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## Exploring planners and public health practitioner's views on addressing obesity: Lessons from local government in England.

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### Biographical notes

Amelia is a dietitian and public health nutritionist working as Reader in Food and Nutrition at Teesside University and Fuse. Amelia's current work is to explore the

Obesogenic Environment. She has a particular interest in food policy, the food environment, environments of young people, energy drinks and the workplace environment. Her mixed methods research involves transdisciplinary collaborations to examine how the environment interacts with, and shapes behaviours. Amelia has extensive experience of working with practitioners, policy maker and non-specialist audiences as well as academics.

Dr Emily Henderson is a medical anthropologist with interests in inequalities, stress and public health, and obesity and mental health in children. She recently completed a Research Fellowship in Complex Health Systems at Durham University's Centre for Public Policy and Health, a WHO Collaborating Centre on Complex Health Systems Research, Knowledge and Action. Currently she is undertaking a secondment as Children and Young People's Mental Health Lead, Northern England Clinical Network, and is an Honorary Senior Research Associate at Newcastle University.

Tim is a Professor of Urban Design for Health at Newcastle University, UK. He has an established national/international profile in health/built environment work through a range of publications that cross disciplinary divides. His work has addressed diverse topics from obesity to mental well-being. Tim's work always attempts to maximise its impact and as such is always policy relevant. He has been a consultant on a series of national reports and policy documents.

## **Abstract**

Obesity is a complex health and social issue globally. The 2013 restructuring of Public Health in England resulted in a move from within the National Health Service to local government. The aim of this research was to understand the views of individuals working in public health and those working in spatial planning within local government on their respective responsibilities for addressing obesity through spatial planning. Spatial planning measures include planning policy, development control and built environment design at different scales. Findings identified a range of barriers for planners to be engaging with outcomes that can help reduce obesity. These include having an insufficient understanding of the causes of obesity and the importance of addressing obesity through multiagency approaches. They also include what was seen as a fragmentation in the health system and conflicting priorities. Our findings indicate that planners could be better engaged in the obesity agenda through formal incentives and also soft approaches. Formal approaches include written responsibilities within planners' job descriptions or regulations. Soft approaches include aligning spatial and health priorities and providing planners with public health leadership roles.

## **Keywords**

Obesogenic environment; obesity; local authority; local government; whole systems approach; England

## Introduction

Obesity is a complex health and social issue globally; it is a growing issue in every region of the world (Ford *et al.*, 2017). Obesity can be usefully addressed at a local government level, given the importance of considering its contextual factors that vary across local areas. In England, The White Paper<sup>1</sup> (HM Government, 2010) of the coalition government (2010 – 2015) and subsequent documentation (Department of Health, 2011a, Department of Health, 2011b) point to the role that local authorities have in tackling obesity as part of a bigger more radical shift of public health back to local government from the National Health Service (NHS). From April 2013, in England, local authorities took on their new public health responsibilities including responsibility for obesity, community nutrition and increasing physical activity.

In the UK and USA, modern town planning grew out of concern to tackle the unhealthy and insanitary conditions of the 19<sup>th</sup> Century. The two professions of planning and public health grew together and Public Health Acts transformed working class housing in particular; however as key issues, such as clean water supply were resolved collaboration between the two professions dropped away (Lake and Townshend, 2006, Department of Health, 2011b). Since the 1980s and the growth of the Health Cities movement, however, worldwide there has been increasing recognition that the built environment - and thereby planning - is implicated in a range of contemporary health concerns and influences, physical, mental and social health (Northridge, 2003).

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<sup>1</sup> A White Paper is an authoritative report or guide that informs readers concisely about a complex issue

In England the 2012 National Planning Policy Framework (Department for Communities and Local Government, 2012), placed new emphasis on the role of planning in supporting healthy communities<sup>2</sup>. In 2012 the Town and Country Planning Association (TCPA)<sup>3</sup> launched a UK wide initiative entitled ‘Reuniting Health with Planning’ (Ross and Chang, 2012). This included a special edition on this topic in the journal *Town & Country Planning* (The Journal of the Town and Country Planning Association, 2014). Additionally, The Royal Town Planning Institute (RTPI)<sup>4</sup>, published its ‘Promoting Healthy Cities’ document in which it parallels increasing diabetes with increased urbanisation (RTPI, 2014a). One area where there is a burgeoning research base and development of specific planning policy is in the relationship between the built environment and obesity (Townshend and Lake, 2017)

A large body of international research, as well as previous government policy, has highlighted the transdisciplinary effort required to tackle obesity due to its multifactorial nature and underpinning health inequalities (Lake and Townshend, 2006, Foresight, 2007, Department of Health, 2008, Townshend and Lake, 2009, Townshend *et al.*, 2010). This international body of work on a theme entitled ‘obesogenic environments’ has suggested that, globally, planning policy may have an impact on people’s wellbeing and energy balance in terms of their access to food and their environment being conducive to physical activity.

While there has been much international and national discussion of this responsibility, there appears to be little evidence that English planners have engaged with the new

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<sup>2</sup> What is a healthy community? <https://www.gov.uk/guidance/health-and-wellbeing>

<sup>3</sup> TCPA are a campaigning body that seek to reform the UK planning system

<sup>4</sup> RTPI are the accrediting body for planning qualifications in the UK

public health agenda. In England in 2010 the short-lived Education Network for Healthier Settlements found few planning courses ran modules specifically addressing public health issues (Townshend, 2010) and despite the recognition of the role of planning in promoting healthy cities, the RTPI policy statement on initial education does not include an understanding of the links between health and planning in its schedule of learning outcomes (RTPI, 2014b). In England, the Department of Health funded the 'Healthy Towns' initiative (Sautkina *et al.*, 2014), and some individual local authorities are addressing issues around planning permission and fast food restaurants (NHS London Healthy Urban Development Unit, 2013). However, such initiatives are more the exception than the norm. Despite the international academic and policy interest in the topic of planning and health, many planning practitioners and other local government members do not seem to be adopting this evidence into practice. While, this lack of interest may be explained by prevailing financial, legislative and policy priorities, alongside restructuring and staff cutbacks that limit the scope for more proactive forms of planning, thus far no detailed investigation has attempted to fully understand the barriers to engaging planners in health issues.

The obesity, planning and socio-economic contexts of North of England makes for useful case study to explore perceptions around responsibility for addressing obesity in local authorities. This region of England has high profile health issues and inequalities. Life expectancy and the health of the population is lower than the England average and there are high levels of deprivation (Association of Public Health Observatories, 2010). Rates of obesity are high in the North of England compared with other areas in England (Health and Social Care Information Centre, 2015). Moreover while the planning profession have focussed their efforts on economic regeneration in the region, with a potential for improved health outcomes

(Bond *et al.*, 2013), those outcomes have been largely missing from planning policies themselves. Therefore, the aims of economic regeneration and particularly a focus on development and job creation at any cost can run counter to the priorities of public health.

With public health now rehomed in local government in England, it is a timely opportunity to address this issue, to discover if it is a simple lack of interest, resources and training or whether more endemic problems exist.

The aim of this research was to understand the views of individuals working in public health in local authorities and those working in spatial planning within local government in England on their respective responsibilities for addressing obesity through spatial planning.

## **Methods**

### **Study design**

One-to-one semi-structured interviews were conducted with individuals working in public health and spatial planning in Northern England between November 2013 and March 2014. Ethical approval for this work was granted by Durham University's School of Medicine, Pharmacy and Health Ethics committee. The interview schedule is detailed in Box 1 and was developed by a multi-disciplinary team. The interviews aimed to explore the respondents' perceptions concerning the wider issue of their role in public health before asking them about tackling issues of obesity, community nutrition, and increasing levels of physical activity. In addition to exploring the current situation with regards planners' levels of awareness around public health related issues and the levels of importance they place on these health issues (in



relation to other issues e.g. economics), the interviews also identified whether there is a need for professional level training for planners on such topics.

## Recruitment

All local authorities in one region of Northern England were invited to take part. Directors of Public Health (DsPH), Deputy Directors of Public Health and heads of spatial planning were approached. Fuse the Centre for Translational Research in Public Health, a UKCRC Centre of Excellence in Public Health, provided recruitment support ([www.fuse.ac.uk](http://www.fuse.ac.uk)) via the Fuse Knowledge Broker, who sent emails and followed up with phone calls. Interviews were conducted until thematic data saturation was reached (Guest et al., 2006).

## Analysis

Professional transcripts were made of the audio recordings of interviews. Transcripts were anonymised and imported into the Nvivo 10 software package, a tool to help support qualitative analysis. Framework Analysis was employed as the method of analysis (Ritchie and Spencer, 1994). This method was developed for applied policy research and allows for the exploration of *a priori* issues and for new themes to emerge. A thematic and case based approach was used so as to explain participants' views on responsibility of creating health communities. Data were analysed (EH) using the five steps of Framework: familiarization; identifying a thematic framework; indexing; charting; and mapping and interpretation. Transcripts were read and reread independently (EH and AAL), and the construction of the framework discussed in order to develop the final framework and its interpretation.

## **Box 1 Interview schedule**

Introductions and state the purpose of the interview.

1. What is your job title and your role (including where you work)?
2. Whose responsibility is public health?
3. How are health and spatial planning related in your view?
4. How do you see *your/ planning's* current role with regards to public health?
5. Have you seen a change within the local authority around public health issues since April 2013?
6. Have you had seen any change in *your/ planning's* responsibility with regards to issues around public health?
7. Where do you obtain information about public health and obesity?
8. How does your role relate to issues around to obesity, community nutrition and physical activity?
9. What are these roles?
10. What information do you need to change policy, regulations, current practice in relation to public health and obesity prevention?
11. Are you confident dealing with issues around obesity, community nutrition and physical activity?
12. Do you have the knowledge base to tackle issues around obesity, community nutrition and physical activity?
13. Are there areas you would like more training on relating to public health? / Do you believe planners require more training?

## Results

Five local authorities in Northern England were invited to participate. Eight interviews were conducted with three DsPH, one Deputy Director (also referred to as DsPH) and four planners with a range of seniority. One DPH from one local government expressed an interest but was not able to interview due to availability. One senior planning officer was not interested in taking part, providing the explanation (by phone) that obesity was “not their responsibility” and they had “nothing to contribute” to the research, which is an interesting finding in and of itself. Seven themes were identified in the data across the two professional groups; five were emergent themes and two fit with the *a priori* lines of questioning (experiences of recent trends; knowledge and evidence in obesity, community nutrition and physical activity).

### *Shared versus sole responsibilities*

DsPH and planners had different conceptions of who is responsible for public health. All the DsPH believed in a broad, shared responsibility, citing various actors including the council, planning, the national government, employers and individuals. One DPH was able to identify the potential widening of inequalities if too much responsibility is expected of the individual:

*“The evidence base is quite clear that if you place all the responsibility onto the individual then you’ll get probably increased health inequalities, and those with the wherewithal to responsibility will take it and those who don’t won’t, so therefore actions need to be taken on their part, so to speak.” DPH 1*

When planners were asked about responsibility for obesity, physical activity and community nutrition, they saw a clearer link between planning and physical activity than with community nutrition, primarily citing sustainable transport, path provision and recreation, though one identified takeaways. One planner said, “At the end of the day, it’s down to the individual to address their obesity (Planner 4)”.

These differences in views on responsibility for health would suggest a difference of understanding amongst some in the local government about the complex causes of obesity and how to address inequalities. However, one planner did point out that it is health professionals’ responsibility to “make the link” between planning and health, “because I don’t think people from planning would start from a health improvement stance”. This has implications for leadership and leadership roles.

#### *Joined up versus fragmented practice*

DsPH were able to provide many examples of how they are joining up with various organisations and taking whole systems approaches in efforts to promote healthy lifestyles for their communities. For community nutrition, working with environmental health officers, one local government provided health awards for local education authorities, nurseries, schools, takeaway restaurants. It also provided a range of community projects such as urban farming and allotments, specifically in deprived areas and with people with mental health issues. Planners indicated working with other organisations, but to a lesser extent.

Relationship building was identified as key to bridging the divide between planning and public health. Planner 1 felt that planning was “reactive” when it came to

incorporating public health into their work, but was starting to see signs of planning being more “proactive”, with reference to using the Takeaway Toolkits (Greater London Authority, 2012) for example.

### *Experiences of recent trends*

DsPH reported more and intense experiences of changes since the restructuring of the NHS in April 2013, whereas planners seemed to have experienced changes more due to the introduction of the National Planning Policy Framework (Department for Communities and Local Government, 2012) in March 2012. DsPH also did not notice a major change in planners’ responsibilities as a result of the restructuring, though again, planners demonstrated better awareness of their potential to impact health and wellbeing, especially around licencing of alcohol and food outlets.

DsPH identified “huge economic constraints” as a result of the restructuring, for example cutting back on spending in park maintenance, and actually expecting “neighbourhoods to look after those kinds of spaces themselves...to find the drivers in the community for self-management” (DPH 2). DPH 2 said further:

*“It’s almost at the point where you might think, oh well we’re going to be able to influence planners around spatial planning and tackling obesity...but this is just at a point when actually councils may have less to do with some of that green space than they have had previously.”*

Planner 4 confirmed this observation, adding further:

*“I don’t think this government, potentially even if there was a change of government, making it such a high priority to try and address something which they aren’t going to be able to claim as a success.”*

DPH 3 felt despite public health’s “coming home” back to local government, the age-old challenge remained in trying to address deeper complex issues as associated with obesity with a “target driven” culture, knowing that long-term solutions are required. DPH 4 made similar comments, but referenced more the difficult decisions ahead with local authorities having to reduce already stretched budgets in the future.

#### *Knowledge & evidence in obesity, community nutrition and physical activity*

All participants appeared to use personal contacts for their main sources of evidence. DsPH consulted colleagues in leadership roles such as other DsPH and managers, those in roles responsible for keeping up to date with evidence and those who take a particular interest, looking for information on planning rules around spatial planning, how national policy determines local policy. DsPH kept up-to-date by consulting public health profiles, public health websites (e.g. NICE, PHE), public health intelligence services and sharing good practice with colleagues outside of the region. Most DsPH seemed confident in the areas of community nutrition and physical activity, often citing evidence through the interviews, e.g. the role environments play in health; how to reduce gaps in inequalities. For example, DPH 1 felt their staff “got” issues of obesity, so rather than training, they required the means to implement the evidence base.

Planners looked for evidence to support policy making (e.g. case studies of good practice). They would consult the Planning Policy Guidance Notes, the Local Government Association (LGA, 2017) and local “statistics” on obesity. Some planners explained that they did not feel confident in the area of community nutrition and physical activity, and expressed little if any interest in obtaining further training in these areas, indicating they would contact individuals who did know. Planner 2 for example felt the integration of public health into local authorities had helped to raise awareness in these areas, and DPH 1 confirmed this observation.

#### *Conflicting versus shared priorities*

DsPH recognised that planners have large pressures in other areas besides health, such as concerns for sustainability and climate change. Economic regeneration as a driver in urban development is understandably prioritised in the North of England. Economic regeneration, however, can run counter to health priorities in areas desperate for *any* inward investment and development. DPH 2, for example explained how in their area, the local government was allowing the development of new properties in more affluent areas, which provided more profit for developers, but widens inequalities as the housing shortage is still a major issue in the more deprived areas. Planner 4 raised a similar issue regarding the establishment of new takeaways, whereby such development was “more to do with retail rather than health.” For example, in this case, despite being within 400m of a school, planning inspectors approved the development of takeaways because they demonstrate investment and job creation.



DPH 4 said, “What we’re trying to do is just say, look tackling obesity isn’t just an impact for public health and the NHS, it is cross cutting, and if not tackled this will have a big impact on the demands to a range of council services”.

### *Formal versus organic responsibilities*

Planners are able to refer to the National Planning Policy Framework to change policy regulations and practice in relation to public health and obesity prevention, but it is considered “very high level and not very easy to interpret”. One planner cited the development of a Supplementary Planning Document<sup>5</sup> to provide the “how to” details. Speaking about the need for health assessments for individual planning applications, one senior planner said:

*“Planners have to be aware of all societal changes and the needs of society in the round, and one of them of course we need to be aware that new development can contribute to better health. So it’s in the back of our minds but we’re not required to do it as a direct link...there would need to be a government directive.” Planner 1*

Rather than providing training for planners on health and obesity, DPH 3 believed public health needs to connect better with planners and build relationships by which

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<sup>5</sup> Supplementary Planning Documents (SPDs) provide detail to support policy in higher level Development Plan Documents (DPDs). SPDs are a material consideration in the assessment and determination of any planning application. (ref from <http://www.newcastle.gov.uk/planning-and-buildings/planning-policy/supplementary-planning-documents>)

the two areas can innovate new approaches together. DPH 1 identified a “critical leadership role putting it all together.”

### *Business as usual versus potential for transformational change*

The DsPH also appeared to think outside of their daily professional practices and towards larger, more long-term changes. DPH 1 said on the role of planning with regards to public health, “it’s one where there’s a lot of potential, but with one or two honourable exceptions in different parts of the country, untapped potential”.

DPH 3 said:

“I think it’s useful to have a kind of whole area approach...I get the impression if you had a local champion that was really passionate about all this would probably achieve more than any number of kind of well-meaning strategies and policies...Some of it is about opening people’s eyes to what’s possible, isn’t it?”

By the same token, DPH 4 acknowledged that in terms of engaging their whole population on the “obesity agenda”, there are areas that cannot be addressed locally but require national policy shifts. For example a planning application cannot currently be denied solely on the basis of public health grounds, which this DsPH felt would be useful, as well as changes to the regulation of the sugar and food industries.

## **Discussion**

### **Summary of findings**

This research focuses on two professions, DsPH and local planners, from five local governments across a region in Northern England and reports perceptions around the responsibility for obesity.

Findings identified a range of barriers to engaging with planners, including an insufficient understanding of the causes of obesity and the primacy of addressing obesity via multiagency approaches, fragmentation in the health system and conflicting priorities. An illustrative example of the extent to which planners may be disconnected from the obesity agenda, one planner declined the interview claiming obesity was “not their responsibility” and they had “nothing to contribute”. The data indicates that planners could be better engaged in the obesity agenda via formal incentives (e.g. written within planners’ job descriptions or regulations), and aligning priorities via ‘soft approaches’ (e.g. public health leadership roles).

We can compare the issue of planning for healthier foodscapes with planning for housing that’s supports healthier lifestyles. In England, the recent Housing White Paper (Department for Communities and Local Government, 2017) is somewhat belated recognition by the government that many of the problems of housing supply are not to do with the English planning system, rather the way in which the housing market operates and the dominance of a small number of extremely powerful housing companies. In poorer areas desperate for housing, developers effectively hold all the cards and even if planners request that healthier features, such as cycling provision, are incorporated, developers may seek to negotiate these out, often citing they are economically unviable or threaten to ‘move’ their investment to a neighbouring authority for example. Similarly, where powerful organisations such as multi-national food outlets, offer the chance of inward investment and jobs, this may be hard to resist in some deprived communities, even if ultimately that investment is damaging to community health and the jobs provided are low skilled and low paid (Townshend and Lake, 2017). In essence, therefore, even where planning staff are engaged with

the health agenda and seek to deliver a healthier built environment their attempts may be ultimately thwarted by other factors. Additionally, there are anxieties among planners that their profession has been portrayed as ‘meddling’ and as part of the ‘nanny state’ by popular media, politicians etc., (see for example (Southern, 2015) and therefore are reluctant to push a health agenda which would give critics more ammunition.

### Comparison with the literature

Obesity is complex, multifactorial and challenging to address (Townshend and Lake, 2017)<sup>6</sup>, and no country has “reversed” obesity (Roberto *et al.*, 2015). As observed in this research, some environmental factors influencing obesity are the result of the exploitation of the vulnerabilities of populations, for example local government decisions to prioritise regeneration in deprived areas via increased retail in the form of takeaway outlets over creating healthy communities (Sarkar and Webster, 2017).

Worldwide, including in the UK, strategies and policies tend to focus on changing individual behaviours rather than considering the complexity of obesity by seeking to change environmental factors, which can lead to healthier population level behaviours (Swinburn *et al.*, 2011). As well, these initiatives largely remain ineffective (National Prevention Research Initiative, 2015). This tendency, to continue to focus on individual level solutions, despite evidence indicating that wider determinants are the driving contributors, has been termed ‘lifestyle drift’ (Popay *et al.*, 2010) was observed in this study amongst planners. Shifting of focus to more

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<sup>6</sup> For a complete discussion of obesity, built environment and complexity, please see Lake, A., Townshend, T., Alvanides, S., 2010. *Obesogenic Environments: complexities, perceptions and objective measures*. Wiley-Blackwell.

upstream strategies can be achieved through whole systems approaches to obesity, for example cross-sector and multi-agency working by considering the multiple factors involved in the aetiology of obesity that influence individual determinants, such as planning.

In relation to planning there is a lot of inertia that impedes transformational change, not least because we have generations of planners who have been trained with very little consideration of health consequences of planning decision making. While this is changing, leaving it to the natural job cycle will take a long time. The finding by (Cullingworth *et al.*, 2015) that some planners made explicit links between health and sustainable transportation is a positive foundation on which to build. Links between transportation, sustainability and climate change are already well embedded in planning education. Moreover, the research evidence that has emerged over the past two decades on this issue is becoming clearer. Reviews of studies suggest access to local shops and services and public transportation, aesthetics and safety are linked to increased walking and cycling (Ding and Gebel, 2012, Kerr *et al.*, 2016).

Neighbourhoods which are ‘activity supportive’, in other words provide a range of recreational opportunities promote the highest levels of physical activity (Adams *et al.*, 2013), while perceived safety and proximity to local and services have been associated with lower Body Mass Index (BMI) in local populations (De Bourdeaudhuij *et al.*, 2015). The provision of local shops and services aligns with the broader sustainability aims of reducing private transportation; however developers are often resistant as the returns, for example from retail units, are less than that for residential units. Therefore, stronger central policy may be required to improve incentives.

Likewise the provision of adequate greenspace is also a topic which is embedded into traditional approaches in planning, with a general appreciation of parks and open space and their importance for recreation and leisure time. Moreover there has been a long standing concern over their survival in urban areas (Greenhalgh, 1995). Recent studies have associated access to good quality parks with increased levels of physical activity (Limstrand 2008, McCormack *et al.*, 2010, de Vet *et al.*, 2011) and inversely associated to BMI (Pate *et al.*, 2013). More generally recent studies emphasise 'general greenness' as being associated weight management, for example (Halonen *et al.*, 2014), without physical activity being the mediating factor. However, again, importantly developers are often resistant to providing adequate greenspace and landscaping as it reduces profit margins and creates on-going maintenance. Additionally, as our findings show, local authorities are increasingly unable to find funding to support even basic functions of green space maintenance such as grass cutting.

It is understandable why planners find engaging with food environments more challenging. Firstly there is less of a connection between food access and other areas of planning education, moreover the field is inherently complex covering a wide variety of sources, which do not necessarily map on easily to the 'Use Class'<sup>7</sup> order approach which planning has traditionally used to distinguish different types of land use. For example, as stated an increasing number of local authorities are using Supplementary Planning Guidance<sup>8</sup> to control fast food outlet proliferation (Lake *et*

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<sup>7</sup> The [Town and Country Planning \(Use Classes\) Order 1987](#) (as amended) puts uses of land and buildings into various categories known as 'Use Classes'.

<sup>8</sup> Supplementary Planning Documents (SPDs) provide detail to support policy in higher level Development Plan Documents (DPDs). SPDs are a material consideration in the assessment and

*al.*, 2017). However, not all takeaway outlets are unhealthy. Moreover, where seating is provided food outlets are classified as restaurants and therefore are exempt from takeaway restrictions. This system of classification, in relation to food outlets requires an overhaul, but the planning system is probably never going to be nuanced enough to differentiate between health and unhealthy outlets.

### Recommendations for policy, practice and research

Given participants identified much value in organic modes of working together, this would require increased capacity including leadership (champions were cited). While the importance of ‘boundary-spanning’ leadership has been identified (Hunter and Perkins, 2012) and reports have suggested strong leadership in this area is needed (Town and Country Planning Association, 2016), our research suggested that such leadership was still lacking. However, again, given budget cuts to local authorities in England, the issue may be a lack in leadership skills and capacity to carry out these less formalised, ‘non-core’ aspects local government staffs’ roles. Similarly, with respect to the anticipation that the relocation of public health to local government in England could improve impact, the current austerity measures somewhat limit local government ability to fund preventative measures, e.g. maintaining green spaces (Hall, 2015). In some countries, public health may have always been within local government, but there is a silo between the professions.

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determination of any planning application. (ref from <http://www.newcastle.gov.uk/planning-and-buildings/planning-policy/supplementary-planning-documents>)

Political will is also critical. In France, the EPODE programme (the largest global childhood obesity prevention programme) observed that local authorities needed to engage with the programme on a voluntary basis and there to be local political will for success (Borys *et al.*, 2012). However for progress to be made not only do individuals and civil society have a role but regulatory action from governments is required (Roberto *et al.*, 2015). Roberto *et al.* (Roberto *et al.*, 2015) describe examples where ‘Health in all Policies’ approach has been used including South Africa, Southern Australia and Victoria (Australia). However, they conclude that despite increased attention to health and obesity, the response is not adequate.

Based on our findings, we recommend health and wellbeing be explicit learning outcomes of planning education, in England, the UK and internationally. In 2010 the RTPI undertook consultation on planning education and this was made by a number of senior planning academics (Townshend, 2010). One DPH in the present study pointed out that planners do not need to be experts in public health, but they do need to be aware of their contribution. Town and Country Planning Association (2016) suggest that local authorities provide shared training across public health and planning as well as offer secondments. However addressing the responsibility of planners in public health is only one aspect of the complex issue of obesity, which requires a “systemic, sustained portfolio of initiatives” (McKinsey Global Institute, 2014). These should include addressing political leadership, national guidance and statutory measures; training and professional reorientation; financial incentives and joint investments.



Future research could focus on these areas of leadership identified by the McKinsey Institute (2014), as well as an exploration into the extent to which public health leaders use the full suite of influences available to them. For example, they might re-profile public health budgets away from orthodox intervention treatments, into supporting policies that affect the wider determinants of health; this could include incentivising and financially supporting planning teams.

### Strengths and limitations

This is the first study to interview both planning and health professionals within local government. Qualitative research does not seek to make its findings generalisable to the whole the population, and as such our study rather provides a rich account of the views of those in public health and planning on their roles with respect to addressing obesity, with which we have been able to make key recommendations for policy, practice and research

Key limitations of the work should be acknowledged, however. This was a focused study in which we researched five local governments across the North of England. While this number is too small to draw conclusions that might influence policy, and more research is required to do so, the research can serve as a starting point for addressing this important issue. Moreover, while this study explored both public health and planning, as noted above future research might also usefully look at a wider multiagency sample, including for example education, transportation and so on as well as the levers for change. This would acknowledge that achieving a paradigms shift in the obesogenic environment is a responsibility for all.

## Conclusions

While public health in England may have returned ‘home’ to local authorities (Gorsky *et al.*, 2014) the full potential of what could be achieved remains to be seen.

Internationally, local governments have a range of options and interventions to address the obesogenic environment including healthy school programmes, spatial planning, green infra-structure, transport (active transport and public). There needs to be a shift and clear leadership within local authorities to a shared model of responsibility for obesity and more broadly for wellbeing. Planners’ priorities need to be better aligned with public health. This could come in the form of formal incentives for example health and obesity prevention be written within planners’ job descriptions or regulations (a health-in-all-policies approach). Additionally the use of ‘soft approaches’ such as a stronger public health leadership role encouraging stronger cross disciplinary collaboration. However, the likelihood of this formally happening in England and the UK is low given the current the political environment of ever dwindling public health resources, conflicting priorities and prioritisation of economic regeneration over healthy communities.

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