Making an Impact: building capacity for health impact assessment in Liverpool

Workshop Report August 2005

Rapid Health Impact Assessment of the

Draft Liverpool Alcohol Strategy

IMPACT

The International Health Impact Assessment Consortium

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1 About this document

The aim of this document is to:

- provide feed back to members of the Liverpool Alcohol Strategy Group (LASG) from participants in the rapid health impact assessment of the Liverpool Alcohol Strategy (hence forth called the Strategy) workshop held 11th April 2005
- to make recommendations as to how to enhance the Strategy based on these findings.

Action required by Steering Group members is to:

- discuss and agree recommendations that will be included in development of the Strategy;
- agree the next steps in implementation of the Strategy.

2 About IMPACT

IMPACT, The International Health Impact Assessment Consortium is based within the Department of Public Health at the University of Liverpool. IMPACT's mission is to improve the health and wellbeing of individuals and populations by promoting the understanding, development and application of health impact assessment at all levels (i.e. policy, programme or project).

We achieve this through:

- the promotion of academic research, education, training, consultancy, dissemination of information, and collaboration, nationally and internationally, in both organisational and community settings;

- promoting the integration of HIA into public policy development and planning, public health policy-making and practice, and other forms of strategic and project-level impact assessment.

3 Introduction

It is generally acknowledged that alcohol can have good and bad effects on health (Kemm 2004). Alcohol in moderation has some health benefits, can enhance social interaction, and contributes to the economy through employment and generation of revenue. Conversely, the misuse and abuse of alcohol impacts negatively on individual wellbeing for example physical and mental health, the social and physical infrastructure of social spaces such as antisocial behaviour, family disruption, and the economy by loss of productivity (Public Health Northwest Alcohol Strategy Group 2004).

It is therefore to be expected that the relationship between alcohol and health is of concern to policy makers and service providers alike. Particularly in a landscape of increasing public concern about binge drinking and antisocial behaviour, and the variety of mechanisms for harm these create for individuals and communities. Alcohol policy is an area that impacts on many aspects of life and touches numerous cross-cutting themes.

3.1 Background to Liverpool Alcohol Strategy

Within England, alcohol abuse has become a major public health issue as:

> "there is evidence that patterns of heavy and binge drinking may be particularly serious in the UK, leading to an increase toll of premature deaths and health problems, and alcohol related disorders and injuries."
>
> (Prime Minister's Strategy Unit 2003)

Consequently this has led to the Alcohol Harm Reduction Strategy (Prime Minister's Strategy Unit 2004) which represents a whole systems approach to identifying priority areas that require action. This approach is an inclusive approach that recognises the contribution that *all* partners make to the delivery of high quality services across *all* sectors and ensures that *all* stakeholders are involved in both planning and delivery. The UK strategy is based on the assumption that any collective behavioural change requires success on three broad fronts: Environment, Empowerment and Encouragement.

In Liverpool, an Alcohol Reference Group produced a report 'Invest to Save Final Report' (1999) and an initial strategy for reducing alcohol related harm (Liverpool Crime & Alcohol Project). It was within this context the current Alcohol Strategy Steering Group (LASG) was established. The Steering Group consists of all key stakeholders including the Health Service, the Police, Local Authority, Voluntary Sectors as well as the drinks industry & service users. A draft alcohol strategy specific to Liverpool (henceforth called the Strategy) has been developed.

Increasing awareness of the significance of alcohol and public health is supported by a number of national policies such as the Alcohol Harm Reduction Strategy for England (2004); National Service Frameworks (Mental Health 1999b;CHD 2000;Older People 2001;Children and Young People 2005); the Public Health White Paper Choosing Health (Department of Health 2004), and the New Licensing Act (2003). The Alcohol Strategy Group (henceforth called LASG) revisited the draft strategy to 'reflect a public health approach to partnership working'. The purpose of LASG is to bring together key stakeholder organisations to agree a strategy to promote healthy life styles, encourage self-management of safe drinking and reduce alcohol related harm.

3.1.1 Aim of the Strategy

- To prevent any further increase in alcohol related harm in Liverpool through effective partnership working across local government, the Police, health services, the drinks industry, voluntary sector organisations and community members.

3.1.2 Objectives of the strategy

- To create a cultural change within the community by promoting knowledge and safe drinking concepts through a programme of education.
- To prevent the misuse of alcohol through the promotion of healthy life styles
- To create a vibrant, safe environment within the city for social interaction and sensible alcohol consumption
- To encourage and support commercial activities which will result in the safe and acceptable use of alcohol
- To provide a robust model of care for the effective treatment for those affected by alcohol abuse
- To reduce current levels of criminal and disorderly activities associated with the inappropriate use of alcohol

3.2 Background to the Health Impact Assessment

'Making an Impact: Capacity Building for HIA in Liverpool' is a two and a half year project integrating HIA into policy, projects and programmes across the city. It is a collaboration between the Liverpool Primary Care Trusts, Liverpool City Council and IMPACT at the University of Liverpool. It is based on partnership working with support and commitment from the highest and strategic level throughout these organisations.

The Alcohol Strategy was identified as a potential policy to build a Health Impact Assessment (HIA) Action Learning Set (ALS) around as it represents a partnership approach to resolving the health impacts of alcohol misuse. The ALS could be used to support work on four work streams: Information and Intelligence, Treatment & Intervention, Crime & Disorder and Industry & Commerce. This would also allow for a more in-depth assessment of the Strategy and the potential impact on health and wellbeing across different groups in the drafting stage of the Strategy to ensure existing health inequalities are acted upon and new ones inadvertently created.

3.2.1 Health Impact Assessment

Health Impact assessment (HIA) is commonly defined as 'a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population' (European Centre for Health Policy 1999).

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. Factors such as housing, income, employment, where you live, the range of services you have access to such as schools, shops etc., influence the degree of health, wellbeing and quality of life achievable by individuals and communities. These factors are referred to as 'determinants of health' (Acheson 1998;Department of Health and Social Security 1980;Whitehead, Diderichsen, & Burstrom 2000). Health Impact assessment uses a socio-environmental model of health (Dahlgren & Whitehead 1991) to encompass these broader determinants to gain a clearer picture as to how a strategy such as the Liverpool alcohol Strategy may impact upon health.

3.3 National Drivers for HIA

In the last 10 years there have been various developments in the UK, Europe and further a field, which have drawn attention to the health effects of non-health care policies. These developments have included HIA as a tool to consider the health effects of policies such as housing, regeneration and transport. In the UK, the English, Welsh and Scottish public health strategies have all included undertaking HIAs of local and national developments as a priority, and funded research and development projects to build capacity for HIA. For example, 'Saving Lives: Our Healthier Nation' (Department of Health 1999a) outlines an intention to make HIA "a part of routine practice for policy making in government" and "to encourage local health impact assessment when planning investment…" The latest White Paper: Choosing Health incorporates HIA as part of Regulatory Impact Assessment (Department of Health 2004).

3.3.1 Use of HIA within Local Government

There are a few published examples in England that demonstrate how HIA can be brought into mainstream local policy-making and planning activities (Bowen 2004;Milner 2004). Probably the biggest commitment made by a local authority to undertake HIA to date is that made by the Greater London Authority (GLA). The GLA committed each of the mayoral strategies, for example transport, economic development, air quality, biodiversity, spatial development and culture to name just a few, to prospective rapid HIAs. Liverpool City Council and the three Primary Care Trusts have also recently committed themselves to improving health and reducing health inequalities through health impact assessment.

A mapping exercise carried out by the Health Development Agency (HDA) found a variety of applications of HIA across different sectors such as housing, transport, regeneration and health projects programmes and policies – all within the remit of Local Government. Regeneration and transport interventions were the most commonly found. The use of HIA by LSPs is currently being evaluated.

Other Local Authorities are using HIA methodology as part of Scrutiny function and Best Value Reviews: for example, to assess how the policies of council departments improve health and reduce inequalities in health, and to assess whether Health Partnership structures and planning processes are fit for purpose.

3.3.2 Use of HIA within the NHS

The use of HIA within the NHS, like Local Authorities, is sporadic but rapidly growing. For example HIAs of capital development programmes at Salford Royal, St Helens & Knowsley Hospital, Central Manchester & Manchester Children's, and most recently of the Choice and Future Healthcare programmes in Merseyside. In addition Ashton, Leigh and Wigan PCT have developed a HIA Policy for screening and undertaking HIA.

3.3.3 Lessons learned

This is a synthesis of the key learning points identified from early HIA work:

- Policy and legislative frameworks are key drivers for action
- HIA is a useful tool for creating healthy public policies (HPPs)
- Local authorities are extremely important for the development of HIA as they have considerable influence on the determinants of health.
- HIA champions are invaluable in HIA agenda-setting
- High profile strategies to raise awareness of HIA and its application are important

- HIA supports and strengthens partnership working – shared vision and corporate objectives
- Need to ensure adequate resources for HIA activity
- Early engagement of decision makers in HIA development is important
- Reflective approach to learning is valuable in HIA capacity building
- Greater understanding of health and its determinants ('health consciousness') is needed to understand and use HIA

3.4 Undertaking a HIA on the alcohol strategy

Undertaking a HIA on the Strategy allows a wide ranging group of key stakeholders to come together to look at the issues relating to alcohol and health specifically for those who live and work in Liverpool. It is a way of capturing the best evidence available at the time to help justify policy content and the assumptions as to what it will achieve. It enables stakeholders to identify the main health determinants likely to be influenced by the Strategy, the direction of change of these determinants (ie positive or negative) the potential health outcomes and, most importantly ensure existing inequalities are not exacerbated or new ones created.

Members of the LASG, for a variety of reasons, were finding it difficult to engage with the concept of participating in an Action Learning Set, therefore it was agreed that holding a rapid HIA workshop would provide partners valuable time to think and work together on the Strategy development that they would not otherwise have. It was agreed that the HIA would consist of a participatory workshop only.

4 What we did

17 people attended a participatory HIA workshop at the Foresight Centre (see appendix-list of attendees. The day was divided into 4 sections; each group used a social model of health to explore:

- **Section 1**
  Relationship between alcohol and health,
- **Section 2**
  the potential health impacts of the strategy, and which determinants would change,
- **Section 3**
  Prioritisation of impacts, and
- **Section 4**
  Developed recommendations to inform development of the strategy

We worked in two groups. Group one focused on 'Treatment and Intervention' and 'Information and Intelligence'. Group 2 focused on 'Crime and Disorder' and 'Industry and Commerce'. At the end of the day the two groups fed back their prioritised recommendations.

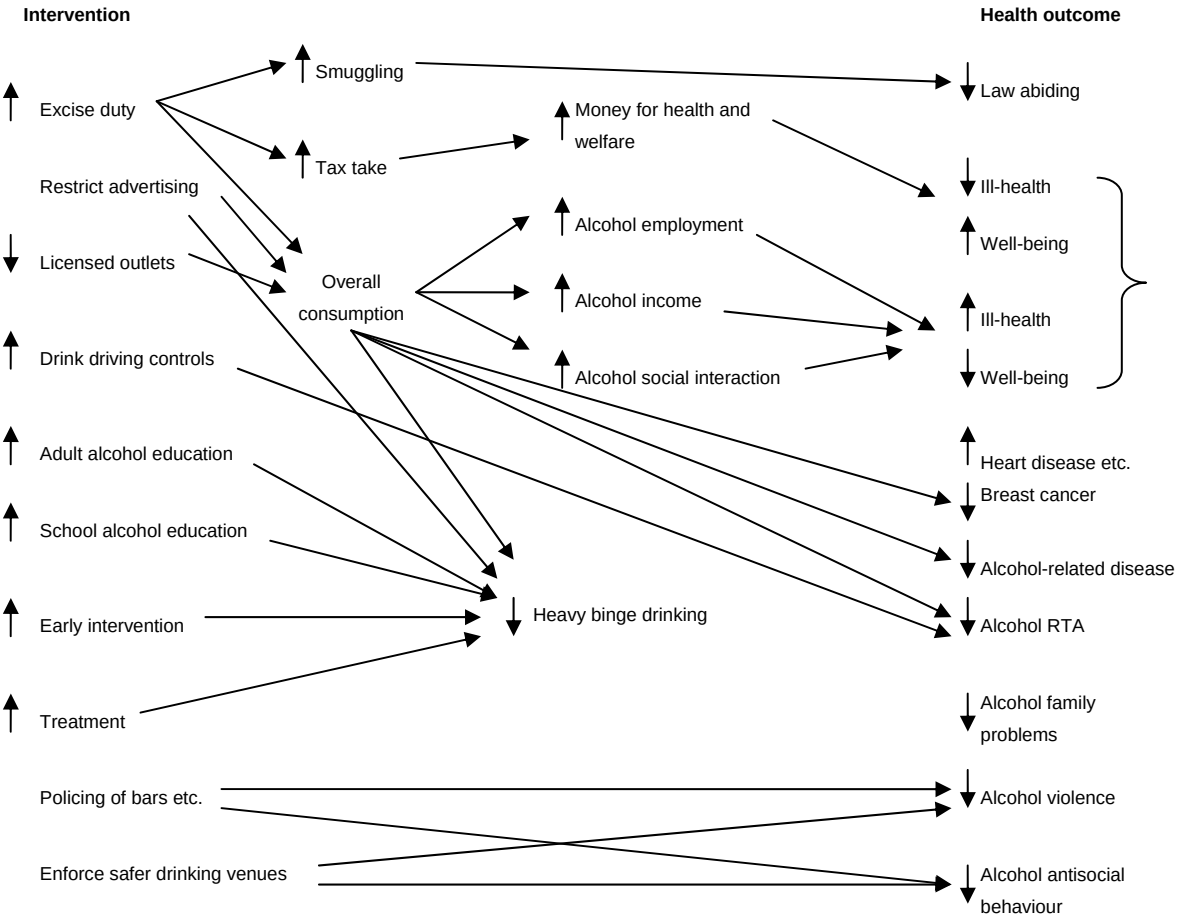
5 What we learned

Alcohol plays an important role in Liverpool. Both groups had intense discussions with a wide range of views being expressed. There are mixed attitudes towards alcohol with alcohol being seen to have positive as well as negative aspects. Generally there appears to be no coherent picture of the relationship between alcohol and health in Liverpool. For example, although Liverpool and the Northwest in general is reported to have some of the highest levels of alcohol consumption, morbidity and mortality in the UK (Public Health Northwest Alcohol Strategy Group 2004), there was a view by some participants that alcohol related health and social problems were no worse in Liverpool than any other large city. Nevertheless all participants identified the need to have good accessible data and analysis of the situation in Liverpool.

There was also discussion about the Liverpudlian and more generally the English drinking culture. There is concern that England is different from mainland Europe and may encounter problems if continental style drinking regulations such as longer opening hours are introduced. Some participants recommended that when looking for examples of best practice internationally we should particularly look to countries with similar drinking cultures such as Australia and New Zealand.

Participants predicted changes in health determinants and likely health outcomes as a result of a Liverpool Alcohol Strategy similar to those identified by Kemm (2004)(figure 1).

Figure 1 Causal pathways in alcohol policy (after Kemm 2004)



Generally it was found that there is a lot going on in Liverpool much of which is very good quality. However this work is often piecemeal and generally it was felt that opportunities are being lost for partnership working. Many of the opportunities and challenges identified in the following section relate to this.

5.1 Opportunities and challenges

5.1.1 Resources

- Services are now target driven. The pressure to fulfil targets means that if something does correspond with a target it is more difficult to obtain funding. Some participants found that the focus on targets means that decisions are made based on what will fulfil targets rather than what will best promote health.
- Commissioning frameworks are service driven tending to focus on acute care and treatment. This makes it difficult to acquire funding for prevention work.
- Presently it is unclear how alcohol fits into the commissioning framework. It comes up in different areas but there is no specific alcohol focus.
- It is also unclear how services are rationed. The principles related to planned versus unplanned care are confusing.

5.1.2 Partnership working

- The drive to mainstream partnership working has often resulted in organisations using the language of partnership and also the existence of formal partnerships but (as evidenced by the LASG itself) this has not resulted in real partnership working.
- Partners are often working in silos which lead to duplication of work and opportunities for sharing and learning being lost.
- A characteristic of the relationship between the voluntary and statutory sector appears to be a lack of understanding of how each other works or rather, how they could best work together. A strong theme that came through was that the voluntary sector feels that they carry out good effective work but the bureaucratic hurdles and general difficulties in finding ways of slotting into statutory resources means that they are unable to carry out as much work are capable of.
- There were examples given of missed opportunities for partnership working. For example, it was felt that Joint Agency Groups (JAGs) presently work reactively. There is potential for the Cluster boards, who have good grass roots knowledge, to potentially feed into the JAGs which would enable the JAGs to act more strategically.
- Alcohol related industry is often left out of this partnership working. It was felt that there should be more linkages with the industry. A wider range of alcohol related industry such as supermarkets should also be included.
- There are also some potential stakeholders that have not yet been included in the alcohol strategy development such as planners.

5.1.3 Community involvement

- The statutory organisations represented on the LASG have obligations to consult and involve communities and the voluntary sector.
- These organisations can also be sources of funding. However community groups and the voluntary sector are often put off by the bureaucracy involved in applying for funding. It was felt that these resources could be utilised more effectively if ways of overcoming these barriers could be found.
- Another barrier to working together more effectively was seen to be the often differing values between community and statutory organisations. For example

it was suggested that voluntary organisations need to fit their projects into the statutory organisations' targets to increase their chances of receiving funding.
- Some participants felt that we should be explicit about the power differentials between these different groups when we work together.
- The alcohol strategy as it presently stands does not take into account the cultural diversity of Liverpool.

5.1.4 Data collection, Monitoring and Evaluation

- There is a large amount of data being collected in Liverpool. Presently much of this in inaccessible or only accessible to a narrow range of partners. A mapping exercise would provide an overview of what data is available and being collected. It is suggested that a data warehouse would make data more accessible.
- The way data is gathered should also be reviewed. For example the way hospital data is gathered means that a lot of alcohol related injuries are not recorded.
- Presently there are limited resources to fund monitoring and evaluation. This means that good practice is often not shared and bad not picked up.
- It was felt that the alcohol strategy should have an independent evaluation of interventions. Evaluations should consider short, medium and long-term interventions and effects.

5.1.5 Mixed messages

- Information around alcohol and health is often unclear. Unlike most other drugs we are given mixed messages about the risks and benefits of alcohol.
- It was suggested that relationships need to be built up between different stakeholders so that issues such as this could be discussed. For example in the courts alcohol is often seen to be a mitigating rather than aggravating factor.
- The different stakeholders relevant to the alcohol and health relationship often have different interests and perspectives (e.g. police vs. licensees)
- We need to look for opportunities for including alcohol issues in areas that we may not traditionally think of. For example tenancy agreements in social housing can have clauses about alcohol related anti-social behaviour.
- We need to support and promote positive practices rather than being purely enforcement orientated. For example, identify responsible retailers and using them as examples of good practice.

5.1.6 Differential impacts

- Participants thought that the strategy as it stands does not take into account enough the differential impacts alcohol and alcohol related strategies have in Liverpool.
- Different groups that should be specifically considered are;
    - Age- It was suggested for example that work with young (<18s) should focus on education and restricting access, 18-24s- safe drinking. There may also be different impacts on elderly people
    - Ethnicity- for example Liverpool has significant Chinese, black Caribbean and Somali populations. Race Equality Impact Assessments could identify particular impacts on those groups
    - Literacy- when planning strategies levels of literacy should be taken into account. Messages should be available in appropriate language and languages. Alternative means of communication should be considered.

    - Gender
- Differential impacts over time should also be considered. The strategy should aim to support sustainable action.
- Alcohol related strategies were also thought to affect different geographical groups. For example if resources are targeted at the city centre, suburban residents may miss out.
- The planning department is a potential valuable partner. They can influence how land is used and the designing out of alcohol related problems.

6 Recommendations

1. Mainstream action on alcohol and health across LASG partnership.	1a. Promote a strategic approach through the Joint Agency Groups to ensure initiatives meet the aims and direction of the alcohol Strategy. 1b. Develop a communication strategy so that the public get the same messages about the relationship between alcohol and health from all partners; 1c. Promote the inclusion of health related Key Performance Indicators (KPI's) within the Crime & Disorder Reduction Partnership (CDRP) Business Plan. 1d. Encourage a Public Health approach within all services but particularly in the Youth, Education and Social Services section; 1e. Develop, initiate and monitor a policy to ensure all commissioning and policy planning is routed through the Alcohol Strategy group to ensure effectiveness and efficiency in delivery of Strategy objectives.
2. LASG should gather information and identify opportunities for effective behaviour change through education and health promotion activities.	2a. Education needs to be more than providing information. Members of the Intelligence and Information work group should identify who has access and support. 2b. Activities should be linked to National curriculum, Personal and Social Education (PSE), Healthy Schools Programme and Youth Services
3. Benchmark current activity across the City relevant to the Strategy aims and objectives.	3a. Establish a Data Warehouse to inform all partners, service providers, voluntary groups and the public; 3b. Identify and ring fence resources for the Data warehouse 3c. Members of the Information and Intelligence workgroups should undertake a baseline assessment to include: • Liverpool City Profile

	• Identify data sources, existing data, gaps, accessibility to data and information; • Develop a LASG commissioning framework • Mapping exercise – what already being done, where and by whom; how it fits together – identify existing partnership work
4. Lobby service commissioners to include alcohol related action.	4a. Commissioning frameworks – should explicitly target alcohol related health prevention interventions across all sectors – ie PCTs LCC and Voluntary sectors 4b. The Information and intelligence group should be responsible for monitoring and evaluation of treatment services in terms of efficiency, effectiveness and cost sensitivity (ie best value) and report to findings to LASG.
5. Expand membership of LAGS.	5a. Action on mainstreaming requires representation from Planning division of LCC and Liverpool's Legal system eg Lawyers, victim support groups etc 5b. Action to identify the needs of the diverse culture within Liverpool and ensure effective interaction with hard to reach, excluded or minority groups should ensure cultural competency in strategy implementation;
6. Partner organisations should lead the way in demonstrating good corporate citizenship.	6a. Review policies in place for alcohol misuse and management programmes in the workplace 6b. Identify actions based on best practice (evidence) likely to influence cultural acceptance of binge drinking and drunkenness 6c. Encourage partnership alliances particularly with the Alcohol Industry including supermarkets licensed to sell alcohol, to develop a code of practice.

If the problems associated with misuse and abuse of alcohol consumption and it's consequences for health are to be influenced in the long term, particularly with Liverpool City of Culture 2008 celebrations, the actions commissioned should be assessed for their short, medium, and long term sustainability.

6.1 Workshop evaluation

Twelve of the seventeen people who attended completed evaluation sheets. Overall the responses were favourable with many participants finding the HIA process particularly useful in thinking about how the Strategy will influence the broad determinants of health and wellbeing, and what changes are needed to make this happen. Participants were asked to use three words to describe the day. Words used included productive, stimulating informative, educational worthwhile, challenging, confusing (at times), hard work.

In answer to how the day contributed to their understanding of the relationship between alcohol and the broader (holistic) model of health, people commented that it:

> "reinforced my knowledge of the key health issues and the importance of partnership working" and,
>
> "understanding has led to awareness of what knowledge gaps are there."

One participant did not think they had learnt anything new.
Whilst some found the workshop challenging, there was a general consensus that HIA was

> "a very useful way to get people to think about the issues from a broad perspective" and,
>
> " an important tool in influencing future policies
>
> "I recommend HIA for further projects that require a clear structure."

Whilst the utility of HIA for evaluating the Strategy was applauded, some did raise concern that there was a danger of vastness which could make it appear too hard to do, but this could be avoided by ensuring the parameters of the HIA were explicit ie in the scoping stage of the HIA.

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Rapid Health Impact Assessment of the Liverpool Alcohol Strategy
Participatory Workshop

Date: 11th April 2005
Venue: The Foresight Centre, University of Liverpool
Time: 9.30 am to 4.30pm **(Refreshments and lunch is provided)**

Aims of the Workshop

- To explore the impact of implementing the Liverpool Alcohol Strategy and Action Plan on the health and wellbeing of people who live and work in Liverpool;
- To identify priority areas and develop an action plan to take the strategy forward.

Workshop Design

Facilitated group work and guided discussion

Outcomes

At the end of the workshop participants will have

- a raised awareness of Health Impact Assessment;
- a shared understanding of the relationship between alcohol, health determinants and health;
- contributed to a baseline assessment by providing evidence (personal knowledge and experience) as to current issues on alcohol, health and wellbeing in Liverpool;
- identified priority areas for action within the 4 core themes of Education, Support and Treatment, Commerce, and Crime and Disorder, (ie which determinants of health will be changed and how);
- agreed a list of outcomes, which are measurable and can be used to evaluate implementation of the strategy and its outcomes.

Workshop Programme

9.00	Registration
9.30	Welcome and introductions — Soraya Meah and Debbie Fox
9.40	What is health impact assessment?
10.00	Introduction to workshop – how it works
10.10	Exercise1 Alcohol and Health – what do we already know
10.45	Feed back
11.00	.**Break**
11.20	Exercise 2 HIA of Liverpool Alcohol Strategy and Action Plan
12.30	**LUNCH**
1.45	Exercise 2 continued
2.20	Group work. Exercise 3 Recommendations and Priorities
3.00	**Break**
3.20	Feed back
4.20	Reflection on the day
4.30	Finish

Facilitators: Debbie Fox, Fiona Haigh, Sophie Grinnell

Workshop Guidance

Liverpool Alcohol Strategy

Participatory Rapid Health Impact Assessment Workshop Guidance

Foresight Centre
University of Liverpool

Monday 11th April 2004

Workshop Guidance

10.10 Exercise 1 Alcohol and health: what do we already know? (35 minutes)

Introduction to Rapid HIA Exercise

The facilitator will divide you into small groups. Each group facilitator will explain the exercise.

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. Factors such as housing, income, employment, where you live, the range of services you have access to such as schools, shops etc., influence the degree of health, wellbeing and quality of life achievable by individuals and communities. These factors are referred to as 'determinants of health (Black, 1980; Acheson, 1998; Whitehead et al, 2000). Health Impact assessment uses a socio-environmental model of health (Dahlgren & Whitehead, 1991) to encompass these broader determinants to gain a clearer picture as to how strategies such as 'The Liverpool Alcohol Strategy' may impact upon health and wellbeing.

One of the aims of this exercise is to reflect and share skills and knowledge you already have that can be used in assessing the potential impacts of the proposed Strategy on the determinants of health, and consequently, health outcomes. Some members in your group will have knowledge and experience of working with health determinants, for others it will be completely new. What you *will have* in common, is a desire to promote health and wellbeing, act to reduce inequalities in health, and deliver the best service to those who live, work and visit Liverpool.

Remember this is about teamwork and the sharing of knowledge and experience. There are no right or wrong answers. Everyone has a voice.

1. **In your small group think about the relationship between alcohol and health/determinants of health. Use the social model of health to help you think through the issues.**
2. **What is the current picture of the relationship between alcohol and health in Liverpool?**

Jumping in
The first exercise in the workshop provides an opportunity to "jump in". See this as a mind mapping exercise.
As a reminder, the rules are as follows

There is no right or wrong answer;
Items are added without critical analysis;
Everyone's contribution is equal.

Use post it notes, one issue on each note. Then sort them into the different categories ie personal, social, etc. on flip chart paper. (You will want to refer back to these charts for exercise 2)

Meet back in the main plenary room at 10 .45 prompt – bring the charts with you.

10.45 Feedback (15 minutes)

Each small group will alternate and feedback issues raised from the exercise. The aim is to develop a picture of the relationship between alcohol and health/health determinants and how this is expressed in Liverpool.

11.20 Exercise 2 The Liverpool Alcohol Strategy (1hr 55 minutes)

In your small group for each of the elements of the Strategy your group has been given please:

1. Identify which health determinants are likely to change. In each case will this change be negative or positive?

2. What impact will this change have on health and wellbeing for i) individuals ii) specific groups (ie the distributional effects -will there be different implications for different groups?) iii) Liverpool City population as a whole: Are there winners and losers?

3. What are the barriers/risks (potential/actual) to implementing the Strategy elements proposed?

Guidance for exercise 2

1. Think back to the picture painted of the relationship between alcohol, health determinants, and health in Liverpool, identify the key health issues relating to your group's elements of the Alcohol Strategy.
2. Think about the population groups, whose health is most likely to be affected by the Strategy(e.g. elders; people in poverty; men; ethnic minorities, young people, professionals, business owners and traders etc).
3. List the elements / activities of the Strategy which are likely to impact on these population subgroups.
4. Discuss and record the potential health impacts – the beneficial and adverse effects - of the Strategy.
5. What may be the wider implications in terms of the City as a whole? – (eg Capital of Culture 2008)

2.00 Exercise 3 (30 minutes)

In your small group for each of the elements of the Strategy your group has been given please prioritise the themes/issues identified. Remember to justify your decisions and write them down. The group facilitator will guide you through this process using a colour coding scheme.

1. In almost all HIAs it will prove impossible to consider all potential impacts in detail, therefore you must prioritise those you consider the most important.
2. Because of differential perceptions of risk there may not be complete consensus so you may need to negotiate. The facilitators will try to record everyone's views for inclusion in the write up of the workshop and highlight areas of conflicting views.

2.30 Feedback (30 minutes)

Each small group will alternate and feedback issues raised from the exercise. The aim is to develop a generic list of priority areas to help identify recommendations.

3.20 Exercise 4 Developing Recommendations (60minutes)

This will be done in the large group in the main plenary room.

1. Whether or not the group has the power to make direct decisions on the strategy, members will be in a position to recommend potential change to the proposal, highlighting practical ways to maximise health gain and minimise potentially harmful/unfair impacts.
2. The group needs to agree a set of recommendations: a maximum of six for each element/theme of the Strategy.

Guidance for making recommendations

- Recommendations should be:
    - Practical
    - Aim to maximise health gain and minimise health loss
    - Are sociably acceptable
    - Consider the cost of implementation
    - Consider the opportunity cost
    - Includes preventative as well as curative measures
    - Try and prioritise (if time) as short, medium or long term objectives
    - Suggest ways of dealing with barriers to change
    - Identify lead agency or individual
    - Should be amenable to monitoring and evaluation

For example:

- ways in which the proposed policy could be changed to maximise the positive health impacts, to minimise the negative ones or to reduce inequalities between population groups (e.g. between affluent and poor; elders and adults; men and women; black and white people);
- ways in which local partnerships could be strengthened to benefit health; or ideas about further work or information which is needed in order to inform future developments.

16.30 Reflection and evaluation of the day

Thank you for your involvement in this initiative. It would be really helpful if you could fill in the evaluation form before you leave.

Debbie, Fiona and Sophie

Based on guidelines developed by Alex Scott-Samuel and Ruth Barnes IMPACT 2001

A social model of health

Dahlgren and Whitehead, 1991. Policies and strategies to promote social equity in health. Stockholm: Institute of Future Studies

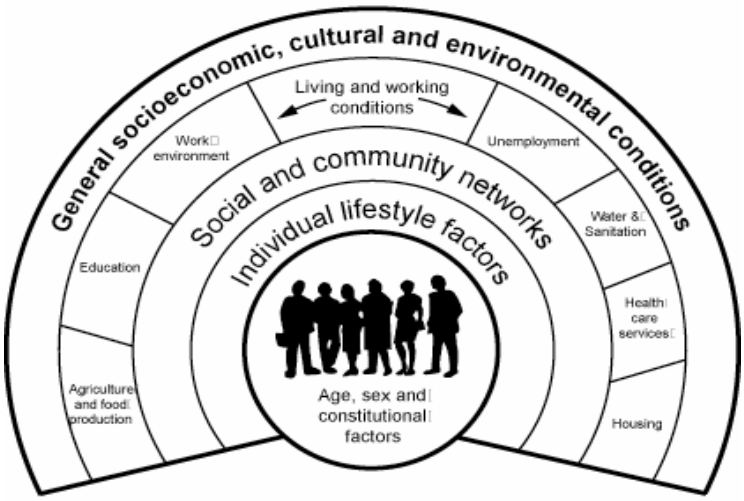

Table1: Key areas influencing health

Categories of influences on health	**Examples of specific influences (health determinants)**
Biological factors	age, sex, genetic factors
Personal / family circumstances and lifestyle	family structure and functioning, primary / secondary / adult education, occupation, unemployment, income, risk-taking behaviour, diet, smoking, alcohol, substance misuse, exercise, recreation, means of transport (cycle / car ownership)
Social environment	culture, peer pressures, discrimination, social support (neighbourliness, social networks / isolation), community / cultural / spiritual participation
Physical environment	air, water, housing conditions, working conditions, noise, smell, view, public safety, civic design, shops (location / range / quality), communications (road / rail), land use, waste disposal, energy, local environmental features
Public services	access to (location / disabled access / costs) and quality of primary / community / secondary health care, child care, social services, housing / leisure / employment / social security services; public transport, policing, other health-relevant public services, non-statutory agencies and services
Public policy	economic / social / environmental / health trends, local and national priorities, policies, programmes, projects

Participant List

	Name	Organisation
1.	Alexis Macherianakis	South Liverpool PCT
2.	Carole Parr	Drug & Alcohol Team
3.	Elizabeth Kane	Service Users Representative
4.	Gail Leech	Drug & Alcohol Team
5.	Ian Hannant	LCC Licensing Unit
6.	Jan Hanratty	Drug & Alcohol Team
7.	Dave Heron	Police
8.	Kieran Doherty	Windsor Clinic
9.	Lee Le-Clerq	British Beer & Pub Association
10.	Lesley Thompson	LCC
11.	Lianne Thomas	Liverpool YOT
12.	Martin Levine	Alder Hey
13.	Phil Sadler	Central Liverpool PCT
14.	Ruth Hunter	Health R&D North West
15.	Shirley Ashton	Community Integrated Care (C-I-C)
16.	Soraya Meah	South Liverpool PCT
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