

## **Case-study 8.4.2**

# **Health impact assessment on the Ferrier Estate ... work in progress**

*Ruth Barnes and Karen MacArthur*

### **Introduction: The programme and project being assessed**

In this case-study, we report on an intermediate, prospective health impact assessment (HIA) centred around a successful bid for Round 5 single regeneration budget (SRB5) funding in Greenwich.

The area covered by the resulting SRB5 programme is located in a residential community to the south east of Greenwich and west of Eltham. £23 million of government funding will be invested in this area in the next 7 years to finance an extensive regeneration strategy, which has three main aims:

- tackling social exclusion and promoting opportunities for employment and education;
- addressing crime and raising the level of public safety in the area; and
- transforming the housing stock and local infrastructure<sup>1</sup>.

The largest single project within the SRB programme is a proposed radical transformation of local housing on the Ferrier estate. Given the scale of the possible housing developments to the estate - an investment of £10 million of SRB5 monies, affecting a population of 6,800 people - and the established links between health and housing, the potential health impacts are sizeable. It is therefore important that all efforts are made to ensure that the potential positive health impacts are maximised and negative ones minimised. Because of this, and because housing has also been found in other areas to be a suitable subject for HIA, this project was chosen as an appropriate area for HIA in Greenwich and for developing HIA methods and methodologies which can be applied to regeneration policies, programmes and projects elsewhere. The HIA is being funded by the Department of Health HIA team as part of a series of national pilots.

### **Aims of the HIA**

The broad aims of the HIA are:

- to assess the potential health impacts on residents, both positive and negative, of changes in housing and land use on the Ferrier estate;
- to highlight the impact of the proposed development on health inequalities; and
- to make recommendations to enhance the predicted positive impacts and minimise the negative ones.

More specifically, in terms of influencing future policy development, the HIA is focussing on the land use options which are currently being developed for consideration by the local authority and SRB Partnership Board. Some of the options may result in a considerable reduction in the number of housing units on the Ferrier, involving the movement of a proportion of the population to other locations. The HIA is thus timed to come at a strategic planning stage where its recommendations can be most effective not only in informing the options for the future development of the estate but also in assessing the health impacts of the transitional phase of the changes.

### **The HIA – process and content**

#### ***Tools and overall approach***

The HIA is being carried out at a very early stage in the development of options for the Ferrier estate when there is little detail or clarity about what changes may be made. This lack of clarity presents considerable difficulties in designing and carrying out the HIA. However we have had clear messages

from community representatives and from the housing department at the London Borough of Greenwich that they feel our input at this stage is very important in putting health on the agenda and having maximum influence on the development of the SRB programme. The HIA will therefore be part of the process to formulate and assess the options and so some emphasis is being placed on generic health impacts of regeneration and how these may be applicable in the possible scenarios for the Ferrier estate.

It is also envisaged that this approach will contribute significantly to HIA methodological development, not least by offering lessons relating to the optimum timing of HIAs in the future.

The Merseyside Guidelines<sup>2</sup> have been the starting point for the development of our methodology, providing a basic framework for the work programme and for the HIA itself. We are, however, adapting and adjusting these frameworks to the particular needs of our study.

### ***Scope of the HIA***

The HIA covers the whole of the Ferrier estate and its residents although it is recognised that the SRB programme will also have more wide reaching effects in the neighbouring areas. In addition, other initiatives based outside the area may have some impact on Ferrier residents.

Long-term and shorter term, transitional health impacts are being considered in the initial HIA. The work was started in January and a draft first report will be produced in May 2000 to inform the options for the development of the Ferrier. We are also hoping to secure further funding to extend the HIA to review the more detailed options, once they have been clarified, in the summer in order to ensure the health impacts on the population are included in every part of the decision making process. In addition, we are also starting to explore the possibilities for undertaking a cohort study of current residents to track changes in their health and well being over a number of years, regardless of whether or not they continue to live on the Ferrier estate during and after its development.

### ***Stakeholders and their respective roles, responsibilities and accountabilities***

The HIA is being led by Bexley and Greenwich Health Authority and overall responsibility rests with the Public Health Directorate and the Director of Public Health, Dr Allison Streetley. Day-to-day project management responsibility rests with the epidemiologist. A consultant - who is a public health specialist - has been employed to work with the health authority in carrying out the HIA, and the responsibility for producing the final report rests with her.

There is, however, a strong emphasis on partnership, particularly with the Greenwich Health Unit, which has been set up as a joint local authority/health authority initiative, the London Borough of Greenwich Housing, Social Services and Education Services and community and voluntary group representatives. All of these are represented on the Steering Group, which was established at an early stage.

In addition to the Steering Group, we have established a Working Group with a membership of six, comprising representatives of public health, housing, the joint Health Unit and the South Greenwich Forum, an umbrella group for local community organisations. The main criteria for membership of the Working Group were that people would have time to commit to the day to day work of the HIA and that they were particularly key to its success. Essential tasks in which members of the Working Group are involved include shaping the nature of and facilitating community involvement and designing and carrying out parts of the research as appropriate.

### ***Public participation***

Public participation and involvement of the community is seen as crucial to the HIA, and we have involved community representatives both formally and informally. Members of the working group have attended a Tenants' Forum and are working alongside the Independent Tenants' Advisers to be part of an integrated consultation process with the residents, to involve residents in the HIA and to ensure its widest possible ownership.

### ***Health determinants and health outcome measures***

The WHO definition of health and, in line with this, a social model of health determinants underpins the HIA. Examples of these determinants are used in interviews with key stakeholders to help identify the potential health impacts of the SRB project.

Although these interviews and the subsequent analyses are in the preliminary stages, established links between health and housing suggest that improvements in housing design and the environment might lead to a number of long-term health outcomes:

- decrease in accident rates<sup>3,4</sup>
- decrease in respiratory disease<sup>5,6,7</sup>
- decrease in excess winter deaths<sup>8,9</sup>
- decrease in cardiovascular morbidity and mortality<sup>8</sup>

In addition, several possible process indicators for long-term changes in health status have also been identified from the existing literature and early discussions with the Steering Group, Working Group, and some of the individual key stakeholders, as follows:

- access to better transport routes;
- access to green spaces;
- access to better food and nutrition through improved local shopping facilities;
- design provision for lifetime homes;
- enhanced community safety measures, leading to better mental health;
- energy efficient central heating; and
- good infestation control.

In the shorter term, population movement and the process of change is clearly linked to high levels of stress and anxiety, which has implications in terms of family and community breakdown which increase the chances of poor mental health. Possible process indicators for short term transitional outcomes include:

- noise pollution being kept at acceptable levels;
- ensuring that building sites are made safe against accidents;
- facilitating good resident involvement and ensuring an increased sense of control over decision-making; and
- providing clear information about events and timescales in order to minimise anxiety.

### ***Nature of the evidence base***

The framework for interviewing - one of our main methods of data collection - has been adjusted to take into account both long-term health impacts of housing developments and shorter term impacts of the change process. We also intend to incorporate qualitative evidence of factors which have proved effective in other regeneration projects.

### **Learning points**

This work is still at a relatively early stage so our main learning points to date relate to the planning and commissioning stages of the HIA.

### ***Planning***

The key issues in planning our work were to ensure that the HIA is carried out in such a way as:

- to raise awareness of health issues among key decision-makers and the local community;
- to ensure the fullest possible participation and ownership by the local community; and
- to ensure that the recommendations are taken on board and used in the final decisions affecting the development of the Ferrier estate and the health of its residents.

This necessitates a clear understanding of the political processes and structures involved in public policy- and decision-making in order to be able to identify and involve key people early and consistently in the HIA. We anticipate that, by doing this, there will be the maximum likelihood of the HIA's recommendations being taken on board and implemented successfully.

### ***Commissioning and training issues***

The shortage of researchers and consultants experienced in HIA was an issue at the planning stage, but we were able to find someone who had considerable experience of HIA both in Merseyside and London to work with us. In developing the work programme, we have also ensured that there is an opportunity for a wide range of partners to gain "hands on" experience of HIA in order to build up the levels of skills, knowledge and experience for future work. This local capacity building is seen as essential if HIA is to become "embedded" into public policy development in the future.

### ***Skills***

The skills required for an HIA are diverse. Those we have identified to date include:

- public health , epidemiological and social science research skills;
- experience of community development and involvement;
- team working;
- interpersonal and communication skills;
- influencing and negotiating skills, at a range of levels; and
- good project management and organisational skills.

### ***Timing***

It was difficult to gauge the appropriate time for the HIA. The original plan was carry out the HIA on clear land use options. The political timetable, however, has slipped to such an extent that we are now planning to do it as a two-stage process. The major part will be carried out between January and June 2000, and contribute towards developing the options for the future of the Ferrier estate. The second stage will be carried out when the more detailed options are confirmed to apply the findings from the initial assessment. This should help us in understanding what the most effective timescale is for the future. In the meantime, our main learning point is that external political decision-making processes can make it very difficult to plan an HIA and to tie it in effectively to those processes.

The budgeted time commitment for the initial 6 months is as follows:

- consultant 1½ days a week for 6 months; and
- epidemiologist 1 day a week for 6 months.

In addition, the other members of the Working Group are making a considerable time commitment to the project through their existing work programmes.

### ***Leadership***

Commitment from the top is necessary to secure support for carrying out the HIA - for example, ensuring that staff have HIA built into their work programmes - and for implementing its recommendations.

### ***Gaining support and commitment***

Gaining support and commitment from other organisations and getting them to see health as part of their agenda is crucial to be able to influence the decision-making process. We have, so far, been able to engage very effectively with partner organisations and this has been due largely to two factors:

- the strong health input to the development of the original SRB bid by the epidemiologist; and, related to this,
- the good working relationships which were already in place between the epidemiologist and other key individuals in our partner organisations at the start of the HIA process.

### ***Communication and networking***

This is time-consuming and somewhat intangible but very important for developing ideas and getting others on board. Without it the process of developing our work programme and carrying it out would have been severely hampered.

### ***Data issues***

We are still working to clarify the individual “data items” - both quantitative and qualitative - that will form the basis of our HIA analysis. We have identified, however, a number of data issues that need to be resolved in any work of this nature.

- How do we decide what is or isn't important in terms of health determinants?
- How do we weight the contributions of the various stakeholders?
- How do we balance the qualitative and quantitative data?

### ***Funding and staff***

For HIAs in the long term, issues about funding and staff are important. We are finding that even an intermediate HIA such as ours can produce a mass of data and information which, without considerable dedicated HIA time, would be impossible to handle. This throws up a number of questions.

- How can anything other than rapid HIAs be done elsewhere unless they have the same resources, given that earmarked Department of Health funding will probably not be available on an ongoing basis?
- How can staff and monetary resources be freed up for HIA to be done as a routine part of public policy development in the future?
- How can we ensure that HIA is a top priority and that it is valued appropriately?

### ***Level of detail***

We plan to evaluate the HIA at the end of the process and to estimate what extra value we added by doing an “intermediate” HIA rather than a rapid one. We also intend to consider the potential advantages and disadvantages of a comprehensive HIA. An early and obvious learning point from our work so far is that one big disadvantage would be the timing in that we could invest a great deal of effort in developing an excellent evidence base but it would be too late to use it for the Ferrier.

### **References**

1. Greenwich Council (1999). *South Greenwich – building new links*. Single Regeneration Budget Round 5 bid.
2. Scott-Samuel A, Birley M and Ardern K (1998). *The Merseyside guidelines for health impact assessment*. Liverpool: Merseyside Health Impact Assessment Steering Group.
3. Department of Trade and Industry (1991). *Home and leisure accident research: twelfth annual report, 1988 data*. London: Department of Trade and Industry, Consumer Safety Unit.
4. Constantinides P (1998). Safe at home? Children's accidents and inequality. *Radical Community Medicine* Spring: 31-33.
5. Department of Health Committee on the Medical Effects of Air Pollutants (1998) *Quantification of the effects of air pollution on health in the United Kingdom*. London: The Stationery Office.
6. Arblaster L and Hawtin M (1993). *Health, housing and social policy*. London: Socialist Health Association.
7. Platt S., Martin C., Hunt S. and Lewis C. (1989). Damp housing, mould growth and symptomatic health state. *British Medical Journal* 298: 1673-1678.
8. Best R (1995). The housing dimension. In: Benzeval M., Judge K. and Whitehead M. (eds.) (1995). *Tackling inequalities in health: an agenda for action*. London: Kings Fund.
9. Christopherson O. (1997) Mortality during the 1996/7 winter. *Population Trends*, 90: 11-17.

### **Contact:**

Karen MacArthur (Epidemiologist), Bexley and Greenwich Health Authority,

221 Erith Road, Bexleyheath, Kent DA7 6HZ

Ruth Barnes (Independent Public Health Consultant)

e-mail: [ruthbarnes@queenspark98.freeserve.co.uk](mailto:ruthbarnes@queenspark98.freeserve.co.uk)

© Karen Macarthur and Ruth Barnes, Bexley and Greenwich Health Authority; April 2000

*Copyright* for each case-study belongs to the author(s) or, where appropriate, the health authority or local authority concerned. Permission to quote from this work must be obtained from the authors. Moreover, each author or, where appropriate, the health authority or local authority retains the intellectual property rights (IPR) to the work.