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How can planning add value to obesity prevention programmes? A qualitative study of planning and planners in the Healthy Towns programme in England

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ABSTRACT

The planning profession has been advocated as an untapped resource for obesity prevention, but little is known about how planners view their roles and responsibilities in this area. This paper investigates the role of planners in the Healthy Towns programme in England, and explores the limits and potential for obesity prevention within planning policy and practice. Using a qualitative approach, 23 planning stakeholders were interviewed, identifying the potential for planning in public health, particularly the 'health proofing' of local planning policy. National and local governments should better align planning and health policies to support collaboration between planners and public health practitioners.

1. Introduction

With the link between obesity and a wide range of non-communicable diseases well established (Butland et al., 2007) reducing the population prevalence of obesity is now a key goal of global health policy. It has been suggested that failure to implement preventive measures against overweight and obesity will lead to more than half of the UK population being obese by 2050 (Kopelman, 2007). The rise in obesity prevalence has been attributed to modern living, resulting in an increased focus on the role of the social and built environment in which individuals live, work and play (Butland et al., 2007; Fairchild et al., 2010; Dannenberg et al., 2011). As a result researchers and policymakers are advocating environmental approaches for the modification of obesity-related behaviours, such as diet and physical activity, as one way to improve population health and reduce health care costs.

A range of physical and mental health problems have been associated with the urban environment and land use (Barton and Tsourou, 2000; Butland et al., 2007; Renalds et al., 2010). For example, obesity due to physical inactivity and increases in the intake of more energy dense foods have been associated, in part, with features of the urban environment such as walkability (Ewing and Cervero 2010; Rao et al., 2007) and the increasing availability of opportunities to purchase fast-food (Astrup et al., 2008; Burgoine et al., 2014). While theories that link the urban environment to health are plausible, empirical evidence that supports the implementation of environmental interventions to ameliorate these impacts is needed to aid the case for further policy change (Northridge et al., 2003; Allender et al., 2011; Kent and Thompson, 2014).

Planners have been advocated as one group of professionals who should engage more with public health in order to facilitate implementation of health promoting changes to the urban environment that help tackle obesity-related behaviours (Edwards and Tsouros, 2006; Butland et al., 2007). The urban environment has been defined as a "*human-made environment that may be subject to planning. It does not refer only to buildings and hard infrastructure but to all the physical elements that go to make up settlements, including green space*" (Barton, 2009, p. 116). Historically health and land use planning were inextricably linked, looking to address unsanitary conditions and mass over-crowding which were prominent during

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the 18th and 19th centuries (Fairchild et al., 2010; Northridge and Freeman, 2011). For example, in the 19th century Fredric Law Olmsted is renowned for the design of New York's Central Park, which was developed because "*parks were hoped to reduce disease, crime and social unrest, providing 'green lungs' for the city and areas for recreation*" (Rohde and Kendle, 1997, p. 319). Olmsted was an innovative architect who thought that healthy places that should be freely available to all social classes (Frumkin, 2003). However, planning's link with health fell out of favour as national health services developed and assumed responsibility for public health. For planners this meant a shift away from a focus on creating healthy environments, towards other remits such support for economic development and environmental protection (Barton, 2009; Corburn, 2010).

As part of a wider approach to tackling obesity-related behaviours, policymakers are encouraging urban planners to work more closely with public health professionals in order to develop partnerships and rekindle the idea of public health as an important part of local and national planning policy. Key government policy documents, such as *Healthy Lives, Healthy People: A Call to Action on Obesity in England* (Department of Health, 2011) advocate spatial planning as one way to support healthy behaviour change through modification of the urban environment. This is reflected in the government's National Planning Policy Framework which states that local plans should "*take account of and support local strategies to improve health, social and cultural wellbeing for all*" (DCLG, 2012, p. 6). This document is supported by recently published National Planning Practice Guidance (DCLG, 2014), which includes a section on the role of health and wellbeing in planning. Within many local authorities, community health became a significant consideration in Local Development Frameworks (now also referred to as Local Plans). Local Development Frameworks provide a detailed framework that guides most day-to-day planning decisions for the control of land use and development of local areas. More specifically they set out strategic policies and targets related to new and existing development management and policies regarding site allocations. Within this remit, planners have an opportunity to develop strategic policies that can influence spatial development, usually for ten or more years. As part of the Local Development Framework, some local authority planners have used Health Impact Assessments, which assess possible health effects of a new urban development as a way to reconnect spatial planning with public health.

Whilst Health Impact Assessments and Local Development Frameworks routinely consider environmental health issues such as air quality and noise pollution, other areas of public health, such as obesity, have been overlooked (Burns and Bond, 2008; Carmichael et al., 2013). Reasons include difficulties in measuring health outcomes, a lack of expertise in public health and a lack of interdisciplinary working (Sutcliffe, 1995; Greig et al., 2004; Kent and Thompson, 2014). Public health workers and planners also speak different professional languages and work within different working structures and cultures (Burns and Bond, 2008; Fischer et al., 2010; Corburn, 2010), which can lead to problems of communication and collaboration between the two sectors.

This paper presents a case study of how planning and planners may support population health initiatives in the Healthy Towns (HT) programme in England. The HT programme was conceived in 2008 as part of a £30 million government investment to evaluate environmental approaches to obesity prevention. The programme was funded for three years from initial success following a competitive tender process to the funding end point, which included two and a-half years of expected intervention delivery. Nine HTs were commissioned by the Department of Health to develop and implement a series of programmes and interventions designed to increase the opportunities for residents to be more physically active and make healthy food choices. Six of the nine HTs included planners or planning related initiatives as part of their intervention programmes. Planners were involved in physical infrastructure decisions and policy development of Health Impact Assessments and Local Development Frameworks that would include a substantial health element congruent with the HT agenda to reduce the prevalence of obesity. The six HTs that included planners within their programmes were a London borough (Tower Hamlets), a large city (Sheffield), a medium-sized town (Halifax), one metropolitan borough (Dudley), and two smaller provincial towns (Tewkesbury and Thetford).

This paper reports on data gathered from the six HTs that included planning-related activities and interventions as part of their programmes. The aim of this paper is to understand what role planners played within the HT programme and what measures were taken to ensure obesity prevention was considered within wider planning policy and practice. We also focus on how planners worked in partnership with health professionals to advance public health agendas, and how learning from the HT programme could inform future obesity policy and encourage broader community health based programmes to include elements of spatial planning and urban design.

2. Methods

2.1. Participants

Participants were purposively selected from across the six HTs to comprise stakeholders who were involved in elements of the HT programme, which included planning policy and physical built infrastructure changes. The final sample consisted of 23 stakeholders including 11 planners, 10 programme/bid managers and 2 programme leads for whom planning-related interventions were a substantial part of their respective programmes.

2.2. Procedures

Interviews were semi-structured, allowing the interviewers to explore emerging themes as well as salient issues in relation to planning elements of the HT programme (Spencer et al., 2003). Stakeholder interviews covered the development, implementation, management and sustainability of the HT programme in relation to participants' roles and responsibilities. For example, while the programme and bid manager interviews focused on the overall programme, planners were asked more directly about their role and the contribution of planning to public health. Throughout the interviews, stakeholders were asked to discuss any barriers and facilitators that may have affected their ability to deliver each stage of programme development, and any issues related to the sustainability of planning interventions and policies.

The interviews were conducted face-to-face by three of the authors (DG, FM and ES) with a first wave of interviews conducted during July and October 2010, and a second wave during October 2011 and February 2012. The second wave interviews were conducted to gain further insight into programme development and the sustainability of initiatives beyond the life of the programme. Twenty-three stakeholders were interviewed, of which eight were interviewed in both waves of data collection. Stakeholders not interviewed a second time had either left the organisation or were no longer directly involved in programme development/delivery. Interviews lasted between 50 and 110 min each, were audio-recorded and transcribed verbatim.

2.3. Analysis

Interview transcripts were coded and analysed thematically (Boyatzis, 1998). The initial thematic analysis was guided by the interview schedules. Transcripts were read and coded by two authors (DG, FM), using the broad research questions as an initial coding framework. Themes were then discussed by DG, FM and SC and dominant themes were identified and mutually agreed. The emerging themes were [1] HT approaches to planning and health; [2] relationships, processes and cultural regulation; and [3] policy alignment and sustainability. These initial analyses were then explored with all authors, with two authors (DG, FM) refining the coding on the basis of group discussion. Throughout the analysis the interpretation was compared with the verbatim data. Direct quotations from interview transcripts are used to illustrate the key themes. The names of local areas are anonymised as HT A to F. Extracts from interviews quoted below are labelled with the HT label, the interviewee (planner or key local actor) and the wave of data collection (1 or 2).

3. Results

3.1. HT approaches to planning and health

3.1.1. Role of the planner

Planners had two main roles within the programme: firstly to assist projects that required planning permission, and secondly to develop existing planning policy (primarily Local Development Frameworks) that considered local population health needs. When discussing the development of planning policy, the principle of "health proofing" was often invoked. This relates to taking appropriate action to mitigate against potential barriers to performing healthy behaviours and the inclusion of health indicators in new and existing built infrastructure developments. For example, in the following quotes, one planner and one key local actor explained the concept of "health-proofing" in relation to promoting general health and physical activity within their Local Development Framework.

> "*The local development framework is a spatial based plan for how we want the district to develop over the next thirty years or so, that covers everything to do with the place and the environment… We wanted to make sure that all of the considerations within that were health proofed and where possible were promoting health and people being active*" (HT D, planner, w2).

> "*We were keen to work with our local planning department to make sure that they took account of wellbeing and health considerations in the work they did, and we tried to in a sense health-proof the planning, or some aspects of the planning process, and we made some good progress on that because of the local development framework*" (HT C, key local actor, w2).

Health proofing was enabled through the additional resources afforded by the HT programme (e.g. funding for specialised healthy urban planners) and knowledge transition through professional relationships with health practitioners. The concept of "health proofing", either implicitly or explicitly, was adopted in five out of the six towns to describe their local approach to planning's role in public health. This suggests some commonality in the conceptual interpretation of the role of planning within planning-related interventions and policies with the overall programme. The following quote provides an example of why health proofing was important to optimise health outcomes within the locality:

> "*So what we were trying to do was get health issues, health policies, health appraisal written into that* [HT C] *Area Action Plan, so in other words you know, whatever happens in* [HT C], *whether it's in that new so-called sustainable urban extension or whether it's within the existing town, the plan will say something about that and the aim obviously is to optimise health outcomes as opposed to make things worse*" (HT C, planner, w2).

3.1.2. Planning resources

Towns that specifically allocated funding towards employing a planner maintained that they were able to develop health initiatives that may have been otherwise overlooked or not been possible. As part of their role, planners became central contacts for other sectors concerned with health, which helped develop partnership working and assisted in acquiring information and evidence to support the inclusion of health within the wider planning agenda. The value of funding planners through the programme was noted by a senior planner and programme developer:

> "*Well the planning project was the Healthy Urban Planner, so it was literally about having somebody who would provide the focus and direction and to embed health into the development of planning policy going forward and that person would get known to have that kind of portfolio if you like. So they would work with people in development control that deal with the applications, people in our landscape, people in urban design so all these other elements of people that work within the planning service and other people who've got different portfolios of policy but which impinge on health in some way, most things do*" (HT A, planner, W2).

> "*We set up a dedicated public health planning post, who works with the planning department and we have a lead in public health who was working with planning anyway. So our lead, the new post and the planning department have worked directly together and some of things we've done is health's been built in* [to the local development framework]. *There was always references to health in it, but health has been built in much more explicitly and then some very specific statements have been made around the impact of planning decisions, both looking at open spaces, walking and cycling routes…*" (HT B, key local actor, W1).

3.2. Relationships, processes and cultural regulation

3.2.1. Building professional relationships

It was acknowledged that there was some scepticism among planners and other professionals (including those in public health) about what planning can practically add to public health practice. However, as the quotes below illustrates, by being receptive and open and developing an understanding of what is possible, partnerships could develop that may be beneficial to health:

> "*I'd certainly spoken to people in planning and outside of planning over the course of the two years who are very sceptical about what we can do, but I found that by going to a lot of different events and meetings and meeting people who I wouldn't have necessarily met beforehand I could understand a bit more how there were links between the work we were doing and the work they were doing… so I think it's important, just not to go into this sort of thing with a closed mind because it was sort of quite innovative, quite new*" (HT A, planner, w2).

> "There's a lot of literature now around how planning should engage with health and it's written from both planning professionals and from people in the health profession, so there's a lot of

recognition that there should be some links there and there are links to be exploited. But you still read about people who say that planning shouldn't be interfering with health because it's not our role and we should be just restricting our involvement to worrying about different types of land use and that's where it should stop. Fortunately I think we don't believe that in Sheffield and then I'm sure there's lots of other authorities who don't believe that anymore either. And there is this sort of growing feeling I think that planning decisions have a wider impact and one of those is on people's health or potential to be healthy, so I think it can only be a good thing that people are having that realisation and trying to build it into their work. But I'm sure there are still people who remain to be convinced" (SH Planner w1)

Indeed the Healthy Towns programme increased the focus on multi-sector partnership working and helped accelerate the creation of joint agendas that may have otherwise taken longer to naturally develop. As the following planners describe, during their time working on the programme, relationships with other departments were developed and strengthened and further assisted by board meetings that attracted stakeholders from a range of policy sectors:

"*We were now talking to the people downstairs in the open spaces department, we were talking to the street, highways and so that I think was a major outcome of this entire project. And because this is where the Healthy* [HT B] *Programme work helped, because they used to have these meetings where everybody shared their experiences*" (HT B, planner, w2).

"*I think more generally through the local development framework and the transport work through Healthy* [HT D], *we have developed very good relationships with spatial planners and transport planners locally, which is really good… and I think we increasingly speak the same language, from both sides, and consequently there are lots and lots of opportunities now for working together as long as we have the time to do that*" (HT D, planner, w2).

3.2.2. Culture and time-bound regulations

It was acknowledged among planners that although their profession can influence public health, at times there is superficial understanding from those outside of the profession about how this can best be achieved. Although planning and public health may have similar objectives in developing and sustaining healthy communities, the approach adopted by each sector is different. One of the main drivers for this can be attributed to different working practices, where planners routinely operate within structures that facilitate long-term planning (ten or more years). In the following extract, one planners discusses how it is now largely recognised that planners and health professionals should work in unison, but how there are still resistance to this concept by some professionals in each sector:

"*There's a lot of literature now around how planning should engage with health, and it's written from both planning professionals and from people in the health profession. So there's a lot of recognition that there should be some links there and there are links to be exploited. But you still read about people who say that planning shouldn't be interfering with health because it's not our role and we should be just restricting our involvement to worrying about different types of land use and that's where it should stop*" (HT A, planner, w1).

Additionally, in the extract below, the example of hot food takeaways crystallises the problem of time scale and the subsequent clash of perspectives that can occur when trying to "merge" planning with public health:

"*There have been political problems, but also cultural problems within planning, which are regulatory. Where, to some extent, some health professionals have suddenly said, "We think planning should stop all hot food takeaways". And to actually do that is quite a process – you can't just do it. Councils can't just suddenly say "We're stopping all hot food takeaways and have a policy" because it's got to be tested, it's got to be put into a development plan, the whole process takes time. There's been a mismatch of expectations, where people have thought we can click our fingers and the whole world changes, and unfortunately the system that we've been working within hasn't allowed that at all"* (HT D, planner, w1).

Furthermore differences in language and working practices adopted within the health and planning sectors can hinder the commitment to collaborative working. As one programme manager explained, there is a learning curve that must be appreciated to aid understanding of different roles, the barriers that can exist, and how collaborative working can move forward to support healthy communities.

"*I have been on a very steep learning curve… The amount of pre-planning feasibility studies, consultations, considerations for the environment, all this kind of stuff has to be documented and gone through before you can actually put a spade into turf and start creating a path. It's just unbelievable. Part of the learning that I think needs to come out of this process for healthy lives and for this programme to roll it out, is we need to be aware of local authority and NHS processes and how long they can take to actually get a decision made and the one thing that might massively impact on the obesity agenda is totally contrary to something else's agenda that's got something else going on. So you'll get a council department that's biggest barrier is the person in the next office has got a totally different agenda and it's not being looked at in the round, as they say, as a holistic issue*" (HT E, key local actor, w1).

3.2.3. Local politics

Issues arose in one town, whereby local political activity had an influence on the development of local planning policy. This occurred despite an increased interest in the integration of planning and health within the local authority. As one planner explained, the political uncertainty around future national policy change that could potentially influence local systems in the future meant local planning policy development stalled:

"*We were developing the core strategy of the local development framework, which was going to talk about health* […] *We were developing that quite nicely 18 months ago and then our members suddenly got cold feet about the local development framework altogether, because at that point we were Conservative controlled and the instructions coming out of the central* [national] *office were hold back, don't do it, because we're going to change the planning system. And so our members took that to heart and didn't allow us to do various things*" (HT D, planner, w1).

3.3. Policy alignment and sustainability

3.3.1. Fortuitous timing of the HT programme

The Healthy Towns programme was implemented at a time when changes were taking place within local planning policy. The quotes below illustrate that the additional resource and heightened interest which accompanied the programme provided an opportunity for public health stakeholders and planners to ensure that health was

embedded in long term planning strategy documents to a greater degree than it may otherwise not have been:

> "*In a sense the Healthy Towns came along at exactly the right time, in that with that extra resource we were able to put more things into the research base when it was needed at that stage of the local development framework. So the Healthy* [town B] *for us lined up with a good stage at the local development framework*" (HT B, planner, w2).

> "*I suppose what was quite fortuitous was that we were starting the process of the* [HT A] *development framework which is the new strategy plan. The core strategy was adopted in 2009 and so what* [the health planner] *was doing was embedding it into the next document that is part of the plan, which is the city sites and policies document… Ensuring that there was a health focus to policies, ensuring that we had policies embedded, you know that sort of health and mainstream through open space as well as access across the piece really*" (HT A, planner, w2).

Additionally, two of the towns were being developed as growth points (a government initiative to develop local areas to support enlarged populations), which provided a new opportunity to influence new housing and community developments that could notably include health actions. The following quote from a planner provides a concrete example of the benefits of aligning policies across public sector agendas to maximise population health outcomes:

> "[HT C] *being identified as a growth point, was a significant issue because that was going to bring into play all sorts of planning considerations, new housing, new transport, blah-blah-blah, all that kind of stuff.* […] *Because of the situation* [HT C] *finds itself in, something like five or six thousand houses will be built in a very, very tight, constrained location. So there's a plan for that as well. So if you were to look for a situation where you had some potential to influence the planning framework,* [HT C] *is as good a place as any to come across*" (HT C, planner, W1).

3.3.2. Sustainability considerations

Planners considered the integration of health in planning policy as a tangible output. In this sense, success represented the development of long-term policies that considered health impacts on local communities.

> "*Well it's difficult to measure* [success] *but I would say the main thing we'd hope to change will be a sort of cultural change within planning, so planning is routinely considered, not as an afterthought or it would be nice to think about it. It's just under a normal planning thing, that's success. Because in planning terms even if they get permission now they may not build it for five years so there's no way we could measure it in terms of outcomes further down the line than that*" (HT B, planner, w1).

> "*I would say our aim was to ensure that through the planning mechanisms health outcomes in* [HT C] *were promoted, that we avoid damaging health in* [HT C] *and we reduce health inequalities. And if you look at the* [HT C] *area action plan, it says precisely that every development will be expected to promote health through various means, pass a healthy urban planning checklist, major developments will be expected to carry out health impact assessments and all development will be expected to show how it's going to help reduce health inequalities within the town*" (HT C, planner, w2).

The "shelf-life" of a planning policy was particularly evident. The nature of decision-making around spatial planning meant that policies developed now could have a long-term, significant impact on relevant health behaviours and outcomes many years into the future.

> "*I mean the policies that we were working on would be lasting for fifteen or twenty years and they might be tweaked along the way but in principle they should be part of the plan for* [HT A] *and so they should be influencing development as it comes forward*" (HT A, planner, w2).

4. Discussion

4.1. Summary of findings

Healthy Towns exemplifies how the inclusion of planners in the development of community-level health programmes has the potential to bridge the gap between planning and health. Specifically, health focused planners were considered an important resource for the "health proofing" of local planning policies that could support community health improvement. Below we discuss the findings, and identify the key learning points that may inform future practice around the inclusion of planners in the development of public health programmes.

4.2. Healthy Towns programme: a vehicle for building relationships and developing a joint agenda

Though the relationship between healthy communities and sustainable planning has long been recognised (Barton and Tsourou, 2000), within current planning practice the public health potential of planning has yet to be fully realised. The Healthy Towns programme provided a space for planners to become involved in tackling the environmental determinants of obesity. The programme also provided an opportunity to develop and nurture relationships between planners and public health practitioners, which might have otherwise been neglected. These closer working relationships helped to develop a reciprocal appreciation of working cultures and practices within each other's sector and acted as an "open" channel between local public health and planning departments. The Healthy Towns programme thus provided an opportunity to revive the historical link between the planning and public health professions (Northridge et al., 2003); the resulting improvements in collaboration and knowledge translation between the two sectors would additionally strengthen such a link (Chapman, 2010; Corburn, 2010; Dannenberg et al., 2011).

4.3. "Health proofing" planning

The Healthy Towns programme presented an opportunity to accelerate the integration of planning into public health (including obesity prevention). On the whole, planners referred to how their role could impact the overall health agenda, as opposed to focusing directly on obesity. Planners were considered central to the development of local planning policies and built infrastructure developments that could support healthy living. One way planners achieved this was through articulating the concept of the "health proofing" of local planning documents (such as Local Development Frameworks), which involved placing health at the centre of major spatial planning decisions. Enabling the consideration of public health in planning policy is an achievable outcome for planners who wish an increased focus on health, and to influence public health (Barton, 2009; Corburn, 2010; Carmichael et al., 2013).

'Health proofing' was considered a positive and tangible 'outcome' by programme stakeholders, largely because of the perceived long term implications for community health. While health

proofing was considered a positive outcome that supports sustainable population health improvement, it is not a 'health' outcome per se. Therefore the development of 'good' planning policy should be regarded (and valued) as an appropriate outcome in the initial steps on a programme's causal pathway, as opposed to the actual health impact of the policy (Ogilvie et al., 2011).

4.4. The need for policy alignment

The Healthy Towns programme was implemented at a time when change was taking place within local planning, predominantly the updating of Local Development Frameworks and Health Impact Assessments. This fortuitous timing provided the catalyst for getting health onto the local planning agenda; without this the planning elements of the programme may have been less successful. This indicates a need for a more managed and formal policy alignment between health and town planning which could ensure more integrated working practices between the two sectors.

Indeed, there is a need for more guidance and a national policy that supports easier cross-sector joint working and collaboration (Burns and Bond, 2008; Corburn, 2010). Ideally the town planning and public health sectors should be working towards a set of working practices that includes a shared language and interdisciplinary working (Dannenberg et al., 2011). The data suggest that, if planning policy changes coincide with significant changes or initiatives taking place within public health, then there are opportunities for closer alignment. The recently released National Planning Practice Guidance is a positive step towards this goal (DCLG, 2014).

While this may support integrated working practices and understanding between the planning and health sectors, there is less clarity about what these shared practices may look like. Currently the two sectors work to different agendas, timeframes and frameworks. For example, there are more robust systems in place for the long-term sustainability of planning policies (e.g. Local Plans) that span longer periods of time (15+ years). Although towns had shown how this could be achieved, more exploration needs to take place into how changes to political and administrative practices could reconnect public health and planning to support aligned working practices (Corburn, 2010).

5. Strengths and limitations

The research reported here afforded an opportunity to undertake in-depth interviews with stakeholders involved in planning practice as part of a community-wide programme aimed at reducing obesity. Interviews with planners were supplemented with commentary from stakeholders who either managed the programmes within their respective 'towns' or required planning input as part of a theme (i.e. active travel). Interviews were conducted at the start and end of the funding period which provided an opportunity for stakeholders to reflect on the progression and achievements of planning initiatives and in particular the development of local planning policy. A limitation of the data collection is that although the interviews were conducted in the context of obesity prevention, the term 'health' was often invoked but respondents did not volunteer views on their own definition and meaning of the term. Furthermore, we were restricted in the number of interviews conducted that specifically focused on planning within the programme. Those interviews which were undertaken represented all of the main stakeholders involved with planning initiatives across the programme.

6. Conclusion

Healthy Towns provided an example of how planners can contribute to improving public health as part of a community level obesity programme. Planners involved in the programme expressed their views that planning decisions, in particular the development of Local Development Frameworks, were expected to promote the health of the local population more than in the absence of the programme. In particular, the 'health proofing' of planning policy demonstrates a positive outcome of what can be achieved when health and planning agendas are aligned. It is, however, important that 'health proofing does not become the primary outcome of planning policy, but part of a longer term developmental pathway.

There is a need for health practitioners to better understand the regulatory systems within which planners work (e.g. in relation to the control of fast-food outlets) and in order to have realistic expectations about how planning can impact on community health. This would be assisted through a process of knowledge exchange between the two sectors.

While this case study supports the inclusion of planning in current government health policy and of health in government planning policy (see NPPF and NPPG), work still needs to be done in terms of developing relationships between sectors and encouraging policy alignment across health and planning. Recent cross-sector public health initiatives provide an opportunity for closer working practices between public health practitioners and those who can influence the planning process, but timing is crucial in order that ensure agendas in the two sectors are properly aligned.

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Ethical approval

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