

## **Committee of the Faculty of Public Health in Scotland Advocacy Subgroup**

### **Health in All Policies: Making it a reality for Scotland**

#### **Report of a Workshop held on 10<sup>th</sup> December 2018 in Edinburgh**

## INTRODUCTION

This is a report of a workshop held in December 2018 that was organised by the Advocacy subgroup of the Committee of the Faculty of Public Health in Scotland (CFPHS).

CFPHS published *Healthy Lives Fairer Futures: A call to action* in 2017. It identifies 8 priorities for action, the first of which is 'Include Health in All Policies for Scotland'.

The aim of the workshop was to consider and discuss what Health in All Policies (HiAP) means and discuss possible options to implement it in Scotland. It aimed to provide both a learning opportunity for participants and also to help CFPHS to define its advocacy work to achieve HiAP in Scotland.

The workshop was held in Edinburgh Training and Conference Centre on 10<sup>th</sup> December 2017. As it was funded by the Faculty of Public Health, it was free to FPH members but non-members paid a fee of £40. There were places for 25 delegates, and 25 people attended on the day including speakers.

Health Scotland provided events management for the workshop and CFPHS would like to thank them for this support.

The programme is given in Appendix 1. The workshop included three presentations and three rounds of world café discussions to debate the pros and cons of different mechanisms for HiAP.

## PRESENTATIONS AND INITIAL DISCUSSION

The slides from the three presentations are reproduced in Appendix 2.

### ***What is Health in All Policies?***

Margaret Douglas, from the CFPHS Advocacy subgroup and the Scottish Health and Inequalities Impact Assessment Network (SHIAN), introduced the event then gave a presentation on the rationale and definition of Health in All Policies, some international examples and current Scottish experience, and possible mechanisms for HiAP in Scotland.

HiAP was defined as *a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas*. (California HiAP task force). It was suggested that it differs from other forms of advocacy in working more closely with policy makers, starting with a proposed policy and considering the full range of health impacts that could arise, rather than starting with public health priorities and then identifying relevant policies.

The presentation concluded with the following possible mechanisms for further discussion:

- Requirement for mandatory HIA
- Require organisations to appoint lead Health and Wellbeing officer
- Appoint Commissioner for Health
- Scrutiny role for Public Health Scotland
- Requirement for HiAP teams in each Community Planning Partnership

### ***Health Impact Assessment in Wales***

Liz Green, Principal of the Wales HIA Support Unit (WHIASU) in Public Health Wales, then gave a presentation on the use of Health Impact Assessment (HIA) in Wales and the new requirement for public bodies to complete HIAs in specific circumstances, as legislated in the Public Health (Wales) Act 2017. The Act also requires Public Health Wales to provide assistance to those carrying out HIA.

The regulations are still being drafted. Factors which facilitated this legislation included: the existence of WHIASU as a specialist unit, training and capacity building over several years, 'champions' in different sectors who have seen the benefits of HIAs, the use of a rapid participatory approach to HIA, partnerships and use of case studies to raise awareness.

### **Public Health Reform Improving Health Commission**

Patricia Cassidy, co-chair of the Improving Health Commission, then spoke about the work of the Commission. Within the overall vision of Public Health Reform, which is 'A Scotland where everyone thrives', the Commission has defined the specific ambition for health improvement as a Scotland where:

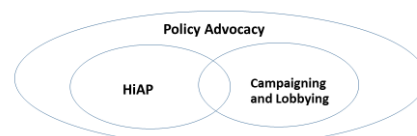
- We all prioritise health as a human right
- We take a Health in All national and local policies approach
- We prioritise prevention and build local capacity for effective preventive action

### **Discussion on presentations**

The plenary discussion focused on the use of HIA and the importance of ensuring it is meaningful. Key points were:

- The relationship between HIA and Integrated Impact Assessments – as health has broad determinants it is often useful to integrate with other assessments. SHIAN advocates using a scoping workshop that considers a wide range of impacts, and using this to identify the relevant impacts that require further evidence and assessment.
- The importance of involving stakeholders, sharing ownership and culture change. SHIAN scoping workshops are always a group exercise to ensure different perspectives are heard.
- A suggestion to gather information on how the outcomes of HIAs have influenced policy – although it was also recognised that sometimes it is difficult to attribute changes made to policies during their development.
- A concern that if HIA were mandatory it could be 'tick box' and less meaningful.
- Liz clarified that the Welsh legislation only applies to public bodies in Wales.
- Examples of HIAs were given in Criminal Justice and the Night Time Economy. WHIASU has been working on an HIA of Brexit.
- Accountability –The Welsh legislation requires public bodies to publish both the HIA and their responses, ie whether they intend to implement the HIA recommendations.
- Quality assurance – WHIASU has produced a Quality Assurance Review Framework, based on recognised best practice. WHIASU has some role in quality assuring HIAs and is often asked for an opinion.
- Capacity – WHIASU has trained Environmental Health Officers to carry out HIAs. (But it was recognised that EHO numbers have declined sharply with austerity so this may not be a viable option in Scotland.)

The plenary also challenged the distinction made between advocacy and HiAP and suggested that policy advocacy was broader than campaigning. An alternative representation might be as follows:



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| <ul style="list-style-type: none"> <li>• 'Inside' policy making</li> <li>• Consider range of impacts of a policy systematically</li> <li>• Prioritise policy areas of most impact</li> <li>• Collaboration with policy makers</li> </ul> | <ul style="list-style-type: none"> <li>• 'Outside' policy making</li> <li>• Focus on single issue or solution</li> <li>• Build alliances with other interests</li> </ul> |
|--|--|

## WORLD CAFÉ DISCUSSIONS

There were three discussion tables, each of which discussed different possible mechanisms for HiAP. Tamasin Knight, Sheila Duffy and Lynsey Martin acted as table facilitators to lead discussion about the pros and cons of these mechanisms. The facilitators remained on the tables while participants rotated, so all participants had the opportunity to discuss all of the potential mechanisms in turn. A summary of discussions at each table is presented below.

### ***Table 1: Promoting assessment of health impacts***

Table 1 discussed the following mechanisms:

- Making Health Impact Assessment (HIA) mandatory in a similar way to Equality Impact Assessment.
- Requiring NHS Boards and Community Planning Partnerships to jointly identify a small HiAP team in each area, which would undertake HIAs or similar analyses of developing local policies. There would be an agreed way to prioritise the policy areas of focus.

#### 1. Requiring mandatory HIA

The value of HIAs was acknowledged, and with this the need to promote HIA as a positive addition. It was also recognised that HIA alone is not sufficient to lead to beneficial change - the findings of HIA need to be acted upon.

A key theme from this table's discussions was of the desire for high quality HIAs. There was concern expressed that if HIAs were mandatory this may lead to poor quality HIAs, with HIA being 'just a tick box' and people doing the minimum required. However, the view was also expressed that if HIA is not made mandatory it would not be done at all.

It was commented that if HIA was made mandatory, there would need to be accountability for this. There was also discussion about what the consequences would be if organisations chose not to carry out mandatory HIAs.

Possible ways of reconciling these perspectives were discussed. These were:

- Making HIA mandatory for some situations / policies, but not others (who decides criteria?)
- Making Health in All Policies mandatory, but not specify which tool (e.g. HIA) should be used
- Not make HIA mandatory – but make it easier and more appealing to do HIA, by increasing the resources and support available for HIA work.

Methods of ensuring high quality HIAs were discussed. It was commented that in order to ensure high quality HIAs there would need to be a process of quality assurance of HIAs. It was noted that there are resources from Wales which could potentially be used or adapted to support this, and that there could be peer review of quality assurance. The need for HIA training to help ensure high quality HIAs was highlighted (noting that there is a HIA competency course in Wales), along with a proposal that in order to ensure quality, HIA training could be made mandatory for anyone doing a HIA.

## 2. CPP teams

There was discussion as to whether HiAP teams would be needed, or whether a different mechanism (such as describing and promoting the HiAP process) would be able to achieve the same desired outcome. There were some concerns expressed that if there was a local HiAP team this may discourage people from seeking to make their own policies health promoting, as they may not consider that their job.

It was commented that in some areas of the country there may be resistance to the proposal of being required to have a local HiAP team.

It was noted that CPPs are powerful and could provide accountability to ensure HiAP is happening if there were local HiAP teams.

There was discussion about the resourcing requirements of the proposed local HiAP teams. The need for public health input was emphasised, and it was commented that a team approach would enable a variety of perspectives to be heard. It was noted that some of the smaller CPP areas may not have the resources to have a HiAP team. There was a suggestion that national experts on HiAP could be based within Public Health Scotland, and provide input to the local HiAP teams. It was commented that having local HiAP teams could be a starting point for increasing HiAP in this country, with the acknowledgement that this approach may not be suitable for all local areas.

### ***Table 2: Health scrutiny***

Table 2 discussed various models intended to provide health scrutiny:

- Making it mandatory for public organisations to appoint a lead health and wellbeing officer, whose role would include ensuring internal scrutiny of the health impacts of policies
- Appointing a Commissioner for Health as an independent office similar to the Children's Commissioner, with powers to challenge public bodies where there was evidence that their policies would have/ had adverse impacts on health
- Giving the new Public Health Scotland organisation a scrutiny role and powers to challenge SG and other public bodies

### General comments

- Need appropriate levels of scrutiny and accountability
- Should this become part of existing reporting and inspection regimes eg Care Inspectorate, Audit Scotland, LAN networks, HIS, Education Scotland...
- Note Christie Commission – need for proportionality of external inspection; deep dive or light touch?
- Who takes responsibility – eg CEOs, DPHs?
- Issues of profile and visibility at local level eg not all DPHs are executive members of their Boards
- Need to beware of increasing health inequalities ie some areas more equipped to present their case and more likely to question and argue back than others
- What about the practicalities of data sharing?
- Who calls out poor performance or gaps eg not engaging with key stakeholders?
- Joint oversight health and local authorities (LOIPs?)
- Need resources and capacity
- Role of public health needs to be made clear at local level
- How do we triangulate findings and results and reports

### 1. Lead officer/HIAs

- How does Welsh model work – health impact assessments
- How relationship oriented are they – relationships and individual approaches are key
- Should they be made a statutory duty
- Who takes responsibility in the event of poorly performed HIAs/what sanctions
- What behaviours do we reward
- Need risk assessment and clear priorities
- Performance framework with credibility that articulates pros and cons
- Should planning officers have requirement to submit for HIA as part of planning submission
- Health boards need to be named as statutory consultees

### 2. Commissioner

- How does the Children’s Commissioner role work – eg rights based
- Can they investigate, hold people to account
- Can they issue statutory/legal non-compliance notices
- Any penalties/incentives

### 3. Public Health Scotland

- Danger this may get lost in PHS
- Danger PHS is either too close or viewed as too close to ScotGov
- Need clear water between funding and scrutiny
- Needs leadership from PHS – independent, rights-based
- Will having a scrutiny role alter relationships

### ***Table 3: Using existing structures and processes***

Table 3 discussed the potential to use existing structures and processes to build understanding of impacts on health and wellbeing, build relationships with policy makers, involve people in decision making, and create better policy. The following examples were given, but participants were also invited to consider others.

- National Performance Framework
- Community Empowerment Act
- Community Planning Partnerships and Local Outcomes Improvement Plans
- Equality Impact Assessments
- Fairer Scotland Duty
- Work to improve legislative and policy making processes – eg focus on deliberative democracy

Other structures/processes that were identified include:

- Health and social care partnerships
- Integration Joint Boards, in particular their Locality planning groups
- Public Health Priorities
- Joint Health Improvement Plans (where they still exist)

## 1. Use of existing legislation

- Overall, participants agreed that the current legislative and policy landscape is cluttered and hard to navigate.
- Some participants felt that additional legislation for HiAP may be unnecessary if it is already implied by existing legislation. However, others felt that there was a need for more explicit legislation or policy to drive HiAP.
- Equality and poverty impact assessments were identified as opportunities but it was felt that environmental impact assessments do not cover health well enough.
- Participants identified a need for support to navigate the relevant legislation and structures.

## 2. Who should implement HiAP at local level

- Participants discussed who was best placed to implement HiAP, and whether this should lie with Public Health Scotland or should be championed from within localities.
- There was agreement that the workforce and skills need to be present within CPPs and there were discussions about capacity for this, particularly if HIA were to be used and who would be responsible for undertaking these.
- Public Health Scotland could act as a statutory community planning partner and sit on community planning partnerships; it could have a role in advocating for health from a wider perspective. Often, there is only 1 seat for 'health' at CPPs and this is used to represent health services rather than the population health focus that public health could bring. A national body may bring more weight to the public health perspective.
- Rather than PHS, it could be that there is a local PH representative supported by the national body, but there were concerns over capacity for this.
- Would use of a national body be dis-empowering to local areas?
- There may be options to use a 'once for Scotland approach' if there are examples of good practice/ if there are good pieces of work on health impact of certain projects.
- There also needs to be a mechanism to ensure local needs are represented at a national level (e.g. Public Health Scotland should be made aware of what comes out of CPPs as health issues and could have oversight of the key issues and policy areas affecting health).
- Some people felt a whole systems approach is too big involving a large number of agencies.
- Participants identified a need for a local health 'voice' and referenced the health improvement officers who previously took this role in Local Authorities.
- Local area champions in HiAP would require training; this could include people who don't consider themselves as 'health professionals' – train/involve non-health decision makers. Consultations on PH reform may identify stakeholders to involve.
- Whoever leads on HiAP at local level, there was consensus that individuals need to be trained, skilled and supported.

## **PLENARY DISCUSSION**

The final plenary discussion heard a very short summary of the table discussions. The following key points were made:

- Although much of the discussion focused on HIA, other approaches can also be useful. It is important to distinguish between HIA, which is one specific approach, and HiAP, which is broader and may be achieved through different mechanisms.
- The one mechanism that seemed to be excluded following discussion was the suggestion of giving Public Health Scotland a scrutiny role. This is because it was recognised that formal scrutiny powers would place the organisation in a more adversarial relationship with other public bodies, and to build a HiAP approach requires the development of more collaborative working relationships to influence policies on an ongoing basis.
- Capacity and skills are critical – HiAP requires people with the relevant public health skills, training, support, and dedicated time to build relationships with policy makers across relevant sectors.

Finally, Margaret Douglas closed the workshop and thanked the speakers, facilitators, and participants for all of their contributions, and Claire Hendry from Health Scotland for events management.

## **POST WORKSHOP FEEDBACK**

Following the event, participants were asked to provide comments on the workshop, and any further thoughts on how to develop HiAP in Scotland via an online survey. Four participants completed this. Their comments highlighted the following:

- Participants liked the world café format and would have liked more time for this part of the workshop
- Public Health Scotland should provide national expertise and leadership, which could support local teams at CPP level
- The need to involve stakeholders, raise general awareness and encourage dialogue about HiAP
- The importance of ensuring HiAP is meaningful and leads to better policies
- Recognition of need for broad definition of health and for dialogue
- Support for ensuring accountability for showing that health has been considered in policy making, one participant specifically supported mandatory HIA
- Suggestion to integrate HiAP into existing guidance and planning requirements
- Recognition of the need for guidance, training and support



## REFLECTIONS AND NEXT STEPS

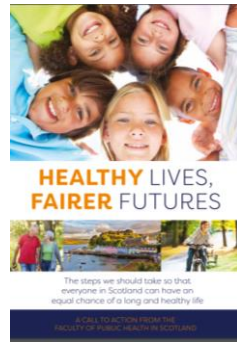
Following the workshop, the CFPHS Advocacy group has considered the discussions above and made the following overall reflections on how to develop HiAP in Scotland:

- HIA is useful and an important approach to HiAP that should be encouraged and supported, but not the only way to achieve HiAP – health should be considered at all stages of policy cycle during needs assessment, policy development and evaluation. It may be useful to use elements of HIA – eg an HIA scoping session is a good way to identify main areas of impact arising from a policy proposal, but it is not always necessary to proceed to gather more evidence and complete a full HIA.
- HIAs should be proportionate – they do not all need to be very long, time consuming pieces of work.
- It was felt that advocating for mandatory HIA in Scotland would not be the right approach just now as there is a high risk the HIAs would be poor quality and tokenistic. It would be better to encourage use of HIA and disseminate examples of HIA instead.
- Some public health time is needed to devote to HiAP, including HIA. It needs to be seen as sufficient priority by PH colleagues to enable this.
- CPPs are a good location/platform for HiAP and a good route to engage with partner organisations whose policies are likely to impact on health at local level. It is important for PH professionals to be present and give time to building relationships with policymakers.
- There seemed to be less enthusiasm for health scrutiny processes at the workshop, with a lot of questions about how they could work in practice and in particular a strong view against PHS having a scrutiny role.
- There are many current structures and processes that can be built on, but the landscape is cluttered and there is still a need for a specific focus on health to ensure health issues are considered and policies are designed to maximise health.

The group plans to focus on the following actions:

- Identify policies being developed that seem likely to have significant effects on health and write to relevant policy leads and politicians to ask if they are subjecting them to HIA and how they intend to maximise health impacts.
- Share experiences of HiAP and HIA – write up and disseminate – The group will put forward a proposal to have a dedicated session at the next PH conference.
- Promote HIA training that is available on request from SHIAN – target to people who have identified a policy to subject to HIA. Aim to have a local champion who supports and ideally co-facilitates the training, and can support colleagues locally on an ongoing basis.
- Identify implications of new National Performance Framework and ask how it will be implemented.
- Share this report with DsPH, SHPMs group, CoSLA, CPP managers and offer to meet to discuss HiAP.

## Appendix 1: Programme
















### Committee of the Faculty of Public Health in Scotland Advocacy Subgroup

#### Health in All Policies: Making it a reality for Scotland














##### Programme

- 12:00 **Lunch**
- 1:00 **Welcome**  
Margaret Douglas  
*Chair, Scottish Health and Inequalities Impact Assessment Network*
- 1:05 **What is Health in All Policies?**  
Margaret Douglas  
*Chair, Scottish Health and Inequalities Impact Assessment Network*
- 1:25 **Health Impact Assessment in Wales**  
Liz Green  
*Principal, Wales Health Impact Assessment Support Unit*
- 1:55 **Public Health Reform - Improving Health Commission**  
Patricia Cassidy  
*Co-chair, Improving Health Commission*
- Groups in world café format** – tea/coffee available during groups
- 2:10 Introduction to the Group work  
Margaret Douglas
- 2:15 Discussion 1
- 2:55 Discussion 2
- 3:15 Discussion 3
- 3:35 Comfort break
- 3:45 **Plenary feedback and discussion**  
Margaret Douglas
- 4:15 **Close**




With thanks to NHS Health Scotland for their support to organise this workshop

 <h2 style="text-align: center;">What is Health in All Policies?</h2> <p style="text-align: center;">Dr Margaret Douglas December 2018</p> <p style="text-align: center;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>	<h2 style="text-align: center;">Outline</h2> <ul style="list-style-type: none"> <li>• Health in All Policies – rationale and definition</li> <li>• International examples</li> <li>• Current Scottish policy and practice</li> <li>• Possible mechanisms for HiAP</li> </ul> <p style="text-align: center;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>
<ul style="list-style-type: none"> <li>• What policy decisions or plans have had a large impact on people's health in your area in last 3 years?</li> </ul>  <ul style="list-style-type: none"> <li>• How do we influence these decisions?             <ul style="list-style-type: none"> <li>– Beyond delivery of 'projects'?</li> <li>– Without just 'throwing tomatoes'?</li> <li>– (And other pitfalls...)</li> </ul> </li> </ul> <p style="text-align: center;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>	<h2 style="text-align: center;">Health in All Policies</h2>  <p style="text-align: center;"><i>Shared governance for health and wellbeing</i></p> <p style="text-align: center;">WHO</p> <p style="text-align: center;"><i>Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.</i></p> <p style="text-align: center;">California HiAP Task Force</p> <p style="text-align: center;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>
 <ul style="list-style-type: none"> <li>• 'Inside' policy making             <ul style="list-style-type: none"> <li>• Consider range of impacts of a policy systematically</li> <li>• Prioritise policy areas of most impact</li> <li>• Collaboration with policy makers</li> </ul> </li> <li>• 'Outside' policy making             <ul style="list-style-type: none"> <li>• Focus on single issue or solution</li> <li>• Build alliances with other interests</li> </ul> </li> </ul> <p style="text-align: center;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>	<h2 style="text-align: center;">Health in All Policies - tools</h2> <ul style="list-style-type: none"> <li>• Inter-ministerial and interdepartmental committees</li> <li>• Cross sector action teams</li> <li>• Integrated budgets and accounting</li> <li>• Cross cutting information and evaluation systems</li> <li>• Joined up workforce development</li> <li>• Community consultations and citizens juries</li> <li>• Partnerships platforms</li> <li>• Health Lens Analysis</li> <li>• Impact Assessments</li> <li>• Legislative frameworks</li> </ul> <p style="text-align: center;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>
<h2 style="text-align: center;">Formal and informal mechanisms</h2> <ul style="list-style-type: none"> <li>• Systematic use of tools like HIA and health lens analysis</li> <li>• Formal partnerships</li> <li>• Scrutiny processes</li> <li>• Sharing information</li> <li>• Building relationships, aiming to be 'at the table' to influence decisions for health</li> <li>• But either needs dedicated public health time</li> </ul> <p style="text-align: center;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>	<p>'Health Impact Assessment is a combination of procedures, methods and tools by which a policy, program 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.'</p>  <p style="text-align: center;"> <small>WHO Gothenburg consensus paper 1999</small>    <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>

**Appendix 2: Presentation slides**

<p><b>HIA can be used for HiAP or Advocacy</b></p> <ul style="list-style-type: none"> <li>• Well established but flexible approach, use of multiple sources of evidence, comprehensive scoping of health issues</li> <li>• Can be good way to engage community – but not just a consultation tool</li> </ul> <p>Consider:</p> <ul style="list-style-type: none"> <li>• 'Inside' or 'outside' policy process?</li> <li>• How are policies selected for HIA?</li> </ul>  <p>Scottish Health and Inequalities Impact Assessment Network</p>	<p><b>Some international examples of HiAP</b></p>  <p>Scottish Health and Inequalities Impact Assessment Network</p>
<p><b>Finland</b></p>  <ul style="list-style-type: none"> <li>• Long history of Inter-sectoral action</li> <li>• 2006 Presidency of EU focus on HiAP</li> <li>• Ministerial Advisory Board</li> <li>• HIA of national legislation (but low compliance)</li> <li>• Health objectives in Municipal Strategies</li> <li>• Requirement for Human Impact Assessment of municipal decisions</li> </ul>  <p>Scottish Health and Inequalities Impact Assessment Network</p>	<p><b>California HiAP Task Force</b></p>  <ul style="list-style-type: none"> <li>• 22 departments, agencies and offices across State Government</li> <li>• Cross departmental team             <ul style="list-style-type: none"> <li>– Promotes culture to prioritise healthy, equitable, and sustainable communities</li> <li>– Health and equity approaches, tools, data</li> <li>– Forum for shared goals and collaboration</li> </ul> </li> <li>• Sectoral Action plans: Housing, Food, Transport, Greenspace, Community safety, HPP</li> </ul>  <p>Scottish Health and Inequalities Impact Assessment Network</p>
<p><b>South Australia</b></p>    <p>The diagram shows a circular process: Gather evidence → Generate → Navigate → Evaluate → Engage → Gather evidence. It is supported by Governance (General Government Mandate, Cabinet Taskforce, Senior Officers Group, etc.) and Public policy and health and wellbeing outcomes (Joined up Government, SASP targets, etc.).</p>  <p>Scottish Health and Inequalities Impact Assessment Network</p>	<p><b>(Selected) impact assessments in Scotland – brief history</b></p>  <p>Scottish Health and Inequalities Impact Assessment Network</p>
<ul style="list-style-type: none"> <li><b>1998</b> Green paper: 6 mentions of Health Impact Assessment</li> <li><b>1999</b>: 'The Public Health Strategy Group will promote the widespread use of Health Impact Assessment when formulating Government policies'</li> <li><b>2008</b>: 'Integrated impact assessment processes for public policies and programmes should be developed and implemented at national and local levels'</li> <li><b>2010</b>: Legal obligation to pay due regard to the need to eliminate discrimination, advance equality of opportunity, foster good relations – based on 9 protected characteristics</li> <li><b>2018</b>: Duty to pay due regard to how public bodies can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions.</li> </ul>  <p>Scottish Health and Inequalities Impact Assessment Network</p>	<p><b>Scottish Health and Inequalities Impact Assessment Network</b></p> <ul style="list-style-type: none"> <li>• Aim to promote and support HIA and inclusion of health in other impact assessments</li> <li>• Running since 2001, now part of ScotPHN</li> <li>• Funded half day per week</li> <li>• Guidance, training, support and advice</li> <li>• Better policies – not just better assessment</li> <li>• Integrated assessment, build into other processes</li> <li>• Proportionate use of resources and methods</li> </ul>  <p>Scottish Health and Inequalities Impact Assessment Network</p>

## Appendix 2: Presentation slides

<h3>Examples of HIAs in Scotland</h3> <ul style="list-style-type: none"> <li>• Fuel Poverty Strategy</li> <li>• 50,000 Affordable Homes</li> <li>• Unconventional Gas</li> <li>• South Lanarkshire Leisure and Culture</li> <li>• Mineral extraction in Fife and South Lanarkshire</li> <li>• Welfare Reform</li> <li>• Shetland wind energy</li> <li>• Argyll Array</li> <li>• Closure of military bases in Moray</li> <li>• Commonwealth Games Glasgow</li> <li>• Govanhill Baths</li> <li>• And many integrated IAs ....</li> </ul> <p style="text-align: right;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>	<h3>Opportunities for HiAP in Scotland</h3> <ul style="list-style-type: none"> <li>• Interest in social determinants, PH review supported HiAP</li> <li>• History of collaboration, Alliances and joint plans</li> <li>• Community Planning Partnerships</li> <li>• Public Health Scotland</li> <li>• PH reform</li> </ul> <p style="text-align: right;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>
<h3>Possible mechanisms</h3> <ul style="list-style-type: none"> <li>• Requirement for mandatory HIA</li> <li>• Require organisations to appoint lead Health and Wellbeing officer</li> <li>• Appoint Commissioner for Health</li> <li>• Scrutiny role for Public Health Scotland</li> <li>• Requirement for HiAP teams in each CPP</li> </ul> <p style="text-align: right;">   <small>Scottish Health and Inequalities Impact Assessment Network</small> </p>	

## Appendix 2: Presentation slides

  <p><b>HIA IN WALES: FROM VOLUNTARY TO STATUTORY</b> Liz Green Principal HIA Development Officer Wales HIA Support Unit/Public Health Wales</p>	<h3>DEVOLVED GOVERNMENT</h3> <ul style="list-style-type: none"> <li>Emphasis on: <ul style="list-style-type: none"> <li>Health and wellbeing</li> <li>Addressing inequalities within population</li> <li>Sustainable Development</li> <li>Citizen centred public services</li> <li>Partnership working</li> <li>Integrated agenda</li> </ul> </li> <li>Devolved Powers include: health, planning, social services and social care</li> <li>Ability to legislate for these through Assembly Bills and Acts</li> </ul>
<h3>IMPORTANCE OF CONSIDERING HEALTH AND WELLBEING</h3> <ul style="list-style-type: none"> <li>Wales exhibits high levels of poor health</li> <li>Increasing rates of obesity and associated illness ie diabetes, heart disease and respiratory diseases</li> <li>Smoking and alcohol</li> <li>Inequalities in health - deprived communities exhibit higher levels of ill health and have shorter life expectancy than more affluent communities</li> <li>Not just physical health - wider determinants of health and mental wellbeing</li> </ul>	<h3>HIA AND HIAP IN WALES: STRATEGIC DRIVERS</h3> <ul style="list-style-type: none"> <li>Wellbeing of the Future Generations (Wales Act) 2015 - Sustainable Development focus</li> <li>Consideration of Health in All Policies (HiAP)</li> <li>'Prosperity for All', 2018 - Long term Welsh Govt Strategy</li> <li>Public Health (Wales) Act 2017 - includes statutory requirement for HIA for public bodies</li> </ul>
<h3>HIA IN WALES - EVOLUTION</h3> <ul style="list-style-type: none"> <li>Establishment of a Unit in 2004 - collaboration between university/health agency</li> <li>Proactive approach with 'Development Officers'</li> <li>Remit to provide: <ol style="list-style-type: none"> <li>Advice and guidance - in person/phone/email/all</li> <li>Training - in house/formal/'learning by doing'/online</li> <li>Support - facilitation, use of rapid methods</li> <li>Research - papers and book chapters</li> <li>Resources - website, HIA guides, HiAP resources</li> </ol> </li> <li>2013 fully transferred into Public Health Wales</li> </ul>	<h3>MANY VOLUNTARY LEVERS FOR HIA...</h3> <ul style="list-style-type: none"> <li>Planning Bill (2015) and Planning Policy Wales (PPW)</li> <li>Welsh Transport Appraisal Guidance (WelTAG) (2008)</li> <li>MTAN2: Coal (2009) - open cast mining. EIAs require a broad HIA to be undertaken</li> <li>Wales Waste Strategy and Collections, Infrastructure and Markets Waste Sector Plan (2013)</li> <li>Vibrant and Viable Places: Welsh regeneration framework (2013)</li> <li>NHS Infrastructure Investment Guidance (2016)</li> </ul>

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<p><b>PUBLIC HEALTH (WALES) ACT 2017</b></p> <ul style="list-style-type: none"> <li>○ HIA required in 'specific circumstances for public bodies' in Wales</li> <li>○ Public Health Wales (PHW) 'must provide assistance to those carrying out a HIA'</li> </ul> <p><i>Details as yet unknown but likely to be:</i></p> <ul style="list-style-type: none"> <li>○ Planning related policies and plans</li> <li>○ Major public body services reconfiguration</li> <li>○ Licensing of fast food outlets</li> <li>○ Wellbeing Objectives and statements (WFGA)</li> </ul> 	<p><b>WHY NOW? WHY SUCCESSFUL?</b></p> <ul style="list-style-type: none"> <li>○ Window of opportunity in Wales - political and social context</li> <li>○ Health and wellbeing status linked to economic development</li> <li>○ WFGA - Wellbeing Goals inc Health/Equality</li> <li>○ UN Sustainable Development Goals and SD agenda</li> <li>○ Success of HIA in practice at a national/local level and many benefits gained i.e. strengthened plans, community consultation/involvement; avoided unintended consequences</li> <li>○ Strategic advocates created i.e. BMA Cymru, Chartered Institute of Environmental Health (CIEH), Public Health Wales (PHW)</li> </ul>
<p><b>FACTORS WHICH HAVE FACILITATED THIS</b></p> <ul style="list-style-type: none"> <li>○ WHIASU - independent specialist unit for HIA</li> <li>○ Training and capacity building i.e. LAs/LPHTs</li> <li>○ Application of HIA/HiAP - strategic work with Welsh Government; 'non health' sectors - created 'champions' who have benefited</li> <li>○ Pragmatic approach taken i.e. Rapid participatory HIA is time and resource effective and efficient</li> <li>○ Creation of strong partnerships with organisations and individuals</li> <li>○ Case studies/presentations to highlight work - raise awareness of importance of health and wellbeing and HIA role</li> </ul> 	<p><b>CHALLENGES FOR THE FUTURE</b></p> <ul style="list-style-type: none"> <li>○ Lack of capacity in WHIASU and public health system - new model of working for HIA?</li> <li>○ WG HIA Statutory Regulations - circumstances are as yet to be defined; no definition of assistance...</li> <li>○ Implications of the Act not understood widely - only a few PBs are prepared for the HIA duty</li> <li>○ A whole system approach is needed with joined up working and resources (mirrors the WFGA)</li> <li>○ Austerity</li> </ul>
<p><b>SUMMARY</b></p> <ul style="list-style-type: none"> <li>○ Need the right policy context BUT can still influence the successful use of HIA to drive HiAP</li> <li>○ Exploit every lever possible to 'sell' HIA/HiAP</li> <li>○ Utilise a 'Top Down' approach at the same time as a 'Bottom Up' one</li> <li>○ Community involvement, avoiding unintended consequences - selling points</li> <li>○ Creation of strategic and local advocates - key</li> <li>○ Role of dedicated specialists to support and provide advice, guidance and resources</li> <li>○ Demonstrate 'added value' and evaluate any success</li> </ul>	  <p><b>Diolch yn fawr!</b></p> <p><a href="mailto:Liz.Green@wales.nhs.uk">Liz.Green@wales.nhs.uk</a></p> <p><a href="http://www.whiasu.wales.nhs.uk">www.whiasu.wales.nhs.uk</a></p>

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 <p><b>PUBLIC HEALTH REFORM IMPROVING HEALTH COMMISSION</b></p> <p>Patricia Cassidy Chief Officer Falkirk Integration Joint Board 10 December 2018</p>	<p><b>VISION FOR SCOTLAND</b></p> <p>“A Scotland where everybody thrives”</p> <p><a href="https://publichealthreform.scot">https://publichealthreform.scot</a></p>
<p><b>PUBLIC HEALTH PRIORITIES</b></p> <ul style="list-style-type: none"> <li>○ A Scotland where we live in vibrant, healthy and safe places and communities.</li> <li>○ A Scotland where we flourish in our early years.</li> <li>○ A Scotland where we have good mental wellbeing.</li> <li>○ A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.</li> <li>○ A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.</li> <li>○ A Scotland where we eat well, have a healthy weight and are physically active.</li> </ul>	<p><b>“A SCOTLAND WHERE EVERYBODY THRIVES”</b></p> <ul style="list-style-type: none"> <li>○ Collective endeavour to improve health</li> <li>○ Prioritise health as a human right</li> <li>○ Health in all policies</li> <li>○ Prioritise prevention and build community capacity</li> </ul> <p>Requires whole system working and a culture for health</p>
<p><b>TO DELIVER THE VISION FOR PUBLIC HEALTH REFORM, SCOTTISH GOVERNMENT AND COSLA WILL:</b></p> <ul style="list-style-type: none"> <li>○ agree public health priorities for Scotland that are important public health concerns and that we can do something about</li> <li>○ establish a new national public health body for Scotland bringing together expertise from NHS Health Scotland, Health Protection Scotland and Information Services Division</li> <li>○ support different ways of working to develop a whole system approach to improve health and reduce health inequalities.</li> </ul>	<p><b>WORK OF THE COMMISSION</b></p> <ul style="list-style-type: none"> <li>○ Our Challenge: Improving Health of Scotland’s people</li> <li>○ Document describing the current health improvement landscape</li> <li>○ Produced a detailed description of the health improvement function in health boards and HSCPS</li> <li>○ Stakeholder engagement</li> </ul>
<p><b>THEMES FROM STAKEHOLDER ENGAGEMENT</b></p> <ul style="list-style-type: none"> <li>○ Better communication</li> <li>○ Culture change</li> <li>○ Resource allocation</li> <li>○ Advocating for preventative approaches</li> <li>○ Strong national leadership</li> <li>○ Innovation ideas</li> </ul>	