Rule 6 Statement of Case

Inner Leeds Health Monitor

Appeals by the Morley House Trust against the non-determination of five planning, conservation area and listed building applications on the site of the former Leeds Girls High School, Headingley Lane, Leeds:

APP/N4720/A/10/2140564

APP/N4720/A/10/2140572

APP/N4720/A/10/2140575

APP/N4720/A/10/2140578

APP/N4720/A/10/2140587

Our evidence to the Public Inquiry will relate mainly to the Medical and Public Health aspects of these planning applications and appeals.

When considering planning appeals, it is necessary to address all material planning considerations. These include health considerations in Planning Policy Guidance 17 (PPG17) and the requirements of the various Equalities Acts and the Race Relations Act 1976. The government has indicated that it intends to transfer responsibility for Public Health to Local Authorities. The need to provide adequate recreational open space will exist regardless of who has responsibility for Public Health, but the Inquiry should consider how exactly the Council (or other public authority) could discharge their responsibilities in this area.

The relationship between physical activity and good health was appreciated by the Ancient Greeks. The effects of obesity on life expectancy have been known to Life Assurance companies since the 19th century. In the last twenty years these insights have been placed on a much firmer scientific footing.

The area of Leeds surrounding the former Leeds Girls High School (LGHS) has a significant South Asian population. Throughout the world this ethnic group is characterised by very high rates of visceral adiposity, type 2 diabetes, hypertension and cardiovascular disease. Nowadays this pattern is often referred to as the "metabolic syndrome". The close links between lack of exercise and development of the metabolic syndrome are well established in the medical and scientific literature, with hundreds of peer-reviewed papers published each year on this specific topic. The cluster of symptoms is widespread in all ethnic groups, but South Asians are particularly sensitive and would derive particular benefit from improvements to local sports and recreational provision. The area surrounding LGHS is among the most deprived in terms of recreational provision in the entire city.

Knowledge of the particular problems faced by the South Asian Diaspora has only been appreciated over the last ten years. This reflects a growing scientific awareness of the genetic basis of many disease processes. For example, the sickle cell trait is particularly common in Black populations, thalassaemias among people from the Eastern Mediterranean, and cystic fibrosis among Western Europeans. Diabetes and Cardiovascular Disease affect South Asians everywhere (not just in the UK) and this is a matter for international concern.

We will quote from a review article by Barnett et al (2006) which summarises the situation without excessive recourse to technical terms. These workers are based Birmingham. Much of the UK research on this topic originates from the midlands, where there is a significant South Asian population, as there is also in Leeds. These workers observed:

• The prevalence of type 2 diabetes and cardiovascular disease is significantly increased in immigrant south Asian compared with indigenous populations.

• South Asians generally have a characteristic risk factor profile that is representative of the metabolic syndrome.

• The characteristic risk factor profile of south Asians, consisting of a clustering of the major metabolic abnormalities predictive of type 2 diabetes and cardiovascular

disease, suggests it is prudent to hold a high index of suspicion for these conditions in south Asians.

• Conventional approaches to treatment and prevention are based on trials performed in white Caucasian populations and may underestimate risk in south Asians and result in undertreatment.

• New approaches to management that incorporate the specific needs of south Asian communities are required.

"Moderate to high levels of physical activity are known to significantly reduce the risk of CHD. Exercise can improve HDL cholesterol levels and ameliorate insulin resistance in south Asian as well as white Caucasian populations."

We have received a series of reports to the Health Scrutiny Board about the appalling health gap between different areas of Leeds. Reducing this gap is an important Council objective, and the Town and Country Planning System must be part of this. These "all cause" mortality figures have been standardised to facilitate comparisons between areas according to a system agreed by the Office for National Statistics that is used throughout the European Union. This takes account of the differing age structures to the population in different parts of Leeds, and shows that the risk of death in the most deprived, largely inner-city areas is up to three times higher than in the most prosperous ones. This translates into a ten to twelve year difference in average life expectancy. This outcome is not acceptable in a civilised society.

We should soon have the same data broken down by Census Super Output Areas, which will be even more revealing than the present set. Please note that many of the other UK core cities lack Leeds extensive rural hinterland, which generally has good life expectancy. If we compared the old Leeds County Borough area with our fellow cities, we would look very bad indeed.

This isn't simply a problem of cardiovascular health. Recent figures suggest that depression (which is a major problem in Leeds) is also correlated with lack of physical recreation and lack of recreational open space.

NHS statistics show that inner Leeds in general, and specifically the areas adjacent to LGHS, have very high rates of diabetes and cardiovascular disease and exceptionally high age-adjusted death rates from these conditions. These translate into the ten-year difference in life expectancy between areas adjacent to LGHS compared with the outer areas of our city. At least five local primary schools within easy traveling distance of LGHS do not achieve DfES norms for recreational open space provision, and despite their best efforts have difficulty in offering a full PE curriculum. Children who attend these primary schools have the highest rates of childhood obesity in the whole of Leeds, and they are expected to encounter serious health problems in their later life as a direct result of this under-provision.

Central Leeds has among the worst recreational provision in the entire country, per head of population, which is the most relevant measure. Although Leeds City Council has collected this data, and we have seen much of it under FoI, but there appears to have been some reluctance to put this information before the Plans Panel (and

elected members generally) until after the LGHS planning applications have been determined. It seems that elements within the Council are trying to manipulate the views of elected members and the public by denying them access to relevant data.

To our astonishment, Leeds City Council planning officers have sought to downplay the Public Health aspects of the LGHS planning applications and appeals, and have attempted through procedural devices to prevent the councillors even discussing these issues. This seems perverse because the Government has indicated that in the future local authorities will assume much greater responsibility for Public Health. There are no suitable alternative sites for improved recreational open space in the vicinity of LGHS.

List of Documents

Leeds Census Data

Planning Policy Guidance 17

Leeds Unitary Development Plan

Leeds City Council Open Space Statistics

Leeds City Council Health Scrutiny Board Reports

Leeds City Council Statement of Community Involvement

Leeds City Region Green Infrastructure Strategy (and associated reports)

National Institute for Health and Clinical Excellence (NICE)

Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (CG43)

Type 2 diabetes (CG66)

NICE public health guidance 2 Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling

NICE public health guidance 8 Promoting and creating built or natural environments that encourage and support physical activity

NICE public health guidance 9 Community engagement to improve health

NICE public health guidance 17 Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings

NICE public health guidance 25 Prevention of cardiovascular disease at population level

2008 *Physical Activity Guidelines for Americans* (U.S. Department of Health)

Barnett et al (2006) *Type 2 diabetes and cardiovascular risk in the UK south Asian community.* Diabetologia **49**, 2234-2246

Booth & Lees (2007) *Fundamental questions about genes, inactivity, and chronic diseases*. Physiological Genomics **28**, 146–157

Byberg et al. (2009) *Total mortality after changes in leisure time physical activity in 50 year old men: 35 year follow-up of population based cohort.* British Medical Journal **338**, b688

Franks et al (2010) *Childhood Obesity, Other Cardiovascular Risk Factors, and Premature Death*. New England Journal of Medicine **362**, 485-493

Goodpaster et al (2010) *Effects of Diet and Physical Activity Interventions on Weight Loss and Cardiometabolic Risk Factors in Severely Obese Adults*. Journal of the American Medical Association **304**, 1795-1802

Hawley & Holloszy (2009) *Exercise: it's the real thing!* Nutrition Reviews **67**, 172–178

Inoue et al (2008) *Daily Total Physical Activity Level and Premature Death in Men and Women: Results From a Large-Scale Population-Based Cohort Study in Japan (JPHC Study)* Annals of Epidemiology **18**, 522–530

Katzmarzyk et al (2003) *Physical inactivity, excess adiposity and premature mortality*. Obesity Reviews **4**, 257–290

Kokkinos et al (2009) *Exercise Capacity and All-Cause Mortality in Prehypertensive Men.* American Journal of Hypertension **22**, 735-741

Kokkinos et al (2010) *Exercise Capacity and Mortality in Older Men* . Circulation **122**, 790-797

Logue et al (2011) *Obesity is associated with fatal coronary heart disease independently of traditional risk factors and deprivation.* Heart doi:10.1136/hrt.2010.211201

Ross & Bradshaw (2009) *The future of obesity reduction: beyond weight loss*. Nature Reviews Endocrinology **5**, 319–326

Sattelmair et al (2010) *Physical Activity and Risk of Stroke in Women.* Stroke **41**, 1243-1250

Willet et al. (1999) *Guidelines for Healthy Weight* New England Journal of Medicine **341**, 427 – 433

Wing et al (2010) *Long-term Effects of a Lifestyle Intervention on Weight and Cardiovascular Risk Factors in Individuals With Type 2 Diabetes Mellitus*. Archives of Internal Medicine **170**, 1566-1575

Yates et al (2010) *Levels of physical activity and relationship with markers of diabetes and cardiovascular disease risk in 5474 white European and South Asian adults screened for type 2 diabetes*. Preventive Medicine **51**, 290-294