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A Healthy Relationship

Public health and transport collaboration in local government

Researched and written by Dr Adrian Davis, Adrian Davis Associates

This report was commissioned by ***pteg*** and researched and written by Dr Adrian Davis of Adrian Davis Associates.

The Passenger Transport Executive Group (***pteg***) represents the six strategic transport bodies which, between them, serve more than eleven million people in Greater Manchester (Transport for Greater Manchester), Merseyside (Merseytravel), South Yorkshire (SYPTE), Tyne and Wear (Nexus), the West Midlands (Centro) and West Yorkshire (West Yorkshire Combined Authority). ***pteg*** is also a wider professional network for Britain's largest urban transport authorities.

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01 Project purpose

April 2014 saw the first year anniversary of public health teams moving into top-tier local authorities. It was hoped that the move would promote more local cooperation between public health and other sectors, including transport, and that this collaboration would be championed by Directors of Public Health (DsPH).

Through an England-wide survey of DsPH and follow-up interviews, this study investigates whether or not public health and transport are working more collaboratively in different areas of the country since public health teams moved into local authorities. It also seeks to identify any barriers to closer collaboration as well as provide examples of good practice that other local authorities can learn from as they seek to improve collaboration between transport planning and public health.

02 Background

Twenty one years ago road transport was described as a hidden health issue.[1] At this time collaboration on transport and health was extremely rare beyond acute events, principally concerning road traffic injuries and air pollution.[2] The European Healthy Cities movement, started in the mid-1980s by the World Health Organisation (WHO), has been identified as being a key enabler for public health and other practitioners in providing legitimacy for issues including transport planning as well as climate impacts to be articulated at the local level.[3] By 2000 research into transport planning and health impacts had developed sufficiently for the WHO the to be able to report that the greatest disease burden from road transport was likely to be from physical inactivity since growing car use was substituting previously active travel with sedentary travel and with no increase in other physical activity participation to compensate for this loss.[4]

Despite efforts to highlight the links between transport and health in Europe over the past decade plus,[5,6,7] there remains little research to demonstrate how it has been received and acted upon at the local level, not least in England.[8] Three previous studies have, however, produced findings of relevance to this research.

Firstly, a survey of both transport authorities and public health Directorates in Primary Care Trusts (PCTs) in South West England was conducted in 2002.[9] At this time the focus was particularly on Health Improvement Plans within the then new PCTs and their inter-relationship (or lack of) with Local Transport Plans (LTP) in order to attempt to strengthen links between the two sectors. On-going links with PCTs were reported to be in place in 73% of the responding transport authority areas in the South West although responses from PCTs were low, probably, the author noted, due to transition at that time in England from health authorities into PCTs.

Next, in 2007, a survey addressing PCT promotion of cycling noted that most PCTs (60%) had worked on their Local Transport Plan although cycling did not seem to be high on PCTs' agendas.[10]

Lastly, in 2012 Sustrans undertook a survey of DsPH.[11] This survey found that while some public health teams in England did collaborate with their transport planning colleagues through significant engagement in major transport policy and practice initiatives, the majority appeared not to have achieved such a level of collaboration. It consequently recommended that future transport funding bids and investment planning decisions, such as ongoing work on LTPs, should involve public health from director level down, and that the Plans should specifically address and commit to measure progress towards public health as well as transport objectives – perhaps via the Joint Strategic Needs Assessment (JSNA).

In April 2013, as a result of the Health & Social Care Act (2012), local public health directorates in England were placed within top tier local authorities (i.e. those with highway authority functions). PCTs were abolished and replaced by Clinical Commissioning Groups. In theory, this move which 'returned public health to local government', where the public health function was until the 1974 NHS re-organisation, provides public health practitioners with increased opportunities for collaboration with colleagues from professions such as transport planning, housing, education etc. and enables public health to better address the wider determinants of health such as poor housing, education, and transport systems. The main mechanisms to foster local joint working include the development of joint strategic needs assessments and health and wellbeing strategies.[12] Thus, this survey of DsPH 18 months after the return to local government can provide some valuable insights into whether collaboration on transport and health has increased, and if so, to explore in which ways.

03 Scope

This research has been carried out by public health and transport specialist, Dr Adrian Davis of Adrian Davis Associates, with support from Dr Tom Ellerton and Rebecca Fuller of ***pteg***. Dr Davis has particular insights to local highway authorities, firstly having had an embedded part-time post within Bristol City Council's transport team since 2008, funded by Public Health. Secondly, he is a training provider to these professions in developing and sustaining effective collaborative working, with 30 years' experience from across the UK, and mainland Europe.

The project has surveyed all DsPH in England, in order to ascertain views about how high a priority they place on the health impacts of road transport, levels of collaboration with transport colleagues both pre April 2013 and since, issues such as data sharing, joint funding, as well as barriers to effective collaboration. In addition, through the survey a task has been to uncover good practice examples and local variations in the extent of collaboration. Questions were generated drawing on insights from previous surveys and knowledge as to the varying levels of collaboration likely to be occurring across England. In this way, the survey provides a cross-sectional snap-shot of the state of collaboration between public health and transport planning teams in local authorities as of late autumn 2014. The survey questions were drafted to try to capture the wide variations that there may be between different local authorities.

The survey has been followed by interviews to further draw out good practice examples and explore responses in greater depth. Case studies that are most relevant and transferrable to different transport authority types (Metropolitan, Non-Metropolitan, and London Boroughs) have be prioritised for further exploration.

The survey, interviews and subsequent analysis include consideration of:

- The priority given to the health impacts of transport by public health teams and the extent to which transport features in local public health plans, strategies and discussions.
- The extent to which public health teams have been involved in the development of local transport plans.
- Strength of relationships between transport and public health before and after public health teams moved into local authorities.
- Any jointly funded projects or initiatives between public health and transport.
- Any data sharing between public health and transport.
- Any embedded or co-located roles - either from public health to transport or vice-versa.
- Any joint training undertaken, planned, or being considered between public health and transport.
- Identification and exploration of any barriers to collaborative working and how these might be overcome.
- Identification and exploration of good practice examples.

04 Methodology

An online survey (using Survey Monkey) has been used to provide the most cost efficient and time effective means of reaching DsPH. It is acknowledged that a DsPH may have asked for the survey to be completed by a member of their team but for the purposes of reporting we discuss results as if all responses received were from DsPH.

pteg has sought to increase the response rate by an endorsement for the research from the Vice Present of the Faculty of Public Health (FPH). The cover text used to accompany the survey invitation can be found at Annex A. Almost all DsPH are members of the FPH. A further effort to increase the response rate was through the Association of Directors of Public Health (ADPH), which included a link to the survey in one of its mailings in November to DsPH.

Eight questions offered the opportunity to provide additional free text responses. This has provided rich qualitative data to augment the quantitative data. The survey has been followed by interviews with six of the responding DsPH where survey responses suggest good practice in collaboration between public health and transport. The interviews and text provided further drew out good practice examples, exploring responses in greater depth.

The survey was piloted and then issued in late October 2014 and analysis was undertaken commencing 24th November when the survey was closed. The survey is included in Annex B.

05 Analysis

There were a total of 43 responses to the survey although not all questions were answered by each respondent. We therefore provide the absolute response number to each question. Segmented by authority type in absolute numbers Non-Metropolitan authority DsPH (i.e. Shires and Unitary authorities) provided the greatest number of responses and London Boroughs the least, as shown in Table 1.

Table 1: Responses according to authority type

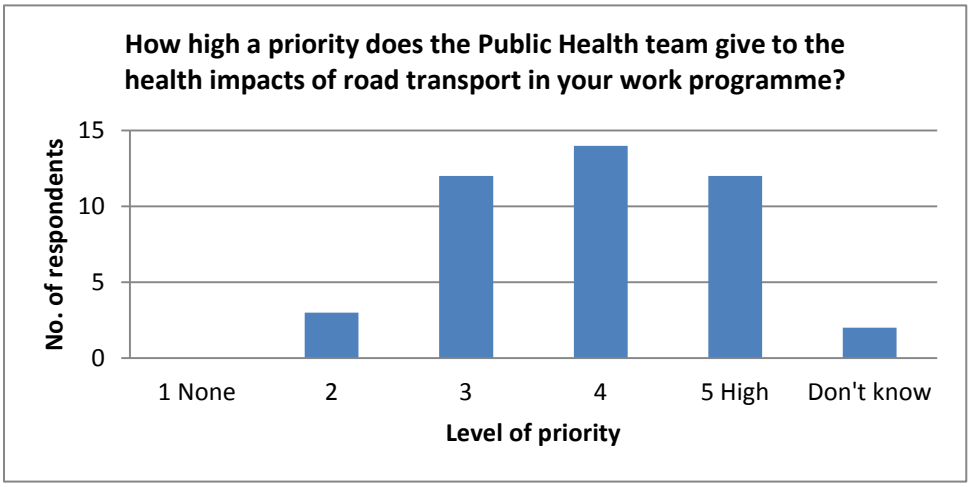
Authority Type	Number
Non-Metropolitan authorities	21
Metropolitan authorities	9
London Boroughs[13]	6
Not stated or identifiable	7

From the eight questions offering the opportunity to provide a free text response there were, in total, 193 free responses giving information to augment quantitative data provided. This has enabled a much richer analysis of the topic than otherwise could be provided by quantitative question responses alone.

Transport planning and public health priorities and strategies

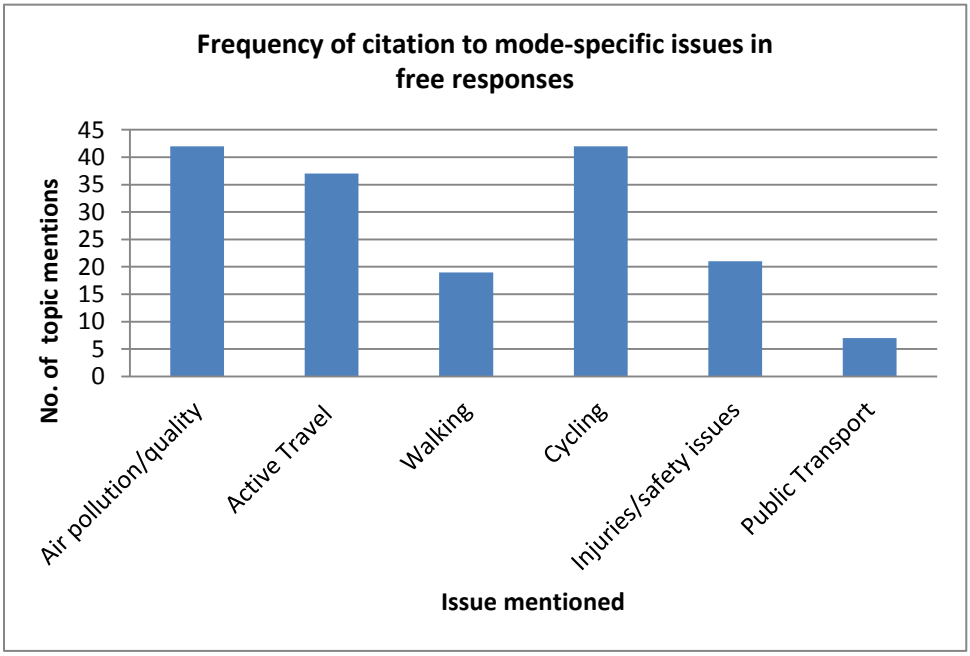
The survey commenced from the more general to specific issues. The first question was: ***How high a priority does the Public Health team give to the health impacts of road transport in your work programme? (e.g. in respect of physical inactivity, air quality, traffic injuries).*** From Graph 1 we can see that among respondents most DsPH give a middling to high priority to the health impacts of road transport in their work programme. The level of priority is very similar across all authority types, being slightly lower in London and in the Non-Metropolitan authorities. However, the differences are small.

Graph 1 Priority given to health impacts of road transport in Public Health team work programmes



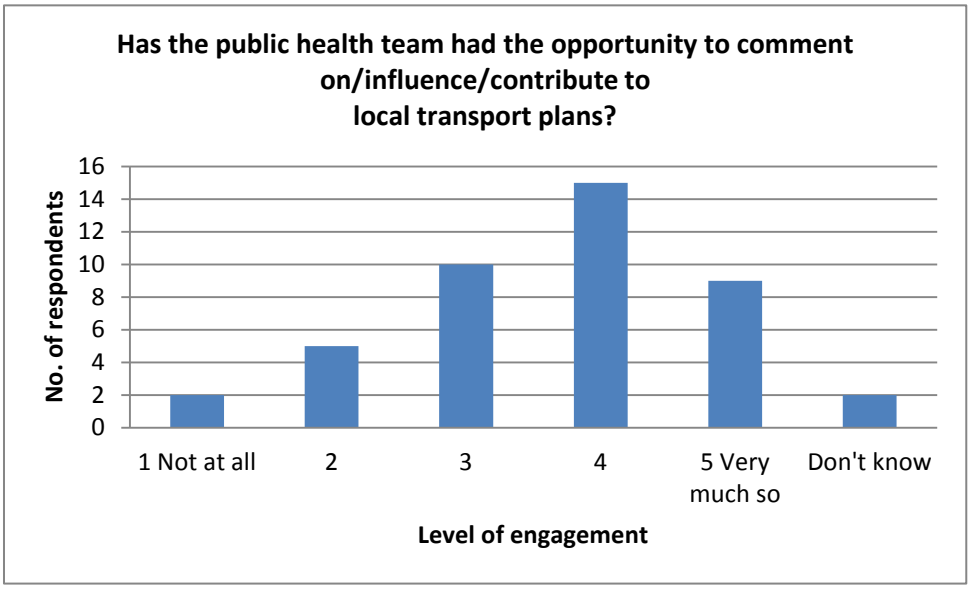
Through a contents analysis, the areas of transport planning which the DsPH most frequently referred to include a range of mode-focused issues. However, the single biggest issues by citation are air pollution/quality (42) and cycling (42) although when the latter is combined with specific references to walking and active travel these collectively dwarf references to other issues (121) – three in five of all citations. The next most cited area relates to road traffic injuries and issues relating to road safety risks e.g. speed (20). This is illustrated through the graph below.

Graph 2 Key issues as mentioned most often by respondents



There was a more mixed response to the question ***Has the public health team had the opportunity to comment on/influence/contribute to local transport plans?*** This does suggest some significant signs of progress in collaboration with fifteen respondents scoring '4' and nine scoring '5' on the five point scale where '5' is 'Very much so' and '1' is 'Not at all' (Graph 3). Level of opportunity to comment on transport plans increases as the level of priority given to transport by public health teams increases. There is very little difference between local authority area types.

Graph 3 Commenting on/influencing of local transport plans by Public Health



It is through the 27 free responses given that we can see the range of opportunities to comment on and influence local transport plans. Some comments were general in their explanations or suggested little activity to influence local transport plans, such as:

> *"We have regular meetings with transport colleagues."*
>
> *"Not as much yet as we hope to achieve. Some of this is still about settling in to the Council and developing optimal working relationships."*
>
> *"Comment yes, but to date without achieving any significant change."*

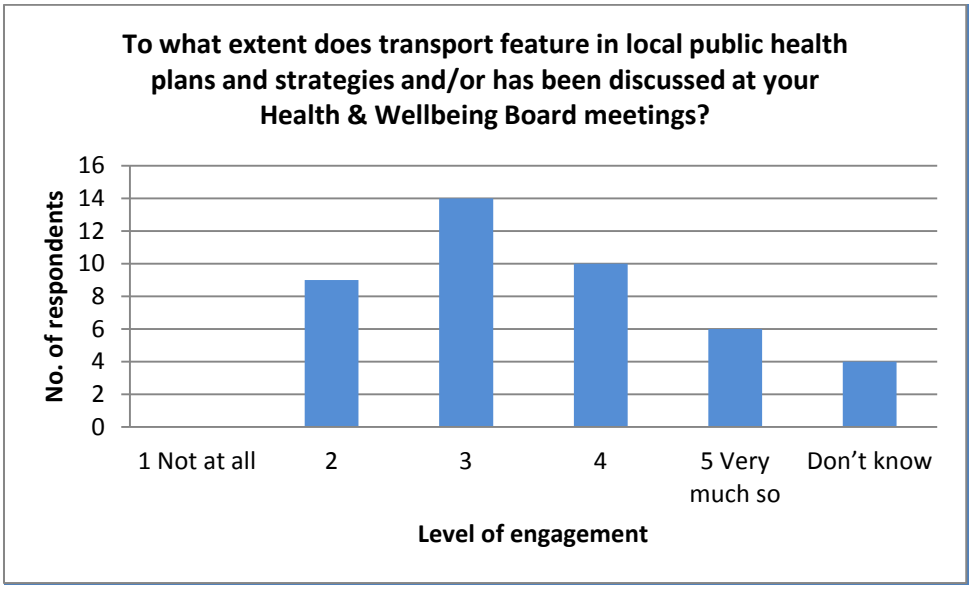
Other comments were more specific and detailed, often indicative of greater collaboration levels with transport planning colleagues:

> *"We are working together on a canal strategy, signage, travel to work and low emission vehicles."*
>
> *"Yes and we have now established a specific work programme on wider determinants including developing Health Impact Assessment capacity and taking Health In All Policies approach across LA and Districts"*

"Funding for active travel, delivered by the Public Health team has been transferred from the local sustainable travel fund. The LSTF extension fund focussed around air quality. This was supported by the DPH and is used to address pockets of poor air quality as identified in the JSNA."

Looking at the extent of collaboration in detail in terms of transport issues penetrating into public health work, responses to the question ***To what extent does transport feature in local public health plans and strategies and/or has been discussed at your Health & Wellbeing Board meetings?*** suggest that transport planning issues have largely yet to impact public health plans and strategies or significant public health decision-making forums. This is illustrated in Graph 4. It is of note that the extent to which transport features in health plans/strategies/discussions is only high when the priority given to work on the health impacts of road transport is high (bar one case).

Graph 4: Transport featuring in public health planning work



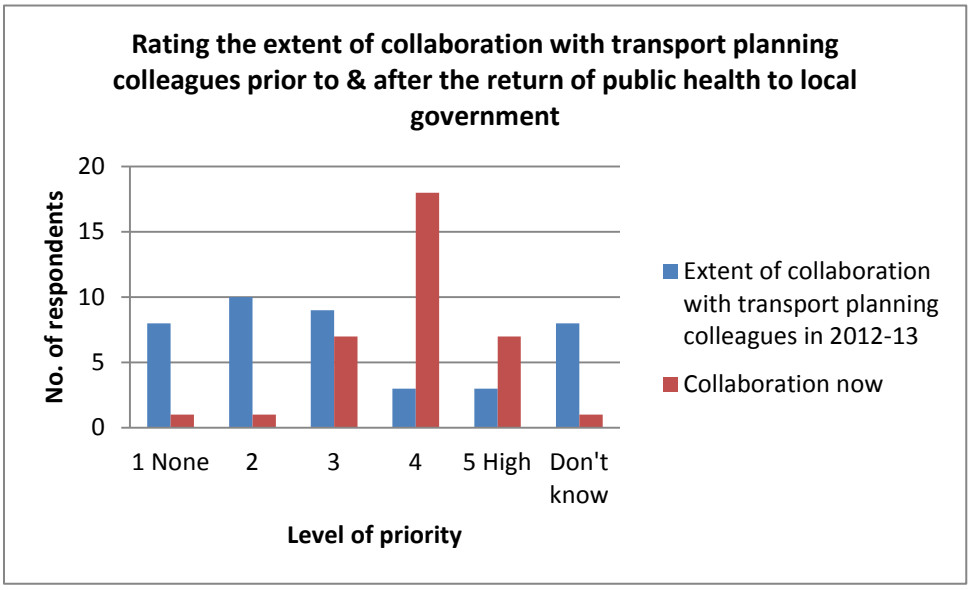
The level to which transport features in local public health plans and strategies and/or has been discussed at Health and Wellbeing Board meetings is on average 4.2 in London, 3.4 in the Metropolitan authorities and 2.7 in the Non-Metropolitan authorities.

Collaboration before and after public health's move into the local authority.

Given that public health has returned to top-tier local government after almost 40 years, and at a time of increasing budgetary austerity, it is highly pertinent to ascertain views as to whether the extent of collaboration with the transport planning department has changed pre- and post-return, according to the experiences of each DPH.

The survey asked two inter-related questions Firstly***, In 2012-13 prior to public health's return to local government, how did you rate the extent of collaboration with your transport planning colleagues?*** Secondly, ***How do you rate collaboration with your transport planning colleagues now?*** The result is that there has been a significant shift towards greater collaboration with transport planning colleagues.

Graph 5 Changes in levels of collaboration with transport planning colleagues pre and post return of public health to local government



As Graph 5 suggests, most respondents feel that there has been an improvement. Where '1' is no collaboration and '5' is high levels of collaboration, reflecting back to prior to the move, eighteen DsPH answered '2' or below for collaboration whereas only two did for the situation as of late autumn 2014. Furthermore, prior to public health's return to local government, only six DsPH rated collaboration as '4'or '5' compared to 25 post-return to local government.

The average rating for collaboration has increased from 2 to 3.5, showing a significant shift from 2012/13 to autumn 2014 towards more collaboration with transport planning colleagues across the respondent DsPH.

Where people answered '1' (i.e. no collaboration) for 2012-13 (prior to public health's return to local government), the average answer is now 2.75. This is the largest increase of any group suggesting that progress is being made in the places with the lowest levels of collaboration. The biggest change has been in London, where the average level of collaboration has increased by almost two (from 1.7 to 3.5). In the Metropolitan areas and non-Metropolitan areas the average level of collaboration also increased, by 1.2 and 1.5 respectively. If the findings here hold true across England it could be said that even in a period of austerity, returning to local government has enabled public health to work more collaboratively with transport planning.

Analysis shows that the average level of priority given by public health to the health impacts of road transport is slightly higher than the average level of collaboration. This suggests that there could be unmet demand from public health for greater joint working with transport colleagues. This is underlined by the very strong correlation suggesting that the better collaboration is rated, the more chance there is that public health teams have had the opportunity to comment on local transport plans.

Exploring collaboration: Jointly funded projects

One outcome of increasing collaboration could be increasing jointly funded work programmes, among other initiatives. In answer to the question: ***Do you collaborate with transport colleagues on any projects or initiatives which are jointly funded by transport and public health budgets?*** 24 DsPH said 'yes' while another fifteen said 'No' and two said 'Don't know'.

On average almost two-thirds (62%) of public health and transport planning teams in local authorities are collaborating on jointly funded projects or initiatives. In the Metropolitan areas 78% of respondents report collaborating on jointly funded projects compared to 55% in non-Metropolitan areas and 50% in London.

There were 24 free responses and a sample of these are given to reflect their breadth:

> *"Not direct resource allocation but Healthy Schools is funded by Public Health and used as a tool for transport colleagues."*
>
> *"Cycle strategy, general physical activity budget and obesity budget in Public health to support their/joint work."*
>
> *"We will be. Some of PH allocation will be used on transport projects. Appetite to implement 20's Plenty."*
>
> *"These relate to active travel programmes that encourage walking and cycling to school, work and leisure. We are also increasing investment in air quality monitoring where it relates directly to transport related air pollution."*

"Road traffic injuries and deaths - campaigns and school interventions. Also includes some school active travel interventions."

From these and other responses it is clear that there are some joint funding initiatives taking place within some authorities while for others there exists intentions to establish some.

Exploring collaboration: Data sharing

A specific form of collaboration is through data sharing and there is potential for greater intelligence if more data can be shared across local authorities. In response to the question ***Is there any data sharing between public health and transport planning in your area?'*** 28 DsPH out of 41 respondents (three in four) reported that there is data sharing, eight said there was no data sharing and five did not know. Data sharing is highest in London where the figure is over four in five respondents share data. Perhaps unsurprisingly, where DsPH gave a priority level of '2' or below to health impacts of road transport there was no data sharing. With the majority of DsPH responding that there is data sharing this may signal that as conversations and collaboration commence or develop the opportunities for data sharing are expanding. There were an additional 24 free responses and the range is illustrated below from current frustrations about a lack of data sharing to jointly commissioned work.

"Not yet. Request repeatedly."

"We have shared the relevant PHOF[14] indicators with transport colleagues. We are exploring obtaining transport data in order to inform our forthcoming Annual Public Health Report."

"Joint data report on road traffic injuries and deaths. Also discussing shared indicators for active travel and physical activity."

"The data has been used to inform the advice given by public health teams to transport teams. A process has started to ensure this information feeds into the JSNA."

"We have commissioned joint modelling on the health impact of transport that did an economic assessment."

"Data sharing as in prevalence of morbidity and lifestyle behaviour / prevalence/demographic and post codes to align programme development and to support bids to such as Centre, LSTF programmes etc."

The question also asked whether data sharing had informed the JSNA. The JSNA was also listed as a prompt in the question addressing ***To what extent does transport feature in local public health plans and strategies and/or has been discussed at your Health & Wellbeing Board meetings? Please give details e.g. in JSNA, HWB Strategy, DPH Annual Report or discussed at HWB meetings.*** There were nineteen free responses mentioning JSNA which tended to reflect the inclusion of transport data in the JSNA and drawing on the JSNA evidence to support specific pieces of work e.g. air pollution action plans. Responses often linked JSNA with Health and Wellbeing Board work suggesting recognition at decision-making level of local government concerning transport's impacts on public health. A representative sample of the range of responses is given starting from those with limited progress:

> ***"****Included in JSNA Some limited collaboration with Road Safety team."*
>
> ***"****DPH Annual report for 2014/15 will have a focus on physical activity - active travel will be a key component of this. The JSNA references active travel in relation to physical activity (although it is only a single reference) and references transport in relation to air quality (again a single reference)."*
>
> *"More developed within our obesity programme. Some reference in JSNA and Joint Health & Wellbeing Strategy."*

Where there was active use of JSNAs the focus was often targeted to specific areas:

> ***"****A Transport JSNA is being developed. Public Health have funded Bikeability and theatre show on transport for schools. Air Quality has been discussed at the Health and Wellbeing Board."*
>
> ***"****It has now been proposed to include data around active travel and KSI data within the JSNA. Although not explicitly indicated in the HWB strategy, there is a focus on development of sustainable communities which will include a future focus on increasing the opportunities for active travel across the city."*
>
> *"We are currently carrying out a Transport and Health JSNA at the request of the Health and Wellbeing Board, which will report in April 2015. This has three main themes: Access to services/opportunities - including specialist health services but also wider social opportunities. Active travel and physical activity, air quality and transport planning."*

Exploring collaboration: Embedded or co-located roles

A stage further along a path of collaboration might include embedded posts or at least co-located roles (still line managed by same profession manager). In response to ***Do you have, or are you actively considering, embedded or co-located roles - either from public health to transport or vice-versa?*** 26 DsPH responded 'No' as opposed to twelve who said 'Yes' and three who did not know. The authorities that have an embedded or co-located role or are considering it are those that also rate the health impacts of road transport as a '5' (high priority) although interpretation of what an embedded or co-located post meant was broad and often appeared to rather mean having a lead on transport planning within public health who may or may not physically be located within the transport planning team. Unsurprisingly there are no embedded roles when the level of priority given to the health impacts of road transport is low (i.e. '2' or '1'). A sample of free responses is provided to illustrate the variety of responses starting with the least to the most advanced regarding embedded or co-located posts.

"Not at the moment although it is something we will consider."

"Only relating to individual projects- nothing more long term (at present)."

"We had an embedded post in transport to lead healthy walks but repatriated it to public health post transition as it fitted better there."

"Two proposed Public Health posts to work in planning will also be first contact for transport/health related issues."

"We have taken over some transport staff and funded an expansion."

"Lead public health consultant with responsibility for liaison with the economy, transport and environment directorate, supported by part time health improvement manager post with remit for public health comment on local housing and transport plans. Funded from the PH ring-fenced grant."

Exploring collaboration: Joint training

On the issue of ***Is there any joint training undertaken, planned, or being considered between public health and transport****?* 24 of the 41 respondents said 'No', thirteen said 'Yes' and four did not know. Where a high priority ('5') was given to the health impacts of road transport there was a greater chance of joint training, but there is no correlation where the score was less than '5'. Cross-tabulations by authority types suggests that it is the Non-Metropolitan authorities and London Boroughs that have done or are planning joint training. For comparison, in London half the authorities are considering joint training but in the Metropolitan authorities none are. Eighteen free responses were given and a range from these are provided below. These give a flavour of interest and some joint training approaches but also equally signal appetite among some other DsPH to take forward plans to engage with transport planning through joint training.

"Not at the moment, but we have already done some joint organisational development work to develop understanding of the Council's responsibility to improve the public's health."

"This has happened informally by association and joint working, there is a greater understanding of the differing agendas and processes on both sides."

"This is fairly new area of work and training will be one of the activities in our emerging work programme."

"We would like to but limited resources to plan and undertake."

"Bespoke transport and health training, invitations extended to obesity complex systems training events and others."

"Public Health have offered to train staff appointed within the Local sustainable transport fund in behaviour change skills to ensure staff have the correct skills to improve the impact the fund in increasing cycling and walking."

"2-part workshop undertaken by Adrian Davis, providing comprehensive background of each service's priorities and focus, followed by exercises to generate further collaboration."

Barriers to collaboration

In response to the question ***What do you see as the main barriers to collaboration between public health and transport and what might assist in overcoming these?*** of the 36 free responses there were some consistent messages from DsPH. Some ways forward are proposed, as reflected in the responses, including greater use of Health and Wellbeing Boards to draw attention to the importance of transport planning issues.

"None, we work well together. Strong focus in transport on physical activity and improving air quality. Public transport targets around accessibility of communities. Dial a ride bus service provided by Transport for less mobile people to use to access shops and community facilities. Cycle training to improve road safety delivered by Transport. Work closely on plans for major residential developments, living streets, electric buses etc."

"Legislation, two tier authority, language, new developments."

"Barriers include cultural/organisational differences on how to weight information and proceed in the absence of a clear evidence base."

Some of the barriers appear to be cultural and structural. Issues with funding, not least lack of funding, the cultural dominance of the car and associated local political positions, walking and cycling being viewed as leisure activities, issues around evidence quality in transport, and narrow or silo views re-occurred as comments.

"The financial pressures placed on local authorities has caused significant reductions in staff and reduced the opportunities for joint investment in programmes that would benefit the health and well-being of our communities. Changes in national policy has not assisted joint working."

"Councillors views, so looking to take an incremental approach initially focusing on urban areas and particularly deprived urban areas."

"Resources, lack of political buy in (especially if proposals impact on car use), traditional work/professional approaches take time to change. Greater use of Health & Well-being Board to highlight transport and health issues particularly air quality and unintentional injury."

"Transport understanding the bigger picture and how perhaps older styles of working from within existing County Council staff are hampering a wider outlook of their work impacting on public health outcomes."

"Cultural - the car is very dominant in the minds of decision makers and the economic benefits of motorised travel are perceived to be high, relative to dis-benefits of congestion etc and benefits of active travel. Walking and cycling are viewed as leisure pursuits, we need to reframe the physical activity agenda to prioritise active travel. There are local tensions between leisure cyclists and local communities/ road users, which influence decision-makers views of active travel…".

06 Case Studies

The survey included a space for respondents to "***share any examples of good practice in collaboration between public health and transport which your organisation has been involved in"***. Using these, as well as drawing on examples mentioned elsewhere in survey responses, we have been able to identify six case studies for further investigation. These were explored further through interviews with each of the selected case study areas. The case studies can be found at **Annex C**.

In summary, the case studies cover:

Metropolitan areas/Cities outside London

- Leeds and Bradford: cross-Committee working; Transport and Health JSNA development; collaboration on CityConnect Cycle City Ambition Fund programme and associated walking programmes, with a particular focus on communities with the worst health outcomes.
- Dudley: multi-agency groupings to tackle active travel, childhood obesity, physical activity and planning issues; joint delivery of schemes; partnership working on Active Travel Corridors to 'Healthy Hubs'.
- Bristol: Co-location of health and transport specialist; improving access to peer reviewed evidence summaries; joint bid-writing; joint training.

London

- Greater London Authority/Transport for London: embedded public health consultant; joint training; Transport and Health in London report; Improving the Health of Londoners Transport Action Plan.

Non-Metropolitan areas outside London

- Cambridgeshire: Work on shared priorities including a Transport and Health Joint Strategic Needs Assessment.
- Wiltshire: Placing public health at the core of Wiltshire Council business; partnership working on air quality.

07 Discussion and Conclusions

The survey of DsPH has drawn out some important findings, leading to the following conclusions. First and foremost the findings provide grounds for optimism in that there appears to have been a significant increase in the extent of collaboration between transport planning and public health since the return of public health to local government. This finding alone should provide encouragement to public health and transport planning teams within local government in that identifying a shared agenda for action is helping (not least in a time of austerity) to advance policy implementation, demonstrating locally the value of breaking down inefficient silo approaches of single departments.

For central government there are further grounds for optimism given that joint working is likely to signal greater efficiency in addressing key issues such as congestion, air pollution, carbon reduction, and the ambition to increase walking and cycling levels.

On average, DsPH give a middling to high priority rating for the health impacts of transport on public health and the survey suggests that this either has increased since the return of public health to local government or that the ability to take action on this issue has been increased by working in the same organisation as the local transport authority. Perhaps not surprisingly, collaboration is greater where DsPH rate more highly the impact of road transport on public health and have the opportunity to input to local transport plans.

This survey confirms that there is a considerable shared agenda and that there are opportunities to work collaboratively in order to achieve objectives which are (or are perceived to be) more challenging if addressed by either public health or transport planning alone. By topics of concern or interest, active travel, a focus on the promotion of walking and cycling, is by far the single most reported area of activity. This is followed by air quality issues, and then by injury and road safety issues. This ordering may not be surprising given that for transport authorities outside London, the Local Sustainable Transport Fund (LSTF) has provided a major boost to local efforts to promote walking and cycling.[15] Without the LSTF it is feasible that areas for collaboration might have been significantly different. The LSTF has allowed public health concerns targeting low population physical activity to be allied with interest and funds in the transport departments to pursue interventions which address some of the Public Health Outcome Framework's indicators.

Data sharing appears to be occurring, albeit often in limited ways, as part of a broader process of generating trust and commitment to new and on-going collaborative initiatives. This includes the use of the JSNA in particular as a means to bring transport planning issues into public health policy and strategic planning. It would be informative to review this situation in a few years hence in order to ascertain whether or not data sharing does significantly increase.

With regards to a possible step-change in commitment, via embedded or co-located posts, there is evidence suggesting that, at least among some public health teams and transport planning departments, collaboration had taken a more formal approach through creation of notably public health posts with some responsibility for collaboration with transport planning. Despite a majority not having taken up these options, indicating that it is too soon to consider or do so, the fact that twelve DsPH had done so, or were considering doing so, suggests that a significant minority of local authority public health and transport teams have a strong enough relationship to enable embedded or co-located roles. The origins of such relationships may well have preceded public health's return to local government.

The Case Studies at **Annex C** provide some more detailed insights into collaboration and these may be particularly helpful to other public health and transport planning teams. These can be summarised as:

- The value of documenting the health impacts of road transport in identifying a shared agenda, gaining senior management support from both professions.
- Finding particular local shared agendas, possibly through use of the JSNA, in order to identify priorities on which to act on together.
- Public health providing expertise in peer reviewed evidence to strengthen the case for transport planning work.
- Public health teams contributing to major transport planning funding bids and using this experience to build stronger collaborative working between the disciplines.
- More generally, sharing data and knowledge to mutual benefit.

Interwoven with the above are the various barriers to collaboration. For DsPH, moving their teams and work programmes from an NHS environment, where political barriers were more distant and indirect, to an environment with the need to garner Elected Member support is often challenging, especially when robust evidence does not always trump other considerations. Combined with cultural and professional training differences with transport planning colleagues, codified languages, structural re-organisations and declining budgets, mean that significant barriers remain.

There are limitations in this research which need to be acknowledged. Of most note is the risk of sample bias given that around 30% of DsPH responded to the survey. The most obvious risk is that those DsPH most favourable to the subject matter of transport planning responded in the greatest numbers while those DsPH whose priorities lie elsewhere did not.

With the above acknowledged, there remains a strong top-line message from this research. This is that the extent of collaboration on transport planning and public health has increased substantially in the first eighteen months since Public Health's return to local government in April 2013. While intra-organisational collaboration is still beset with its own challenges, these generally are less than where two organisations have to overcome institutional barriers to working with external partners.[16] Furthermore, there are numerous examples of emerging good practice in joint working between public health and transport that can be learnt from. Thus, the return of public health to local government has provided an opportunity for two largely disparate disciplines to make common cause - aided not least by the existence of the LSTF outside of Greater London and a mutual recognition of the value of active travel - to pursue goals sought by both professional groups.

Annexes

A_Cover text to accompany survey invitation
B_Survey questions
C_Case Studies

Annex A

Cover text to accompany survey invitation

Over the past two decades, there has been growing evidence of the importance of transport in determining health outcomes. Transport choices affect physical activity levels, access to services, exposure to air pollution and risk of injury.

Given this relationship, I would like to invite you to contribute to a survey of all Directors of Public Health in England investigating **the extent of collaboration between public health and transport teams**. The survey will seek to identify any **barriers** to closer collaboration as well as **explore examples of good practice** that others can learn from. The survey will take just **10 minutes** to complete and can be found here: https://www.surveymonkey.com/s/MZY2GPV

This England-wide study is being led by Dr Adrian Davis FFPH, UK specialist on Transport and Health and has been commissioned by the Passenger Transport Executive Group (***pteg***) who represent the UK's largest urban transport authorities. ***pteg*** is keen to understand the scope for collaboration with public health teams to enable joined-up policy making which achieves mutually beneficial outcomes. For more information about ***pteg***, please visit: http://pteg.net/. If you have any questions about the research please email adrian.davis@phonecoop.coop.

Gaining a snapshot picture of where, what, and how much collaboration is taking place across England can help us all to be aware of innovative collaborations, what funding mechanisms might be in place to support them and how any barriers to closer working might be overcome. ***pteg*** will be sharing the findings in due course which we hope will be of value to you. **The deadline for survey responses is Tuesday 18th November**. I do encourage you to complete the survey and contribute your views.

Regards,

Dr John Middleton

Vice President

UK Faculty of Public Health

Annex B

Survey questions

Collaboration between public health and transport - are we making the

1. About the research

Thank you for taking part in this survey. This survey of all Directors of Public Health in England will investigate the extent to which public health and transport teams are working together since public health teams moved back into local authorities. It will seek to identify any barriers to closer collaboration as well as identify and explore examples of good practice that others can learn from.

The survey will take about 10 minutes to complete.

The study has been commissioned by the Passenger Transport Executive Group (***pteg***) who represent the UK's largest urban transport authorties and is being led by Dr Adrian Davis FFPH.

None of the information you supply will be used to identify you or your local authority without specific permission. Otherwise all information will be anonymised. The research team may contact you to further explore areas of good practice. Analysis of the results of the survey will be published by ***pteg***. If you have any questions or queries please contact:

Dr Adrian Davis FFPH
Consultant on Public Health and Transport Planning
adrian.davis@phonecoop.coop

***1. I understand that completion of the survey will constitute my consent to participate.**

- ◯ Yes
- ◯ No

2. Transport and your work programme

2. How high a priority does the Public Health team give to the health impacts of road transport in your work programme?** ***(e.g. in respect of physical inactivity, air quality, traffic injuries).

1 None	2	3	4	5 High	Don't know
◯	◯	◯	◯	◯	◯

***3. To what extent does transport feature in local public health plans and strategies and/or has been discussed at your Health & Wellbeing Board meetings?**

1 Not at all	2	3	4	5 Highly	Don't know
◯	◯	◯	◯	◯	◯

Please give details e.g. in JSNA, HWB Strategy, DPH Annual Report or discussed at HWB meetings

Collaboration between public health and transport - are we making the

***4. Has the public health team had the opportunity to comment on/influence/contribute to local transport plans?**

1 Not at all	2	3	4	5 Very much so	Don't know
◯	◯	◯	◯	◯	◯

Please give details

3. Collaboration before and after public health's move into the local authorit...

***5. In 2012-13 prior to public health's return to local government how did you rate the extent of collaboration with your transport planning colleagues? (please ask colleagues if you were not working for the PCT then)**

1 None	2	3	4	5 High	Don't know
◯	◯	◯	◯	◯	◯

***6. How do you rate collaboration with your transport planning colleagues now?**

1 None	2	3	4	5 High	Don't know
◯	◯	◯	◯	◯	◯

4. Exploring collaboration

***7. Do you collaborate with transport colleagues on any projects or initiatives which are jointly funded by transport and public health budgets?**

- ◯ No
- ◯ Yes
- ◯ Don't know

If yes, please describe including which budgets

Collaboration between public health and transport - are we making the

***8. Is there any data sharing between public health and transport planning in your area?**

- ◯ No
- ◯ Yes
- ◯ Don't know

If yes, please describe what this is and how the data is used. Please state if data sharing has informed the JSNA. If there have been issues about data confidentiality please describe these and how they may have been overcome.

***9. Do you have, or are you actively considering, embedded or co-located roles - either from public health to transport or vice-versa?**

- ◯ No
- ◯ Yes
- ◯ Don't know

If yes, please describe including how posts are funded

Collaboration between public health and transport - are we making the

***10. Is there any joint training undertaken, planned, or being considered between public health and transport?**

- ◯ No
- ◯ Yes
- ◯ Don't know

If yes, please describe

5. Exploring collaboration

***11. What do you see as the main barriers to collaboration between public health and transport and what might assist in overcoming these?**

12. Please use this space to share any examples of good practice in collaboration between public health and transport which your organisation has been involved in, along with any contact details for further information. ***Examples provided may feature as good practice case studies in the final report and we may contact you to explore examples further.***

Collaboration between public health and transport - are we making the

13. About you - Your personal details will not be used with your responses, these questions are purely for data validation purposes. We may contact you to explore the possibility of including your local authority as a good practice example.

Your name	
Name of local authority	
Your job title	
Email Address	
Phone Number	

14. If you have a lead member of staff responsible for transport planning please give their name and e-mail address

Annex C

Case Studies

Case study one: Leeds and Bradford

Transport and health is one of the three priorities of Leeds City Council's Health Committee (one of five city council service Committees led by elected Members) which covers public health and health scrutiny. The Council has a joint member Champion to encourage joint working between the Committee covering strategic transport issues and the Health Committee. There is a part time post in the Public Health team with the specific remit of working with the Economy, Transport and Environment Directorate to comment on plans for new housing developments and on transport plans. There are two 'shared priorities' across Council directorates directly relevant to transport.

1) Reducing road traffic injuries and deaths.

2) Increasing physical activity through promoting walking and cycling, particularly in areas with low physical activity/ high inactivity rates.

Public Health is carrying out a Transport and Health JSNA at the request of the Health and Wellbeing Board, which will report in April 2015.

There is much evidence to support the case for active travel and the potential impact on the public's health. Not the least is that although modest capital investment has resulted in improvements to infrastructure, this has not always been delivered in a way that successfully engages current and future users and schemes have not necessarily been complemented with programmes to support communities make the most of active travel opportunities. In order to successfully marry capital and revenue investment, collaboration across agencies, drawing on diverse experience, is essential in developing more comprehensive programmes to translate policy and evidence into practice.

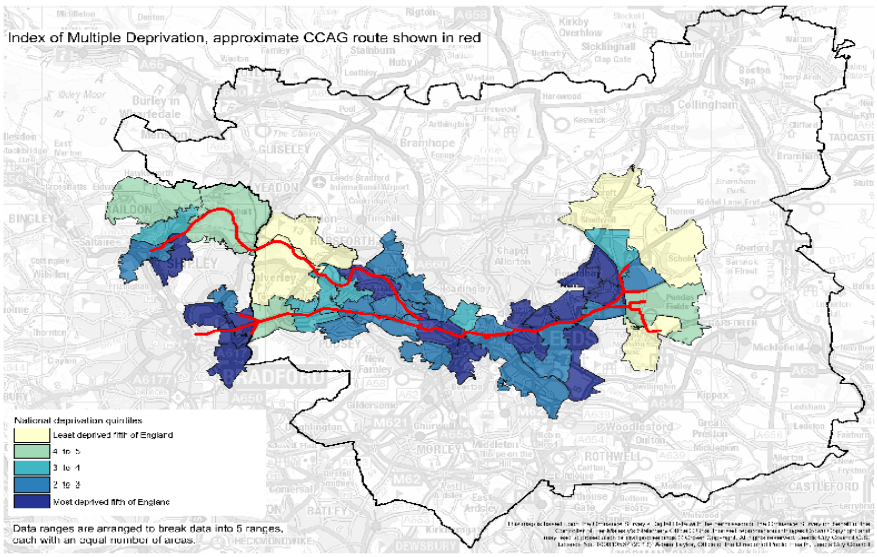
In 2013 the DFT announced a dedicated Cycle City Ambition Fund (CCAF) to initiate a step change in capital and revenue investment over the next decade. At the same time, following the Health and Social Care Act (2012), Public Health Departments were in the progress of migrating from NHS organisations to top-tier Local Authorities. In Leeds there was an appetite to embed the Public Health function across the council and directorates were encouraged to consider the opportunities where Public Health could add value to existing and new work programmes. This resulted in Public Health being invited, by transport colleagues, to join a group tasked with preparing the CCAF bid. In the same way, Bradford Metropolitan District Council identified a Public Health representative to work with transport planning colleagues.

A lens on good practice: CityConnect

What did you do?

The CCAF bid, 'CityConnect' was submitted from West Yorkshire ITA/PTE (now West Yorkshire Combined Authority), Leeds City Council and the City of Bradford MDC and was successful in securing funding for a programme of high quality cycling infrastructure improvements, complemented by a package of engagement and communication activities and a monitoring and evaluation scheme. The total spend identified for CityConnect is £29.2m includes a £18.0m contribution from the DfT, £3.7m of eligible existing local/third party contributions and an additional £7.5m from the Integrated Transport Authority, which has been committed specifically for this bid and is available to spend on the proposed new schemes.

The bid included an East /West cross city 23 kilometre cycle 'superhighway'; a route (see map below) that will connect a large housing growth area in East Leeds through to East Bradford and joining both city centres. The route of the proposed superhighway will link key sites of economic regeneration, facilities, population centres and potentially expand training, education and employment opportunities for residents. Public Health was particularly interested in the geographical footprint of the superhighway which directly impacted 44 Middle Layer Super Output Areas (MSOA) in Leeds and Bradford, 30 of which ranked in the bottom two quintiles of the index of multiple deprivation (shown in the darker shades of blue on the map below).



In the development of the bid, Public Health was able to draw on a range of health intelligence to help identify the potential health benefits that the superhighway could bring to some of the most deprived areas of the cities. The Public Health teams were also able to bring experience of working with the communities on other health behaviour change issues which confirmed the challenges the programme could potentially face in engaging local residents in both securing support for the scheme and becoming the future users of the scheme.

In addition to the CCAF grant, the programme was also successful in obtaining further funding from the Department of Health to establish an additional project linked to CityConnect called CityConnect Walking (CCW). This project is being managed by Living Streets and is overseen by a lead from Public Health who reports to the programme board. The project aims to gain further understanding of the pathway from inactivity to active travel by encouraging more people to walk, as the first step and is working in six of the most deprived MSOAs along the CityConnect Superhighway route, where communities experience the worst health outcomes. The project is gaining insight from the communities by exploring external barriers e.g. within the built environment and internal levels of motivation which would impact on intention to walk and then exploring methods and behaviour change techniques in translating that intention into action.

What was achieved?

The benefits of structured consultation, gaining insight and not just focusing on the numbers of potential end users but giving consideration to where those users are coming from, their own lived experiences and how the programme might positively impact on inequalities across the cities, is well recognised in CityConnect, to the extent that the programme is being viewed as a behaviour change programme and not an exclusive infrastructure programme. These key elements have enjoyed equal consideration of importance with the programme board of which Public Health continues to be represented along with transport and engineering colleagues.

What were the key success factors?

To date, the component projects of CityConnect have progressed well, including completion of the design phase of the 'superhighway'. Early engagement and insight of stakeholders (including local cycle campaigning groups and communities along the route), and the learning being obtained from the CCW project have been crucial, and will continue to be in ensuring the programme successfully meets the needs of current and future users. This alongside utilisation of more traditional population profiling and marketing tools will help ensure that communications will continue to be delivered in an informed and appropriate manner.

What were the challenges? How were they/ or could they be overcome?

For Public Health in Leeds this was the first time that it had been involved in such a large scale transport programme. Bringing departments who speak different languages and have different agendas requires understanding and possible negotiation. However, through the management of the programme and having a clear, high level aim, each component project has been able to recognise its own contribution and the contribution of others in achieving that aim.

One of the defining features of the 'Managing Successful Programmes' methodology used to deliver the CityConnect programme has been the establishment of a business change group (again including Public Health). This group will review the programme throughout its life and will consider the impact of different ways of working that have become used as the programme develops and whether these have been positive and, if so, how they may be embedded into future programmes of work. This will be reported on as the programme progresses.

The transfer of Public Health into the local authority - and in Leeds and Bradford in particular, involvement in CityConnect - has enabled Public Health to establish new working relationships with colleagues in transport and the West Yorkshire Combined Authority. As a result, Public Health has been invited to contribute to developing further bids including a successful LSTF application to include the behaviour change elements of CityConnect in a region wide scheme of work. In recognising the inclusion of using active travel schemes as one of a number of means to improve the public's health, this has been supported by the regional Directors of Public Health group and additional funding of £60k (a minimum of £10k per area) has been agreed, through individual approaches to the DPHs, to support the LSTF workstreams around engaging with local communities to encourage and support active travel.

Acknowledging the mutual benefits of collaboration around active travel has also resulted in the establishment of a new regional health and transport group, which will continue to build on the so far successful collaboration of CityConnect.

Contact: Heather Thomson - Health Improvement Manager, The Office of the Director of Public Health, Leeds City Council heather.thomson@leeds.gov.uk

Case Study 2: Dudley

For a long time there has been an approach within Dudley Public Health, and in particular its physical activity and obesity prevention work, on delivering supportive environments that provide people with a healthy default option. At a strategic level this approach was reflected in Dudley's Obesity framework 2005-2010 and subsequent Health Needs Assessment (HNA) 2011-12 and the refreshed (from the HNA) Healthy Weight Strategy. This manifested itself in particular in the areas of active travel, active green spaces and parks based programmes. This approach started when the Public Health department was hosted within the local Primary Care Trust of the NHS, and this work has continued through the transition of Public Health into the Local Authority, now called the Office of Public health (OPH).

This approach, linking transport and health, also forms a key part of the Physical Activity and Sport Strategy 2014-19 and as a stand-alone sub chapter of that document, the emerging Active Travel strategy. Due to this approach there has been a long standing working relationship between Public Health and the Local Authority's Transportation team (over ten years). Transport and Public Health also work together and independently on issues relating to air quality as the targets of increasing active travel obviously help in improving air quality via less private motorised traffic, less congestion and increased activity, as well as impacting on obesity and social cohesion. Transport and Public Health were involved in the development of Dudley's Air Quality strategy.

The multi-agency active travel group in Dudley is chaired by OPH's Primary Prevention Services Programme Manager and administered via OPH. Members of the transport team are also involved in OPH's Child Weight Management steering groups, physical activity sub groups and planning and health work. This long standing work between the OPH and transport has been consistent and regular, and has taken the form of bid writing, shared funding, data sharing and joint planning. It has been achieved by using an evidence based approach drawing on secondary data and desktop work; utilising NICE, DFT, Sustrans and planning work via the TCPA and others; having a strategic set of frameworks to deliver against; sharing skills and experience and developing genuinely good working relationships. It has delivered collaborative work ranging from setting up individual walking buses, to major infrastructure schemes and multi million pound projects e.g. Local Sustainable Transport Fund (LSTF) programme which developed a local active travel partnership (£375,000), rail station active travel links to the central shopping area (£130,000), Better Bus Fund programme including active travel provision, crossings and footpaths (£500,000) and the Healthy Towns programme (£4.5 million). In general, there have been only minor challenges to collaborative working, initially based around language, priorities and agendas, which were ironed out through communication and greater awareness.

Funding was also provided by the OPH to the Transport Department at the end of the 2012-13 to coincide with the transition of Public Health into the local authority and as a one off grant. The funding was granted due to the Public Health evidence base on the impact of transport on health, to help meet the actions and outcomes outlined in the local obesity and activity plans and strategies.

A lens on good practice: Dudley Active Travel Corridors

What did you do?

The main partnership programme involved the development of the 'Active Travel Corridors' component of Dudley's Healthy Towns programme. Dudley's programme was one of nine towns and cities granted funding from the Department of Health's Healthy Community Challenge fund in November 2008, the aim of which was to develop innovative programmes to tackle childhood obesity, through environmental change. Work started in 2009 on the programme, which aimed to develop five 'Healthy Hubs' in five of the borough's parks. The Hubs were developed as green outdoor activity centres and included and outdoor gym, a bespoke activity centre building including a functional teaching kitchen, toilets and activity room and an office base for the activity rangers based on site. Rangers were developed from the existing Park Keeper job description. Their role and person specification was developed to include skills and experience to deliver physical activity services and programmes. They then developed a range of physical activity services for children and families, and facilitated other service providers to use the sites to prevent obesity.

The second tier of the programme was to connect the Hub sites via just under 30km of active corridor developments. These corridors were designed to get the catchment populations of the Hubs to, from, and around the Hubs. They also connected routes across the borough and to schools and town centres. The corridor developments ranged from large scale infrastructure developments including major road crossing and cycling and walking route developments, to off-road path developments to signage and cycle storage on route and at key destinations. The programme was managed by Public Health and designed and delivered by transportation staff. The feasibility, planning and rationale was determined via the Active Travel steering group, comprised of officers from both professions. Plans were consulted on via wider stakeholders and the general public and catchment residents. The routes were informed by obesity and physical inactivity data and were positioned to maximise visible impact, tackle congestion hotspots and capitalise on existing schemes, and supportive geography and topography.

What was achieved?

The programme as a whole has been very successful. It is the only programme of the nine Healthy Towns that is still operating in its entirety. The programme has been independently evaluated by Worcester University and has shown population increases in physical activity and demonstrated increased rates of walking and cycling in the catchment populations. Each area had different spends due to different infrastructure needs. The evaluation noted that the two sites that had the most spent on Active travel corridors had the highest increase in walking and cycling rates which demonstrated the joint approach had an impact.

What were the key success factors?

A key success factor was the development of the multi-agency Active Corridor steering group, which is now functioning as the Active Travel Steering Group. The programme has been further enhanced by funded, commissioned work between OPH and transportation. The funding supported a range of new initiatives; filling of some of the infrastructure gaps identified through the Healthy Towns Active Corridors programme; and the development of new cycle storage facilities including at local leisure centres. It also provided a source of match funding.

The programme delivered five separate active travel schemes which covered 23 of the 25 wards in the borough and delivered around 30km of active travel infrastructure. This took the form of large scale dual use cycling and walking lanes, toucan crossings, numerous off road routes with new surfacing, signage and connections to existing provision, canal towpath improvements and promotion (see photos included at the end of this case study).

Another outcome which has enabled the development of more formal cycling activity in parks and open spaces was the lifting of a local bye law dating back to the early nineteen hundreds which prohibited cycling within Dudley's parks. The programme developed a cycling code of conduct. This was piloted for twelve months, during which any crashes and incidents were reported. On the back of an incident free year, the bye laws were lifted across all the boroughs parks, enabling the formal promotion of rides and training programmes.

As a result of this work there is a greater understanding between the partners of each side's areas of work, their priorities and drivers. This has meant that each new piece of work has been smoother. There is more of a shared language, and expectation to do more together. The partnership is just completing a two year SkyRide programme in partnership with British Cycling and its Active Travel Strategy and Action Plan, thus ensuring active travel and the partnership continues into the foreseeable future. Because of this work programme, the profile of active travel has been significantly raised in Dudley.

What were the challenges? How were they/could they be overcome?

Initially challenges were based around understanding what drove the transport and health agendas (e.g. the constraints that transport were working to and the impact of local politics) and what drove Public Health (e.g. inequalities, empowering communities, health outcomes). Over the course of the programme and as these learning curves levelled out, and due to the shared successes, this enabled better understanding and smoother progress.

In relation to the Healthy Towns programme there was a challenge that affected the timescales for the delivery of the corridors. Due to a national change of government, funding was suspended for three months until the incoming government agreed to carry on supporting the development of the nine programmes. This delay happened at a key time in the construction phase of the programme, which had a knock on effect with the evaluation phase. This was somewhat out of our control, but did highlight the political influence on large scale transportation programmes which is still apparent today and needs to be considered at all stages.

The future for transport and health working together on one hand is bright supported by an ever-growing array of evidence, strategies and generally positive rhetoric at a national and local level. This has further been cemented by the four Black Country Authorities joining together with Birmingham to focus on transport and economic regeneration issues. However, all of this is within the context of ever decreasing local authority budgets and restructures and where this agenda generally sits in the importance rankings when compared to other agendas.

Contact: Dean Hill - Primary Prevention Services Programme Manager (Physical Activity/ Food and Nutrition), Office of Public Health, Dudley MBC dean.hill@dudley.gov.uk

Examples of programme implementation relating to the Dudley Healthy Towns Active Corridor programme.	
	**Cycle storage and “paved wheels area” at Huntingtree park Halesowen.**
	**Off road cycling and walking provision to Mary Stevens Park Stourbridge.**
	**New Toucan crossing point to cross A4123 and access Silver Jubilee park Coseley.**
	**Dual use walking and cycling route adjacent to the A4123, connecting Silver Jubilee Park to Dudley Town centre, a distance of around 4.5 kilometres.**

	**Internal walking and cycle route (DDA compliant). Silver Jubilee Park Coseley.**
	**Internal walking and cycling provision to the Netherton Healthy Hub activity centre and outdoor gym.**
	**Walking and cycling route development connecting the Dell and Fens pools Healthy Hub from the A4036 regeneration corridor.**
	**Canal towpath and access path development in to the Dell and Fens pools Hub site and outdoor gym.**
	**Active corridor signage directing people from Dudley number 2 canal towpath development to The activity centre at Netherton healthy Hub.**

Case study three: Bristol

It is recognised that the role of the Director of Public Health alone is insufficient to address the range of wider health determinants. From a public health perspective, how people live in a city and how healthy and happy they are depends to a considerable extent on their urban environment, their access to employment, to services, to travel and transport, to green space and on the community around them. So, by bringing together the spectrum of inputs through specialist 'experts' and developing the influencing skills at different levels of the system of local government change can be effected. Yet, influencing officers alone is insufficient and so the 'experts' must also be skilled at developing political support.

Consequently, a number of Public Health specialist staff were appointed by the DPH to posts working inside Bristol City Council from 2008, well ahead of announcements which led to the return of public health to local government in 2013. These specialist posts to help NHS Bristol (the Primary Care Trust) work effectively within Bristol City Council addressed aspects of the built environment including transport, town planning, climate change and carbon, food systems, and other determinants of physical activity. Thus, the Specialist in transport planning has been in post for over six years (half time) which has enabled significant progress to be made in promoting greater understanding of the health impacts of road transport. Co-located firstly with traffic management, then Bristol's Cycling City Team for 2 years, and since 2011 with the Transport Policy team, the Specialist has been able to build a substantive level of trust with colleagues which has enabled close relationships to develop.

Barriers to this joint working have lessened not least due to relationship building and contribution to major successful funding bids. Work has included contributing to all sustainable transport funding bids and developing the largest element of the West of England's Local Sustainable Transport Fund programme (£34M) through introducing an evidence-based life-course approach to travel behaviour and behaviour change. The West of England Local Transport Plan (2011-26) has, arguably, benefited substantially from evidence guidance, although this was partly resisted at the time due to less familiarity with the issue of public health and consequent belief that the relationship between transport planning and health was limited. This view has largely changed over the years and recognition of the many connections has increased including as a result of external links nationally and internationally to evidence on the health impacts of road transport which has also grown substantially since 2008.

The Specialist has regular liaison with senior transport officers and the Assistant Mayor with transport planning responsibilities. He is a member of both the 20mph Project Board which oversees the roll-out of 20mph speed limits across most of the city's roads (which was originally proposed by Public Health), and the Highways Quality Assurance Project Board. Such linkages have enabled work streams to be developed at arguably substantially faster pace than would have been possible without this long term co-located post. Other work programmes have addressed road danger reduction, and the ambition of using the WHO Health Economic Assessment Tool as standard practice when developing all new pedestrian and cycle schemes, including in bid documents. This continues to be developed through training sessions with officers in order further embed an understanding of the power of routine physical activity to keep people well and have longer lives free of disease.

A lens on good practice: Essential Evidence on a Page www.travelwest.info/evidence

What did you do?

The Public Health and Transport Specialist wrote and published short, de-jargonised summaries of academic studies on the relationships between health and transport. The approach has partly been to translate bite-sized amounts of peer-reviewed evidence, often with the aim of strengthening the case for work that is already being progressed as a result of identifying health benefits, including the quantification and distribution of such benefits. One of the most visible manifestations of this translational work is the Essential Evidence on a Page series: begun in 2009 it involves the selection of topical transport issues or concepts, identifying robust peer-reviewed papers, and then distilling key findings into a one-page, de-jargonised format.

There are 130 editions, some of the subjects of which have been requested by transport planning colleagues in Bristol City Council. The intention has been to provide information available 'at ones fingertips' for transport planner and other planning specialists in order to enable greater understanding and articulation of the health impacts of road transport in its many and diverse manifestations.

What was achieved?

The series has proved popular and is, of January 2015, subscribed to (free of charge) by over 1,000 people, over half of whom are from outside Bristol (the original target audience being the Council's transport and urban environment planners). The feedback from a survey of users and individual comments is very positive including statements of how it has helped inform their work. In Bristol City Council individual summaries have been used to support reports to Committees and some of the Elected Members receive Essential Evidence on a Page.

What were the key success factors?
One of the central offers from public health professionals as they joined local government in April 2013 was their proficiency in evidence-based practice and policy, drawing on methodologically robust peer-reviewed studies. The critical factor with Essential Evidence on a Page has been the one page de-jargonised summary format which provides valuable information to transport planning and other built environment specialists who are time-pressed and may otherwise not know where to look to find similar sources of de-jargonised information.
What were the challenges? How were they/could they be overcome?
Evidence-based practice is grounded in all public health work. However, anyone faced with making a decision about the effectiveness of a road transport intervention, such as traffic restraint or cycling promotion behaviour change programme, faces a formidable task. The research findings to help answer the question may exist, but locating the research, assessing its evidential "weight" and relevance, and incorporating it with other information is often difficult. There is often evidence of interventions and other research which, while being published, is to all intents hidden to non-academics. Making such wholly relevant evidence available in an accessible and brief format helps to slowly change existing thinking and fill knowledge gaps and so help improve health outcomes of transport planning interventions.
Contact: Dr Adrian Davis - Public Health & Transport Specialist, Bristol City Council adrian.davis@bristol.gov.uk

Case study four: Greater London Authority/Transport for London

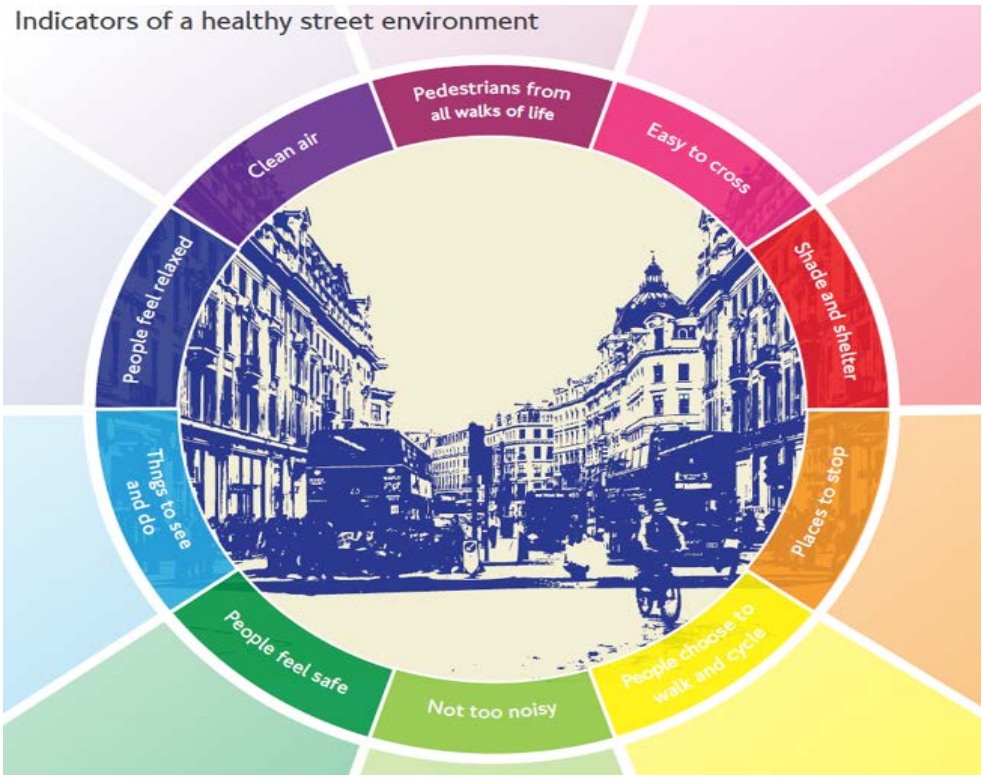
Lucy Saunders, a Public Health Consultant employed by the Greater London Authority (GLA), works at Transport for London (TfL) spending four days per week inputting to transport planning and one day working at the GLA influencing the political level of transport planning and policy making. She reports to the Head of Health at the GLA and the Head of Policy & Strategy at TfL, and agrees work objectives with both of her managers at joint meetings.

It is of note that in the survey of DsPH, prior to the return of public health to Local Government but more especially the appointment of the Public Health Consultant, there was no collaboration with transport planning. The only engagement between the GLA Health team was information sharing rather than policy development and influencing.

Lucy is invited by a wide range of different stakeholder groups to present to them on the subject of transport and health. She has been making the case for how it is useful to the transport sector to consider health impacts as an additional tool for them to achieve the outcomes they want (e.g. more walking, cycling and public transport) and to make the case against outcomes they do not want e.g. additional on-street car parking. For the public health audience she has been making the case for why focusing on streets delivers a wide range of health benefits and is the most cost effective option for increasing population activity levels.

Lucy delivers training sessions which she tailors to her audience and their priorities and she presents in a positive and engaging way. Once the case has been made to the audience they sometimes ask for training on particular topics or issues or tools. The sessions are well attended because it is the stakeholders who ask for them rather than arranging a session independently and then sending out invitations to a wide range of people. She has spent three years building up an extensive network and is now well known so she can now hold specific presentations and training sessions and achieve a good turnout. She also tries to reach new audiences through word of mouth rather than running sessions which are attended by those who are already engaged in this issue. It is acknowledged that there are lots of barriers, and it is a very complex job with multiple facets and hundreds of stakeholders.

Lucy has commissioned a piece of research to demonstrate the relative impacts of different aspects of the transport system on health because she found a common refrain amongst transport professionals was ‘what is more important, air quality? Access to hospitals? Something else?’ She then translated the findings into a report ‘Transport and Health in London’ to make it accessible to a wide range of stakeholders. She has also been working with the transport database and developed a new survey tool for the ten indicators of a healthy street, the preliminary results of which was published in December 2014. The ten indicators are shown in the diagram below.



Picture: Lucy Saunders

A lens on good practice: Improving the Health of Londoners: Transport Action Plan *https://www.tfl.gov.uk/cdn/static/cms/documents/improving-the-health-of-londoners-transport-action-plan.pdf*

What did you do?

Wrote and published a document which serves multiple purposes:

- Demonstrates commitments to health from the most senior level of the organisation (Foreword by commissioner and sign-off by board).
- Provides summary text on the five main health impacts of transport on health using local data where available. This can be used in policy documents and business cases.
- Provides links to key research documents for those who want to read further on the subject.
- Sets out ten actions that will be undertaken to embed health considerations into transport planning, policy and practice in TfL.

What was achieved?

The document was published in February 2014 and is the first of its kind in the world as the Transport Authority has no legal obligation towards improving health and yet it has made commitments to do so. As a result of publication and dissemination of this report, awareness of this issue has been raised among stakeholders in London and further afield. Within TfL a wide range of teams are working to deliver the actions in the health action plan and to incorporate health considerations explicitly into their work. The 'Healthy Streets' approach is being increasingly used and has been recently developed into a tool for gauging the 'healthiness' of different types of streets in London to identify priorities for future action.

What were the key success factors?

There were three essential elements:

- Senior manager who was willing to champion the publication of such a report to the board.
- Policy maker available who was skilled to write the report and ensure its implementation.
- Document was closely aligned with a major organisation-wide strategy of roads modernisation (Roads modernisation programme using a streets typology) and used a framework (10 indicators of a healthy street) that was compatible with that strategy.

What were the challenges? How were they/could they be overcome?

The biggest challenge was changing the framework of understanding that transport professionals have about how their work relates to health. They tend to underestimate their role in population physical activity (and the importance of physical activity) and overemphasise access to district hospitals or exposure to common respiratory infections on public transport. To ensure the report was signed off for publication there is more of an emphasis on access to hospitals than the Consultant in Public Health would have chosen. Another challenge is that the transport colleagues who are interested in or designated as 'health' champions are often not those with the greatest influence over improving health through the transport network (technical gatekeepers and senior strategists). This can mean that a balance has to be struck between the interests of your engaged stakeholders with the need to reach unengaged stakeholders.

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Case study five: Cambridgeshire

Cambridgeshire County Council's Public Health (PH) and Economy, Transport and Environment (ETE) Directorates have recognised the importance of working collaboratively to best address major drivers of population health such as transport and active travel, access to services and green space; and in response have developed strong links. The return of Public Health to local government has played a role in enabling the progression of this collaboration and driving the development of shared priorities. The core PH Team working closely with ETE are led by a Consultant in Public Health Medicine (Dr Angelique Mavrodaris for approximately 1.5 days per week) together with a Senior Health Improvement Specialist (Iain Green) and a Public Health Registrar (Emmeline Watkins).

The PH Team provide input and advice to Transport at a number of levels identified during attendance at ETE Leadership Team Meetings which the PH Team attend every two weeks. The roles of the PH Team in Council Transport activities range from providing advisory/technical input to co-development of strategies and policy, building public health perspectives and recommendations into a number of strategies and projects and at working groups listed below.

1) Active travel including:

- Walk Local/Buggy/School projects (ensuring equal access across the County and that initiatives are aligned with needs and address inequalities)
- Council-wide Obesity Strategy in development (to drive recommendations for increases in physical activity and active travel in areas with higher rates of obesity)
- Living Sport and Exercise initiatives
- Major sporting events e.g. Tour de France (embedding of public health messaging at sporting events to encourage participation and healthy, active lifestyles).

2) Major Infrastructure and Growth Sites

As a rapidly developing County, Cambridgeshire is host to a number of new housing and infrastructure developments. Plans are reviewed by the PH Team and the Team are members of the working groups linked to each development project. Priorities and recommendations from the Team so far have included:

- Ensuring Health Impact Assessments are a mandatory requirement for all planning applications
- Securing the facilitation of active travel as part of planning design and layout for each new development
- Ensuring access to services and that public transport is accessible and in place at new developments
- Advocating provision of safe pedestrian paths and cycleways across the County, particularly near schools, care facilities and town centres (in response to local resident views)

3) Local Sustainable Transport Fund allocation and prioritisation to align with PH recommendations

4) Travel for Work Guidance development

5) Transport initiatives and intervention review (evidence-base and outcomes)

The Team are also members of working groups such as the Road Safety Partnership (PH work with Acute Trusts to map traffic injuries in the County and design interventions to minimise risk and outcomes) and the Cambridgeshire Access Group (covering all aspects of access across the County together with private and Council providers, ensuring PH impacts are addressed across all levels of transport provision). An educational role within the Council has allowed for greater engagement with PH and Councillors for which the Team are responsible for providing training and information on the links between transport and health at a local level.

Currently, the PH Team and Transport are driving two major pieces of work aiming to identify joint priorities and facilitate the development of joint strategy and policy:

- Shared Priorities: Transport and Health
- Transport and Health Joint Strategic Needs Assessment

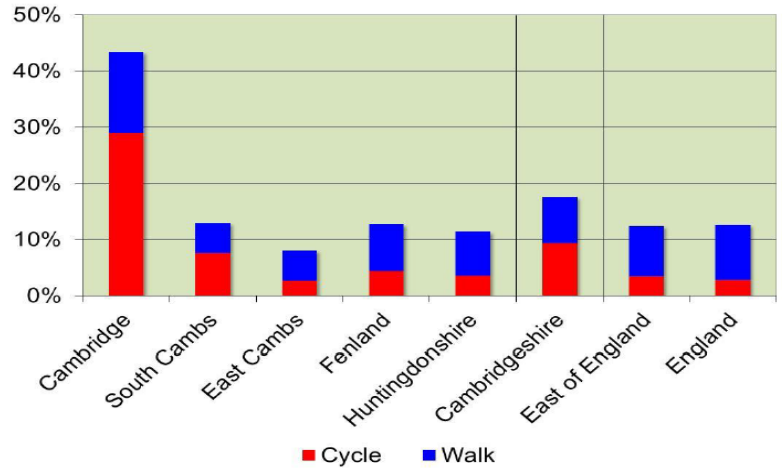
Shared Priorities: Transport and Health

PH and Transport are currently undertaking a Shared Priorities exercise whereby co-funded transport and health initiatives are reviewed and more closely aligned with the Public Health Outcomes Framework and local PH priorities to ensure initiatives are addressing local health needs and delivering clear health impacts. The exercise is focussing on two local priority areas: Walking and Cycling (particularly in areas of deprivation with lower physical activity rates) and Reducing Road Traffic Injuries and Deaths.

Transport and Health Joint Strategic Needs Assessment

Cambridgeshire has a mixed rural and urban population; so although Cambridge city currently has the highest cycling to work rate in the UK, rural areas have much lower cycling and walking rates (figure 1) as well as many problems accessing acute or primary services. Cambridgeshire is also predicted to have high growth with new developments, new roads and higher levels of motorised traffic which have the potential for increasing road danger and therefore impacting on active travel rates and exacerbating air pollution. Key factors in the development of the Transport JSNA scope and how the work will be taken forward are outlined below.

Levels of Walking and Cycling to work in Cambridgeshire (based on 2011 Census data)



Source: Cambridgeshire Local Transport Plan (http://www.cambridgeshire.gov.uk/info/20006/travel_roads_and_parking/66/transport_plans_and_policies)

A lens on good practice: Transport and Health Joint Strategic Needs Assessment

What did you do?

The Cambridgeshire Health and Wellbeing Board (HWB) identified the need for a Transport and Health Joint Strategic Needs Assessment (JSNA) for the County and incorporated this into the JSNA future workplan to be delivered in April 2015. The JSNA is to support the HWB strategies around developing and maintaining effective and accessible transport links to ensure access to services and also the encouragement of activities such as walking and cycling. Particular issues around transport to specialist services were also raised by the HWB as Cambridgeshire has a large rural population. Consequently the County Council scoped and developed a Transport and Health JSNA for Cambridgeshire

- Scoping document highlighting the 3 areas of active transport, air pollution and access was approved by the HWB
- Created opportunities for early involvement of stakeholders including Transport within the County Council, academic groups, 3rd sector patient groups

What was achieved?

Formation of 4 working groups around data and analysis, air pollution, active transport, and access. Much of the work so far has focused on encouraging collaborations with stakeholders as much of the data and expertise is held outside Public Health. The key gap identified by stakeholders was the explicit link between the transport data and the health impact, for example the beneficial impact of cycling and walking on levels of morbidity and development of health outcomes. Therefore three questions have been identified and prioritised and are being explored in depth in collaboration with stakeholders:

- ***In which Cambridgeshire populations can levels of walking and cycling be improved and what are the benefits to health?*** Academic collaborators based at the Centre for Dietary and Activity Research (CEDAR), University of Cambridge, are providing expertise around cycling and walking flows in Cambridgeshire as well as scenario planning around active transport initiatives and the predicted benefits to health.
- ***What are the health impacts of current and future traffic-related air pollution levels in Cambridgeshire?*** The District Councils are providing local air pollution levels and models of future air pollution to allow predictions of health impact and mortality.

- ***In which Cambridgeshire populations does transport to services have a negative impact on health?*** Public Health Intelligence are determining where patients go to access acute services, which is to be supplemented by Department for Transport accessibility data for Cambridgeshire and patient/community transport data from acute trusts, District and County Councils. Organisations from the 3rd Sector are also providing qualitative data on access issues from the patient perspective.

Stakeholders for each these topics are very different and so the process behind the Transport and Health JSNA has had to reflect this, with separate Working Groups for each topic.

What were the key success factors?

There were three essential elements

- A commitment from the HWB and Public Health to focus on road transport.
- Early communication to Transport colleagues in the County Council through 1:1 meetings, presentations to key groups which has resulted in both collaboration with respect to data and stated interest in using the key findings of the JSNA as soon as they are available.
- Early links to District Councils, 3rd sector and academic groups who are now involved in data and analysis.

What were the challenges? How were they/could they be overcome?

Although all three strands can contribute to an integrated view of transport and health, the majority of stakeholders have an interest in only one aspect of the JSNA, so one of the biggest challenges has been dealing with disparate groups of stakeholders and ensuring efficient engagement through smaller meetings.

The data involved in this JSNA is also very disparate with no one group having expertise or access to all data. Therefore a Data Working Group has been formed to help input and collaboration between Transport, Public Health Intelligence and CEDAR.

This is the first County-wide Transport and Health JSNA with much to deliver, yet aims to produce practically applicable and locally relevant solutions that could improve Cambridgeshire's environment, transport and active travel rates and so equitably improve health outcomes at a population-level.

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Case study six: Wiltshire

Wiltshire is characterised by extensive areas of unspoilt countryside and enjoys very good air quality, giving rise to a high quality environment for residents, visitors and businesses. There are, however, a few specific areas in the county's market towns that have issues with air quality, posing challenges for public health.

Wiltshire Council became a unitary authority in 2009 and introduced Area Boards as a new way of working to bring local decision making back into the heart of the community. There are 18 Area Boards, a formal part of Wiltshire Council that try to find solutions for local issues. The purpose of Area Boards is to work towards the Council's vision of creating stronger and more resilient communities across Wiltshire's community areas. Wiltshire Council has recognised the importance of environmental factors on the health of its residents. The commitment to improving the environment for all residents is encapsulated within common strategic outcomes in the Council's Business Plan 2013 – 2017, the emerging Core Strategy, Health and Wellbeing Strategy, The Local Transport Plan and The Energy Change and Opportunity Strategy and the emerging Green Infrastructure Strategy. Public Health is at the core of Wiltshire council business and as such any reports to cabinet must now consider the impact on public health.

The Council inherited two Air Quality Action Plans and new Air Quality Management Areas (AQMA) were declared in Wiltshire for breaches of nitrogen dioxide and in one town, particulates (PM_{10}) due to motor vehicles. It quickly became apparent that the plans needed updating and a new approach was required to gain the support of the local communities to improve local air quality. It was essential that Public Health and Public Protection worked closely with colleagues in Highways and Transport to improve air quality. Moreover, an integrated approach was required on the part of agencies, partners and communities and that the Council had to adopt more innovative ways of working to improve the air quality in those areas that required action. An early action was the drafting of an Air Quality Strategy mirroring the thematic approach used in writing the Joint Strategic Needs Assessment (JSNA).

The JSNA is one document in particular that has helped strengthen this understanding as the transportation section includes air quality and health and has required the two departments to work closely on its production. The Strategy provided a focus and mechanism to promote communication and cooperation within the Council, between external organisations and with the local communities to address the localised areas of poor air quality. The process started important communication with the Green Economy Team, Transport, Planning and Spatial Planning, Minerals and Waste and Communities.

Producing the Strategy provided the building block to get a policy on air quality included in the Wiltshire Core Strategy and to write an air quality supplementary planning guidance document. By 2012 air quality was embedded in many of the Councils policies and strategies, including transport and planning. The local Area Boards with AQMAs provided the ideal platform for creating local community groups with an interest in improving air quality within their area. Each Area Board with an AQMA has created or will create a specific Air Quality and Community Action Plan Group (AQAPG) to generate a community air quality action plan. The plans will feed into the Wiltshire Air Quality Action Plan. Sustainable transport colleagues attend many of the AQAPG meetings.

In November 2014 a new air quality website was launched providing real time air quality data and a 'Know & Respond' text alert service warning users of poor air quality. The project is a joint initiative and access to data has been a long term desire of the communities with AQMAs as it will help in developing local actions to improve air quality. Following the website launch an air quality forum for representatives of each AQAPG was held. This enabled the groups to network with each other and discuss the challenges they had faced/are facing as well as having the opportunity to exchange ideas. The forum was well received and participants want to hold a forum event at least once a year. The group also identified a common project of improving school engagement so public health will now take this forward.

A lens on good practice: Air Quality and Community Action Plan Groups (AQAPG)

What did you do?
The air quality groups have created their own terms of reference and membership. Composition of the groups varies according to the aspirations of each of the community areas. Generally they include a transport planner, environmental health officer, public health, local members and community representatives. Approaches taken to producing the community air quality action plans have varied considerably, however they all have the common goal of improving air quality and health outcomes. The AQAPG report directly to the Area Board. It is envisaged that progress on the community air quality action plans will be reported annually to the Area Board and then to the Public Health and Public Protection Service for inclusion in the annual action plan progress report for Defra and updates for Cabinet and the Environment Scrutiny Panel.

What was achieved?

The most successful AQAPGs are those that are now looking at the bigger picture. Air quality doesn't interest everyone, however, issues such as children's health, obesity, green open space in the context of air quality does enable engagement. The public wanted to be able to interrogate the real time data, understand when exceedances were occurring to enable them to tackle those problem times of day. Public Health and Public Protection jointly commissioned an air quality website which was launched on the 13th November 2014 which provides all real time data, reports, health information and a 'know and respond' text alert service alerting people to poor air quality.

At the launch, three of the AQAPGs were invited to talk about their experiences. The presentations can be downloaded from the site: http://www.wiltshireairquality.org.uk/news. The site also links people to the Connecting Wiltshire website (a site set up with LSTF money) http://www.connectingwiltshire.co.uk/. The site provides information about walking and cycling routes within Wiltshire, bus and rail times and routes and personal travel planning.

In Salisbury, the AQAPG secured funding from the Area Board to plant silver birch trees in the city along the busy main roads. Evidence from Lancaster University research shows they are good at trapping particulates. All volunteers received community time credits. As a result, the group have been contacted by a local hospital offering their site and 150 trees obtained through a Woodland Trust grant. Tree planting is just one small step, but already the scheme is proving successful and more suitable sites are emerging resulting in a greener city with improvements to air quality.

In Devizes the AQAPG have concentrated on cycling and business travel planning and aim to embark on a school travel planning project with a schools. Through working with the sustainable transport team they have successfully introduced business travel planning to Aster Housing Association who has a main office in the town. Over 150 personal travel plans are being produced for staff and the company have managed to save many business miles and officer time wasted travelling to meetings by introducing smarter ways of working. The next stage is to engage with major employers within the town. The project came out of an in-depth origin and destination study undertaken in the town through work with transportation colleagues. Air quality data was shared with them to enable a model to be run looking at the impact on air quality of scenarios such as junction improvements and travel planning initiatives.

What were the key success factors?

The Public Health Team remained together through transferring to the council. Importantly, 'Public Health' is a mandatory heading in all Council and Cabinet papers. In April 2014 a new public health specialist post was created and located within the Public Health team in part to address air quality and the wider health aspects. This role has really helped the AQAPGs get over the stumbling block of ‘air quality data’ and ‘breaches of EU levels’ and help them look at ways of improving air quality through other health outcomes such as addressing childhood obesity, and increasing active travel.

Although the AQAPGs work independently of each other it was felt that they needed to be able to promote their work. A generic logo (see example below) is now used with each AQAPGs individual strap line. This has helped with the group’s identity and communities will begin to recognise it as projects are implemented.

What were the challenges? How were they/could they be overcome?

In the early days of the AQAPGs, there was very little trust of the council by group members as to what could be achieved and the focus was very much ‘what was the council going to do to resolve the problem?’ However, as information and data has been provided to the groups on an individual basis the trust has been built and community led actions have started to emerge from the groups. The move of Public Health into the authority provided additional support to the groups and very much focused the groups on the health impacts associated with poor air quality.

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