Developing spatial planning's delivery role: examining the potential for achieving health outcomes in England

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The role of spatial planning in the delivery of a variety of outcomes, particularly those that are wider than those covered by traditional land-use planning, has started a range of policy and delivery discussions about spatial planning's role in the responsibilisation agenda. This includes attitudes towards health outcomes, where a more personal approach to policy delivery requires the provision of services and facilities to support individual activities. This paper examines the ways in which spatial planning has responded to these changes through greater engagement in a full range of health outcomes and the institutional drivers that have contributed to this more integrated focus. The specific potential of spatial planning to deliver wider health outcomes is undertaken through a review of spatial planning policies being utilised in three regions of England and discusses the drivers for this development of health outcomes being delivered by spatial planning through Local Development Frameworks.

Introduction

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[2] Thanks to Stephen Hincks, Simon Pemberton, Adam Sheppard and Nick Smith for their helpful comments on an earlier draft of this paper

The role of spatial planning in providing wider and deeper approaches to delivery has extended beyond the physical manifestation of place to the way that places deliver social and economic outcomes (Morphet, 2009). The development of integrated approaches to public policy and delivery in the Blair period (6 et al, 2010; Morphet, 2008) have not only been manifest in joint services such as the merger of the local authority and the Primary Care Trust (PCT) as in Herefordshire and Hammersmith and Fulham but also in support systems such as the common use of shared evidence and consultation through shared duties to involve and cooperate, local responsibility to align budgets and joint scrutiny with a greater focus on the technology of governmentality (Imrie and Raco, 2000; Huxley, 2007). Services not only have to demonstrate how they work together within and between agencies but also over administrative boundaries. A more engaged citizenry does not only imply the need for more effective participation in decision making but also an expected self actualisation of change through the development of responsibilisation. If this is to be achieved, then facilities and support need to be available for these objectives to be met. Cross boundary provision and investment supports both efficient working and greater access. The post-2004 planning system in England was also reformed during this period, following policy and practice knowledge transfer from Australia (Morphet, 2010b), is centrally within this responsibilisation mix. Spatial planning has been given a key role to play in the making of places and the provision of facilities which enable people and communities to take a lead for themselves. This article, considers the development of these approaches through the lens of health,

which is central to the responsibilisation agenda and where spatial planning, is developing wider engagement.

The relationship between spatial planning and health is now being explored more extensively. Some strategic interrelationships have already been noted at regional level (Kidd, 2007; Harris and Hooper, 2004; Pilkington, 2009, Haughton et al 2010). At the local level, the relationship between planning and health has related to public and mental health issues and the location and provision of health facilities (Forsyth et al, 2010; Barton et al 2010; Barton 2005). The development of active citizens and the notion of responsibilisation in policy delivery, particularly between 2000-2007 have also heightened the awareness of provision and capacity for more active engagement in health by individuals (PMSU, 2003; Halpern et al 2004; Mulgan, 2009). Public health approaches include encouragement to take exercise and the provision of safe and secure environments. Decisions on the locations of health infrastructure have been left to health providers including meeting the requirements of changing or new populations. Is there any evidence that the separation between the corporate and professional interests in planning (Lambert, 2006; Brownill and Carpenter, 2007) could be on a more convergent pathway (Morgan, 2010)? This paper discusses this issue in more detail particularly through the analysis of published local planning documents and assesses the extent and range of expectations of how spatial planning can be used to improve health outcomes through the planning process. Secondly, this review seeks to understand more of the drivers that have encouraged the greater integration between spatial planning and health outcomes. At present this

paper can only deal with the policy frameworks put into place and their expected delivery, as much of this work is recent and does not yet yield outcome evaluation. As planning policy has widened it suggests that planners are recognising the increasing importance of spatial planning in achieving health outcomes and that they expect to have effects which contribute to the health of communities and individuals, even if they cannot yet be measured.

The transitional integration of spatial planning into the local governance architecture

The introduction of spatial planning in England following the Planning and Compulsory Purchase Act in 2004 comprised a Local Development Framework (LDF) which was made up from a number of Development Plan Documents (DPDs). One DPD, the Core Strategy (CS) has the overarching role, although it was not required to be undertaken before other DPDs until 2008 (CLG, 2008a). Unlike the predecessor development planning system, the LDF was not a free standing document or process but was transformed into a delivery role. The overarching plan for any area is a Community Strategy, introduced in the 2000 Local Government Act and developed further in its role as the 'plan of plans' in the 2007 Local Government and Public Involvement in Health Act as the Sustainable Community Strategy (SCS). The relationship between the SCS and the LDF was made clear by Government, 'The LDF must be a key component in the delivery of the Sustainable Community Strategy' (ODPM, 2005:24). This reinforced the incorporation of planning within the mainstream of local government thereby moving planning

away from being a separate service with specific legislation. This also made spatial planning a delivery mechanism (including both policy and development management) firmly at the heart of the local governance architecture similar to the role that spatial planning in the Netherlands (Needham, 2005), Norway (Amdam, 2004), France (Booth, 2009), and Sweden (Sehested, 2009).

The introduction of this new spatial planning system received a mixed response. Some argue that this was due to structural dislocation between the new and the former system (Haughton et al, 2010), cultural factors (Shaw and Lord, 2007; 2009; Stead and Meijers, 2009), misunderstanding (Lambert, 2006; Doak and Parker, 2005) or poor implementation (Morphet et al, 2007). Initially greeted with enthusiasm by planners as a faster approach (Cullingworth and Nadin, 2008), early adopters found that the transition to LDFs was more challenging and differentiated than they anticipated. Early failures of submitted plans (e.g. those for Lichfield (2006) and Stafford (2006)) sent a wave of concern through the local planning system and the main response was to concentrate on saving policies in existing plans rather than developing new Core Strategies (Wood, 2008). Although funding was supplied to support culture change and implementation of the new system, through the Planning Delivery Grant (PDG) (2003-2008), this was primarily used by local authorities to improve their league table position in determining planning applications through the purchase of IT systems or the employment of temporary staff and thus improve the potential for higher PDG funding awards in subsequent years (Addison Associates, 2006). The main purpose of PDG, was largely ignored. An action orientated project, *Spatial Plans in Practice,*

was also developed as a means of sharing emerging practice but it also became absorbed into translating the new system back to its predecessor (Baker Associates, 2006).

The new remit of spatial planning within the local governance architecture was not developed into a coherent narrative that was communicated to both planners and the wider governance community (Morphet, 2010a). The relationship between LDF and SCS has been particularly problematic. The role of Community Strategies (CS) as the overriding policy plans for any area was introduced through the Local Government Act 2000 and renamed as Sustainable Community Strategies (SCS) in the 2007 Local Government and Public Involvement in Health Act. Both CS and SCS have been regarded as unclear in their overall role and purpose (Sullivan and Skelcher, 2002) and criticised as having too many objectives which has resulted in bland documents (Sullivan and Davies, 2009). There was also an expectation that the relationship between the SCS and LDF provided 'significant opportunities' to 'work together' (Lambert, 2006, 246) rather than recognising their legal and hierarchical relationship. This was also underplayed in a study specifically commissioned by Government to support the transition of policy practice between the CS and LDF (Entec, 2003). Initially both the corporate centres and planning services within local authorities saw the relationship as distant and with no specific interrelationship. The extension of the SCS role in the 2007 included more clarity on its overriding, formative function that has primarily been seen in relation to its role in providing the basis of the LAA (Kelly, 2009) and potentially being turned into a tool of regulation (Coulson,

2009). Its relationship with other policy plans such as the LDF has been less considered (Morphet, 2009).

Planners were not fully aware of the overarching role of the SCS and in many localities have been dismissive, describing the SCS as 'motherhood and apple pie' – too vague, insufficiently robust in its evidence base, too bland and untested through the same kind of formal processes required of the LDF (Morphet et al 2007; Sullivan and Davies, 2009; Doak and Parker, 2005). Lambert (2006) pointed to early mismatches between the systems and Government responded through *Planning Together* (CLG, 2006; CLG, 2008a) which was aimed at both the corporate centre and the professionals involved in the SCS and LDF, although its status as informal advice undermined its intended role. Some of the responses to these changes reflected the separation between the respective policy communities, the struggle for policy leadership and fear of displacement in the overarching policy role (Williams, 2002; Ackroyd et al, 2007; Turok and Taylor, 2006; Enticott, 2006).

The need to provide greater clarity of planning's delivery role was recognised (Morphet et al, 2007) and subsequently new advice was issued in PPS 12 (CLG, 2008a) and clarity on its integration into the wider local governance mode was set out a month later (CLG, 2008b). Gradually, legislation on spatial planning has also been merged with that on wider local governance through the use of a single evidence base, the duty to involve and scrutiny powers all being set within the 2007 Local Government and Public Involvement in Health Act. Although now being dismantled, further changes in

the spatial planning system were introduced in the 2009 Local Democracy, Economic Development and Construction Act would have extended this integration which is now expected through the 2010 Localisation Bill. There seems to be a trend for planning legislation to be contained within a wider local government legislative and operational context. Whilst specific legislation for planning was enacted in 2008, it dealt with planning applications at both ends of the spectrum, householder to major infrastructure, rather than dealing with integrated policy and regulation as was previous practice.

Following the 2007 Act, individual SCS have been substantially reviewed and there has been more focus on their evidence base. Although it was intended that SCS should be reviewed prior to negotiation of the LAA in 2007, this was quietly dropped in favour of obtaining agreement between parties on the specific outcomes to be achieved locally. However, many areas did commence SCS reviews and undertook them within the ambit of the Local Strategic Partnership (LSP), which was given a statutory role in their 'ownership 'of the SCS and the LAA (CLG, 2008b). A second feature of post-2007 SCS has been their more programmatic nature. Once evidence based issues have been identified, concentrating on obesity, worklessness, needs for independent living or reducing congestion, the SCS has moved from a generally platitudinous response to one that is more focussed and measurable. Many SCS now have delivery statements or programmes which cover public sector partners in delivering these changes. As the most recent approach to public policy delivery has been resting on notions of repsonsibilisation, an important part of successful delivery will depend on

having the facilities and capacity available to make this transition. This is a more critical issue in some policy areas such as health which depend on individual actions to achieve the targeted policy outcome. Also, as 6 et al (2010), show, some government departments, particularly the Department of Health have relied more on information and persuasion than other delivery approaches for their own outcomes.

Another contributing factor in bringing together health and spatial planning outcomes has been the changes in the political structure of local government. Before 2000, many councillors specialised in planning and had close operational relationships with planning officers. The change in the role of the LDF and an increase in the delegation of planning consent determinations to officers have both served to reduce this relationship. Before the reforms to local authority structures that followed on from the 2000 Local Government Act, planning was a function with its own committee and dedicated councillors. The introduction of executive models and thematic portfolios reduced this relationship and left planning within a larger and less sponsored mix. Over the subsequent period, whilst some councillors have kept their close interest in local planning applications, executive councillors have developed a more integrated approach and see less of a direct match between professional policy silos and delivery. Reforms in children's services and some regulatory functions have supported greater emphasis on places, communities and individuals away from a professionalised producer focus. As Gains et al found (2009) this has reduced bureaucratic autonomy and although councillors may have less detailed knowledge of services they have a greater interest in

outcomes, which they use to evaluate policies and programmes. It could be that Councillors have been responsible for a more integrated approach between spatial planning and the priorities as set out in their SCS which has been developed whilst the LDF process has been in a hiatus of policy uncertainty and transition. As councillors have been refocusing towards wider community outcomes, planners have been in an aporia. The ability to develop active approaches to health outcomes through spatial planning policies which support responsibilisation may have made this an easy target for policy and delivery.

More recently, at the local level, work has been progressing to support the development of the delivery role of spatial planning through local Infrastructure Delivery Plans (IDPs) which are components of Core Strategies (CLG, 2008a; Morphet, 2009a). This has taken spatial planning into the mainstream of local governance structures and within the ambit and framework of Local Strategic Partnerships (LSPs), which are non-statutory organisations with statutory duties placed upon them (CLG, 2008b). LSPs have duties that extend beyond more recent infrastructure concerns in planning, that is through the provision of infrastructure funding through developers' contributions (Crook et al, 2010; Baker and Hincks, 2009) to an approach which brings together investment processes across the local authority area and in particular works within local governance models to draw together public sector investment programmes. This approach to public sector investment has also been the subject of wider policy initiatives relating to capital investment including PSA 20, (HMT, 2007), Total Place (HMT, 2009),

Total Capital (HMT, 2010), Place Based Budgets (LGA, 2010) and community budgets (Pickles, 2010a). In effect, the introduction of spatial planning has switched the role of the local development plan from that of a policy-led vision delivered by others to one that delivers the objectives and vision for an area which is owned by the LSP and set out in the SCS. It has to work within the local contracts for the delivery of a wide range of outcomes set out in Local Area Agreements (LAAs) (2008-2011, CLG 2008b)) as well as interpreting national and regional policy at the local level, with the regional framework being replaced by sub-regional mechanisms, including Local Enterprise Partnerships (LEPs) (Pickles, 2010b).

The role of LDFs in delivering LAA targets was not widely promoted or understood. LAAS have been seen as part of local gaming strategies both between the locality and the state (Coulson, 2009; Bevan and Hood, 2006) and within the authority (Gains et al, 2008). Evolving from earlier contractual processes (Kelly, 2009), they were primarily concerned with promoting joined up working by different public agencies working with the same client group. Other local authority services, such as those concerned with regulation, were regarded by the central and local state corporate centres with less interest as part of the LAA process. Those who have reviewed the operations of SCS and LAA have concentrated more on the ways in which they have directly influenced local expenditure and shifts between priorities and less on the informal influence that they may have brought to bear on policy delivery (Russell, Johnson and Jones, 2009).

Identifying spatial planning's role in delivering local outcomes: the case of health

This more integrated working is an essential feature of spatial planning and has been seen primarily to operate at more strategic spatial scales. Kidd (2007) reviews how health has been integrated into regional health objectives and Harris and Hooper (2004) anticipated this wider role in a nation, and then taken further in the update of the Spatial Plan for Wales (WAG, 2008). In these studies, there was cautious optimism about spatial planning's potential for the delivery of health outcomes. A later study in the Thames Gateway (Haughton et al, 2010) is less sanguine about the processes. This work concentrated on health facilities planning to support housing growth and concluded that silo-based approaches to investment planning to support new development remains inured in non-integrated approaches despite any attempts to implement new spatial planning systems, continuing to locate the relationship between health and planning within a more traditional construct.

Understanding of health issues has a strong spatial correlation as life expectancy and mortality rates demonstrate (Congdon, 2009) and the use of spatial data in public health observatories (www.apho.org.uk). Targeted approaches to spatial inequalities in health have been progressed through initiatives such as the creation of Health Action Zones (NHS, 2004), Public Service Agreements and LAAs. Evidence shows that health is associated with locality, whether this is related to the environment such as air quality or noise or whether through the clustering of people with similar socio-economic

characteristics (Barton et al 2010). Other factors such as physical and social access to care can also be key spatial issues.

The provision of health services is organised around four key elements. The first is public health which focuses on prevention and includes a range of services such as the management of communicable diseases, diet, exercise, air quality, food standards and safety and pre-screening for specific conditions. The second element relates to specific age or lifelong conditions such as dementia or disability which require longer term care management in the community which is mixed with health service provision. Since 1948, local authorities have primarily been actively involved in these first two elements of health service provision and both are seen to be areas where individual behaviours can affect life chances and where family and community support influences delivery and outcomes. In lifelong conditions, individualised budgets for self-managed care have emerged since the 2007 period and are being widely implemented at the local level. The third element comprises acute services which are accessed through the primary care system that acts as a filter. Acute services are specialised and operate over larger geographies. In this area, the individualisation has developed through the role of the 'expert patient' who is able to access information and knowledge about treatments, drugs and therapies through the internet and connected support groups. The final element is mental health which is primarily undertaken in the community although there is a need for secure mental health facilities in all communities. For these latter two elements, the local authority's role has been

more mixed and planning has primarily been concerned with the provision of adequate facilities in the right location rather than direct service provision.

Public service reforms since 2000 have led to more integrated approaches to service provision (6 et al, 2010) with increasing coalescence of service objectives and blurring of budgets. The focus has shifted from the producer to the user or community (HMG, 2006). Total Place has demonstrated the costs and failures of multiple agency approaches to the same communities and individuals (HMG, 2010) and there are increasing pressures and commitments to establish place based or community budgets which see the whole of public investment in one place rather than through organisational silos (LGA, 2010). This combined approached is underpinned by a common evidence base for all local authority services and partners, the Joint Strategic Needs Assessment (JSNA), that was introduced as a requirement in the 2007 Local Government and Public Involvement in Health Act and is now being further reviewed to play a more central role.

There are a range of sources of advice and guidance on the delivery of health outcomes through spatial planning, many of which also include examples and case studies. Longstanding relationships between the delivery of public health outcomes through development planning have now been extended into concerns with achieving sustainable outcomes for issues such as food distribution, climate change and carbon reduction (RTPI, 2009; UWE). The Planning Advisory Service (2008), RTPI, (2009) and the NHS (2007a; b) have produced introductory guides on the relationship between health and

planning. A more detailed set of guidance on ways that health outcomes can be delivered through Core Strategies has been prepared for health professionals through guides prepared by the NHS Healthy Urban Development Unit (HUDU). *Health Issues in Planning Best Practice Guidance,* (MoL, 2007) provides another comprehensive approach to considering ways in which health outcomes are delivered through spatial planning at the local level. More detailed advice on design of built and natural environments which encourage healthier lifestyles is provided by the National Institute for Health and Clinical Excellence and CABE (2006). Both of these concentrate on more detailed delivery issues including design, access, assessment of walking and cycling routes and how these should be planned into development. There is also an education network for healthier settlements that has been established to develop the planning/health curriculum in higher education,

The delivery of health outcomes through spatial planning: study approach

As indicated, there are a number of ways in which spatial planning can relate to health outcomes, and advice from a variety of sources about how this can be incorporated within planning policies. However, apart from specific case studies, there is less evaluation of the scale and coverage of health related policies within spatial plans. The study reported here sets out to respond to this issue. If spatial planning is wider and deeper than land use planning, how could it engage with health outcomes? In order to assess this, the study has

taken an approach to review health outcome content in LDFs. The health content has been defined through the set of National Indicators (NIs) applied to all local authorities and other public bodies 2008-2011 (CLG, 2008c). Of these 198 NIs (later recued to 189, CLG 2009), 42 were identified by Government as having specific health outcomes, although some were combined to secure multiple outcomes. Whilst having to report progress on all 189 NIs, each LSP agreed that it would choose up to 35 where evidence indicated a greater gap between local conditions and national averages for concentrated cross- organisational action and set out in the LAA. In addition, LSPs could set their own additional local indicators. Progress would be subject to closer monitoring and be stretched further into a local set of outcomes. The LDF was required to deliver the LAA targets as part of its process (2008a, §2.7). This meant that those preparing the LDF had to be aware of the LAA and wider NIs, and find ways that the spatial planning process could contribute to the delivery of their specified outcomes. However, apart from the mention in this guidance, few practical steps were taken by government to reinforce these links with within the wider local governance or planning communities.

This study concentrated on the range of spatial planning policies and health outcomes in Core Strategy components of the LDF. The documents reviewed in each local authority were not all at a final stage but drafts published for consultation through the process give a good indication of the response to local issues and the likely components of policy. The review was conducted in three regions of England. Yorkshire and Humberside was chosen because it

has a small number of local authorities and has created a cooperative way of working on spatial planning which includes a major focus on health. The West Midlands is regarded as having a good approach to innovative health care and management, as recognised through the establishment of three innovation health care centres in early 2010 but as a region has achieved less progress in spatial planning as measured by sound core strategies. The South West which has made good progress in planning and is regarded as having some integrated and innovative approaches to rural health care (Swindlehurst, 2005) was the third region to be selected.

This study was not concerned to review the frequency of the occurrence of health policies but rather to examine the range of policies that had been included. The NI health subset includes a variety of outcomes including those related to teenage pregnancy, drug abuse and mortality. Could spatial planning policies address this range of outcomes? The review was undertaken in February and March 2010, prior to the UK General Election in June 2010, since when the Coalition Government has retained the collection of data on NIs until their planned conclusion in March 2011. This study provides an illustrative indication of the range of policies which are considered appropriate to achieve health outcomes in spatial planning. Initially the study reviewed the Core Strategies in these regions against the LAA priorities that had been selected for each local authority. When expanded to the NI health subset, a fuller framework of health outcomes against which to review spatial planning content was available.

Expected Spatial planning delivery of health outcomes: findings

The results of this review are shown on Table 1 and demonstrate that the great majority health of outcome NIs have been included within a Core Strategy. The level of detail achieved for each varies, with some acknowledging required action e.g. NI 39 and NI 40 on alcohol and drug abuse whereas others are more proactive and detailed e.g. the responses to road traffic accidents (NI 47 and NI 48). Although not necessarily seen as central planning issue, a number of Core Strategies have addressed issues related to mortality and life expectancy, including specific causes such as the Forest of Dean's inclusion of deaths from cancer (NIs 120, 121, 137). Some of the approaches go into detail about how to respond to an issue including the relationship between settlement policy and older people (NI 136), and the provision of local shops for vulnerable and older adults (NIs 141, 151). Some have tackled mental health issues through calm environments, safety and reducing fear of crime (NIs 5, 21, 50 and 51). In relation to the provision of affordable housing, all Core Strategies include policies to address this provision (NI 155) within statutory guidance (CLG, 2008b). In terms of access to services, many Core Strategies tied these to transport policies but also to street cleanliness and attractiveness to encourage people to walk (NIs 167, 175, 186, 195 and 198). Finally some Core Strategies addressed fuel poverty and saw this as a key issue to be tackled (NI 187). In addition to the range of policy responses to these health NIs, there were also other health polices included such as that in Bradford's Core Strategy that specifically addresses the health needs of gypsies and traveller communities.

The inclusion of an issue within the Core Strategy signals the intention to include a policy but that does not necessarily mean that the policy will be delivered or that the intended outcome will be achieved. The recognition of the high level of smoking in the area (Hull) or high level of cancer deaths (Forest of Dean) does not immediately lend itself to identifiable policies. In some cases, such as the reduction in teenage pregnancies, the response may come through more detailed development management policies such as the provision of pharmacies. Similarly on smoking this may be an issue of planning control over smoking shelters. In some cases, Core Strategies in areas outside the three case study regions are demonstrating a more detailed planning policy such as Bolton, where, in the town centre, it is using planning policy to reduce the number of drinking establishments through the Use Classes Order by promoting A3 rather than A4 uses, promoting non-alcohol based leisure and alternative uses. Bolton has also included access to fresh food, particularly for those living in deprived areas and the provision of allotments as part of their health outcomes in a Core Strategy background paper

When reviewing the potential policy derivation and relationship between health and the Core Strategy policy on a specific issue, it was found that inclusion of a health priority in the LAA was not generally accompanied by an LDF policy. However, when the relationship between the Core Strategy and the SCS was examined there was a much stronger association. Frequently, the same issues were identified and described in the same words. This was

true in all cases, although to different degrees in all local authorities cited here with the exception of Bradford, South Somerset, Taunton Deane and the Forest of Dean. Given the expressed uncertainty in the relationship between the SCS and LDF, it might be expected that this would be a repetition of the issue in the LDF rather than any integrated or developed policy approach. However, the policy transfer has been contextualised within the LDFs and not just included as a headline to ensure compliance or a 'box ticking' approach. Thirdly, in many cases, there have been active attempts to identity planning means of contributing to ameliorating the specific health issue that has been defined as shown in Table 1.

Conclusions

The introduction of spatial planning in England included within it the expectation that planning would go beyond the land use development planning role that it had taken between 1980-2004 but there has been little evidence of this approach being absorbed into practice. Instead the literature has concentrated on the slow adoption of spatial planning processes. The study reported here has started to examine how far spatial planning has responded to this widening role through the context of the Core Strategy now the main component of the local spatial planning system. The role of the Core Strategy in the delivery of LAAs and a full range of national indicators has not yet been much considered and in this study, the purpose was to examine how far this wider and deeper role of spatial planning had been put into practice. In

reviewing this through the lens of one specific issue, health, it has been possible to see that spatial planning is now expressing its role in a range of ways that extend beyond more land-use based concerns such as facilities, green space and transport. Although specific advice and case studies have been provided, there was no specific policy leadership provided by central government on this issue until March 2010 when a draft PPS was published but this again sidelined health issues to green spaces and environment (CLG, 2010). The responses that have been made in Core Strategies have been to local issues and this is frequently the way in which they are expressed.

The inclusion of wider and deeper approaches to achieving health outcomes may have come through addressing the LAA although there is no overt evidence of this here. The response of the LDF to the Sustainable Community Strategy which the Core Strategy is required to deliver appears to be much stronger and more integrated. Despite many planners dismissing SCS as 'motherhood and apple pie' it seems likely that the inclusion of health objectives in the SCS has had an effect in forming policy content. At present it is not possible to assess whether the level of policy detail will be adequate to influence outcomes. However, their inclusion in the Core Strategy demonstrates a commitment to action and an expected contribution to achieving wider health outcomes through spatial planning.

Why has the SCS been a greater influence on the health content of the LDF than the LAA? Firstly, planners have been less involved in LAAs and that involvement has generally been concerned with NIs related to housing

provision and not the wider delivery. Secondly, the LAA is shorter lived and may have a lesser impact on the LDF which is seen to be longer term, ranging over 15 years. Thirdly, there may be a policy implementation lag where the relationship between the SCS and LDF has taken some time to establish and the LAA has been too specific and short lived to develop this relationship. More widely, the role and expectations of executive councillors may also have had an important role in raising issues about content and the role of the LDFs in meeting wider objectives. Despite planners' 'professional' concerns, this wider expectation may have structured debate and content at early stages in the LDF process through councillor and partner working arrangements. They may also be a submerged relationship between health outcomes and the need for provision of facilities which immediately relates to planning outcomes. The coincidence of timing in the development of responsibilisation approaches and the Core Strategy may have been an intended synergy. There may be a convergence in the understanding of the relational roles of the LDF and SCS which is now being recognised on both sides. It could also be that planners are more engaged in reviewing SCSs post-2008 and the more formal and targeted documents make it easier for policy transfer. Government has reinforced the relationship between the LDFs and SCS through guidance and letters sent by Planning Inspectors on specific CS. Finally, some integration and influence of the SCS on the LDF is now observable to the point where the same words are used but the planning response is being stretched and challenged into considering how the LDFs can deliver on a full range of more locally determined health outcomes.

Table 1: Spatial planning policies to deliver health outcomes: examples from LDFs over three regions

	National Indicator	examples in LDF (Y identifies priority inclusion in SCS)
NI 005	overall satisfaction with the area	**Bristol (Y)** is using the survey of Quality of Life indicators as part of its evidence base for the Core Strategy and has also linked to mental health
NI 008	adult participation in sport and active recreation	**Bradford** (NA) Issue and options topic paper 'enhancing access to facilities'; **Calderdale (Y)** identifies issues about increasing more active transport options; **Bristol (Y)** has considered the pattern of development as one of the mechanisms for improving levels of activity; **South Somerset (NA)** is using health and well being and sport and leisure strategies as part of their evidence base for their Core Strategy. **Staffordshire Moorlands (Y)** has directly linked to this objective in its SCS to deliver it through the LDF
NI	dealing with local	**Birmingham (Y)** has identified fear of crime

021	concerns about anti-social behaviour and crime by the local council and police	as one of the key issues that it needs to deal with on its issues and options paper; **Scarborough (Y)** has identified the need to address anti-social behaviour in its Core Strategy and has it as a key objectives – it is approaching this through the night-time economy and the pattern of development in town centres; **Wyre Forest (Y)** is using the design of streets in the Core Strategy to promote feelings of safety
NI 039	rate of hospital admissions per 100000 for alcohol related diseases	**Scarborough (Y)** has identified alcohol abuse as a key issue in its Core Strategy.
NI 040	number of drug users recorded as being in effective treatment	**Scarborough (Y)** has identified drug abuse as a key issue in its Core Strategy.
NI 047	number of people killed or seriously injured in road traffic accidents	**South Somerset (NA)** is developing a proactive policy on Home Zones to support safer travel and reduce child deaths from RTAs; **Bath and NE Somerset** (**Y)** is reviewing the location of all its secondary school provision to reduce journeys to school across the town to minimise travel and accidents; **Harrogate (Y)** is requiring all

		planning applications for certain types of development to be accompanied by green travel plans
NI 048	children seriously injured or killed in road traffic accidents	**South Somerset (NA)** is developing a proactive policy on Home Zones to support safer travel and reduce child deaths from RTAs; **Bath and NE Somerset (Y)** is reviewing the location of all its secondary school provision to reduce journeys to school across the town to minimise travel and accidents
NI 050	emotional health of children	**Swindon (Y)** has identified access to children's centres as an issue that needs to be tackled in their LDF; **Scarborough (Y)** has identified 'fear of crime' as a major issue that the LDF needs to tackle**;** **Taunton Deane (NA)** has identified the particular requirements for children and their families to live in safe environments
NI 051	Effectiveness of child and adolescent mental health services (CAMHS)	**Swindon (Y)** has identified the need for schools and facilities for children with special needs to be addressed through the Core Strategy; **Taunton Deane (NA)** is addressing this through specific polices on 'free play' environments

NI 054	Services for disabled children	**Birmingham (N)** has identified the need to address specific facilities in its issues and options report; **Taunton Deane (NA)** is prioritising the provision of facilities in its Core Strategy
NI 055	obesity in primary age children in reception	**Taunton Deane (NA)** has identified the links between childhood obesity and life expectancy and is focussing on ways in which children can be more active from their early years in order to address this; **Staffordshire Moorlands (Y)** is addressing high levels of childhood obesity through its Core Strategy
NI 056	obesity in primary age children in Year 6	**Calderdale (Y)** identifies obesity levels in Issues and Options and seeks views; **Barnsley (Y)** Issues and Options identifies child obesity as a specific issue to be tackled and proposes to address this through local transport actions including improving access to facilities by walking, cycling and pubic transport and improving personal safety through design improvements as well as green space improvements.
NI	children and young	**Bristol (Y)** has identified the need to

057	people's participation in high-quality PE and sport	promote wellbeing in its Core Strategy and sets out how it intends to achieve this through location, design and the pattern of development;
NI 110	young people's participation in positive activities	**Bath and NE Somerset (Y)** has identified the needs of young people particularly focussing on the locations where additional facilities are required particularly in villages in their Core Strategy; **Scarborough (Y)** has identified the needs of young people as one of the key priorities to be met including the provision of housing in their Core Strategy
NI 112	under 18 conception rates	**Bristol (Y)** is using JSNA as part of the evidence base for its Core Strategy and which has addressing teenage conception rates as one of the issues that it is tackling.
NI 115	substance misuse by young people	**Bristol (Y)** is using JSNA as part of the evidence base for its Core Strategy and which has addressing teenage drug dependency rates as one of the issues that it is tackling; **Scarborough (Y)** has identified substance abuse as a key issues to be addressed through the Core Strategy
NI	proportion of children in	**Torridge and North Devon (Y)** joint Core

116	poverty	Strategy has identified the need to tackle child poverty in an holistic way in their Core Strategy; **Swindon (Y)** has identified the most deprived areas in the Core Strategy and is focussing growth and regeneration strategies to help to deal with this issue
NI 117	16-18 year olds who are not in education, employment or training (NEETS)	**Bristol (Y)** has identified the needs of those who are deprived in South Bristol in their Core Strategy and is seeking to meet these through identified development opportunities to create more jobs in this area; **Scarborough (Y)** wants to raise the aspirations of young people, their skills and education in the Core Strategy and is addressing employment policy towards the needs of this group; **Torridge and North Devon (Y)** joint Core Strategy has identified the needs for young people to attain jobs and to retain young people as part of their Strategy.
NI 119	self reported measure of people's overall health and well being	**Herefordshire's** Options paper includes proposals to encourage local food production and processing both to support healthier living and wider sustainable objectives; **Bristol (Y)** has identified the

		need to promote mental and physical health through its approaches to green space, good environmental quality standards and access to safe forms of walking a cycling in its Core Strategy. **Torridge and North Devon(Y)** have undertaken an Health Impact Assessment as part of the development of the Core Strategy
NI 120	all age all cause mortality rate	**Bristol (Y)** have identified the need to address health inequalities in their Core Strategy particularly in those areas of the City where health outcomes and life expectancy are lower; **Bath and NE Somerset (Y)**have included mortality and life chances as one of the issues which their Core Strategy will address; **Forest of Dean (NA)** has identified the need to address high levels of cancer deaths in their Issues and Options stage; **Wyre Forest (Y)** is designing street to promote activity and has identified health 'hot spots' where life expectancy opportunities need to be advanced through the Core Strategy
NI 121	mortality rates for all circulatory diseases at	**Stoke on Trent and Newcastle under Lyme (Y)** have identified health outcomes

	ages under 75	as a significant element to be addressed in their joint Core Strategy that was adopted in 2009. All the potential approaches listed here have been addressed in the Core Strategy; improving health outcomes including mortality rates is used as justification for the delivery of improvements in facilities, green space, opportunities for walking and cycling and links improved facilities to programmes to improve activity levels by other agencies; identified as a specific target to be measured in AMR
NI 123	stopping smoking	Most local authorities have development management policies and use conditions to control smoking shelters – no specific policies on smoking found as yet in any Core Strategy
NI 130	social care clients receiving self directed support per 100,000 population	**Harrogate (Y)**, in their adopted Core Strategy, has identified the need for more specialist open market housing for people needing on site support or access to support for their existing and future population based on expectations that older people will want to live independently for longer (using the North Yorkshire

		Supporting People Strategy as evidence); **East Riding (Y)** has identified the need to provide adequate dwellings for people who need support in their Issues and options paper; **Bath and NE Somerset (Y)** have recognised in their Core Strategy that assistance needs to made available in a coordinated way.
NI 131	delayed transfers of care	**Birmingham (Y)** has asked if there any specific issues to consider for housing older people in their Issues and Options report; **Christchurch and East Dorset (Y)** have the support and care of vulnerable people as one of the key objectives of their Sustainable Community Strategy**.** Choosing Health Strategy has been used as part of their evidence base and the Issues and Options Report has identified the need for more support for carers to enable people to live at home, and more community and day care facilities to support older people living at home They have identified potential of more jobs in the social care sector in their Issues and Options report
NI	people supported to live	**Coventry (Y)** have used the Older People's

136	independently through social services (all adults)	Housing Strategy as part of their evidence base for the Core Strategy; **Herefordshire's (Y)** Options paper suggests that one approach they could adopt would be to provide specific housing types for elderly people. **Torridge and North Devon (Y)** have developed a settlement policy in their Core Strategy to support independent living; **Staffordshire Moorlands (Y)** is using its Core Strategy to reduce social exclusion for adults and older people
NI 137	Health life expectancy at age 65	**Herefordshire's (Y)** Options paper has as one of its main objectives the creation of robust polices to promote good health and well being as part of its commitment to social progress.
NI 139	the extent to which older people receive the support they need to live at home	**Swindon (Y)** has identified the need for local shops for those who find it difficult to get out frequently**; Scarborough (Y)** has identified the need for extra care housing including discussing whether these should be located in extra care communities or integrated into existing communities
NI	percentage of vulnerable	**Leeds (Y)**has used the CABE 'Building for

141	people achieving independent living	Life' Criteria as part of its evidence base in preparing the Core Strategy; **Bath and NE Somerset (Y)** has identified the need for local shops for those who find it difficult to get out
NI 145	adults with learning disabilities in settled accommodation	**Bath and North East Somerset** (**Y)** are supporting the development of Lifetime Homes for people who need support
NI 151	overall employment rate (working age)	**Swindon (Y)** has identified employment rates and unemployment as a key issue that needs to be addressed particularly in areas of high deprivation and are doing this though their employment land and location policies**; Scarborough (Y)** has identified unemployment as a key issue that it wishes to address in its Core Strategy
NI 152	working age people who are on out of work benefits	**Bristol** (Y) has identified those parts of the City with higher unemployment and in those areas it has identified locations for development including new potential workplaces; **Torridge and North Devon (Y)** are intending to reduce unemployment through supporting businesses to increase their turnover and monitoring it.
NI	working age people	**Bristol** (Y) has identified those parts of the

153	claiming out of work benefits in worst performing neighbourhoods	City with higher unemployment and in those areas it has identified locations for development including new potential workplaces;
NI 155	number of affordable housing delivered (gross)	**All** LDFs include provision of affordable housing although it is generally considered as a social or economic policy rather than a health policy
NI 158	% non decent council homes	**Taunton Deane (NA)** is focussing on achieving decent homes in its Core Strategy
NI 166	median earnings of employees in the area	**Black Country Joint Core Strategy (Y)** has as one of its main objectives to increase income levels through regeneration and transport investment. **Barnsley** Core Strategy has associated income levels with access to affordable housing for the residents
NI 167	congestion average journey time per mile during the morning peak	**Bristol (Y)** has identified congestion and air quality as key issues in their Core Strategy and also that congestion has been related to lack of investment in public transport in more socially deprived areas giving poorer access to jobs; **Taunton Deane (NA)** has identified the link between congestion and air quality and it pursuing the issue through

		its Core Strategy
NI 171	new business registration rate	**Torridge and North Devon (Y)** is addressing new businesses and monitoring though VAT registration**; Swindon (Y)** is monitoring new business registration rates and also identifying potential for new business openings through its green infrastructure polices
NI 175	access to services	**Bradford (NA)** Issue and Options topic paper – re-siting GP surgeries into health clinics (3.4); identified as a key issue; **Calderdale (Y)** has identified access to health facilities through area forum in Issues and Options; **Wyre Forest (Y)** is intending to improve access to local services by walking and public transport; **East Devon (Y)** is specifically addressing the needs of older people in rural areas including access to services; **Staffordshire Moorlands (Y)** is promoting co-location of services to improve accessibility
NI 186	per capita reduction in CO2 emissions in la area	**Bath and North East Somerset (Y)** is addressing CO2 reduction through the 'Bath Package' transport programme that is part of the Core Strategy; **Torridge and North**

		Devon (Y) are addressing this through location policies and decentralised energy generation; **South Somerset (NA)** is working on air quality improvement as part of its CO2 reduction polices in the Core Strategy.
NI 187	tackling fuel poverty % of people receiving income based benefits living in homes with low energy efficiency rating	**Calderdale (Y)** has identified fuel poverty in Issues and Options (2.86) and sees only as an indirect issue and not to be delivered through the LDF**. Taunton Deane (NA)** has identified where there are the highest levels of fuel poverty an is using its Core Strategy policies to reduce this number
NI 195	improved street and environmental cleanliness	**Wyre Forest (Y)** is enhancing streets in ways that will that encourage people to use them
NI 198	children travelling to school mode of transport usually used	**Bath and NE Somerset (Y)** are focussing on the redistribution of secondary school provision in order to reduce cross city journeys by the majority of school children; **South Somerset (NA)** is progressing school travel plans for the whole area

Source: the author

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