Draft Guidance on Health in Strategic Environmental Assessment

Consultation Document
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Consultation document

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### DH INFORMATION READER BOX

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For recipient's use
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<tr>
<td>APHO</td>
<td>Association of Public Health Observatories</td>
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<td>APHR</td>
<td>annual public health report</td>
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<td>CLG</td>
<td>Department for Communities and Local Government</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>DA</td>
<td>devolved administration</td>
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<td>Department for Transport</td>
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<td>DPD</td>
<td>development plan document</td>
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<td>Equality Impact Assessment</td>
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<td>ER</td>
<td>Environmental Report</td>
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<td>Greater London Authority</td>
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<td>HIA</td>
<td>Health Impact Assessment</td>
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<td>Health Protection Agency</td>
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<td>HPU</td>
<td>Health Protection Unit</td>
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<td>IPPC</td>
<td>Integrated Pollution Prevention and Control</td>
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<td>KSI</td>
<td>key success indicator</td>
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<td>LA</td>
<td>local authority</td>
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<td>Acronym</td>
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<td>LAA</td>
<td>local area agreement</td>
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<td>local development document</td>
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<td>local development framework</td>
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<td>local delivery plan for primary care trusts</td>
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<td>Local Involvement Networks</td>
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<td>local planning authority</td>
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<td>local and regional services of the Health Protection Agency</td>
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<td>local strategic partnerships</td>
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<td>local transport authority</td>
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<td>Local Transport Plan</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>ODPDM</td>
<td>Office of the Deputy Prime Minister</td>
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<td>PAH</td>
<td>polycyclic aromatic hydrocarbon</td>
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<td>PCT</td>
<td>primary care trust</td>
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<td>PHO</td>
<td>Public Health Observatory</td>
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<td>planning policy statement</td>
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<td>Public Service Agreement</td>
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<td>Quality and Outcomes Framework</td>
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<td>RBMP</td>
<td>River Basin Management Plan</td>
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<td>RES</td>
<td>Regional Economic Strategy</td>
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<td>Regulatory Impact Assessment</td>
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<td>ROWIP</td>
<td>Rights of Way Improvement Plan</td>
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<td>RPHG</td>
<td>regional public health group</td>
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<td>RSS</td>
<td>regional spatial strategy</td>
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<td>RTPI</td>
<td>Royal Town Planning Institute</td>
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SA    Sustainability Appraisal
SCI   statement of community involvement
SCS   Sustainable Community Strategy
SEA   Strategic Environmental Assessment
SHA   strategic health authority
SPD   supplementary planning document
THE PEP Transport, Health and Environment Pan-European Programme
UKPHA United Kingdom Public Health Association
WAG   Welsh Assembly Government
WHO   World Health Organization
Executive summary

This document supplements existing UK-wide guidance on Strategic Environmental Assessment (SEA) (*A Practical Guide to the Strategic Environmental Assessment Directive* (2005) ODPM et al), by providing a good practice guide to including the population's health in SEA. This document has been written by the Department of Health (DH) in close collaboration with the Health Protection Agency (HPA) and has been prepared in consultation with the Department for Communities and Local Government (CLG) and the Environment Agency (EA). The guidance is intended to help authorities assess the health effects of their plans and programmes more effectively and is based on current good practice. We are asking consultees for their views on the effectiveness of this guidance.

This guidance is relevant to SEAs that cover England, or England plus any other part of the UK, so will be relevant to plans at a UK level. It has two main audiences:

- health organisations, including primary care trusts (PCTs), the HPA and Public Health Observatories (PHOs) to help in engagement in and responding to the SEA process, thereby maximising public health gains; and
- organisations responsible for preparing plans and programmes subject to the SEA Directive (known as Responsible Authorities or RAs) to identify the right people to contact in health organisations, and where to obtain the most relevant information on the effects of plans and programmes on the population's health.

Relevant contacts for Wales, Scotland and Northern Ireland are listed in Annex A. The Welsh Assembly Government (WAG) will be producing separate health and SEA guidance later this year.

Key messages are as follows:

- SEA consultation must be carried out with the public and certain named organisations (known as Consultation Bodies). As a health organisation is not included amongst the Consultation Bodies, this guidance encourages interaction between RAs and health organisations to ensure that the population's health is assessed during the SEA process.

- SEA is a major opportunity to prevent ill health and tackle health inequalities as set out in the White Papers *Choosing Health* and *Our health, our care, our say.*
• RAs should know and understand how health is affected by their plans and programmes so that, in assessing them, major relevant health issues are covered, maximising positive effects and preventing, offsetting or minimising negative ones, and promoting healthier planning as set out in the White Paper *Strong and Prosperous Communities*.

• Health organisations should be effectively engaged in the process, with the health needs of the population being addressed in the SEA process.

SEA assesses the effect of certain plans and programmes on the environment, including on the population and human health (see Resource box 2). To cover these, this guidance refers to the population’s health.

The guidance is designed to be a resource for further information and is set out as follows.

Chapter 1: Sets out the benefits of integrating health assessment within SEA for plan makers and health organisations.

Chapter 2: Introduces the SEA and Sustainability Appraisal (SA) process, including links to other forms of assessment and related plan making processes.

Chapter 3: Presents information for considering the population’s health in SEA.

Chapter 4: Sets out the stages of SEA and contains detailed information on how to consider possible effects on health throughout the assessment process.

Annex A: Contains information on devolved administrations and their health consultation links.

Annex B: Provides an overview of health organisation roles, responsibilities, information and resources.

Annex C: Gives more detailed information on health effects in types of plans.

Annex D: Provides examples of evidence for topics covered by SEA.

Annex E: Contains frequently asked questions for quick reference.

Annex F: Sets out two sets of “do’s and don’ts”, one for PCTs and one for RAs. These have been designed as a form of quick access to essential information.
Annex G: Lists the participants in stakeholder workshops that have informed this guidance.

A glossary of terms is provided to explain the terminology used in the document and there is a bibliography with websites for key documents.

The guidance is illustrated by a number of examples, case studies, resources and key point boxes. These are not intended to represent best practice, but simply to show how health has been addressed in SEA to date. These are colour coded for ease of reference:

- Example box
- Case study box
- Resource box
- Key point box

The Government is committed to ensuring that any net additional cost of new burdens placed on local authorities is funded as required under the new burdens rules.
The consultation document is available on the Department of Health website at www.dh.gov.uk/consultations. The consultation period is from 19 March to 19 June 2007.

All consultation responses should be sent to:

Colleen Williams  
Department of Health  
Room 580D  
Skipton House  
80 London Road  
London SE1 6LH  

Email: Colleen.Williams@dh.gsi.gov.uk

Consultation events

There will be a number of events during the consultation period in each of the Government Regions, where PCTs, RAs, EA, HPA, PHOs, Government Offices and public health groups can discuss the practical details of considering health issues as an integral part of SEA. To find out more about these and other events still being planned, please contact the regional public health group in your area through the Regional Government website.

Confirmed events are as follows:

North East Region  March  
East of England  End of March event on planning and health  
East and West Midlands  Combined event March/April

The guidance will be available at related professional conferences including the Institute of Environmental Management and Assessment (IEMA) SEA Forum on 14 March in Leeds, UK Public Health Association (PHA) on 28–29 March in Edinburgh, and Chartered Institution of Water and Environment Management (CIWEM) on 26 April in Birmingham.
The consultation criteria

This consultation is being conducted in accordance with the Government’s Code of Practice on Consultation. The criteria below apply to all UK national public consultations on the basis of a document in electronic or printed format. The criteria are as follows:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your department’s effectiveness at consultation, including through the use of a designated consultation coordinator.
6. Ensure your consultation follows Better Regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

A summary of responses will be published on the Department of Health website at www.dh.gov.uk/news

Unless you specifically state that your response, or any part of it, is confidential, we shall assume that you have no objection to its being made available to the public on the Department of Health website.

The final document will be published in summer 2007 and will be supplemented by additional web-based information regarding the evidence base on human health impacts.

Complaints

If respondents have comments or complaints about the consultation process, these should be directed to:

Consultations Coordinator
Department of Health
Skipton House
80 London Road
London SE1 6LH

Email: mb-dh-consultations-coordinator@dh.gsi.gov.uk
Consultation questions

Your views about the relevance and content of the advice is sought through responses to the following questions, the questions at the end of each chapter and any other comments you wish to make. Comments and suggestions are welcome on all aspects of the document. These will be used to inform the final document to be published later this year.

1. Is it clear how the consideration of human health can be covered in the SEA process and how this can be achieved?
2. Are the right health organisations and contacts referred to and included in this guidance?
3. Does this provide you with the right type of information and data sources for considering the population’s health in the SEA process?
4. Does the guidance make clear the process for obtaining information and advice on the population’s health?
5. Is the type of health-sector input appropriate for the five stages of SEA?
6. Is the health organisations’ input provided at the most appropriate time within the process?
7. What additional information, if any, would be helpful for RAs when addressing health in the SEA process?
8. Do you feel there are any other issues relating to equality that should be covered?
9. Do you think the length of the document and level of detail is appropriate?
10. What impact do you anticipate this guidance will have on the work of your organisation (NHS and RAs)?
11. Are there any other comments you would like to make?
European Directive 2001/42/EC, known as the Strategic Environmental Assessment or SEA Directive, requires a formal environmental assessment of certain plans and programmes. In undertaking this assessment, the likely significant effects on the environment of implementing these plans and programmes must be considered, including the effects on population and human health.

Strategic Environmental Assessment (SEA) and Sustainability Appraisal (SA) provide a significant opportunity for the population’s health to become a central part of assessing plans undertaken by plan makers (identified in the UK SEA Regulations as Responsible Authorities (RAs)). RAs include local authorities, the Environment Agency and others whose plans and programmes are captured by the SEA Directive. The guidance is intended to help authorities assess the health effects of their plans and programmes more effectively and is based on current good practice.

For Responsible Authorities, this guidance will assist them in meeting their obligations to take account of human health in SEA.

For health organisations, the SEA process presents an opportunity to prevent ill health and promote good health through influencing the wider determinants of health (transport, housing, education, employment, community safety and the built environment). Further benefits are detailed in Example box 1.

Example box 1: Potential benefits to primary care trusts (PCTs) in engaging in the SEA process

- improvements in the health of the population through providing the right environment for healthier lifestyles;
- ensuring the wider determinants of health are considered by plan makers where relevant;
- reduction in health inequalities;
- reduction in the financial burden on the PCT – both by reducing the prevalence of ill health and by preventing illness at an earlier stage;
- aid in meeting PCT national and local targets (eg Public Service Agreement targets);
SEA presents an opportunity and broad framework for bringing plan makers and health organisations together to achieve healthy planning, as set out in *Choosing Health, Our health, our care, our say,* and *Strong and Prosperous Communities.*

- strengthened partnerships between planning and health stakeholders;
- capacity building will increase the ease of dealing with other assessment processes requiring potential PCT involvement (e.g., Environmental Impact Assessment and Integrated Pollution Prevention and Control) via the systematic, rigorous, integrated consideration of health issues in strategic planning decisions;
- other organisations encouraged to help the PCT deliver its health targets;
- the opportunity to focus on longer-term health objectives, tackling the causes of ill health rather than ‘fire fighting’ present problems; and
- improved community engagement.
Chapter 2: Strategic Environmental Assessment

Key point box 1: Health and Strategic Environmental Assessment

“The environment in which we live is a major determinant of health and well-being. Recent concerns about levels of physical activity, obesity, asthma and increasing environmental inequality have put health back on the planning agenda. It is widely recognised that public health is being compromised by both the manner of human intervention in the natural world and the manner of development activity in our built environment.” (Larkin, 2003)

2.1 Strategic Environmental Assessment (SEA)

The SEA Directive (Directive 2001/42/EC) came into effect on 21 July 2004 and has been transposed into UK law by the Environmental Assessment of Plans and Programmes Regulations 2004 and in Scotland by the Environmental Assessment (Scotland) Act 2005. A Practical Guide to the Strategic Environmental Assessment Directive, 2005 (the SEA “Practical Guide”) was prepared and issued jointly by the administrations responsible for implementation throughout the UK, and provides information on the requirements of the Directive and ways of meeting them.

Resource box 1: SEA guidance


The SEA Directive requires an environmental assessment of certain plans and programmes which are likely to have significant effects on the environment. Key activities for organisations responsible for preparing and/or adopting a qualifying plan or programme (identified in the Regulations as Responsible Authorities) include:

- prepare an Environmental Report on the likely significant environmental effects of implementing the plan or programme;
- consult statutory environmental authorities and the public on the plan or programme and its accompanying Environmental Report;
- take the report and the results of the consultation into account during the preparation process and before the plan or programme is adopted; and
• make information available about the plan or programme as adopted and how the environmental assessment was taken into account.

SEA is an independent assessment of the plan or programme and is carried out concurrently. RAs will either carry out the assessment themselves or commission consultants to assist.

The Department for Communities and Local Government (CLG) has overall responsibility for implementing the SEA Directive throughout the UK, and for subject plans and programmes in England, whilst the Scottish Executive, Welsh Assembly Government and the Department of the Environment in Northern Ireland have similar responsibilities in Scotland, Wales and Northern Ireland respectively.

**Key point box 2: SEA in the devolved administrations**

Where plans relate to England (or England plus any other part of the UK), the UK regulations will apply. Where they relate to Scotland, Wales or Northern Ireland only, under devolved powers, SEA legislation adopted by the devolved administrations will apply.


This specifies that an Environmental Report should be written that includes an assessment of “the likely significant effects on the environment, including on issues such as biodiversity, population, human health, fauna, flora, soil, water, air, climatic factors, material assets, cultural heritage including architectural and archaeological heritage, landscape and the interrelationship between the above factors.”

(Footnote: “These effects should include secondary, cumulative, synergistic, short, medium and long-term permanent and temporary, positive and negative effects.”)

**2.2 SEA and consultation**

**Consultation requirements**

The SEA Directive requires RAs to consult other authorities with certain environmental responsibilities (referred to as Consultation Bodies) at the screening stage in determining the requirement for SEA; on the scope and level of detail required in the Environmental Report; and on the draft plan or programme and accompanying Environmental Report itself. The SEA Regulations specify three Consultation Bodies in England:

• Natural England (formerly English Nature and the Countryside Agency);

• English Heritage; and

• Environment Agency.
The Consultation Bodies have produced a description of the services and standards that Responsible Authorities can expect:

The Environment Agency holds information useful in assessing health impacts, specifically in relation to the environmental quality of soil, water and air and the impact of flooding:
www.environment-agency.gov.uk/

Natural England promotes access, recreation and public well-being:
www.naturalengland.org.uk/

**Consultation in relation to health**

However, in order to cover the full range of potential health effects in SEA, it is recommended that RAs contact the relevant Director of Public Health (DPH) (see Key point box 3 and Figure 1) for an opinion at the same time as they engage with the Consultation Bodies, particularly at the scoping stage and during consultation on the draft plan or programme and Environmental Report. See Annex A for all Consultation Bodies in the UK.

RAs may already have direct links with a number of professionals such as Environmental Health Officers (EHOs) and other health organisations such as Health Protection Units and Public Health Observatories. It is recommended that these should be consulted as appropriate, at key stages of the SEA process.

**Key point box 3: Who to contact in relation to the health sector**

The relevant health organisations are:

- **national plans and programmes** – Department of Health, Health Improvement Directorate;

- **regional plans and programmes** – make contact in the first instance with the Regional Director of Public Health;

- **local plans and programmes** – where the plan or programme covers the same geographical area as the local primary care trust (PCT), make contact in the first instance with the Director of Public Health for the relevant PCT; and

- **regional/local** – where a plan or programme covers more than one PCT, consult with both the Regional DPH and each of the relevant PCTs for the area.
2.3 Sustainability Appraisal (SA)

In the UK, most plans and programmes subject to SEA are spatial plans. Sustainability Appraisal (SA) must be undertaken for spatial plans, and involves an assessment of the economic, social and environmental effects of implementing such plans as Regional Spatial Strategies (RSSs), development plan documents (DPDs) and supplementary planning documents (SPDs). Health considerations are relevant to all three components of assessment. The requirements of SEA have been fully incorporated into SA in England.

Resource box 3: SA guidance

- The CLG guidance on SA is available at: www.communities.gov.uk/index.asp?id=1164579

2.4 Other related forms of assessment

The population's health can be incorporated in many forms of assessment. The relationship between some of these is set out in Figure 2. For presentational purposes, the relationship between the planning hierarchy and different forms of assessment has been simplified (eg only some plans/programmes are subject to SEA, and only some projects are subject to an Environmental Impact Assessment (EIA). A Health Impact Assessment (HIA) can be applied outside the context shown here as well.
**Health Impact Assessment (HIA)**

HIA assesses the impact of the potential and sometimes unintended effects of a policy, plan, programme or project on the population’s health and well-being and the distribution of those effects within the population. It uses both quantitative and qualitative information, data from population needs assessments, literature reviews of the evidence base, and stakeholders and local people’s experience and knowledge. It suggests how adverse effects could be mitigated and beneficial ones enhanced to inform decision-makers.

HIA is not a statutory requirement for SEA; however, health considerations should be integrated within the SEA process and other forms of assessment where relevant. An example of how an HIA and SEA have been integrated is shown in Case study box 1.

For further information on HIA, see the HIA gateway website:
www.hiagateway.org.uk/page.aspx?o=hiagateway
Case study box 1: Incorporating health in the assessment of the London Plan – the Mayor’s Spatial Development Strategy

The need to consider health, sustainability and equalities issues in all policy making is set out in the Greater London Authority (GLA) Act.

An innovative approach is being taken to the SEA of the further alterations to the London Plan: the HIA has been integrated into the SEA. The key aspects of the method are:

- a health representative involved in all aspects of the assessment;
- a literature review of the relevant health evidence;
- key findings from the initial assessment tested on a health stakeholder workshop and the outcome from the workshop fed into the assessment; and
- a report bringing together the health findings of the assessment.

The advantage of integrating health into the SEA process is that this is an iterative process that aims to influence the plan as it develops, so health is considered at an early stage of plan or policy development. There was a close dialogue between policy makers, the SEA team and health professionals.

This resulted in:

- health stakeholders being involved during every stage of drafting the plan;
- a close dialogue between policy makers, the SEA team and health professionals;
- health input into scoping workshops and developing objectives;
- improved access to the health evidence base;
- alternatives being tested on health stakeholders;
- the Environmental Report containing a health section; and
- a separate publication of a summary of the health assessment and literature review.

For further information see: www.londonshealth.gov.uk/urban.htm

Environmental Impact Assessment (EIA)

EIA is a procedure that must be followed for certain types of projects prior to determination of an application for development consent. It requires the developer to compile an environmental statement describing the likely significant effects of the development on the environment, including the effects of a project on human beings (which may include the
population’s health issues) amongst a range of other factors, and proposed mitigation measures.

For further information on EIA, see:
www.communities.gov.uk/index.asp?id=1143248

**Integrated Pollution Prevention Control (IPPC)**

The IPPC aims to achieve a high level of protection of the environment by preventing or reducing the emissions of certain industrial activities into the air, water and land. PCTs are statutory consultees for permits issued to industry by the environmental regulators. The primary focus is on health protection.

Health Protection Agency guidance:

Defra guidance

**Equality Impact Assessment (EQIA)**

Public bodies have a duty to assess the impact of their policies on different groups within the population to ensure they do not discriminate and, where possible, promote equality of opportunity. RAs are required to carry out an EQIA on their plan or programme. Each plan or programme will have a differential impact in relation to age, disability, gender, race, religion or belief, or sexual orientation and will need to ensure that human rights are protected by treating everyone with fairness, respect, equality and dignity.

An EQIA screening has been carried out in relation to this document, but not in relation to plans and programmes to which it is applied. It shows that there are likely to be differential experiences, issues and priorities for the six equality categories and that there is potential for promoting equality of opportunity and promotion of good relations between different groups. A summary of the assessment is in Annex B.

### 2.5 Relevant plans and programmes

**Overview of plans and programmes subject to SEA**

SEA is required for certain categories of plans and programmes where they are determined to be likely to have significant environmental effects.
### Key point box 4: Plans and programmes subject to SEA

SEA is mandatory for plans and programmes which meet the criteria of the SEA Directive, and which:

- are prepared for agriculture, forestry, fisheries, energy, industry, transport, waste management, water management, telecommunications, tourism, town and country planning or land use and which set the framework for future development consent of projects listed in Annex I and II of the EIA Directive (85/337/EEC) or the likely effect on sites which have been determined to require an assessment pursuant to Article 6 or 7 of the Habitats Directive (92/43/EEC);

- which, in view of the likely effect on sites, have been determined to require an assessment pursuant to Article 6 or 7 of the Habitats Directive (92/43/EEC).

The SEA Practical Guide includes a list of types of plans and programmes that meet the criteria of the Directive. These are outlined in Table 1.

### Table 1: Plans and programmes requiring SEA

<table>
<thead>
<tr>
<th>Plan/programme</th>
<th>Examples</th>
<th>Responsible authority (RA)</th>
<th>Approximate no. and review period</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>Oil and Gas Licensing Rounds; Offshore Windfarm Site Licensing Rounds</td>
<td>Department of Trade and Industry</td>
<td>One per year</td>
</tr>
<tr>
<td>Regional</td>
<td>RSSs; Mayor's Spatial Development Strategy (London Plan)</td>
<td>Regional planning bodies; Greater London Authority</td>
<td>One per Government Region (9), reviewed as required and highlighted by annual monitoring reports</td>
</tr>
<tr>
<td></td>
<td>Regional economic strategies</td>
<td>Regional development agencies; London Development Agency</td>
<td>As above</td>
</tr>
<tr>
<td></td>
<td>River Basin Management Plans (RBMP); National Park Management Plans</td>
<td>Environment Agency; National Park Authorities</td>
<td>11 RBMPs</td>
</tr>
</tbody>
</table>
Local Plans and programmes have different timescales according to their statutory requirements. Based on current statistics, there are between 300 and 400 plans and programmes subject to SEA being prepared each year in England (most of which are at the local level) but there are peaks and troughs of activity. In addition to the types of plans and programmes outlined above, it is for the RA to decide whether other plans or programmes require SEA.

Plans and programmes covered by SEA are those that are required by legislative, regulatory or administrative provisions (Article 2 of the Directive); they therefore have a different status from health plans, which are usually required as a result of national policy and priorities for the NHS.

It has been established that the SEA Directive does not apply to any NHS plans or programmes. However, the NHS may choose to undertake voluntary SEA on large-scale plans (see Case study box 2). This could result in both financial benefits for a PCT and health benefits for its population. Furthermore, it would build SEA capacity within the PCT, allow an opportunity to demonstrate good practice and support the creation of networks between PCTs and planners.

It is important that national and regional plans and programmes consider the population’s health, as they provide the framework for more localised plans and programmes. The level in the planning hierarchy will also determine the appropriate detail required.
Case study box 2: Voluntary SEAs

Health organisations have found it extremely useful to carry out SA/SEA procedures on plans, programmes and strategies that do not require assessment. An SA was carried out on the West Midlands Health Strategy to ensure all the relevant effects of this important policy were assessed.

www.go-wm.gov.uk/497745/docs/379127/482801/choosinghealth

Spatial plans

England has a ‘plan-led’ system which sets out what can be built and where. The highest tier of this is national policies including planning policy statements (PPSs), which explain statutory provisions and provide guidance to local authorities and others on planning policy and the operation of the planning system. They also explain the relationship between planning policies and other policies that have an important bearing on issues of development and land use. Health considerations are found throughout many PPSs. See also: www.communities.gov.uk/index.asp?id=1143803

Regional planning bodies and local planning authorities must have regard to PPSs in preparing RSS revisions and local development frameworks (LDFs) respectively. LDFs are comprised of:

- local development documents (LDDs) – DPDs and SPDs;
- a local development scheme, setting out the programme for LDD preparation;
- a statement of community involvement (SCI) specifying how the authority intends to involve communities and stakeholders in all aspects of the planning process;
- an annual monitoring report, setting out progress in terms of producing LDDs and implementing policies, and also meeting the requirements of the SEA Directive where applicable; and
- any local development orders and/or simplified planning zones that have been adopted.

SA, incorporating the requirements of the SEA Directive, must be undertaken in preparing RSS revisions, DPDs and SPDs. DPDs, together with the relevant RSS, form the statutory development plan for an area. An overview of the spatial planning system in England is provided in Figure 3.
There are already set processes for involving health organisations and health considerations in planning. For example, strategic health authorities are specified Consultation Bodies for both RSS and LDFs, and are therefore already likely to be involved in the spatial planning process. Similarly, PCTs may already be involved in commenting on emerging SCIs for LDFs.

The Department of Health is developing guidance for the NHS on town planning, and separate guidance for local planning authorities on the NHS. These will be available on the DH website.
Example box 2: Potential health benefits of planning

- To enhance accessibility by foot and by bike and thus to promote healthy exercise and the sense of local community, increasing equity in the access to services for people with poor access to transport.

- To enhance the viability of public transport as a means of increasing travel options and cutting reliance on car use, hence reducing accidents, air pollution and CO₂ emissions.

- To increase the choices open to all sectors of the population – especially people who do not use cars – for access to employment, education, health, shopping and leisure activities.

- To increase the range and quality of residential accommodation, and facilitate finding housing to suit their needs and income.

- To foster the economic buoyancy of settlements, increasing the range of job opportunities and creating the resources needed to both regenerate urban areas and provide services. (Barton and Tsourou, 2000)

Consultation question

Is this sufficient information on types of assessment tools, how they can be linked and what they cover?
Chapter 3: Considering the population's health in SEA

3.1 The European context

Key point box 5: The influence of the environment on health

“However important individual genetic susceptibilities to disease may be, the common causes of the ill health that affects populations are environmental: they come and go far more quickly than the slow pace of genetic change because they reflect the changes in the way we live. This is why life expectancy has improved so dramatically over recent generations: it is also why some European countries have improved their health while others have not, and its is why health differences between different social groups have widened or narrowed as social and economic conditions have changed.” (Wilkinson and Marmot, 2003)

EU guidance on the implementation of the SEA Directive states that “The notion of human health should be considered in the context of the other issues mentioned (eg biodiversity, fauna, flora, soil, water, air and climatic factors) and thus environmentally related health issues such as exposure to traffic noise or air pollutants are obvious aspects to study” (paragraph 5.26). See also: ec.europa.eu/environment/eia/pdf/030923_sea_guidance.pdf

But there are other factors, including potentially positive effects, that need to be considered. The World Health Organization (WHO) Europe view is that a broad definition of health, taking into account social determinants, ought to be used in SEA: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The WHO’s broad conception of health suggests that plans and programmes may be able to influence health in many ways, both directly and indirectly, and will often be synergistic, with different types of impact combining to bring either benefits or adverse influences. See also: www.who.int/about/definition/en/ and for WHO discussion papers about health and SEA: www.euro.who.int/healthimpact
There are some other relevant European-level initiatives:

- The EU Environment and Health Action Plan 2004–2010 has reviewed where it is appropriate to use Health Impact Assessment (HIA), health and environment data quality and gaps for further research.
  ec.europa.eu/environment/health/index_en.htm

- The Transport, Health and Environment Pan-European Programme (THE PEP) was established in 2002 to address the issues of the long-term sustainability of present mobility trends and launched at the World Summit on Sustainable Development.
  www.thepep.org/en/welcome.htm

### 3.2 UK health policy

The benefits of considering health in government plans, programmes and policies has been set out in a number of key national policy documents which recognise the influence of the wider determinants of health:

- *Securing good health for the whole population* Report to the Treasury (Wanless, 2004)
- *Choosing Health: making healthier choices easier* (November 2004)
- *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services* (July 2006)
The Council for Science and Technology has recently published a report *Health impacts – A strategy across Government*, which sets out a series of actions to strengthen the consideration of health across Government.

www2.cst.gov.uk/cst/reports/files/personal-information/csthealthimpacts.pdf

Regional public health groups work with nine departments in the Regional Government Offices, and are involved in regenerating communities, fighting crime, tackling housing needs, improving public health, raising standards in education and skills, tackling countryside issues and reducing unemployment. They participate in developing strategies and most regions have developed an integrated approach to assessing strategies through SEA and sustainability appraisal (SA).

Local strategic partnerships (LSPs) bring together all the key organisations in the public, private and voluntary sector to agree local priorities for action. As outlined in *Strong and prosperous communities*, local authorities (LAs) will have a duty to prepare a Sustainable Community Strategy (SCS). The local development framework (LDF) provides the spatial expression of the SCS. There will be a new statutory requirement for health and well-being under the LSP. There will be a duty on LAs to prepare a local area agreement (LAA) and a duty on named partners, including primary care trusts (PCTs), to cooperate with each other to agree targets in the LAA. Together, these provide the overarching system for developing plans and programmes in the local area so that any specific plans requiring an SA or SEA will be linked into these local networks and planning systems.

The Director of Adult Social Services and the Director of Public Health will have a statutory duty to produce a local strategic health needs assessment covering public health and primary and community care needs of their local population. This will cover health-related data held by PCTs, LAs, youth offending teams, the police, independent providers, voluntary and community organisations, Supporting People, the Department for Work and Pensions, census data and other data holders. It will inform commissioning for health and well-being and the SEA of qualifying plans and programmes.

**Department of Health Public Service Agreement targets relating to the environment**

Key Department of Health (DH) Public Service Agreement (PSA) targets that may be addressed and influenced through the spatial plan-making process and related SEA/SA include:

- improving the health of the population. By 2010 increasing life expectancy at birth in England to 78.6 years for men and 82.5 years for women;
- substantially reducing mortality rates by 2010 from heart disease and stroke and related illnesses by at least 40% in people under 75, with at least a 40% reduction
in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;

- reducing health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth;
- improving access to services; and
- halting the year-on-year rise in obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole (jointly with the Department for Education and Skills and the Department for Culture, Media and Sport).

Other Government PSA targets that contribute to health and well-being are listed in Annex B.

The extent to which SEA can integrate such considerations will vary depending on the type of plan or programme being assessed.

DH policy is to reduce the number of targets nationally so that there is maximum flexibility for locally agreed targets through the LAA process. It is expected that national targets will be reflected in local assessments and that any other targets should be through agreement with regional public health groups or PCTs as part of a duty on partners to have regard to relevant targets.

An assessment of the likely impact on the NHS is set out in Annex B in the Public Sector Threshold Test, which estimates the amount of time and cost of the NHS input into SEA.

### 3.3 Health considerations in SEA

Organisations undertaking SEA need to be able to identify:

- relevant health issues;
- the kinds of effects such plans or programmes might have; and
- how authorities can utilise health information to promote and enhance good health, and minimise or offset any adverse effects which may arise from their proposals.

The following provides an overview of what health covers. More information is provided in Annex D on assessment of effects.
**The determinants of health**

As outlined in Chapter 1, factors that have the most significant influence on the health of a population are called determinants of health and relate to: individual genetic and biological factors; individual lifestyles; the environment; culture and societal structures; and policies. Many factors that affect health are covered through other considerations such as improving education and skills, income, housing, employment, air quality, transport, water and waste disposal.

There is an increasing legal as well as moral and social imperative to tackle inequalities, not only related to socioeconomic factors, but also in relation to age, disability, gender, race, religion or belief, or sexual orientation. Also, due regard to human rights should be taken to ensure everyone is treated with fairness, respect, equality and dignity.

Figure 4 explores the potential effects of the natural and built environment on the population's health.

“People are at the heart of the map, reflecting not only the focus on health but also the anthropogenic definition of sustainable development (Brundtland, 1987) and the range of factors affecting their health and well-being.” (Barton 2006)

“All the different facets of a human settlement are reflected in the series of spheres which move through social, economic and environmental variables. The health and well-being of all sectors of the population is at the centre and this is profoundly affected by personal lifestyle (physical activity, diet and stress levels). Mental well-being and lifestyle choice are in part shaped by the connections to, and the culture of, the social networks and the communities in which individuals participate. These spheres are influenced in turn by the economic opportunities available (income being a key determinant of health), and beyond that the pattern of urban activities and the shape of the built environment. It is often the relationship between spheres which needs attention in developing plans and programmes.” (Barton 2005)
Figure 4: Population health and the environment

Key point box 6: Health inequalities

Health inequalities are one of the DH’s top six priorities for the NHS, which reflects a growing recognition of the impact of social disadvantage on the population’s health. Inequalities in health reflect differential exposure – from before birth and across the life span – to risks associated with socioeconomic position. These differential exposures are also important in explaining health inequalities that exist by ethnicity and gender.

A review of the empirical evidence concerning place as a contributor to health inequalities concluded that while individual characteristics are very important for the health inequalities observed between people, their geographical setting also has some significance. This has implications for policies aiming to reduce health inequalities (Curtis and Jones, 1998). A review of the health inequalities infant mortality PSA has recently been published, which shows that there is scope for reducing inequalities.

DH and the Association of Public Health Observatories (APHO) have produced a targeted health inequalities tool for Spearhead areas primarily for NHS commissioners, but that will also be of use to local authority partners. It focuses on key drivers of local life expectancy gaps and measures to reduce them.
3.4 Direct and indirect effects on population health

There are often multiple factors that influence health and health inequalities and the interactions between them. Figure 5 provides an example by showing the potential effects of traffic volume and speed on physical and mental health.

Figure 5: Potential effects of traffic volume and speed on physical and mental health

Source: West Midlands Public Health Observatory, 2006

3.5 Health in types of plans or programmes

The potential effects on health identified will vary, depending on the type of plans and programmes subject to SEA. Table 2 outlines some possible health effects; however, a more comprehensive list of plans and programmes with health topics to consider can be found in Annex C.
### Table 2: Examples of types of effects on health to be considered by plan type

<table>
<thead>
<tr>
<th>Types of plans</th>
<th>Responsible Authority</th>
<th>Health topics to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional planning body/local planning</td>
<td>Regional planning body/local planning authority</td>
<td>• Community safety&lt;br&gt;• Housing provision&lt;br&gt;• People with low incomes&lt;br&gt;• Access to open space and recreational activities&lt;br&gt;• Affordable food outlets, allotments&lt;br&gt;• Local education and employment&lt;br&gt;• Walking and cycling opportunities&lt;br&gt;• Development of sustainable communities</td>
</tr>
<tr>
<td>transport</td>
<td>Local transport authorities</td>
<td>• Transport to work, shops, schools and healthcare&lt;br&gt;• Walking and cycling opportunities&lt;br&gt;• Community severance&lt;br&gt;• Frequency and severity of crashes&lt;br&gt;• Collisions causing injury and fatal accidents&lt;br&gt;• Air pollution, noise&lt;br&gt;• Ageing population and increasing disability</td>
</tr>
</tbody>
</table>

### 3.6 SEA topics and health evidence

The population’s health is affected by all the different SEA topics so their inter-relationship needs to be considered. For some topics there is a substantial amount of detailed evidence, for example the effects of air quality on the population’s health. However, there are also many gaps, as outlined in the EU environment and health review mentioned earlier in this chapter. It is expected that these gaps will be gradually filled, for example through the EU programme of research on environment and health. Examples of the evidence base can be seen in Table 3 with a more comprehensive table in Annex D.
Table 3: Sample of health evidence of effects of plans and programmes on health

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the plan or programme contribute to climate change?</td>
<td>Climatic factors, air</td>
<td>UK 2006 Climate change programme planning policy statement (PPS) and Climate change – supplement to PPS1</td>
<td>Climate instability and rising sea levels have major long-term health implications through extreme weather events (heat waves, floods and cold). The elderly are more vulnerable to heat as the body’s regulatory systems change with age. Prolonged exposure to heat causes heat exhaustion and heat stroke. Children and infants are especially susceptible. Avoidance or mitigation of adverse effects can make a difference.</td>
</tr>
<tr>
<td>Does the plan or programme encourage walking and cycling?</td>
<td>Climatic factors, air</td>
<td>Department for Transport (DfT) Walking and Cycling Action Plan Walking in towns and cities: Government response to Select Committee Report (2001) DfT sustainable travel policies Choosing Activity: physical activity action plan 2005</td>
<td>Physical activity is one of the best ways of improving overall health and reducing obesity. Neighbourhoods with mixed land use, high population and employment density, street connectivity, pedestrian-oriented design and safety encourage more physical activity, have lower obesity prevalence, and are particularly helpful in reducing social isolation for older people. The proportion of people engaging in physical activity declines with age, particularly after the age of 25.</td>
</tr>
</tbody>
</table>

3.7 How health organisations contribute to the SEA process

Directors of Public Health (DPHs) at national (Department of Health, Health Improvement Directorate), regional and/or PCT level should be the first point of contact for Responsible Authorities seeking a health input. A detailed SEA will benefit from public health input when establishing parameters of the assessment and identifying objectives.

If the DPH decides that health involvement is necessary, then they will be able to give an opinion on issues such as those listed in Key point box 7.
Key point box 7: DPHs’ areas of expertise

- the likely significant effects on the population’s health and well-being of implementing the plan or programme;
- how the population’s health impacts should be considered in all stages of the SEA process, especially in **scoping, objective setting, assessment and monitoring** as appropriate;
- commenting at the scoping stage and on the Environmental Report;
- signposting access to public health information and evidence and advising on the interpretation of health information;
- the quality of, and coverage of the population’s health in the SEA and Environmental Report; and
- how the population’s health information is collected for monitoring progress against objectives.

The DPH will not carry out the health element of the assessment, but will give an opinion on the best way to consider effects on the population’s health through the SEA and the social, economic and environmental elements in SA.

The Health Protection Agency’s local and regional services (LRS) and Public Health Observatories (PHOs) hold information relating to the population’s health and will provide this to the DPHs. How health is organised and what it does is covered in more detail in Annex B.

Contact details for the Regional DPH can be found through the relevant Government Office website.

For the PCT DPH in your area, refer to the NHS website, which has details of all NHS organisations.


Resource box 5: SHAPE – DH tool to support service reconfiguration

The strategic health asset planning and evaluation (SHAPE) is currently under development by DH; it is a web-enabled toolkit designed to support the strategic planning of health and care services and physical assets across a whole health economy.

www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/PrivateFinanceInitiative/InvestmentGuidanceRouteMap/InvestmentGuidanceArticle/fs/en?CONTENT_ID=4133060&chk=1FULSf
3.8 Information sources

There is a large amount of information on possible effects on the population's health from many different sources. More details are given in Resource box 7 in Annex B. As a general rule, it is best to start with information that has already been compiled and analysed.

Standard information

Resource box 6: Standard information on health

DH published the *Health profile of England* in October 2006, which provides a collection of national and regional data to provide a yardstick against which people can compare data from their own local health profile.

Local health profiles, developed by the APHO, are now available for each local authority area. An example of the type of information they provide is in Annex B. They can be found on the following website:

www.communityhealthprofiles.info/

For national and regional plans there are national surveys such as the Health Survey for England, which is an annual survey, undertaken since 1991, allowing national and regional trends to be identified.

www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/fs/en

A Strategic Needs Assessment (SNA), which PCTs and LAs will carry out, will describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs. SNAs form a part of the new duty to cooperate for PCTs and LAs that is contained in the current Local Government Bill. Guidance will be published shortly.

Other sources are listed in Annex B, Resource box 7.

The DH has developed the Information and Intelligence Strategy to support Choosing Health, which aims to improve the availability and quality of health information and intelligence across England and to increase its use to support population health improvement, health protection and work on care standards and quality. A Public Health Desktop is being developed, which will provide a single point of entry to computerised health data such as health and care records and survey data and the National Library for Public Health; and will provide opportunities for networking between communities of practice. It is planned to release Phase 1 in December 2007 and it will be developed over time to meet wider stakeholder needs.
Local authorities hold a great deal of health-related information and Responsible Authorities (RAs) should contact Environmental Health Officers (EHOs) for information on nuisance issues, noise, air quality and food safety as well as other departments such as leisure and recreation, parks, housing, waste management, education and social services. The police, other public agencies and voluntary organisations in the area will also hold health-related information.

Existing documents will also contain relevant information, for example:

- Local area agreements/local public sector agreements;
- data that forms the basis of the community strategy;
- the Chief Medical Officer’s Report for England and PCT Directors of Public Health annual public health reports (APHRs);
- local delivery plans which set out how PCTs intend to achieve key targets and how funding allocations will be used to deliver them.

**Specific health information for plans or programmes**

Health information is divided into data (information to track and monitor progress on national targets and commissioning data) and evidence of health impacts, which is drawn from published research. To focus the information that is relevant for the plan or programme, it is best to briefly explain to the relevant DPH the key aims, objectives and scope of the plan or programme, so that they can guide the RA to the most relevant information source. The RA can then tailor it according to the objective of the plan or programme and focus it on likely key health issues.

Health information can be mapped for the local area using the local health profile or annual public health report. An example from the health profile is in Annex B.

The Health Protection Agency provides information on communicable diseases, chemicals and poisons, radiation, and emergency response to PCTs, and LAs. Further information is in Annex B.

www.hpa.org.uk/default.htm

Public Health Observatories hold health and census data on regions and provide analysis for reports on local health issues, population profiles such as health inequalities, or survey information, e.g. local lifestyle survey information, small area statistics. They also provide access to grey literature. They can be accessed through the APHO website. Further information is in Annex B.

www.apho.org.uk/apho/
3.9 Performance management for population health

To ensure progress is made on improving health, the DH has a system of performance management for the National Health Service. The DH monitors strategic health authority (SHA) performance against national targets and SHAs performance manage PCTs through their local delivery plans which include national and local targets.

The Healthcare Commission regulates and inspects the performance of all healthcare organisations. See Resource box 7 in Annex B for details.

*National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08* states that progress is expected to be made against the developmental standards across much of the NHS:


Participation in the SEA process will support PCTs in meeting the Public Health Developmental Standard D13 which states that health care organisations should:

- identify and act upon significant public health problems and health inequality issues, with PCTs taking the leading role;
- implement effective programmes to improve health and reduce health inequalities; and
- take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

**Consultation question**

Does this chapter cover the right amount of information for practitioners of SEA?
Chapter 4: Stages in the SEA process

Key point box 8: SEA stages and health sector input

It is recommended that the Director of Public Health (DPH) should be the first point of contact for Responsible Authorities (RAs) seeking information on potential effects on the population's health and on the involvement of the health sector in the Strategic Environmental Assessment (SEA) process.

This section sets out the stages of the SEA process, the role that the DPH can play and how RAs can ensure health effects are considered throughout the SEA process.

4.1 Overview

There are five key stages in the SEA process, as outlined in the SEA Practical Guide. To ensure adequate consideration of the population’s health throughout the assessment process, the RA will want to ensure that there is health-sector input at key stages. It is most important to obtain advice at the beginning of the process as to whether there are health impacts and, if so, what input would be appropriate for the SEA (ie ‘scoping in’ significant health effects and ‘scoping out’ minor health effects). Table 4 outlines the key areas where health-sector input will be valuable to the process, and the following sections provide more information on the steps involved at each stage.

Table 4: A summary of the stages of SEA and relevant health-sector input

<table>
<thead>
<tr>
<th>SEA stage</th>
<th>SEA tasks</th>
<th>Potential health-sector input</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage A: Setting the context and objectives, establishing the baseline, deciding on scope</td>
<td>A1: identifying relevant plans, programmes and environmental protection objectives</td>
<td>• Cover key health issues from existing documents</td>
</tr>
<tr>
<td></td>
<td>A2: Collecting baseline data</td>
<td>• Include relevant health data in the baseline, including a review of health evidence</td>
</tr>
<tr>
<td></td>
<td>A3: Identifying environmental problems</td>
<td>• Involve health organisations in objective setting</td>
</tr>
<tr>
<td></td>
<td>A4: Developing SEA objectives, indicators and targets</td>
<td>• Consult Regional DPHs and primary care trust (PCT) DPHs for their opinion on the scope</td>
</tr>
<tr>
<td></td>
<td>A5: Consulting on the scope of SEA</td>
<td>• Identify vulnerable groups</td>
</tr>
</tbody>
</table>
An example of the SEA process for a local plan and time taken for each stage is outlined in Example box 3 and management of the process in Case study box 3.

**Example box 3: West Midlands Local Transport Plan (LTP) timeline**

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEA scoping report</td>
<td>December 2004</td>
</tr>
<tr>
<td>Provisional LTP</td>
<td>July 2005</td>
</tr>
<tr>
<td>Environmental Report and non-technical summary</td>
<td>October 2005</td>
</tr>
<tr>
<td>Technical appendices</td>
<td>October 2005</td>
</tr>
<tr>
<td>Final LTP</td>
<td>March 2006</td>
</tr>
<tr>
<td>SEA statement</td>
<td>July 2006</td>
</tr>
</tbody>
</table>
4.2 Stage A: Setting the context and objectives, establishing the baseline and deciding on scope

The scoping stage of SEA is crucial for setting out the scope of issues to be covered in and the level of detail of the Environmental Report (ER). This will determine both the time input and data sources that the health sector will need to consider as well as provide information about the timescale and processes that will need to be gone through to comply with the SEA Directive. An example is in the following case study.

Case study box 4: West Midlands Regional Spatial Strategy

To ensure representation of relevant stakeholders in this strategy, a reference group has been set up to ensure the process is “open, inclusive and transparent”. This group contains, inter alia, the following groups/partnerships: housing, transport, health, social inclusion, sustainability and rural-urban.

Stage A1: Identifying other relevant plans, programmes and environmental protection objectives

At the scoping stage, information must be provided on the plan or programme’s relationship with other relevant plans and programmes; the relevant environmental protection objectives, and policies and legal requirements should also be considered.

The review is used to determine how the policy, plan or programme may take on board the objectives, requirements or targets of other relevant plans and programmes. It also encourages a more holistic approach to identify where measures may be needed in the plan in relation to existing plans and programmes.
The SEA Practical Guide describes relevant plans and programmes as:

- land use or spatial plans for areas affected by the plan or programme, eg LDFs and component documents;
- plans dealing with aspects of the physical environment, eg River Basin Management Plans; and
- plans or programmes for specific sectors or types of activity, eg regional economic strategies, local transport plans.

Case study box 5 shows how health and equalities can be covered at the scoping stage.

**Case study box 5: Town centre area action plan – health and equalities scoping for sustainable communities**

- high standards of accessibility in the retail, leisure and cultural core of the town centre, particularly for mobility- and sight-impaired;
- public transport links capable of meeting accessibility needs of all;
- sufficient provision for disabled parking;
- improved accessibility for pedestrians, wheelchair-users and sight-impaired people throughout the town centre;
- safe and secure routes and public spaces for vulnerable groups – women, children, elderly, people of all ethnic or religious backgrounds; and
- facilities for specific cultural or faith community needs.

The next step may then include assessing these plans and programmes for relevance to the subject plan and SEA, as outlined in the Example box 4.

Relevant health-related plans and programmes for consideration are illustrated in Key point box 9 and Example box 4.
### Key point box 9: Relevant health-related plans and programmes

<table>
<thead>
<tr>
<th><strong>International:</strong></th>
<th>EU Health Strategy (to be developed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Environment and Health Action Plan and relevant Directives</td>
</tr>
<tr>
<td></td>
<td>World Health Organization (WHO) Regional Health Plans</td>
</tr>
<tr>
<td><strong>National:</strong></td>
<td>Choosing Health</td>
</tr>
<tr>
<td></td>
<td>Our health, our care, our say</td>
</tr>
<tr>
<td></td>
<td>Obesity Strategy</td>
</tr>
<tr>
<td></td>
<td>Strong and prosperous communities,</td>
</tr>
<tr>
<td><strong>Regional:</strong></td>
<td>Regional Health Strategy if available, and other regional</td>
</tr>
<tr>
<td></td>
<td>strategies covering the wider determinants of health</td>
</tr>
<tr>
<td><strong>Local:</strong></td>
<td>Annual public health report</td>
</tr>
</tbody>
</table>

See Example box 4 on the obesity strategy, which identifies key objectives that could become a relevant plan or programme.
Stage A2: Collecting baseline data

The amount of detail on the population’s health will depend on the level (national, regional or local) and the scope of the plan or programme. It is best if information is focused on key local health-related issues and those that are most significant.

RAIs will be able to access standard sources of information as outlined in Resource box 6. It will need to be tailored according to the focus of the plan or programme. The baseline data may need to use proxy information, especially for health determinants.

Example box 4: Obesity strategy

Description: Operating in a strategic context to address wider, long-term obesity issues, alongside the Foresight Obesity Project, the Public Service Agreement (PSA) target on childhood obesity (see section 3.2) will be delivered using a tiered approach, ranging from general preventative population-based interventions to holistic targeted interventions aimed at secondary prevention and treatment.

Objectives, requirements and targets: The obesity strategy aims to:

- support national initiatives that will have an impact on obesity through creating a positive environment to change eating behaviour and physical activity patterns;
- adapt universal programmes to focus on early interventions that will target children and families at risk of becoming overweight or obese; and
- support for holistic local targeted initiatives aimed at secondary prevention and treatment of overweight and obese children, together with their families.

The target is “to halt, by 2010, the year-on-year increase in obesity among children under 11 in the context of a broader strategy to tackle obesity in the population as a whole”.

Implications for subject plan and SEA: Consider the opportunities for promoting active lifestyles and healthy eating by taking into account:

- Food Standards Agency and National Consumer Council food access mapping toolkit, available at: www.foodvision.gov.uk/pages/food-mapping
- Other cross-government obesity prevention toolkits.
Requests for health information should relate to existing data collections only as any new data collection that applies to all the NHS will need to be approved at national level through the Review of Central Returns (ROCR) at the Information Centre for health and social care.

An SEA will need to consider the evidence base that underpins the assessment in relation to the population’s health. Evidence includes: published evidence (eg peer-reviewed articles and “grey” literature); local data such as community profiles and census data; and stakeholder experience from write-up of workshops, surveys and consultation reports. The extent of evidence available on environment and health is very variable. Topics traditionally used in Environmental Impact Assessment such as air quality and noise have a substantial body of evidence, although health effects may be limited to meeting certain standards, whereas social impacts such as community cohesion have a less robust evidence base. Examples of evidence for SEA topics can be found in Annex D.

Evidence can be both quantitative (eg assessing the amount) and qualitative (eg assessing stakeholders’ views). In considering the population’s health, it is necessary to evaluate both approaches. It is important to consider the direct and indirect health effects and their interrelationships with other topics covered by SEA such as air, water and climate change.

Evidence-based estimates are not definite facts and so RAs may look to DPHs or public health professionals to help interpret such data. It is not recommended that RAs interpret raw health data without some form of specialist public health advice. Causality is often not clearly linked to a certain health determinant and the level of uncertainty should be understood and made plain. It might be more helpful for RAs to focus on outcomes.


The key to getting the best evidence is to ensure the right questions are asked. The proposed plan or programme should be examined to formulate the correct questions. Decisions at the scoping stage will help focus the approach. If there is limited information available, this needs to be acknowledged. DPHs can advise on the best sources of information for the relevant plan or programme in response to specific questions from the RA.

At this stage, an option might be for RAs to review the evidence base to see if a significant gap has been identified. If there is, this will need to be acknowledged and consideration given as to how this could be filled as part of the RA’s assessment process.
There are an increasing number of reviews of evidence on the environment and health which should prevent the need for new reviews. An example is the Milton Keynes review, Healthy sustainable communities, which covers many of the health-related effects, plans and programmes requiring an SEA, available at: www.mksm.nhs.uk//FileAccess.aspx?id=148. The Royal Commission on Environmental Pollution has published its report covering environmental impacts on health and well-being, available at: www.rcep.org.uk/urbanenvironment.htm

The prioritisation of health and well-being baseline data may be achieved by utilising a risk-based approach to balance the importance of effect and probability (see Table 5).

<table>
<thead>
<tr>
<th>Effect (beneficial or adverse)</th>
<th>Probability</th>
<th>Significant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>HIGH</td>
<td>YES</td>
</tr>
<tr>
<td>HIGH</td>
<td>LOW</td>
<td>MAYBE (if there is an exceptionally high effect)</td>
</tr>
<tr>
<td>LOW</td>
<td>HIGH</td>
<td>MAYBE (cumulative effects may result in significant effects)</td>
</tr>
<tr>
<td>LOW</td>
<td>LOW</td>
<td>NO</td>
</tr>
</tbody>
</table>

There are other decision-making tools to help measure health impacts, such as matrices.

Guidance on quantification can be found on the DH website link to HIA: www.dh.gov.uk/assetRoot/04/09/54/14/04095414.pdf

**Case study box 6: Poole town centre area action plan**

Health issues were implicit in the scoping report and included:

- providing shelter for homeless people and addressing the implications of reducing informal areas of shelter (such as subways);
- providing housing with high energy-efficiency standards;
- ensuring public transport links are capable of meeting all accessibility needs;
- preventing pollution and using sustainable urban drainage systems;
- providing health facilities commensurate with development and residents’ needs; and
- retaining/enhancing open spaces and links.
Stage A3: Identifying environmental problems

Baseline data can be used to identify environmental problems and issues that should be taken into account when developing SEA objectives. Depending on the type of plan or programme being assessed, there may be various issues of interest and opportunities to explore them. Table 6 is an example of potential health-related environmental considerations. Further suggestions are in Annex C.

<table>
<thead>
<tr>
<th>Type of plan or programme</th>
<th>Responsible Authority</th>
<th>Potential health considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waste management plans</td>
<td>Local authority</td>
<td>• Emissions to air</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dust emissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Noise, odour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pollution to surface water and groundwater</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transportation</td>
</tr>
</tbody>
</table>

Stage A4: Developing SEA objectives, indicators and targets

SEA objectives are assessment tools developed by the RA. SEA objectives are separate from objectives contained in the plans and programmes. The different types of objectives are explained below.

- **SEA objectives:** these are to identify the effectiveness of the plan or programme, eg to protect biodiversity. The test would then be: do the strategic actions of the plan or programme help to achieve this objective, or work against it?

- **Plan or programme objectives:** these indicate the success of the plan or programme itself, and are usually adopted through a process of expert consideration, public consultation and political approval. They may also include social or economic issues relevant to the plan or programme.

- **Environmental protection objectives:** these are the goals for environmental protection set out in international and national legislation and policy.

Objectives are used to develop a systematic, rigorous and consistent framework with which to assess environmental impacts. An SEA objective is a goal for a particular environmental parameter: the assessment asks whether the plan or programme furthers this goal or works against it. For example, if an SEA objective is to “improve the health of residents and reduce health inequalities”, the assessment would then consider whether or not the strategic actions of the plan or programme would move towards this objective.
The SEA process is a ‘policy aiding’ not ‘policy-making’ tool. The Directive and associated Regulations do not prescribe that the final plan or programme should incorporate the best environmental option or the recommendations of the ER. It does, however, provide policy formulators with evidence and information upon which to base decisions.

It is desirable that public health professionals are involved in setting objectives which are key for the assessment process. They will be able to relate them to health targets and the wider determinants of health. Many of the objectives relating to the environment will indirectly cover health, but there may need to be ones that focus specifically on health, particularly around health inequalities, as often these issues are not picked up in other assessments. Clear goals are needed to track movement towards objectives, especially in long-term plans such as LDFs.

Objectives can be expressed either as goals, outcomes or outputs, the achievement of which may be measurable using indicators. Objectives, indicators and targets can be revised as baseline information is collected and environmental problems and opportunities identified, and can be used in monitoring the implementation of the plan or programme.

**Case study box 7: Cardiff City Council**

Objectives and indicators were developed from issues arising from the policy review and an issues workshop. They were based on evidence and key issues, and were discussed with health professionals. An overarching objective with sub-objectives informing indicators was refined during the consultation process.

**Case study box 8: Poole LDF**

**Identifying key relationships between sustainability objectives and health**

Does the sustainability objective have implications for:

- health facilities: level of provision and accessibility?
- safety and security of places and routes?
- addressing health and welfare needs of the elderly?
- addressing health and welfare needs arising from social exclusion?
- access to recreation and open space and promoting participation?
- climate change: providing shelter and protection from heat, cold or flooding?
- reducing air pollution and its health impact?
It is very important to get the objectives right and, as an example of best practice, it is worthwhile taking the time to consult widely so that they reflect the priorities of stakeholders and the public. They should be broad, relate to the needs of the relevant population and be capable of being monitored for significant changes or to show when the objectives have been met. They must also be relevant to the plan or programme that is being assessed in terms of what it can realistically achieve in health terms.

Hierarchy of objectives
Experience so far suggests that it is helpful to have a small number of overarching objectives with a series of sub-objectives which can then be broken down into indicators and targets, where appropriate, for monitoring purposes. Figure 6 shows an example of how this can be done.

**Figure 6: Hierarchy of objectives**

[Diagram showing the hierarchy of objectives with layers for overarching objectives, sub-objectives, indicators, and baseline data.]
Indicators
A series of indicators can be identified which can be tracked or measured to establish whether progress has been made towards achieving the intended outcomes and objectives of the assessment.

There are already a number of indicators available, such as those developed by the Association of Public Health Observatories (APHO). Examples include the local authority health profiles (www.communityhealthprofiles.org.uk), and the “basket of indicators” for smaller geographical areas, available on the London Health Observatory website at: www.lho.org.uk

Throughout this process, the choice of indicators and decisions about how these are to be monitored should be developed in consultation with the DPH and be based on information that has already been collected.

There is considerable potential for the development of information systems within which standard indicators may be made available for the purpose of an SEA. Examples include the possible inclusion of such variables within the Public Health Desktop, or purpose-built systems for collecting and sharing data such as the I-Gather system, a multi-agency pilot system being developed in conjunction with South West Public Health Observatory. For more information, see: www.swpho.nhs.uk

Probability/causality
It will be necessary to consider a number of factors that can impact on health. It is not enough simply to have evidence of correlation; what is needed is a transparent assessment of causality. For example, one could argue that the provision of a particular facility such as day care may affect mental health, but there will also be many other causes of mental health problems in the local population.

In many circumstances it may be necessary to use proxy indicators, eg the number of patients on a particular GP disease register for coronary heart disease could be used as an indicator of comparative prevalence of heart disease.

Targets
Where targets are used they should include those relevant to the plan or programme, statutory requirements and national PSAs as well as local ones agreed through Local Area Agreements. Furthermore, they should facilitate a meaningful measurement of progress towards an objective.

Tracking will depend on the existing data available. Proxy information may need to be agreed for tracking whether or not targets have been met.
It may be helpful to develop targets over time in response to locally agreed data collection systems to reflect what is possible and feasible to collect.

**Monitoring health information**

A great deal of information is collected on a regular basis through mortality statistics, Hospital Episode Statistics and general practice systems and is reported for national and local targets. It is best to use these existing measures. Some may be a proxy where there is not an exact match. Other information will be found in robust survey data and reviews of evidence and research.

It is important to understand the actual impact of the plan on the factors that it is trying to change and then monitor progress and build in evaluation. This can be tested through consultation.

Some examples of objectives, indicators and targets are given in Table 7.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Objective</th>
<th>Indicator</th>
<th>Target</th>
</tr>
</thead>
</table>
| **Unitary Development Plan**              | Provide a healthy and safe environment                                      | - Percentage of new housing accessible to major public open space  
- Percentage of new housing with access to:  
  - health facilities: clinics, GPs and hospitals, etc  
  - educational facilities: primary and secondary schools  
  - community facilities: library, police, post office, shops and local shopping  
- Percentage of “affordable housing” within and outside settlements  
- Unemployment rates for men and women  
- Amount of new businesses and employment created  
- Employment in agriculture and farm diversification | Targets set by monitoring  
- Targets set by monitoring |
<table>
<thead>
<tr>
<th>Plan</th>
<th>Objective</th>
<th>Indicator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Transport Plan (LTP)</td>
<td>SEA objectives</td>
<td>Number of people killed and seriously injured on roads</td>
<td>Targets are linked to the LTP targets:</td>
</tr>
<tr>
<td></td>
<td>• Reduce people’s exposure to high noise levels and transport-induced vibration</td>
<td>• Number of children killed or seriously injured on roads</td>
<td>• A 40% reduction in all key success indicators (KSIs) from the 1994–98 average to 2010, and a 30% reduction from 2004 to 2010</td>
</tr>
<tr>
<td></td>
<td>• Improve the health of metropolitan residents, reduce health inequalities and improve access to health facilities</td>
<td>• Number of slight casualties on roads</td>
<td>• A 50% reduction in child KSIs from the 1994–98 average to 2010, and a 35% reduction between the 2002–2004 average and the 2008–2010 average</td>
</tr>
<tr>
<td></td>
<td>• Reduce the number of road accidents (particularly in deprived areas) and accidents on public transport and pavements</td>
<td>• Percentage of children travelling to and from school by different transport modes</td>
<td>• A 10% reduction in slight casualties from 2004 to 2010</td>
</tr>
<tr>
<td></td>
<td>• Reduce the number of crimes (and fear of crime)</td>
<td>• Cycling trips indicator</td>
<td>• Increase the total population within 30 minutes inter-peak travel time of a main NHS hospital by “accessible” public transport from the 2005 baseline of 580,000 by 50% by 2011</td>
</tr>
<tr>
<td></td>
<td>• Improve accessibility of goods, opportunities and services to all, particularly those in disadvantaged communities</td>
<td>• Increase in cycling</td>
<td>• A 1% increase in the cycling index between 2003/04 and 2010/11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improved accessibility to a main NHS hospital</td>
<td>• Increase the number of people attending job interviews per year via “access” initiatives from the 2005 baseline of 1,150 to 2,300 by 2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Change in number of road casualties or deaths</td>
<td>• Improve actual and perceived personal safety whilst travelling on public transport by 10% between 2005/06 and 2010/11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adoption of Rights of Way Improvement Plans (ROWIPs)</td>
<td>• Adoption of ROWIPs by 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increase in the number of people attending job interviews per year via “access” initiatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Number of new dwellings within 250m of a local network stop with a service between 0700 and 2000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve actual and perceived personal safety whilst travelling on public transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Stage A5: Consulting on the scope of SEA**

As outlined in Chapter 2, RAs must seek the views of the Consultation Bodies at key stages of the SEA process. It may also be useful to consult other organisations and individuals concerned in order to obtain information and opinions. Consultation may occur more than once where plans and programmes are developed in several stages, for example in spatial planning.

They should also consider contacting the relevant DPH to discuss the scope, issues and implications of the plan or programme where consideration of the population’s health is concerned. Where steering groups are used, the involvement of relevant partners can help to oversee the process and ensure that it focuses on the key issues and keeps everyone informed of timescales and progress. This will save time and unnecessary work as well as helping with determining the significance of key health issues.

The health definition of “significant” is that it refers to the whole population, a major sub-group of the population or the degree of severity of the impact as set out in the health assessment screening guidance, available at: www.dh.gov.uk/PublicationsAndStatistics/Legislation/HealthAssessment/fs/en. This needs to be linked with Annex II of the SEA Directive, which outlines criteria for determining the likely significance of effects as part of the screening stage and Stage B, eg considering effects in terms of scale and permanence, the nature and sensitivity of the receiving environment. Moreover, as what is “significant” may vary depending upon the plan or programme type, the area it covers and the extent of existing health issues, it is recommended that the significance criteria used are clearly stated in the relevant documentation.

**Case study box 9: Dorset SEA Group**

This was set up in response to concern amongst local authorities over the workload implications of the SEA Directive. The representatives (local authorities, Consultation Bodies, economic and social stakeholders – including Bournemouth & Poole PCT) and the Government Office for the South West agreed a protocol that would encourage good practice and enable the pooling of resources.

The benefits for all organisations involved in SEA are in:

- identifying key milestones for stakeholders;
- working towards common baseline information; and
- giving opportunities for joint working and scrutinising the assessment.
4.3 Stage B: Alternatives and assessment

Good practice suggests that RAs would benefit from including DPHs in considering alternatives, refining options and developing mitigation measures of negative effects and enhancing positive impacts based on outcomes of the SEA scoping process. More information is in the SEA Practical Guide.

Stage B1: Testing the plan or programme objectives against the SEA objectives

This stage involves RAs testing the plan or programme’s objectives against SEA objectives which may help identify potential synergies and inconsistencies and inform the development of alternatives. This should be carried out in a transparent way and it is therefore necessary to distinguish between expert opinion (understanding the problem) and quantification (how big it is).

Stage B2: Developing strategic alternatives

RAs are required, as part of the SEA process, to appraise the likely significant environmental effects of a plan or programme and any reasonable alternatives. Each of the alternatives, or different ways of meeting a plan or programme’s objectives, can be tested against the SEA objectives. Effects considered can be both positive and negative, and there can be some uncertainty about the nature or significance of identified effects.

Alternatives or “scenarios” that are often considered include “no plan or programme” (not introducing a plan or programme where none already exists), no further action to implement a plan or programme and “business as usual” (continuation of an existing plan or programme). RAs should ensure that each alternative is clearly defined.

Stage B3: Predicting the effects of the draft plan or programme, including alternatives

The prediction of effects of the draft plan or programme includes any changes to the baseline without the plan or programme (ie what will happen without the plan). This will be informed by information on trends identified in the review of baseline data.

Each alternative should then be assessed against the SEA objectives, ie what will be the effect of the plan compared with if there was no plan. The magnitude, geographical scale, time period of effects, and whether effects are permanent or temporary, positive or negative, probable or improbable, frequent or rare, and whether or not there are secondary, cumulative and/or synergistic effects should be described. Finally, the environmental effects of the alternatives identified should be compared.
WHO’s broad conception of health (well-being, not merely the absence of disease) in itself suggests that plans and programmes may influence health in many ways. Some of their effects are direct and self-evident, and many of these are already recognised, but others are indirect and may not be readily apparent. It is also important to be aware that the effects of plans and programmes on health will often be synergistic, with different types of impact combining to bring about both beneficial and adverse consequences.

Assessment of health within SEA should focus on identifying those who are particularly vulnerable through age, employment status, different cultures, language and disability. People who live in deprived areas have poorer health than those living in more affluent areas. A particular priority is to tackle health inequalities. Plans and programmes need to ensure that they are not shifting problems from one area to another, e.g. gentrification, immigration or migration.

It is not realistic to expect RAs carrying out SEA to have expert knowledge of the potential effects, beneficial or harmful, of their plans and programmes on health. Nor would it be practicable to attempt new studies to predict the effects of their proposals. In many cases, however, they should be able to rely on existing research and knowledge.

The table in Annex E provides examples of typical questions that authorities or practitioners might consider in SEAs of plans or programmes, together with notes on accepted links between these issues and the health of individuals and social groups. The questions are loosely ranged according to the rings in Figure 4 on page 32:

- direct environmental impacts on health, such as those from traffic accidents, pollution, noise or climate change;
- factors affecting healthy lifestyle: reducing car use, public transport, facilitation of walking and cycling;
- factors related to communities and living conditions: impacts of crime on communities, availability of facilities, services and quality of housing, indoor air quality, etc;
- local economy, employment issues and income – a major influence on health;
- activities and community design matters: community cohesion or severance/fragmentation; and
- built or natural environment issues: subjective but demonstrable influences on mental states and well-being.


If there is conflicting evidence, the principles used to draw conclusions should be stated explicitly, for example the weight given to the evidence could be determined using an assessment of the quality of the data. In some cases it may not be possible to reach a conclusion. At times there may be trade-offs. This is where an expert, such as a public health professional, needs to form a judgement in relation to relevance, significance, and weighing the balance of impact and probability. Public consultation can also contribute to making a decision.

**Stage B4: Evaluating the effects of the draft plan or programme, including alternatives**

This stage involves the evaluation of whether or not a predicted effect will be environmentally significant.

Analysis of likely significant effects should include secondary, cumulative, synergistic, short-, medium- and long-term, permanent and temporary, positive and negative effects, based on the criteria in Annex II of the SEA Directive, and the definition in Stage A5.

Often significant issues at the beginning of an assessment change by the end of the process, especially when resources need to be allocated. A quantitative approach, which assesses how much the plan meets certain needs and what the results of these would be, will help to show how to inform decisions.

**Cumulative effects**

Cumulative effects are particularly important to consider in relation to health, as the gradual build-up of, for example noise, can have long-term and significant effects that can lead to long-term or chronic illness.
Table 8: Examples of cumulative effects

<table>
<thead>
<tr>
<th>Topic</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of residence</td>
<td>Conditions in the area of residence during childhood appear to have had a measurable association with health outcomes later on in life (Curtis et al, 2004)</td>
</tr>
<tr>
<td>Noise, residential overcrowding, housing quality</td>
<td>Cumulative environmental risk exposure amongst low-income families may contribute to bad health, beginning in early childhood (G. W. Evans et al, 2004)</td>
</tr>
<tr>
<td>Infrastructure such as community centres, libraries</td>
<td>These provide local people with opportunities to decide, resulting in community empowerment, informed choice, better lifestyle and better housing (Curtis et al, 2002)</td>
</tr>
<tr>
<td>Housing</td>
<td>The periodic approval of additional dwelling units in an urban area can, over time, lead to significant pressures on local health services and other facilities</td>
</tr>
<tr>
<td>Obesity</td>
<td>Key contributors to reduced physical activity in the UK population are the use of cars for short journeys, sedentary occupations, lower sports participation, parental reluctance to allow children to play outdoors, increased time pressures reducing school sport, and greater TV and computer use (Wanless 2004)</td>
</tr>
</tbody>
</table>

Stage B5: Considering ways of mitigating adverse effects

Where significant adverse effects are predicted, the ER should include mitigation measures to prevent, reduce or offset these effects when implementing the plan or programme.
Table 9: Examples of mitigation

<table>
<thead>
<tr>
<th>Policy</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working in the North West</td>
<td>Recognise the importance of a healthy population and robust environment to a successful economy.</td>
</tr>
<tr>
<td></td>
<td>Recognise the importance of local, healthy food retailing to local communities in addition to the policy focus on convenience shopping.</td>
</tr>
<tr>
<td></td>
<td>(North West Regional Assembly Sustainability Appraisal of the NW Regional Spatial Strategy)</td>
</tr>
<tr>
<td>Living in the North West Ensuring a strong, healthy and just society</td>
<td>Consider the importance of engaging with local communities as well as the house-building industry.</td>
</tr>
<tr>
<td></td>
<td>(North West Regional Assembly Sustainability Appraisal of the NW Regional Spatial Strategy)</td>
</tr>
<tr>
<td>Social impacts of Local Transport Plan (LTP)</td>
<td>For accessibility, policies and proposals that reduce the ability of people to easily reach key community facilities such as workplaces, schools and hospitals should be avoided, and measures to improve access should be actively pursued.</td>
</tr>
<tr>
<td></td>
<td>(SEA of the Brighton and Hove LTP)</td>
</tr>
<tr>
<td>Social impacts of LTP</td>
<td>For health, policies and proposals of the plan should not impact adversely on the health of local people, especially those in sensitive groups such as the young and very elderly. Measures to reduce the effects of noise and air quality, and improvements in road safety, should have a benefit. Policies aimed at promoting walking and cycling would also be likely to raise levels of physical activity, with consequent health benefits.</td>
</tr>
<tr>
<td></td>
<td>(SEA of the Brighton and Hove LTP)</td>
</tr>
</tbody>
</table>

Stage B6: Proposing measures to monitor the environmental effects of plan or programme implementation

RAs are required to propose measures to monitor the significant environmental effects (both positive and negative) of the plan. These measures should be considered early in the SEA process, reflect consultations with stakeholders including the DPH, and be finalised throughout the course of preparing the plan or programme. Stage E involves implementing such measures.
4.4 Stage C: Preparing the Environmental Report

The ER is a public document and will be subject to consultation, when views from the public and stakeholders are invited. These views are then taken into account prior to adoption of the plan and are described in the SEA statement at the end of the process.

Health should be clearly visible within the ER. It is helpful to bring together the various elements that will affect the population's health, possibly in a separate section with cross-references to health effects in other sections, so that people can see how health considerations have been considered and addressed. Any significant adverse or beneficial health effects in the preferred option and alternative should be clearly stated.

The SEA Practical Guide provides a checklist for quality assurance purposes.

4.5 Stage D: Consultation and decision making

The ER must be made available at the same time as the draft plan or programme, as an integral part of the consultation process, and the relationship between the two documents clearly indicated.

It is worth noting that HIA practitioners have developed creative ways of engaging with the public through a variety of consultation and involvement techniques ensuring that people who do not usually take part in consultations have a mechanism for expressing their views. These could be used, and contacts made with health organisations to tap into their Local Involvement Networks (LINks) which work with existing voluntary and community sector groups, as well as with interested individuals to promote public and community influence in health and social care. It is often more effective if the questions relate to health outcomes, e.g. obesity or quality of life issues. Consultation should be participatory, not just provision of information. Other useful consultation suggestions are found on the community planning website at: www.communityplanning.net/

At local level, PCTs will coordinate the health response and include NHS trusts and additional organisations as appropriate, and suggest mitigation of adverse effects.

The SEA Directive requires the information in the ER and the responses to the consultation to be taken into account in the preparation of the plan or programme and before the final decision is taken to adopt it. RAs must produce a summary of how they have taken these findings into account, and information about how monitoring will be carried out.

When the plan or programme is adopted, it has to be made available to the public, Consultation Bodies and EU Member States where these have been consulted.
4.6 Stage E: Monitoring implementation of the plan or programme

The Directive’s provisions for monitoring apply when the plan or programme is being put into effect, rather than during its preparation and adoption, although preparations for monitoring will need to be considered in the course of preparing the plan or programme and in earlier stages of the SEA process.

Monitoring must compare objectives with outcomes, and whether they have been achieved. There should be a continual process of checking to allow for adjustment over time, depending on the life-span of the plan or programme. It is especially important for secondary and cumulative effects, and offers opportunities for identifying synergies.

RAs will need to ensure that systems are in place through the relevant organisations for collecting and monitoring the health-related information and for regular review of progress against the objectives. This should be based on what is routinely collected by health organisations.

The SEA monitoring process can then show how the population's health status changes over time (ie showing trends).

The DPH will ensure that the data used for ERs is updated and integrated into health surveillance systems.

Case study box 10 shows how monitoring and mitigation measures were addressed in the West Midlands LTP.
Case study box 10: West Midlands LTP SEA statement

This document was prepared to accompany the final LTP before its implementation and monitoring of effects are carried out.

The LTP seeks the active promotion of cycling and an improvement in air quality, with monitoring to ensure the following targets have been met:

- a 1% increase in the cycle index; and
- a 1% local reduction of nitrogen dioxide levels.

Mitigation measures against the increased carbon dioxide emissions due to a predicted 14% growth in car trips include:

- greater centralisation promoted by the Regional Spatial Strategy;
- the use of demand management measures; and
- solar-powered lighting at 200 bus shelters.

Centralisation should limit the growth in vehicle kilometres to only 8%, and the solar-powered lighting will cut greenhouse gas emissions by 13 million tonnes per year.

Consultation question

Are there any aspects of health and well-being that have been left out of the SEA stages?
Annex A: Devolved administrations information

Scotland

The Environmental Assessment (Scotland) Act 2005 requires all public sector policies, plans and programmes to be subject to SEA.

SEA guidance

Scottish SEA toolkit (Chapter 11 Human health):

Health organisation contacts

The Scottish Public Health Observatory (www.scotpho.org.uk/)

ISD Scotland (www.isdscotland.org/isd/CCC_FirstPage.jsp) provide access to most health data sets in Scotland. This data needs to be interpreted with care; public health specialists are well placed to do this.

Health Protection Scotland (www.hps.scot.nhs.uk) is the national health protection agency providing support and expertise to local health protection teams

Support and advice about Health Impact Assessment (HIA) is available from the Scottish HIA Network (www.healthscotland.com/resources/networks/shian.aspx).

SEA Consultation Bodies

In Scotland these are referred to as Consultation Authorities. They are:

Scottish Ministers (Historic Scotland)
Scottish Natural Heritage
Scottish Environment Protection Agency
Wales

Health organisation contacts

National
Welsh Assembly Government: Office of the Chief Medical Officer, Department of Health and Social Services
National Public Health Service
Wales Centre for Health
Welsh Local Government Association

Regional
NHS Wales Regional Offices: North West, South East, Mid and West.
Regional Directors of Public Health

Local
Local Health Boards (Chief Executives)
Local Directors of Public Health
Local authorities

SEA Consultation Bodies

Wales – Cadw (Welsh Historic Monuments)
Countryside Council for Wales
Environment Agency Wales

Northern Ireland

Health organisation contacts

Department of Health, Social Services and Public Safety – Investing for Health Team
www.investingforhealthni.gov.uk/
Institute of Public Health in Ireland
www.publichealth.ie
Health Estates Agency
www.dhsspni.gov.uk

SEA Consultation Bodies

The Department of the Environment’s Environment and Heritage Service
Annex B: Health organisations in England – roles, responsibilities and information

There are many different organisations involved in contributing to the population’s health and health care. The main functions are:

- commissioning health care to meet the needs of the population;
- providing health and care services from NHS trusts, private healthcare organisations and the voluntary sector; and
- engaging with the population to improve their health and well-being.

Figure 7 is a summary of the relevant health organisations and the information they hold.

Figure 7: Organisations providing health-related information in England

Environmental effects on health and health services

The demand on health services is increasing and, with the increasing numbers of older people, faces significant challenges in delivering health care. The impact of the environment on health has been estimated in the evaluation of the Air Quality Strategy.
Health functions carried out by the NHS and other health organisations

The Department of Health (DH) is responsible for setting policy and funding and supporting the NHS. There are DH regional public health groups in each region, which work with other government departments on issues relating to the population’s health.

Strategic health authorities (SHAs) performance manage primary care trusts (PCTs). Their main functions are:

- strategic leadership for innovation and reform;
- organisational and workforce development; and
- ensuring local systems operate effectively and deliver improved performance.

PCTs are responsible for promoting health and emotional well-being, with stronger local services and support to reduce the prevalence of physical and mental illness (NHS, 2006). Their main functions are:

- engaging with their local population to improve health and well-being;
- commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors; and
- directly providing high quality responsive and efficient services where this gives best value.

NHS trusts, private healthcare organisations and the voluntary sector provide healthcare services.

Example box 5: Impact of improved air quality on healthcare costs

The evaluation report shows that the policies in the road transport sector and the electricity generating sector have had a major impact in reducing air pollutant emissions. They have also had a major effect in improving air quality and ensuring progress towards the UK air quality objectives and European air quality limit values.

In addition they have resulted in extremely large benefits by reducing the health and environmental impacts of air pollution, with road transport policies achieving benefits worth £2,941 to £18,370 million and policies in the electricity generating sector achieving benefits worth £10,809 to £50,609 million between 1990 and 2001. The majority of these benefits were as a result of improvement in health.
Health activity

Health improvement

Health improvement activity focuses on individuals’ health in terms of leading healthier lifestyles and working with community and environment-based initiatives that seek to address the wider determinants of health as well as personal health. For example health improvement staff will work with populations to increase levels of activity and healthy eating to reduce the levels of coronary heart disease and cancer.

There is a lot of evidence to show that housing, education, employment, transport and community safety can impact on the population’s health and well-being.

Prevention of ill health

Preventing ill health and enabling people to play a full role in their local communities are key parts of the Government’s work on regeneration and building sustainable communities. The quality of the environment, for example air and water, is vital to health and is an important aspect of health protection. Access to green spaces, clean and safe open air spaces where people can meet and exercise informally, and planning and design that encourage walking and cycling are all important factors in supporting health and well-being.

Education and training is provided for lifestyle advice, for example to manage asthma, or to identify factors that cause illness, such as the quality of food and water. Monitoring and/or surveillance is carried out by Environmental Health Officers (EHOs) in local authorities, the Health Protection Agency (HPA) and PCTs, and through primary care data.

Other government departments’ contributions to preventing ill health are shown in Table 10.
Table 10: Other government departments’ Public Service Agreement (PSA) targets related to health and well-being

<table>
<thead>
<tr>
<th>Government department</th>
<th>PSA targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department for Environment, Food and Rural Affairs</td>
<td>Promote sustainable development. Protect the public’s interest in relation to environmental impacts and health</td>
</tr>
<tr>
<td>Department for Transport</td>
<td>By 2010, increase the use of public transport (bus and light rail) by more than 12% in England compared with 2000 level, with growth in every region</td>
</tr>
<tr>
<td>Department for Communities and Local Government</td>
<td>Tackle social exclusion and deliver neighbourhood renewal, in particular narrowing the gap in health education, crime, worklessness, housing and liveability outcomes between the most deprived areas and the rest of England, with measurable improvement by 2010</td>
</tr>
<tr>
<td>Home Office</td>
<td>That people are and feel more secure in their homes and daily lives</td>
</tr>
<tr>
<td>Department for Work and Pensions</td>
<td>Promote work as the best form of welfare for people of working age, while protecting the position of those in greatest need</td>
</tr>
<tr>
<td>Department for Education and Skills</td>
<td>Safeguard children and young people, improve their life outcomes and general well-being and break cycles of deprivation</td>
</tr>
</tbody>
</table>

Health protection

There are specific programmes of disease and illness protection such as childhood immunisation programmes and influenza vaccination for elderly or vulnerable people.

The Health Protection Agency’s Centre for Radiation, Chemical and Environmental Hazards (CRCE) has two divisions covering chemical hazards and radiation protection. These provide advice to UK government departments and agencies on the human health effects from chemicals in air, soil, water and waste, and on the health effects of ionising and non-ionising radiation. Advice is also provided to support the NHS and in response to potential health care emergencies including possible acts of deliberate release. The CRCE also undertakes research to advance knowledge in these areas.

Treatment of ill health

This is provided through the NHS by trusts (primary care trusts, care trusts, hospital trusts, mental health trusts and foundation trusts) as well as through independent practitioners or through service level agreements with private or voluntary sector organisations.
Health organisations which can contribute information for plans and programmes

National level plans and programmes

The Department of Health (DH) is responsible for improving the health and well-being of people in England. The Health Improvement Directorate will be the first point of contact for national Strategic Environmental Assessments (SEAs) for both the process and access to data, together with the relevant national agencies and organisations.

The Information and Intelligence Strategy originates from Choosing Health: making healthy choices easier to support wider health priorities such as action on health inequalities, health protection and effective commissioning of health and well-being. A public health desktop is being developed as one of the workstreams bringing together data, evidence and experience of practitioners through communities of interest.

The Health Protection Agency’s (HPA’s) role is to provide an integrated approach to protecting the health of the UK’s population through the provision of support and advice to the NHS, local authorities, emergency services, other arm’s length bodies (eg National Institute for Health and Clinical Excellence), DH and the devolved administrations.

The HPA has a network of staff based regionally and locally throughout England and Wales, known as the Local and Regional Services (LaRS). It has three major centres providing specialist services. The Centre for Radiation, Chemical and Environmental Hazards is based at Chilton and provides advice to UK government departments and agencies on human health effects from chemicals in air, water, soil and waste and on the health effects of ionising and non-ionising radiation as well as information and support to the NHS and health professionals on toxicology. The Centre for Emergency Preparedness and Response, focusing on applied microbiological research and emergency response, is based at Porton.

The HPA provides an annual report and collates Health Protection Unit (HPU) activity from LaRS relating to specific topics. It provides technical advice to PCTs to support their statutory role in the Integrated Pollution Prevention and Control (IPPC) regime. www.hpa.org.uk

The Association of Public Health Observatories (APHO) is a network across 12 PHOs in the UK and Ireland sharing scarce health intelligence skills.

Central to this is a series of information and intelligence tools produced consistently across the observatories. These include: health profiles, regional indications reports, the health
poverty index, and the local basket of inequalities indicators. All of these resources can be accessed through the website below.

Each PHO also leads on behalf of all PHOs for specified projects or topics. This involves providing a single point of contact for external partners, being an advocate for users of public health information and coordinating work across public health observatories.

www.apho.org.uk/apho/

Regional level plans and programmes

The Regional Director of Public Health is responsible for the public health functions within the Government Offices for the Regions and the strategic health authority. They provide the strategic leadership on health and well-being for the region to improve health outcomes and enable monitoring and research to guide delivery of health and well-being goals.

They provide input across all government departments in the region and participate in the development and assessment of all regional plans and programmes, for example the regional spatial strategy, economic, housing and transport strategies. Regional public health groups (RPHGs) improve and protect their local population's health by addressing all determinants of health. Their details are on the Government Offices’ websites.

Where available, health strategies developed by the region will provide initial data for baseline information and will highlight key health issues.

The strategic health authorities have the same Director of Public Health (DPH) as the regions. The South East Region is divided into two SHAs. They have an overview of the health of the population of the PCTs in their area as well as service reports, strategies and reconfigurations. They do not performance manage foundation trusts; this is carried out by Monitor (their regulator).

The relevant SHA can be found on the following website:
www.nhs.uk/England/AuthoritiesTrusts/Sha/showTrust.aspx?id=Q33

Public Health Observatories fulfil three broad roles in their region:

- the regional health intelligence service;
- the focus for capacity building and skills development for health intelligence staff; and
- the ‘bridge’ between academic public health and practice.
Each PHO is a source of health intelligence capacity and capability, available to serve the needs of regional, sub-regional and local partners. This includes providing:

- health intelligence to the local area agreements process;
- regional updates on progress towards meeting health inequalities targets;
- analysis of data from the Quality and Outcomes Framework;
- a Hospital Episodes Statistics safe haven service;
- analysis and reporting of child height and weight surveillance data;
- a focus for training and professional development of health intelligence staff;
- health profiles at local authority level; and
- support for Health Impact Assessment.

The PHOs collate, process, analyse and publish data on health issues for the region. They also provide advice and support on methods and analysis techniques, and access to grey literature. They can be accessed through the APHO website.

**Local level**

**Primary care trusts** are the local health organisations which are the main gateway into health services and information. Since 1 October 2006, the majority (70%) are coterminous with local authorities. This will facilitate joint work. To contact the DPH for the PCT in your area look up the NHS website, which has details of all NHS organisations. www.nhs.uk/England/AuthoritiesTrusts/Pct/Default.aspx

You may also need to make sure that the Chief Executive, Director of Commissioning and the estates officers know about the plan or programme as these people will be responsible for developing services and ensuring health inequalities are addressed.

PCTs have a duty, with the Director of Adult Social Services (DASS), to carry out regular needs assessments of their population as outlined in section 3.2.

The DPH produces an annual public health report, which describes the health status of the population and outlines the key health issues. Their local delivery plans show the PCTs’ priorities and how they plan to use their resources in order to meet the targets in the NHS Improvement Plan and ensure faster and higher quality health care for patients over the next three years. The PCTs’ input into the community strategy and local area agreement contains information for compiling baseline data.
Local authorities hold health-related information in environmental health. Depending on whether it is a rural or urban area, their services include noise, air quality and pollution control, food and health and safety, pest control, land contamination, hazardous substances and animal health.

Other departments such as leisure and recreation, parks, housing, waste management, education and social services have relevant health-related information. In many areas local organisations are bringing together their information systems to support work being carried out through the local strategic partnership. The police and other public agencies and voluntary organisations in the area will also hold health-related information. All these plans have an influence on the wider determinants of health.

Health Protection Units, within the HPA, provide information on communicable diseases, chemicals and poisons, radiation, and emergency response to PCTs, and will receive advice and support from HPA specialist centres as required.
Figure 8: Example of a health profile of a local authority area

### Health summary

#### How to interpret:
First look at the circle which shows how this local authority is doing, compared with the England average (central line), best (right side) and worst (left side). Look at the numbers, values and time periods in the columns. Some numbers shown are totals over more than one year. Red is significantly worse and amber significantly better than the England average (95% confidence intervals used for the local data). Amber may still indicate a significant public health burden. A clear circle is not significantly different from the England average. Then, compare with the regional average (*+* symbol), and the range for similar areas - London cosmopolitan (—*ONS group cluster*).

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>No.</th>
<th>Value</th>
<th>Period</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation</td>
<td></td>
<td>191,010</td>
<td>75.7%</td>
<td>2001</td>
<td>1,2</td>
</tr>
<tr>
<td>Air quality*</td>
<td></td>
<td></td>
<td></td>
<td>2001</td>
<td>2</td>
</tr>
<tr>
<td>Poor quality housing*</td>
<td></td>
<td>10,059</td>
<td>50.5%</td>
<td>01.04.05</td>
<td>3,10</td>
</tr>
<tr>
<td>Children in poverty*</td>
<td></td>
<td>26,593</td>
<td>44.9%</td>
<td>2001</td>
<td>2</td>
</tr>
<tr>
<td>GCSE achievement (A*-C)*</td>
<td></td>
<td>1,651</td>
<td>51.1%</td>
<td>2004</td>
<td>05</td>
</tr>
<tr>
<td>Violent crime</td>
<td></td>
<td>7,977</td>
<td>32.2%</td>
<td>2004</td>
<td>05</td>
</tr>
<tr>
<td>Older people supported at home*</td>
<td></td>
<td>1,894</td>
<td>89.6%</td>
<td>31.03.06</td>
<td>4</td>
</tr>
</tbody>
</table>

#### Smoking in pregnancy

- Smoke

#### Breastfeeding

- Breastfeeding

#### Obese children

- Obese children

- Physically active children

#### Teenage pregnancy (under 18)*

- Teenage pregnancy

#### People who smoke*

- People who smoke

#### Binge drinking

- Binge drinking

#### Healthy eating

- Healthy eating

- physically active adults

#### Obese adults

- Obese adults

#### Life expectancy - Male*

- Life expectancy - Male

#### Life expectancy - Female*

- Life expectancy - Female

#### Deaths - smoking

- Deaths - smoking

#### Early deaths - heart disease & stroke*

- Early deaths - heart disease & stroke

#### Early deaths - cancer*

- Early deaths - cancer

#### Infant deaths (under 1 year)*

- Infant deaths (under 1 year)

#### Road injuries and deaths*

- Road injuries and deaths

#### Pensions in poverty*

- Pensions in poverty

#### Mental health treatment*

- Mental health treatment

#### Alcohol related hospital stays

- Alcohol related hospital stays

#### Drug misuse treatment*

- Drug misuse treatment

#### People with diabetes

- People with diabetes

#### Children’s tooth decay

- Children’s tooth decay

#### Sexually transmitted infections

- Sexually transmitted infections

#### Notes

1. No. and % of people in this area living in the 20% most deprived areas of England.
2. No significance is calculated for this indicator.
3. No data for authorities that have undertaken large scale voluntary transfer (LST).
4. Data only available for County/Unitary Authorities/London Boroughs; data presented at District Authority level is County data.
5. SAP indicator - no data currently available, but will be provided when it becomes available.
7. New indicator - People killed or seriously injured per 100 million vehicle kilometres.
8. High rates considered ‘better’ as reflects better service provision.
9. High rates considered ‘worse’ as reflects high prevalence.
10. Data incomplete or missing for some areas.
11. DMFT: Average no. decayed, missing or filled teeth.

Key:


<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSR1</td>
<td>Directly age standardised rate / 100,000 population</td>
</tr>
<tr>
<td>DSR2</td>
<td>Directly age standardised rate / 100,000 population under 15 years</td>
</tr>
<tr>
<td>DSR3</td>
<td>Directly age standardised percentage</td>
</tr>
<tr>
<td>DSR4</td>
<td>Directly age standardised rate / 100,000 population aged 65 or over</td>
</tr>
<tr>
<td>CR1</td>
<td>Crude rate / 1,000 population</td>
</tr>
<tr>
<td>CR2</td>
<td>Crude rate / 1,000 population aged 15-17</td>
</tr>
<tr>
<td>CR3</td>
<td>Crude rate / 100 million vehicle kilometres</td>
</tr>
<tr>
<td>CR4</td>
<td>Crude rate / 1,000 live births</td>
</tr>
<tr>
<td>CR5</td>
<td>Crude rate / 100 million vehicle kilometres</td>
</tr>
<tr>
<td>CR6</td>
<td>Crude rate / 100,000 resident population aged 65 or over</td>
</tr>
<tr>
<td>CR7</td>
<td>Crude rate / 100,000 resident population aged 15-17</td>
</tr>
</tbody>
</table>
Figure 9: Example of ward-level health inequality data

This map shows inequalities in life expectancy at birth for males and females combined, by ward. It is based on significance above and below the England average.

Comparison to England average (78.5 years) 2000-04
- Significantly lower
- Lower but not statistically significant
- Higher but not statistically significant
- Significantly higher

Life expectancy in the lowest fifth of wards is 74.1 years compared with 79.5 years for the highest fifth.

This map shows deprivation by ward. The four categories are population-based, i.e. ‘most deprived 25%’ refers to the most deprived wards accounting for 25% of England’s population.

Index of Multiple Deprivation
2004 Ward averages
- Most deprived 25%
- Second most deprived 25%
- Second least deprived 25%
- Least deprived 25%

Ward legend:
1 Acre Rigg
2 Blackhalls
3 Dawdon
4 Dene House
5 Deneside
6 Easington Colliery
7 Easington Village and South Hetton
8 Eden Hill
9 Haswell and Shotton
10 Horden North
11 Horden South
12 Howllete
13 Hutton Henry
14 Murton East
15 Murton West
16 Passfield
17 Seaham Harbour
18 Seaham North
19 Thornley and Wheatley Hill
20 Wingate

Easington © Crown Copyright 2006
Resources to consult on health

**Resource box 7: National organisations and websites for data and information**

**Office for National Statistics** is responsible for producing a wide range of key economic and social statistics and provides data on population (epidemiology, causes of death) and society at national and local level.

www.statistics.gov.uk/

**Health and social care topics.** The DH website contains a comprehensive range of topics in health care and social care, including categorised policy documents, non-clinical guidance, newsletters, links and other resources.

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/fs/en

The **Health care Commission**, set up by the Health and Social Care Act 2003, promotes improvement in the quality of the NHS and independent health care. It has a statutory duty to assess the performance of healthcare organisations, and award annual performance ratings for the NHS, and can also undertake reviews of health care. There are public health performance measures and explicit references to health inequalities, which are taken into account in the annual process by reference to public health information.

www.healthcarecommission.org.uk/homepage.cfm

The new **National Institute for Health and Clinical Excellence (NICE)** formed in 2005 has taken on the functions of the Health Development Agency to create a single excellence-in-practice organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. It has recently reviewed the evidence of interventions that use the environment to encourage physical activity. For other reports and reviews of evidence see the website.

www.nice.org.uk/

**The Information Centre.** The Information Centre for health and social care (The IC) was created in April 2005. It provides the National Electronic Library for Health and focuses primarily on health care and clinical practice, but these activities are interwoven with public health. It works with the PHOs and NICE to create a complete service, and this will extend to include other aspects of public health and screening as part of the process of creating a national public health network and a comprehensive knowledge service for public health professionals.

www.ic.nhs.uk/

**The Health Impact Assessment (HIA) gateway** website is currently attached to the NICE website pending a permanent host. HIAs contain literature reviews and there are many topics covered.

www.hiagateway.org.uk/page.aspx?o=hiagateway
The **London Health Observatory** has a guide to reviewing published evidence for use in HIA which is both web-based and hard copy. It also has HIA guidance.  
www.lho.org.uk/HIA/ReviewingEvidence.aspx

The following websites hold information and resources on HIA:

**London Health Observatory**  
www.lho.org.uk/HIA/AboutHIA.aspx

**Birmingham University HIA Research Unit**  
www.pcpoh.bham.ac.uk/publichealth/hiaru/

**IMPACT International Health Impact Consortium**  
www.ihia.org.uk/ABOUTHIA.html

**Welsh Health Impact Support Unit**  
www.wales.nhs.uk/sites3/home.cfm?OrgID=522

The **Public Health Electronic Library** was set up by the Health Development Agency, which has now merged with NICE. It is being reviewed to create a modern hybrid, network-based library service for the NHS, providing seamless access to high quality knowledge. Further information will become available through the information and intelligence strategy.  
www.phel.gov.uk/

The **King’s Fund** is an independent charitable foundation working for better health, especially in London. They carry out research, policy analysis and development activities, working on their own, in partnerships, and through funding.  
www.kingsfund.org.uk/

**Academic research at universities**  
Faculties or schools teaching public health courses.
Public Sector Threshold Test (PSTT)

This PSTT has been carried out for NHS front-line staff only.

This should be applied at the early stages of policy thinking to all proposals and initiatives impacting on public services and staff.

Cost calculation

Calculate the impact of your public sector initiative or policy proposal, in terms of both time and monetary costs (see Table 11). Represent these per public service group 1 affected. Monetary costs should be the sum of all staff and non-staff costs.

Table 11: Public Sector Threshold Test

<table>
<thead>
<tr>
<th>Government department</th>
<th>PSA targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of public service staff affected 1</td>
<td>Time impact per person</td>
</tr>
<tr>
<td>Per group</td>
<td>Total additional hours per annum</td>
</tr>
<tr>
<td>Approx 450 = number of SEAs per year (approx 3 per PCT pa)</td>
<td>20 days = 450 SEAs x 150 hours each</td>
</tr>
<tr>
<td>Totals:</td>
<td>150 hours per SEA</td>
</tr>
</tbody>
</table>

Apply these criteria to your proposal or initiative.

- **Criterion 1:** Is the total additional monetary cost, more than £30 million (NHS) or £5 million (elsewhere) per annum?
  - No

- **Criterion 2:** Is the policy likely to attract high levels of political or media interest?
  - Unlikely
Equality Impact Assessment (EQIA)

An EQIA screening has been carried out on this document. It is expected that the equalities groups’ needs and issues will be taken into account in the assessment process.

The guidance relates to the whole population in England for strategic assessment purposes and emphasises the need to ensure that specific groups within the population are considered. This includes the categories of the EQIA as set out in section 3.3.

The guidance refers to EQIA as an assessment that has to be carried out alongside the SEA. Responsible Authorities will have to carry out an EQIA for each plan or programme. The effects of each plan or programme will be different according to its aims and objectives but it is likely that age, disability, gender and race will need to be considered, though religion, belief or sexual orientation is less likely. There is a strong emphasis on consultation throughout the SEA process to ensure human rights are considered in treating everyone with fairness, respect, equality and dignity.

The guidance encourages Responsible Authorities to consult proactively with vulnerable groups (as set out in the SEA Stage D on page 62).
## Annex C: Health by types of plans and programmes

<table>
<thead>
<tr>
<th>Types of plans and programmes</th>
<th>Responsible Authority</th>
<th>Topics to consider in assessing the effects on health</th>
</tr>
</thead>
</table>
| Regional Spatial Strategies and Local Development Documents | Regional planning body/planning authority | • Community safety  
• Housing provision  
• People with low incomes  
• Access to open space and recreational activities  
• Affordable food outlets, allotments  
• Local education and employment  
• Walking and cycling  
• Development of communities  
• Flooding  
• Air quality in urban areas  
• Traffic  
• Accessibility  
• Inequalities and inequities in health and care |
| Local Transport Plans | Local transport authority | • Transport to work, shops, schools and healthcare  
• Walking and cycling  
• Community severance  
• Frequency and severity of crashes  
• Collisions causing injury and fatal accidents  
• Air pollution, noise  
• Ageing population and increasing disability |
| Minerals Development Plan Documents | Minerals planning authority | • Contamination on surface water and land, and chemical releases  
• Dust, contaminated air, water and soil |
| Waste Development Plan Documents/Municipal Waste Management Strategies | Waste planning/disposal/collection authority | • Emissions to air  
• Dust emissions  
• Noise, odour  
• Pollution to surface water and groundwater |
| Air Quality Action Plans | National government and local authority | • Emissions of greenhouse gases  
• Other emissions to atmosphere  
• Transport |
<table>
<thead>
<tr>
<th>Types of plans and programmes</th>
<th>Responsible Authority</th>
<th>Topics to consider in assessing the effects on health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Housing Strategies</td>
<td>Local authority</td>
<td>• High-quality affordable housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access to shops, services and employment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Overcrowding, deprivation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Homelessness, use of temporary accommodation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Communities and social cohesion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Home safety, indoor pollutants and infestation</td>
</tr>
<tr>
<td>Regional Economic Strategies</td>
<td>Regional development agencies</td>
<td>• Unemployment for specific communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mental health in the workplace</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quality of jobs and education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Middle-aged and older people</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Public transport</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• External work environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Social capital and community engagement</td>
</tr>
<tr>
<td>Areas of Outstanding Natural Beauty Management Plans, National Park Management Plans</td>
<td>Joint advisory committee for the relevant park or area</td>
<td>• Access to open space, exercise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stress and mental ill health</td>
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<td></td>
<td></td>
<td>• Community engagement and social capital</td>
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<tr>
<td></td>
<td></td>
<td>• Sustainable recreational use</td>
</tr>
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<td></td>
<td></td>
<td>• Healing effects of the natural environment</td>
</tr>
<tr>
<td>River Basin Management Plans and Programmes of Measures</td>
<td>Environment Agency</td>
<td>• Quality of surface and groundwater</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Drinking and bathing uses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Flooding</td>
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<tr>
<td></td>
<td></td>
<td>• Food chain</td>
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<tr>
<td></td>
<td></td>
<td>• Recreational value of rivers</td>
</tr>
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<td></td>
<td></td>
<td>• Employment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of river transport</td>
</tr>
<tr>
<td>Salmon Action Plans</td>
<td>Environment Agency</td>
<td>• Healthy food</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recreational opportunities</td>
</tr>
<tr>
<td>Oil and Gas Licensing Rounds</td>
<td>Department of Trade and Industry (DTI)</td>
<td>• Health and safety of the workforce</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asthma, respiratory and cardiovascular illnesses, autoimmune diseases, liver failure, cancer and other ailments such as headaches, nausea and sleeplessness</td>
</tr>
<tr>
<td>Offshore Windfarm Site Licensing Rounds</td>
<td>DTI</td>
<td>• Wildlife and biodiversity</td>
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<tr>
<td></td>
<td></td>
<td>• Noise and visual impact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Renewable energy and sustainable development</td>
</tr>
<tr>
<td>Types of plans and programmes</td>
<td>Responsible Authority</td>
<td>Health topics to consider</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Nuclear Decommissioning Strategies</td>
<td>DTI</td>
<td>• Radiation dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contaminated waste</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proximity of local population</td>
</tr>
<tr>
<td>Community Strategies</td>
<td>Local authority</td>
<td>• Local communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Equity of housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access to facilities including health and care, employment, recreation and food and transport</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Air quality, active lifestyle and access to fresh food</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accidents, crime and fear of crime</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Opportunities for work and social contact</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Local decision-making, social capital, partnerships and user control of local systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Wealth creation and regeneration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Employment, education and transport to attend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Environmental quality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Wildlife and open country for habitat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Natural resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Emissions and energy efficiency</td>
</tr>
</tbody>
</table>
## Annex D: SEA topics and health evidence

Table 3: Examples of questions on the effects of plans and programmes on health (to be posed or adapted as relevant), together with notes on the relevance to health of the issues raised

These examples are drawn from a review of evidence taken from *Healthy sustainable communities: what works?* Cave, Molyneux and Coutts (2004) (ODPM funded) and other reviews listed in the Bibliography.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct environmental effects on the population’s health and well-being</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Could the plan or programme lead to impacts on people from noise or disruptive activities?</td>
<td>Population</td>
<td>Environmental Noise Directive 2002/49/EC</td>
<td>Environmental noise (road, rail, aircraft, construction and noise releases from products, eg tyres, cars) causes annoyance and sleep disturbance to many people. There is evidence of a causal relationship between it and hypertension and heart disease (<em>Medical Research Council, IEH Report on the non-auditory effects of noise</em>. Report R10, ISBN 1 899110 14 3, 1997). The problems are worse in areas of high density housing, rented accommodation, areas of deprivation and areas of urban density.</td>
</tr>
<tr>
<td>Will the plan or programme give rise to emissions to air or water?</td>
<td>Soil, water, air</td>
<td>UK Air Quality Standards and Objectives (Defra) Air Quality Strategy 2000</td>
<td>Air pollution has both short- and long-term damaging effects on health, can worsen the condition of those with lung or heart disease, and may reduce average life expectancy. Water pollution via surface run-off and leaching into groundwater can lead to contamination, such as through hydrocarbons, heavy metals, herbicides, pesticides, and chlorinated hydrocarbons and radioactive contamination, which can lead to adverse health effects.</td>
</tr>
<tr>
<td>Does the plan or programme improve drinking and bathing water?</td>
<td>Water</td>
<td>EC Bathing Water Directive (76/160/EEC) Water Framework Directive 2000</td>
<td>Water safety plans should identify potential contamination. Acid land contaminants lead to corrosion problems for metal pipes and plastic pipes are susceptible to physical degradation or permeation by organic and inorganic chemicals plus biological contamination (such as polycyclic aromatic hydrocarbons) which can lead to pollution.</td>
</tr>
</tbody>
</table>
### Questions Related SEA topics

**Direct environmental effects on the population’s health and well-being (continued)**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the plan or programme contribute to climate change?</td>
<td>Climatic factors, air</td>
<td>UK 2006 Climate Change Programme, PPS and Climate Change – supplement to PPS1</td>
<td>Climate instability and rising sea levels have major long-term health implications through extreme weather events (heatwaves, floods and cold). The elderly are more vulnerable to heat, as the body’s regulatory systems change with age. Prolonged exposure to heat causes heat exhaustion and heatstroke. Children and infants are also especially susceptible. Avoidance or mitigation of adverse effects can make a difference.</td>
</tr>
<tr>
<td>Does the plan or programme affect the production and availability of fresh food?</td>
<td>Population</td>
<td>Choosing Health? Choosing a Better Diet, 2004</td>
<td>Fresh fruit and vegetables promote health. Low-income families are least able to eat well because cheaper foods are most likely to be high in fat and sugar, and poorer access to fresh fruit or vegetables outlets is a significant cause of health inequalities. Local authorities can influence healthy eating and improve access to healthier food, particularly in deprived areas through its own services and functions, such as planning, housing, education, transport and through a leadership role for its community.</td>
</tr>
</tbody>
</table>

### Effects on people’s lifestyles

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan or programme encourage the use of public transport or alternative means of transport other than private cars?</td>
<td>Air, climatic factors, population</td>
<td>DfT sustainable travel policies (see DfT website), DfT Climate Change and Transport, 2006</td>
<td>Reduced car use lowers direct exposure to exhaust pollutants. Reduction in traffic congestion and noise can be expected to improve quality of life and well-being. Any reduction in carbon emissions, however small, contributes to the achievement of climate change objectives.</td>
</tr>
</tbody>
</table>
### Effects on people’s lifestyles (continued)

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan or programme encourage walking and cycling?</td>
<td>Air, population</td>
<td>DfT Walking and Cycling Action Plan Walking in towns and cities: Govt response to Select Cttee Report, 2001; DfT sustainable travel policies (see DfT website); Choosing Health: Physical Activity Action Plan, 2005</td>
<td>Physical activity is one of the best ways of improving overall health and reducing obesity. Neighbourhoods with mixed land use, high population and employment density, street connectivity, pedestrian-oriented design and safety encourage more physical activity and have a lower obesity prevalence. These features are particularly helpful to older people, to reduce social isolation. The proportion of people engaging in physical activity declines with age and particularly after the age of 25. Participation in walking has been shown to decline from 45 per cent among men aged 16–24 to 8 per cent among men aged 75 or over. Among women, walking remained relatively stable among those aged 16–54 (29–32 per cent) but declined rapidly to 5 per cent for those aged 75 and over.</td>
</tr>
</tbody>
</table>

### Effects on local communities

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do plans and programmes contribute to regeneration and tackling health inequalities?</td>
<td>Population</td>
<td>Tackling Health Inequalities: status report on Programme for Action, 2003</td>
<td>Where you live influences the length of your life as it is a proxy for wealth, income, education, good environmental conditions and access to opportunities/amenities/services. Some parts of the country have the same mortality rates now as the national average in the 1950s. Places that exclude or segregate certain groups will tend to increase health inequalities. Mixed communities are not characterised by the same problems often linked with low-income areas.</td>
</tr>
<tr>
<td>Could the plan/programme create a risk of flooding?</td>
<td>Water, soil</td>
<td>PPS25: Development and Flood Risk</td>
<td>The social environment affects how people behave, so preventing social isolation, supporting community engagement and creating a sense of belonging supports social capital. Community severance from physical barriers caused by transport infrastructure, and psychological barriers caused by road safety fears, limit travel horizons and affect people’s ability to self-mitigate these barriers in order to reach key services such as employment, education and health facilities.</td>
</tr>
</tbody>
</table>
### Questions Related SEA topics

**Effects on local communities (continued)**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan or programme involve provision of facilities, eg general practitioner surgeries, health centres or hospitals, leisure/ sports centres, swimming facilities</td>
<td>Population, material assets</td>
<td>Tackling Health Inequalities, 2003; Choosing Health, 2004; Our Health, Our Care, Our Say, 2006; Sustainable Communities: People, Places and Prosperity, 2005</td>
<td>Higher rates of GP consultation are associated with greater social and economic deprivation, although those in greatest need are least likely or able to access it. Communities most at risk of ill health tend to experience the least satisfactory access to key cultural, social, recreational and leisure amenities and preventative health services. Community facilities accessible to all is a key message in the Our health, our care, our say White Paper 2006, which envisages care being provided closer to home through community hospitals, state-of-the-art diagnostic centres, day surgery and outpatient facilities closer to where people live and work.</td>
</tr>
<tr>
<td>Does the plan or programme encourage a sense of community safety, identity and social cohesion?</td>
<td>Population, cultural heritage, landscape, biodiversity</td>
<td>Living Places: Cleaner, Safer, Greener, October 2002 (now CLG lead); National Community Safety Plan 2006–09</td>
<td>Good design encourages greater community ownership of the environment and reduces negative effects such as vandalism and under-use of facilities. A sense of community identity and belonging is known to foster health and the sense of well-being. Fear of crime reduces social solidarity, and has an adverse psychological impact. Fear of leaving their home exposes older people in particular to isolation and vulnerability. Good urban design can help to “design out crime” and enhance community safety.</td>
</tr>
</tbody>
</table>

### Effects on the local economy

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan or programme have employment implications for all sections of society?</td>
<td>Population</td>
<td>European Employment Strategy 2005–08</td>
<td>Isolated developments can lead to exclusion of vulnerable groups. Local job opportunities enable walking and cycling as travel to work or commuting options. Unemployed people have a higher risk of poor physical and mental health and shorter life expectancy. Low-paid, insecure employment carries greater risks of accidents, infections and heart disease and increased health-damaging behaviour such as smoking.</td>
</tr>
</tbody>
</table>
## Effects on people’s activities

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan or programme promote easy and sustainable access to services such as workplaces, shops, schools, healthcare facilities and social activities?</td>
<td>Population</td>
<td>Cabinet Office Social Exclusion Unit <em>Health and Transport</em>, June 2006</td>
<td>Poor transport contributes to social exclusion as it restricts access to activities that enhance people’s life chances, such as work, learning, healthcare, food shopping and other key activities. Communities are severed by physical barriers (e.g., transport infrastructure) and psychological barriers (e.g., road safety fears) limit travel horizons and can affect access to services such as employment, education and health facilities. Lack of access to services (e.g., by foot or affordable transport) is experienced disproportionately by women, schoolchildren, the elderly and disabled people. Poor access to services is a significant factor in social exclusion, which is associated with health problems.</td>
</tr>
<tr>
<td>Does the plan or programme affect people’s access to health facilities?</td>
<td>Population</td>
<td>Health policy documents as listed in section 3.2; Cabinet Office Social Exclusion Unit <em>Health and Transport</em>, 2006</td>
<td>Lack of access to services (e.g., by foot or affordable transport) is experienced disproportionately by women, schoolchildren, the elderly and disabled people. Poor access to services is a significant factor in social exclusion, which is associated with health problems.</td>
</tr>
</tbody>
</table>
### Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effects of the built environment on people</strong></td>
<td></td>
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</tr>
<tr>
<td>Does the plan or programme promote <strong>exercise</strong> as part of daily living?</td>
<td>Population</td>
<td>Obesity strategy</td>
<td>Modern inactive lifestyles possibly represent the dominant factor driving obesity. They are typified by high levels of car use, 24-hour food availability, abundant desk jobs and low levels of physical activity. Decreasing obesity may only be achieved if we adapt our built environment to make it easier for us to regularly be more active in our everyday activities. A challenge will be to ensure that personal and community health considerations are included as future infrastructure is designed and built.</td>
</tr>
<tr>
<td>Will plans or programmes for <strong>housing</strong> take into account sustainable provision, conservation of warmth, ventilation, flexibility?</td>
<td>Population, material assets (depending on definition), climatic factors</td>
<td>CLG <em>Making Homes Decent</em>; CLG <em>Draft Code for Sustainable Homes</em></td>
<td>Cold, damp homes are associated with cardiovascular and circulatory diseases. Fuel poverty affects mental health and contributes to health inequalities. Housing needs to be suitable for people with disabilities, families and the ageing population.</td>
</tr>
<tr>
<td>Is the plan or programme concerned with contaminated <strong>land</strong> or waste management or disposal?</td>
<td>Soil, water, air</td>
<td>Defra Circular 1/2006 <em>Contaminated Land</em></td>
<td>Contaminants such as polycyclic aromatic hydrocarbons (PAHs), heavy metals, oil, asbestos and landfill gases are injurious to health. Waste disposal can be a major generator of road transport, noise and dust, with potential adverse effects on safety and air quality.</td>
</tr>
<tr>
<td>Does the plan or programme promote a <strong>healthy environment</strong>?</td>
<td>Population</td>
<td><em>Choosing Health</em>, 2004</td>
<td>Urban environments that are dense, mixed use, easily accessible on foot or bicycle with high-quality green infrastructure can deliver positive health outcomes and provide the right environment for promoting active lifestyles and good use of resources. In rural areas the interrelationship between home, work, leisure and mobility is key to healthier lives.</td>
</tr>
</tbody>
</table>
### Effects of the natural environment on people’s health and well-being

<table>
<thead>
<tr>
<th>Questions</th>
<th>Related SEA topics</th>
<th>Government policies</th>
<th>Evidence base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan or programme provide greater access to the countryside and coast?</td>
<td>Population, landscape, biodiversity</td>
<td><em>Rural Strategy 2004</em> (Defra)</td>
<td>Greater opportunities for walking and cycling beneficial to physical health. Greater contact with nature is beneficial to mental health.</td>
</tr>
<tr>
<td>Will the plan or programme promote health and well-being in the natural environment?</td>
<td>Biodiversity, flora, fauna, population</td>
<td><em>Health Concordat</em>, 2005</td>
<td>Contaminants such as PAHs, heavy metals, oil, asbestos and landfill gases are injurious to health. Waste disposal can be a major generator of road transport, noise and dust, with potential adverse effects on safety and air quality.</td>
</tr>
<tr>
<td>Will the plan or programme provide for locally accessible green spaces?</td>
<td>Population, biodiversity, fauna/flora, cultural heritage, landscape</td>
<td><em>Living Places: Cleaner, Safer, Greener</em>, October 2002 (now CLG lead)</td>
<td>Green space encourages social contact and exercise, and is associated with lower crime rates and increased safety. People who can see trees or green space from their homes report higher levels of health and well-being.</td>
</tr>
</tbody>
</table>
Annex E: Frequently asked questions

1. What is the difference between Strategic Environmental Assessment (SEA), Environmental Impact Assessment (EIA), Health Impact Assessment (HIA), Integrated Pollution Prevention and Control (IPPC) and Sustainability Appraisal (SA)?

SEA applies to plans and programmes typically concerned with broad proposals and alternatives, whilst EIA is project-specific and requires more detailed information on the effects of a particular proposal (usually individual installations). SEA can help the preparation of an EIA, but does not remove the need for one where EIA is required. IPPC is a “permit to pollute” undertaken outside planning (again at the level of single installations). Separate HIAs can be carried out on developments and policies at any level. Health is assessed to differing degrees within each of these assessments (see Figure 2).

Basically, SAs are a broader assessment of the “triple-bottom-line” of economic, social and environmental impacts carried out on regional strategies. The important thing to remember is that SAs must also meet the requirements of the SEA Directive.

2. Should a separate HIA be carried out?

No. We recommend that the effects on health be fully integrated into the SEA process. This will reduce costs/burdens whilst also ensuring that the SEA (and within this any health-related recommendations) is considered during the decision-making process. However, the SEA may need to address all the relevant links to the wider determinants of health, and health effects should be clearly visible within the Environmental Report (ER).

3. Who is responsible for paying for and writing up SEAs?

SEAs will be carried out by public bodies who are preparing plans or programmes subject to the SEA requirement. These are known as “Responsible Authorities ” (RAs). Most will be local authorities, who have a legal requirement to carry out SEA of their local development documents. A number of SEAs will be carried out by the Environment Agency on its internal plans and programmes. Some organisations, eg water companies, may voluntarily carry out SEAs. The help of consultants may be sought by RAs.

4. When should health organisations be consulted?

Health organisations should be consulted at the same time as Consultation Bodies: first during scoping and then at full public consultation on the draft plan or programme and accompanying ER.
5. How many SEAs are expected?

Based on current statistics, there are between 300 and 400 per year for England, with the majority from local authority planners and around 50 from the Environment Agency.

6. How should I assess which determinants of health, health outcomes, health effects or health targets/objectives are important?

An initial breakdown can be achieved by thinking of health in terms of:

1. impacts on health and facilities;
2. adverse impacts; and
3. beneficial impacts.

Simple risk assessments can also be useful. Using basic significance criteria, the magnitude and probability of an effect can be worked out. This process should be fully transparent and the criteria stated clearly in any assessment. See also Chapter 4.

7. Which key plans and programmes inform other planning documents?

The two key documents are the Regional Spatial Strategy as it feeds into other regional programmes and the local development framework, as a health input here should inform other local plans.

8. What is the difference between the plan (eg a local transport plan) or programme and the SA/SEA?

The plan sets out the RA's vision and how this will be achieved. The SA/SEA is an independent assessment of the effects of implementing the plan or programme. SEA must be undertaken at the same time as the preparation of the plan or programme. The plan and SEA targets and objectives may be different and therefore the long-term goal of influencing the plan or programme should be kept in mind whilst engaging with the SEA process.

9. Who should I contact for a health response?

- **National plans and programmes** – contact the Department of Health, Health Improvement Directorate.

- **Regional plans and programmes** – make contact in the first instance with the regional Director of Public Health (DPH) in the regions.
• **Local plans and programmes** – where the plan or programme covers the same geographical area as the local primary care trust (PCT), make contact in the first instance with the DPH for the relevant PCT.

• **Regional/local** – where a plan or programme covers more that one PCT, consult with both the regional DPH and each of the relevant PCTs for the area.

The PCT covering a particular town or county can be found at:
www.nhs.uk/england/authoritiestrusts/pct/townSearch.aspx

Further health data and consultation responses can be gathered from a variety of organisations (detailed in Annexes A and B of this guidance).

**Consultation questions**

Are there any other questions you would like answered?

Do you have any comments on the current answers?
Annex F: Do’s and dont's (short summaries of the guidance)

There follow two sets of ‘do’s and dont’s’ guidance – first for primary care trusts (yellow shading) and second for Responsible Authorities (blue shading).
Overview of SEA stages and potential health input

Addressing health in SEAs for PCTs – do’s and don’ts

The European Directive on Strategic Environmental Assessment 2001/42/EC, or SEA Directive, requires the likely significant effects of proposed plans and programmes on human health to be assessed.

This advisory note provides health organisations (particularly primary care trusts (PCTs)) with an overview of the five SEA stages and how to help Responsible Authorities (RAs), the bodies that prepare plans and programmes and carry out SEA, establish the current situation, identify problems, predict the effects of their proposals on health and develop ways of tackling adverse effects and enhancing positive ones.

All the actions suggested would not be required for each SEA. The level of involvement will depend on the type of plan or programme, the resources available, and the level of engagement with the RA.

Although health bodies are not Consultation Bodies, your response can be effective in including health promotion, prevention, and protection in plans and programmes. A companion note advises RAs on how to consult effectively on health issues.

Do’s
Plan ahead for consultation – have systems in place and ask authorities for information on future plans or programmes

- ✓ Raise awareness of SEA across your organisation
- ✓ Provide data that is spatially and temporally relevant, describing trends over time and aim for an easily understandable format
- ✓ Focus on the key strategic health issues that will be affected by the plan or programme
- ✓ Use the SEA to identify how the plan or programme will influence or affect health determinants
- ✓ Be proactive and engage with RAs, thereby encouraging participation

Don’ts
Plan ahead for consultation – have systems in place and ask authorities for information on future plans or programmes

- X Focus on every single possible health effect
- X Rely on one person to deal with all SEA queries
- X Attempt to carry out the SEA for the RA
- X Expect health to addressed separately from the rest of the SEA
- X Consider health impacts without reference to the SEA process
- X Swamp the RA with irrelevant or over-detailed information
- X Wait to be consulted – you may not be!
### Overview of SEA stages and potential health input

#### Guidance for PCTs

<table>
<thead>
<tr>
<th>SEA stage</th>
<th>Health considerations</th>
<th>Information sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage A: Setting the context and objectives, establishing the baseline and deciding the scope</strong></td>
<td>Provide baseline information and/or advise on relevant sources</td>
<td>NHS, eg PCT</td>
</tr>
<tr>
<td></td>
<td>Advise on appropriate health objectives</td>
<td>Government departments, eg Department of Health (<a href="http://www.dh.gov.uk/">www.dh.gov.uk/</a>), Defra, CLG, Treasury, Home Office, Department for Transport (<a href="http://www.transtat.dft.gov.uk/">www.transtat.dft.gov.uk/</a>)</td>
</tr>
<tr>
<td></td>
<td>Suggest other information that may be useful</td>
<td>Public Health Observatories (<a href="http://www.apho.org.uk/">www.apho.org.uk/</a>)</td>
</tr>
<tr>
<td></td>
<td>Influence decision-making by identifying the two or three main health issues and ensure the promotion of beneficial effects is given the same importance as the mitigation of adverse effects</td>
<td>Disease registries, eg Cancer Registries (<a href="http://www.ukacr.org.uk/">www.ukacr.org.uk/</a>), Perinatal Institutes, APHO Hospital Episode Statistics, Safe Havens</td>
</tr>
<tr>
<td><strong>Stage B: Developing and refining alternatives and assessing effects</strong></td>
<td>Check that qualitative or quantitative effects on health indicators of all alternatives – including both positive and negative effects – have been considered</td>
<td>Health Protection Agency, eg environmental health surveillance data, guidance, position statements (<a href="http://www.hpa.org.uk/">www.hpa.org.uk/</a>)</td>
</tr>
<tr>
<td></td>
<td>If asked, comment on predicted effects and monitoring proposals</td>
<td>Area profiles (wwwauditcommission.gov.uk/areaprofiles)</td>
</tr>
<tr>
<td><strong>Stage C: Preparing the Environmental Report</strong></td>
<td>No action for consultees at this stage</td>
<td>Office for National Statistics (<a href="http://www.statistics.gov.uk/">www.statistics.gov.uk/</a>)</td>
</tr>
<tr>
<td><strong>Stage D: Consultation and decision making</strong></td>
<td>Reply, if necessary, to consultation requests from RAs</td>
<td>Local Health Profiles (<a href="http://www.communityhealthprofiles.info">www.communityhealthprofiles.info</a>)</td>
</tr>
<tr>
<td><strong>Stage E: Monitoring implementation of the plan or programme</strong></td>
<td>Check that monitoring includes the collating of health data (eg via questionnaires, pollution monitoring) to determine whether objectives and targets have been met</td>
<td>World Health Organization: SEA Protocol (<a href="http://www.euro.who.int/healthimpact/mainacts/20040908_14">www.euro.who.int/healthimpact/mainacts/20040908_14</a>)</td>
</tr>
<tr>
<td></td>
<td>Check that monitoring is integrated with existing health surveillance/tracking systems (eg those of the PCTs)</td>
<td>Health Impact Assessment Gateway website (<a href="http://www.hiagateway.org.uk/page.aspx?o=hiagateway">www.hiagateway.org.uk/page.aspx?o=hiagateway</a>)</td>
</tr>
</tbody>
</table>

#### Other SEA guidance and support

- Environment Agency at: www.environment-agency.gov.uk/seaguidelines
Overview of SEA stages and potential health input

Addressing health in SEAs for RAs – do’s and don’ts

The European Directive on Strategic Environmental Assessment 2001/42/EC requires the likely significant effects of proposed plans and programmes on human health to be assessed.

This note is to advise RAs – the bodies that prepare plans and programmes and carry out SEAs – on how health organisations, particularly PCTs, can help them establish the current situation, identify problems, predict the effects of their proposals on health and develop ways of tackling adverse effects and enhancing positive ones.

The level of health input will be depend on the type of plan or programme and the resources available, although all SEAs could benefit from the consideration of these steps in considering health as part of the SEA process. Health bodies are a useful source of health information, and early consultation should ensure that the most relevant health effects are assessed. A companion note advises health organisations on how to be effective SEA consultees.

**Do’s**

- Use SEA to include relevant health issues in the decision-making process
- Develop links with health organisations as early as possible and keep them involved
- Consider inviting a (public) health professional to be a member of your SEA steering group
- Identify health issues relevant to your plan or programme
- Consider health benefits and well-being, and aim to enhance these where possible
- Seek views on health when consulting the public

**Dont’s**

- Focus only on direct health effects – also consider indirect health effects
- Treat health effects separately from the rest of the SEA
- View health organisations as marginal to the SEA process
- Waste effort on health issues on which the plan or programme will not impact
- Focus solely on adverse effects of plans and programmes
- Collate new data sets if existing data sets are readily available
- Assume the public consulted will have no relevant information or views
### Overview of SEA stages and potential health input

**Guidance for Responsible Authorities**

<table>
<thead>
<tr>
<th>SEA stage</th>
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<th>Information sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage B: Developing and refining alternatives and assessing effects</strong></td>
<td>Predict effects on health of the plan or programme implementation. Consider beneficial health effects as well as adverse ones. Develop proposals for any health monitoring during implementation. RAs may find it helpful to consult at this stage.</td>
<td>Health Impact Assessment Gateway website (<a href="http://www.hiagateway.org.uk/page.aspx?o=hiagateway">www.hiagateway.org.uk/page.aspx?o=hiagateway</a>). Sources of expert interpretation and guidance providing valuable intelligence, e.g., HealthPromis (healthpromis.hda-online.org.uk/), Cochrane Collaboration (<a href="http://www.cochrane.org/">www.cochrane.org/</a>), National Institute for Health and Clinical Excellence (<a href="http://www.nice.org.uk/">www.nice.org.uk/</a>).</td>
</tr>
<tr>
<td><strong>Stage C: Preparing the Environmental Report</strong></td>
<td>Likely significant health effects should be included in the Environmental Report and where appropriate this could contain a specific human health section.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage D: Consultation and decision making</strong></td>
<td>Include health organisations in consultation on draft plan/programme and Environmental Report.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage E: Monitoring implementation of the plan or programme</strong></td>
<td>Monitor health effects of implementing plan (if appropriate integrate this with existing health surveillance/tracking) bearing in mind that info collected may need to be refined. Where significant health effects are identified consider consulting with health organisations.</td>
<td></td>
</tr>
</tbody>
</table>

### Other SEA guidance and support

Annex G: Workshop participants

Birley HIA Consultancy
Cardiff Council
Department for Communities and Local Government
Department of Health
Devon Primary Care Trust
Environment Agency
Greater London Authority
Halcrow
Health Protection Agency
Hyder Consulting
IMPACT, University of Liverpool
Land Use Consultants
Liverpool City Council Planning
Liverpool John Moores University
London Health Observatory
Manchester City Council Planning
Mott MacDonald Consultants
Peter Brett Associates
Plymouth Public Health Development Unit
Poole Local authority
Redbridge PCT
Regional Public Health Group
RPS Consultancy
Scott-Wilson Consultants
Consultation Bodies: Authorities which because of their environmental responsibilities are likely to be concerned by the effects of implementing plans and programmes and must be consulted at specified stages of the SEA. The Consultation Bodies in England, designated in the SEA Regulations, are:

- Natural England (formerly English Nature and the Countryside Agency);
- English Heritage; and
- the Environment Agency.

However, for UK-wide plans and programmes, where UK regulations will apply, a wider range of Consultation Bodies may need to be consulted.

Environment: For health, the environment covers the sum of the total of the elements, factors and conditions in the surroundings which may have an impact on the development, action or survival of an organism or group of organisms as opposed to genetics.

Environmental appraisal: A form of environmental assessment used in the UK (primarily for development plans) since the early 1990s, supported by Environmental Appraisal of Development Plans: A Good Practice Guide (Department of the Environment, 1993); more recently superseded by Sustainability Appraisal. Some aspects of environmental appraisal foreshadow the requirements of the SEA Directive.

Environmental assessment: Generically, a method or procedure for predicting the effects on the environment of a proposal, either for an individual project or a higher-level “strategy” (a policy, plan or programme), with the aim of taking account of these effects in decision-making. The term “Environmental Impact Assessment” (EIA) is used for assessments of projects (see definition below). In the SEA Directive (Article 2(b)), an environmental assessment means “the preparation of an Environmental Report, the carrying out of consultations, the taking into account of the Environmental Report and the results of the consultations in decision-making and the provision of information on the decision”, in accordance with the Directive’s requirements.

Environmental health: Concerned with the health and well-being of communities, individuals and organisations; the condition and sustainability of the places where people live, work and relax; and the safety of food. The Chartered Institute of Environmental Health maintains, enhances and promotes improvements in environmental and public
health through knowledge, understanding and campaigning. Environmental Health Officers (EHOs) are located in local authorities.

**Environment and health:** The EU Ministerial Conferences on Environment and Health have set up a programme of work to bring the information together through the Environment and Health Action Plan 2004–2010 which involves the World Health Organization (WHO) and EU Member States.

**Environmental Impact Assessment (EIA):** Generic term used to describe environmental assessment as applied to projects. In this guide, “EIA” is used to refer to the type of assessment required under European Directive 85/337/EEC.

**Environmental Report:** The report required by the SEA Directive as part of an environmental assessment, which identifies, describes and evaluates the likely significant effects on the environment of implementing a plan or programme.

**Health Impact Assessment (HIA):** The definition of HIA has recently been updated by the International Association of Impact Assessment, adapted from the *Gothenburg Consensus Paper* (1999). HIA may be defined as a combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a policy, plan, programme or project on the health of a population and the distribution of those effects within the population. HIA identifies appropriate actions to manage those effects.

**Health status:** The state of health of a person or population assessed with reference to the morbidity, impairments, anthropological measurements, mortality, and indicators of functional status and quality of life.

**Health risk:** A measure of likelihood that an identified hazard causes harm to a particular group of people at a particular time and place (e.g., floodwater affecting property may have been contaminated with sewage, animal waste and other contaminants, although infection problems arising from floods in the UK are actually rare).

**Health hazard:** A situation where harm may result (e.g., certain chemicals, poor housing, access to resources).

**Incidence:** The number of cases of specific diseases diagnosed or reported during a defined period of time, divided by the number of persons making up the population in which they occurred.

**Indicator:** A measure of variables over time often used to measure achievement of objectives.
Local delivery plans: Set out how PCTs intend to achieve national key targets through service improvement plans for the healthcare community and how funding allocations will be used to deliver them.

Mitigation: Used in this guide to refer to measures to avoid, reduce or offset significant adverse effects on the environment.

Morbidity (the burden of disease): Can refer to the degree or severity of a disease, the prevalence of a disease – the total number of cases in a particular population at a particular point in time, the incidence of a disease – the number of new cases in a particular population during a particular time interval, and disability irrespective of cause (e.g., disability caused by accidents).

Mortality: Death.

Mortality rate: A measure of the number of deaths (in general, or due to a specific cause) in some population, scaled to the size of that population, per unit time.

Obesity: “An excess of body fat frequently resulting in a significant impairment of health and longevity” (House of Commons Health Committee, 2004). Being obese or overweight is associated with a higher likelihood of suffering numerous chronic illnesses, including life-threatening cardiovascular disease, diabetes, certain types of cancer and gallbladder disease (WHO 2003, 2005a; Wanless 2004).

Objective: A statement of what is intended, specifying the desired direction of change in trends.

Output indicator: An indicator that measures progress in achieving plan or programme objectives, targets and policies.

Plan or programme: For the purposes of this guide, the term “plan or programme” covers any plans or programmes to which the Directive applies.

Population health: The assessment of the population's needs is the responsibility of Directors of Public Health for their area. This includes the quantitative and qualitative assessment, including managing, analysing, interpreting, and communicating information that relates to the determinants and status of health and well-being. The aim is to reduce health inequities amongst population groups by addressing a broad range of factors that impact on the health of the whole population, such as environment, social structure and resource distribution.

Prevalence: The number of people suffering from a specific disease at a particular moment in time in a defined population.
**Responsible Authority:** The organisation that prepares and/or adopts a plan or programme subject to the Directive and is responsible for the SEA.

**Scoping:** The process of deciding the scope and level of detail of an SEA, including the environmental effects and alternatives which need to be considered, the assessment methods to be used, and the structure and contents of the Environmental Report.

**Screening:** The process of deciding whether a plan or programme requires SEA.

**Spatial planning:** Refers to the methods used by the public sector to influence the distribution of people and activities in spaces of various scales. This includes urban (urban planning), regional (regional planning), national and international levels.

**Strategic Environmental Assessment (SEA):** Generic term used to describe environmental assessment as applied to policies, plans and programmes. In this guide, “SEA” is used to refer to the type of environmental assessment required under the SEA Directive.

**SEA Directive:** European Directive 2001/42/EC “on the assessment of the effects of certain plans and programmes on the environment”.

**SEA Regulations:** The Regulations transposing the SEA Directive into UK law.

**Significant environmental effects:** Effects on the environment which are significant in the context of a plan or programme. Criteria for assessing significance are set out in Annex II of the SEA Directive.

**Sustainability Appraisal (SA):** A form of assessment used in the UK, particularly for regional and local planning, since the 1990s. It considers social and economic effects as well as environmental ones, and appraises them in relation to the aims of sustainable development. Sustainability Appraisal fully incorporating the requirements of the SEA Directive is required for local development documents and regional spatial strategies in England and local development plans in Wales under the Planning and Compulsory Purchase Act 2004.

**Target:** The goal intended to be attained (and believed to be attainable) and which can be measured.

**Wider determinants of health:** The wide range of personal, social, economic and environmental factors that determine the health status of people or communities. These include health behaviours and lifestyles, income, education, employment, working conditions, access to health services, housing and living conditions, and the wider general environment.

rsh.sagepub.com/cgi/reprint/126/6/252.pdf

*A New Commitment to Neighbourhood Renewal* National Strategy Action Plan (2001)

‘Area effects on health variation over the life-course: analysis of the longitudinal study sample in England using new data on area of residence in childhood.’

www.environment-agency.gov.uk/yourenv/857406/1218772/


*Choosing Health? Choosing a Better Diet.*
www.dh.gov.uk/assetRoot/04/08/14/56/04081456.pdf


Community Severance Views of Practitioners and Communities, E James, A Millington and P Tomlinson, TRL Limited.
www.dft.gov.uk/stellent/groups/dft_localtrans/documents/page/dft_localtrans_610194-11.hcsp

ec.europa.eu/environment/health/index_en.htm


Healthy Sustainable Communities: What Works? B Cave, P Molyneux, A Coutts, October 2004. This provides a comprehensive review of a wide range of health and well-being topics, including social and cultural, environmental, housing and the built environment, transport and connectivity, economy and services.


www.nice.org.uk/page.aspx?o=526671

Interventions that use the environment to encourage physical activity – Evidence review, National Institute for Health and Clinical Excellence, C Foster, M Hillsdon, N Cavell, F Bull, K Buxton, H Crombie, 2006.
www.nice.org.uk/page.aspx?o=366133


*Saving Lives: Our Healthier Nation* White Paper (July 1999)

www.communities.gov.uk/index.asp?id=1137789


The National Institute for Health and Clinical Excellence (NICE) guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children, December 2006.
www.nice.org.uk/guidance/CG43/?c=296726


www.euro.who.int/document/e81384.pdf

Trends and drivers of obesity: A literature review for the Foresight project on obesity.
www.foresight.gov.uk/Obesity/Reports/Literature_Review/Literature_review.htm

Watch out for Health – Planning Checklist, NHS London Healthy Urban Development Unit.
www.healthyurbandevelopment.nhs.uk/
