healthy**. In Worcestershire, health outcomes are broadly in line with national averages. There are issues on a more local level in Worcestershire which are significantly worse than nationally. These include: the number of women smoking in pregnancy; number of under-18 hospital admissions for alcohol-specific conditions; adult obesity; hospital admissions for self-harm; and diabetes (although this can be seen as a positive sign of diagnosis rates being better than in other areas nationally.)

3.4 **The proportion of the population in older age groups is increasing rapidly, so that new challenges are developing**. There are 557,000 people in Worcestershire[31] (Census 2011). Nearly one in five is aged 65 or over and one in forty is aged 85 or over. The population is projected to increase to over 600,000 in the next 20 years. This increase will be mainly in the older age groups. The number of people aged 65 and over will increase by 30,000, and the number aged 85 and over by 6,000 by 2020[32]. Over the next 8 years, the proportion of the population aged 65yrs+ is expected to reach one in four, and over the same time period the number of people living with a limiting long-term illness is expected to exceed 68,000. The ageing population can be attributed to the 'baby boomers' (babies born between 1946 and the early/mid 1960s), retiring and reaching old age. With this ageing population we need to plan for the scale of care/support they need, taking account of their health-related issues and implications for their quality of life, notably their needs for appropriate housing, care, and health services. The scale of the challenge described above can be seen pictorially in Figure 1.5 below, showing a steady increase in the number of people with a life-limiting illness in Worcestershire from 2011 until 2021.

31 Office of National Statistics http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/index.html
32 Worcestershire County Council, 2013a, Worcestershire Health and Well-being Board Joint Health & Well-being Strategy, 2013-2016

Figure 1.5 Projected number of people with a limiting long term illness[33]

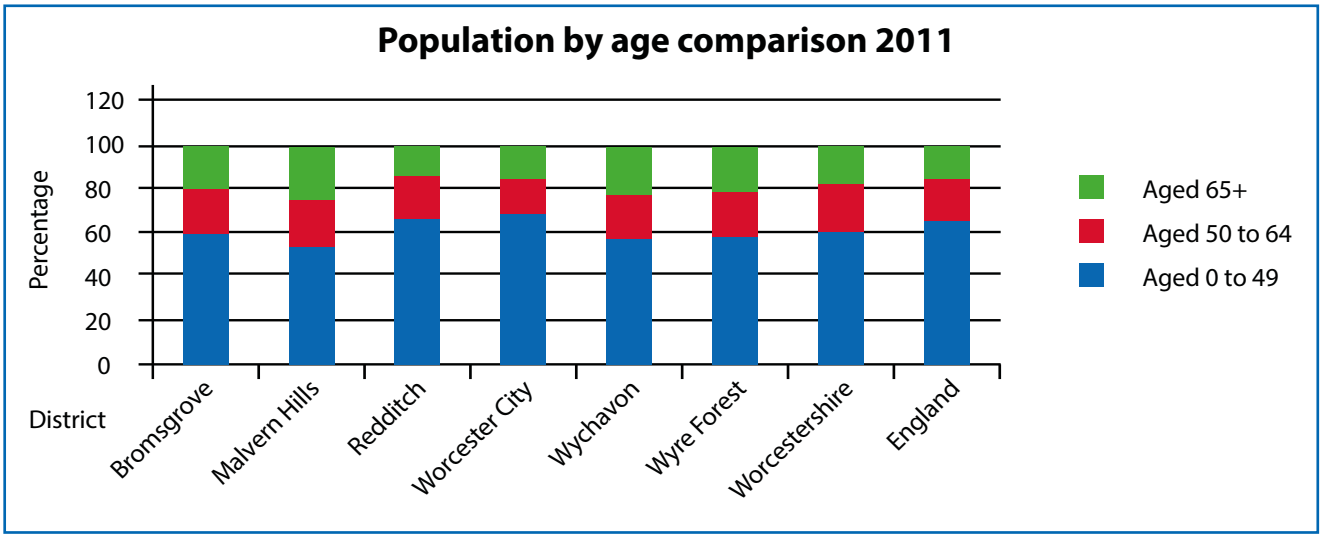


3.5 The speed of population growth is greatest among the very old age groups, which are those who place the greatest demand on health and social care services. For example, the number of older people with dementia is expected to double in the next 20 years. The number of hospital admissions for falls among people over 65 is around 2,500 a year, and this is expected to rise by up to 80% in the next 20 years. Stroke is one of the most significant causes of disability and poor quality of life in old age and the current prevalence of 6% in the 65 – 74 years age group and 10% in the 75 and over group, is expected to rise significantly. Other key conditions linked to an ageing population are diabetes, chronic obstructive pulmonary disease and hypertension (high blood pressure). All have significant health consequences, and all are increasing sharply as the population ages.

3.6 It should be noted that there is variation across the county in terms of the proportion of older people in the population, and also in the rate at which this is changing. Malvern Hills and Wychavon have the highest proportion of people over the age of 65, but Bromsgrove has experienced the largest increase in people over 75 since the last census.

3.7 Figure 1.6 below shows the age distribution of the people living in each of the county's districts, with Malvern Hills and Wychavon showing the largest proportion of older people.

Figure 1.6 Population by age comparison 2011[34]



33 Worcestershire County Council, September 2013, Worcestershire Future Fit - Corporate Plan 2013-2017
34 Worcestershire County Council , September 2013, as above

3.8 **There is a high health burden from conditions which are linked to behaviours such as smoking**[35]. At a county level, there is a picture of widespread adoption of behaviours which are linked to poor health outcomes, and these are, of course, all amenable to change. About 14.7 % of the adult population smokes (below the national average of 18.4 %), but about 14.3% of pregnant women smoke (which is higher than the national figure of 12%)[36].

3.9 **Obesity**. About 25.6% of the adult population is obese, which is significantly higher than the national average of 24.2%. About a quarter of children starting school in Worcestershire are either overweight or obese, and about a third are overweight or obese by the time they leave primary school at the end of year 6. The most recent figures relating to childhood obesity show a picture of great concern.

3.10 **Drinking alcohol**. In 2012/13 3,465 people in the county had a stay in hospital which was related to alcohol, which is rather better than the national picture (although rising). Worcestershire's rates of admissions for under-18's for alcohol specific conditions are significantly worse than national rates.

3.11 **Mental ill-health is evident**. At the most general level, people living in Worcestershire have good levels of physical health and this is reflected in positive mental health. However, as with physical health, there are large numbers of people in the county living with mental ill-health, and this is an important feature of the health landscape. Mental health problems are wide ranging and, as detailed in the points below, some outcomes, such as self-harm, are significantly above the national figures. Worcestershire is high in terms of the risk factors[37] for mental illness in comparison with national averages. Again, however, there is no room for complacency as some risk factors, such as old age, are above the national averages and others, such as unemployment, have risen in recent years and are only slowly responding to efforts to tackle them.

3.12 Key figures for Worcestershire, extrapolating from the national prevalence are: 68,925 adults (1 in 6) has a mental health problem at any given time; 7,655 children (1 in 10) aged 5-14 years has a mental health problem at any given time; 619 new mothers (1 in 10) experience post-natal depression at any given time. Mental well-being is intimately connected with physical health. We do not usually measure the burden of mental ill-health by reference to the physical problems it links to, yet we know that if mental well-being was significantly improved, significant improvements would be seen in local prevalence rates for coronary heart disease (25,955 people in Worcestershire); type 2 diabetes (22,422 people in Worcestershire); adult obesity (115,990 people in Worcestershire); and childhood obesity 11,357 children in Worcestershire). The number of directly standardised rate (DSR) for emergency admissions for self-harm in 2011/12 was 222 in Worcestershire, significantly worse than an England average of 207, and an England best of 52. There were 1,290 hospital admissions for self-harm (all ages) in Worcestershire in 2010/11; There were 8,200 referrals to the local Child and Adolescent Health Services from 2008/09- 2010/11. Social deprivation is known to impact negatively on mental well-being, although this is difficult to measure at a very local level. In Worcestershire, just over 51,000 people live in the 20% most deprived communities in the country; More than one in ten adults are living with depression in Worcestershire;

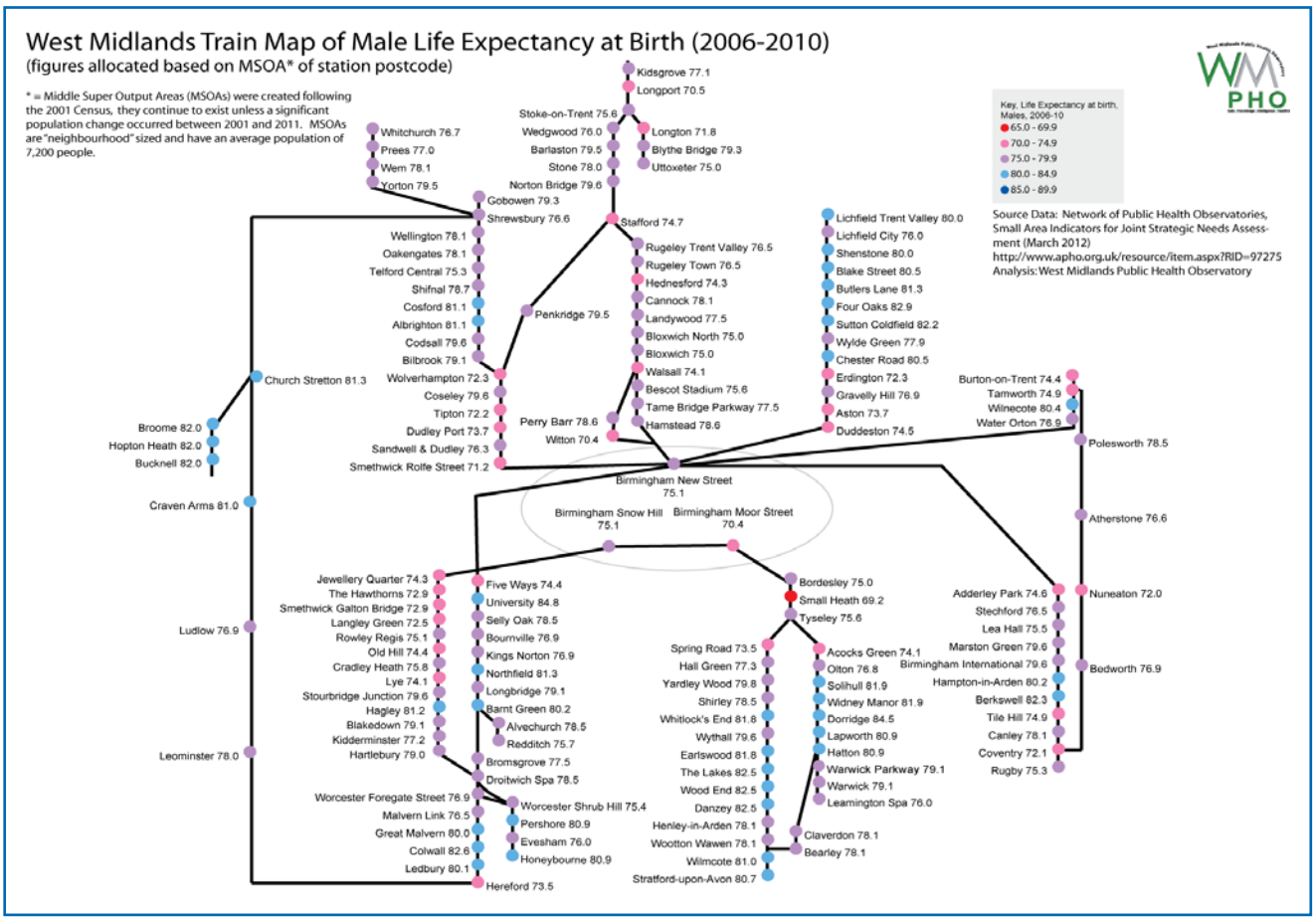
3.13 **Life expectancy varies across the county**. As nationally, there has been growing understanding locally of the spatial distribution of good health. The West Midland Train Maps of Male and Female life expectancy at birth, 2006-2010 (Figure 1.7), demonstrate the different life expectancy rates depending on what area of the county you were born in, plotted against the railway line. It found that on average the male life expectancy for a male born in the Worcester Shrub Hill station area is 74.5 years of age. This compares to Great Malvern, a few stops on the railway line, where life expectancy is 5.5 years longer at 80 years of age. In Blakedown, a woman can be expected to live to 84 years, while her female neighbours in nearby Kidderminster can only expect to live until 80.7 years.

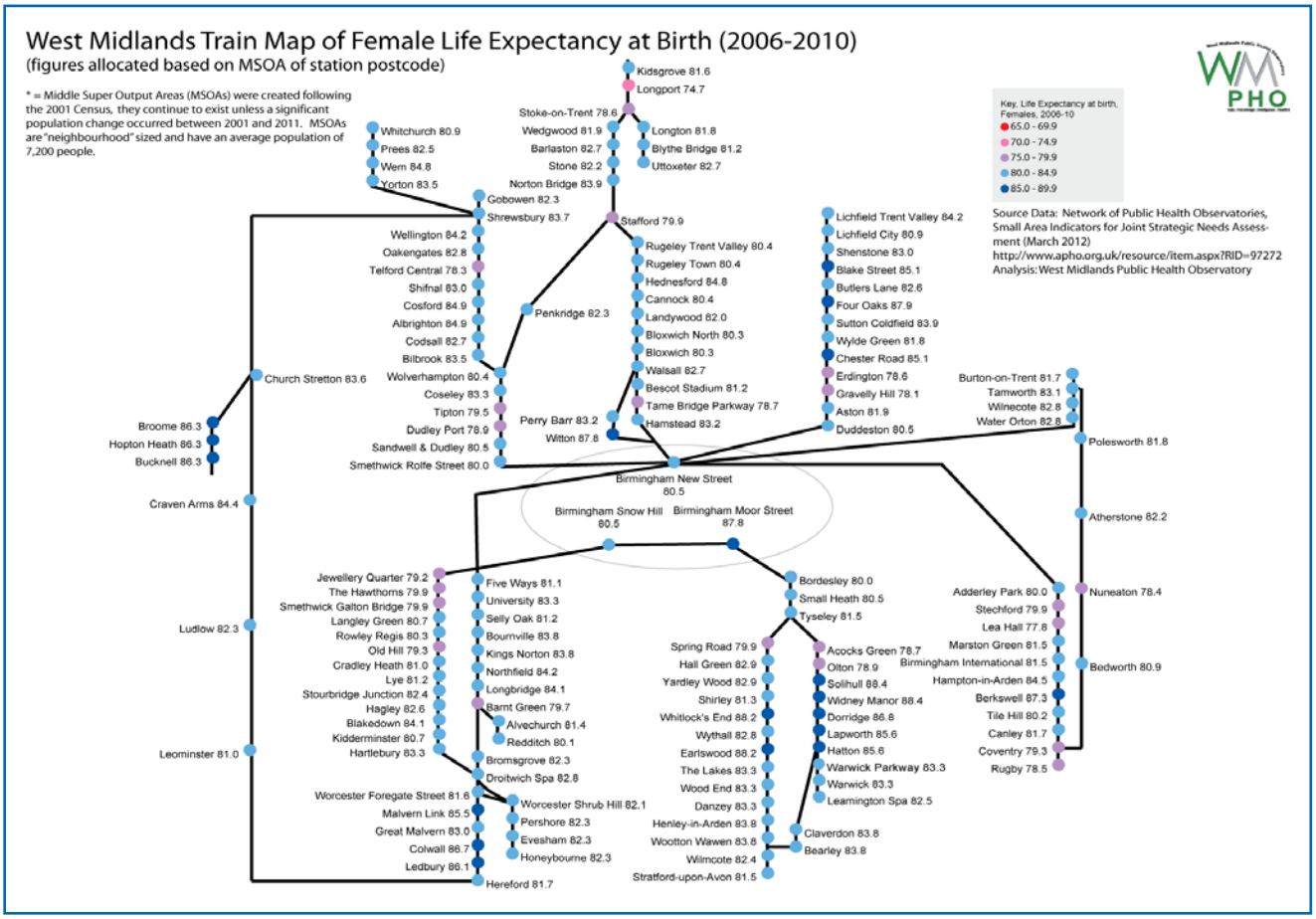
35 Please note the figures in paragraphs 3.8- 3.10 are 'synthetic estimates based on lifestyle survey sample data', which means "A model based technique to combine data from national surveys with a set of local predictor variables to estimate the prevalence of lifestyle behaviours at a small area level."

36 Public Outcomes Framework http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000005/are/E10000034

37 Risk factors include being under- and over-weight, low levels of physical activity, drug abuse, tobacco and alcohol consumption, and homelessness. Community Mental Health Profile, Worcestershire (2013)

Figure 1.7 The West Midland Train Maps of Male and Female life expectancy at birth, 2006-2010





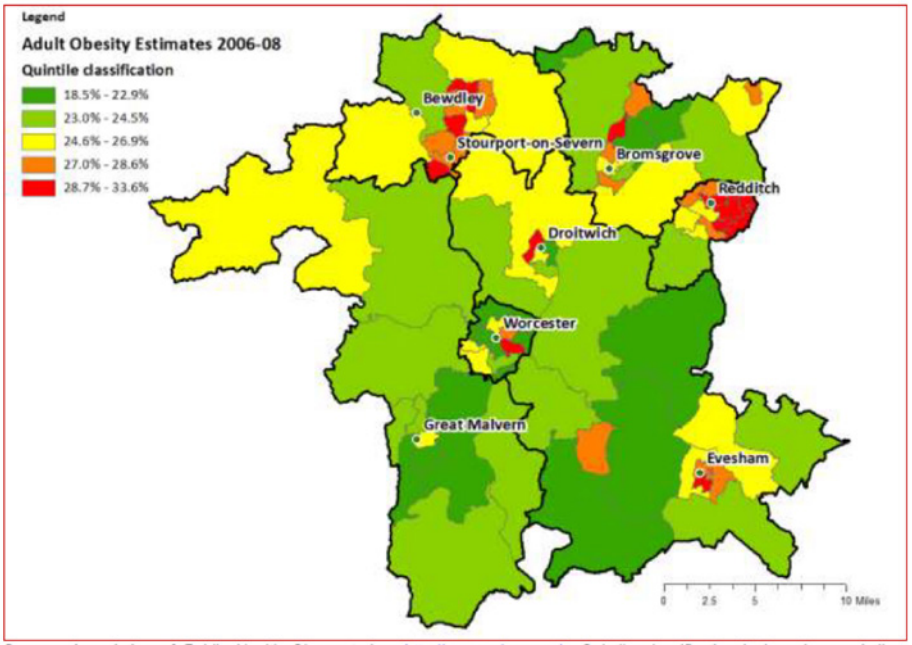
3.14 Spatial variation is evident too in the prevalence of the main disease groups. Again, explanations for this will vary, and include individual behaviour as well as the provision of and uptake of health care. One example of this is Coronary Heart Disease (CHD), which is one of the key causes of premature death as detailed in Figure 1.8 below.

Figure 1.8 CHD prevalence rates in the Worcestershire Districts 2009[38]

Worcestershire	Estimated Population with CHD			
	Number	Percentage	Confidence Intervals [39]	
			Lower	Upper
Bromsgrove	4,223	5.5%	5.34%	5.67%
Malvern Hills	3,956	6.4%	6.20%	6.59%
Redditch	3,290	5.1%	4.90%	5.24%
Worcester	3,742	4.9%	4.76%	5.06%
Wychavon	5,651	5.8%	5.63%	5.92%
Wyre Forest	5,093	6.2%	6.00%	6.32%
England	2,376,627	5.6%	5.63%	5.64%

3.15 The above table shows the coronary heart disease prevalence rates in the Worcestershire districts in 2009. It shows that Malvern Hills and Wyre Forest have a higher percentage of estimated population than the national average of people with coronary heart disease (CHD). Worcester, Redditch and Bromsgrove have lower average percentage populations. Adult obesity estimates for 2006-2008 throughout Worcestershire are shown on Figure 1.9 below. The hotspots are highlighted by the red areas on the map.

Figure 1.9 Adult Obesity Estimates[40]



Source: Association of Public Health Observatories, http://www.apho.org.uk. Quintile classification is based on quintiles calculated for the whole of Worcestershire.

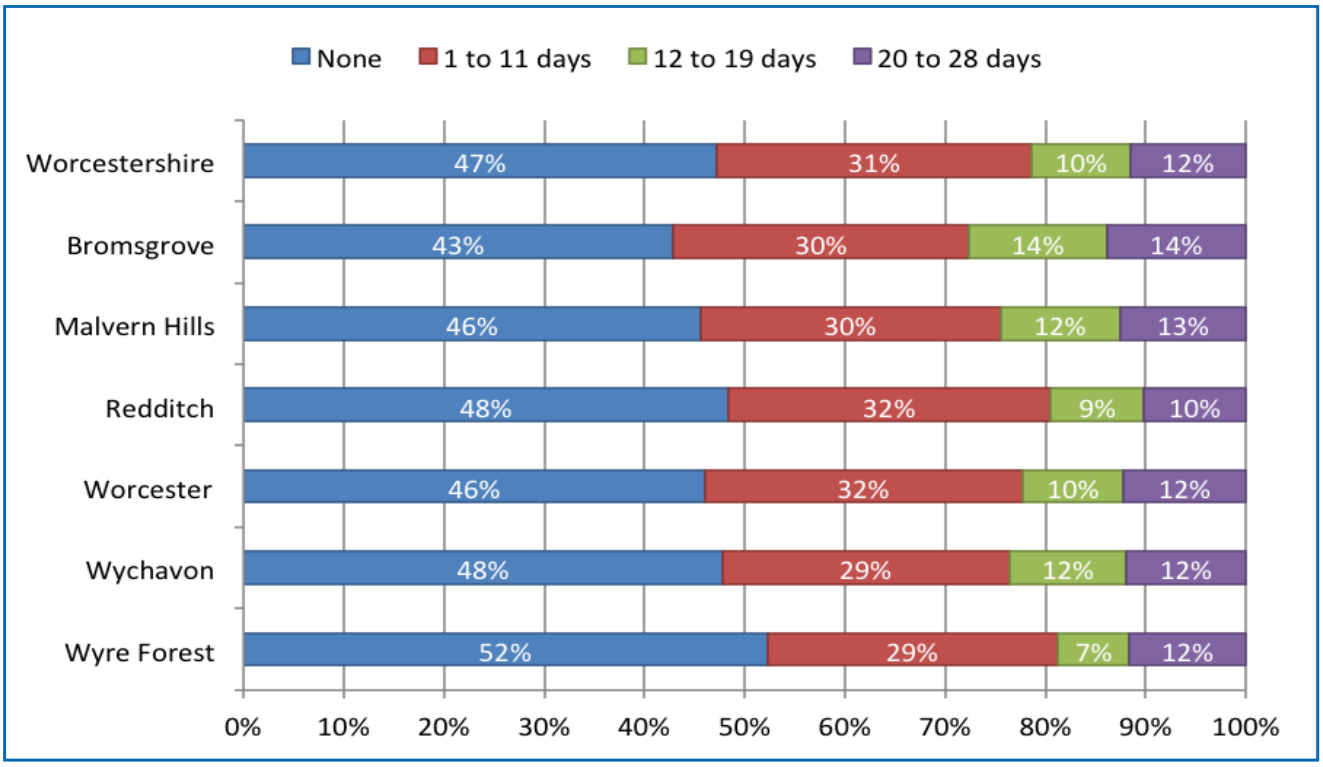
38 Data from National Obesity Observatory website http://www.noo.org.uk/. Original data source is the Yorkshire and Humber Public Health Observatory http://www.yhpho.org.uk

39 A confidence interval is a range of values that describes the uncertainty surrounding an estimate

40 www.apho.org.uk

3.16 Spatial variation is evident too, in the patterns of behaviour which affect life expectancy. Figure 1.10 below shows the proportion of all adults in each district area by the number of days out of the previous 28 that they participated in sport and active recreation.

Figure 1.10 - Adult Participation in Sport and Active Recreation 2009/11[41].



3.17 As can be seen in Figures 1.9 and 1.10, Wyre Forest has the highest percentage (52%) of people who do no exercise, and the second highest rate of adult obesity out of the 6 district areas. In Redditch, where there is the highest level of estimated obesity, there are relatively low levels of participation in sport and active recreation compared to other Worcestershire districts. It is likely that where there are high levels of obesity there is little or no exercise being performed each month.

3.18 Understanding this difference in spatial variation is as complex locally as it is nationally. There are strong associations between poor health outcomes and living in an area of social deprivation. One striking example of this is childhood obesity, shown in the Figure 1.11 below, where 20.7% of those children living in the least deprived areas are overweight or obese, compared with 27.9% in the most deprived.

Figure 1.11 National Child Measurement Programme Quintile Results for Reception Year Pupils in Worcestershire: 2009/10 - 2011/12 pooled data[42]

IMD 2010 Quintile (National)	1 - Most deprived	2	3	4	5 - Least deprived
Underweight	0.7%	0.5%	0.4%	0.5%	0.4%
Overweight	15.5%	14.9%	16.1%	14.1%	12.8%
Obese	12.4%	10.7%	9.7%	8.5%	8.0%
Overweight or Obese	27.9%	25.7%	25.8%	22.6%	20.7%

41 Sport England and Health and Wellbeing Board – Healthy weight, healthy lives 2012
42 ONS, National Child Measurement Programme.

Figure 1.12 National Child Measurement Programme Results for Year 6 – Children living in the most and least deprived areas in Worcestershire 2009/10 - 2011/12[43]

Quintile	Weight category	2009/10	2010/11	2011/12
Quintile 1 (most deprived)	Overweight	13.5%	14.0%	15.8%
	Obese	23.0%	24.3%	22.0%
	Overweight or Obese	36.5%	38.3%	37.9%
Quintile 2 (least deprived)	Overweight	14.0%	16.6%	16.0%
	Obese	13.3%	13.4%	15.5%
	Overweight or Obese	27.4%	30.0%	31.6%

3.19 The above table demonstrates that there has been an increase in the levels of overweight and obese children in both quintile 1 and 5 from 2009/10 to 2011/12. There are more obese and overweight children in quintile 1 (most deprived).

3.20 **Health issues which are linked to planning**. Ross (2011)[44] has reviewed research into which planning interventions are most effective for improving health. A summary of the findings is presented below, and further detail can be found in Appendix 4.

3.21 The research found that the health risks which can be addressed via spatial planning included: heart disease, respiratory disease, mental health (short- and long-term effects), obesity, injuries and increased mortality and morbidity. Strong evidence was found that open space that is safe and easy to get to increases exercise, and moderate exercise improves health outcomes. Reducing traffic leads to reductions in air pollution. The research also found that access to green spaces improves mental health.

3.22 The research found both 'strong and/or inconclusive evidence' that traffic interventions reduce accidents and/or increase physical activity; green spaces improve rates of physical activity; better insulation and heating improves health; and mental health might improve even if physical health does not. Anecdotal evidence found that local access to healthy food may improve diets.

Summary by district

3.23 This next section further demonstrates the spatial variation of the key health issues affecting each district within Worcestershire, drawn from the Worcestershire Joint Strategic Needs Assessment[45] which indicates the differences across the county by district.

Worcester City

3.24 Worcester City contains the largest urban areas in Worcestershire, so has very different health and social parameters to the rural parts of the county. The population totalled 98,768 people at the 2011 census (an increase of over 5% since the 2001 census). Worcester City has a higher proportion of younger people aged 0-24 and lower numbers of older adults in comparison to other districts.

3.25 Life expectancy for women in Worcester City is slightly below the county average at 82.3 years (Worcestershire average is 82.7). For men, life expectancy is the lowest of all six districts in the county, and is significantly lower than the national average too at 77.5 years (the England average is 78.3, and the county average is 78.1).

43 ONS, National Child Measurement Programme
44 Ross, 2011Plugging health into planning: evidence and practice, A guide to help practitioners integrate health and spatial planning
45 Worcestershire County Council, September 2013, as above

3.26 The long-term unemployment rate, which is a particular issue in the Rainbow Hill ward, is higher than the Worcestershire average, but is still lower than the England average. Housing overcrowding is an issue here with the highest rate in Worcestershire (7%) compared to the county average of 4.8%. All indicators for wider determinants of health, including life expectancy at birth, low birth weights, and emergency admissions for stroke, are worse than the England average and only those indicators of people living with limiting life-long illness or disability are significantly better[46].

Wyre Forest

3.27 With a population of 97,975 (2011 census) and an increasing number of men and women aged 60-75 compared to the national average, Wyre Forest has a high percentage of people living in the most deprived quintile (17.2%), which is higher than the Worcestershire average (10%). People in Wyre Forest also experience a high level of fuel poverty. Health indicators which are of concern here include overweight and obese children age 4-5 and 10-11, which is greater than the England average, and the high rate of violent and sexual offences. Wyre Forest has a lower rate of child casualties and a lower mortality rate in the under-75s for preventable respiratory disease than the county averages[47].

Malvern Hills

3.28 A rural district of Worcestershire with a population of 74,706 (2011 census), an increase of 3.5% since the 2001 census, Malvern Hills has a high proportion of elderly people with the largest population increase in people aged 65-74 of all Worcestershire districts. The consequences of this include the higher number of potential people living with dementia and other long-term conditions such as diabetes, cardiovascular disease and chronic obstructive pulmonary disease (COPD) (the name for a collection of lung diseases) into the future. Higher mortality from stroke is of concern, and reducing risk factors for this is important. Unemployment is lower here than the county average, and more people are self-employed here than in any other district in the county. Housing quality is generally good with a high proportion of detached properties in the area[48].

Redditch

3.29 Redditch is a semi-urban district with a population of 84,214 (2011 census) with a mixed demographic. Here, child poverty is higher than the national average and about 3,200 children live in poverty, and life expectancy is 8.7 years lower in men and 9.4 years lower in women in the most deprived areas, compared to the least deprived. Healthy eating rates are worse and obesity levels are higher than the England average, as are levels of violent crime and self-harm. Statutory homelessness, long-term unemployment and drug misuse are below the England average[49].

Wychavon

3.30 Wychavon district represents a large rural area of Worcestershire, but has a number of sizeable towns, including Droitwich Spa, Evesham and Pershore. This contrast means there are different health and social parameters in different parts of the district.

3.31 The population totalled 117,000 according to the 2011 census (an increase of 3.7% since the 2001 census), with a higher proportion of elderly people compared to the national average and a lower proportion of young people, particularly those aged 0-24. Life expectancy is the highest in the county, being above the national average, and the proportion of those living with limiting long-term illness and disability is 17.6%, slightly lower than the county average, but around the same level as the national average.

46 http://www.worcestershire.gov.uk/downloads/file/2878/2013_briefing_on_worcester_city
47 http://www.worcestershire.gov.uk/downloads/file/2887/2014_briefing_on_wyre_forest
48 http://www.worcestershire.gov.uk/downloads/file/2879/2013_briefing_on_malvern_hills_district
49 http://www.worcestershire.gov.uk/downloads/file/2881/2013_briefing_on_redditch

The proportion of those providing unpaid care (11.5%) is high; this needs addressing, as the health consequences of this in an elderly population are not favourable. Prostate cancer incidence is also high, comparable to the worst quartile in England, but may be explained by the high levels of elderly people in the area[50].

Bromsgrove

3.32 With a population of 93,732 (2011 census), this district has experienced the highest increase in the number of over-75s. Obesity is an issue, with one area in the highest quintile for obese people. Alcohol related hospital stays are a problem, with two areas in the top quintile. Just above 4% of young people in Bromsgrove are not in education, employment or training, which is a similar level to Malvern Hills and Wychavon districts. Life expectancy is good for men in Bromsgrove, being the joint highest in the county (with Wychavon) at over 80 years[51].

District Conclusions

3.33 The district summaries provide a description of some of the key health issues affecting each district within Worcestershire. For further details on the health indicators for the different districts please refer to the web links in the footnotes. The Joint Strategic Needs Assessment (JSNA) Summary provides information on the Worcestershire Health and Wellbeing Board's four priority areas and also identifies emerging trends and threats to health in the county. The 2013 Summary is available at

http://www.worcestershire.gov.uk/homepage/109/joint_strategic_needs_assessment

50 http://www.worcestershire.gov.uk/downloads/file/2882/2013_briefing_on_wychavon_district
51 http://www.worcestershire.gov.uk/downloads/file/2877/2014_briefing_on_bromsgrove

Chapter 4: Challenges and issues in Worcestershire

4.1 This next section has been broken down into the following areas:

- Health related challenges and issues;
- Challenge of fostering behavioural changes;
- Economic issues;
- Challenges of processes involving planning and health;
- Climate Change;
- Improving health through the environment; and
- Defining a healthy urban environment.

These draw on the evidence base in chapters 2 and 3 and Appendix 3.

Health related challenges and issues

4.2 The Joint Health and Wellbeing Strategy for Worcestershire recognises that the county's health and well-being is improving and is mainly at or above the national average. However, it also identifies the following challenges to be addressed:

- An ageing population, with a rising demand for health and social care services.
- A growing burden of lifestyle related ill-health, particularly due to obesity.
- A growing need for savings across the public sector, including health and social care services.
- Relatively poor health in our most disadvantaged communities.

Challenge of fostering behavioural changes

4.3 We need to influence behaviour that fosters a move towards prevention of illness and move away from an 'individual approach' to a 'universal approach'. Figure 1.13 shows that the relationship between availability of green space and health outcomes is not a simple one, with Wyre Forest for example having particularly high availability, yet low health outcomes and the highest percentage (52%) of obese people who do no exercise (as demonstrated in Figure 1.10). These point to the complexity of health outcomes being a combination of individual factors (such as behaviour) and structural determinants (such as green space).

Figure 1.13 Percentage of Land that is Green Space in Worcestershire Districts 2005[52]

Worcestershire	Estimated			
	Area of Green Space	Percentage of All Land	Confidence Intervals	
			Lower	Upper
Bromsgrove	182,341	84.0%	83.85%	84.16%
Malvern Hills	533,661	92.5%	92.42%	92.56%
Redditch	36,581	67.4%	67.03%	67.82%
Worcester	13,518	40.7%	40.22%	41.27%
Wychavon	605,155	91.4%	91.30%	91.43%
Wyre Forest	164,547	84.1%	83.94%	84.27%
England	115,741,625	87.5%	87.46%	87.47%

4.4 The Foresight Report 'Tackling Obesities: Future Choices' demonstrates the complexity in achieving behaviour change and it is this which must be considered when hoping to change the behaviours of others. The report used the following examples: tackling obesity; those not wanting to drink and drive; and giving up smoking.

- If someone is trying to lose weight, they need to achieve a variety of short- and longer-term goals, including what may be challenging alterations to diet, changes in shopping behaviour, increases in exercise, different choices of transport, reductions in alcohol consumption, etc.
- Those who do not want to drink and drive need to plan other means of transport, designated drivers, or even overnight accommodation.
- For a person to quit smoking, they need to consider how they will cope with nicotine craving and avoidance of the cues that have habitually prompted smoking.

Carrot and stick analogy

4.5 This demonstrates the complexity in instigating behavioural change and sticking to it; some of the changes and goals are short term, whilst others are long term and require long term commitments. This next section provides further examples of behavioural change: the 'carrot approach' (on this occasion achieving short-term immediate change), and the 'stick approach' (on this occasion being a long-term change in behaviour). A carrot (encouraging through incentive and rewarding good behaviour) versus a stick (negative consequences of action through punishment of poor behaviour) may be used.

4.6 An example of a carrot approach in Sweden was the use of arts/culture in a campaign to improve stairs usage in a train station over use of the escalator. Pre-intervention, most people were using the escalator. A piano/keyboard colouration of the steps, together with touch pads on each step consistent with piano keys, was installed. People were intrigued by the new design and could make their own tune by walking up the stairs. Stairs usage improved by 60%[53].

4.7 It is not envisaged that we use this in Worcestershire, but it is evident that by making places attractive, fun, safe and easily accessible, people are more likely to use them. The stick approach could be best described using the example of the often-discussed/threatened tax on unhealthy food (a fat tax). However, as the saying goes, you can lead a horse to water but you cannot necessarily make them drink, so we can put improvements in place but we have to do so in a way which will encourage them to be taken up, understanding that not everyone will want to change and some of these changes require long-term commitment to see any results.

52 National Obesity Observatory website http://www.noo.org.uk/. Original data source is the Office for National Statistics http://www.neighbourhood.statistics.gov.uk/

53 See video at http://creativity-online.com/work/volkswagen-fun-theory-piano-staircase/17522

Economic issues

4.8 Being unwell is costly personally and to the country as detailed earlier in chapter 2. The provision of health and social care under the current model is not sustainable. Healthy people are more likely to be in work which is good for the economy. These people are more likely to play an active role in society and to contribute to the economy through their families, local communities and workplaces.

Challenges of processes involving planning and health

4.9 The key objectives for healthy urban planning have been the subject of considerable debate. The objectives have been presented by the University of the West of England's review for the World Health Organisation's Collaborating Centre for Healthy Urban Environments[54]. The objectives are based on the Barton and Tsourou (2000) determinants map, and, as demonstrated in Figure 1.14, provide a core list which defines objectives for planning to achieve health improvement and to narrow health inequalities.

Figure 1.14: Healthy Urban Planning objectives (UWE 2010)

Spheres of the Health Map	Objectives for Healthy Urban Planning
People	• providing for the needs of all groups in the population • reducing health inequalities
Lifestyle	• promoting active travel • promoting physically active recreation • facilitating healthy food choices
Community	• facilitating social networks and social cohesion • supporting a sense of local pride and cultural identity • promoting a safe environment
Economy	• promoting accessible job opportunities for all sections of the population • encouraging a resilient and buoyant local economy
Activities	• ensuring retail, educational, leisure, cultural and health facilities are accessible to all • providing good quality facilities, responsive to local needs
Built environment	• ensuring good quality and supply of housing • promoting a green urban environment supporting mental well-being • planning an aesthetically stimulating environment, with acceptable noise levels
Natural environment	• promoting good air quality • ensuring security and quality of water supply and sanitation • ensuring soil conservation and quality • reducing risk of environmental disaster
Global ecosystems	• promoting substitution of renewable energy for fossil fuel use • adapting of the environment to climate change

4.10 **Health Impact Assessment (HIA)** is one tool that planners can use to ensure that they have taken health and wellbeing into account. Some local authorities carry out HIA alongside the Sustainability Appraisal, whereas others do it independently of it, but for it to be at its most useful a HIA should be done early on in the planning/proposal process. It is a decision-supporting tool that planners (as well as others) can use to provide evidence of the health impacts of a policy, programme or project if implemented. It can assess the potential and unintended effects of a proposal on health and wellbeing on a population and tries to identify actions to manage the negative effects of a proposal and enhance the positive effects. Further detail of HIA and a case study of the HIA on the Redditch Local Plan No.4 can be found in Appendix 2.

54 Building Health Planning and designing for health and happiness, One-day conference, 22 January 2010

Environmental challenges

4.11 **Climate change** is having a mixed impact on the health and wellbeing of the UK population. Of course climate change could have some positive impacts on human health; warmer summers and milder (albeit wetter) winters may encourage more people to partake in different forms of physical activity, or take up hobbies such as growing vegetables. However, there are negative impacts and the health system needs to be prepared for different volumes and patterns of demand, as a result of climate change. Climate change is impacting the operational delivery of the NHS and affects the health system infrastructure (buildings, emergency services vehicles, models of care) and supply chain (e.g. fuel, food).

4.12 Climate change will impact on members of the community, with the very young and old in particular being susceptible to the risks and outcomes of climate change, for example dehydration and overheating in hot weather. We have already identified the ageing population in the county and know that climate change needs to be taken account of and planned for when considering all members of society, but particularly older people.

4.13 Cardiovascular disease can be exacerbated by high and low temperatures. With respiratory disease, there can be a high number of admissions during cold and very warm weather. Urban heat islands are known to be associated with higher heat-related mortality. London and Birmingham have both implemented change through increased planting of greenery to reduce urban temperature. A tree transpires 450 litres of water a day, using lots of heat energy, meaning that urban trees are an effective way of reducing temperatures. Parks with greater numbers of trees and shrubs are therefore more effective at reducing heat than hard paved surfaces with little greenery[55]. Other measures to help people living in an urban environment to cope with higher and lower temperature include, but are not limited to, types of materials used; design/orientation of buildings; and sustainable drainage systems.

Case Study: London Clean Air Fund

4.14 Excessive levels of air-borne particulate matter linked to cardiovascular disorders and respiratory tract infections were tackled through a £1m investment in 600 large trees, smaller trees and shrubs at hotspots along the Transport for London network. The ability to reduce particulate matter depends on species and leaf characteristics of the plant. It was concluded by the research group at Imperial College London that green infrastructure is best used as a supplementary measure to support emissions reduction, reduce the urban heat island effect, and maximise biodiversity gains and aesthetic values[56].

Case Study: Birmingham Natural Health Improvement Zones

4.15 The societal cost of death as a result of poor air quality in Birmingham is around £182m per year. A programme to tackle extreme air pollution has just been launched through introducing extensive greenery. Providing street trees, green walls, green roofs, and hedges in harsh urban environments helps to absorb particulates, improve levels of shade, and reduce the impact of flooding risk through slowing and storing surface run-off water[57]. This is, of course, complementary to encouraging changes in behaviour towards using more sustainable transport, plus technology improvements to reduce vehicle emissions.

4.16 Flooding can have consequences on physical health including injury/drowning, respiratory diseases, skin complaints and water borne diseases. It also has mental health consequences, including postÐtraumatic disorder, anxiety and psychological issues. In the West Midlands flooding is a big issue, with 3 of the 10 most serious UK natural disasters between 1900Ð2009 being floods. Adapting landscapes and infrastructure to changed patterns of future rainfall will require the restoration and recreation of habitats that increase infiltration into groundwater and reduce surface water flows. Mitigation measures such as the provision of SuDS[58] as part of green infrastructure or open space can provide health and well-being benefits and increase the resilience of critical infrastructure such as energy and water utilities and the road network.

55 Landscape Institute, November 2013, Public Health and Landscape: Creating Healthy places – Landscape Institute Position Statement
56 Landscape Institute November 2013, as above
57 Landscape Institute November 2013, as above
58 SuDS are a sequence of water management practices and facilities designed to drain surface water in a manner that will provide a more sustainable approach than what has been the conventional practice of routing run-off through a pipe to a watercourse.

Case Study: Flood Alleviation Scheme in Peopleton, Worcestershire

4.17 The village of Peopleton in Worcestershire helped to fund its own flood defences in 2010. The village was severely affected by the 2007 floods, where 45 homes were inundated with flood water in the village. The project involved the digging of a ditch, the installation of a road culvert and the laying of huge pipes beneath the fields surrounding the village, a process which had estimated costs of £150,000. The funding was secured through a mixture of revenues raised from the parish council/local residents (£25,000), a Government loan (£50,000) and contributions from both the district council and the county council.

Improving health through the environment

4.18 The built and natural environment can have a significant impact on the determinants of health and in turn an individual's health. For example the way we plan a new development and the way houses within it are designed and configured (through Local Plans and the development management process) will influence a person's living, working and travel patterns, their opportunity to access locally grown produce, the shape of the local economy, and even their tendency to be physically active[59]. It is reported that wooded environments are known to relieve stress and provide a spiritual value that supports improved mental health and wellbeing. Trees absorb airborne pollutants which result in cleaner air which benefits those suffering with asthma[60].

4.19 The King's Fund[61] reported that increasing access to parks and open spaces could reduce NHS costs of treating obesity by more than £2 billion and reduce mental health admissions as well, resulting in savings for the NHS. However, research by the Woodland Trust shows that less than 17% of the population of England has access to local woodland within 500m of their home. In Worcestershire this figure is lower at 15%. Providing more accessible trees, woods and green space can provide a critical link to healthier lives in Worcestershire and can lead to savings for the NHS.

Case Study: Therapeutic Farming at Top Barn[62]

4.20 The Top Barn special needs training centre is located on a 300 hectare mixed farm five miles north of Worcester on the banks of the River Severn. The site has a history of extensive mineral working and has been restored to a mixture of farmland and recreational uses. The client list at Top Barn includes people with severe learning disabilities, physical disabilities and brain injuries, as well as mental health patients and disengaged young people. There is also a wide range of courses for the local community and anyone interested in rural skills and a sustainable lifestyle. A staff member, Roger Bates, adds his own perspective: *"Coming to the farm provides people with an opportunity to achieve something. They can make a connection from making the seed beds, planting things and looking after them. They can see they are not isolated tasks."* The main aim is to provide training, education and therapeutic opportunities with a rural theme. Activities include horticulture, farming, animal husbandry, woodland skills, alternative building and farmhouse style cookery using home-grown produce. Lessons take place both inside and outdoors. Ian Iontton, visually impaired, visited Top Barn for several months and said that *"Being with animals and out in the countryside is better than being in a classroom, all closed in. Here, I am thrown challenges that show me I can do things rather than getting stressed about things I can't."*

Case Study: Reducing Health Inequalities in Stoke on Trent

4.21 As part of a wider approach to reduce health inequalities in the city, a 'Healthy Urban Planning' Supplementary Planning Document has been produced, alongside a community-based programme called 'my health matters'. Here, development workers work within communities to identify barriers to health and find solutions, e.g. improving green space, better lighting, reducing speed. They work with area implementation teams and relevant service areas to get these improvements delivered[63].

59 Royal Town Planning Institute, 2009
60 Forestry Commission, 2010
61 Buck and Gregory, 2013
62 Taken from the GI framework 4 Source: Community Care, "The therapeutic value of care farms", 22nd March 2007 and Farmers Weekly Care
63 Ross, 2011, Plugging health into planning: evidence and practice, A guide to help practitioners integrate health and spatial planning

Case study: Diglis Bridge[64]

4.22 Plugging health into planning: evidence and practice, A guide to help practitioners integrate health and spatial planning, In 2010 Sustrans, in partnership with Worcestershire County Council and Worcester City Council, completed the development of Diglis Bridge over the River Severn in Worcester. The project created a series of new and improved walking and cycling routes which led to a new non-vehicular crossing over the River Severn which links into national cycle networks. This created a high quality traffic-free riverside loop and improved access to the riverside. The riverside loop has transformed the way local residents incorporate exercise into their daily routine by running and walking for fitness, health reasons or the enjoyment of surrounding landscapes and wildlife. Many walking and cycling groups have either set up or moved to take advantage of the new routes. There are now five regular walks run under the national Walking for Health initiative run by the British Heart Foundation. It is estimated that that there are approximately 1,000 cyclist and 4,000 pedestrian journeys using the bridge each month.

Case Study: Increasing Physical Activity in Leicester

4.23 In Leicester, a sustainable community strategy was launched that included a priority action of 'planning for people not cars'. The aim was to make it easy for people to get around any part of the city without using a car. The Council is using section 106 contributions on new developments to set aside money for personalised journey planning for residents. The aim is to reduce car use and increase active travel which will help reduce obesity and promote a healthy lifestyle[65].

What is a healthy urban environment?

4.24 The World Health Organisation reports that in Europe two thirds of the population live in urban areas. It goes on to say that these places are often characterised by heavy traffic, pollution, noise, violence and social isolation for elderly people and young families. With this population often suffering from increased non-communicable disease, injuries, and alcohol and substance abuse, the poorest in society are predictably exposed to the worst environments.

4.25 Tackling these issues needs a joined-up approach not just by the health sector but also by others in local government, education, planners, engineers, and by providers of physical infrastructure and access to social and health services to address these problems and create a healthy urban environment[66].

4.26 One way to create a healthy urban environment is through increasing/improving access to and quality of green spaces (often referred to as 'Green Infrastructure'). Green infrastructure is often described as multi-functional, providing a range of environmental, social and economic services or "ecosystem services"[67] which include health and well-being benefits. The Worcestershire Green Infrastructure Partnership (2014) reported that accessible and high-quality green spaces encourage physical activity, improve social interaction, help build self-esteem, and contribute to the social mobility of disadvantaged people.

Case Study: The Worcestershire Green Infrastructure Strategy

4.27 The Worcestershire Green Infrastructure Partnership (made up of statutory agencies, the voluntary sector, and district and county councils) formed in 2009 to develop a strategic green infrastructure framework to support the environmental, economic and social needs of the county. The Partnership developed an extensive natural environment and socio-economic evidence base and produced the Worcestershire Green Infrastructure Strategy 2013-2018 to inform local planning policy and to guide the delivery of green infrastructure. The Partnership is also involved in master-planning at the site level to ensure that strategic development sites provide quality, accessible

64 Sustrans (nd) Health Benefits Getting people active in Worcester and Sustrans (nd) Case study: getting Worcester walking and cycling
65 Ibid
66 http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/urban-health
67 Ecosystem services are the benefits that a healthy environment provides for people, either directly or indirectly.

and multifunctional networks of green spaces. The Strategy states that "There is a strong link between the provision of accessible and good quality green spaces and improved health of residents. GI offers opportunities for increased physical activity, exposure to nature, and climate change resilience and mitigation, which could help to reduce levels of ill-health and increase the wellbeing of local residents"[68]. To support this work a series of "framework documents" have been produced which provide the evidence base for the GI Strategy. Framework document 4 explores the relationship between health, climate change, the economy and green infrastructure. The Worcestershire Green Infrastructure Strategy aims to contribute to the sustainable growth of the economy, to improve the community's experience of natural and historic places, to deliver health and well-being benefits, and to underpin the county's resilience to climate change.

4.28 There are also many benefits to living in a urban environment. Access to health services, job markets, education, cultural and leisure activities is often more easily obtained for those living in urban areas than in rural areas[69]. This can have a positive impact on the health of an individual and community, which in turn helps to create a healthy urban environment.

4.29 In Bermondsey Spa, London, the Hyde Housing Association and Southwark Borough Council have been working together to develop 900 new homes, two doctors' surgeries, a dentist, pharmacy and several re-landscaped open spaces. They worked to make the scheme commercially viable while ensuring the facilities and new homes were affordable. Space standards and sustainability put Bermondsey Spa ahead of other developments for health and wellbeing outcomes. Despite the high density of housing (1,000 habitable rooms/hectare), there is a large amount of amenity space and open spaces with larger and better laid-out homes.

Case Study: Dudley Changing Lifestyles

4.30 A Department of Health 'Healthy Community Challenge Fund' of £4.5m has helped transform five local parks into family health hubs. The informal, structured physical activities on offer here aim to reduce levels of childhood obesity in the area. The outdoor gym equipment was selected for durability, safety and ease of access. The works have enabled greater cycling in the park, integrated wheelchair accessible routes to the parks, and made the facilities more inclusive. Anecdotal evidence so far suggests that landscape is valuable for delivering improved health and active lifestyles for the population of Dudley[70].

4.31 It is important to understand the challenges faced in tackling health inequalities in order that we can address these issues and plan for improvements. This chapter summaries the vast array of important issues and challenges we face when tackling health and wellbeing through the planning system, from environmental issues such as climate change to legislative issues, then providing case studies to demonstrate the ways others have tried to overcome these issues. The next section looks at how we might progress this work.

68 Worcestershire Green Infrastructure Strategy 2013
69 Roderick & Fudge, 2009, as above
70 Landscape Institute 2013, as above

Chapter 5: Monitoring and further work "where do we go from here"

5.1 Key to the further progression of this work is the promotion and circulation of this document to key stakeholders to start the process of change in Worcestershire. This should help to start the discussion of how the challenges and issues identified in this document can be tackled in order that the health inequalities as described are reduced.

5.2 Further work to promote and raise the profile of public health and plan-making/development management will include the following:

- Publication of this evidence paper.
- Three workshops/CPD sessions to include the launch of this paper, an introduction to Planning for Health in Worcestershire, training in Health Impact Assessments, and the usefulness of the Joint Strategic Needs Assessments (JSNA) in everyday practice. All three workshops will include an interactive element to help participants better understand the subject and assist us in directing our future areas of work and understanding how we can better include planning and health in our work-streams.
- Launch this paper on the JSNA website.
- A new secondment opportunity for a planner in public health to take this work forward and implement best practice and pilots.
- Regular review and monitoring of the use of this document in planning decisions to evaluate effectiveness and to keep it relevant to everyday work.

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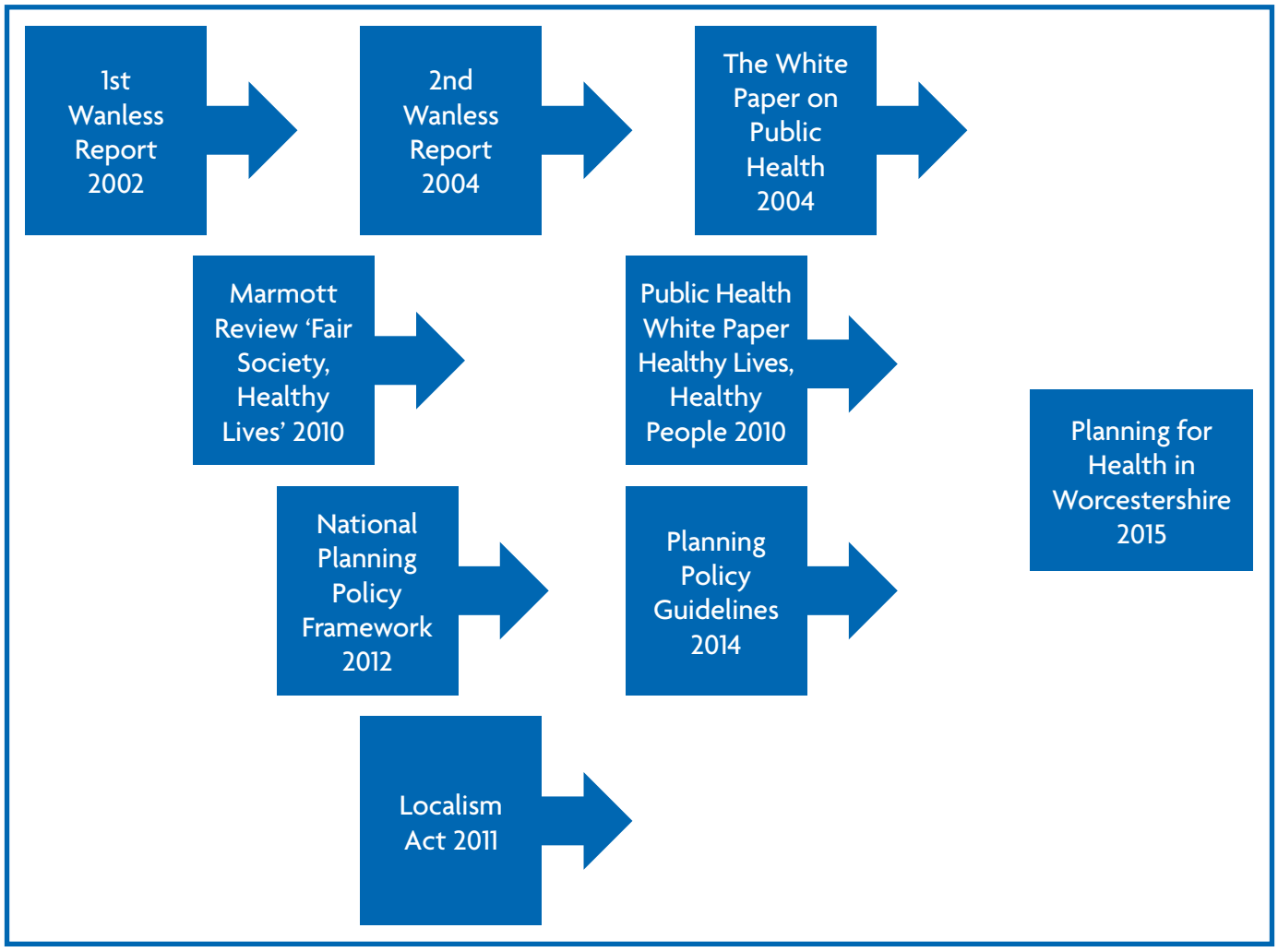
Appendix 2: The context: legislation, policy, guidance and research

National Legislation, Policy and Strategy documents and their relationship to this Planning for Health in Worcestershire Paper.



National

Marmot Review 2010 'Fair Society Healthy Lives'

The Secretary of State for Health for the then Labour government commissioned Sir Michael Marmot to chair an independent review 'to propose the most effective evidence-based strategies for reducing health inequities in England' (Marmot 2013).

The Review had four tasks:

1 Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action

2 Show how this evidence could be translated into practice

3 Advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy

4 Publish a report of the Review's work that will contribute to the development of a post- 2010 health inequalities strategy

The Marmot review was published in 2010. It found that health inequities which arise from a number of interacting factors (such as housing, income, education, occupation, etc.) are largely preventable. It reported that there is a social gradient in health and the lower a person's social position, the worse their health is likely to be. It went on to say that universal action is needed to reduce the steepness of the social gradient. However, this should not just focus on the most disadvantaged, as this will not reduce health inequalities sufficiently, but should be considered at a scale and intensity which is proportionate to the level of disadvantage.

One of the recommendations was to "create and develop healthy and sustainable places and communities" and to do this through the integration at a local level of planning, transport, housing and health policies, to address the social determinants of health.

White paper Healthy Lives, Healthy People 2010

Later in 2010 the Government produced its response to the Marmot report in its public health white paper Healthy Lives, Healthy People. This set out the Government's aspiration to "support local areas with streamlined planning policy that aligns social, economic, environmental and health priorities into one place". It set out a 'radical' new approach to tackling health, through empowering local communities and enabling professional freedoms with new ideas based on 'what works' and ensuring that the country remains resilient to and mitigates against current and future health threats. The approach will address the root causes of poor health and be:

- Responsive – owned by communities and shaped by their needs;
- Resourced – with ring-fenced funding and incentives to improve;
- Rigorous – professionally-led and focused on evidence; efficient and effective; and
- Resilient – strengthening protection against current and future threats to health.

Health and Social Care Act 2012

The Government believes that many of the social determinants of health can be addressed by local authorities and as a result the Health and Social Care Act gives local government a new set of duties to protect and improve public health, transferring the responsibility for public health to upper-tier local authorities i.e. county councils.

The Act says that upper tier authorities must establish a health and wellbeing board and employ a director of public health. These boards are forums where key health leaders can work together to improve the health and wellbeing of residents and reduce health inequalities, through agreeing priorities for action and encouraging commissioners to work together. As a minimum, the health and wellbeing board should comprise a local elected council member, the director of public health for the local authority, representatives of the local Healthwatch organisation and local clinical commissioning group, the director for adult social services, and the director for children's services. The director of public health will be supported by a new ring-fenced budget. These directors of public health will be responsible for publishing annual reports that will chart local progress. The boards will be the principal vehicle for joint working, "which will bring the whole system together at a local level and will maximise opportunities to deliver integrated care

across the NHS, public health and social care services, and to influence the wider determinants of health. Health and wellbeing boards will be able to draw on all the outcomes frameworks if they wish, to help inform strategic planning through Joint Strategic Needs Assessments, and Joint Health and Wellbeing Strategies, which must underpin local commissioning plans. In this way, the outcomes frameworks can be used to support local strategic planning". The introduction of health and wellbeing boards marked a "step-change away from national measures which focus on processes, and towards measures of the outcomes that people are supported to achieve, and their experiences of care".

Commissioning in the future will be done by the National Commissioning Board, Local Authorities (Public Health) and over 200 Clinical Commissioning Groups (CCGs). The commissioning architecture is being reformed. In April 2013 the Worcestershire PCT was abolished and its functions transferred to:

a) Clinical Commissioning Groups (CCGs), including one for South Worcestershire.

b) An NHS Commissioning Board, based in Leeds, which has some sub-national structures with a second tier covering West Mercia (Worcestershire, Herefordshire, Shropshire and Telford & Wrekin).

Other changes include, but are not limited to, the abolition of the Health Protection Agency (its functions transferred to the Secretary of State) and the creation of Public Health England in April 2013 to bring together public health specialists from over 70 organisations into a single public health service.

2013 'Eighth Report: The role of local authorities in health issues'

The Eighth Report issued by the Communities and Local Government Committee details this new role for local authorities and states that councils are well-placed to "make the most of a move away from a medical model of health, based on clinical treatment, to a social model, based on health promotion, protection and disease prevention". This will see them tackling the social and environmental causes of poor health (the 'social determinants') rather than poor health in itself.

NHS Outcomes Framework

From April 2013, the NHS Outcomes Framework has formed part of the way in which the Secretary of State holds the new NHS Commissioning Board to account for the commissioning system in the English NHS. The purpose of the framework is:

- to provide a national level overview of how well the NHS is performing;
- to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spend of some £95bn of public money; and
- to act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

The framework sets out the following outcomes they wish to see achieved

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating people in a safe environment and protecting them from avoidable harm

Public Health Outcomes Framework for England 2013-2016

The framework is focused on the following two high-level outcomes:

1. Increased healthy life expectancy.
2. Reduced differences in life expectancy and healthy life expectancy between communities.

To support this framework, public health indicators have been developed to annually monitor the achievement of the outcomes. These public health indicators have been grouped into four domains: health protection, health improvement, and healthcare public health (and preventing premature mortality); and improving the wider determinants of health.

Adult Social Care Outcomes Framework 2013/14

The Adult Social Care Outcomes Framework is to be used locally and nationally, to set priorities for care and support, measure progress, and strengthen transparency and accountability. The framework will be used to inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability.

The purpose of the framework is locally to provide information and comparable data for use by councils to improve the quality of care and support, identifying priorities and best practice. The framework will also foster greater transparency in the delivery of adult social care, for residents. Nationally the framework measures the performance of the adult social care system as a whole, and its success in delivering high quality, personalised care, and supporting Ministers in discharging their accountability to the public and Parliament for the adult social care system, and will inform and support national policy development.

National Planning Policy Framework

Publication of the National Planning Policy Framework (NPPF) in 2012 reinforced the requirement to take public health into account, in plan making and planning decisions. The NPPF contains a whole chapter on promoting healthy communities and states that the planning system can play an important role in facilitating social interaction and creating healthy, inclusive communities. It goes on to say that local planning authorities should create a shared vision with communities of the residential environment and facilities they wish to see. It contains measures aimed at reducing health inequalities, improving access to healthy food and reducing obesity, encouraging physical activity, improving mental health and wellbeing, and improving air quality to reduce the incidence of respiratory diseases.

A core planning principle in the NPPF is for plan-making and planning decisions to take account of and support local strategies to improve health, social and cultural wellbeing, and to deliver sufficient community and cultural facilities and services to meet local needs.

Localism Act

The Localism Act aims, through setting out a series of measures, to bring about a shift in power away from central government towards local people. These measures include: new freedoms and flexibilities for local government; new rights and powers for communities and individuals; reform to make the planning system more democratic and more effective, and reform to ensure that decisions about housing are taken locally' (CLG November 2011). The Act brings in the Duty to Co-operate, Community Right to Build Orders and Neighbourhood Development Orders, discussed in more detail below.

The Natural Environment White Paper

The Natural Environment White Paper (NEWP) The Natural Choice: securing the value of nature (2011) recognised that a healthy natural environment is the foundation of sustained economic growth, prospering communities and personal wellbeing. It sets out how the value of nature can be mainstreamed across our society by facilitating local action; strengthening the connections between people and nature; creating a green economy; and showing leadership in the EU and internationally. It set out 92 specific commitments for action[71].

Regional

There are currently no regional planning documents in place, nor is there a West Midlands-wide policy on planning. This has been the case since the coalition government abolished the regional tier of plan-making. Instead, larger-than-local policy has been derived from the National Planning Policy Framework (NPPF) and the Planning Practice Guidance (PPG), which integrate health into the planning system. The PPG can be accessed from the Department of Communities and Local Government website. The Town and Country Planning Association (TCPA) is also a source of information. The West Midlands health and planning group is currently working to develop relationships with developers.

West Midlands Healthy Urban Development Group

Since the previous West Midlands healthy planning forum stopped meeting a number of practitioners from across the West Midlands have come together to develop a West Midlands response to Local Transport Plans and the NPPF. There was an agreement that a West Midlands Healthy Urban Development group would be beneficial and could help share learning, experience and best practice.

West Midlands Regional Spatial Strategy

The Direction of the Secretary of State revoking the West Midlands Regional Spatial Strategy came into effect on 20 May 2013.

Local Authority Health Responsibilities

The Health and Wellbeing Board in Worcestershire has the following four priorities over the period 2013-16:

1 Older people and the management of long term conditions

2 Mental health and wellbeing

3 Obesity

4 Alcohol

The recent Joint Strategic Needs Assessment report goes into the above topics in more detail, but a summary of the content is below.

1. Older people and the management of long term conditions

Worcestershire has a higher percentage of its population in the older age groups than other counties, and these numbers are increasing rapidly. This combined with increased life expectancy is resulting in more people living longer, but spending these additional years in poor health, living with long term conditions. Stroke, dementia, diabetes and Chronic Obstructive Pulmonary Disease (COPD, the name for a collection of lung diseases, including chronic bronchitis, emphysema and COPD). The likelihood of being transferred to residential care increases with worsening ill health (both physical and mental). Investment in prevention, early diagnosis and early intervention is key to reducing the burden of long term conditions. Encouraging people to manage their own condition at home through projects such as assistive technology has the potential to radically change the landscape of health and social care.

71 DEFRA (2014)

2. Mental health and wellbeing

By 2020 major depression could be the second most disabling condition in the world behind heart disease. It is growing in all age groups but seen most in the young, especially teens. This is reflected in self-harm admissions. Support and education for young people is therefore an important investment.

Mental health needs to be firmly embedded in the public health agenda. It is important to stress the positive dimension of mental health, as described in the World Health Organisation definition: "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". With a greater proportion of older people and the associated higher rate of dementia in Worcestershire it is key that mental ill-health is diagnosed as early as possible to ensure the most effective management. This is also in line with the Joint Health and Wellbeing strategy that calls for "a greater emphasis on prevention and early help to avoid later ill-health". There is an urgent need to maximise the benefits of community assets, reducing the need for less effective and more expensive central services.

3. Obesity

Around one in four reception year children (24.2%) and one in three year 6 children (33.7%) were either overweight or obese in Worcestershire in 2011/12. Of those wards with the highest proportion of children who were overweight or obese at reception, eight were in Wychavon and six were in Wyre Forest and Malvern Hills. Of the wards with the highest proportion of children who were overweight or obese at year 6, six each were in Wychavon and Wyre Forest, with three in each of the remaining areas. Although the estimated percentage of obese adults in Worcestershire has remained fairly stable over time, is has been consistently above the national average.

4. Alcohol

The overall rates of both alcohol-specific and alcohol-related hospital admissions have steadily increased since 2006/07. These rates vary considerably at both the district and ward level, with higher rates generally occurring in more deprived areas. Redditch in particular contains a number of areas currently experiencing high rates of both alcohol-specific and alcohol-related hospital admissions.

The Duty to Cooperate

The Duty to co-operate was introduced through Section 110 of the Localism Act, which inserted a new section 33A into the Planning and Compulsory Purchase Act 2004. The duty calls upon those involved in the preparation of Local Plans to demonstrate constructive cooperation between the 'prescribed' bodies in the formation of their plans regarding strategic cross-boundary matters. County councils and the health functions within them are one of the relevant bodies that plan makers would need to demonstrate co-operation with. The Duty to Cooperate applies to a number of specified strategic priorities as set out in paragraph 156 of the NPPF. Health infrastructure is included within these priorities.

The Courts and Local Plan inspectors are now testing legal and soundness issues respectively, i.e. whether Local Planning Authorities have demonstrated effective and constructive cooperation with prescribed bodies in ways which:

- Meet the legal requirements of S33A of the Planning and Compulsory Purchase Act 2004
- Show that the Local Plan is 'positively prepared' and therefore meets one of the tests of soundness specified in the NPPF.

Neighbourhood Plans, Neighbourhood Development Orders and Community Right to Build Orders

Under the Localism Act, communities have the right to draw up Neighbourhood Plans. These plans allow communities to say where they want new houses, businesses and shops to go in their local area – and what they should look like - by establishing general planning policies for the development and use of land in their neighbourhood.

Neighbourhood Development Orders can be drawn up by communities to permit the development they want to see in a specific area (in full or in outline). When in place, they will remove the need for certain planning applications to be submitted to the local authority.

Both Neighbourhood Plans and Neighbourhood Development Orders need to be in line with national and local plans and other legal requirements and they will only come into force if there is a majority of support in a neighbourhood referendum.

A Community Right to Build Order is a type of Neighbourhood Development Order, allowing certain community organisations to bring forward smaller-scale development on specific sites without the need for planning permission, as long as they meet minimum criteria and can demonstrate local support through a referendum. The benefits of the development, such as new affordable housing or profits made from letting homes, will stay within the community, and be managed for the benefit of the community.

Planning for Infrastructure in Worcestershire, Worcestershire Infrastructure Strategy: Consultation Draft

The County Council's Strategic Planning team is leading on development of a Strategy which will identify the infrastructure required to deliver the economic growth needed in Worcestershire. It will prioritise the strategic locations for investment and delivery of infrastructure in the county. The Strategy is separate from the formal infrastructure planning documents being prepared by District/City and Borough Councils, but has been prepared with a view to being complementary to such plans.

Infrastructure Delivery Plans

Infrastructure Delivery Plans (IDP) are prepared by district/unitary councils to inform the evidence base to support the Local Plan. The IDP provides a baseline of the existing infrastructure capacity and needs in that district, highlighting the infrastructure requirements (including health) needed to support the predicted growth set out in the Local Plan.

County Council Structure Plan

On the 20th May 2013 the County Council Structure Plan was revoked as part of the direction to revoke the WMRSS. It has therefore ceased to be part of the development plan. As a result the 'development plan' for an area now comprises any adopted Development Plan Documents, plus 'saved' policies in older, adopted Local Plans that have not been superseded by adopted DPDs. However, the weight that can be accorded to these plans depends on whether they are 'up to date', including their degree of consistency with the NPPF.

Local Plans and Local Development Framework

It is Local Plans that set out strategic policies and allocate sites for development. When adopted, these plans replace policies and proposals in previously adopted local plans.

The Local Plans are "Development Plan Documents" (DPDs) and are tested at an examination in public. The plans must be supported by proportionate evidence that demonstrates that the plan is justified. The plans also have to be positively prepared, effective and consistent with national policy, as well as passing a range of legal tests. The evidence to support the preparation of the new Local Plans and the justification of policies and proposals includes Sustainability Appraisals and Strategic Environmental Assessments. These can be prepared as integrated assessments that also include health issues considered through Health Impact Assessments and Equality Impact Assessments (such as the Integrated Assessment of the South Worcestershire Development Plan).

Local Planning Authorities adopt Supplementary Planning Documents (SPDs) that support the implementation of policies in the Local Plans. These SPDs can be produced by the LPAs, or by other bodies, but to be recognised as an SPD they must be adopted by resolution of the Local Planning Authority. SPDs are subject to consultation. Unlike DPDs they are not tested at examination but they can be subject to legal challenge and therefore must be underpinned by proportionate and robust evidence and may require a sustainability appraisal.

Wyre Forest District Council has completed its Core Strategy, which was adopted in December 2010 and refers to health in relevant policies. The remaining district councils' Local Plans have yet to be adopted, but they will need to ensure that they take account of health and are in conformity with the NPPF.

Local Plans prepared by the County Council

Worcestershire County Council also prepares Local Plans and, once adopted, these also form part of the Development Plan. At present the County Council has adopted the Waste Core Strategy for Worcestershire and is preparing a Minerals Local Plan.

Waste Core Strategy

The Waste Core Strategy was adopted in November 2012 and has taken account of health through Objective WO2 "To base decisions on the principles of sustainable development by protecting and enhancing the County's natural resources, environmental, cultural and economic assets, the character and amenity of the local area and the health and wellbeing of the local people." This is delivered through policies which direct development to the right locations and control working practices to avoid health impacts. Policy WCS 14 Amenity includes a specific requirement to consider impacts on health, with specific reference to Air Quality Management Areas and bioaerosols. In addition, the Environment Agency regulates waste management activity in order to prevent harm to human health and the environment from pollution and emissions, currently through Environmental Permitting.

Minerals Local Plan

The Minerals Local Plan is at an early stage in its development. It will include policies which protect human health, including those which address noise and dust throughout the life of minerals development. It will also promote the provision of informal access and recreation on restored mineral workings, through a high-level restoration strategy for the county which takes a Green Infrastructure (GI) approach. Provision of GI can have significant benefits for physical and mental health. Once adopted the Minerals Local Plan will supersede the "saved" policies in the Hereford and Worcester Minerals Local Plan; until then, the saved policies remain part of the Development Plan. These saved policies do not make reference to health issues.

Green Infrastructure Strategy 2013-18

GI is a holistic approach to viewing and managing the natural environment (networks of green spaces). The underlying principle of GI is that the same area of land can frequently offer multiple benefits. The functions delivered can be environmental (such as conserving biodiversity or adapting to climate change); economic (such as supplying jobs or increasing property prices); or social (such as supporting the health of residents). There is a strong link between the provision of accessible and good quality green spaces and improved health of residents. GI offers opportunities for increased physical activity, exposure to nature, local food production and climate change resilience and mitigation, which could help to reduce numbers of physical (including obesity, diabetes, respiratory and cardiovascular diseases) and mental health sufferers in the county.

The Worcestershire Green Infrastructure (GI) Partnership (consisting of statutory agencies, the voluntary sector, and district and county councils) has developed a strategic green infrastructure strategy to support the environmental, economic and social needs of the county. The Partnership developed an extensive natural environment and socio-economic evidence base to enable the strategy to inform local planning policy and to guide delivery of green infrastructure. The GI Partnership also helps to inform site masterplanning to ensure that strategic developments provide high-quality, accessible and multifunctional networks of green spaces.

Health Impact Assessment

Health Impact Assessment (HIA) is defined as a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within a population.

Broadly it is a systematic process that assesses the potential and sometimes unintended effects of a proposal on the health and wellbeing of a population and the distribution within a population. It tries to identify appropriate actions to manage those effects to reduce negative impacts and enhance positive ones.

For planners the HIA is a decision support tool, providing evidence-based recommendations which influence the decision-making process so that proposals can be amended. It may predict the consequences of implementing different options, increase awareness of health and wellbeing and involve the participation and engagement of stakeholders.

The HIA should be done early in the planning/proposal process to enable change before implementation. It is useful to enhance health, reduce negative impacts on health, reduce health inequalities or obtain mitigating actions. Importantly the core values are equity, sustainability, openness and ethical use of evidence. It is a proactive approach.

There are 5 stages to HIA:

1. Screening – considering whether to perform a HIA by asking four questions: does the proposal affect the health of the population? Can we change the proposal? Is there community concern about the proposal? Do you have resources to support an HIA? A yes to these questions means you may be able to move onto stage 2: Scoping.
2. Scoping – planning how the HIA is to be performed. This involves formulating a steering group, identifying aims and objectives, identifying stakeholders, areas and populations, the determinants of health, experts, and gathering evidence.
3. Appraisal.
4. Recommendations – fed back to make amendments to the proposal.
5. Monitoring and evaluation after the implementation of the recommendations.

There are 3 types of HIA:

- Rapid HIA/desktop - the brief investigation of health impacts and exchange of existing knowledge which tends to be rapid and with minimal resources.
- Intermediate HIA – more detailed investigation of potential health impacts including searching community and environmental assessments.
- Comprehensive HIA - extensive investigation, collection and analysis of new information, working together with the community in a collaborative process.

A Case study example of an HIA.

Examples of HIAs can be found on the 'Health Impact Assessment Gateway' (www.hiagateway.org.uk). One example within Worcestershire is the Redditch Partnership 'Borough of Redditch Local Plan No.4 health impact assessment', published in January 2013. The full version is available from http://www.apho.org.uk/resource/item.aspx?RID=130552, but the key issues are summarised below.

This HIA considers the positive and negative impacts of the Borough of Redditch Local Plan No. 4. This document, once adopted, will be the most important planning document at a local level, providing a framework approach for growth of the borough through a series of policies.

The purpose of the HIA was to ensure the policies in the Local Plan No.4 actively promote health gain for the local population, reduce health inequalities and do not actively damage health where possible. The way that places are planned, develop, and change, impacts on the health and wellbeing of the communities that live within them.

The Redditch health profile is detailed in the district-by-district summary (section 3 of this paper). Health priorities in Redditch are smoking, obesity, heart disease and stroke. After screening and scoping, the health impacts were identified and are summarised below.

Positive health impacts

Health and Wellbeing Issue	Local Plan contribution
High levels of deprivation	• Identify land for employment development that will lead to increased employment opportunities. • Support education, training and skills allowing more people to access employment • Improve district centres to help create stronger communities
Obesity (children and adults)	• Increase sustainable transport opportunities, e.g. walking/cycling to increase physical activity and reduce CO2 emissions • Improve access to open spaces to encourage healthier lifestyles and improve wellbeing • Increase opportunities for leisure and recreation activities • Encourage healthier eating by limiting the number of hot food take-aways in the district centres.
Violent Crime	• Improve the environment of the town and district centres to help reduce anti-social behaviour • Incorporate high quality and safe design in all developments to reduce crime risk

Negative impacts on health taken from the HIA

- Construction impacts can include noise, air quality, access to local services, disruption and anxiety. These impacts can be alleviated a little through planning conditions such as limited working hours, but this will be tailored through the development management process.
- Overcrowding – by safeguarding open spaces and green belt, there is concern that other areas of the borough will become overcrowded. Setting appropriate densities for residential development helps reduce this concern. Supplementary Planning Guidance 'encouraging good design' sets spacing standards for new developments.
- Increased demand for health and social care services – an increasing population will most likely cause an anticipated increased demand. New and improved health facilities will be located in sustainable and accessible locations, e.g. town and district centres.

Conclusions and recommendations from the HIA

There are mainly positive impacts on health and wellbeing resulting from this plan. The potential negative impacts will require mitigation to try and reduce the impact. Implementation of the plan is only part of the puzzle in tackling the health and wellbeing issues in Redditch. Policies need to work with plans and initiatives of other council departments and external organisations.

The HIA needs to be reviewed and the policies within the Local Plan No.4 revised prior to adoption.

Appendix 3: Relationship between spatial planning and health inequalities

The table below is taken from Ross (2011), who carried out a review of the research undertaken where the evidence of the relationship between spatial planning and health inequalities was 'particularly strong'.

Environmental factor	Health inequalities impact	Health inequalities impact
Air pollution	Poorer communities have a higher prevalence of cardio-respiratory and other diseases.	Strong evidence that reductions in traffic to reduce air pollution are successful in improving health.
Green/open space	35 per cent of people in the lowest social grade visit green spaces infrequently (less than once a month), which is likely to be due to both the low availability and bad quality of green space in deprived areas.	Strong evidence that provision of green space effectively improves mental health. Less strong/inconclusive evidence that provision of green space improves levels of physical activity.
Transport and traffic	Children are four times more likely to be hit by a car in the 10 per cent most deprived wards than in the least deprived wards.	Strong evidence that traffic interventions reduce road accidents. Some inconclusive evidence that traffic interventions improve physical activity.
Food	Low income and area deprivation are both barriers to purchasing fresh or unfamiliar foods.	Anecdotal evidence that local access to healthy foods improves diets.
Housing	Children in bad housing are more likely to have mental health problems, such as anxiety and depression, and a range of other ill health effects – cold housing can affect the numbers of winter deaths and respiratory diseases.	Some evidence that targeting home improvements at low-income households significantly improves social functioning as well as physical and emotional wellbeing.
Community participation and social isolation	In many communities facing multiple deprivation, stress, isolation and depression are all very common, and low levels of social integration and loneliness significantly increase mortality.	Some evidence that increasing community empowerment may result in communities acting to change their social, material and political environments.

Appendix 4: Glossary

Active ageing
Active ageing means helping people stay in charge of their own lives for as long as possible as they age and, where possible, to contribute to the economy and society.

Baby boomers
People born between the years 1946 and 1964 (post Word War 2).

Cardiovascular disease (CVD)
General term that describes a disease of the heart or blood vessels.

Chronic Obstructive Pulmonary Disease (COPD)
The name for the collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. COPD is characterised by airflow obstruction that is not fully reversible.

Clinical Commissioning Groups (CCG)
Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Cohort
In statistics and demography, a cohort is a group of subjects who have shared a particular event together during a particular time span.

Coronary Heart Disease (CHD)
A condition in which fatty deposits build up in the walls of the arteries that run to the heart, causing them to narrow. This can reduce the supply of oxygen to the heart, potentially leading to angina or a heart attack.

Development Management
The process whereby a Local Planning Authority manages, shapes, and considers the merits of a planning application and whether it should be given permission.

Development Plan
The Development Plan is a statutory document or set of documents that set out the local authority's policies and proposals for the development and use of land in their area.

Health and Wellbeing Boards
The Health and Social Care Act 2012 established health and wellbeing boards as fora where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Health inequalities

Differences in health status between individuals or groups, as measured by (for example) life expectancy, mortality or disease. Health inequalities are preventable differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.

Joint Health and Wellbeing Strategies

Joint Health and Wellbeing Strategies are based on the findings of the Joint Strategic Needs Assessment. Preparation of the Strategy is a statutory duty for the County Council and the Clinical Commissioning Groups under the Health and Social Care Act 2012. The Strategy sets the context for other health and well-being plans and for commissioning of NHS, public health, social care and related children's services.

Joint Strategic Needs Assessments

Local authorities and local health services are required to undertake Joint Strategic Needs Assessments of health and well-being. This work is a continuous process of assessment designed to inform decisions made locally about what services are commissioned. The core aim is to improve the public's health and reduce inequalities.

Local Plan Documents (LPD)

Local Plan Documents are documents set out in a council's Local Development Scheme. They are statutory documents which are part of the Development Plan under the provisions of the Town and Country Planning Act 1990 (as amended). Their purpose is to guide long-term decisions about the future of the area and day-to-day development management decisions on individual planning applications.

Minerals

Minerals and substances in or under land of a kind ordinarily worked for removal underground or surface working, except that it does not include peat cut for purposes other than sale.

Minerals Local Plan

The Minerals Local Plan sets out the long-term spatial vision for minerals for the local planning authority area and the strategic policies and proposals to deliver that vision. It also sets out the scale and preferred location of minerals extraction in the authority area.

Neighbourhood Plan

Plans produced by Parish Councils or other designated neighbourhood areas, outlining how they envisage their area developing in the future. Neighbourhood Plans should be in conformity with the respective council's Local Plan Documents. When legally adopted Neighbourhood Plans become part of the statutory Development Plan.

National Planning Policy Framework (NPPF)

This was adopted in March 2012 and replaces previous national planning policy, formerly contained in a series of planning policy statements and guidance notes. The Framework sets out the Government's planning policies for England and how these are expected to be applied.

Non-communicable diseases

Also known as chronic diseases, these cannot be passed from person to person. They are of long duration and generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.

Planning Policy Guidance (PPG)

The Government's web-based planning practice guidance which supplements the NPPF. The PPG brings together planning practice guidance for England in an accessible and usable way.

Social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, legislation and resources at global, national and local levels.

Supplementary Planning Document (SPD)

SPDs are Local Plan Documents that explain how policies in Development Plan Documents will be implemented. They do not form part of the Local Plan and cannot allocate land, but are material considerations when determining relevant planning applications.

Sustainability Appraisal

Sustainability appraisal is an appraisal of the economic, environmental, and social effects of a plan from the outset of the preparation process to allow decisions to be made that accord with sustainable development.

Waste Core Strategy (WCS)

The Waste Core Strategy sets out the long-term spatial waste vision for the local planning authority area and the strategic policies and proposals to deliver that vision. It also sets out the scale and preferred locations for waste facilities in the authority area.

Please contact us if you need this document in another format, or if you have any questions.

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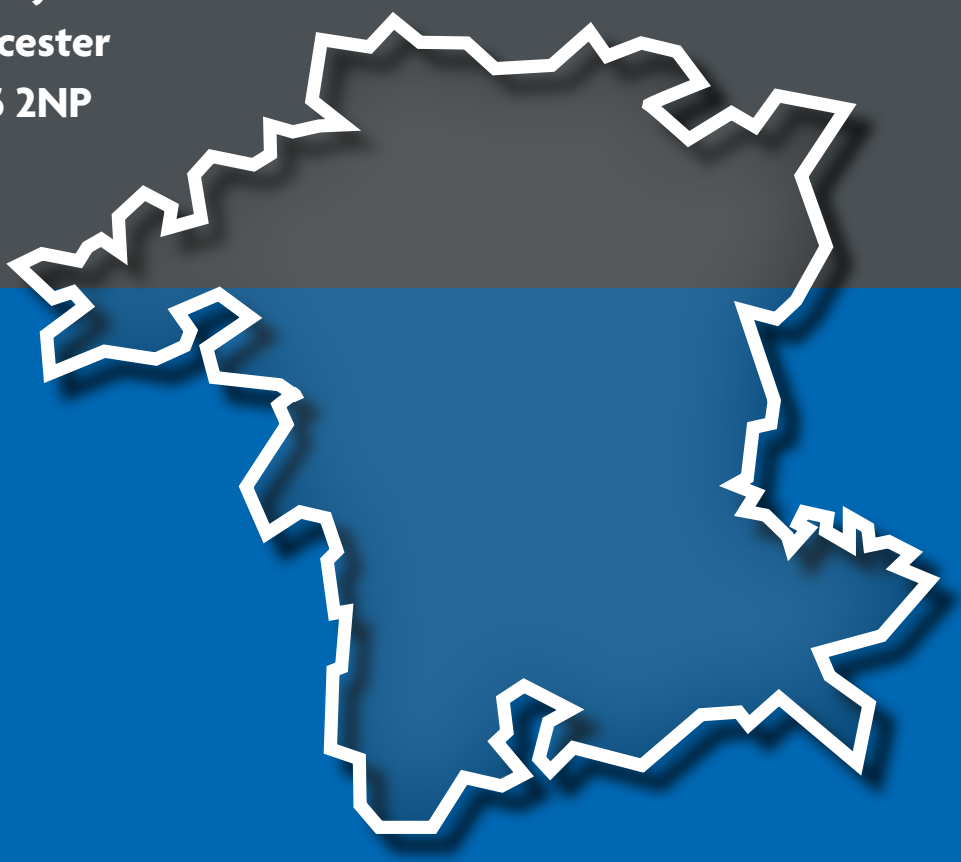

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