HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Prevention in health and social care, HC 965

Wednesday 18 October 2023

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Chris Green; Mrs Paulette Hamilton; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 246 – 295

Witnesses

I: Dr Mark Green, Reader in Health and Geography, University of Liverpool; Julia Thrift, Director of Healthier Place-making, Town and Country Planning Association.

II: Chris Naylor, Senior Fellow in Health Policy, The King's Fund; Simon Reeve, Deputy Director, Public Health Systems and Workforce, Office for Health Improvements and Disparities.

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Examination of witnesses

Witnesses: Dr Mark Green and Julia Thrift.

Q246 **Chair:** Good morning. This is the Health and Social Care Select Committee. We are back after conference recess. There is no grandstanding here and no platform speeches; there is just our next public evidence session on our big prevention in health and social care inquiry, which has garnered a huge amount of interest out there in the sector and in the general public. We have 10 different workstreams as part of this inquiry. We have already done the vaccination workstream and are publishing the Government response to our report on that later on today. We are now working on what we call the healthy places workstream, which is looking at how where we live and work contributes to our health or otherwise.

Today, we have two panels. The first panel that is with us now includes Dr Mark Green, who is a reader in health and geography at the University of Liverpool—a city I know well and where I was a student. Welcome. We have Julia Thrift, who is the director of healthier place-making at the Town and Country Planning Association. Thank you very much.

I will open up the session to members from our cross-party Committee shortly. I do not suppose that any members have any interests to declare on this particular thing, and nor have I, so I will start with Julia, if we may. Just help establish for our viewers, in their minds, the connection between where we live, where we work, and health. How well proven is that link? What can you bring to that argument by way of opening this discussion today?

Julia Thrift: There is a huge amount of evidence that suggests that the places where people live and work have a profound influence on their health and wellbeing. In 2017, Public Health England did a review of all of the evidence and published something called *Spatial Planning for Health: evidence review,* which brought together all the evidence and looked at how strong or weak the evidence was, and concluded that the places where we live influence our health.

They came up with five themes, which are, if I remember correctly, neighbourhoods and neighbourhood design, transport, the food environment, the natural environment and housing. Academic researchers, as I am sure Dr Green can confirm, from all around the world say in one form or another that those things are hugely influential on people's health.

The consensus is that the NHS provides about 20% to 30% of the things that keep us healthy, but the overwhelming majority of the factors that keep us healthy are the places where we live and work, and the environments in which we find ourselves. The NHS is good at mending us when we are not very well, but it is not really what keeps people healthy in the first place.

Q247 **Chair:** Dr Green, is the biggest challenge what was just alluded to by Julia Thrift, which is that the NHS has no control over all five of those things?

Dr Green: That shows why it is really important to invest in building healthy places, because we want to prevent people from developing conditions that then lead them to using the NHS and NHS services. In terms of the environment, we can design healthier places and better environments. We know how to do this, and Julia is exactly right. We have long known that place really matters for our health and wellbeing. The evidence has now moved on to exactly how and why it matters, and also what we can do. How can we modify the environment to maximise health and, ideally, tackle health inequalities at the same time?

Q248 **Chair:** Could you develop that for us in terms of neighbourhood design, which is the first one that Julia referred to? Could you just develop how we do that? We will be in Singapore as a Committee next week as part of our future cancer inquiry, and I am expecting to see quite good environmental design with health in mind when we are there. Certainly, that is what I have read about. Just try to develop the neighbourhood design part of it.

Julia Thrift: There are general things that can be done that will support the health of the whole population. Those are things like making it easy for people to be active in their day-to-day lives. The evidence around the benefits of physical activity to physical and mental health is now enormous. It is not just major physical activity. We are not talking about people running marathons or playing rugby. It is that everyday physical activity, like getting up, walking to the shops, taking your kids to school or doing a bit of gardening. That sort of activity is very beneficial to people’s health, and yet in this country many people are very inactive.

Anything that we can do to create environments that make it easy and attractive to walk a little bit is good. If you open your front door on to a busy main road with lots of air pollution and lorries rumbling by, you probably will not want to go for walk. If, when you open your front door, there is a pleasant street, maybe some trees and a nice wide pavement, and it perhaps leads to a nice green space that is attractive, that will encourage you to get out and be a little bit active.

Those are general things, but, if we want to reduce health inequalities, we really need to think about things that will support those people who have the very worst health or are the most vulnerable. That could be making sure, for instance, that, in our local spaces, there are benches for people to sit on. If you are not feeling very well, if you are elderly, or if you have little kids, you can walk a bit, and then you know that you can take a rest. It could be making sure that the pavements are very level, so that people who use wheelchairs or who are unstable on their feet can get around more easily.

There is also something about being connected. Can you get from A to B really easily by walking or perhaps cycling, or do you, quite literally, have to go all around the houses? If you do, you probably will not bother. You will probably jump in the car. Places need to have good connections and need to be complete. There need to be the sorts of the things that you need reasonably nearby. If the local shop, the local park or the school is easy to walk to, you will probably walk there, but, if it is miles away or if it is a horrible journey, you will get in the car. The quality of housing comes into that as well.

Q249 **Chair:** This sounds all very theoretical. Clearly, if you have a terrace of houses that open on to a busy road, we are not going to be able to change that. We are not going to be able to reverse-engineer the build. Low-traffic neighbourhoods may help in that respect, but, if we are going to be building significant numbers of new homes in the forthcoming years, and we are going to be building new towns, for instance, in the forthcoming years, is that the opportunity to get this right?

Julia Thrift: That is a big opportunity to get this right. A few years ago, NHS England initiated something called the Healthy New Towns programme, which I think you will be hearing about later. That looked at all the evidence and came up with very practical recommendations for getting it right for brand new places.

One of the things to think about is where you locate those brand new places. If what you end up with is a housing estate with no public transport, people are, of course, going to jump in their cars, but, if you end up with proper place that is big enough to support schools, healthcare and cultural facilities—things to do and things to see—you do not need to jump in your car. If that place is connected—if it has a railway station and good buses—then, if you do need to go to a larger centre, perhaps for a hospital appointment or whatever, you can use public transport. Sadly, for a number of reasons, many of the places that have been built in the last 10 years have often been housing estates in disconnected places, which bakes in car dependency.

Q250 **Chair:** This is a very parochial point, but it will probably have a read-across to other areas. In my constituency, we have a new housing development that is being built. The main road that goes along the side of it is being diverted through it as part of the planning consent. Some people like that and some do not. Where would the Town and Country Planning Association sit on something like that, which cannot be purely an isolated example to Winchester? I would suspect that there are many examples of new developments where there are arguments around the road access.

Julia Thrift: I really cannot talk about a particular situation.

Chair: Talk about it generally.

Julia Thrift: Generally, nobody is saying that nobody should ever drive anymore. People do need to drive, but we are very conscious that about

40% of journeys in urban areas are less than two miles, so there are opportunities to reduce the amount of traffic.

There are then urban design things that can be done to mitigate the effects of that. If you have a huge road going through an urban centre, it is not ideal, but you can make sure that there are crossings in the places where people need them that are not dingy underpasses that people are scared to use. You can prioritise the needs of pedestrians, so that, as the traffic goes through, you can perhaps have plenty of greenery that helps reduce the air pollution. The design of the edges can make a big difference. There are urban design things that mitigate the effects.

Q251 **Chair:** Just before I bring in James Morris, Dr Green, is this all just theoretical or is there somewhere that we should be looking at as the apple of our eye in respect of what we are talking about here?

Dr Green: The evidence is pretty conclusive around why places impact on our health and wellbeing. There are plenty of good examples out there that we can do. What Government can do better, though, is take time to evaluate when we change things in the environment. When we introduce policies and strategies, a lot of local authorities do not necessarily bake in that evaluation from the start.

For example, we are working as part of our GroundsWell project with the Woodland Trust around a project where they are rewilding an old golf course. The Woodland Trust is doing that for biodiversity reason and is not really thinking about health, but there is probably a very strong health reason for creating and rewilding a park that would benefit those constituents.

Q252 **Chair:** Could you give us any examples of specific places that we should be looking at?

Dr Green: We are doing quite good work in Merseyside. At the minute, in Birkenhead, they are doing a redevelopment of what is called Wirral Waters, which are the old dockland areas. A lot of that is around building new housing and new industry, but they are also building new parks and converting old railway lines into parks, which is going to be very exciting.

This is a good thing that we can get involved in now. It is about getting into that evaluation and design right at the forefront, and also thinking that it is not just about new places and new towns, but about the maintenance of what we already have. The majority of our housing and where we live is going to be pretty consistent over the next 50 to 70 years. When we talk about green spaces, it is about making sure that we do not lose those green spaces that we already have by building on them for various things, as well as new things that we can do.

Q253 **James Morris:** As you will know, the national planning policy framework is the key planning document for local authorities. It is going through a process of consultation now. The Government published a revised version, which is open to consultation. It contains material about local

planning authorities having to consider some of the issues that we are discussing, but, in your evidence, Julia, you suggested that health was not woven through the revised NPPF. Can you just talk a little bit about what you meant by that?

Julia Thrift: Yes, of course. The national planning policy framework mentions an enormous number of different things, all of which are material considerations. Paragraph 92 is the significant section on health. It is not a priority. There is no legal requirement for planning to consider health outcomes. There is no big policy requirement for planning to consider health outcomes. It is one of many things that could be considered and it makes it very difficult for councillors to prioritise health. We support them. My day job is supporting councils and communities to try to prioritise health in the planning process, but it is an uphill process.

Q254 **James Morris:** What, specifically, would you like to see in the NPPF that would strengthen the health outcomes part?

Julia Thrift: You could ask, "What is the point of planning? Why do we have a planning system?" Surely the point of planning should be to create places in which people can thrive and live healthy lives. There should be a very clear statement that the purpose for planning is that, and there should be a legal requirement for planning to consider health.

At the moment, although many councils are very concerned about the health of their populations and really want to improve population health, it is very difficult for them, for instance, to reject a planning application on the grounds that it will not support good health. They can do their best to have a local plan that supports good health, they can bring in public health evidence, but it is just not a priority. Directors of public health are not statutory consultees. OHID, which you are hearing from later, is not a statutory consultee.

Q255 **James Morris:** Are you suggesting that the current NPPF pays a bit of lip service, as it were, but is not specific enough in terms of directing local authorities in their planning decisions?

Julia Thrift: It is not. The NPPF is a very technical document. It uses terms like "viability", "land allocations" and things like that. It is not about people. If you look at the latest Scottish planning policy—national planning framework 4—it is about people. It is about what sorts of places we should be creating to help people thrive.

Just as one example, the English NPPF does not mention inequalities once. The Scottish planning policy mentions inequalities 32 times. They are completely different beasts. The Scottish one is about how we can create places that will support good health and recognises that places are different. Some places are supporting good health better than others, so there needs to be a focus on the places that are worst off in terms of health.

Q256 **James Morris:** Dr Green, have you any thoughts about the way in which

the NPPF would need to be strengthened or otherwise, or the nature of it?

Dr Green: I echo everything that Julia said. That is really Julia's area of expertise. It is not really mine.

Q257 **Rachael Maskell:** I really want to follow on about delivery, given that we do not have that legislative backup at this stage. We know that we need leadership behind that. What does that look like, particularly at a time when there is not a lot of resource? That is not only around new build but also retrofitting the current environment and neighbourhoods that we have. Could I start with you first, Julia?

Julia Thrift: Individual planning applications are judged according to the local plan, which is the statutory document that each planning authority produces. That, in turn, has to fit in with the national planning policy framework. You really need to get the stuff at the top right, because it then filters down to all these other policies and affects what councils can do.

Councils, as we know, are short of cash and under pressure. They are not going to challenge things unless they are really certain that they are going to win that challenge, because they do not have the time or the resources to challenge developers effectively. They need the back-up of a strong national planning policy framework that, for instance, says that public health data must be included in local plans. Public health teams have an enormous amount of data about the health of their communities; that sometimes gets into local plans, but very often it does not. Each local place has a health and wellbeing plan that is produced, based on data in the joint strategic needs assessment, but it is very hit-and-miss as to whether that data influences the local plan.

At a national level, there could be a much stronger requirement for public health data to be included in local plans, and for local plans to reflect the health needs of their local populations. That would make it much easier for councils to deliver those things, and to require developers to consider those things in their developments and to respond to them.

Q258 **Rachael Maskell:** I want to just broaden it out a little bit. We know what has to be done. We know what interventions will really make a difference. How do we see a prioritisation of those? Is it a targeted approach around focusing particular elements of that as a first step, or should it be more devolved and broader? How do we hold decision-making bodies to account around this agenda?

Dr Green: The way in which we can hold places to account is by building in that evaluation from the offset. When local areas or national Government do something, there should be some element of evaluation and some data as part of that that allows a judgment of, "Was this a success? If it was not a success, what can we take away from that? If it is a success, what should we do next?" and feeding that back in.

A lot of places do things and then move straight on to the next priority or intervention. There is not a lot of reflection or time to look back on things. That is some guidance that you can give in your role. You can give a lot of national direction on these things, but local areas understand their local populations best and they understand the local context, so it is has to be a bit of both in terms of thinking around, "What should be our priorities?"

There are a lot of things that we can do, but how do you identify what you should do when you can do everything? We could have a recommendation on what is the best-buy set of interventions, such as, "If you have this amount of resources, you should be looking to do these types of things. If you want to maximise health outcomes, these are the best things you can do. If you want to tackle inequalities, maybe focus on these areas". Having that from the top down and shared to local government would be really effective in guiding them and letting them make the decisions around what to do.

Q259 **Rachael Maskell:** I would like to just pick up on one other issues, which is an observation that I have in my own local authority in York. It is around skill. We have a fantastic director of public health who is just so data-rich. Other people perhaps do not have the urgency within their list of priorities around the importance of creating healthy places, particularly through planning. What work is being done around education and training, and ensuring that we have new skills coming in to be able to deliver this? Even if you have all of those frameworks, if you do not have the people who can really drive this, it is just not going to get off the ground. I am just wondering what work is being done to create that skills environment.

Julia Thrift: DLUHC, the Department responsible for planning, is well aware that there is a shortage of planners and that there is a skills gap, and they are doing work to try to address that. I do not think that that work is necessarily going to be around health. Traditionally, planning has thought about health. The roots of planning and public health are the same. They go back to that same Victorian idea of trying to get people out of poor-quality living conditions and into better living conditions.

Over the last 20 or 30 years, planning has been a bit out of touch with what we now understand are the health needs of today. That is about not only supporting people around acute illnesses but helping them avoid chronic illnesses. There could be a lot more education for planners around health creation. It is not just about protecting people from harms, but creating places that really support health, particularly for those with the worst health. We do a bit of that training at the TCPA, but it is not a systematic thing through the system.

With the policies that come out of DLUHC, which is a very large Department with many staff, we notice that they will sometimes say something that is very pro this agenda. For instance, the national design guide is very good on elements that support good health, such as green

spaces or walkable environments and so on. Other things that come out of DLUHC, though, seem to be quite ignorant of the role of planning in supporting and creating health. There is a skills gap there and it does need to be addressed.

Q260 **Rachael Maskell:** If I can ask you and add the issue around equality, we know that this is an agenda that is embedded in inequality, particularly around social deprivation, but also, for instance, disabled people and ethnic minority communities being at a disadvantage within this. I wonder if you could just comment on that.

Dr Green: There are two things to add to what Julia said. One opportunity that we have is around academic and public partnerships. If I can give an example, during the pandemic I was part of a project called Local Data Spaces, which was about building capacity in local government to do the types of data analyses that they needed.

We identified that local government was quite strained at the time. It was often in firefighting mode, because it was a crisis. Indeed, that is pretty much continuing now as we go from one crisis to the next. There is a lack of capacity to do a lot of that analysis, particularly after years of cuts to the area.

We did some work with York on tourism. It was about opening up data skills that academics have to do a lot of that analysis, where local authorities might not necessarily have that capacity themselves. That goes both ways in having secondments of academics to local and national Government, for them to learn and help embed the skills that they need, and also people going in the other way and getting a lot of that education and skills development.

With regard to the comment about inequalities, when we talk around public health, we often focus on the health of the individual and on maximising health. We do not necessarily build in the inequalities and inequities side of things, and we do not always think about how intersectional categories or how specific issues, such as place-based disadvantage, impact on certain outcomes. There should be a remit that that should always be looked at, because a lot of what we do often might benefit just a small part of our population and can widen inequalities, particularly if we are doing things around improving educational programmes around health.

Q261 **Mrs Hamilton:** My question is predominantly for Julia, being with the Town and Country Planning Association. You talked about five areas at the beginning, but the area that I wanted to concentrate on was around the food environment. Planners have talked about connecting food markets. They have talked about allotments. They have talked about community gardens. How can neighbourhoods be designed to enable people to make healthier food choices?

Julia Thrift: When we talk to planners about the food environment, that is the area that they find most difficult to understand that they have a role in supporting. It is absolutely vital. There are some things that planning can do and some that it cannot. Through planning, for instance, some councils have tried to reduce the proliferation of hot food takeaways, which can sometimes be achieved if there is a lot of evidence that an extra hot food takeaway in a particular place would be detrimental. Planners cannot, of course, say what food is served in a restaurant. It could be fantastically healthy food, but, generally, it often is not. There are limits to what planning can do.

There are definitely things that can be done around the food environment in terms of ensuring that new developments have spaces where people can grow food and that there are community gardens. Those are things that can be planned in. I recommend you have a look at Ebbsfleet Garden City, which has done a lot around the food environment and taken it very seriously. There are some really good initiatives there. It is partly to do with planning and partly with supporting community groups and activities that happen within those spaces that planners create.

There are things that planners can do, but we have to realise that changing the food environment will require action across a very wide range of Government Departments. Any shop you go into will sell you unhealthy food. At the newsagent, the first thing that you see is that rack of unhealthy snacks. At the supermarket, the petrol station or the train station, there is unhealthy food everywhere, so it is going to take a lot of individual actions. Planners have a role to play in that, but they cannot solve that problem on their own.

Q262 **Mrs Hamilton:** I will talk about a local issue in my area where it really relates quite well to my second point. We have large numbers of houses of multiple occupancy. Many of those people are unemployed. They do not have access to open spaces, because you have four or five people living in one property. Open spaces are just not close by. You try to change the area through traffic management and it causes uproar, because all it does is move the problem to another area.

The food establishments within that area are just not thought through enough, because you get one area, as you have said, being able to say yes to a project, and another saying that it is not the best project for that area. On a little strip, you will have four fish and chip shops, whereas you will not have a shop where you can get fruit and vegetables, as I have in parts of my neighbourhood.

Once that has happened, what can we do to reverse some of that? What is happening is that there are so many different Departments and so many different things that we are facing in many of our towns and local areas. Going back to what Rachael was saying about inequalities, it is the poorer areas that are facing this onslaught, and it seems that we cannot change it in any way. It just seems to be getting worse. Is there anything that we can do to help change some of these things that have already

gone wrong?

Dr Green: A really good place to start would be subsidising rents. In terms of supermarkets or places that will sell fresh fruit and vegetables, we could provide some incentive to encourage them to open up. You can use that business rate side of things to nudge places that we want to open or close. We could target particular high streets around that, like you say, but we have to caveat that. On my phone, I can access unhealthy food quite easily through Deliveroo or Just Eat, so moving places around does not necessarily stop our accessibility to them.

The other thing that I want to say is that we can focus on things like McDonald's and unhealthy food, but there are twice as many food banks in the country as there are McDonald's. It really comes down to affordability and making sure that we have accessible, healthy and nutritious food. We have been looking at this among people who are at risk of food insecurity in our FIO-FOOD project. In particular, when we speak to our residents through surveys and interviews, we see that affordability is the most pressing issue at the moment in terms of what people want to see done.

We can think around the food environment, but, ultimately, what we are faced with at the minute is a highly expensive environment that is nudging people away from healthier diets. What we have seen in our data is that people are moving towards budgeting. Budgeting is leading to lower-quality diets, which, of course, will have an impact on their health and wellbeing in the short and long term.

Julia Thrift: I absolutely agree with that. There is a limit to what planning can do around the food environment. There are things that councils can do—for instance, taking over empty shops and making them available for community food organisations—but that is not particularly a planning issue. There is something called the Obesity Health Alliance, which has come up with some very strong recommendations, but they span the whole of society. Planning has a role to play, but its role is limited. It should absolutely do what it can, but it cannot solve all of those problems.

Q263 **Mrs Hamilton:** I am a great believer in vertical farming and using old car parks and what-have-you to get local residents planting food, and just different ways of using space that you would not normally have thought of. What are your views on this and how easy it is to transfer land from, say, a parking lot to growing food? I am asking you this because I was once the chair of an allotment association. That is how I learned how to be a politician.

Julia Thrift: There are all sorts of things that could be done. Councils often own land that could be made available for growing. That is not particularly a planning issue either. There are new things like vertical farming. I do not think that there is anything to stop that happening. People sometimes think that there are reasons for not doing things, when

they could happen. I do not think that there is any reason why that could not happen, but I will look into it, as it is a very detailed question, and we will see if we can send you a more detailed response.

Dr Green: I share your enthusiasm and I am a fan. We know that there is quite well-established literature that, when people garden or get involved in community gardens, it has a very positive impact on their wellbeing, so vertical farming would fit into that. We can grow food in cities, and we should do more of that, but we are possibly not going to be able to sustain what we need in terms of the food that we need to generate in this country.

A lot of the vertical farming that we have seen in Liverpool is often just growing lettuce or salad leaves, which is great. I am happy with that, but it is not necessarily going to solve all of the problems or build all of our resilience in the food system. If you get the community involved and you get the community along, there is evidence that shows that that is going to have a really positive impact on wellbeing, so there is a positive side to this.

Q264 **Chair:** The Government's Healthy Start scheme has been rebooted in recent years. Surely that is a positive, is it not, in terms of helping people with support for healthy eating?

Julia Thrift: I am afraid that that is slightly outside my area of expertise. I cannot comment.

Q265 **Chair:** Do you know anything about that, Mark?

Dr Green: No, not at the moment. I am happy to write back and provide evidence later.

Chair: Maybe the second panel might touch on that. It is good to hear you mention gardening. I spoke at an event organised by Gardening 4 Health in Emsworth, Sussex last week. It was a one-day conference talking about the benefits of gardening to our physical and mental health, so a good plug for them there.

Q266 **Taiwo Owatemi:** I want to focus on planning in areas of high deprivation. One of my biggest concerns is that, in some areas of my constituency, particularly in Coventry, we have a lot of community education around food and how to live healthily, based on one area of the city, but the target population that needs it more is on the opposite side of the city. In terms of, first of all, changing the behaviour of the community, it is more difficult, because people have to travel and make sacrifices. Secondly, it is about how we plan better to ensure that each area within a city—for example, Coventry—has its needs tailored to in terms of healthy living and ensuring that they have the necessary support to be able to achieve that.

The reason why I ask that question is because, in areas of high deprivation in my city, we are noticing that we have a lot of children

coming in who are malnourished, but not necessarily because their parents do not have access to food; it is about having the knowledge around how to make a well-balanced diet.

Julia Thrift: When we visit councils, we often bring together the planning team and the public health team. What is often the case is that the public health team has very detailed spatial knowledge of communities. They can show you on a map where the communities with the worst health live and where the areas of multiple deprivation are, but planners are often quite ignorant of that. When planners look at a map, they often do not know where the communities with the worst health live.

A first step is making sure that planners have that information, and that is why it is absolutely vital that the national planning policy framework prioritises health and says that local plans must include health data and that directors of public health must be statutory consultees. Once planners are told that a particular area has terrible health, they will think, "We did not know that. Now we know that, as we think about how our town or city or village is going to develop over the next 30 years, we can start thinking about how the changes that are going to happen can be positive for those communities with the most need". Having that knowledge is the first step, and then understanding from the public health team what the needs are in those communities is also helpful.

However, there are more systemic problems to do with the way that, when developments happen, they usually produce some income for the council from section 106, as it is known, or CIL. In areas of high development values, there is more money to go around, so there is more that goes into that pot that can then be spent on local needs and infrastructure, such as schools, parks and whatever is needed—affordable housing in particular.

In areas of low land value and low development values, such as the north-east, there is not really much money in that pot. In some places, there will be no money in that pot at all. There is just enough money to create the development, possibly to a rather poor standard, but there is nothing left over.

What that means is that areas that are already quite prosperous have more money to create better places, and areas that are already struggling, which tend to have populations with the poorest health, do not have access to that money. As time goes by, the healthier places are going to get healthier, and the least healthy places are going to remain where they are and get worse. There should be some redistribution at a national level to ensure that the places with the worst health have access to funds to improve their areas.

Dr Green: Your question is really that we need more bottom-up thinking and engaging with our communities to design what we should be doing, and not necessarily just that top-down, "This is what we think and we are going to just target this area".

Your question also talks about accessibility and geographic accessibility. In Liverpool, one of the ways in which they are trying to improve access to healthy food at the minute, which is slightly different from what you are describing, is by having a bus or a van, which drives around different communities. You pay a small membership fee to be part of it, but you get much cheaper food. We can get around that by thinking a bit innovatively around these things.

We worked with Liverpool City Council during the pandemic to try to use, essentially, a bus to help improve vaccination rates by taking the bus into communities that had low vaccination uptake and allowing people just to get vaccinated there on the bus. We can use geography in quite powerful ways to get around some of these barriers as well.

Q267 **Taiwo Owatemi:** Is changing the way that town planning is done sufficient to change people's behaviour around health and healthy living? What is the limitation in that?

Julia Thrift: Planning has a really important role in shaping places, but it is not going to solve all the problems. We are part of the Inequalities in Health Alliance, which thinks that, in terms of inequalities, there should be a cross-Government strategy. Planning should play its role in that, and it can influence the way that people behave a bit. As I mentioned earlier, if your local environment is attractive and welcoming, you are much more likely to go out in it, meet people, go to the park and do healthy things, but there is a limit to what planning can do.

There is also education. There is the way the NHS operates. There is housing. There are multiple things that influence people. There is advertising. There is the commercial environment. Planning absolutely must play its part, but it is not going to solve all the problems.

Q268 **Paul Blomfield:** My question follows on from Taiwo's. It is something that we have already touched on this morning, but we ought to talk explicitly about the debate that is going on around 15-minute cities. I had no idea what this was until about 12 months ago, when I started getting a very small number of campaign emails urging me to oppose the tyranny of 15-minute cities. I then looked into the idea and wrote back to constituents saying, "What is not to like about having things conveniently placed locally?" I wonder what thoughts you have, recognising, Julia, the points you were making about the limitation of planning, about the concept and its potential to impact on public health.

Julia Thrift: If we go back to the research that Public Health England published called *Spatial Planning for Health: evidence review*, which brings together all the evidence about what makes a healthy place, one of the things that comes out of that evidence is that healthy places are complete, compact and connected, which is another way of talking about 15-minute cities or 20-minute neighbourhoods.

They are complete, so they have most of the things that most people might need for their daily lives, such as schools, parks and whatever the community wants. They are compact, so things are quite close together; they are not miles and miles apart. They are connected, so you can get from A to B quite directly.

There is public health evidence that supports the idea of having local amenities and making it easy to walk or cycle between them. Places around the world have been trying to apply this. What they are talking about is a very positive vision for the future. They are talking about places where it is nice and attractive to walk, where streets are green and easy to walk along, and where there are local shops and things that you might want to see and do. It is a very positive vision.

That has got rather muddled up with traffic management schemes, which can be entirely different things. There is a bit of muddle. There is an overlap, and so, if you want to create streets that are attractive to walk down, you might want to restrict some traffic—fair enough—but it is absolutely not about restricting choice generally. It is about allowing people to have more choices, whereby you could get in your car and drive 10 miles to the supermarket, but why would you, when there is a nice shop around the corner and a street market selling healthy food? It is about increasing people's choice, and it is unfortunate that it has got muddled up with some traffic management schemes that some people do not like.

Q269 **Paul Blomfield:** That is very helpful. There are some practical issues, are there not? We are the Health and Social Care Select Committee, so I ought to reflect on the fact that my local ICB, not exceptionally, is looking at centralising services in health hubs and closing down GP practices. I have supported it, because they have some significant benefits in terms of the service, but it is going to involve people travelling greater distances, and probably beyond walking and cycling. How do you square those circles? Mark, do you have any reflections on that? You know Sheffield.

Dr Green: Yes. It is a lovely city. There are a few things. One is that there are efficiency gains if you centralise certain specialised services. In terms of primary care and GPs, we know that people who live further away from their nearest GP are less likely to go to their GP. It might just be the slight nudge of, "I do not want to walk half an hour to my GP. I will not get checked out", and then something progresses a little bit further before you go. With secondary and more specialist care, we find that distance does not really matter. When things get serious, people will travel because it is really important to them.

There is a bit of negotiation over what we keep in the local community and what we specialise in and have in these hubs, where we can then get all of the specialist services in one place. There are a lot of benefits, say, if you go in for one operation and then have your post-care team there

around you, so that you can get all of that specialist care in the same place. That is going to be much more positive for you.

Q270 **Paul Blomfield:** I would like to explore that further. I am conscious of time, but I would like to ask one last question on a related issue that has similarly been a bit controversial. It is around how we tackle air quality in cities. I represent central Sheffield. We have recently launched a clean air zone, not without controversy. It has caused some practical problems for small businesses, and taxi drivers in particular. I wonder what reflections you have on how we get the balance right between protecting people from the very real health risks involved in poor air quality and providing the sort of choice that you, Julia, were talking about a moment ago.

Julia Thrift: As I expect you are aware, the evidence around the health impacts of air quality has grown recently, and it is now clear that it is really significant, much more so than perhaps had been recognised.

I will come back to the thing I said before, which is that something like 40% of journeys in urban areas are less than two miles. There is definitely something about encouraging people to walk and cycle, but also about good public transport. That is outside planning but it is absolutely vital. If there is a local bus that can get you there and can get 100 people down the road, that is better than 100 cars. Many schools are trying to introduce school superzones, as they are called, where they are thinking about the area around the school and making it easier for parents and children to walk safely to the school.

It needs to be tackled on all fronts. Lots of things need to be tried. Towns and cities are really complicated places and it might be that, if you try something and it does not quite work and needs to be adjusted, we need to have an attitude of that not being a failure. If you try it and it is not quite right, tinker with it, make it a bit better and see what works, rather than saying, "That was a failure. We will scrap that".

Councils are sometimes criticised, whereas they should be encouraged to try things out and see what works, and not give up if the first plan or design does not quite do the job. It is partly about helping people understand why air quality is such a problem as well, and why everybody would benefit from cleaner air.

Q271 **Paul Blomfield:** Do we do enough on that? We are increasingly alerting people or giving them detailed information about UV levels, so that they can both address their behaviour on a particular day but also be aware of the risks. Do we do enough on alerting people to the problems around pollution levels?

Julia Thrift: A lot more could be done. I do not think that people are aware of the multiple illnesses that are impacted by air quality. Many of them are illnesses that people absolutely would not want to get and would not want their family members to get, so there is something about helping people understand and make decisions around that.

These are quite complex things. If you are saying to people, "Go by bus", there has to be a bus. If you are saying to people, "Walk or cycle", there have to be safe walking and cycling routes. You have to get the infrastructure in place. You cannot just say to people, "Get out of your cars", if they have absolutely no choice about how they get around.

Dr Green: Education can go only so far. It is well-established that smoking is really bad for people's health, but people still smoke, even though they might understand that there are risks to them. Education can go only so far, and we need to be aware of that. In particular, educational campaigns tend to benefit more affluent populations, so they end up widening inequalities at the same time.

There are things that we should just do, and we should take the role that we can do these because they are positive for our citizens. There is a lot of work that we need to do to bring our citizens along with us in those decisions and to get them on board, but accepting that some things, while beneficial for their health, are just going to be unpopular.

Q272 **Chair:** Thank you very much. If the next panel could ready themselves from their chair, that would be great. I will just thank Dr Mark Green from the University of Liverpool and Julia Thrift from the Town and Country Planning Association for that. There are lots of other things that we could explore. I would quite like to have had a chat with you about the Government's plan for drivers, but we will save that particular treat for the next panel. We thank you very much for giving evidence to us today. If there is anything that you committed to follow up in writing, please do so. Equally, if there is anything that you wanted to make as a point but did not get to do so during the session, please feel free to write to us. We will be publishing this workstream of the inquiry in due course. Thank you very much for joining us.

Examination of witnesses

Witnesses: Chris Naylor and Simon Reeve.

Q273 **Chair:** We have a second panel, which we are just going to switch over to now. While we are doing that, I will introduce them. We will probably finish this panel by about 11.45, because it is Prime Minister's Questions here today. We have not had one of them for a while and we probably will not have too many of them for a while after.

The second panel is interesting in that we have the King's Fund in. Taking his seat now is Chris Naylor, who is a senior fellow in health policy at the King's Fund. Chris has also been working on NHS England's Healthy New Towns programme and conducted some reviews of the programme back in 2019, as well as this year, so I would be interested in touching on that with you, Chris. Welcome.

We also have Simon Reeve, who is deputy director of public health

systems and workforce at the Office for Health Improvement and Disparities, who I worked with when I was a Minister. I suspect that Mr Morris also came across him during his time when he was a Minister at the Department. Welcome to you, Simon.

Thank you very much for being here. You have heard the first panel and heard the discussion that we had. I want to start on whether, from the conversation that we have just had and from the things that you know, it is clear who is responsible for promoting health in town planning and in organising healthy places at both a local and national level. Is it clear who is responsible?

Chris Naylor: The NHS is a statutory partner in planning processes, so it has to be consulted, but the same is not true of public health teams, so their role could be clearer. What we saw in the Healthy New Towns programme was that there are real benefits of town planners working more closely with public health teams and with colleagues in the NHS, so it would be helpful to clarify that that is the norm that we should be working towards.

Q274 **Chair:** To what extent is it the exception rather than the rule at the moment?

Chris Naylor: If we look at integrated care boards, for example, they are engaged in planning processes, but their engagement is often about the provision of healthcare facilities rather than thinking about the prevention agenda and how influencing the planning and development process could deliver real health benefits.

Q275 **Chair:** Why do they not think strategically like that? Is it that they are busy with the day job and that that is just a bit of a luxury nice-to-have, which, frankly, they would love to get to but cannot, or are they not getting any help, guidance and training on that? Why do you think that is?

Chris Naylor: It is a mixture of barriers. Both ICBs and their predecessors, clinical commissioning groups, often have limited capacity and expertise around planning and estates, so the right skills are sometimes not there. There is a mismatch of time horizons that sometimes gets in the way. The NHS will typically be focusing on, “How do we make sure that our services are sustainable over the next year or so?” Planners are talking about something going on over the next 30, 40 or 50 years. There can be issues around mutual understanding. We sometimes see people in the NHS struggling to speak the same language as planners and developers.

Simon Reeve: I have a couple of observations. At a very simple level, of course, national Government set the policy and legal framework for planning. They also set who has what responsibilities in statute with regard to health. Since 2013, those things have come together, at least to a degree. I appreciate that planning operates at different levels of local government, but, certainly in the upper tier of local government, the

discussion that we are having is really part of the sense behind returning the statutory health improvement function to local government in 2013 in order to enable the wider levers that local government is involved with to be brought to bear on health.

I was reading the LGA's assessment of 10 years on from those changes that they published, and one of the points that it highlighted was a perceived growth in breadth and depth of public health team engagement in infrastructure, transport and planning. It is a long game, but putting some of that responsibility in the same broad place is a helpful step so that, over time, we will build relationships. The rate at which people can develop, exploit, take advantage and see results from those relationships will vary, depending on a number of things.

Then you have the ICS part of the picture, which Chris mentioned. The ICP element of that is quite interesting, of course, because the integrated care partnership is the level at which you look right across that broader perspective on health needs. There is real potential there, because, again, if you look at the way that relates through the NPPF, that puts particular weight on taking account of health in planning, particularly in relation to healthy behaviours, where that will support needs that are identified in a health strategy.

You can see a chain here, where you have, in a sense, national Government deciding what hooks and what the overall priorities are in the system. You have the ICS/ICP umbrella saying, "Let us take an overview or cross-system consensus on what local health needs and priorities are". You then have local government where there is overlap with the ICS bit, but it is where health and planning then come together and you can start to feed some of that through. It is a chain, but it is not impossible to navigate.

Q276 **Chair:** Could I just ask you both about the Government's plan for drivers, which arrived during party conference season, talking about guidance against the blanket use of 20 mile an hour zones and a commitment to addressing existing low traffic neighbourhoods without consent? What do you think about the plan for drivers and its impact on healthy places? Have you given it any thought?

Chris Naylor: There is going to be a review of low-traffic neighbourhoods to see what the evidence is around that. We know some things already, though. We know air pollution is responsible for 30,000 premature deaths every year in the UK. Traffic is a big contributor to that. We need to be thinking about effective solutions to that.

There is evidence around low-traffic neighbourhoods. Research teams in Imperial College London and the London School of Hygiene and Tropical Medicine have done a number of studies looking at this. The overall picture from that research is that there is good evidence for health benefits from low-traffic neighbourhoods, but there is also a big variation in the scale of those benefits across different schemes.

This really points to the importance of careful design of those schemes and ongoing monitoring at a local level of what effect they are having. The research suggests that some low-traffic neighbourhoods clearly are delivering health benefits. That is not to say everything you call a low-traffic neighbourhood will have the same effect. We need granular evidence and ongoing monitoring of what is working and what is not.

Q277 **James Morris:** I just wanted to come back to the interrelationship between health and planning that you were talking about, Simon. In our previous session, the Town and Country Planning Association was saying that the revised NPPF, which is currently out for consultation, does not have health woven through it. To what extent is that true? What other things would you like to see in the national policy planning framework?

Simon Reeve: There is not a new version of the NPPF. There is a range of development policy consultation work going on that will ultimately inform it.

James Morris: Yes, that is correct.

Simon Reeve: In terms of what is there at the moment, there are definitely specific hooks. As I was saying, there is definitely a link to understanding local health needs and, where you understand those and where you have a plan, giving explicit licence. In fact, it says "should" rather than just "may". It is reasonably strong.

We know from recent survey work that not a majority but a substantial minority of local authorities have explicit plans in place that reference the need to do health impact assessments in certain cases or have a specific reference to local health and wellbeing strategies or joint strategic needs assessments.

Those hooks are there. Given the range of things the NPPF has to cover and the range of priorities you have to juggle, the debate is about how far you dial those up and down.

Q278 **James Morris:** To what extent have you been trying to influence that process? We had evidence from the Deputy Chief Medical Officer saying that you were going to be influencing that. To what extent have you been successful?

Simon Reeve: There are two dimensions, looking at what Jeanelle said. In terms of the national framework, as I say, we are not quite at the stage of statutory reforms yet because the Levelling-up and Regeneration Bill is still going through. There are various consultations going on. At the point when DLUHC officials sit down to look at how this translates into the NPPF, we would definitely envisage being a part of that conversation.

Q279 **James Morris:** In the previous session, there was a concern that there was not enough specificity and the legal framework needed to be clearer and firmer. What is your view?

Simon Reeve: Ultimately, that is a judgment for Ministers. We can help support an informed discussion about what the evidence says. There are lots of informed stakeholders who will feed in and have fed in views to the consultations and people like Julia who have told you things today. Ultimately, it is a balance, is it not? There are definitely some quite strong pushes in there at the moment. The judgment about whether you want to weight up health and be stronger on health, implicitly at the expense of something else, is something that needs to be considered.

Q280 **James Morris:** Chris, do you have any views about the national planning policy framework and whether it needs to be tougher or more specific?

Chris Naylor: One of the lessons from the Healthy New Towns programme is that it is really helpful to make health an explicit goal in planning policy. The reason I say that is because there is a superficial way in which you can create healthy places. You can say, "We are putting in a park and a bike lane. It is a healthy place".

In terms of delivering the biggest possible health gain for the local community, you need to look at local data about what is going to deliver that. You often get the biggest health gains by focusing not on people who are already quite active and making them even healthier but by doing things targeted at people who currently have the poorest health outcomes and perhaps helping them to incorporate just a little bit of physical activity in their daily life, which might just be walking short distances.

If you make health an explicit expectation in planning policy, it leads you to focus on different things. For example, are we putting enough benches along walking routes so that people can stop and take a rest? Are we ensuring there are enough public toilets so that people who are reliant on them have the confidence to leave their homes? We need to think about the groups with the poorest health outcomes and how we can design the built environment with them in mind.

Q281 **Rachael Maskell:** Chris, I would like to know who is doing this well, either in the UK or across the world, and why it is working so well for them.

Chris Naylor: I will pick out some examples from the Healthy New Towns programme because that has been my closest direct involvement in this. There were 10 demonstrator sites involved in that programme. They brought together planning teams with NHS colleagues, public health teams, developers and others to try to develop a shared vision of what they are trying to achieve in their place. If you look at places like Ebbsfleet, Bicester, Cranbrook and several of the other demonstrator sites, they did really good creative and cross-sectoral partnership work that is delivering some benefits to local people now.

One of the critical things that led to the programme having that impact was putting in a small amount of investment to have some dedicated

people in the local system whose job it was to connect all those dots and to catalyse things. These are small teams who can cut across all of the organisational boundaries, identify better opportunities for collaboration and help all of the local partner organisations to navigate the complexities around funding. Just having a small amount of resource for people in those connecting and catalysing roles can actually deliver quite significant benefits.

Q282 **Rachael Maskell:** Simon, I do not know whether you want to add to that. It certainly seems like there is an issue around leadership as well, which is really important in this space.

Simon Reeve: Just to reflect and build on what Chris said, with which I agree, part of the work my team does is outward and system-facing. By the end of this year we will have run something like 30 local workshops on health impact assessment. This is local places reaching out to us and asking for support and advice. I mention this point because I ran one in York last week.

In those workshops, we tend to find that part of what we are doing is the start of that joining up or contributing to that joining up and giving people a common focus for a conversation. Just because we have put planning and public health in the general space of local government does not automatically mean it all sits nicely together. Just knitting some of that together a bit and providing some focus can be really helpful.

Underneath it all, right across the system, we need to have a core understanding of population health, population health need and why that is important. That is a potentially vital underpinning.

Q283 **Rachael Maskell:** We have talked a lot about planning infrastructure, which is absolutely vital, but things like time and people are also really important to ensure that people live healthy lives. I do not know whether you have any observations about the leadership that is required in that area, not only in local authorities and their new placed-based approach to communities but also in workplaces. We spend a lot of our time at work, and we may not use that to the best of our ability with regards to our own health and wellbeing.

Simon Reeve: The work and health point is a really good one. You may be aware that there is a joint Work and Health Unit that sits between OHID and DWP, which is looking at precisely some of those issues. It is looking partly at health-related reasons for economic activity and some of what was announced earlier this year in terms of the focus on MSK and the mental health investment in around that, but it is also about amplifying the thinking on how we can work with employers and what interests they have in this space.

Q284 **Rachael Maskell:** If I can close with you, Chris, one of the incredible interventions in the health arena has been social prescribers. They are really helping people to go on a journey around their own wellbeing.

What kind of catalyst could help change that whole personal approach to being able to live a healthier lifestyle in the communities we have, let alone the ones we aspire to? Is there something equivalent that we could invest in? It seems that catalysts can often cause a change of direction and enable people to prioritise things differently.

Chris Naylor: The thing that can be really catalytic is where you have multiple interventions in a local place that are all reinforcing each other. In the Healthy New Towns sites, as well as designing new built infrastructure, they were also engaging with communities and thinking about how to shift healthcare services to a more preventative model in these places.

As an example, you might have a new walking route built in the community. As well as putting in that built infrastructure, they were engaging with community groups and saying, "Okay, how are you going to make use of these new infrastructures we are creating? Can we, for example, set up walking groups that make use of the new routes that we have built?" At the same time, they were also engaging with local GPs and saying, "Okay, how can you link the patients you are seeing to some of these community groups that are using the new walking routes through things like social prescribing?"

You got that layering, where you had the synergistic effects of multiple things being done in a place. That is a really key lesson from the Healthy New Towns programme. Focusing on a place and the people who live in it in that way is very powerful because of those synergistic effects. It would be hard to design that from Whitehall. It can only really be done at a local level.

Q285 **Rachael Maskell:** Just as a quick follow-up, we have talked a lot about adults, but it is also absolutely crucial to set children on the right trajectory. The UN's Child Friendly Cities Initiative is another intervention that could assist. I do not know whether Healthy New Towns has looked at that at all.

Chris Naylor: Yes, quite a few of them have things like play strategies. How do we create an environment where it is safe and fun for children to play outdoors? It is absolutely crucial.

Q286 **Chair:** On the Healthy New Towns, you mentioned Bicester. I know where that is. Could just say the other ones again for the record? Where is Cranbrook?

Chris Naylor: There were 10 of them. You are testing my memory here.

Chair: You mentioned Cranbrook. Where is that?

Chris Naylor: There is Cranbrook in Devon, Barking Riverside in London, Barton and Bicester in Oxfordshire, Darlington, Halton, the Fylde coast and Ebbsfleet.

Q287 **Chair:** That is fine. I have tested you enough. It just gives us some to look up. You talked about demonstrator sites. Where is the new towns programme at the moment? Where does it stand at the moment?

Chris Naylor: NHS England and Public Health England, the predecessor to Simon's organisation, jointly led the programme between 2015 and 2019. The 10 demonstrator sites received some funding and some national support over that period of time. As I said, there is evidence that it did have an impact in those 10 sites.

One of the things that is regrettable is that, like a lot of the innovation programmes we have seen from the NHS in recent years, it was funded for a period of time. That means pilots are done, but then there is not as much resource—

Q288 **Chair:** That is what I am getting at. I know the demonstrator sites finished in 2019. We are about making recommendations. We are about making and driving change. What would you have us say in respect of new towns?

Chris Naylor: To be clear, the work in the local demonstrator sites has continued off their own backs since the national programme ended, but there has not been the same level of national support. The recommendation to Government around that would be, when they are trialling new approaches, which is what the Healthy New Towns programme was trying to do, to invest as much effort into wider rollout as you do into the initial pilots.

Q289 **Chair:** Finally, on the subject of trialling approaches, I want to come on to the childhood obesity trailblazer programme. Simon, you will remember that this was in part 2 of the childhood obesity plan, the update chapter. We trialled that in Birmingham, Bradford, Lewisham, Nottinghamshire and Lancashire. Where is the obesity trailblazer programme? For those who do not know, this was about the conversation we were having earlier with the first panel about the rows of unhealthy food shops near schools and helping local authorities make the most of the existing powers they have. Whatever happened to that?

Simon Reeve: I cannot speak to that as a whole. In terms of the healthy food environment issue, there were a number of places, either trailblazers or other local authorities, that were putting in place specific policies to try to tackle food density and the relationship with healthy food.

There is actually an NIHR-funded research study ongoing—it is due to report next year—looking at what impact that has had and what difference it has made. It comes back to the point that was made earlier about evaluating and learning. It is not confined to the trailblazers. It is looking more broadly at the experience of local authorities' efforts specifically on hot food and takeaways.

Chair: We will look out for that.

Q290 **Paulette Hamilton:** You have sort of answered my question. I just have one question; it might be a point. You have talked an awful lot about new towns and new developments. What about old towns with lots of issues? You highlighted rollout. I would like to know how some of this good work is going to be moved out into other areas. In areas like Birmingham, we desperately need some of what you have talked about in some of the new areas, especially Bicester and what-have-you. They are wonderful, but the point is, because of some of the deprivation and some of the issues that are being faced there, we do not seem to be able to sustain it even if we try.

I would just like your thoughts on that. How do we take this forward for places such as London and Birmingham? I do not know about Rachael's area in York, but in other areas we have established towns and cities that would really benefit from some of this good work.

Chris Naylor: A lot of the fundamental principles that came out of the Healthy New Towns work are the same in existing communities as well. It is about trying to develop a shared vision across the NHS, public health planning teams and developers for how to create a healthy place; getting health into local policy frameworks, planning policy frameworks; and understanding the specific health needs and assets of the local population you are talking about. Some of those fundamental principles are the same.

Many of the practical interventions that we used in the demonstrator sites are also things that can be done in existing areas, whether that is making walking and cycling easier, enabling healthy eating or trying to link NHS services into wider community assets through things like social prescribing.

The other thing I would say about the Healthy New Towns programme is that it really showed that, where you have a new housing development or a regeneration scheme going on in part of your town or city, you can use that as an opportunity to help bring about improvements for the established communities in the surrounding area.

In the demonstrator sites, they tried to make sure they did not get into an us-and-them situation. They made sure the new assets they were creating were also available to existing communities. In Ebbsfleet, for example, they have had quite a bit of success using a digital app to incentivise local people to be active. They made that app available to the established communities as well as the new community in the new town.

You can use development as an opportunity to have a wider impact beyond the boundaries of the development itself.

Simon Reeve: I will give you a bit of a plug. I agree entirely. I was thinking about this before I came. When you think about the difference between a greenfield or brownfield development, one of the areas I am very familiar with in north Leeds, which is dense two-up-two-down, back-

to-back terraced housing, you need to use different approaches. One of the assets you have in a place that is already built is that you already have a community; you already have people. You have people who can talk about what will work.

I will give you an example of good practice. This is a tool rather than the place. It is a Scottish one, but we are not shy about borrowing. It was highlighted in the ADPH planning policy note that came out this week. It is something called the place standard tool. It is effectively a framework for having a structured local conversation with people and communities about what matters to them in respect of their space and their health and their wellbeing. It has won various awards. It is quite well known and quite well published. It is still active. It has got a website. It is internationally recognised. The WHO has picked it up.

It provides you with a scalable way of talking to people in their real world. It has been used by some English authorities. Some of the best examples I have seen come out of it are really small things. It is things like, "It would be really nice if there was better lighting on this walking route because we do not feel safe walking and therefore we do not use it". If there is a particular pedestrian crossing on a critical path that links one area of a neighbourhood to another, it can help make the difference in terms of whether people can walk safely from one place to another and how easy it is to get around.

It can do bigger things as well. You can use on greenfield. I have been really impressed with it as a structured approach for saying, "In the reality of the place we have, what can make a difference? A lot of the solutions are there. Some of the stuff that came out of the Healthy New Towns programme is Building for a Healthy Life, which is one of the many good documents that has lots of fantastic real-world examples of good things you can do. When it comes to working out what you can and should apply where, there is no substitute for talking to the people in the place about that.

Q291 **Paulette Hamilton:** When we do these pilot sites, there always seems to be a lot of funding to get those sites to a very high standard. As you start rolling out, the money becomes scarcer. What recommendations would you make to Government? If you could make Government hear anything relating to funding and re-scaling, what would be the thought you would like to put across?

Chris Naylor: When these national programmes are running pilots in a set number of areas, clearly those pilots can only receive funding for a certain amount of time. It would be unfair for them to continue to get all the resources. It would be helpful if, when the pilots are over, when that funding comes to an end, you still have a team in a national body that is there to oversee rollout across other areas and to make sure the learning from those pilots is applied elsewhere, rather than an abrupt end when the programme finishes.

Paulette Hamilton: That is a good point.

Simon Reeve: As an official, it is not really appropriate for me to say what I think the Government should do when it comes to things like that. I would just go back to a couple of good points that have been made. This links to Chris's point. We need to make sure that, where we do something, we try to extract the learning and look at how we can get something sustained from it rather than just stopping and starting. That is a fair challenge, and that links to evaluation.

We also need to make the most of the co-location of public health and planning in local government, which, of all the bits of Government, is the one that understands its people and its communities best. How can we play to that strength in this whole conversation rather than making it all about the top down?

Q292 **Paul Blomfield:** That covered one of the areas I was going to raise because I represent a very established community in central Sheffield. I will perhaps pick up on another point you made, Chris, about how we carry forward the lessons. You have talked about the 10 learning points from the Healthy New Towns programme. That stopped in 2019. How effectively has NHS England learned those points? How is it driving them forward? Is there enough leadership from the NHS on the creation of healthy places?

Chris Naylor: As I said earlier, the impact within the 10 demonstrator sites has been quite real. The wider impact is less clear. There are probably three reasons for that in my mind. The first is the issues with the national programme design itself and the fact there has not been continued leadership of the work that was done nationally.

The other reasons why the programme did not have as much impact as it could have done are about some of the challenges in local public services. It has been very hard for people in planning teams in the NHS and elsewhere to carve out the time to do this sort of collaborative work. The desire is often there, but on the NHS side, when people are busy firefighting and responding to the very urgent issues in the health and social care system at the moment, doing more farsighted collaborative work that could lead to dividends in the future is sometimes deprioritised.

The other challenge has been on the private side in relation to whether there are strong enough incentives and requirements for developers to engage with some of the Healthy New Towns principles. Julia touched on this in the previous session. I know some developers are trying to apply those principles. A Healthy New Towns developer network was created for developers who wanted to try to pursue the Healthy New Towns principles in their work.

It is easier when the developers have a business model where they are long-term investors in the places they are creating rather than building

and exiting. The incentives and regulatory requirements for developers to take up these principles have not always been there.

Q293 **Paul Blomfield:** I want to try to push you a little bit on that. Developers are part of the equation for new towns, but I want to look at areas like those that Paulette and I represent, where it is important that those 10 principles are learned in relation to established communities. I think I heard you say that there has not been continued leadership from the NHS on these issues. We are looking with a view to making recommendations. Understanding your point about the desperate pressures on those working in the NHS, could more be done from a health perspective to drive that agenda from within the NHS?

Chris Naylor: I do a lot of work with integrated care system leaders. Many of the people who have gone into those leadership roles in integrated care systems are systems thinkers almost by default. They have taken up those roles because they are attracted to this new model of working where the NHS is supposed to be working in closer partnership with local government and other partners to do this kind of preventative work, which includes the place-shaping work.

Going back to the pressures, what I hear when I talk to ICS leaders off the record is that the job they are doing in practice now is not always the job they thought they were going into because of the short-term pressures within the NHS. Despite that, there is good work being done. There are people who are managing to find the time to do the longer-term work as well as the urgent work, but it is hard.

Q294 **Paul Blomfield:** Simon, you were nodding vigorously. Would you like to make a final point?

Simon Reeve: Yes, I agree entirely with that. I was thinking that it does not need to be NHS England that is providing NHS leadership. There is something about what the health leadership in a place is.

Again, I would plug the integrated care partnership element of this. I was doing a bit of casual reading, as you do. Well over half of ICP chairs and co-chairs are from local government, which tells us something about the opportunity to take a broader perspective on the population's health rather than the population's illness. It is a bit hackneyed, is it not? Subject to space, priorities and pressures, that is putting the right people, the right relationships and the right mission in the right place.

Q295 **Chair:** In closing, we are in the business of recommendations, ideas and trying to move the agenda on with Government. What would you put as your top ask in this area, Chris?

Chris Naylor: Thinking about the inquiry on prevention as a whole, you will clearly want to recommend some things that are about national actions. There are some things that national Government can really do to shift the dial on population health. One of the messages needs to be that some preventative work is best designed locally. Government need to be

thinking about how national bodies can go about their roles in a way that best enables that local partnership working. Part of that, of course, is about making sure there is cross-departmental alignment at a national level.

The other thing I would say is that we really need to try to aim for alignment between health policy, planning policy and climate policy. Lots of the things we want to do to create healthy places are the same things we would want to do to create sustainable places in the future.

Simon Reeve: I do not have anything to add to that, to be honest. That was a helpful set of observations.

Chair: Thank you very much to both of you for your time, Chris Naylor from the King's Fund and Simon Reeve from OHID. That concludes today's evidence session and this particular workstream of our mammoth prevention inquiry. Thank you for your time and thank you for watching, if you have.