Tower Hamlets Health Impact Assessment (HIA) Policy Process Evaluation

These brief presents a summary of participants' views based on in-depth individual interviews conducted by ActEarly researchers[1] with three Public Health (PH) specialists and three Planning strategic leads, and two focus groups with seven Development Managers (DM) and four consultants who use the Tower Hamlets HIA guidance to develop the assessment on behalf of developers. This independent evaluation aims to complement the HIA Implementation Programme review prepared by the TH HIA Working group.

Benefits of the HIA policy

- **The HIA was an advocacy tool**, a start of a conversation about health and an opportunity to assess new developments through the lens of health impacts.
- **The HIA was regarded as a learning and collaboration tool**; a way of learning about the characteristics of healthy, happy environments that people would want to stay in. This helped planners overcome silo working and gained access to information to forward to developers.
- **The HIA officer was regarded as an expert 'single point of contact'** who was a 'comprehensive consultee' to inform planners about what to look for, what the joint strategic needs/priorities were and to keep them accountable for the quality of the HIAs.
- **There was a close partnership between PH/DM and PH** which has been instrumental in spearheading the policy. The HIA Officer played an important bridging role between PH and DM and had the benefit of a background in both planning and public health.

General challenges of the HIA policy

- **The HIA was regarded as a soft policy that lacked 'policy hooks'**, was difficult to implement because lack of capacity (time) and was unlikely to lead to refusing of an application for development. It was felt that the policy could be stronger if it was part of national planning policy. However, health outcomes did not feature strongly in the current national planning policy reforms-.
- **The HIA needed to be linked to existing regulations** (i.e. conditions and obligations within 106s) to inform the decision making as there was already many policies to ensure healthy planning.
- Strategic leads considered that **no clear impact related to alterations to schemes due to the HIA had been observed.** It was felt to be too much of a 'tick box' exercise to be meaningful.
- **The timing for completing the HIA was an issue**, developers often asked consultants to do the HIA just before the application when it was too late for the HIA to influence designs. Participants thought that health impacts needed to be considered at the pre-application stage.
- **There were limited resources**, little spare capacity (time) within the DM team to deliver the policy. DM officers needed to focus on core business such as conservation and urban design.
- **If the HIA Officer had been co-located and embedded within the DM team** the partnership could have been stronger.
- **The HIA lacked a way of evaluating and monitoring its impact** on developments and there was no way of holding anyone from planning to account if the developer had not implemented changes as a result of an HIA.
- **For the HIA policy to succeed joint support by the senior leadership team is needed**, namely the Director of Public Health and the Director for Planning.
- **HIA guidance was regarded as too high level and all-encompassing for it to be utilised** to influence change at local authority level. It was difficult to identify the differences between a rapid and a detailed HIA.
- **Developers tended to have a vested interest** in developing 1–2-bedroom accommodation because

[1] This brief forms part of the ActEarly research project, supported by UK Prevention Research Partnership (MR/S037527/1). It was written by N Christie and A Ortegon-Sanchez.

of profitability, which contributed to churn as people leave because they cannot be accommodated as their family grows.

Challenges related to Community engagement

- **Communities needed to be engaged in place-shaping** so that planning was not just delivering housing targets, but also understanding the effects on neighbourhoods.
- Strategic leads and PH had **scepticism whether any meaningful community engagement had been carried out by developers** as part of the HIA. Developers would rarely seek to engage on how a development could improve health as often communities wanted space to be left open and undeveloped.
- **Opportunities for community engagement were hindered by late completion of the HIA** in the planning process.
- **Parts of the community were regarded as hard to engage with.** Children and teenagers, people with poor health, or experiencing health inequalities (e.g., Bangladeshi population), language or cultural barriers were not engaging with public consultation.
- **There was a need to understand how to engage with hard-to-reach groups** and identify what was expected out of that engagement.
- **Developers should be encouraged, at pre-app stage, to employ an engagement consultant** because developers might lack the required expertise to identify and engage with relevant population groups (e.g., vulnerable population).
- **The council could further support developers to engage with the community**. A draft community engagement guide for developers existed but had not been published.
- **The LBTH statement of community involvement was regarded as too high level** without specific advice about who to consult with. It was felt that the council should develop its own engagement strategy for developments, though it was not clear who should do this - planners or public health officers.

Challenges related to evaluation of the HIA

- **The HIA policy needed to be evaluated to record what difference it made to developments** including post-occupancy surveys and monitoring reports at least every 1,3,5 years to assess what were the secured public health benefits.
- **Simplification and operationalisation of the HIA impacts was needed** to facilitate their measurement.
- **The HIA outcome evaluation was regarded as highly problematic** because it was several years until the development was completed and there was little power to do anything if it did not represent what was written in the HIA.
- **An interim process evaluation focusing on the level of community engagement** in the HIA and how that made a difference to the developers' plan, could be carried out by DM.

Challenges related to training and capacity

- **Capacity building was a challenge** because there is pressure on planners to review many different documents and there is a high level of churn in planning staff.
- **CPD would help capacity building and confidence within the DM team**, especially with technical aspects of the HIA and how existing aspects of developments would secure a public health benefit.
- **Online courses and a suite of support tools could be developed as part of training** for the DM role vis a vis the HIA including guidance on HIA policy, the wider determinants of health in TH.
- **Need to engage with professional bodies** like the Royal Town Planning Institute and Faculty of Public Health in Buildings to explore the shared knowledge base between planners and Public Health and accredited training for HIA practitioners.

Strategies to improve engagement

- Developers could consult with the ward councillor.
- DM officers could look at groups consulted in the Local Plan to identify which groups are interested in various areas and developments.
- The HIA implementation could be supported by the publication of a community development guide (already produced) and by an external guide for developers and internal guide for DM.
- More engagement could be done via local health and wellbeing boards that have expertise for hyperlocal communities and the voluntary community sectors.
- Developers could ask for an introduction to the community consultation team to familiarise with their processes, to understand local priorities and then suggest health related questions.