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**IMPACT**

**THE INTERNATIONAL HEALTH IMPACT ASSESSMENT CONSORTIUM**

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**Draft Report**

**A desktop Health Impact Assessment (HIA) of the West  
Devon Borough Council Local Plan – “Our Plan”**

**February 2015**

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## **Acknowledgements**

This desktop HIA was commissioned by West Devon Borough Council, following an initial enquiry from Georgina Fox and Phil Baker of South Hams District Council in March 2014. Further scoping discussions also included a contribution from Martin White, Devon County Council Public Health Team.

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# Executive Summary

## Introduction

1. IMPACT, the International Health Impact Assessment Consortium, Department of Public Health and Policy (a WHO Collaborating Centre for Research on the Social Determinants of Health) at the University of Liverpool, was invited in March 2014 to undertake a desktop HIA of a draft joint Local Plan for South Hams District and West Devon Borough Councils. The Councils decided later in 2014 (August) to each produce a Local Plan, one prior to the 2015 General Election as part of their Plan approval process; the other likely to be after the 2015 General Election. This report is the first, for West Devon Borough Council (WDBC).

2. HIA is concerned with improving health and wellbeing and reducing health inequalities. It is a systematic process, which aims to identify what the health effects of a policy or strategy, programme, project proposal (in this case, a plan) might be on a particular group of people. HIA can be done at a national, regional, city or local geographical level. It considers which health determinants may be affected and how these may impact on the health and wellbeing of a population under consideration. By providing evidence to policy and decision makers (and stakeholder communities, with appropriate publication) on the potential health effects of these proposals, it helps to strengthen community equity in, and inform, their decisions.

3. This HIA is a desktop assessment, examining evidence already in the public domain and at summary (or secondary) literature, level. By definition, there is no primary data collection, nor any stakeholder engagement. Searches are purposive and opportunistic. While there had been preliminary searches at the outset and again in the Autumn and before Xmas 2014 (in anticipation of a prospective HIA), most of the work took place between January and February 2015, ie on receipt of the draft document "Our Plan", just immediately prior to its approval for Regulation 19 public consultation. As a consequence, it is now a concurrent desktop HIA, being concurrent with a public consultation process. It is therefore not possible for the HIA report to be sufficiently timely to properly inform the planning Regulation 19 public consultation process, as had been envisaged in the original scoping discussions. It also now takes place in much closer proximity than perhaps was envisaged to the impending UK General Election, in May 2015. It aims to assess the potential health effects of the draft Local Plan using a generic HIA methodology (Abrahams et al (2004).

4. This report will describe the methods and process, the data collected and the evidence defined from these data. The potential health impacts emerging from the analysis of this evidence will then be described in broad, qualitative terms. Finally, conclusions and recommendations for West Devon Borough Council, Devon County Council (responsible for Public Health) and adjacent Districts (such as South Hams) and other relevant parties will be presented.

## HIA Methodology

5. The Health Impact Assessment methods and procedure used were based on a validated generic HIA methodology (Figure 2). It is underpinned by a socio environmental model of health (Dahlgren,G.,Whitehead,M.,1991) shown in Figure 1.

6. This HIA is described as desktop HIA, reflecting the depth of assessment. In this HIA, data were collected from sources easily accessible in the public domain and existing (secondary) summary literature. From this, the evidence and impacts were described.

7. The Local Government Association (LGA) Planning Advisory Service (PAS) publish a range of guidance and checklists for local authorities. Their Good Plan Making Guide (2014) provided evidence with regard to the plan making process and was utilised as a “methodological yardstick” to inform the HIA.

8. The limitations of the assessment were its’ desktop scope, particularly the limited duration after a long lead-in, untimely proximity to the Regulation 19 public consultation and the General Election. As a desktop HIA, primary qualitative evidence from stakeholders was not gathered, but some summary ‘proxy’ information was available from the Regulation 18 public consultation process undertaken by West Devon Borough Council.

## Impact Analysis

9. In the absence of a Profile in the public domain for that portion of the population of West Devon covered by Our Plan and the issues pertaining to small numbers at local level, it has been challenging (and perhaps imprudent) to make specific recommendations in an obviously positively developing organisational and policy environment.

10. Based on the evidence collected for this report, which is primarily from publications and sources available and easily accessible in the public domain (sections 3,4,5,6 and 7) positive and negative health impacts have been described, where possible, with regard to the defined population under consideration (that portion of the West Devon Borough Council population residing outside the Dartmoor National Park Authority).

11. The most significant positive impact for the local population of West Devon will probably result from firstly, **a much closer co-operative (and reciprocal) working relationship between the Borough Council and its partners, particularly embedding public health ethos and practice, with an explicit focus on reducing health inequalities, closer to its’ daily activities, to better achieve Health in All Policies.**

12. Secondly, it is probable that this will **bring to the fore locally identified population sub-groups** (such as those in occupied sheds and caravans, etc) and how “Our Plan” may be more explicit in consideration of future arrangements beyond the present 5 year land supply, over the duration of the Plan period (to 2031).

13. The main and probable negative impact identified relates to **achieving a balance (or trade-off) between producing an accessible, useful and comprehensive Plan, that is linked to Borough and County policy agendas across the wider determinants of health to reduce health inequalities** (as well as maintaining health and wellbeing), that is easily accessible and with clear local interpretation of the available supporting data for community members (in all appropriate languages), stating how the Council would wish to act over the entire planning period, **and a Plan document that succinctly meets only NPPF requirements for central approval and the responsibilities of the Borough Council in the (relative) short term.** The latter may result in a more constrained and less dynamic narrative, while the former may better reflect localism and the lived experience of the defined population.

14. The net impact of Our Plan on future population health, particularly in reducing health inequalities, is uncertain. Much will depend on wider policy, economic and market factors particularly with regard to the now very imminent (less than 100 days) General Election. Based on the evidence presented, it is speculated that despite clear strategic commitment, the potential benefits of the proposed Local Plan may be less than optimal due to factors beyond local control.

## Recommendations

- For ease of access and reading for the public, the draft “Our Plan” could include the use of hyperlinks within the document to reach sources of evidence cited, obviating the need for them to search the websites of several other organisations.
- West Devon Borough Council may wish to consider refreshing/reintroducing the Devon Health Forum (2003) HIA Screening Checklist in an updated format, perhaps, for use in all its’ departments, for systematic HIA screening and to achieve Health in All Policies.
- West Devon Borough Council may wish to consider adding such a presentation to the final version of Our Plan (if it is possible to extrapolate from the available data) for that portion of the West Devon population covered by the draft Plan. (page 8)
- Links should be made to explicitly identify how the Local Plan might contribute to reducing health inequalities, in line with the main Health and Wellbeing Strategy (page 15). Ease of access for the public could be improved by placing hyperlinks in the Our Plan section of the Council website.
- Given the move towards fewer GP practices/hubs for one stop integrated care, reduced duplication of “specialist” centres for hospital provision and more care in the community, all against a background of financial challenges, shortcomings in transport network infrastructure and services, increasing elderly population and for example, high levels of dementia in the county, it is an imperative to demonstrate explicitly in all Local Plans (in this case, West Devon) how local planning systems will deliver such infrastructure as may be required (Page 15).
- Further summary analysis of policy documentation should be undertaken, to clarify the non-health policy context and to provide a timely description of the emerging health (including commissioning and procurement) policy environment for that part of West Devon within the purview of the Local Plan (ie outwith the Dartmoor National Park and including both NEW CCG and South Devon and Torbay CCG) (Page 16).
- Further examination of the potential impacts on health inequalities of the financial and organisational model to be introduced for the Integrated care Organisation (ICO) and “community hubs” should form part of any rapid HIA. Particular regard needs to be given to the coherence of plans for such facilities and related transport infrastructures with the Local Plan. (Page 15).
- Close monitoring will be required to ensure that challenges to future service provision do not exacerbate existing inequalities and consequently become a stressor for the Local Plan, particularly for those population subgroups most likely to be differentially be impacted upon, such as those requiring affordable housing, the homeless, itinerant and migrant workers, unwaged and low income, those in occupied sheds and caravans, etc, who perhaps fall beyond the “traditional” protected characteristic groups (page 16)
- Further consideration should be given to making explicit in the draft Plan, appropriate adjacent communities, local authorities and service commissioning organisations who might be consulted with under the duty of co-operation, with regard to “cross boundary” issues. That is, rather than proscribing the “boundary” of the draft Plan and thinking only “inside” that boundary, it should demonstrate (for the satisfaction of all the stakeholders) how it meets the duty of co-operation with those bodies and communities “outside” the boundary, in reducing inequalities, without making the Plan an inaccessible publication (page 18)

- West Devon Borough Council planners may wish to work more closely with their Public Health partners to develop asset-based approaches (page 19). There is some evidence that members of the Public Health Team at County level are working with “their” designated Councils, but this should be more than two-way communication.

## Background

### The draft West Devon Local Plan – “Our Plan”

Received for the purposes of this HIA on January 9<sup>th</sup> 2015, it is understood that the West Devon draft Local Plan (“Our Plan”), was approved, with no amendments, on January 20, 2015 by Cabinet for publication for the purpose of Regulation 19 public consultation over a period of some six weeks, in keeping with the updated timetable published on the Councils’ website.

It is noted with interest that in an early iteration (April 2014) of a draft joint Plan document for South Hams and West Devon, there was a most useful graphic presentation of the changes and local challenges that have emerged since 2001. This is a simple and clear presentation of both positive and not so positive changes in demographics and the wider determinants of health. It may not be wholly “complete”, but for many readers it provides a succinct summary of information based upon profiling data that are often presented in less accessible terms for the public. For public consultation purposes, and for some population sub-groups, such a graphic may well better reflect their lived experience and encourage participation from those who may not otherwise engage. **REC: West Devon Borough Council may wish to consider adding an infographic presentation to the final version of Our Plan (if it is possible to extrapolate from the available data for that portion of the West Devon population covered by the draft Plan).**



## HIA Methodology

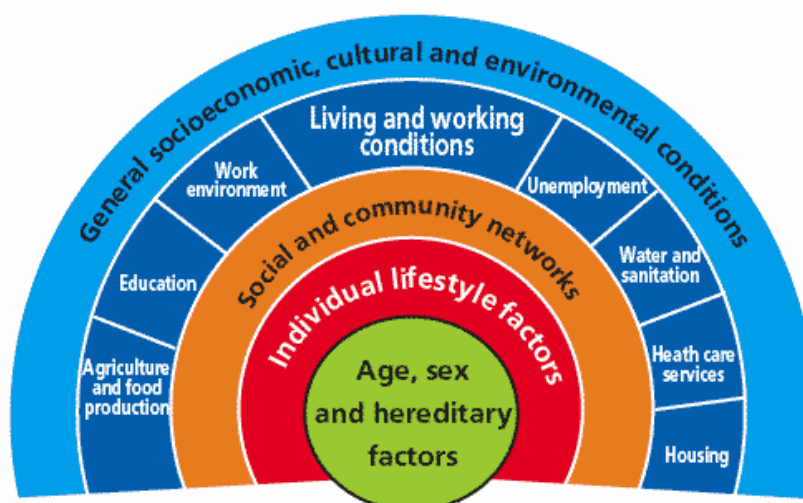
### Concept of Health

*'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* (WHO, 1948).

2.1 Best practice in HIA is founded on this broad definition and the now ubiquitous Dahlgren and Whitehead (1991) socio-environmental model of health that depicts the wider determinants of health in a “rainbow” model, Figure 1.

2.2 The WHO definition and Dahlgren and Whitehead wider determinants model of health make up the conceptual framework that guides the collection, organisation and analysis of evidence in HIA.

Figure 1 A socio-environmental model of health



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

2.3 HIA is a decision support tool, for preparing justified, evidence based recommendations for the management of the future health impacts of a proposal, in order to protect and enhance population health and is 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.'* (WHO,1998)

2.4 HIA identifies potential positive and negative impacts of a policy or intervention and produces a set of evidenced based recommendations (e.g. policy amendments or changes to how a policy, plan, programme or project is implemented) to enhance the positives and reduce, or mitigate, negatives. It has a particular focus on how impacts are distributed differentially across a population and therefore, how a policy or intervention affects health inequities.

2.5 There are many other forms of impact assessment, often sharing common stages in their methodologies. HIA was formalised in the early 1990s in order to better address the wider determinants of health and indeed, the root causes of those determinants. It has values rooted in fairness and social justice, such as democracy, ethical use of evidence, equity, sustainable development (of recommendations), openness and transparency and addressing health inequalities.

2.6 While Environmental Impact Assessment (EIA) focuses “internally”, seeking to improve a (development) proposal by mitigation of negatives within statutory and regulatory frameworks, HIA focuses “externally”, on a wider defined population and vulnerable population sub-groups, whose health and wellbeing may be impacted differentially upon by the development and thus, the contribution made by the project to reducing health inequities.

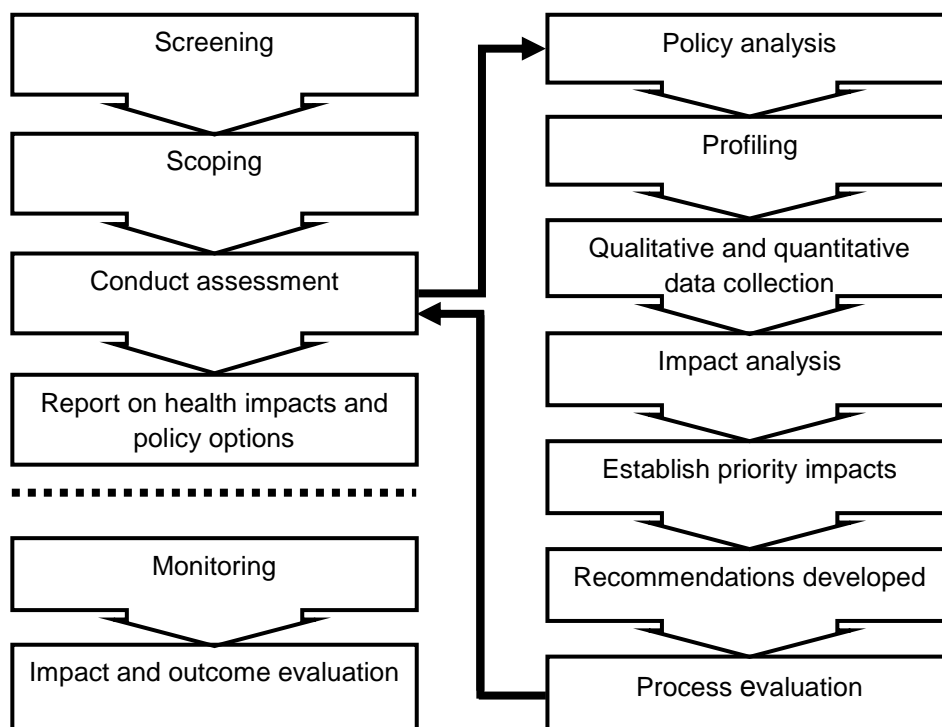
2.7 The concept of “inside the fence or boundary “and “outside the fence or boundary” is discussed (along with use of HIA) in a mining industry context in a report describing best practice for how companies can establish and support sustainable positive health impacts (ICMM, 2013). The International Council on Mining and Minerals (ICMM, 2010) has also published a guide for good practice on HIA to assist companies in protecting the health and wellbeing of their workforce and local communities. The World Health Organisation (WHO) (2010) published a framework for national and local health authorities for managing the public health impacts of natural resource extraction activities.

2.8 Birley (2011) discusses what HIA is not. HIA is intended to make a proposal better for health than it might otherwise have been, but is necessarily imperfect; it does not test scientific hypotheses, but is an opportunity to influence the design and operation of proposals in order to safeguard and enhance the health of human communities; HIAs that lead to real improvements are far more valuable than a large report that sits on a shelf, or is overlooked once a proposal has been authorised; HIA is not a “prediction”, because any kind of enquiry can change the decisions to be made and considering future events in the course of a HIA will influence those who are responsible for planning and managing what happens in future.

**This HIA**

2.9 The methods used in this HIA were based on a validated generic HIA methodology (below), adapted to the requirements of the scope of the HIA, with consideration of plan making informed by the Local Government Association Planning Advisory Service Good Plan Making Guide (2014). As a desktop HIA, there was no Steering Group, with the scope of the work agreed with Georgina Fox and Phil Baker of South Hams Borough Council, with input from Martin White at Devon County Council. The duration of the work was four weeks, mainly January/February 2015.

Figure 2 A Generic Model of Health Impact Assessment



2.10 As a desktop HIA, this report follows the methods shown on the right side of the figure above, by definition constrained to secondary literature and data available in the public domain, at the time of writing and as examined within the time available.

2.11 Gathering evidence from community stakeholders and key informants is beyond the scope of a desktop HIA, but some additional information was provided by Phil Baker, through personal e-communication and from the literature.

# Policy Context

## Introduction

3.1 This section presents a summary analysis of the policy context for the draft West Devon Borough Council Local Plan “Our Plan”. Policy analysis seeks to examine the rationale and context of the proposal (plan); the synergy of the proposal with Planning Policy and the relationship of the proposal to health and non-health policies, within the time available.

3.2 The scope and terms of reference for a rapid HIA set out the nature of policy analysis to be undertaken, such as the geographical levels (e.g. global, European, national, regional, local), organisational levels (eg national, regional, municipal authorities, health organisations and non-health organisations) and the policy areas (i.e. from the wider determinants of health) to be considered. As a desktop HIA, there is no agreed scope for policy analysis, per se. Both desktop and rapid HIAs look to describe the overarching policy scenario, since resources do not usually allow for an in-depth examination of the documentation. Existing policies are not now always carried forward into new organisations (nor remain easily accessible as archived material). Electronic publication makes it challenging to properly single out, within resource constraints, current government policy among a plethora of associated and supporting literature found on web pages that no longer make it clear when they were last updated.

3.3 The current UK government central policy agenda of austerity measures, legislative changes (not least the implementation of the Health and Social Care Act 2012), welfare and benefits reforms, Social Value Act, 2012, etc, changes in data collection and access arrangements, NHS re-organisation and establishment of new commissioning and procurement arrangements, are among a considerable number of external confounders that would ideally be considered in greater detail in the scoping of a rapid HIA. Recent HIAs (for example, Dreaves 2010, Dreaves 2012) have alluded to some of these policies, the consequences (not always positive) of which are now becoming evident in new data and in the literature, discussed in Section 5.

Table 1 Policy Context

International	
Rome Declaration on Health in All Policies (2007)	All EU member states, consider that the health status of the population is largely determined by factors outside the health sector, emphasise that health inequalities are of particular importance and that health should cover both physical and mental health. All decision makers at every level should be fully aware of the health impact of policies and decisions. Health Impact Assessment is an important tool for the implementation of Health in All Policies, assessing health and health equity impacts, making these visible in the policy making process, especially in sectors other than health.
Commission on the Social Determinants of Health (CSDH) (WHO, 2008)	The CSDH brought together the evidence on what can be done to promote health equity and to foster a global movement to achieve it. Partner countries and agencies have started to frame policies and programmes across the whole of society that influence the social determinants of health and improve health equity. It recognised that achieving health equity within a generation is achievable, on the grounds of social justice is the right thing to do and that now is the right time to do it. HIA is advocated as a proven and robust methodology. Three principles for action underpin the recommendations of the commission: <ul style="list-style-type: none"> <li>• Improve daily living conditions</li> <li>• Tackle the inequitable distribution of power, money and resources</li> <li>• Measure and understand the problem and assess the impact of action.</li> </ul>
Adelaide Statement on Health in All Policies (2010)	Emphasises how government objectives are best achieved when all sectors include health and wellbeing as a key component of policy development. Outlines the need for a new social contract between all sectors to advance human development, sustainability and equity, as well as improving health outcomes. This requires a new governance, with joined-up leadership within governments, across all sectors and between levels of government.

Rio Political Declaration on Social Determinants of Health (2011)	Highlights the importance of the work of global institutions to address Health in All Policies, social determinants of health and governance.
Inequalities Matters (Department of Economic and Social Affairs, United Nations, 2013)	Discusses the impacts of inequality on economic growth, poverty, social mobility and social cohesion. It notes that inequality hinders growth and wellbeing in general, as well as affecting the poor, youth, older people, those with disabilities, indigenous people and migrants. Proposes that through macro-economic policy productive employment and decent work should be available to all; public funds should be directed to provide universal, good quality services in health, nutrition, sanitation and education; disadvantaged groups should receive extra help and everyone should work to end discrimination and social exclusion.
National	
Fair Society Healthy Lives (The Marmot Review)(2010)	<ol style="list-style-type: none"> <li>1. <b>Reducing health inequalities is a matter of fairness and social justice.</b> In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.</li> <li>2. There is a social gradient in health – the lower a person’s social position, the worse his or her health. <b>Action should focus on reducing the gradient in health.</b></li> <li>3. Health inequalities result from social inequalities. <b>Action on health inequalities requires action across all the social determinants of health.</b></li> <li>4. Focussing solely on the most disadvantaged will not reduce health inequalities sufficiently. <b>To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.</b></li> <li>5. <b>Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.</b></li> <li>6. <b>Economic growth is not the most important measure of our country’s success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.</b></li> <li>7. <b>Reducing health inequalities will require action on six policy objectives:</b> <ul style="list-style-type: none"> <li>- <a href="#">Give every child the best start in life</a></li> <li>- <a href="#">Enable all children young people and adults to maximise their capabilities and have control over their lives</a></li> <li>- <a href="#">Create fair employment and good work for all</a></li> <li>- <a href="#">Ensure healthy standard of living for all</a></li> <li>- <a href="#">Create and develop healthy and sustainable places and communities</a></li> <li>- <a href="#">Strengthen the role and impact of ill-health prevention</a></li> </ul> </li> <li>8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. <b>National policies will not work without effective local delivery systems focused on health equity in all policies.</b></li> <li>9. <b>Effective local delivery requires effective participatory decision making at local level. This can only happen by empowering individuals and local communities.</b></li> </ol>
Healthy Lives Healthy People (Dept Health, 2010)	<p>The White Paper puts local communities at the heart of public health, ending central control and giving local government the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area. There will be real financial incentives to reward their progress on improving health and reducing health inequalities and greater transparency so people can see the results they achieve.</p> <p>Published in response to the Marmot Review; to A Vision for Adult Social Care: capable communities, active citizens and to Equity and Excellence: Liberating the NHS, it seeks to address the root causes of poor health and wellbeing.</p>
No Health Without Mental Health (Dept Health, 2011)	Guidance, as part of Making Mental Health Services More Effective and Accessible policy. The strategy sets out an ambition to mainstream mental health and establish parity of esteem between services for people with mental and physical health problems. It shows how Government is working to improve the mental health and wellbeing of the population, and get better outcomes for people with mental health problems. Eight supporting associated publications.
National Planning Policy Framework (NPPF) (Department of Communities and Local Government, 2012)	The NPPF sets out the Government’s planning policies for England and how these are expected to be applied. It sets out the Government’s requirements for the planning system only to the extent that it is relevant, proportionate and necessary to do so. It provides a framework within which local people and their accountable councils can produce their own distinctive local and neighbourhood plans, which reflect the needs and priorities of their communities. Planning law requires that applications for planning permission must be determined in accordance with the development plan unless material considerations indicate otherwise. The NPPF must be taken into account in the preparation of local and neighbourhood plans, and is a material consideration in planning decisions. Planning policies and

	<p>decisions must reflect and where appropriate promote relevant EU obligations and statutory requirements. The Framework does not contain specific policies for nationally significant infrastructure projects for which particular considerations apply. These are determined in accordance with the decision-making framework set out in the Planning Act 2008 and relevant national policy statements for major infrastructure, as well as any other matters that are considered both important and relevant (which may include the NPPF).</p> <p>National policy statements form part of the overall framework of national planning policy, and are a material consideration in decisions on planning applications. The Framework should be read in conjunction with the Government's planning policy for traveller sites. Local planning authorities preparing plans for and taking decisions on traveller sites should also have regard to the policies in this Framework so far as relevant. The Framework does not contain specific waste policies, since national waste planning policy will be published as part of the National Waste Management Plan for England. However, local authorities preparing waste plans and taking decisions on waste applications should have regard to policies in this Framework so far as relevant.</p> <p>Links to planning and health are found throughout the whole of the NPPF. Key areas include the core planning principles (para 17) and the policies on transport (chapter 4), high quality homes (see National chapter 6), good design (chapter 7), climate change (chapter 10) and the natural environment (chapter 11). Paras 7, 156 and 162 refer to required health infrastructure.</p>
<p>Planning Practice Guidance. Health and Wellbeing. (Communities and Local Government, updated 2014)</p>	<p>The built and natural environments are major determinants of health and wellbeing. Local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making. The range of issues that could be considered through the plan-making and decision-making processes, in respect of health and healthcare infrastructure, include how:</p> <ul style="list-style-type: none"> <li>• development proposals can support strong, vibrant and healthy communities and help create healthy living environments which should, where possible, include making physical activity easy to do and create places and spaces to meet to support community engagement and social capital;</li> <li>• the local plan promotes health, social and cultural wellbeing and supports the reduction of health inequalities;</li> <li>• the local plan considers the local health and wellbeing strategy and other relevant health improvement strategies in the area;</li> <li>• the healthcare infrastructure implications of any relevant proposed local development have been considered;</li> <li>• opportunities for healthy lifestyles have been considered (e.g. planning for an environment that supports people of all ages in making healthy choices, helps to promote active travel and physical activity, and promotes access to healthier food, high quality open spaces and opportunities for play, sport and recreation);</li> <li>• potential pollution and other environmental hazards, which might lead to an adverse impact on human health, are accounted for in the consideration of new development proposals; and</li> <li>• access to the whole community by all sections of the community, whether able-bodied or disabled, has been promoted.</li> </ul> <p>The first point of contact (including at the pre-application stage) on population health and well-being issues, including health inequalities, should be the Director of Public Health for the local authority, or at the County Council for two-tier areas.</p> <p>The Health and Wellbeing Board; Clinical Commissioning Groups (CCGs) and NHS England are consultees for Local Plans. Engagement with the community, including Healthwatch and other local groups, is important. A health impact assessment may be a useful tool where there are expected to be significant impacts.</p>
<p>Five Year Forward View. NHS England (2014)</p>	<p>The NHS Five Year Forward View sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.</p> <p>The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care that could be provided in the future, defining the actions required at local and national level to support delivery. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.</p> <p>It starts the move towards a different NHS, recognising the challenges and outlining</p>

	potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.
Local	
Health & Wellbeing Strategy. One Year On. Devon Health and Wellbeing Board. Devon County Council (2013)	This update reiterates priorities set in 2013, with the addition of further actions to contribute to the aim of promoting health equality. These include end of life care, long term conditions, improving the health of protected groups, defined under the Equality Act (2010). There is a commitment to make the priorities of the board increasingly visible in the published documentation of Board members, focussing on effective interventions at District, Borough and City (County not listed) authority levels. Each of the authorities has designated Public Health Team members supporting actions that cross reference to the main Strategy. <b>REC: Links should be made to explicitly identify how the Local Plan might contribute to reducing health inequalities, in line with the main Health and Wellbeing Strategy.</b>
West Devon Borough Council. Website searched February 2015.	The Council website map was examined for clear and explicit linkages between Our Plan and other local policies and strategies. There appears to be no access in languages other than English. Our Plan (including identifiable responses to Reg 18 consultation, raising issues of consent to publish in the public domain) lies in the Your Communities section. Data on wider determinants of health such alcohol misuse, domestic violence and abuse, anti-social behaviour and hate crime, lie in a crime subsection. A very substantial Policy and Strategy section provides a plethora of hyperlinks to further substantial documentation. However, Housing Policy appears to amount to only the Private Sector Renewal Policy, concerning grants and loans for warm, safe houses and a Local Tenancy Strategy describing the expectations of the council for Registered Providers of housing in the area to respond to their duties for affordable homes under the localism act. This may well demonstrate "openness and transparency" by the Council, but may not be wholly equitable, particularly for those most likely to be differentially be impacted upon, as it puts the onus on users to have access to the technology in the first instance and not only work their way round the site, but have the will, time, skills and resources to interrogate the site and keep abreast of updates/new publications. <b>REC: Working with those for whom English is not their first language and other population subgroups (for example, reflecting the evidence base on digital exclusion notably among elders and taking account of the gender differences in online usage), the Council should consider increasing the ease of site navigation to bring Our Plan "closer" to local policies and the work undertaken between District and County levels, with regard to health inequalities.</b>
North East West Devon Clinical Commissioning Group (2014) Updated 5 year Strategic Plan.	The predominant and apparently, leading "health commissioning" organisation set out their Strategic Vision for the next 5 years, on behalf of all the partner organisations, in 2014. While the County Council has been involved and patient engagement taken place, the degree of engagement, coherence and synergy with local councils' intentions and thus Local Plans is unclear in the 27 page summary document in the public domain. In particular, page 23 describes costs and benefits of future change only in terms of addressing the financial challenge, rather than population health or health inequalities. The modelling work (which would constitute part of a comprehensive HIA) being undertaken includes evaluating new models of care on current points of delivery (presumably premises and sites) in the current system; scenario modelling (again, part of comprehensive HIA) of these potential impacts and refining them based upon the current (presumably financial) position of the providing Trusts. <b>REC: Given the move towards fewer GP practices/hubs for one stop integrated care, reduced duplication of "specialist" centres for hospital provision and more care in the community, all against a background of financial challenges, shortcomings in transport infrastructure and services, increasing elderly population and for example, high levels of dementia in the county, it is an imperative to demonstrate explicitly in all Local Plans (in this case, West Devon) how local planning systems will deliver such infrastructure as may be required.</b> Failure to do so will once again leave consideration of healthcare provision "last in the queue" and "on the back foot" in planning terms. This can only foster inappropriate (externally proposed elsewhere) recommendations, such as that made to the Department of Transport that elders in rural areas cycle when they become unable to drive (in the absence of public transport) to attend their health and care appointments.
Strategic Plan 2014-19. A Summary (undated). South Devon & Torbay Clinical Commissioning Group (CCG)	The document clearly states that the current model of NHS health and care services will no longer be affordable by 2019, with spending exceeding budget already. The CCG is a pioneer for integrated care, with an Integrated Care Organisation (ICO) anticipated, with "community hubs" envisaged as centres for wellbeing. <b>REC: further examination of the potential impacts on health inequalities of the financial and organisational model to be introduced for the ICO and community hubs should form part of any rapid HIA. Particular regard needs to be given to the coherence of plans for such facilities and related transport infrastructures with the Local Plan.</b>  The document cites 38 bullet pointed actions under 10 headings to be achieved in the next 2 years in order to fulfil CCG priorities for the next 5 years. This will be delivered against a background of a 3 year plan to reduce recurrent financial over commitment, already affected by demand. Financial risk is likely to grow, with

	<p>sustained levels of unprecedented cost reduction and efficiency savings needed among service providers to return to a recurrent balance. Hospital costs are anticipated to reduce as community services grow (although the evidence for this would require further examination, beyond a desktop HIA). <b>REC: Close monitoring will be required to ensure that challenges to future service provision do not exacerbate existing inequalities and consequently become a stressor for the Local Plan, particularly for those population subgroups most likely to be differentially impacted upon, such as those requiring affordable housing, the homeless, itinerant and migrant workers, unwaged and on low income, those in occupied sheds and caravans, etc, who perhaps fall beyond the “traditional” protected characteristic groups.</b></p>
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## Summary

3.4 Within a desktop HIA, it is not possible to wholly interrogate the wider policy environment.

3.5 The nature of electronic publication, for all organisations, has over time added an increasing complexity to the policy environment and thus policy analysis at a summary level, constraining the breadth and depth of the analysis possible within available resources in desktop and rapid HIAs.

3.6 There are some indications that there may be some lack of synergy between local and national policies due to the nature of the setting up and relationship between non-governmental departments, and the policies of government departments, with regard for example to energy, climate change, sustainability, etc. This was identified by Golby and Lester (2005) who noted that inconsistencies between intentions expressed in high level planning documents and the reality of support at lower levels can lead to distrust between stakeholders and authorities. They cited central government policy to reduce reliance on fossil fuels, while open cast mining continued to receive support from governments and planning authorities. Similar analogies might be those between the National Planning Policy Framework and its’ implementation and interpretation at local level and the seeming growing gap between population health needs assessment and eligibility for and provision of health and care services within available resources.

3.7 A broader examination of policy at several levels, such as international, national and local, across the wider determinants of health, would have brought greater clarity to the non-health policy context. The health policy landscape is increasingly dynamic and rapidly changing as a consequence of recent and ongoing austerity measures and legislative changes, for example regarding eligibility for, access to and availability of health and social care services.

3.8 Locally, there is evidence of challenges to NHS service provision in Devon (as well as health and social care provision) in the national news (BBC webpage stories/HSJ journal headlines). Indeed, Devon CCGs are among those local organisations participating in the Challenged Health Communities Programme (NEW CCG, 2014)

3.9 Since recent (2013) NHS re-structuring, ongoing legislative changes and commercialisation, the implications, even in policy terms, are yet to be properly manifest. It should also be noted that the collection of routinely available public health data previously and currently gathered to inform for example, research, service planning, demographic profiling (including inequalities), policy development, surveillance and other health related purposes, including HIA, are also currently under review and similarly subject to austerity measures and legislative changes. **REC: Further summary analysis of policy documentation should be undertaken, to clarify the non-health policy context and to provide a timely description of the emerging health (including commissioning and procurement) policy environment for that part of West Devon within the purview of the**



**Local Plan (ie outwith the Dartmoor National Park and including both NEW CCG and South Devon and Torbay CCG). REC: Close monitoring will be required to ensure that future service provision does not exacerbate existing inequalities and consequently become a stressor for the Local Plan, particularly for those population subgroups most likely to be differentially be impacted upon, such as those requiring affordable housing, the homeless, itinerant and migrant workers, those in occupied sheds and caravans, etc, who perhaps fall beyond the “traditional” protected characteristic groups.**

## Community Profile

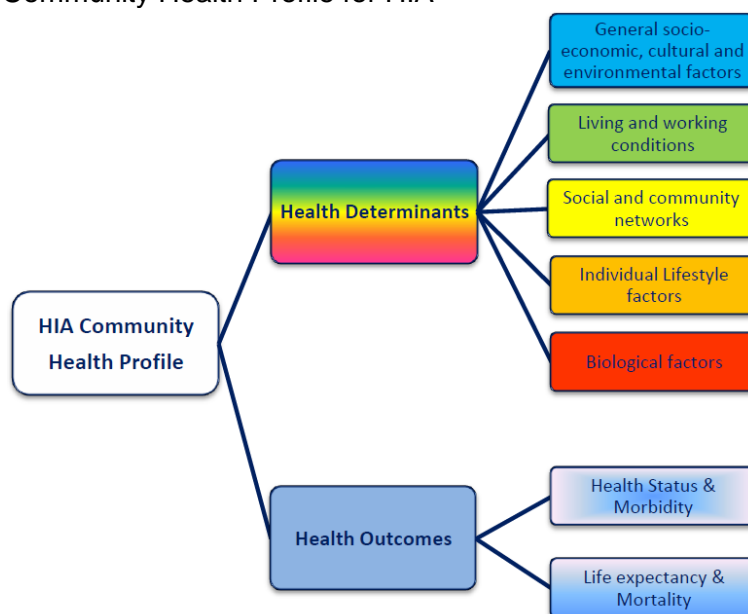
### Introduction

4.1 The purpose of a community health profile in HIA is to give a picture of the health and socio-demographic context of the population of the area under consideration in order to better understand potential health impacts and identify any population sub groups that may be differentially affected.

4.2 The structure of a HIA health profile is based upon the main determinants of health described in 1991 by Dahlgren and Whitehead in their now ubiquitous socio-environmental model of health (see HIA Methodology section).

4.3 Figure 3 shows the range of health determinants and outcomes that are considered in HIA profiling. This is dependent upon the availability and quality of data in the public domain at the required level of analysis, according to the scope of the HIA.

Figure 3 A Community Health Profile for HIA



Source: Haigh, F, et al (2009) A prospective rapid HIA of Liverpool PCT Outside of Hospital Strategy. IMPACT, University of Liverpool.

4.4 A HIA may have a geographical boundary crossing and including several authorities, commissioning organisations and service providers, in order to best describe the demographics and health and wellbeing of the defined population under consideration, particularly where there may be other considerations, for example, infrastructure planning, heritage assets, environmental, habitats, Area of Outstanding Natural Beauty (AONB) and the National Park, with longer term health impacts likely over a wider area. **REC: further consideration should be given to making explicit in the draft Plan, appropriate adjacent communities, local authorities and service commissioning organisations who might be consulted with under the duty of co-operation, with regard to “cross boundary” issues.** That is, rather than proscribing the “boundary” of the draft Plan and thinking only “inside” that boundary, it should demonstrate (for the satisfaction of all the stakeholders) how it meets the duty of co-operation with those bodies and communities “outside” the boundary, without making the Plan an inaccessible publication .

4.5 There are a number of sources of demographic profiling data available in the public domain, appropriate for use in desktop HIAs. None is routinely available pertaining only to that part of West Devon covered by Our Plan.

#### *Public Health England (PHE)*

4.6 PHE publishes public health profiles at local authority area level. The most recent 2013 profile compares West Devon with the England average. This does not correspond to that part of West Devon only by Our Plan. While deprivation is lower than average, some 12.8% (1100) of the total population (54,000) are children living in poverty. There is no significant difference in life expectancy between those in the most deprived and least deprived areas of West Devon. Life expectancy for women is higher than the England average. Although 13.8% of children are classified as obese, this is better than the England average and numbers are small (61). 22.8% of adults are classified as obese. 328 alcohol-related hospital stays per year gives a rate of 580 per 100,000 population, worse than the average for England. Hospital stays for self-harm numbered 109, a rate of 232 per 100,000 population, again worse than average for England. The rate of people killed and seriously injured on roads is worse than average.

4.7 Smoking-related deaths (86) give a rate better than the England average, at 220 per 100,000. Estimated rates of adult physical activity and TB are better than the England average. Other rates better than average include those for statutory homelessness, violent crime, long term unemployment, drug misuse and early deaths from cardiovascular disease. Of course, this does not mean that these events do not occur in West Devon, but as in other large rural areas, necessitate analysis at a lower level (such as Lower Super Output Areas LSOAs, of which there are 31 in West Devon) to identify, with a caution about the effects of small numbers.

4.8 The profile notes that priorities in the West Devon Health and Wellbeing Strategy are to address fuel poverty and the risk of falls, increase physical activity and support the most vulnerable residents.

#### *Office of National Statistics (ONS)*

4.9 Office of National Statistics provides access to Neighbourhood Statistics. While the portal does provide access to lower levels of analysis such as LSOAs, it provides only a series of links to databases and raw data, with no summary analysis and its' collation to the appropriate geography covered by Our Plan is beyond the scope of a desktop HIA.

#### *Devon County Council - Annual Public Health Report*

4.10 The statutory independent annual report of the Director of Public Health outlines local public health priorities. Recent NHS re-organisation nationally in 2013 has taken the public health function once again back into local authorities, from whence it came in 1974. In Devon, the public health team function is at County Council level and the most recent report is for 2014 (Pearson,V., 2014).

4.11 The 2014 report does not focus specifically on assessment of health inequalities in Devon, noting that there are a number of Strategic Needs Assessments that identify inequalities across the County. Needs Assessments are essentially deficit mapping exercises, rather than asset mapping and as such, largely adopt a traditional "medicalised", approach to data collection and a reductionist approach to disease. **REC: West Devon Borough Council planners may wish to work more closely with their Public Health partners to develop asset-based approaches.** There is some evidence that members of

the Public Health Team at County level are working with “their” designated Councils, but this should be more than two-way communication.

#### *Devon County Council - Joint Strategic Needs Assessment (JSNA)*

4.12 Devon County Council published a summary report of the JSNA (2012) on its website. This is prepared for use by commissioners of services, who require a comprehensive picture of current and future health needs, the report being intended to provide an evidence base upon which to make their purchasing decisions, within available resources. Detailed examination is beyond the scope of a desktop HIA.

4.13 In a relatively less deprived area of the country such as Devon/West Devon, small geographical localities which are deprived may be “hidden”. The report notes that the overall health of the population in Devon is good. However, inequalities in life expectancy do exist.

4.14 Table 3.2 on page 18 of the JSNA Summary (2012) indicates the complexity of the various organisational geographies and levels of analysis of public health data available in Devon. While re-organisations may have reduced this slightly, 12 different geodemographies (area types) for the analysis of mortality data suggest the degree of complexity and serve as a reminder of the need for careful communications between organisations and partners.

4.15 Land use planning has great relevance in terms of improving prosperity, the environment, greenspace and the locations of certain businesses and activities. In rural and semi-rural areas and for those without access to a car, lack of physical access to safe and affordable (public) transport can lead to social isolation, which is both a cause and a consequence of mental ill health.

4.16 Demographic change presents challenges to West Devon, not least due to proportionately higher numbers of older people than in other areas of the country. There is an anticipated increase of over 50% in the number of people aged sixty five and over in the two decades to 2030. Clearly this will impact upon the numbers experiencing long term conditions and need health and social care for longer. In- migration, particularly of elders, remains a significant factor in the demographic profile of Devon/West Devon. There have been increases in minority ethnic groups who experience higher levels of poor health, as demonstrated by numbers of languages (100) spoken in the county.

#### *Devon County Council – Town Profiles*

4.17 Devon County Council also publishes health and wellbeing profiles at town level. As with the JSNA, the profiles are intended as an evidence base. Much of the underlying data comes from routine data sources as analysed for the JSNA, but presented in greater detail. Some potentially useful data from routine outputs however, cannot be presented at local level, due to issues of small numbers and potential for identification, since West Devon has a small population. Detailed examination is beyond the scope of a desktop HIA.

#### *Clinical Commissioning Groups (CCGs)*

4.18 Clinical Commissioning Groups (CCGs) are now responsible for commissioning some NHS services for their GP registered population. There are two CCGs covering West Devon, North, East and West CCG (NEW CCG) and South Devon and Torbay CCG.

4.19 Both CCGs are committed to working with a range of partners to reduce health inequalities, but recognise that on their own, the impact can be only limited (reflecting the position of healthcare services on the Dahlgren and Whitehead model). Equitable access to services for those in rural parts of the CCG presents a challenge.

4.20 NEW CCG alone has 897,300 patients registered with its 130 practices, one of the largest in the country (NEW CCG website footer). It is an interesting juxtaposition to note that the ONS population estimate for the whole of Devon in 2012 was somewhat less at 749,900, with projection for 2017 at 778,800 (APHR, 2014).

## Summary

4.21 The South West region is one of the least deprived regions of the country, as yet, (relatively) unscathed by cuts to local authority budgets. Devon is a large and sparsely populated county, but with considerable challenges compounded by this rurality, infrastructure (public transport) issues, the housing market and availability, with a disproportionately increasing elderly population due to in-migration of retirees because of its attractiveness and perceived lifestyle offer.

4.22 While in comparison to national averages, West Devon may seem similarly less deprived (since there are no areas in the least well-off quintile in IMD Index 2010) (PHE Health Profile 2014), it is noted that in analysis at town level, for example Tavistock and Okehampton, it is in fact the rural surroundings of the towns that are more deprived than the towns themselves.

4.23 In what can only be a limited purposive search, it seems that sourcing and interrogation of more recent iterations of profiling data (post 2013) has become more challenging, for example, Lower Super Output Area data seems less accessible and some potentially useful data from routine outputs cannot be presented at local level, due to issues of small numbers and potential for identification, since West Devon has a small population.

4.26 Among a blizzard of detailed geodemographic information, (with perhaps less clearly accessible interpretation of what it means) collated and presented in many formats, it is interesting to note that JSNA/IMD information does not seem to have been collated at Borough level, or to at least be readily available at that level, so inequalities information has been found in the County level and Town level documentation, ie where Public Health now rests at County, but in the Town profiles only where West Devon data are shown as comparators.

4.27 Our Plan pertains only to that part of West Devon Borough outwith the Dartmoor National Park. Summary analysis of profiling data for this geography is not readily available in the public domain and would require a more detailed examination and collation of primary data beyond the scope of a desktop HIA. However, for the purposes of monitoring and evaluation over the duration of the Plan, this may be useful. **REC: For the purpose of monitoring the potential impacts of Our Plan upon the health and wellbeing of that portion of West Devon to which it pertains, the Borough Council and its' Public Health counterparts should seek to derive a profile appropriate to the area covered by Our Plan.**

4.28 It is also interesting to note that while strongly supported in the literature, eg by Health in All Policy and asset-based approaches to health and wellbeing (Foot and Hopkins, 2010) and in keeping with the HIA ethos of accentuating potential positives, moving away from a deficit model (such as needs assessment), may make it harder to recognise local equity target groups among small populations, at least from information available in the public domain. Knowing they exist and where they are, is important for all planning (in the broader sense) purposes, but the information being "sub-clinical" or "unpublished" may be less than optimal for strengthening equity for these groups in decision making processes, reducing inequalities and for example, in co-design, co-production, community resilience, etc.

4.29 It can only be speculated upon that there may be opportunities (issues of individual consent being addressed) for CCGs to enhance their understanding of population health and wellbeing, balanced against their expert understanding of the ill health and sickness of their registered population, by utilising data sets from primary, secondary and tertiary care (and those of their service /commercial providers) not usually available in the public domain.

## Evidence from the Literature

### Health Inequalities

5.1 The health inequalities gap in the UK continues to widen. There are new data to show that for the first time since 2003, life expectancy (a national headline public health indicator) has fallen (especially among elderly women) and as death rates among the elderly and very old have accelerated in the last few years, overall all-age mortality has increased. Sustained absolute rises in mortality, outside of war time, last occurred in the 1930s in Britain.

5.2 There are a number of potential reasons for this, with some commentators examining the political scenario over the last forty or so years and in particular the current political landscape in relation to the data (Dorling, 2014). More people died in 2012 and 2013 than in previous years, when it is widely known that recessions are not usually linked with rising mortality. Spearhead areas of England, identified in 2004 as places where people faced the greatest health challenges, experienced the greatest rise in elderly death rates in 2012. It has been estimated that some 483,000 old and disabled people in the UK have either lost their care support, or are no longer eligible to claim it. With millions fewer social care visits to the elderly, reductions in public service have been described as particularly acute for older people. The nature and provision of residential care may also be a factor for the oldest. The effects of the Health and Social Care Act in 2012 are just beginning to become apparent and will continue into the future.

5.3 Interrogating in detail the political discourse lies beyond the scope of a desktop HIA, but it provides powerful evidence for HIA. Political change may be considered to be a root cause and confounder of the distribution of impacts of any proposal, programme, plan or project in the UK today.

5.4 There is a large literature on health inequalities with particular key documents being the Commission on the Social Determinants of Health report (WHO 2008) and the eponymous Marmot Review (2010).

5.5 Perhaps presciently, Batty and Cole (2010) writing for the Joseph Rowntree Foundation gave their report the strapline “preparing for worse to come?” Assessing the experiences and perceptions of those a considerable way “downstream” from global financial markets, etc, they noted that already, as a consequence of the ‘downturn’, respondents were acting with a degree of foresight and caution in facing up to a bleaker economic future ahead. Rather than seeing resilience as an outcome of personal attributes, resilience could be viewed as a process for meeting successive challenges. But anticipated effects of the primacy of deficit reduction and the consequent need to ‘shrink’ the state in the future were identified as potential “last straws” and their reliance on formal and informal sources of social support will be severely tested. Since the communities being studied are likely to suffer from economic weakness for a longer period than more prosperous areas, they identify that the situation will be especially bleak for households living in areas that have not benefitted from the economic growth of the 1990s and 2000s to the same extent as others and who will find their personal, social and financial resourcefulness stretched to breaking point as they struggle to make ends meet in the years ahead.

5.6 Blane et al (2012) summarised the new measures and changes that were affecting (as GPs) their patients living in very deprived areas (of Scotland). These included austerity measures, which at that time included £81bn of cuts in public spending over four years. In April 2011, claims for benefits on the basis of incapacity for work were transferred to claims for employment and support allowance (ESA). Entitlement was re-assessed using the new

stricter criteria of the Work Capability Assessment (WCA). The Welfare Reform Act – the biggest change to the welfare system for over 60 years – introduced a new Universal Credit which from 2013 replaced most existing benefits and limits the total amount of benefit a person can claim. Changes to working tax credits were to be implemented from April 2012. It was estimated that 25,000 households in the central belt of Scotland would no longer be entitled to tax credits as a result of these changes.

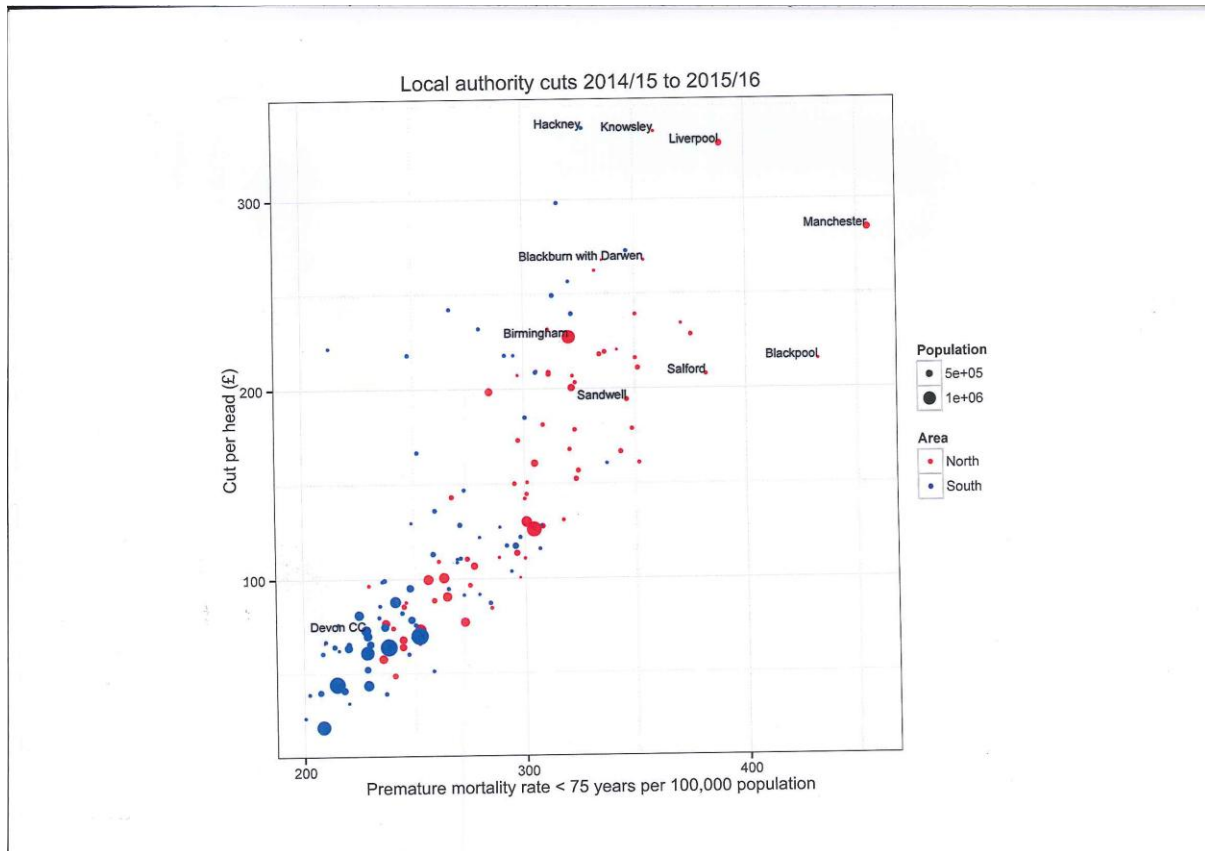
5.7 Their main findings were the increasing numbers of patients with deteriorating mental health, that is both those previously well and in work and those unwell, but deemed to be fit to work and losing benefits. The increased use of drugs and alcohol to alleviate these pressures in turn worsens mental health and consequently physical health, too. Financial hardship and fuel poverty necessitated choosing between heating and eating for some, with stories of visiting friends' houses to wash; reliance on other family members paying for food; and even prostitution to feed a family. Changes to the benefits system created an endless cycle of appeal, impacting on patients' health and practice workload. Practice workload and an increasingly unscheduled nature of appointments were affecting staff morale (and their health). Support services were affected by the cutbacks, for example their ability to provide crisis loans due to cuts, as well as services being harder to access due to increased demand and lower funding. Pressure on housing services was resulting in vulnerable adults and children being unallocated, difficulty in getting patients into respite care and increasing reliance on the voluntary sector (also subject to cuts).

5.8 McCartney et al (2013), also in Scotland (understood to be the only administration in the UK to have a duty of public health) in their report "Making a bad situation worse?", conclude that although health impacts remain uncertain (in terms of measurability), the threats to public health as a result of the welfare changes are grave and all policy options to maximise employment (through good jobs), maximise income for the poorest groups (especially those most vulnerable to benefit change) and to reduce stigmatisation of benefit recipients, should be considered.

5.9 Using publicly accessible data to illustrate the local authority budget cut per head (over three years) in relation to premature mortality, Taylor-Robinson, Gosling et al (2013) demonstrate that the largest spending cuts have occurred in the areas with the highest premature mortality rates and that the cuts are systematically larger in the North of England. Figure 4 shows the relative position of Devon County Council. As public health once again is now the responsibility of local authorities, with local authorities having a legal duty to reduce health inequalities, the authors wonder how local authorities are supposed to reduce inequalities in the face of austerity measures that are likely to do the opposite. Indeed, Public Health England (HSJ, 12 February 2015) have been asked to investigate a drop in elderly life expectancy.



Figure 4 Plot showing local authority spending cuts per capita relative to national premature mortality rates <75 years, showing their differential distribution north/south and position of Devon County Council.



Source: Taylor-Robinson, D. (2015), personal communication

5.10 Taylor-Robinson, Rougeaux et al (2013) examined the evidence of a rise in food poverty in the UK. Examining data on malnutrition related hospital admission rates that have doubled since 2008-9, evidence of a decrease in calories purchased and substitution with unhealthier foods, especially in families with young children and an exponential rise in numbers of people being issued with food bank vouchers, they highlight the potential for a future public health emergency due to the falling nutritional status of the most vulnerable groups in society. For children, this will be particularly important, since malnutrition in children can have lifelong effects, increasing the risk of cardiovascular and other adult chronic diseases.

5.11 Taylor-Robinson, Harrison et al (2013) draw attention to an increase in child poverty in 2011-12, for the first time in nearly twenty years; the consequences of this are inadequate nutrition and food poverty, financial stress and the increased risk this brings, for example leading to poorly heated homes in winter. Stigma, disempowerment and shame, all determinants of mental wellbeing, are being felt by families feeling the effects of “cuts” in services such as Sure Start centres. Anticipating hard times ahead, especially for increasing numbers of children (and thus affecting their life chances), the authors call the medical profession to take a lead against poverty.

5.12 Bird et al (2010) present the case for thinking ahead and focussing on child mental health and wellbeing. The consequences of poor mental health in childhood are profound and long-lasting, impacting on emotional and social wellbeing, qualifications and jobs, all critical for society’s future. The authors present the evidence for investment in early

interventions and early years support; the influence of the family context, usually protective, but a potential source of adversity, necessitating support for those who parent children. Evidence on the important role of schools in promoting positive mental health and the relevance of environmental, spatial and built environments is presented, as is the emerging and important field of media and marketing in a modern age.

5.13 There is a growing literature around finance, debt and mental health and wellbeing. Dreaves (2010) discussed the wide variety of terms used as euphemisms (and search terms) in this area where stigma and labelling are common. The impact of the recession, austerity measures and legislative change, a credit based culture and cuts in financial advice services, moving from “independent, no fee” to a marketised, fee-paying (and costly) model of support, all impact on mental health and wellbeing. Sometimes, the sum involved is extremely small, but the impact on mental health enormous, for example of a grandparent not being able to provide support for family members being almost insurmountable. Dobbie and Gillespie (2010) and the South Coast Cities (2010) provide two further contributions to the literature on the health benefits of financial inclusion, the former a review of the literature and the latter a summary in a more accessible format.

5.14 The published evidence focuses, rightly, on those places and populations most likely to feel the greatest impacts on health inequalities and the life chances of children and young people for the longer term. However, the issues are similarly relevant for individuals and families in places experiencing relatively lower levels of deprivation, such as the South West, Devon and West Devon. Although the numbers of people may be much smaller, the effects may be just as keenly felt (and in combination) by those in population subgroups, such as the homeless and transient or migrant workers, rural or low waged workers (who are not always included in routine data collection), ex-servicemen, those in debt, ex-prisoners, substance misusers, those living in isolation, elders who rely on car transport who become unable to drive themselves, as well as those in the “protected characteristic groups”, more familiar from equality impact assessment, in local authorities.

5.15 Should they be eligible for support from public services, those services may be geographically harder to access and the services may have less capacity and thus reach. The additional burden of increased costs are therefore transferred to those hardest hit. There is emerging evidence in the literature that there may also be safeguarding issues for some of those for whom personal budgets are being introduced. Some of these issues are made explicit in the summary of the Devon County Council Joint Strategic Needs Assessment (2012), but seem less explicit in other more recent publications, post enactment of the Health and Social Care Act in 2013.

### **Local communities and corporate social responsibilities of commercial companies**

5.16 Reflecting on extractive industry operations, Viliani (2009) discusses the relevance of HIA to corporate social responsibility in the extractive industries. Her findings have resonance elsewhere and can be extrapolated. Having analysed the relationship between the industry and communities residing in the same area, as well as the different powers and roles played by them, she concludes that HIA offers a neutral space for dialogue between communities (who are the central focus of HIA), other stakeholders and the proposal proponent (in the case of a local Plan, this would be the municipal authority). Since HIA puts equity, fairness and social justice at the centre of its analysis, the most vulnerable and most marginal groups in society are included and contribute to addressing any imbalance of power between the community and the proponent.

5.17 Acknowledging that large companies are often central to a national economy, they have a unique position in influencing economic growth. But given their relative power, their general contribution to national and regional development has been questioned. One of the

challenges is for investors to ensure that they have a positive impact at community level and are not strictly limited to economic growth. This would reflect key messages from the Marmot Review. Companies may have easier access to decision making actors and control over a part of the local economy, with communities further removed and more marginalised.

5.18 Corporate social responsibility of companies can help contribute to social justice and development. The use of the wider determinants of health in HIA is consistent with a corporate social responsibility approach. In keeping with the recommendations of the Commission on Social Determinants of Health (2008) extractive industries have been identified as having an important role to play in contributing to community wellbeing by establishing equitable partnerships with all their stakeholders. HIA, as an open, consultative process is a means of proposing relevant, effective and culturally acceptable recommendations that extractive companies could financially support, but they should not lead the full process of change. This may also be considered to apply to developers and their role in HIA.

5.19 Colagiuri, Cochrane and Girgis (2012) reviewed the international literature regarding community health and social harms associated with coal mining activity for people living near coal-fuelled power stations. With caveats on the extrapolation of their findings, their key finding was that there are serious health and social harms associated with such activity and proximity to it for people living in surrounding communities. They found health harms (ie illness and disease outcomes) and raised risks of them for adults and children and infants, consistent with those described elsewhere in the literature.

5.20 Defining social injustice as the unequal or unfair social distribution of rewards, burdens and opportunities for optimising life chances and outcomes, they also considered unfair imbalances in access to essential natural resources, opportunities for employment, education, political or social power and influence and social or individual burdens such as financial costs, social or occupational disruption and environmental damage. They found evidence of both real and perceived impacts on environmental degradation and injustice among local communities. These included social distress and environmental injustice (concern over cumulative health impacts, social division and inequalities, feelings of loss and disempowerment, pollution and poor air quality, environmental damage and potential impacts on future generations); asymmetry of power and influence (including access to information, contestation over natural resources and political conflicts of interest); water access and rights (with changes in local territorial systems to favour the coal mining industry); failure to protect (of government and the mining industry to exercise the precautionary principle and protect local communities from potential or actual harms).

5.21 It is interesting to note that the new NPPF, where the presumption is in favour of development, applies only to England. It is outwith the scope of a desktop or rapid HIA to investigate the progress and outcome of individual planning applications, although there are anecdotal examples of varying corporate approaches.

## **Public Consultation**

5.22 As part of the planning process, West Devon BC has carried out a substantial consultation and engagement process, described on the Engagement Strategy webpage. Regulation 18 consultation (July 2014) responses informed the draft of "Our Plan" under consideration.

5.23 Despite a description in the published newsletter summary of the Reg 18 consultation of the broad attempts to achieve maximum coverage, in a very clear and open effort to engage with the public, there is (as in other process driven local authorities) no denominator from which it is possible to estimate a response rate, as an indicator of the coverage, reach,

or market penetration (to use marketing language) or “success” of such a programme. It must be disappointing that the 58/9 responses represent only some 0.1% of the total population, with about half of these being “organisational” and statutory consultees.

5.24 There is no indication of how non-English speakers (JSNA 2012 notes a recent rapid increase in those with (up to 100) additional languages, particularly Polish and Arabic, in Devon), or those with poor numeracy or literacy in their first language, or digital exclusion, might have engaged, how children and young people were included, or how those with for example, limiting long term illnesses, impairments, or those with caring commitments, or members of the protected characteristic groups (plus any locally defined “other” group) might have been engaged.

5.25 The responses (by author) are published on the Council website, not under the Planning section of the website, but under the Communities section, which may potentially be a source of unintentional obfuscation.

### **Working with Communities**

5.26 Elliott, Harrop et al (2010) in light of the 2008 recession and new austerity cuts, reviewed the evidence and lessons learned from previous recessions, citing case studies from de-industrialised areas in South Wales. They noted that while an economic recession may be technically defined as a relatively short time period, the longer term effects of recession can last years and be particularly persistent in some areas. Although recession is often examined in relation to (un)employment, they found that the strongest negative effect is on mental health (including the risk of suicide), with evidence of impacts on physical health.

5.27 As with individuals, places also have histories in which disadvantage and advantage accumulate. Citing Blaenau Gwent in the Welsh Valleys, they noted that ongoing “recession” was reported as a fact of life, exacerbated by the loss of the industries from which they had yet to recover. Social and leisure activities, intertwined with industry, declined and communities became more vulnerable and less resilient to the effects of further recession. The nature of subsequent regeneration activity and the employment opportunities it brought were regarded as transient in nature, perhaps dependent on grant support and unlikely to be sustained into the future. For those unwaged and with existing mental health problems, the effects were less immediate, but judged to be significant in the longer term, as “cuts” took hold. Compared to a more deprived urban area (Cardiff), but one with greater resilience due to a diversified economy, the impacts on Blaenau Gwent were considered to be greater and longer lasting. Inequality and perception of inequality can itself create problems that are relevant to health.

5.28 Reflecting on the challenges of working with communities in a HIA of a controversial planning application, Golby and Elliott (2007) found that use of a robust HIA methodology went some way to assuaging local residents’ emotions and frustrations, with the focus groups allowing the voice of the local community to be heard. That they felt “listened to” and heard, with their contribution recorded and reported, was of importance to them. Building trust was more problematic, as residents felt excluded from the planning application process and misled by those making decisions. The degree to which decision makers took account of lay knowledge when it challenged “expert” opinion was unclear.

5.29 The established and experienced Welsh HIA Unit (WHIASU) unusually carried out the HIA on behalf of a residents group and the assessors reported experience may reflect this arrangement, to a degree.

5.30 Two local authorities were involved in a cross-boundary planning application. As a result of the history of the planning application, the residents felt betrayed by the authorities' failure to deliver on their promise to cease opencast mining at the site. Despite consultation meetings being held, they typically felt that their views and concerns had not been taken into account. They expressed feelings of impotence in relation to the whole process and frustrated that some decision makers were reluctant to participate in the HIA. Steering Group meetings were often volatile, with the assessors acting as mediators between adversaries. At times, residents' views conflicted with those of the local authorities and particularly with the company involved. The residents perceived a power differential and lack of respect from the company (e.g. failure to attend), creating tension when the assessor attempted to present the perspective of the company to them. The assessors themselves were not wholly trusted, with relevant information withheld by residents until the very late stage of finalising the report. Focus groups, held in local community settings went well, capturing valuable qualitative evidence about how the whole experience was impacting upon their lives and wellbeing. Residents expressed fears about the extent to which decision makers would value qualitative evidence and this was not entirely unfounded, as greater weight seemed ultimately, to be given to the environmental factors over those of human health in the planning application decision.

5.31 None of these experiences is unusual in undertaking rapid HIAs, very many of which are now undertaken on contentious topics, topics of high perceived risk, or "new" topics lacking a robust scientific literature to draw on. They emphasise the importance of assessors having a wide and appropriate range of skills and experience in carrying out HIA, the importance of procedural aspects in making a HIA "happen", a shared understanding of the core values and nature of HIA and use of a robust and validated methodology, captured in a terms of reference. Inexperience, or a failure to adequately scope the HIA and successfully manage some of these events can have unanticipated effects on the output and outcomes of a HIA. For example, in seeking to secure a definitive categorical decision, rather than presenting the evidence gathered to the Steering Group, there was a lack of unanimity among the Steering Group described by Wilcox, Holroyd and Gibb (2013) in their report of the HIA carried out in Deanfield, Yorkshire.

5.32 The Welsh Government (2009) noted that case law has identified that public perceptions of harm can be a material consideration in planning decision making even if not objectively justified by the facts. However, little or no weight should be attached to those perceptions if they cannot be justified, for example if accepted international standards for protection of public health are met.

5.33 Elliott, Harrop and Williams (2010) cited this HIA as a case study in considering risk communication and public health. The residents believed that previous activity had already had a negative impact on their health and that an extension in operations would lead to ongoing exposure to risk and cumulative effects on health from PM, dust and noise. Although land remediation would be completed within five years, residents mistrusted the company and doubted this would be achieved, ever. Efforts by the assessor to improve communication were hindered by non-appearance and refusal by representatives of the company to engage in the HIA. Officials with specialist knowledge declined to join the Steering Group, maintaining a role as observers and key informants (author note: This, in fact, is in keeping with good HIA practice. Identifying the "independence" of "experts" is a sign of robust scoping and terms of reference, since the Steering Group is concerned with 'delivery' of the HIA, rather than 'doing' it).

5.34 The methods used in the HIA were robust and indicative of good HIA practice, but beset by conflict and disagreement about definitions of what constituted evidence, fair processes, power and control. Residents wished to carry out "scientific", i.e. quantitative (and thus 'powerful') primary data collection and were perturbed by the assessor explaining

that “small number surveys” would be less than scientifically robust, whereas qualitative data from small numbers in focus groups would be sufficiently scientifically robust, but were perceived to be ‘less scientific’ (and thus less ‘powerful’) by residents. For some residents, this then raised issues of potential vested interests and thus bias. This conundrum reflects in real life how the purpose of HIA itself may be misconstrued, as described by Birley (2011)

5.35 For the residents, their expressed initial concerns were largely framed in terms of potential impact on identifiable diseases, or illness (a biomedical, reductionist approach). Using a broad social definition of health and qualitative methods to gather their evidence legitimised, within a public health frame, their day to day experience of living with a large industrial operation was seen as a useful lever. They could clearly express their frustration, for example, that while the literature showed that no guidelines were being broken, people tasted, felt and touched dust that made them feel terrible every day.

5.36 Over the period of the HIA, a new “knowledge space” was created, with specialists and officers acknowledging gaining a wider appreciation of “what matters” in a meaningful way, not just from ‘evidence’. Although still being researched and emerging evidence published, this is the “hidden added value” of HIA, over and above statutory consultation processes. It is also a key difference between HIA and other forms of impact assessment that are undertaken within a framework.

5.37 The HIA provided challenges to officers charged with managing risk communication in contentious environments. It allowed the meaning of risk in terms of residents’ lived experience to be accepted as having validity in their own right, alongside information known about risk of specific diseases. An emotionally charged, new deliberative space allowed the parties to contest and debate the validity and salience of the potential impacts in a local context. It gave statutory officers an opportunity to identify, debate, respond and so manage, concerns raised by local people about controversial land developments. The residents appreciated that HIA provided an opportunity to debate the nature of scientific method.

5.38 Communities are usually the first to identify a connection between toxic hazards and health and the use of HIA emphasised the importance of seeing knowledge about public health in the round and recognising that ‘science’ is often flawed and inadequate, that it does not ask questions of importance to those likely to be most severely affected and that it is often used to exclude the legitimate and well-informed perspectives of local people.

## **HIA and Planning**

5.39 HIA is not a statutory requirement in the UK (although now mandated for some developments in Wales). It is however, regarded as best practice to consider health and well-being in non-health domains. Increasing numbers of non-health sector officers are voluntarily advocating for HIA as best practice. Globally, different jurisdictions have adopted different approaches to developing legal and policy frameworks for HIA. This could result in HIA becoming a ‘tick box’ exercise, as other impact assessments are, losing the opportunity to bring together evidence of different kinds within a deliberative space, with experiential evidence lost if the participatory focus of HIA were to be sidelined. Legislating for HIA might lead to incomplete institutionalisation, a challenge to overall effectiveness (Chadderton et al, 2013). For example, HIA is a statutory requirement in some provinces in Canada, but incomplete institutionalisation and sustainability of practice resulted in a hiatus of some years, recently evidenced by resurgent demand for HIA training to re-build capacity and organisational capability to meet the statutory requirement.

5.40 Over many years, a broad literature of guides, tools, summaries of evidence, etc., has developed intended to bring health and well-being and spatial planning more closely together through the medium of HIA. HIA practitioners have long included planners in their

HIA capacity building endeavours at local and other levels, e.g. professional development programme for RTPI in the North West, recent TCPA activity. The dis-establishment of PCTs and the introduction of the highly slimmed down NPPF (with which all local planning documentation and decision making processes in England have now to comply) has meant that a number of useful publications have been either archived, or superceded.

5.41 A detailed search of the literature is beyond the scope of a desktop HIA. A useful summary of the NPPF (London NHS HUDU, 2012) highlights the way in which health considerations have been incorporated into the NPPF. The NPPF itself reduces the guidance documentation for local planning authorities and decision-takers from 1,000 pages to around 50, for those drawing up plans and making planning application decisions. Health is given prominence as a cross-cutting theme, now an integral part of national planning policy guidance. Writing primarily for London, they note that in order to comply with the NPPF, the London Plan required alterations to reflect the reforms introduced in the Health and Social Care Act, 2012. (Regional spatial plans were revoked under powers of the Localism Act, 2011).

5.42 The NPPF is indeed a shorter document, bringing together a number of documents from several previous sources and the Healthy Urban Development Unit (HUDU) document helps navigate the HPPF at a “headline” level, but relevant information can be found in the accompanying technical guidance (DCLG, 2012). For example, Authorities are expected to ensure that plan proposals do not have an unacceptable adverse effect on human health and that particular care should be taken in respect of any conditions they (the residents) attach to a grant of permission for working in proximity to communities. Working in close proximity to residential property may be necessary, but for a limited and specified period, without scope for extension. There is no apparent detail with regard to who might define effects as “unacceptable”, of how “close proximity” is defined, or how care for residents’ views might be operationalised. Any programme of work, as far as is practicable, should take account of potential impacts on the local community over the expected duration of operations. This might suggest that the “construction” and “operational” phases of developments lie within the purview of the NPPF, while consideration or responsibility for longer term potential impacts (such as on health) beyond this period might lie either elsewhere, or nowhere.

5.43 Other examples from the literature include Boyce and Patel (2009) who considered the health impacts of spatial planning decisions, recommending that to make optimal progress to reduce the burden of disease, those working in planning at all levels need to regard health as part of their responsibilities. Campbell (2010) summarised for local authorities the scientific evidence with regard to air pollution and how it contributes to health inequalities, noting the disproportionate effects on children, older people, and those with existing illness. She noted that HIA would be a means for councils to better meet their responsibilities with regard to environmental protection and encouraged closer, cross department working.

5.44 Braubach and Grant (eds, 2010) undertook a review of the evidence on the spatial determinants of health in urban settings for WHO. The risks and benefits of spatial planning to health are inextricably linked to wellbeing, with planning, design and management of places, spaces, facilities and buildings paramount. They identify urban plans as key determinants of health and wellbeing, but note that too often this (often unstated) priority is overlooked, since planning practice tends to be fragmented and lacking an integrated approach. Development planning is often separated from daily governance as a direct consequence of sectoral approaches, functional and disciplinary specialisation, in effect being a built-in resistance to intersectoral collaboration founded on specialist values, interests of sectoral agencies and professional institutions. They conclude that urban planning has substantial potential to positively affect physical, mental and social wellbeing

and to enhance social inclusion, thus decreasing health inequalities. Urban planners, public and environmental health professionals, citizens and many others should be engaged in the process.

## **HIAs**

5.45 A number of HIAs are known to have been undertaken on matters pertaining to planning policy over the years. Many will have been carried out under commercial confidentiality and therefore cannot be found in either the published or grey literature. Some HIA activity is likely to have been undertaken as part of personal public health professional development and as such, has not been put in the public domain.

5.46 In countries where communicable disease remains dominant, HIAs based upon a biomedical model of health are considerably more likely to be commissioned (based upon a principle of polluter pays) and adopt a quantitative, risk reduction, approach. In countries who have or continue to progress through the epidemiological transition, where urbanisation is bringing, or has brought, non-communicable disease and mental health and wellbeing to the fore, HIAs are increasingly likely to be based upon a social model of health and contain recommendations intended to strengthen stakeholder equity in decision making and move towards achieving Health in All Policies. In countries where communicable diseases are once again becoming significant public health issues, there is some pressure to move back towards a more quantitative, risk reduction approach. This is re-emerging to a degree in the UK.

5.47 There are at least 85 methodological guides for HIA (and over 51 HIA screening tools) available in the public domain (Pennington, Dreaves, Scott-Samuel, Pope, in press). It is entirely appropriate that they be variously modified for use on particular topics, in particular countries, or for local communities.

5.48 Devon has a long track record in HIA, perhaps not recently sustained in everyday practice, but still evident in the development of HIA methodology and tools commonly in use around the world. Part 2 of The Devon Health Forum HIA Screening checklist (2003) is still today very familiar and easily identified in the literature (but not often properly cited), embedded in a substantial number of iterations of such tools and thus good HIA practice. Recognition and reassertion of this, through renewed HIA capacity building and systematic screening could be an easy “win-win” for any Devonian administration seeking to achieve Health in All Policies. There is some evidence that HIA participation (in the sense of action learning) in itself can offer a means of empowering participants to be more proactive problem solvers, rather than passive managers.

5.49 The two examples cited from Wales of both HIA practice and reporting in that they give equal weighting and properly report qualitative evidence from stakeholders, triangulating evidence with that from the literature and demographic profiles. Both discuss Human Rights legislation relative to the progress of the proposals, as well as health inequalities, stress, anxiety and depression, social capital, effect on property and neighbourhood character and communication, as well as the more usual economic and environmental impacts.

5.50 Articles 8 (1), 14 and article 2 with article 14 of the Human Rights Act (1998) were cited as relevant. Article 8 states that everyone has the right to respect for his private and family life, his home and his correspondence. Article 14 requires access to the Act's other conventions to be equal and refers to different treatment of people 'placed in analogous situations'. Since planning guidance differs across the UK, there may be inequity of protection. Whilst some health issues are addressed by the (then) planning process, others including anxiety and depression, are not. Under Articles 2 and 14, this may constitute a



failure to address a health concern that disproportionately affects one community or portion of a community. State authorities (perhaps local authorities and those who grant planning permission) may violate their positive obligation to protect the right to life (article 2), if it can be established that they failed to take measures within the scope of their powers which judged reasonably, might have been expected to avoid that risk.

### **Cumulative Impact Assessment**

5.51 Consideration of the assessment of cumulative impacts of proposed developments has long been a requirement in environmental impact assessment that practitioners in the UK and Europe have sought to address over the years. The underlying concept of health is not always explicit and is by implication, usually biomedical, focussing on risk reduction and quantitative methods. There is now guidance (International Finance Corporation, 2013) for those in the private sector seeking to achieve this. This states that there is no single accepted state of global practice in cumulative impact assessment. Various mathematical methods are utilised to attempt to estimate such potential effects, within the environmental regulatory framework, largely with regard to the statutory nuisances. These estimates often have caveats regarding accuracy and extrapolation, as the complex interactions and mechanisms involved are incompletely understood.

5.52 Nor is there any valid and robust methodology for assessing cumulative impacts of several developments in spatial relationship to each other (e.g. in a borough, or city) on population health. Fehr and Meikel (2010) reported on an expert seminar brought together by the WHO to consider the use of quantification methods in HIA. The seminar agreed that the precautionary principle be applied, as the mathematical methods considered were based usually on only one health outcome measure and although technically sound, were regarded as insufficiently robust for a wider interpretation, in public health terms. Even researchers working with very large and robust public health data sets, for example on the epidemiology of coronary heart disease, continue to refine their mathematical models, as they are as yet insufficiently robust to take proper account of health inequalities, largely due to ongoing data quality issues at source (O’Flaherty, personal communication). It is interesting to note that despite the lack of any robust methodology, the NPPF (see HIA and Planning) repeatedly calls for consideration of cumulative impacts. Consideration, of course, is not synonymous with quantification.

5.53 Franks, Brereton and Moran (2008) considering the cumulative impacts of multiple extractive industry sites on regional communities and environments found that the compounding impacts of multiple operations have stretched environmental, social, human and economic capitals, multiplying the extent, magnitude and profile of multi-site, community, economic and environmental impacts. This has rendered conventional site by site (ie individual project level) approaches ineffective.

5.54 Cumulative impacts can be both positive and negative and can vary in intensity, as well as in spatial and temporal extent. They tend to persist over time and may interact such that they trigger or become associated with other impacts. They may accumulate linearly, exponentially, or reach “tipping points” after which major changes in system state may follow.

5.55 They observe that most examinations of cumulative impact consist of the contribution of the project to those of other existing activities and whether the increased impacts meet regulatory requirements. Assessments rarely assess the cumulative effects of planned or future projects and do not employ explicit methodologies to do so. The greatest difficulty is, as always, access and availability of data and information. Where it is available, it may not be comparable. Simply meeting the requirements of a planning process provides little

incentive for proponents to consider more comprehensive assessment. Lack of robust methodologies in cumulative impact assessment can be a potential source of delay.

5.56 They conclude that tools and methods for managing cumulative impacts are commonly in practice, but that more advanced approaches, such as co-ordination of industry responses to impacts of high concern to stakeholders, tailored assessment methodologies, facilitation of synergies, data sharing and collective data management and proactive management (about the timing and location of proposals) require greater co-ordination and resource in order to become commonplace.

5.57 In terms of a Local Plan, giving consideration to future local land uses in the medium and longer term, but relative to those of adjacent authorities and larger infrastructure development proposals, there is some emerging evidence suggesting that prospective consideration of cumulative impacts may become a more pressing issue for planning in the imminent future (BBC News, 17 February 2015).

## Limitations and Constraints

6.1 This was an interesting HIA. The major constraint has been the methodological characteristics defining a desktop HIA. In a desktop HIA there is no Steering Group, scoping report, or terms of reference, as the timeframe is extremely short. A rapid HIA would be characterised by the addition of evidence from community stakeholders and key informants and strengthening of policy analysis.

6.2 Electronic publication has increased the complexity of policy searching and analysis for HIA, especially at a summary level. Archive searching and withdrawal of documentation from the public domain add to the challenge of presenting a clear and current policy landscape, synergy or divergence. Headline policy documents (sometimes without a word or topic mentioned in the title) are often now accompanied by a plethora of guidance, associated literature (and hyperlinks) – the devil being in the detail, not the policy. For example, National Infrastructure Planning Policy Statements (12 domains, covering energy, transport, water, waste water and waste) are not readily sourced via the Cabinet Office website.

6.3 There have been some policy areas and topics (such as energy, climate change, sustainability, transport, housing and employment) that have not received as much attention as was anticipated at the outset.

6.4 In considering wider health care services, it has been both interesting and challenging to remain focussed on the Local Plan itself, planning being somewhat “silo’d” but highly significant, for a Borough Council, but not required to demonstrate how it will contribute to enabling the undoubtedly significant change in pattern and accessibility of future service provision. Therein lies another (and possibly larger HIA).

6.5 It is clear from an overview that there are some interesting juxtapositions between government departmental policies and the policies and strategies of non-governmental and other regulatory organisations with which they are associated, or sponsor. It is speculated that a more detailed analysis, including ongoing legislative changes, might demonstrate a lack of synergy between organisations at local level; between local policies and national policies; between departments at national level; and between national and international policies. One example might be the impact of the Growth and Infrastructure Bill, where it is understood that for future extractive industry development proposals over 100 hectares, a developer may choose to take the decision for such an operation to the Infrastructure Planning Commission (unelected) for permission to regard it as a major infrastructure project, enabling it to bypass local mineral planning authorities (elected) (Leary, 2013).

## Impact Analysis

This brings together the evidence from all the data collected from different sources and using different methods; in this instance, a desktop search of the demographic profile of West Devon Borough Council, policy context and evidence from the literature. Where possible, it describes the potential impacts:

**Health impacts** health determinants affected and the subsequent effect on health outcomes, in descriptive terms;

**Direction of change** health gain (+ve) or health loss (- ve);

**Scale** severity (mortality, morbidity and well-being) and magnitude (size/proportion of the population affected), where possible

**Likelihood of impact** definite, probable, possible or speculative, based on the strength of the evidence and the number of sources;

**Latency** when the impact will occur, in broad terms.

For the purpose of systematic impact analysis, a hierarchy of evidence for HIA has been defined describing the relative strength of evidence for an association or causal relationship between health determinants and health outcomes; this includes evidence from the literature, key informants and stakeholders.

<b>Level I</b>	Reviews of (systematic) reviews or meta analyses
<b>Level II</b>	Systematic reviews; reviews of several HIAs
<b>Level III</b>	Single studies or HIAs
<b>Level IV</b>	Expert witnesses (key informants)
<b>Level V</b>	Stakeholders.

Where evidence collected from multiple research methods converges, this adds extra strength to the evidence and the likelihood of impact. Definition of the likelihood of the impacts is described using the following qualitative terms. The likelihood of the impact is based on the assessed strength of evidence. For clarity throughout the impact analysis section, the potential impacts are in **bold** and the likelihood of an impact is underlined.

<u>Definite</u>	=	Will happen. Overwhelming strong evidence from a range of data sources collected using different methods (level I)
<u>Probable</u>	=	Very likely to happen. Direct strong evidence from a range of data sources collected using different methods (levels II/III)
<u>Possible</u>	=	More likely to happen than not. Direct evidence but from limited sources (level IV)
<u>Speculative</u>	=	May or may not happen. No direct evidence to support (level V)

7.1 In the absence of a Profile in the public domain for that portion of the population of West Devon covered by Our Plan and the issues pertaining to small numbers at local level, it has been challenging (and perhaps imprudent) to make specific recommendations in an obviously positively developing organisational and policy environment.

7.2 Based on the evidence collected for this report, which is primarily from publications and sources available and easily accessible in the public domain (sections 3,4,5,6 and 7) positive and negative health impacts have been described, where possible, with regard to the defined population under consideration (that portion of the West Devon Borough Council population residing outside the Dartmoor National Park Authority).

7.3 The most significant positive impact for the local population of West Devon will probably result from firstly, **a much closer co-operative (and reciprocal) working relationship between the Borough Council and its partners, particularly embedding public health ethos and practice, with an explicit focus on reducing health inequalities, closer to its' daily activities, to better achieve Health in All Policies.**

7.4 Secondly, it is probable that this will **bring to the fore locally identified population sub-groups** (such as those in occupied sheds and caravans, etc) and how "Our Plan" may be more explicit in consideration of future arrangements beyond the present 5 year land supply, over the duration of the Plan period (to 2031).

7.5 The main and probable negative impact identified relates to **achieving a balance (or trade-off) between producing an accessible, useful and comprehensive Plan, that is linked to Borough and County policy agendas across the wider determinants of health to reduce health inequalities** (as well as maintaining health and wellbeing), that is easily accessible and with clear local interpretation of the available supporting data for community members (in all appropriate languages), stating how the Council would wish to act over the entire planning period, **and a Plan document that succinctly meets only NPPF requirements for central approval and the responsibilities of the Borough Council in the (relative) short term.** The latter may result in a more constrained and less dynamic narrative, while the former may better reflect localism and the lived experience of the defined population.

7.6 The net impact of Our Plan on future population health, particularly in reducing health inequalities, is uncertain. Much will depend on wider policy, economic and market factors particularly with regard to the now very imminent (less than 100 days) General Election. Based on the evidence presented, it is speculated that despite clear strategic commitment, the potential benefits of the proposed Local Plan may be less than optimal due to factors beyond local control.

## Conclusions and Recommendations

8.1 From a desktop HIA and against a national background of ongoing austerity measures and legislative change, the effects of which have already been shown to be differentially borne by the poorest and most vulnerable in society, widening the inequalities gap and yet to become wholly apparent in the longer term, it would be injudicious to do other than describe how a single draft Local Plan might or might not contribute to future health and wellbeing of a (relatively) small defined population.

8.2 The purpose of prospective HIAs is to make the proposal (draft “Our Plan”) “better” than it might otherwise have been, to make recommendations to accentuate potential positive and mitigate potential negative impacts. The extended lead-in time and the (now) concurrent time frame for this HIA mean that there is significantly less room for informing the Reg 19 public consultation than had perhaps been anticipated at the outset.

8.3 There are clear opportunities for all of the parties to work more closely together to meet their obligations to co-operate and through undertaking a rapid HIA *with* the community, to create an exemplar of a more equal and equitable means of managing future planning *with* the community.

8.4 The responsibilities of a District Borough Council are not comprehensive in terms of the wider determinants of health, and all Local Planning Authorities are now required to produce Plans that are not large and onerous documents. West Devon BC may wish through their planning process to make more explicit and accessible, especially to the public, how they intend their local plan to build on their substantial assets for health and wellbeing of which they are guardians, accentuate potential positive health impacts (of which there are many), while addressing (potentially increasing) health inequalities for locally identified vulnerable population sub-groups.

### STOP PRESS!

8.5 Final preparation of this report (and reflecting the concurrent nature of this desktop HIA) has revealed the most positive impact of all - that in the current iteration of the Locality Public Health Plan for South Hams and West Devon (accessed February 2015) there is now an emerging action plan that explicitly addresses many of the potential impacts and recommendations identified in this piece of work, particularly to do with locally identified population subgroups, health and planning policy and indeed HIA. That this is now in the public domain and has become so since the previous version was received in November 2014 is another welcome positive.

8.6 There remain issues of accessibility, relative to the preparedness of local people to seek out updates (and perhaps an unintended assumption of the level of capability and commitment they may have to interpret a blizzard of data) and non-English access, etc. Ease of access could still be improved by adding to the public consultation process via links in the Plan newsletter and the draft plan pages of the Council website (and online publication may still not adequately reach all intended recipients), but there is considerable reason for optimism, since much seems to have been achieved “behind the scenes” in the last few months that indicates close working, co-operation and indeed co-production, reflecting how the Borough Council is demonstrating their response to reducing health inequalities in West Devon and beyond.

## Recommendations

- For ease of access and reading for the public, the draft “Our Plan” could include the use of hyperlinks within the document to reach sources of evidence cited, obviating the need for the public to search the websites of several other organisations.
- West Devon Borough Council may wish to consider refreshing/reintroducing the Devon Health Forum (2003) HIA Screening Checklist in an updated format, perhaps, for use in all its’ departments, for systematic HIA screening and to achieve Health in All Policies.
- West Devon Borough Council may wish to consider adding such a presentation to the final version of Our Plan (if it is possible to extrapolate from the available data) for that portion of the West Devon population covered by the draft Plan. (page 8)
- Links should be made to explicitly identify how the Local Plan might contribute to reducing health inequalities, in line with the main Health and Wellbeing Strategy (page 15). Ease of access for the public could be improved by placing hyperlinks in the Our Plan section of the Council website.
- Given the move towards fewer GP practices/hubs for one stop integrated care, reduced duplication of “specialist” centres for hospital provision and more care in the community, all against a background of financial challenges, shortcomings in transport network infrastructure and services, increasing elderly population and for example, high levels of dementia in the county, it is an imperative to demonstrate explicitly in all Local Plans (in this case, West Devon) how local planning systems will deliver such infrastructure as may be required (Page 15).
- Further summary analysis of policy documentation should be undertaken, to clarify the non-health policy context and to provide a timely description of the emerging health (including commissioning and procurement) policy environment for that part of West Devon within the purview of the Local Plan (ie outwith the Dartmoor National Park and including both NEW CCG and South Devon and Torbay CCG) (Page 16).
- Further examination of the potential impacts on health inequalities of the financial and organisational model to be introduced for an Integrated care Organisation (ICO) and “community hubs” should form part of any future rapid HIA. Particular regard needs to be given to the coherence of plans for such facilities and related transport infrastructures with the Local Plan. (Page 15).
- Close monitoring will be required to ensure that challenges to future service provision do not exacerbate existing inequalities and consequently become a stressor for the Local Plan, particularly for those population subgroups most likely to be differentially be impacted upon, such as those requiring affordable housing, the homeless, itinerant and migrant workers, unwaged and low income, those in occupied sheds and caravans, etc, who perhaps fall beyond the “traditional” protected characteristic groups (page 16)
- Further consideration should be given to making explicit in the draft Plan, appropriate adjacent communities, local authorities and service commissioning organisations who might be consulted with under the duty of co-operation, with regard to “cross boundary” issues. That is, rather than proscribing the “boundary” of the draft Plan and thinking only “inside” that boundary, it should demonstrate (to the satisfaction of all the stakeholders) how it meets the duty of co-operation with those bodies and communities “outside” the boundary, in reducing inequalities, without making the Plan an inaccessible publication (page 18)

- West Devon Borough Council planners may wish to work more closely with their Public Health partners to develop asset-based approaches (page 19). There is some evidence that members of the Public Health Team at County level are working with “their” designated Councils, but this should be more than two-way communication.



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