Designing Out Fatness: The Built Environment in Anti-Obesity Policy.

Final report – research findings summary.

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Designing Out Fatness - Executive Summary

A. Background

This document reports on an ESRC (Economic and Social Research Council) funded project titled 'Designing out fatness: the built environment in anti-obesity policy'. The project was carried out by Dr. Bethan Evans (Principal Investigator, University of Liverpool – Durham University during the research), Prof. Jon Coaffee (Co-Investigator, Birmingham University) and Dr. Lee Crookes (Research Associate, University of Sheffield – Durham University during the research) between 2009 and 2011.

This research responded to changes in obesity policy in the UK that took place around 2007-8 which led to a move away from interventions which aimed to change individual behaviour by educating people about 'healthy' lifestyles to focus on what has been termed 'passive obesity', or the 'obesogenic environment' (Foresight, 2007). These explanations place the cause of obesity in the relationship between bodies and spaces, particularly with reference to the impact of the built environment on levels of physical activity (Commission for Architecture and the Built Environment [CABE] et al., 2007; National Institute for Clinical Excellence [NICE], 2008). As a result an emerging focus for interventions which aim to tackle obesity has been the design of the built environment and there have been calls for planners[1] to design 'healthy spaces' which will ensure the bodies within those spaces remain active, healthy and thin (DH, 2008).

This policy shift was part of a broader raft of policies to ensure the health and safety of future populations through urban design which has seen planners also asked to consider issues such as crime and terrorism (Coaffee et al, 2008), sport and physical activity (Sport England, 2006) and climate change (CABE, 2007) under the umbrella of sustainable development and sustainable communities.

Despite these intended interventions, there is significant uncertainty in the 'science' surrounding obesity (see Campos, 2004; Gard and Wright, 2005), concerning the links between body size and health and the determinants of body size. There is a particular lack of evidence about 'what works' when it comes to affecting health and body size through planning and what evidence there is, suggests that what works in one place may not work in another (CABE et al., 2007). In broader health arenas there is a growing 'Health at Every Size' (HAES) movement which attempts to divorce health from weight so that interventions are about improving the health of people whatever their size rather than reducing the number of people who are classified in particular weight categories. Planning professionals are therefore being placed in a difficult situation, asked to incorporate health into their practice in policy that continues to emphasise weight, with no consensus on how to do this or with little appropriate training being offered.

This research project therefore sought to raise awareness of the need for planners to consider 'health' in their decision making processes as well as the ways in which planners are responding to calls for them to act to 'design out' obesity given this uncertain knowledge. Previous research on the ways in which teachers incorporate health in their professional practice (Evans and Evans, 2008;

[1] Throughout this report we use the term 'planners' to refer to the range of professionals who influence the design of the built environment rather than those specifically working in planning (including, for example, architects, urban designers and transport planners).

Tinning, 2004) has indicated that this uncertainty often results in a lack of professional confidence and a reliance on generalised assumptions and stereotypes relating to bodies, education and health. Given that planners, like teachers, are being expected to be 'health experts' despite lacking 'expert' health knowledge and training, this research aimed to uncover the sources of health knowledge on which planners base their decisions and the underlying assumptions about the relationships between bodies and spaces which inform this knowledge.

This research therefore did not attempt to establish the effectiveness of specific interventions. Instead, through analysis of key case studies, the research investigated:

- planners' experiences of incorporating health (specifically obesity) into their professional practice in general;
- the ways in which health considerations complement or contradict other design imperatives;
- how 'best practice' models are adapted to fit specific locations;
- and the extent to which health is, or could be, incorporated into planning pedagogy and continuing professional development (CPD) training.

B. Objectives

The project objectives were:

1. To investigate the role and responsibility of the 'planner' (including planning-related professionals) in policy strategies to tackle obesity.
2. To generate new empirical data on the implementation of policy guidance concerning health and the built environment (specifically regarding obesity) in local authority practice.
3. To advance theoretical understandings of the relationship between bodies, health and place.
4. To evaluate planners' knowledge of the role of the built environment in relation to health and make recommendations for Continuing Professional Development needs.
5. To explore the implications of the change of government and associated local authority restructuring for the implementation of policy on health and the built environment, particularly in relation to obesity.

C. Research Design

The project adopted a mixed methods approach:

1. Analysis of UK policy on obesity and planning.
2. A survey of 35 newly qualified planners contacted through the RTPI young planners' network and 2 follow up telephone interviews with survey respondents.
3. Telephone interviews with course leaders (or core teaching staff) from RTPI accredited courses at 10 HE institutions in the UK.
4. Focus groups with students on RTPI accredited planning courses at 4 universities in the UK.
5. Interviews with 6 representatives from national bodies with an interest in health and urban design.

6. Interviews with 15 representatives from planning or health departments in local authorities and private sector firms involved in urban design within 3 case study areas in the North West of England (Liverpool, Manchester and South Lancashire).
7. A dissemination workshop held in Liverpool with approx. 20 delegates (including planning students, educators, representatives from national bodies and local authority personnel).
8. All interviews and focus groups were fully transcribed and analysed through 'reading for themes' (see appendix 1 for full list of themes)
9. Ethical clearance was gained from MMU and Durham University (See appendix 2 for participant information sheet and appendix 3 for consent form).

D. Results

The main findings of the project are as follows:

1. Understanding health

- Most planners spoke about health in much more progressive and holistic terms than public health policy on obesity.
- Many planners felt uneasy with the idea of 'designing out' fatness. They see 'healthy' urban design to be about 'designing in' people rather than designing out fat bodies. In particular, people felt uneasy about the potential for environmental determinism within this approach:

Example: Not environmental determinism:

This idea of kind of designing out fatness. And you know what it reminded me of, I don't know whether you've come across this, but back in the eighties we had a kind of design out crime … But I would hope nobody actually thought about this issue in terms of designing out fatness, I mean it's not designing out anything, it's about designing in. And I guess, you know, that's a kind of core message to my students, it's not about trying to be excluding or anything like that, it's about … choice …The environmental determinism ... it was completely the wrong approach to anything (CL5).

- Many planners felt that the suggested interventions were elements of 'good design' which planners were already implementing without needing to emphasise weight loss and that there isn't the need for an additional imperative here.
- Any imperative to measure the outcomes of planning initiatives using BMI (and hence any specific focus on obesity) was seen to be problematic since this would miss the broader health benefits of some design features and would limit conceptualisations of good design:

Example: More than just physical activity

Public health defines it as physical activity whereas planners think more in terms of a successful place, someone wanting to spend time in a place, to be in a place. Not just excluding cars, could be sitting in space, not necessarily being physically active. Successful 'place making' means making successful, happy, healthy spaces with opportunities for activity within places but opportunities rather than forced. (DW)

- Similar to HAES principles, there were some examples of schemes that successfully increased physical activity through providing the resources, training and changes to the physical infrastructure necessary to facilitate active travel – notably these schemes did not focus on or emphasise weight loss:

Example: Cycle Speke Project:

we've been running a project in Speke for the last eighteen months where we've got cycling up by about 60% our counts show … we got a lot of funding from Europe, the European Regional Development Fund for putting in a lot of infrastructure ….We put in a little bit of infrastructure, we put in cycle shelters in the schools, …We've put in sort of cycle parking on the street as well in various locations and we've done sort of a few other little bits, like a couple of connections, just to sort of link up roads and things like that. But most of it's been about promotion, so it's been either working with community groups in the schools, doing bike rides, doing Dr Bike sessions, doing workshops with the local businesses to offer them Dr Bike to their staff, giving them out a load of information (L2).

- Others discussed how health should be conceptualised in much broader terms than just physical health or weight and gave examples of interventions which were successful because of their social element. In this regard, a specific focus on obesity within healthy urban planning was seen as problematic by several respondents and as limiting the potential to recognise the full benefits of healthy urban design.

Example: Liverpool Walk for Health

83% came for social benefits as well, so the social element was a big factor for a lot of people. So that was one of the reasons why we wanted to use this data to try and influence the powers that be to let them know that you know we're not just talking about physical health we're looking at, …looking at people's perceptions, how they feel naturally, is there good meeting points, you know a lot of the time we made the walk sociable, so things like tea and coffee in the local area as well. So those sort of elements were incorporated into our programme then. (L4).

- However, this didn't always extend to designing for fat[2] bodies. There were some planners, particularly those who worked specifically on matters of accessibility, who did consider the needs of bigger bodies. However, some reported that the dominant association of physical activity with thinness meant that they hadn't thought about the needs of *active* fat bodies:

Example: Facilitating active fat bodies:

I hadn't thought about how we can accommodate that, I've made the mistake of assuming that … we need to allow people or encourage people to get fitter and to lose weight, I hadn't even thought about what, how people are going to start that process. So in my mind, I guess what I'm seeing are this kind of vague thing … I've always imagined that fat person suddenly shrinking and becoming a thinner person, and that's what I've been designing to (L5)

[2] We use the word 'fat' rather than obesity where it is used as a descriptor of bodies, and the word obesity where we are referring to public health framings of fatness as unhealthy. We do so in line with Fat Studies literatures which use the word fat to challenge the medicalisation inherent in the word obesity.

- Planning students in particular often did not consider the needs of fat people as 'valid' users of public space (see point 2).

2. Planning education

- 80% of survey respondents reported receiving no specific training on health and planning during their planning qualification, yet 57.7% reported that health is a priority for planning within their current employment. 93.8% therefore reported a need for further training on planning, health and obesity.
- The lack of a focus on health in RTPI accreditation guidelines and a packed curriculum means the majority of RTPI accredited planning courses have no specific module or content on obesity or health. Health content tends to be driven by the specific research expertise of staff or students. However, whilst not having a specific module on health and planning, some course leaders did report that it was integral to their training and was part of broader pedagogical strategies to develop students critical thinking:

Example: Health in the curriculum:

> *We certainly don't have a kind of module that's entitled 'health and planning' or anything like that, and to be perfectly honest I would be quite resistant about doing that because to me health should be, it's like sustainability, … I'm gradually trying to persuade people that actually we shouldn't have modules that are called sustainable anything because all modules should be sustainable, and to me human health should be interwoven through everything that planners do, it shouldn't necessarily be seen as a kind of stand-alone issue.* (CL 5)

- Many planning students reproduced problematic, stereotypical views of fat people as irresponsible and lazy and saw any consideration of the needs of fat bodies in the design process as antithetical to healthy design – contrasting fat bodies with those who they considered to have 'legitimate' needs:

Example: Stereotypes of fat bodies:

> *If people want to live healthy lifestyles it's our job to make sure they can live a healthy lifestyle, that if, and again it just, it comes back to that choice, if they choose not to then there's not an awful lot as a planner we can do to influence that. … if you've got a disability or if you, you know as you grow older, …those are the things that we should cater for and that should be borne in mind when … particular space requirements are laid out. But in terms of actually designing spaces and designing areas for different body shapes simply due to the fact that it's a person's choice to be a certain size, I don't think it is a job [for planners].* (FG1)

- This reveals that an emphasis on the built environment alone does not necessarily negate a conceptualisation of obesity as the 'fault' of the individual. There is a clear need for more critical planning education to encourage students to think about health in ways that challenge these stereotypes.
- There were some isolated examples of inter-professional training for planning and health students, however, these were few and far between and university structures such as timetabling, staffing, budget areas, etc meant that these often didn't run for long.

3. The role and responsibility of the planner

- As outlined in point one above, many planners see healthy urban design as 'good design'. However, when it comes to obesity, planners identify significant limitations to their responsibility, including: existing infrastructure, competing planning imperatives and the need for cross-departmental working.
- Competing planning imperatives are important. Sustainable development and economic development have greater regulatory weight than health. In some instances there are productive overlaps but in others, these imperatives detract from health (particularly economic imperatives). Particularly in the case of exploiting intersections with sustainability, this skews a focus on health to be a focus on issues of active transportation:

Example: Exploiting intersections with sustainability

I think it's trying to show that compatibility or inter-dependence at each point in that, in those stages, so that in terms of demonstrating the health problems and concerns in the strategy early stages of sustainable community strategy, getting that then articulated in the local development framework, but in the sense that demonstrating that it is about achieving sustainable, other sustainability objectives as well as the health benefits is part of the trick (N1)

- Several planners raised issues about challenges in the translation of plans into the built infrastructure, particularly where these were implemented by private housing developers:

Example: Buckshaw village

when we planned it we had a sort of central spine that would begin to link different residential neighbourhoods and different parts of the development back to the railway station. …that's kind of survived in the layout but not in the way that we saw it back in the mid 90s. But that was important. …I think the developers want slightly more informal, we had quite a formal grid and grids I think are probably, if you're navigating your way through a development or through an area or a neighbourhood, grids are probably the best way of doing it. They've taken what they called an informal street approach …So it's very winding and it's kind of an odd 45 degree offset road arrangement, which actually makes it quite difficult to find your way around…. so I think we've lost a bit of legibility through that, but that was the way the developers wanted to approach it. (Cass Associates)

4. Policy in practice

- There is little community consultation in relation to obesity and planning.
- There is a wealth of guidance on the periphery of health and urban design/planning (see appendix 4), but there is little direct guidance. This meant that many planners are cautious about acting in response to government imperatives to design 'healthy cities' when the evidence is limited.
- In the absence of direct regulation or guidance, those with a commitment to delivering health as part of planning practice reported that local authority tools such as Joint Strategic Needs Assessments (JSNAs) and Local Authority Core Strategies provide routes to get health into practice. There were mixed opinions about the use of Health Impact Assessment (HIA) tools and

many were sceptical about the usefulness of these, particularly given the time and cost involved.

- Good practice models were often drawn on by public health respondents. However, for planners, these cannot easily be applied to existing built, social and political infrastructures.

Example: Good practice models:

the comparability I think is always the major issues, and it's finding those comparators … sometimes it's very difficult to find comparators, and some of the closest comparators are not very useful in terms of some of the, … If we look at some of the Northern European, the Benelex countries, there is stuff we can really learn a lot from and some of the Scandinavian countries, but what has always been of interest to me is where their starting points were, and their starting points weren't as far back as ours. So Germany's a good comparison because it shares a similar industrial heritage as a sort of base, and they struggle with a lot of the same issues, because they stand out, I mean if you go, I mean you probably know this already, but it stands out in terms of like you know, if you compare it to countries like Belgium and Holland or France even, then you're looking at disproportionate car usage in Germany, and a more of a reliance on a similar road system in the UK. And I think that is you know, because it's industrial based. (M3)

- Planners reported that healthy urban design requires collaboration with public health colleagues. In particular, the evidence provided by public health colleagues was seen as important to help emphasise the necessity of elements of design included for health reasons, particularly if there might be the need for legal action to challenge non-compliance with those elements of planning approval.
- However, cross-disciplinary working presents many challenges. Most notably, public health colleagues often have unachievable expectations about what planning can achieve and don't recognise competing planning imperatives.

Example: Unrealistic expectations

And certainly when it comes to things like weight and obesity, some of the kind of, we've gone through a process of people actually saying this is a solution, rather than going through a process of saying well what are the problems, what are the issues, how well are we addressing it? What solutions could we identify? What's the best solution? Some of our health colleagues have said well for example if only planning had a policy on takeaways then they could identify you know kind of ban takeaways from being sited near schools, that would solve all our weight and obesity issues .... Of course it's not quite as simple as that. So we've gone through a process of trying to work with people to decide, to kind of think a little bit more smartly about it, and what we've done is we've done a kind of review of all the core strategies … Working with our health colleagues, we've defined what those priorities were, and we've tried to get the planners to match the core strategies against the health priorities to look at how well planning is addressing health. (M4)

- Further issues were raised about the long timescales in planning processes which often mean that by the time developments are realised, they are out of line with more recent planning imperatives:

Example: Edge Lane, Liverpool

If you look at the Edge Lane run in, there's not many cycle paths in there, there's not many walkways, you know, we've got a little bit of furniture if you like, you know park bench, but there's nothing much. So personally I think we've missed a big trick. I mean again looking around the Strand at the front, …where Albert Dock is, there's no pathways there as such crossing the road, you know, you've got general pedestrian crossings, but it's not been pedestrianised anywhere, there's no cycle routes you know, it's very much traffic centred rather than pedestrian centred. (L4)

- Problems were also reported concerning the challenges of working with private developers who are market-driven and therefore limited in their appreciation of the wider benefits of particular design elements.
- Limited regional coordination was also seen as a problem, particularly in the case of transport policy within a region such as the North West where significan populations move across administrative boundaries during their daily routine. A move away from localism was seen by some to be necessary to facilitate a focus on 'end to end' journeys however (as detailed below) this is counter to the direction that national policy is moving in. Some planners also felt that there was little they could do here because the routes (whether road or rail) across local authority boundaries are controlled by national agencies or private companies:

Example: Regional movements

I mean in terms of you link it with other cities then there's probably not a great deal we can do to influence that, because you are talking about the, well the Highways Agency effectively control the trunk road network, you've got things like the high speed rail link, Liverpool to Manchester, which will obviously assist. But they're more sort of your regional movements, more sort of national importance. (L3)

5. Political change

- The coalition government has maintained a focus on the built environment in policy on obesity and this fits broader political agendas e.g. 'nudge', however, because of the time during which this research took place, much of the detail was uncertain:

Example: Administrative change

because it is a new administration, the actual … language, …their interpretation and presentation of appropriate measures and response may have a different balance to them. And certainly there are other messages that is around a more sophisticated approach to behaviour change…. it's unfolding, … but I, you know our understanding is that issues that, you know the longstanding major health, health and lifestyle issues are understood, the extent to which they see whether that is a personal responsibility and the emphasis on behavioural approaches, or whether it is about systems change and environmental change. Certainly there's a hint and … part of the localism agenda will be local authorities taking that forward. (N1)

- Local authority restructuring has derailed many existing projects. The integration of PCTs within local authorities might facilitate cross-disciplinary working, however, relaxation of planning laws

may mean that healthy/good design is overlooked and cuts to staffing leave fewer people to deliver on health policies:

Example: Loss of Staff and Resources

there's less of us here to do it. I've got a crime and disorder team which is sat around here now that's going down from forty posts to five…. I've got a PCT function that is being decimated and split across three practice based commissioning, which is the forerunners to GP consortia in Manchester. … Their operating costs are roughly half what the current PCT's operating costs are. So it doesn't take a genius to work out that there ain't going to be that many of us left about. (M3)

- The localism agenda was particularly seen as problematic in dismantling the infrastructure for regional coordination:

Example: Localism

Well the whole sort of regional level of doing things is being dismantled by the new Govt. I think there was some reference in the kind of regional level planning documents to health and planning, but the status of that is now quite unclear….Because the Govt's said it's going to get rid of it. … So that, no at a regional level, no there isn't a great deal. (SL3)

E. Recommendations

This project did not aim to evaluate the success of any one intervention, rather it sought to explore the ways in which planners in the North West of England are responding to calls for them to 'design out' obesity. As such the recommendations we make here should be read with this context in mind.

The recommendations we present here are intended as suggestions for how policy and education might better reflect the complexity of approaches and the contested knowledges that surround planners' approaches to the imperative to design out obesity than currently is the case.

Recommendation 1: A broad understanding of health is vital

The planners involved in this project tended to conceptualise health in broad terms, not just body size, but as an issue of social justice, equality and as integral to good design principles. In this context, pushing planners to specifically focus on one issue (such as obesity) may be counterproductive to an aim to improve health since the association of fatness with inactivity means that there is little support for bigger bodies who want to be active in public space and this reinforces the stigmatisation of fat bodies. We therefore recommend that planners are encouraged to continue to use such broad understandings of health and that engaging with Health at Every Size principles might better enable planners to marry these broad approaches to obesity policy. Such an approach would allow planners to consider the needs of larger bodies at the same time as designing spaces for health. Integral to this is challenging stereotypes about fat bodies as part of planning education.

Recommendation 2: Interdisciplinary/inter-professional education is vital

Planners and public health professionals are increasingly asked to work in collaboration with other professionals. This brings significant challenges yet there is little inter-professional training pre-

qualification. We therefore recommend that University and CPD structures need to be more flexible to allow for collaborative training that is on 'equal' terms – ensuring that planning students are confident that their own specialist knowledge is as important as medical knowledge in the partnership to ensure that there is no 'medical imperialism' in this relationship.

Recommendation 3: Local context is important but further regional coordination is needed

Anti-obesity policy often uses 'good practice' models from elsewhere to exemplify good urban design. However, planners' experiences reveal the importance of local context and the difficulty in transferring such 'good practice' models. We therefore recommend that rather than seeking best practice models, policy needs to better work with local policy and built infrastructure contexts. Secondly, regarding public transport, 'end to end' journeys are important in planners' work. This necessitates thinking about mobile bodies that often cross administrative boundaries. However, there is currently little coordination between local authorities within the NW region and this is made more complicated by the fragmented nature of public transport provision. The removal of regional tiers of governance (e.g. the NWDA) by the coalition government has removed some of the infrastructure which would make this possible. However, we recommend that more coordination at regional level is necessary.

Recommendation 4: Demonstrating heath benefits is important but this must not restrict good practice

There is increasing pressure placed on planners to demonstrate the efficacy and value of interventions that aim to design healthy spaces. However, tools which attempt to reduce health to a specific set of indicators conflict with the broader and more holistic understandings of health that many planners adopt. We therefore recommend that care needs to be taken not to use reductive indicators in accounting for the 'success' of planning for health initiatives (e.g. BMI as 'evidence') in ways that may be harmful to broader understandings of health and wellbeing.

Appendix 1: Full list of themes

Meta Theme	Theme	Code
Concepts of health	Evidence/sources of information	Students sources of info/interest = media Uncertainty in evidence (obesity not simple proxy for health) Fat not necessarily inactive
	Process/aims of planning	Target is prevention (not targeting existing obese people) Health service provision vs health promotion Community consultation Problematic to design for fat bodies (condoning fatness) Designing for fat bodies - necessary to consider fat bodies' needs
	Definitions/understanding of health	Broad def. of health - wellbeing rather than obesity Individual choice to be obese vs. built environment Not designing out fatness / environmental determinism - providing choice Complex causes but simple solutions Focus on physical activity rather than body size/obesity Evolutionary discourse Health not separate module but should be taught throughout Confidence / self-esteem important Aspirations/ culture Stigma and representations and language Aesthetics
Education/training	Course content	Historic context, less contemporary emphasis on health Health not separate module but should be taught throughout Health in student specialist options/dissertations No explicit health content Health taught because there's someone with a specialism in health Developing students critical thinking rather than emphasis on regulations Taught as part of broader responsibilities of planners

	Regulations / external training	RTPI regulations inform teaching content, no health content A lot to cover in a year - intensive course not much space Education network CPD important
	Inter-professional education	Interprofessional training Uni structures make cross-disciplinary teaching difficult
Policy intersections	Economy	Regeneration / economic considerations core contemporary planning concern / market forces important Deprivation/class/inequalities RTPI focus on econ dvt Economic benefits of walkable envts Health an issue of social justice Links to employment strategies Rel. with developers Role of / relations to private sector New government cuts
	Sustainability / climate change	Relationship with sustainable development HIA should be in EIA More important issues - climate change RTPI focus on climate change Transport (incl active travel)
	Other	Legacy of sporting events Green space provision Mental health Food availability/fast food regulation Health part of street design and walkability Disability (incl. conflicts) Crime and safety concerns Mixed use Linkeages / overlaps in policies planners expected to deliver Fast food Cost of leisure facilities

Boundary crossings	Interdisciplinary working	Timescales - divergence between public health and planning Public health's unrealistic expectations of planning Cross-dept working /partnerships Planning knowledge impt in cross dept working Role/responsibilities of planners
	Relations with private sector	Conflicts/relationships with developers Role of / relations to private sector
	Cross-regional working	Connects to localism agenda and lack of regional coordination Cross-region working
	Good practice models	International best practice models used / internation comparisons made Context specificity (and probs with best practice models) Culture Weather (problem for UK)
Guidance and regulations	Measures, guidance and regulation	Measurement (incl. problems with BMI) BMI not good measure - physical activity better Impact assessment Translation of evidence into policy National / international guidance / schemes (RTPI / healthy cities) Role of regulation / lack of
	Local governance	Health within local govt regulations / governance procedures (e.g. LDPs, JSNA, core strategies etc) Reflections on localism agenda / shift in local authority structures
	UK politics	Political willingness Behaviourism / nudge Impact of the cuts

Appendix 2: Participant information sheet

Designing Out Fatness: The Built Environment in Anti-Obesity Policy

Background

Obesity policy in the UK is increasingly concerned with so-called 'obesogenic environments'. The Department of Health has therefore called for planners to 'return to their public health roots' to design 'healthy spaces' which will ensure bodies within those spaces are active, healthy and thin. This is part of a broader attempt to ensure the health and safety of future populations through the design of sustainable communities, requiring planners to consider issues such as crime and terrorism, sport and physical activity and climate change.

However, there is significant uncertainty in the 'science' surrounding obesity and a particular lack of evidence about 'what works' when attempting to 'design out' obesity. What evidence there is, suggests that what works in one place may not work in another. Planning professionals are therefore being placed in a difficult position, asked to incorporate health into their practice, with no consensus on how to do this or appropriate training offered. Previous research on the role of teachers in health initiatives has indicated that this uncertainty often results in a lack of professional confidence and a reliance on stereotypes about body size and health. Given that planners, like teachers, are not 'health experts', it is important therefore to investigate how planners resolve the imperative to act now with the lack of evidence about what works. Rather than attempt to establish the effectiveness of one intervention, this research therefore investigates planners' knowledge of, and response to, calls for them to 'design out' obesity.

Research aim and objectives

- To investigate the role and responsibility of the 'planner' (including planning-related professionals) in policy strategies to tackle obesity.
- To generate new empirical data on the implementation of policy guidance concerning health and the built environment (specifically regarding obesity) in local authority practice.
- To advance theoretical understandings of the relationship between bodies, health and place.
- To evaluate planners' knowledge of the role of the built environment in relation to health and make recommendations for Continuing Professional Development needs.
- To pilot research design and methodology and establish the feasibility of a larger scale European research project to consider different national responses to the role of the built environment in health interventions (using case studies from the European Healthy Cities Network).

Methodology and case study locations

At the national level, the research will involve analysis of national policy documents, interviews with national policy makers and advisors involved in developing guidelines relating to the built environment and health, telephone interviews with programme leaders of RTPI accredited planning courses and an online survey of newly qualified planning professionals. The research will then focus in more detail on three case study locations within the North West region: Manchester, Liverpool and South Lancashire, and will consist of interviews with key planning professionals and local policy makers and participant observation at any community consultation meetings.

Project team

This project builds on the investigator's recent work examining the geographies of obesity policy in the UK and the role of built environment professionals in sustainable communities policy. It is funded by the Economic and Social Research Council. The 'Designing Out' project will also involve an advisory group consisting of local authority planning and health professionals, representatives from national advisory groups and private built environment planners.

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Web page: http://www.dur.ac.uk/geography/research/research_projects/designing_out_fatness/

Appendix 3: Consent form

STATEMENT OF INFORMED CONSENT
AND PERMISSION TO USE INFORMATION

Project: Designing Out Fatness: The Built Environment in Anti-Obesity Policy

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Information:

The purpose of this agreement is to ensure that your contribution to the above research project and any subsequent usage is in strict accordance with your wishes. You may withdraw from the project at any time.

This project 'Designing Out Fatness' is being conducted by research teams at Durham University and The University of Birmingham. It is funded entirely by the Economic and Social Research Council (ESRC).

Please see the information sheet provided and the project website for more information. All data will be treated as personal under the 1998 Data Protection Act, and will be stored securely.

Interviews will be recorded by the research team and transcribed by an independent transcriber who has signed a confidentiality agreement. Data collected may be processed manually and with the aid of computer software.

A copy of your interview transcript will be provided, free of charge, if you wish to see it.

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1. USE OF INTERVIEW DATA FOR THIS PROJECT

If you are happy for us to quote your words in publications, please indicate below whether you are happy to be identified or if you want to remain anonymous. Please tick ONE of the following boxes:

I am happy for my words to be quoted in publications and am happy for my name and/or my employer to be revealed (please delete as appropriate). ☐

I am happy for my words to be quoted in publications but request that my name and my employer remain anonymous. ☐

In order to include your words in reports and publications, we need copyright:

I hereby assign the copyright in my contributions to Dr Bethan Evans and Prof. Jon Coaffee (Research Investigators). ☐

PTO

2. DATA STORAGE AND USE BY OTHER RESEARCHERS

We would also like to make an ***anonymised*** transcript available on the UK Data Archive so other researchers can use the information you provide in their research.

If you are happy for us to do this please read through the following and indicate your consent or not:

Please tick if you agree to the following:

I agree for the transcript of my interview to be archived at the UK Data Archive. ☐

I understand that other researchers will have access to this data only if they agree to preserve the confidentiality of that data and if they agree to the terms I have specified in this form. ☐

I understand that other researchers may use my words in publications, reports, web pages, and other research outputs according to the terms I have specified in this form. ☐

OR

I do NOT give consent for the transcript of my interview to be stored in the UK Data Archive ☐

Signed ……..…… Date ……

Please print your name ……...

Organisation ……..

Appendix 4: List of other relevant guidance

The list below is a (by no means comprehensive) list of relevant guidance which, whilst not explicitly being about obesity and planning, touches on these issues:

- RTPI Policy Statement on Health and Spatial Planning (2007) and Good Practice Note on Delivering Healthy Communities (2009)
- Future health: Sustainable Places for Health and Wellbeing (CABE, 2009)
- Community Green – using local spaces to tackle inequality and improve health (2010)
- Plugging Health into Planning: evidence and practice (LGID, 2011)
- Steps to Healthy Planning: Proposals for Action (SPAHG, 2011)
- Green Infrastructure Guidance (Natural England, 2009)
- Health-Proofing Masterplan Designs: A Guide (Stoke-on-Trent Healthy City Programme, 2010)
- Guide to the NHS for Local Planning Authorities (NHS, 2007)
- Active Design guidance (Sport England, 2007)
- Planning for Health in London - The ultimate manual for PCTs and Boroughs (HUDU, 2009)
- Building Health: Creating and Enhancing Places for Healthy Active Lives (National Heart Foundation, 2007)
- Health, place and nature - how outdoor environments influence health and well-being (Sustainable Development Commission, 2008)
- A guide to town planning for NHS staff (DH, 2007)
- Involvement of PCTs in Sustainable Community Strategies
- Joint Strategic Needs Assessment
- Healthy weight, healthy lives (DH, 2008)
- PH8, Promoting and creating built or natural environments that encourage and support physical activity (NICE, 2008)
- PH17, Promoting physical activity for children and young people (NICE, 2009)
- The Marmot Review: Implications for Spatial Planning, 2011
- NICE Spatial Planning for Health evidence review work, 2008-10 (now discontinued)
- Active Travel Strategy (DH/Dept for Transport, 2010)

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