Putting Health into Impact Assessment

A Northwest Regional Scoping Study

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Executive summary

New legislative changes have generated multiple forms of statutory impact appraisals and increasingly, requirement for prospective risk assessment of policies, programmes and projects. Many of these call for the application of health impact assessment technology. This is usually delivered by public health practitioners but not exclusively. Future changes are likely to increase the demand for this technology with consequences for the public health system. The aim of the study was to scope current demand and capacity to deliver HIA technology across the region, identify future demand and potential shortfalls in capacity; identify organisational developmental (OD) needs for impact appraisal, and develop thinking as to how these needs may be met. The study was carried out between March and August 2007 for the Regional Public Health Partners by a Masters in Civic Design (analytical track) student from the University of Liverpool.

Methods Used

- Purposive key informant interviews;
- Iterative literature review;
- Google search of PCT and LA websites for 'health impact assessment'
- Opportunistic short survey of Local Authority Chief Executives via Northwest Employers Organisation.

Findings

Current demand for the application of HIA technology varies across the region. However some PCTs and LAs have institutionalised the technology to some degree. The level of this appears to depend upon the existence of a local champion for HIA. There is an ad hoc level of HIA activity across the region which is mostly clustered around the city regions.

Conclusions

Future demand for health proofing/ HIA is likely to increase considerably due to changes in planning legislation; reconfiguration of health and social care services; changes in statutory sector performance appraisal and commissioning frameworks; and Governments continued modernisation agenda and development of the Third and Private sectors. Other potential demand includes: Human Rights Impact Assessment; Health Systems Impact Assessment; single issue pressure groups; and legal challenges to planning applications.

This additional need on an already stretched public workforce means there is likely to be a shortfall in meeting future demand for HIA and health proofing at Regional and local levels.

Recommendations

Recommendations are made aiming to address issues of leadership, capacity building, partnership working, and integrating health technology into other forms of Impact Appraisal.

Contents

List of Acronyms

APHO's	Association of Public Health Observatory's
CAA	Comprehensive Area Assessment
CHIA	Community Health Impact Assessment
CPA	Comprehensive Performance Assessment
CPD	Continuing Professional Development
DsPH	Directors of Public Health
EHO	Environmental Health Officer
EIA	Environmental Impact Assessment
EqIA	Equity Impact Assessment
ESRC	Economic and Social Research Centre
GONW	Government Office North West
HIA	Health Impact Assessment
IA	Impact Assessment
IAT	Integrated Appraisal Tool
IIA	Integrated Impact Assessment
LA	Local Authority
LAA	Local Area Agreements
LDP	Local Development Plan
LSP	Local Strategic Partnership
LTP	Local Transport Plan
MAA	Multiple Area Agreements
NWRA	Northwest Regional Assembly
NWDA	Northwest Development Agency
PCT	Primary Care Trust
PHO	Public Health Observatory
RDA	Regional Development Agency
RDsPH	Regional Directors of Public Health
RES	Regional Economic Strategy
RSS	Regional Spatial Strategy
RTP	Regional Transport Plan
SA	Sustainability Appraisal
SEA	Strategic Environmental Assessment

How the project was conceived and why it was needed

Since 1997, governments' modernisation agenda, coupled with reconfiguration of the public sector, has generated legislative changes for multiple forms of statutory impact appraisals and prospective risk assessment. Many of these are likely to require some form of health perspective. It is assumed health-related professions will be called upon to deliver this perspective. Public Health professionals in particular, are uniquely placed and likely to be called on to lead and support capacity for this.

Currently there is little knowledge of existing capacity for HIA and the range of regional assets available in the Northwest to deliver the health dimension of different forms of IA; the potential need or interest in building capacity for health in IA (including HIA); or where to target public health resources for best effect to deliver a health perspective.

The aim of the study was to scope current demand and capacity to deliver HIA technology across the region, identify future demand and capacity, and potential shortfalls; identify organisational developmental (OD) needs for impact appraisal, and develop thinking as to how these needs may be met.

Methods Used

- Purposive key informant interviews;
- Iterative literature review;
- Google search of PCT and LA websites for 'health impact assessment'
- Opportunistic short survey of Local Authority Chief Executives via Northwest Employers Organisation.

The study was carried out for the Regional Pubic Health Partners between March and August 2007 by Debbie Fox as part of the Masters in Civic Design (analytical track) Course at the University of Liverpool. Debbie was supervised by Senior Lecturer Sue Kidd and funded by the ESRC. This was initially a qualitative investigation, however during its course, opportunity arose to access unpublished data collected mid 2006 which enabled spatial mapping of HIA activity across the region. In addition a short survey of Local Authority CEOs in August was made possible by The Northwest Employers Organisation. Therefore the study time was extended from four to five months to incorporate this additional information.

What was found out from the literature and key informants

1. Current Demand

- Demand for HIA technology varies across the region, some PCTs and LAs have institutionalised the technology more than others;
- Current demand for health proofing at different spatial levels of governance includes;
    - At Regional level - regional spatial strategies (RSS, RES, RTP etc);
    - At Local level, LAA, LDP, SCP, LTP, EqIA some EIAs;
- Within the NHS the use of HIA technology is a mandatory requirement of capital build programmes in excess of £2 million;
- Not all health proofing activities are done using HIA technology ie use of the IAT tool, and inclusion of health knowledge in LAA;
- Demand for health knowledge/proofing in policy/ project development was predicted to increase.

2. Current Capacity

HIA activity

- There is an ad hoc level of HIA activity across the region (see maps 1-6 appendix 1);
- Google search of LA and PCT websites carried out mid 2006 found:
    - 21/42 PCTs (old boundaries) are doing HIA; 21 have some form of HIA policy; only 3 PCTs were supporting local training in HIA;
    - 17/43 LAs had a HIA policy; 16/43 LAs doing HIAs ; 7 supported local capacity building;
- There are regional hot spots of activity mostly within the city regions of Liverpool and Manchester;
- The degree of activity appears to be related to:
    - existence of local champions for HIA
    - degree of local support
    - joint appointment of DsPH and/or opportunities to influence decision makers;
- Some PCTs and a few LAs have specialist post in HIA or a named person with HIA in their job specification;
- A small cadre of people in the region have a higher level of competence to provide local leadership in HIA/ health proofing activities / and are able to undertake more complex HIAs;
- Private consultancies offering HIA technology in the region are thought to be increasing to meet requirements of SEA legislation (ie EIA Consultancies

approaching HIA experts for input on bids). Established reputable consultants are IMPACT, University of Liverpool and Entec. There are several consultants in HIA outside the region who have been used to support regional activities eg Cave Associates;

- No Third sector organisations were discovered to be offering this service.

Type of HIA and Tools

- Rapid HIAs are more common; some complex comprehensive HIAs on large capital investments have been done,
- Tools and approaches vary according to local need – one PCT are linking EqIA with HIA in a toolkit. There is a lack of consistency in the design and use of screening tools;
- Use of IAT is mostly in LAs but limited, few PCTs are using the interactive web tool.

Knowledge management

It has been difficult to find out who's doing what where within the region in regard to HIA/health proofing. Key regional assets for knowledge management are:

- NWPHO: provides some links to HIA data bases / tools and completed HIAs but this was quite out of date and somewhat limited in scope when reviewed in May. The main strength is the link to public health evidence bases and the forthcoming APHO managed HIA Gateway resource (due 2008/9);
- IMPACT: Experts in their field, IMPACT undertake capacity building activities within the region and further afield, offer consultancy and supply training and Quality Assurance reviews of completed HIA, and develop HIA methodology. They have an international reputation and were the lead partner in developing the European Policy Health Impact Assessment Tool for DG Sanco (EPHIA[1]). IMPACT website has links to HIA data bases / tools and completed HIAs but could be more user friendly;
- The Integrate Appraisal Tool (IAT) hosted by the NWRA[2]: Public Health was involved throughout development of the IAT. This is a dynamic interactive tool with links to evidence covering the determinants of health. There is scope to expand this. Secondment of Public Health specialist perceived as successful by partners.

Education and Training

Public Health Education and CPD:

- All PH Consultants, and specialist are trained in HIA methods, however some are likely to have more hands on practice than others. HIA 'know how' and 'show how' is a core requirement of public health practice, therefore all public health practitioners will have theoretical knowledge if not practical experience;

There is limited HIA teaching in the regions universities:

- LJMU: Socrates programme = 6 hour session on HIA since 2000 approx 25 students per year from across sectors;
- IMPACT: delivers 5 day training twice yearly on comprehensive HIA and offers bespoke packages for organizations. 8 people from the northwest have

[1] EPHIA Guide http://www.ihia.org.uk/ephia/home.html

[2] Integrated Appraisal Tool http://www.sdtoolkit-northwest.org.uk/toolkit/index.php

been trained in Comprehensive HIA technology over the last 2 years. More in the preceding 4 years;
- The Teaching Public Health Network is evolving but HIA technology is not currently a core component of Public Health skills curriculum;
- Croxteth Community University in partnership with Liverpool PCT and IMPACT have delivered a10 week course in community HIA. Comm Uni is seeking resources to enhance and develop the course through the Open College Network;
- Health Trainers training programme has been developed. HIA is not explicit but the curriculum does include learning on the social determinants of health, but the focus is mostly individual level behavior change.

3. Future Demand

This is likely to increase considerably due to:

Changes in planning legislation

- Spatial governance/ SEA – new duty of RDsPH and DsPH / consultation requirements necessary to meet statutory requirements for test of soundness of planning strategies[3];
- HIA Needs to fit in with 3 -5 year planning cycle BUT this is a continuous iterative process (there are approx 300-400 plans per year in England =30 per region: considerably more at the local level);
- The Northwest RSS incorporates a commitment to undertake HIAs as necessary. Once signed off by the Secretary of State this becomes mandatory[4].

Reconfiguration of health and social care services

- Health and Wellbeing commissioning process places a new statutory requirement on DsPH and Director of Adult Social Services to produce a local strategic health needs assessment covering public health and primary and community care needs of their local population[5];
- Demand for better pre and post evaluation/ impact appraisal of investment on health inequalities (See Audit Commission review on health inequalities report July 2007[6]).

Changes in performance appraisal and commissioning frameworks

- In 2009 Comprehensive Area Appraisals [7] (CAAs) will replace Comprehensive Performance appraisals (CPA) of LAs. This will include health profile and health inequalities floor targets;
- Demand for more comprehensive risk assessment, robust evidence, planning, measures and evaluation generally, and in commissioning services specifically.

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[3] Draft Guidance on Health in SEA http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_073261

[4] Submitted Northwest RSS http://www.nwra.gov.uk/?page_id=223

[5] Commissioning Framework for Health and Wellbeing http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

[6] Audit Commission (2007) Improving Health and Wellbeing http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/1F9DA3D9-AF0F-4381-83E2-76D8F94678E6/Health%20and%20wellbeing.pdf

[7] Comprehensive Area Assessment http://www.audit-commission.gov.uk/cpa/cpatransition.asp

Governments continued modernisation agenda

- Devolved responsibility for decision making to the regions and localities[8];
- Increased mandatory involvement of local people in local decision making;
- Drive for health in all policies (the UK accepted the recommendations from the Finnish Presidency in 2006[9]).

Other potential demand

- Health system impact assessment
- Human rights impact assessment
- Single issue pressure groups
- Legal challenges to planning applications

4. Future Capacity

At the Regional level

- The move towards a single integrated regional strategy as proposed by the governments 'Review of sub-national economic development and regeneration'[10] will make RDAs the lead agency for improving economic performance and tackling neighborhood renewal. Local authority leaders will have responsibility for agreeing regional strategies with the RDA and ensuring effective scrutiny. Therefore the RDA will have responsibility for the health and wellbeing of people in the Northwest. However considerable challenges in reducing health inequalities are likely to continue (Hussey, 2006[11]; NWDA, 2006[12]);
- It is not clear whether the Regional Public Health Team will be integrated into the NWDA. If so, positioning the Regional DPH and team within NWRDA enables them to influence policy making at the earliest opportunity across all sectors. This would enhance their sphere of influence and put action to address health inequalities on a stronger political footing;
- Health knowledge could be incorporated during the strategic phase of policy development rather than when options have already been developed;
- Infrastructure continues to be developed across the region to support local action in getting health in all policies ie through networks eg public health teaching network, but this is spatially bottom heavy.

At the local level

- DsPH joint appointments should facilitate access to elected members and their ability to input/ advice on health issues in policy development at an early stage. This is already happening in some places with DsPH or Associate Director on the CEO management team;
- Emergence of integrated education and training models across sectors will enhance capacity over time to use HIA technology;

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[8] Modernising Government Website http://www.cabinetoffice.gov.uk/moderngov

[9] The Health Priorities of the Finnish Presidency http://www.epha.org/a/2235

[10] HM Treasury Review of sub-national economic development and regeneration July 2007 http://www.berr.gov.uk/files/file40436.pdf

[11] Hussey R (2006) Achieving Sustained Improvement in Health and Reducing Health Inequalities in the Northwest. Agenda Item 6 http://www.northwest.nhs.uk/document_uploads/Board_Papers/Health_Inequalities_Report%20item6.pdf

[12] NWDA (2006) Regional Economic Strategy http://www.nwda.co.uk/what-we-do/policy-and-strategy/regional-economic-strategy.aspx

- Potential for growth in the Third sector could lead to public sector commissioning in community HIA and increase civic intelligence. However this sector should not be seen as a 'cheaper' service provider, but rather a way of synthesizing expert and lay knowledge for health promotion and wellbeing;
- The extended public health role of Environmental Health Officers (EHOs) in LAs may facilitate leadership in HIA technology;
- Access to health information and intelligence will improve through APHO via:
    - public health desktop
    - HIA gateway portal – information on HIA and access to evidence base
    - Increased sharing and joining up of data across sectors.

5. Potential Shortfall

Leadership:

- The Chief Medical Officer Annual report for 2005 highlights shortages of Public Health Specialists across the country, and specifically within the North West[13]. This additional demand for the application of HIA technology, on an already stretched public health workforce, means there is likely to be a shortfall in delivery. Current public health capacity needs to significantly increase if governments' public health agenda is to be met. Health impact assessment and health proofing is only one part of this agenda.

Capacity

- Different localities have different capacity building needs (eg skill development) across the Region;
- Similarly different local priorities/externalities have different levels and type of resources to draw on;
- There will be a time-lag to an evidence base and guidance on HIA/health proofing ie HIA gateway of approximately 1 year before it becomes fully integrated into APHO website. Even then there is no guarantee that other sectors will use it.

Partnerships

- Variable levels of commitment/ perception of the value of HIA and its ability to do what it claims may have a negative impact upon partnerships' uptake of the technology. Although new CAA and LSP requirements for a risk based approach to interventions, may change this view.

[13] Lucy J. (2007) Supporting the workforce to deliver better public health: North West Public Health Workforce Action Plan 2007-8

What it all means and what can be done about it

The Northwest has been the forerunner in developing methods and tools for HIA technology and other forms of IA since the early 1990s. Much of this activity has evolved naturally over time. However given the rate of change and forthcoming policy directives', doing nothing is not an option. It is widely recognised in the UK and further afield, that HIA technology has an important role to play in managing risk and addressing inequalities of health and wellbeing. However, few robust evaluations have been done in the Northwest to assess the impact of impact assessments including HIA at regional and local levels.

Four areas for action have been identified: Leadership, capacity building, partnership working and integrating health into other impact assessment.

Leadership

Intellectual property for HIA is perceived to be owned by the NHS. This needs to change. It does not have to be Public Health led although the role and positioning of DsPH may be crucial in identifying local champions/leaders from other sectors: politicians in particular. Other disciplines such as planning policy makers, EHOs can and sometimes do lead on HIA. The aim should be to actively encourage leadership for HIA outside the public health sector. LSPs and Scrutiny committees also have an important role to play in ensuring health is considered in all public policy.

Capacity Building

The region has good examples of integrating HIA technology into organisational systems and structures but these are not easily found. An evaluation of the methods used and their impact on decision making and health inequalities is urgently needed. The aim should be to support cross-sectoral work and open up ownership of public health intellectual property on HIA technologies:

- **Develop a 2 year post for regional lead for HIA** working at a more strategic level, supporting regional and local capacity building activities (see appendix 2 for a possible job description). This should be a joint appointment between GONW, RDA, SHA and academia;
- Develop a two-tiered **participatory evaluation** framework to identify regional and local indicators as measure of successful application of HIA technology;
- Develop opportunities for **learning in the workplace** ie multidisciplinary cross-sector team working in action learning sets;
- Employ **dedicated person in each coterminous area to support health proofing activities across sectors** – not just HIA but any activity requiring specialist health knowledge input (ie joint post at the local level with direct access to and support from HIA champions within organisations to action learning quickly);
- **Hold jargon busting days** to develop a common language as there appears much confusion about what health and wellbeing are generally, and whether local authorities 'wellbeing' responsibility makes the concept of 'health' defunct;

- **Cross-agency partnership events** to raise awareness of the contribution of HIA/ health proofing for elected members ie so what? What difference HIA makes sharing learning across sectors – what gains can be made – link with triple bottom line principle
- **Develop and support** mechanisms for skilling up **third sector** and communities to undertake commissions of HIA. Thus meeting NHS corporate responsibility targets and asset based commissioning. This aims to increase the pool of civic knowledge and understanding of health and its determinants in localities and the region as a whole and share responsibility in decision making ;
- **Develop guidance on commissioning HIA** for LA/ NHS and Third sector service commissioners;
- Capacity should be at all organisational levels eg PCTs support local authority planning departments, RPHT support GONW
- **LSP should be the responsible authority** to ensure HIA/health proofing carried out as appropriate;
- **Develop**/ or commission **an electronic HIA module** to offer as a core component of all core health promotion workers (ie public health / health trainers / other relevant disciplines eg undergraduate education eg in planning curriculum);
- Produce **simple, plain English guide for elected members** on HIA and how it fits with other forms of integrated assessment. This needs to be set in context eg what the current public health issues in the Northwest are, the short and long-tem effects of those issues. It will need to demonstrate CBA followed up with some HIA process training.

Partnership

The aim should be to institutionalise HIA thinking across and within partnership organisations:

- Use the new flexibilities available to **pool funds for joint delivery** of capacity building activities;
- **Work with partners** to exploit opportunities for cross discipline learning and doing eg through integrated workforce training and education
- **Use existing regional forums to support HIA** development through public health networks/ partnership forums/ Academia
- **Improve communication across networks** as to what is going on in the region / through NWPHO/ APHO/ IdEA etc/ Northwest Employers Association. This should include development of a regional repository for HIA (for example within the IAT website, or NWPHO or IMPACT) and links to who is doing what, and where in the region;
- Use **pooled budget for commissioning HIA experts** within the region for ongoing support as and when required ;
- Establish **sub-regional Health Commissions** to provide political and senior health executive leadership (as in Manchester) and feed into the NWDA processes in the integration of regional strategies.

Integrating Health into other forms of IA

The aim should be to minimise the administrative burden of assessment but not at the expense of health inequalities:

- **All new policies should be assessed for health and wellbeing impact.** A simple step would be to assess for health and wellbeing impact with a simple prompt eg "how does the proposal contribute to reducing inequalities in health";
- Develop a mechanism for **contributing to and updating the evidence base for IAT web tool** this will assist joint information and intelligence requirements;
- Make more **explicit the link between sustainability and health** agendas;
- **Include** impact on health inequalities **in a single EqIA framework**.

Appendix 1. Northwest Regional Spatial Distribution of HIA Activity

Search term:

"health impact assessment" site:www.organisationname.abc.uk

This does a website specific search which is better than the inbuilt functions that all local authority/PCT websites have (Vohra personal communication). It was not possible to do a more in-depth investigation within the timescale of the study however the data base has been made available to The Regional Pubic Health team. This is an over view of the findings.The data was collected in August 2006 by Salim Vohra and must be read in that context

The maps on the next 6 pages illustrate spatial activity in HIA across the Northwest Government Region in terms of who has a policy on HIA, who is doing or has done HIA, and who is or has supported workforce skill development ie training in HIA techniques. Some caution should be taken in interpretation as the absence of a hit on the website does not necessarily mean that a local authority or PCT is inactive: simply that the information was not available. Neither can we assume that because a HIA has been done, HIA activity is ongoing and fully integrated into current systems and structures.

Map 1: Local Authorities with HIA policy: 17/43 (39%) Local authority websites indicated the existence of some form of HIA policy. These are mostly in the Greater Manchester and Merseyside conurbations but also parts of Lancashire and Cumbria.

Map 2: Local Authorities doing HIA: 16 (37 %) have links on their website indicating that they are doing or have done some form of HIA.

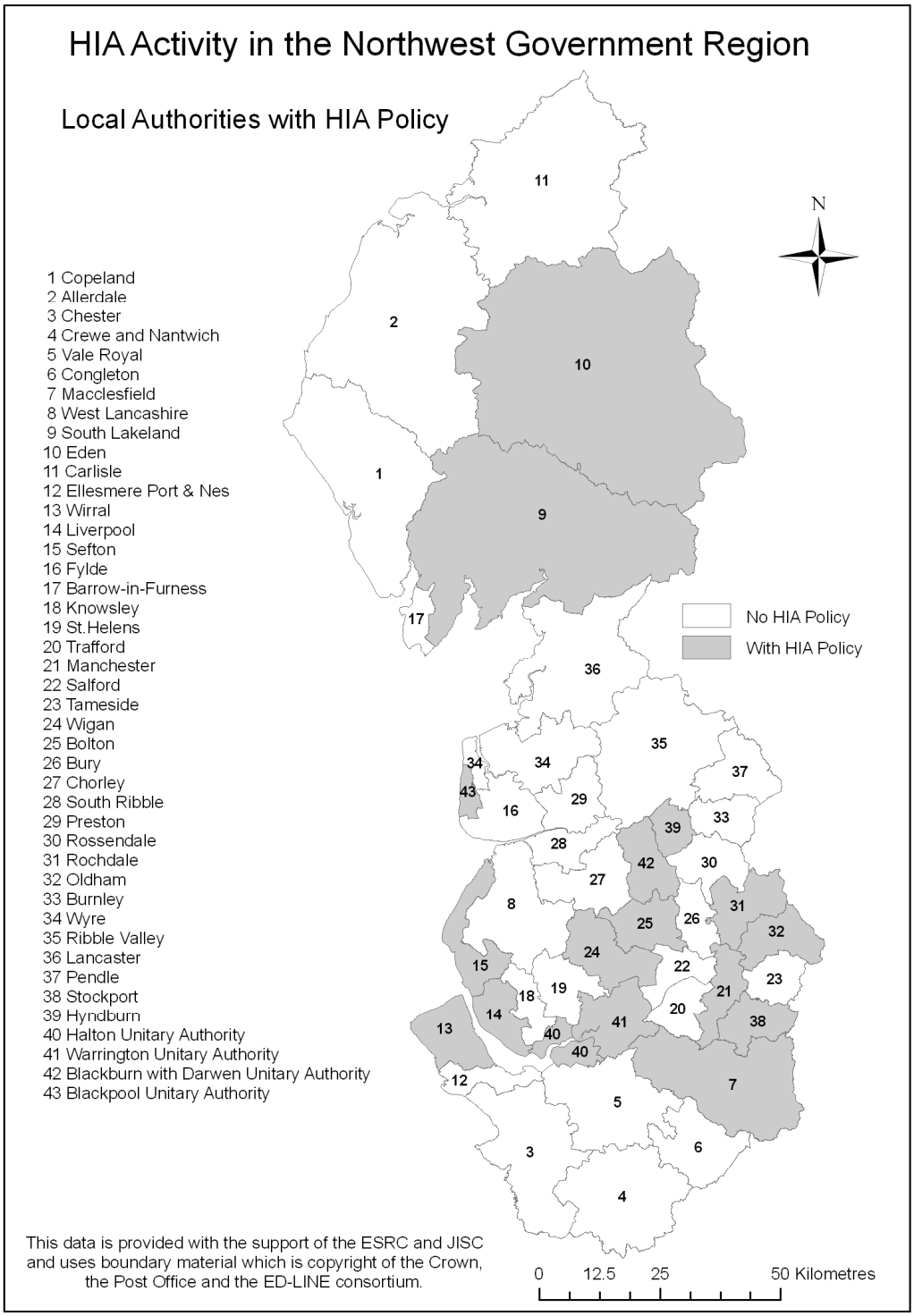
Map 3: Local Authorities supporting training in HIA: 7/ 43 (16%) of LA websites indicate support for some form of workforce training and local capacity building.

Map 4: PCTs with HIA policy: 21/42 (50%)

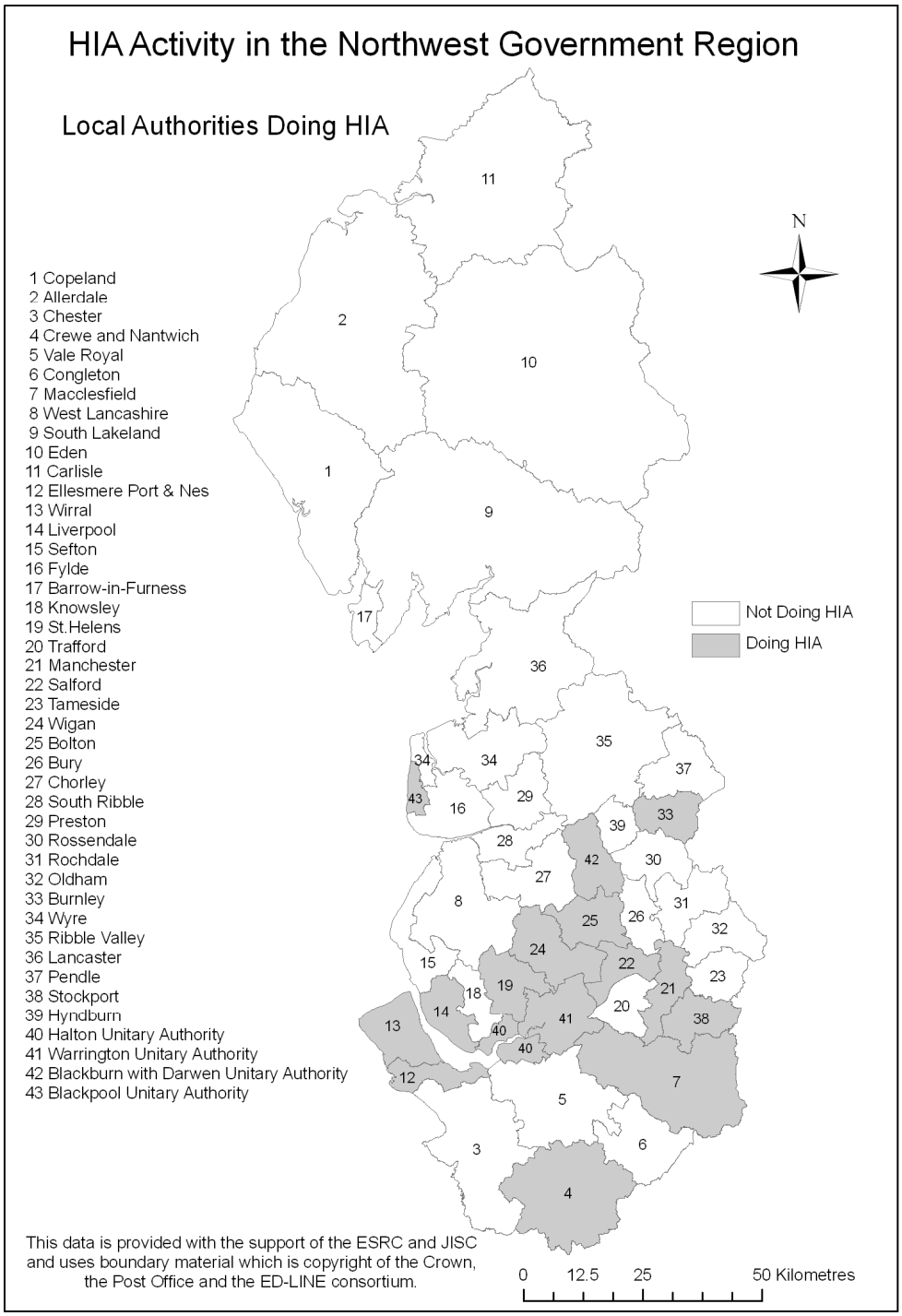
Map 5: PCTs doing HIA: 21/42 (50%) of PCTs have done or are doing HIA.

Map 6: PCTs supporting training in HIA: 3/42 (7%) of PCTs websites indicate support for some form of skill development. This seems very low. One explanation is that this is simply not mentioned on the website. Eg Liverpool PCTs and Sefton PCT commissioned training in partnership with LAs form IMPACT. This information can be found on the LA website but not the PCT. Alternatively skill development in HIA may not be an organisational perceived need. This demonstrates the importance of organisational websites and the power of their search engines in gathering information on health activities generally and HIA specifically.

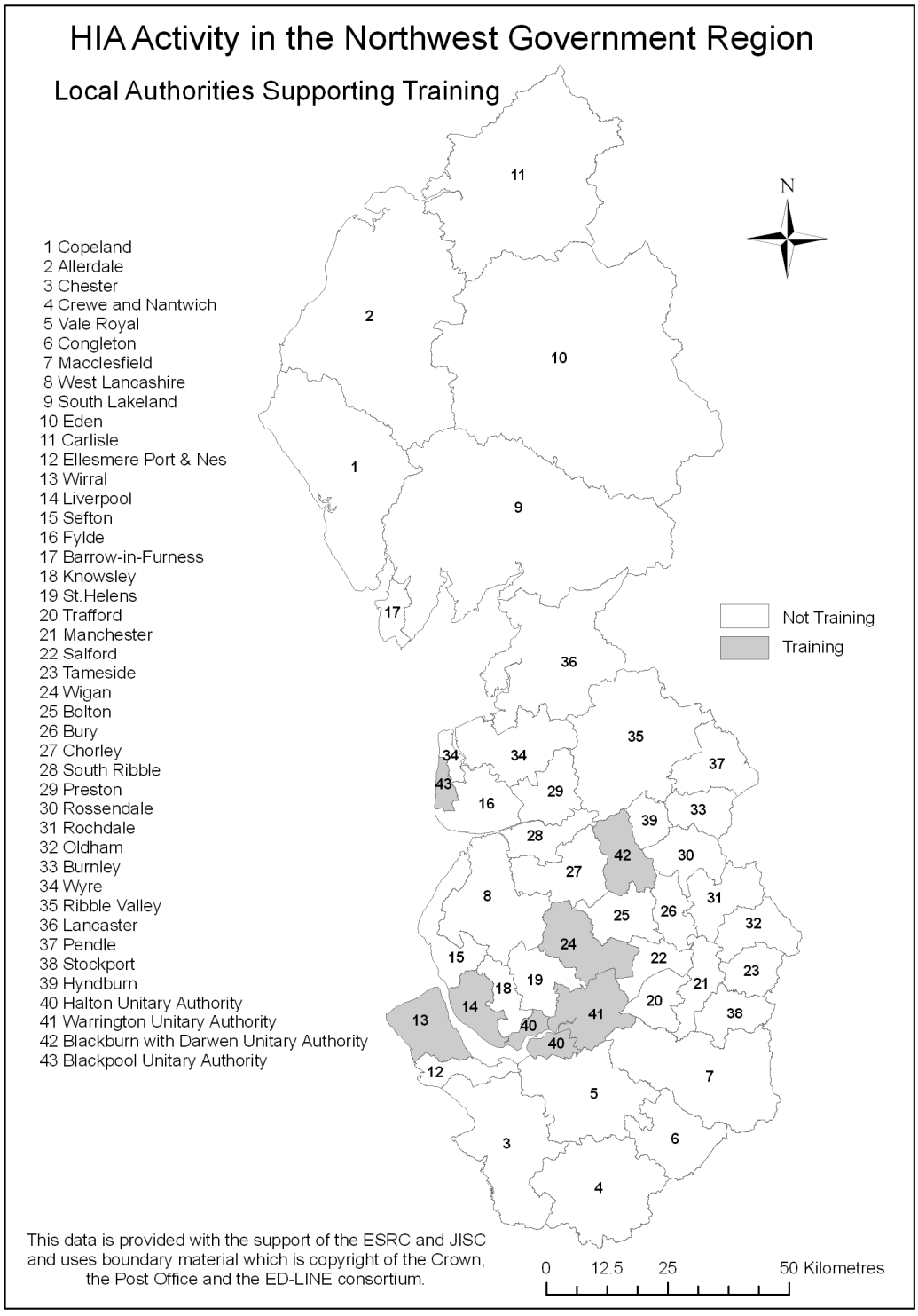
MAP 1 Local Authorities with HIA Policy



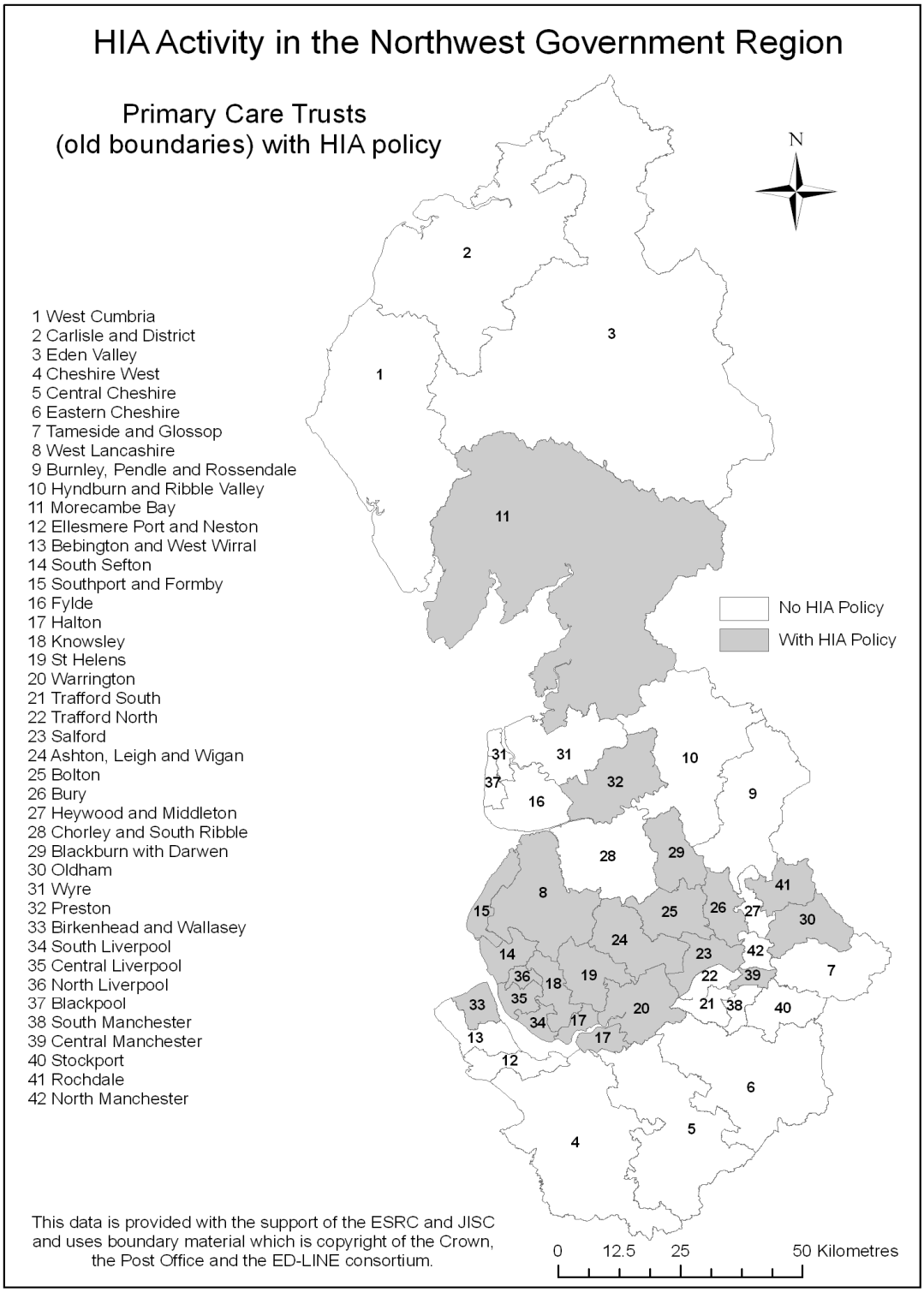
MAP 2 Local Authorities Doing HIA



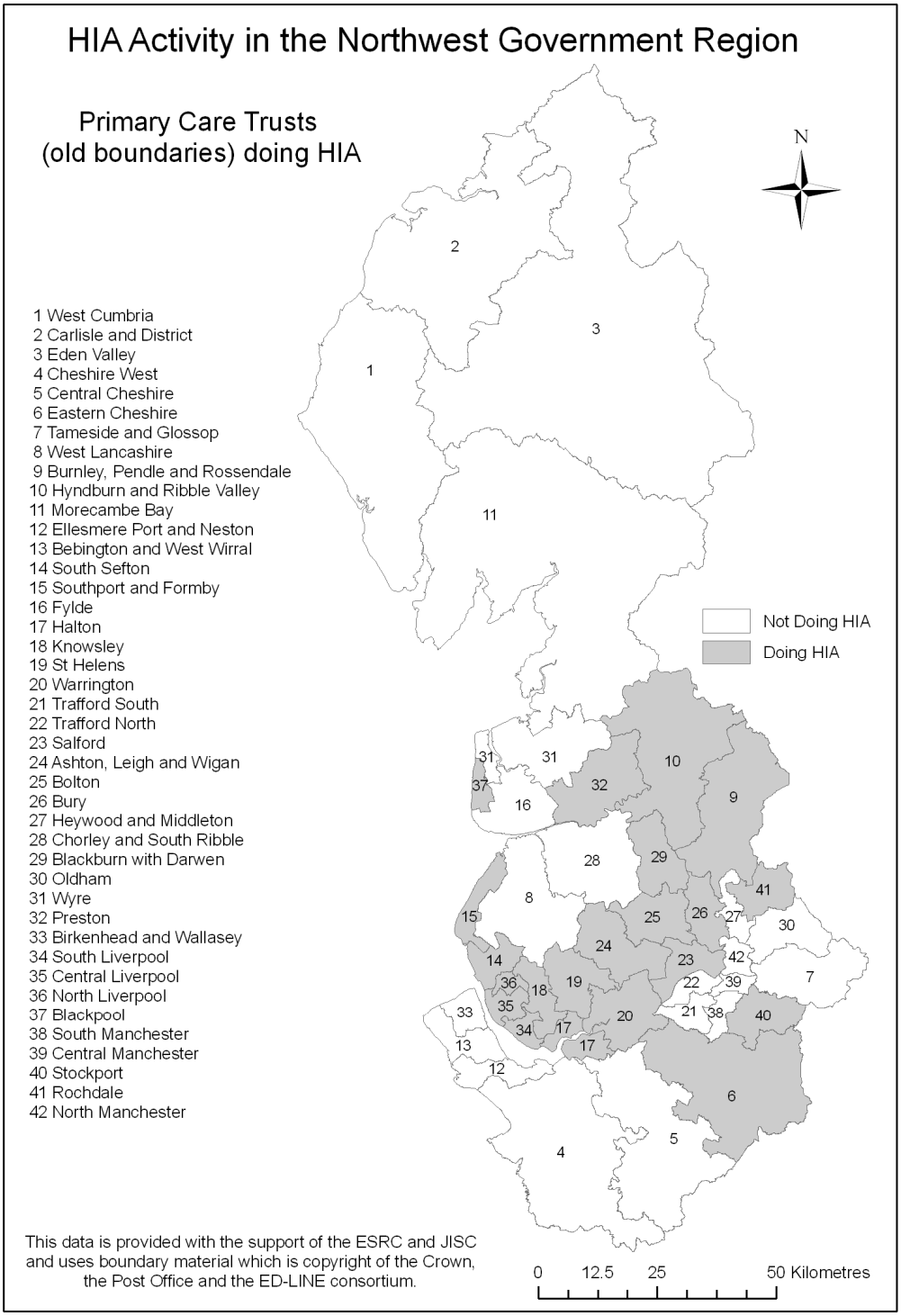
MAP 3 Local Authorities Supporting Training



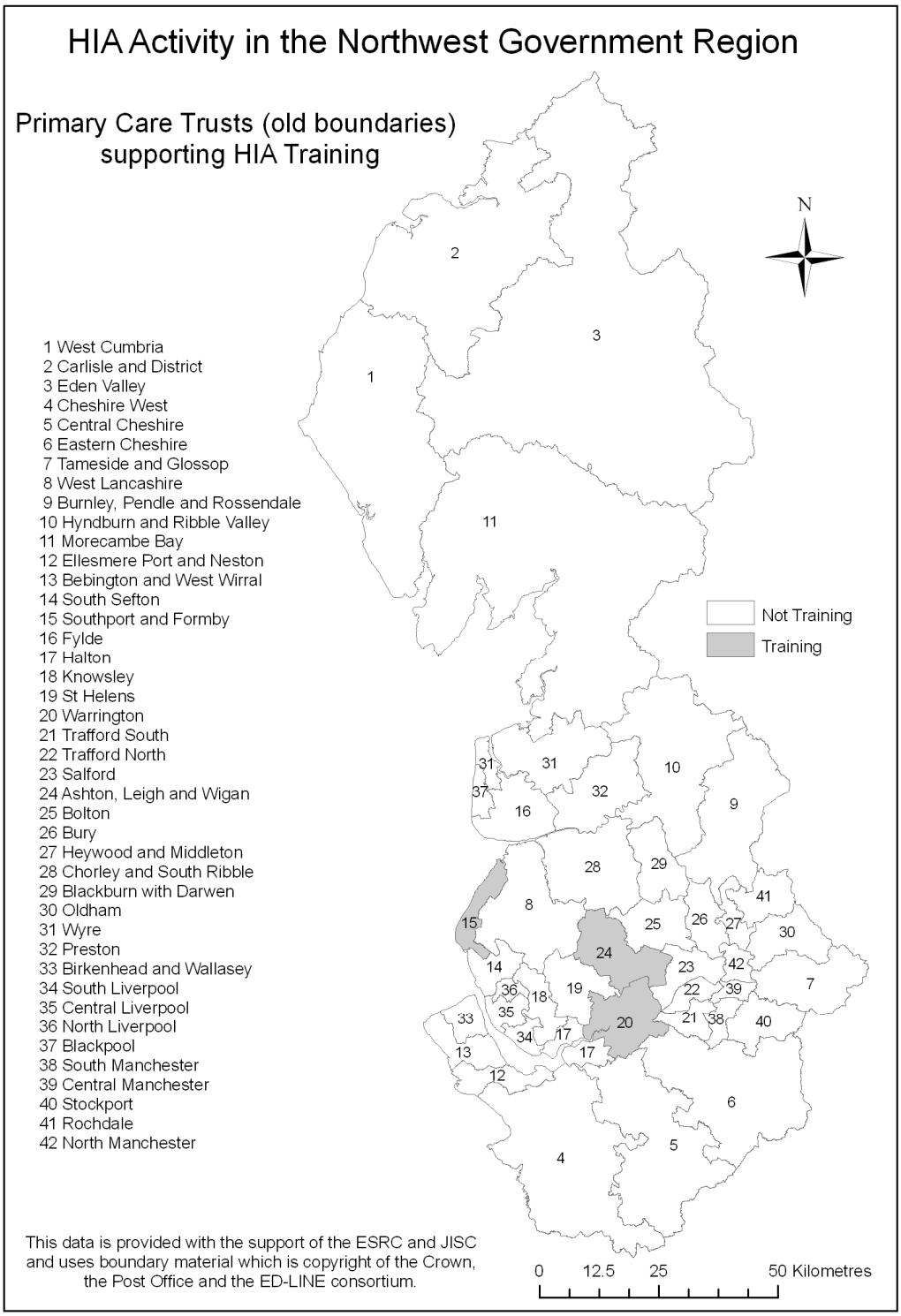
MAP 4 PCTs with HIA Policy



MAP 5 PCTs Doing HIA



MAP 6 PCTs Supporting Training



Appendix 2 Example Job Description for Regional HIA Development Manager

1. JOB IDENTIFICATION

Job Title: **Health Impact Assessment Development Manager**

Department(s): **Yorkshire and Humber Public Health Observatory**

Responsible to: **Director, YHPHO**

Accountable to: **Director, YHPHO**

Band: **Band 7 (Fixed Term 2 Year Appointment)**

2. JOB PURPOSE

- To lead on the proactive development of Health Impact Assessment in the Yorkshire and Humber Region, as part of the work programme of the PHO, in partnership with the Regional Public Health Group, public health networks, and regional partner organisations
- To act as a source of support and information to both regional and local agencies in carrying out HIA
- To influence policy development in relation to HIA within the context of the Integrated Regional Framework, sustainable development, and integrated impact assessment
- To promote standards of best practice in relation to HIA methodology and build capacity in the region for HIA

3. MAIN DUTIES/RESPONSIBILITIES

Proactive development of Health Impact Assessment

- Work with the YHPHO Policy Board to negotiate and agree a work programme
- Continue with the "learning by doing" approach, supporting specific HIAs with high regional impacts (eg. HIA of the M1). Work actively with Local Authority health policy leads to identify their needs in relation to HIA and Local Government Scrutiny/Best Value reviews
- Work with all Public Health Observatories and other relevant national bodies (NIHCE, Department of Health) to take account of the latest methodological developments in HIA and integrated impact assessment

Support, Information and Communication

- Support and organise a regional network of HIA practitioners to exchange experience, knowledge, learning and information
- Provide advice on sources of expertise for agencies and practitioners who need information and support with HIA, including simple tools that can be used by voluntary and community sector organisations
- Advise people on how to commission an HIA and what methodologies and research sources are available – making the most of academic links in the Region
- Advise PCTs in relation to national guidance on health elements of strategic environmental assessment, working with the HPA
- Build up a regional repository of network contacts, HIA projects and reports, and consultants with HIA experience

- Work with the PHO's Public Health Information Specialists in accessing information to support Health Impact Assessments in the Region
- Work on developing a training course in HIA and related techniques that builds on experience and resources within the Region

Policy Development

- Work closely with the Regional Public Health Group, Yorkshire and Humber Assembly, other regional observatories, Yorkshire Forward and GOYH to ensure that HIA is developed in the context of a fully integrated approach, including strategic environmental assessment, and sustainability appraisal
- Raise the profile of HIA in the region, linking with PH networks, local authority officers responsible for sustainability, environment, regeneration and economic development and public health strategy
- Identify opportunities for and support the integration of HIA into regional strategic development processes – e.g. Regional Spatial Strategy, Regional Economics Strategy, Regional Housing Strategy
- Identify how HIA might fit with other assessment/appraisal processes, providing support to those carrying out such appraisals in relation to the health and health inequalities elements
- Support the dissemination of learning from carrying out regional level HIA

Standards and Best Practice

- To identify, disseminate and promote best practice in HIA
- To keep up-to-date with the development of HIA research, including methodological issues and debates
- Link HIA development and learning into the work of relevant regional and national public health development networks
- To develop appropriate training programmes

General

- To work as part of the YHPHO team – undertaking relevant joint personal development, monitoring, and reporting as required by the Director of the YHPHO
- To deliver reports to the regional HIA management group, which will be responsible for supporting and overseeing the objectives for the post