Creating and maintaining a healthy Stratford City: Principles and practices for success

SUMMARY REPORT WITH APPENDICES

UEL
University of
East London

Newham London

NHS
Newham

CREATING AND MAINTAINING A HEALTHY STATFORD CITY: PRINCIPLES AND PRACTICES FOR SUCCESS

Alice Sampson, Angela Harden, Allan Brimicombe, Marcello Bertotti, Shahana Lais, Gail Barrow-Guevera, Ilona Boniwell, Hipolina Joseph, Kevin Sheridan, Faye Adams-Eaton, Patrick Tobi, Yang Li

Team UEL

Centre for Institutional Studies
Alice Sampson, Hipolina Joseph and Jane Stokes

The Centre for Institutional Studies (CIS) is a well-established research centre informed by a distinctive problem-oriented approach to policy analysis, evaluation, and institutional effectiveness. We treat policies and institutions as trial solutions to social problems and our research finds out how problems are formulated and how well policies and institutions are solving them. We have won research grants from central and local government, the Economic and Social Research Council, the Arts and Humanities Research Council, and voluntary organisations on policy and practice issues related to urban regeneration, crime, young people and social enterprises.

Institute for Health and Human Development
Professors Angela Harden and Adrian Renton, Dr Patrick Tobi, Dr Marcello Bertotti, Shahana Lais, Gail Barrow-Guevera, Kevin Sheridan, Faye Adams-Eaton

The Institute for Health and Human Development (IHHD) is a centre for research, innovation and community engagement to promote health and wellbeing with a focus on communities and families. We use creative approaches to design policies and interventions that support people to make sustainable lifestyle and consumption choices which promote their health and wellbeing. IHHD research informs policy and interventions locally, nationally and internationally. Our current work includes community engagement and randomised controlled trial for the Well London project and A Health and Social Care Needs Assessment of Eastern European (including Roma) individuals living in Barking and Dagenham.

The Centre for Geo-Information Studies
Professor Allan Brimicombe and Dr Yang Li

The Centre for Geo-Information Studies (CGIS) focuses on the analysis of spatial phenomena of interest in the social sciences, information science, engineering and architecture. Our hallmark is cross-disciplinary work contributing data harvesting and integration, data mining and analysis using quantitative and computational techniques, and map visualisation. Particular strengths are in data quality issues and the coupling of numerical simulation modelling with geographical information systems (GIS).

LP4, Department of Psychology
Dr Ilona Boniwell

London Partnership for Positive Psychology in Practice (LP4) is a network of like-minded academics exploring and applying theoretical concepts and principles of positive psychology to real-world scenarios. LP4 provides students and external clients with access to the latest studies and development in the field of positive psychology through research, education, training and consultancy.

University of East London, September 2010.

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Prepared by Alice Sampson and Angela Harden

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1 Introduction

Health and other professionals in the London Borough of Newham recognise that there are many challenges and opportunities for the promotion of health and the provision of health services with the construction of the Olympic Park and new homes, retail outlets and businesses adjacent to the site. In particular, incorporating new residents into existing communities and existing health services with an expanded provision requires foresight and careful planning. This report aims to contribute to their thinking, planning and decision-making.

Research findings from a range of sources including reviews of academic literature and case studies are used to propose some principles and practices to inform decision-making by health and other professions.[i] Our proposals recommend a focus on developing and sustaining a healthy place rather than on ill-health and illness. We outline the reasons why we think that this perspective is preferable and how it may be achieved.

The research took place between July 2009 and May 2010 and has been a collaborative enterprise between research staff within UEL[ii] and between UEL researchers and Newham PCT, Newham local authority staff with a health remit and Lend Lease. Regular discussions on progress, feedback sessions on initial research findings, and a workshop held in March 2010 have all contributed to the final proposal about how to create and maintain a healthy place. This process has been facilitated by a willingness of the steering group to adapt the research remit and to adopt a flexible and open approach towards developing proposals arising from research findings.

1.2 Athletes' Village

For the purposes of this study we will refer to the new planned mixed community as the Athletes' Village. The Village includes residential properties, health and community facilities, an education campus that includes a nursery, primary, secondary and higher education, and retail, leisure and commercial properties. The new international passenger station will be located on the southern boundaries of the Village and there will also be a large shopping centre as well as hotel and conference facilities next to the station.

It is anticipated that the Athletes' Village will consist of 4,500 residential units with 70% as market-rate housing and 30% affordable housing including social housing, and that 35,000 jobs will be created as part of the Stratford City development.

2 Scope of the study

As a result of discussions with our steering group, our overarching research question became: 'How can a healthy Stratford City be created and maintained?' This question provides the focus for this summary report.

2.1 Implications of a focus on 'being healthy'

We are aware that responding to ill-health, preventing ill health and promoting well-being may suit different professional skills and backgrounds, yet there are overlapping issues which require the same coherent and disciplined responses from health and other professionals. This study is mainly about the latter two aspects of the concept of health rather than responding to ill health, although to achieve a healthy place all three aspects of health need attention. Our proposals have resource implications as we argue for a greater emphasis on healthy living. This approach, which also directly addresses the problem of health inequalities prevalent in East London, would require a shift in the allocation of resources within the NHS budget towards health promotion and well-being.

Our review of well-being demonstrates that this is a complex and contested concept and that indicators which capture well-being require careful thought.[iii] Not only is well-being a complex social and psychological concept but it can also relate to a person's relationship with the built environment, to their social and economic status and their local transport infrastructure. Both the ability to access facilities easily and the ease of movement through a place enhance a sense of well-being.

Our focus for creating and developing a healthy place requires, we believe, different mindsets and partnership arrangements compared to those partnerships and practices which prioritise illness. However because they embrace issues which lie beyond this study, we have not fully explored how these partnership arrangements might be put in place.

2.2 Wider determinants of health, health inequalities and convergence

Our remit was to undertake systematic reviews and to retain health as our main interest. We have included issues such as employment, crime, and housing but only in their relation to health. Whilst there is a wealth of epidemiological data linking socio-economic disadvantage to poor health, the mechanisms which link these wider determinants of

health to health improvements are not, however, always clear, but where possible these have been identified.[iv]

One option to improve health outcomes is thought to be the introduction of planned mixed communities to 'dilute' concentrated economic and social disadvantage, and to create socially balanced communities with greater economic opportunities. The anticipated mechanisms that bring about change include: residents with high incomes and aspirations role-model healthy behaviours, and improvements in health arise from better employment prospects with employers who are willing to recruit from the community, as well as a greater number of local jobs that are typical of a more prosperous area.[v] The overview of research findings from planned mixed communities can be found in appendix 2 of the full report.

We have also taken into account current strategies and identified where our study complements existing plans. The Marmot strategic review[vi] on health inequalities has national and local implications, and is comprehensive and forward looking. A review of the Strategic Regeneration Framework for the five Olympic host boroughs by the Marmot research team notes that a convergence strategy alone may be insufficient to deliver health equality for local people. They suggest that a key practice will be to enable residents to have control over their own lives so that they can influence their own health and influence community health behaviours. This can happen when service providers engage with existing and new residents.[vii] The recommendations in this UEL report take into account these suggestions and our study is a modest contribution towards how the convergence agenda, outlined in the Strategic Regeneration Framework, for the five host boroughs of the Olympic Games might be achieved.

2.3 A focus on practices that create and maintain a healthy place
The emphasis of our approach is on place. The Stratford area is a place of significance with the Olympic Park, a large retail and commercial development, and international railway station. It is located in an area of persistent economic and social disadvantage, diverse ethnic and cultural communities and migrant groups, and one which will attract wealthy residents and visitors. The challenge is therefore to integrate existing and new residents, those who work in the area and visitors in ways which promotes healthy living. Creating a sense of a place is one way to foster a sense of shared space for diverse social, economic and cultural groups. The emphasis on practice is to provide information about how to foster a sense of place that has an ethos as a healthy and socially integrated place.

2.4 Limits to a place-based approach and limits to this study

This study is about healthy life-styles in one small, albeit significant geographical area and we recognise that health issues such as obesity and diabetes cannot be entirely resolved locally and require a national response.

The academic literature is limited on its understanding of how to stimulate health promoting qualities of a place and how a sense of place might affect place-based determinants of health, including perceptions of a place as friendly, inclusive and positive. Furthermore, studies have had mixed findings on the impact of social networks, social capital, and social cohesion on health; these social characteristics do not necessarily lead to health promoting behaviours and social relationships.[viii] Nevertheless we have used research findings from existing studies and conducted our own primary research to develop two interactive models to predict how we think this may be achieved.

There are many issues that may have health implications which we have not fully explored in this study. These include delivery issues such as how the behaviour of private developers and businesses may be influenced and what regulations might encourage them to make decisions in the interests of a healthy community, rather than maximising profits; by, for example, limiting the purchase of multiple properties for investment and limiting businesses selling unhealthy take-away foods. Other issues such as volunteering opportunities and the Olympic Games are relevant to a broader Olympic legacy agenda but are outside the scope of this study. Other reports discuss the potential legacy of the Olympics, including a report on housing by East Thames Housing and one by London East Research Institute, UEL, to name but a few.[ix]

Due to our focus on practice, the various strategic documents which pertain to the Stratford area have not been analysed in-depth nor their implications for a healthy place fully assessed. There are, however, some interesting issues to consider. For example, the strategic approach to health is different in Manchester and London. In London, strategic documents have a section on health whilst in Manchester, health is considered as an overarching regeneration issue and their Strategic Regeneration Framework does not have a separate section for health. Instead, health is integrated into the sections on education, housing, transport and community.

3 Our research

This paper is informed by three reviews of the literature; one on the relationship between health outcomes and regeneration initiatives, the second on health effects of planned mixed communities and the third on mental well-being and implications for regeneration. Two planned mixed communities were selected as case studies. Documents and findings from existing research studies were analysed and face-to-face interviews were conducted with decision-makers with key roles and responsibilities at the start of developments in both Greenwich and East Manchester.[x] A third 'case study' identified five areas across the country where there are recognised innovative health practices. This case study focused on three themes in the two geographical case study areas identified as being influential for achieving good health outcomes: community engagement, commissioning and service delivery for healthy initiatives. The findings from all these sources have been collated and used to explore how a healthy Stratford City might be created and maintained.

3. 1 Recommendations arising from this study

To write this summary report, we have collated our findings from each part of our study by identifying potential problems for strategists and practitioners and then seeking solutions to the identified problems. Our goal for the analysis of the data was to identify how to create and maintain a healthy Stratford City, taking into account its high profile location and its central place in the legacy of the Olympic Games. Our solutions are therefore recommendations and these are of several types: two practice models which conceptualise an overarching approach to creating and maintaining a healthy place, a geographical area which is the context that increases the likelihood that the recommended practices and initiatives will work, specific practices and activities. The following explains the recommendations in more detail and identifies which sources of research information we have used to make the recommendations.

3.1.1 Creating practice models

Our key proposal is two overlapping and interacting practice models. One outlines some organising principles and the other is a practice model. To construct these models we have used a problem-solving approach. We have drawn on research findings from all aspects of our study to identify health and health-related problems in areas similar to Stratford and have identified how successful practices might work and presented them in the explanatory models.

3.1.2 Why practice models?

There are several reasons for developing practice models. Firstly, whilst there is little evidence that regeneration programmes and planned mixed communities impact on health and health outcomes, there are also gaps in our knowledge about plausible links between urban regeneration initiatives and good health, and there is an absence of evaluation research on the effectiveness of many possible interventions, including community engagement, participatory commissioning and so on. Thus we have used research findings to make inferences about how a health initiative may work and this information is presented in the models. Secondly, there is the problem of replicating programmes and projects. Whilst successful interventions in one area may be introduced into similar areas, things which are similar are only similar in certain respects and the process of replication and rolling out programmes nationally has often had a poor track record.[xi] By extracting principles or generative causal mechanisms from the research data, practice principles can be transferred across locations.[xii]

We recognise that the search for causal mechanisms is difficult and full of uncertainties; many hypotheses can be explored and different types of data collected. Researchers may, however, fail to identify relevant mechanisms. Causal explanations may not involve identifying common characteristics shared across organisations, for example.[xiii] Being aware of these possibilities enables researchers to reflect continuously on their data, question their data analysis and discuss the inferences they make by 'checking' that their judgements are credible. As a research team, we have had meetings to reflect and check on the inferences we have made from the research findings.

3.1.3 Recommending a geographical area for healthy Stratford 'City'

Our recommendation for a larger Stratford 'City' than the Athletes' Village to be identified as a healthy place, draws on research findings collated from all aspects of the research for this study. A geographical area provides the context for the development of a healthy place and research suggests that certain characteristics of an area make it easier to foster a healthy reputation. The area defined as a 'green legacy footprint' and outlined in Figure 2, as well as suggesting that names of areas are synonymous with neighbourhoods, are integral to constructing a suitable context to address health inequalities and to promote a 'healthy' area. We recommend that a name is given to the 'green legacy footprint' area.

3.1.4 Recommending specific practices for a healthy Stratford 'City'

Some specific practices can be identified that facilitate the reputation of a place as being healthy, and these examples such as health outreach workers and community development workers arise from the case studies completed by UEL staff. Other examples of practices include community engagement and local commissioning.

3.1.5 Recommending particular activities for a healthy Stratford 'City'

Three specific place-making and health promoting activities are recommended, not as time-limited projects but rather as activities integral to the social life of the area. These activities are dance, gardening and an oral history group. These recommendations arise from the review of the literature on a mentally healthy place.[xiv]

4 Seeking solutions to problems

In this section, we have identified three types of problems which are relevant to develop practices; conceptualising the health 'problem', the need for effective interventions, and delivery issues. Although they are inter-related each is discussed in turn.

4.1 Conceptualising the health 'problem'

Systematic reviews of research findings have found a lack of certainty about the ability of regeneration initiatives to improve health outcomes and to impact upon health inequalities.[xv] Yet the importance of a healthy population for an economically productive and socially active community and the role of social disadvantage, employment, housing, education and crime in shaping health is well known. The relationship between economically and socially disadvantaged areas and ill-health is illustrated by the accounts we were given of East Manchester before the 2002 Commonwealth Games. These issues were used to start a long journey to become a healthy and economically active community as a legacy for the Games. By the late 1960s, East Manchester suffered from a drastic decline in its manufacturing base, leaving a 1,900 hectare brownfield site sparsely populated by people with various chronic respiratory and other health problems resulting in morbidity rates far above the national average. As well as physical health problems, people suffered from emotional and mental health problems arising from job losses, low self-esteem and low aspirations, all of which led to high levels of smoking and alcohol abuse. Lung cancer was twice the national average, pre-16 conception rates were the highest in the country and over two-thirds (68%) of under 5 year olds had dental diseases.[xvi] Research has consistently found that health problems cluster in this way in particular neighbourhoods and even when individual-level risk factors are taken into

account, community context is also found to be a determinant of health.[xvii] However, less is known about the social mechanisms that link 'being healthy' with place. So how can social policies and programmes be designed to have better health outcomes in geographically identified areas?

The continuing persistence of poverty and poor health in East London despite years of investment suggests that achieving a successful initiative in Stratford will be particularly challenging. From our experience of researching regeneration and health initiatives in East London, a series of time-limited and small scale programmes and projects were typically introduced into economically and socially disadvantaged areas. These included plans to improve access to health services and to encourage people to stop their unhealthy habits such as smoking and illegal drug taking. But on the whole, such projects are thought to be too small for the size of the problem and the problems so deeply entrenched that a longer time horizon would have been more appropriate, a point of view that was frequently expressed in East Manchester.[xviii] Short term initiatives to discourage teenage pregnancy have also been largely unsuccessful.[xix] Rather than projects and initiatives targeting particular health problems, we suggest that an integrated and long term approach is considered and one which starts by carefully considering how the health 'problem' is conceptualised.

We propose that how health is conceptualised in regeneration programmes might be considered using the World Health Organisation's (WHO) definition of health as a starting point. The WHO considers health to be "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The well-being and health promotion perspective is less often prioritised and it is this aspect of health which has implications which have not been fully tested in addressing the problem of health inequalities.[xx] Indeed, a recent overview of the performance of the NHS questioned commitment to reducing health inequalities and commented on the inadequate level of funding allocated to health inequality initiatives.[xxi] We have taken these issues into consideration in our proposals.

There are strategic plans from which such an approach may be developed, although more thought might be given to developing the strategic health indicators. The London Plan, for example, has one key performance indicator for reducing health inequalities. This is to reduce the gap between life expectancy at birth of Londoners living within 11 spearhead (East London) PCTs versus 20 other West London PCTs between 2011 and 2031. The Strategic Regeneration Framework for the five Olympic host boroughs aims to

narrow the poverty gap between East and West London through physical and socio-economic regeneration, which includes enhancing health and well-being by health-focused partnership working, encouraging people to choose healthier lifestyles, for example. Outcome indicators include a convergence in life expectancy, mortality rates from circulatory diseases and cancers, obesity levels in schoolchildren in their last year at primary school, and improved activity levels for adults and children. These strategic proposals provide a framework for taking forward plans for a healthy Stratford City and provide a structure for initiating leadership and promoting a change in health limiting circumstances. .

4.2 The problem of effective interventions

The following research findings have informed how we understand the challenges for developing a healthy Stratford City. [xxii]

Research findings that have informed our thinking about appropriate solutions:[xxiii]

Meta-analyses of evaluation studies reach similar conclusions about the weak impacts of regeneration programmes on health improvements, raising uncertainties about the value of investing in areas to improve the health or socio-economic status of individuals or impact on inequalities.[xxiv]

The strongest correlation between health and disadvantage is poor housing conditions which is unlikely to be an issue where high quality new housing is planned.

People-based interventions tend to have slightly more impact than place-based or area-based interventions, but both have weak links to past regeneration initiatives.[xxv]

Positive health outcomes from the New Deal for Communities (NDC) were evident where health professionals had greater influence through health promotion activities.

In NDC areas, a wide variation in health outcomes occurred and in some areas fewer people smoked cigarettes, and a greater proportion of residents felt that their health had improved.

In NDC areas, an increased satisfaction with local hospitals and GP surgeries did not necessarily impact upon health inequalities, nor did increased physical activities.

In NDC areas, increased community engagement did not lead to any discernible changes in the planned programmes or improved health outcomes.

The Sure Start programme successfully engaged with more families with young children, but the programme typically benefits the less disadvantaged in poor areas, leaving the most disadvantaged and those likely to have poor health without the assistance of enhanced health and well-being services.

At best, weak links have been found between planned mixed tenure neighbourhoods and the reduction of economic disadvantage and social exclusion, both of which lead to poor health.

We are poorly informed about if, and how, planned mixed communities may influence health outcomes, as research studies have rarely included health impacts in their assessment of mixed tenure neighbourhoods.

Where similar people share a neighbourhood, their compatibility leads to support networks including finding each other employment.[xxvi]

Mixed housing tenures does not necessarily lead to social mixing or improved social well-being.

Even where planned mixed communities are innovatively designed to promote healthy living by encouraging physical exercise, social interaction and inclusion, intolerance and tenure prejudice can arise between market-rate residents and social tenants and a lack of community feel can exist.[xxvii]

High land values and property prices in attractive and accessible inner city areas, as well as service charges to keep places clean and orderly, can lead to polarised income inequality in mixed tenure communities. Research has also found that income inequality corrodes social relations and decreases trust, resulting in less cooperation between classes which adversely affects health.[xxviii]

Research has also found that income inequality creates greater mental health problems and higher levels of drug use, obesity, and violence, all of which adversely affect health.[xxix]

Integrating new residents with existing residents is complex and has the potential to be divisive and cause tensions, which create health problems and make it difficult to foster a positive environment in which a healthy place can be created.

Research studies on the impact of large sporting events have found that few, if any, benefits arise for local people.[xxx]

4.3 Delivery issues

Previous research studies and, in particular, our own case study research has identified a range of practice problems which arise during the implementation phase of regeneration and health initiatives. The main issues and problems are summarised below:

Delivery issues[xxxi]

'Joint working' and 'integrated practices' can be more rhetoric than reality with practitioners lacking an understanding of each others' roles and responsibilities, and in meetings where representatives of agencies talk about their own agency rather than the space between agencies where genuine joint working takes place.

Strategic partnership groups can lack clear responsibility and accountability structures and there is a lack of tangible evidence that they facilitate improved health service delivery.

Planners and health professionals typically lack an understanding of each others' roles and responsibilities, speak a 'different language', and work with different planning cycles.

Health professionals can have a limited understanding of local communities, their issues and what it is like to live in the area. Being able to use local knowledge to implement community health services typically improves the use of services.

The delivery of services that are organised around chasing targets has a detrimental impact on service delivery and quality.

Strong senior management support and leadership, with an organisational culture that encourages staff to explore new ideas and to try different practices, that are receptive to 'local knowledge' and changing needs, improves health service delivery.

Practitioners face practical problems and feel supported and valued where these problems are addressed by managers.

Strategies are often felt to be at 'too high a level' and not relevant to their everyday practice problems. Practitioners prefer operational and pragmatic guidance.

A high turnover of staff impedes progress.

Those who have multiple and complex problems can be difficult for health providers to engage and work with to improve their health and well-being.

Many residents are not motivated or perceive too many barriers to adopt a healthy life-style and instead lead sedentary lives.

High levels of mental health problems, which range from mild to moderate depression and anxiety, are found in disadvantaged areas. Offering a rolling programme of non-pharmacological interventions are likely to be beneficial in supporting mental well-being and subsequent health promoting behaviours. Developing individual mental well-being for both staff and community requires encouraging people to learn for themselves, rather than be the passive recipients of an intervention or strategy.

5 Conceptualising a healthy place

Drawing on an analysis of the problems, we propose two inter-related practice models. Our proposed models are, in essence, a set of hypotheses which we predict will foster a healthy place, and are derived from research findings. Where research findings fit one particular explanation better than other explanations, this hypothesis was considered the most plausible explanation.[xxxii] Thus each model is underpinned by a plausible hypothesis to explain how a healthy place may be created.[xxxiii] [xxxiv] Factors that identify how this may be achieved are then identified. The organising principles model identifies values and beliefs that give rise to particular activities and actions that explain how a healthy place can be created and maintained. For example, an 'attachment to place' and 'physical, mental and social well-being' are factors that explain how a healthy place can be achieved, and to achieve this, a set of actions are identified, for example, 'all residents given opportunities to contribute' and 'staff responsive to feedback including criticisms'.

Similarly, the practice model explains how particular practices can create a healthy place. The model shows how responses to services and activities are integral to this process; responses are the links that explain how to achieve a healthy place. In this way, the links between factors describe a hypothesis-building approach which is key to understanding how to be successful in creating a healthy place. Thus services and activities which leave residents 'feeling valued' and which foster a 'sense of belonging and emotional attachment' to the area and which, in turn, lead to 'tolerant attitudes towards difference

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and diversity' are identified as key mechanisms which link services and activities to an 'intention to stay,' and thus create a stable and balanced healthy place.

Each model is presented diagrammatically followed by a description of their characteristics:

A model for a healthy place: organising principles

The most disadvantaged have complex and multiple problems, and continue to experience ill-health and health inequalities despite health and regeneration investment in their area.

Key Requirements
- Fostering a sense of place by:
- Attachment to place
- Physical, social and mental wellbeing

Conditions necessary to achieve key requirements
- Inclination to use public health services and join activities
- Residents feel able to make friendships
- Confidence to participate in planning and running activities
- Belief in pro-active engagement of all residents in preventative and healthy services
- Providers with the confidence to listen, reflect and respond to residents' concerns
- Climate that expects, promotes and supports healthy lifestyles

Actions necessary to achieve key requirements
- Staff responsive to feedback, including criticisms
- All residents given the opportunity to contribute
- Strategies for overcoming problems and constraints
- Joint problem solving to improve policies and practice

Key requirements achieved
- Healthy place: Reputation as a healthy place to live, work and visit

5. 1 Explaining the organising principles model

The following description explains the reasoning we have used to develop the organising principles of the model: starting at the top of the model with the formulation of the problem: 'most disadvantaged have complex problems...' we then work though a series of principles and explanations about how changes will occur and result in the outcome – 'a healthy place...' at the bottom of the diagram. Thus from our analysis of our data, the best hypothesis that fits the data is: if those experiencing ill-health and health inequalities are going to be healthy and ill-health is to be prevented, then appropriate policies and practices are those which foster a healthy place. The explanations are as follows:

5.1.1 Fostering a sense of place

The main organising principle is fostering a sense of place, as this gives people a sense of belonging to a physical environment and provides an opportunity to create a place with a reputation for healthy living.[xxxv] One of the challenges is developing a reputation or ethos that encourages residents to choose a healthy life-style, and is an outcome of the values, beliefs and factors described in the model for a healthy place, outlined above. Fostering a sense of place can be achieved by facilitating an attachment to the place and by promoting physical, mental and social well-being. These two organising principles interact and generate a different, but connected, set of factors and mechanisms to achieve a healthy place.

5.1.2 Attachment to place

The significance of place attachment is that place-making is the mechanism that links the wider determinants of health, such as housing, employment, crime, social and cultural context and environment to individual and community health outcomes.[xxxvi] Attachment is an emotional bond that creates a sense of belonging and satisfaction with an area which promotes physical, mental and social well-being.[xxxvii] A significant, and perhaps often overlooked, aspect to fostering a sense of place is recognising the existence value of particular buildings, facilities and works of art. Existence value contributes to the image and reputation of an area, and the Olympic facilities and the iconic ArcelorMittal Orbit will give the area a distinctive identity which will give meaning to its residents, and shape their identities.[xxxviii] Having pride in where you live improves self-esteem and this leads to health improvements.

Existence value also pertains to the range and quality of services available in an area. The existence of local health services which residents could use if they become ill, and the knowledge of residents that they could be involved in activities should they wish to, gives rise to significant satisfaction rates.[xxxix] Satisfaction with place gives people feelings of comfort and security which can reduce stress and depression.[xl]

5.1.3 Feel able to make friendships and inclination to use health services and to join activities

Place attachment encourages residents to feel that it is worthwhile making and sustaining friendships (social relationships are the strongest correlation with social well-being), and that it is worthwhile 'investing' in their local area. Positive feelings about themselves and the place where they live can motivate residents to access services and join health-related activities. Provided services are appropriate for people's needs and activities are attractive, the expectation is that attachment to place will grow stronger and that this process is reinforced when residents have opportunities to contribute to their community.[xli]

Of course, friendships can develop through a shared interest in criminal activity and anti-social behaviour, and it can be very difficult to foster residents' inclination to use health promoting services and adopt healthy life-styles, even if they feel positive about where they live. Developing positive social relations and a high take-up of services and activities are challenges faced by place-makers that are difficult to achieve. The practice model presented below shows how a healthy place may be realised, and the diagram presented in figure 1 on commissioning and community engagement practices by health professionals outlines 'what works' for this to be achieved.

5.1.4 All residents given opportunities to contribute and confidence to participate in planning, commissioning and running activities

Opportunities arise for residents to shape services and activities where service providers have beliefs and values that allow residents to be included. Deliverers of services and activities with these beliefs conceptualise local people as having positive attributes, as a useful resource and as partners. Their values explain a willingness to give residents opportunities to be involved in many activities, including participatory budgeting and volunteering. Giving people the opportunity to be involved and to make decisions improves their sense of self-worth, which is an attribute of being mentally healthy.[xlii]

5.1.5 Staff responsive to feedback, including criticisms and joint-problem-solving to improve policies and practices

Enabling local residents to be a 'partner' is achieved when agencies are able to respond to criticisms made by local people and feel able to relinquish some of their 'professional' control. This can occur through joint problem-solving, a process which can lead to an improvement in the relevance of policies and procedures, and enhanced levels of services for local people.[xliii]

Joint problem-solving and reflecting on the outcome of problem-solving is a key process which also has risks attached. In our research, practitioners talked about exploring options with local people, being prepared to make mistakes, and the importance of recognising practices which are not working and being willing to make changes. Some health problems are difficult to shift, for example, cigarette smoking and sedentary life-styles, but it was emphasised that achievements will only be apparent in the longer term.

5.1.6 Physical, mental and social well-being and pro-active engagement of all residents in preventative and healthy services

Research shows that a positive sense of place is connected to physical, mental and social well-being[xliv] and they are linked by pro-active engagement. In our health practice case study, there was a strong belief that engagement can increase residents' inclination to use services and participate in healthy activities. Other benefits include opportunities to make friendships. One manager described how residents can also become better informed users of services and implies that they are likely to demand a better level of service:

> 'I see community engagement not as... it should underpin your approach in terms of you should value your community and value its opinion, its voice, its information, its intelligence 'cause without it you've only got half the picture. But ultimately you engage with them in order to arrive at an outcome, and that outcome was we wanted people to think about their health, where possible to amend self harming or certainly not particularly positive behaviours, and to develop an empowered position after that engagement activity whereby they were more likely to engage with mainstream services in a more informed, frankly assertive, manner.' Senior NDC Manager

The quote above recognises that the benefits of community engagement arise from valuing and respect for local people. The key factor that links these beliefs with actions or practice is listening and responding to residents' concerns, attributes and skills.

5.1.7 Service providers with confidence to listen, reflect and respond to residents' concerns, with strategies for overcoming problems and constraints

Engagement practices seem to work well where staff feel confident to listen to residents, and to reflect and respond in ways that motivate residents to make changes to their lives

that lead to health benefits. Participants in our research described the engagement process as follows: firstly, overcoming problems and constraints takes place where practitioners and residents identify issues as problems. One interviewee explains the significance of this:

'Blimey, if we'd only known that it was X and Y that they were worried about, we could have done something about it.' NHS Commissioner

Practitioners were also mindful of the focussing on health issues for residents and how this should be taken into account when planning community engagement 'events'. One manager explained:

'To find out about health issues of the individual takes a different kind of engagement. If you're talking specifically about health, there's often quite a personal issue that people don't want to go to a public meeting or a focus group and necessarily talk about.' NHS Health Improvement Manager

Secondly, practitioners require confidence to solve problems with residents. Being able to work in a cooperative organisational structure and constructively with other agencies facilitates this process. These factors create a healthy working environment which is integral to fostering a healthy place. The importance of keeping joint working informed by the local community and keeping focused on longer term goals was often emphasised by practitioners. One manager commented:

'Often these initiatives come down from some government thing ... so everything changes and then you get another set of things coming at you and then it changes again .... Well it's slow and steady here and driven by the community and not by public health initiatives that come out of the NHS top driven health.' NDC Health and Well-being Manager

Thirdly, learning and responding to ongoing and changing problems and issues requires flexible commissioning practices and appropriate use of section 106 funding.

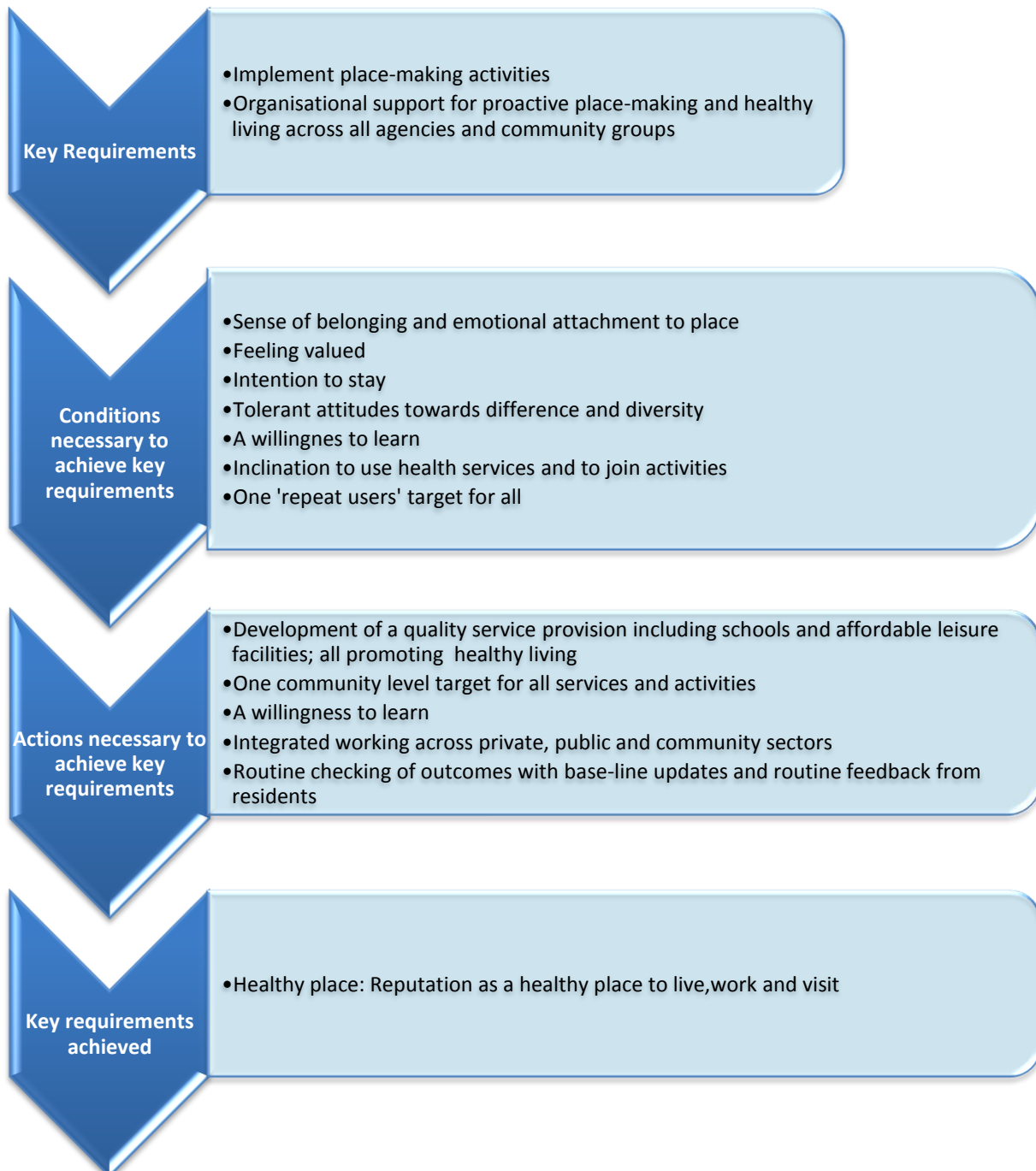### 5.1.8 Climate that expects, promotes and supports healthy life-styles

The combination of an agreed goal amongst all agencies and residents – creating a healthy place – and a proactive and a collaborative agency and community approach will, if successful, influence expectations about the value of living a healthy life-style. Such expectations are integral to understanding how a place acquires a reputation for being healthy. These expectations are a combination of individual aspirations and community practices. Together they explain how a healthy place 'ethos' may be created.

In addition to these organising principles are practice principles which interact and overlap to explain how a healthy place is created and maintained. The practice principles

are presented in the diagram below and are described using the same approach as the organising principles model.

Practices to promote place-making and healthy living

Disaffected groups with complex needs who agencies find it difficult to engage, and residents are reluctant to lead healthy life styles.
Health service providers enabling all residents to engage with services and activities and providing residents with opportunities to engage with each other.

Key Requirements
- Implement place-making activities
- Organisational support for proactive place-making and healthy living across all agencies and community groups

Conditions necessary to achieve key requirements
- Sense of belonging and emotional attachment to place
- Feeling valued
- Intention to stay
- Tolerant attitudes towards difference and diversity
- A willingnes to learn
- Inclination to use health services and to join activities
- One 'repeat users' target for all

Actions necessary to achieve key requirements
- Development of a quality service provision including schools and affordable leisure facilities; all promoting healthy living
- One community level target for all services and activities
- A willingness to learn
- Integrated working across private, public and community sectors
- Routine checking of outcomes with base-line updates and routine feedback from residents

Key requirements achieved
- Healthy place: Reputation as a healthy place to live, work and visit

5.2 Explaining the practice principles model

The practice model starts with the core problem that agencies find it difficult to engage with disaffected groups with complex health and health-related problems and those who are reluctant to adopt healthy life-styles. The challenge is for agencies to engage and work with all groups and to facilitate residents engaging with each other to provide opportunities for mutual support amongst residents. To achieve, this we propose two inter-related strands of activities; implementing place-making and healthy living activities and organisational support for proactive place-making and healthy living across all agencies and community groups.

5.2.1 Implement place-making and healthy living activities

The implementation of place-making and healthy living activities conveys a message to residents that their place is worth investing in, and these activities make them feel valued and a sense of belonging and attachment to place begins to grow. Place-making incorporates a range of activities which includes building on and being sensitive to residents' existing sense of community, respecting valued buildings, and enhancing existing services and activities which work well and that people like. A very clear message from existing research studies and from practitioners who participated in our research was that local people living in disadvantaged areas are typically reluctant to access services and take-up of services low. We found a strong belief in the value of proactively taking health services to places where residents gather socially, such as leisure centres, markets, pubs, and even betting shops where it is possible to check blood sugar levels and give people an MOT health check.[xlv]

The design and location of Stratford City with its state-of-the-art sporting facilities, its local, national and international transport links, and its green open spaces and natural environment up the Lea Valley offer the potential to foster an attachment to the area for residents of all tenures. These features give the area the potential to become a 'mentally' healthy place, and research findings suggest that there are several ways in which this can be developed.[xlvi] Research on well-being has found that: contented people have better coping strategies to overcome negative events; physical activity is the most reliable predictor of well-being and inclusive accessible environments encourage walking, cycling and other activities; time spent in a natural environment contributes to subjective well-being, reduces blood pressure and increases self-esteem.[xlvii] We have identified three

place-making and healthy living activities which are directly connected to these research findings. They are:

Gardening: research shows people prefer natural environments to built environments and community gardening is associated with social mixing and a stronger sense of community.[xlviii] Community space for gardens therefore has the potential to promote a place for social, ethnic and cultural groups, as well as residents across age, gender, and different types of disabilities, to come together to share a common interest. Gardening has the additional advantage that for older people, in particular, it gives them a purpose in life and leads to increased feelings of self-worth. For the general population, regular gardening halves the risk of developing dementia.[xlix]

There is a food growing strategy for the Athletes' Village that is demand led and proposes that a scheme may be set up to encourage residents to have their own planting boxes and that courtyards could be used for growing vegetables and fruit, and that any vacant land in the nearby area could be used for food growing. Currently no space has been allocated for allotments.

Dance: dance is for many people a more preferable form of exercise than sport and it is often culturally popular, as well as a sociable activity. For teenagers and young people, who can quickly become marginalised and labelled as trouble-makers, participating in dance makes them feel good about themselves, allows them to escape from anxieties in their daily lives and to feel calmer, and performing gives them recognition and a sense of pride, all of which contribute to their well-being.[l]

Local history project: this has an additional advantage of being 'sense-making' which promotes a sense of belonging.[li] Research studies have found that people have a drive to make sense of or interpret their environment and psychologically this gives them the capacity to feel able to manage their environment and their own life, a characteristic that underpins the Marmot review on reducing health inequalities.[lii] An oral history project will facilitate the process of making sense of the physical environment, link residents to their local area and has the potential to create an emotional bond and collective identity, and enable them to make connections between their cultural heritage and the Stratford area.

We recommended that these activities are in place as soon as possible to start the process of creating a healthy image for Stratford City and suggest that they could be funded by the Trust Fund.

5.2.2 *Feeling valued, and sense of belonging and emotional attachment to place*

Attachment can also be facilitated by the design and construction of high quality health and community facilities that emanate well-being with welcoming and friendly staff, high standards of accessibility and comfort, all of which sends a message to local people that they are 'worth it'.[liii] Practitioners who we interviewed for this study recognised the importance of culturally sensitive practices which originate from listening to local people and can be developed through culture specific engagement practices, staff training, and commissioning.

5.2.3 *Tolerant attitudes towards difference and diversity*

A particularly important characteristic in developing place-making is tolerant attitudes amongst residents and between residents and service providers, and an ethos that fosters trust and respect.[liv] The layout of play facilities and social spaces and familiarity can improve understanding and tolerance.[lv] Affordable housing is located in blocks and the blocks are distributed throughout the Athletes' Village development, making it easy to distinguish between social tenants and market-rate home owners. How the development as a whole is maintained and managed in ways that fosters tolerance will be crucial for creating an inclusive sense of community.[lvi] Tolerance has positive health effects, due to the presence of fewer community and social tensions and less violence and, importantly, tolerance is the mechanism which creates a friendly environment that leads to feelings of well-being.

5.2.4 *Developing quality service provision for all residents including schools, affordable leisure facilities; all promoting healthy living, and intentions to stay*

Research studies have found that a reason market-rate families leave planned mixed communities are poor services, in particular poor performing schools, and this migration pattern leaves communities with a social imbalance. Families also facilitate social interaction across housing tenures and therefore have the potential to play a vital role in enabling planned mixed communities to work.[lvii] So too does fair policing, and considered responses to anti-social behaviour will enable tolerance and respect to develop. Similarly, affordable access to leisure facilitates promotes a sense of fairness and equality. The combination of quality service provision and an ethos of tolerance and fairness are likely to contribute to residents' intentions, across all housing tenures, to remain in the area.

5.2.5 One community level target for all services and activities

A community measure to capture the retention of a 'balanced' community, as well as tolerance and feeling valued, would keep a focus on the practice principles outlined in the model to promote place-making and healthy living activities. Having one target is likely to foster integrated working and to provide a focus for making tangible and measurable progress. In our view, a community level target or indicator is best agreed between community and agency representatives working together.

5.2.6 Organisational support for proactive place-making and healthy living across all agencies and community groups and integrated working across private, public and community sectors

Two key organisational practices have emerged from the research. Firstly, engendering support for a particular goal across an organisation, in this instance, proactive place-making activities. This may require breaking down 'silos' within an organisation and informing staff about how this goal is to be achieved so that they feel well-informed. Secondly, organisational support for proactive healthy living can be achieved through integrated working across private, public and community organisations. Research studies consistently emphasis how difficult this is to achieve.[lviii] Our case study findings suggest that several practices may be pursued with some success. Joint working appears to be most successful where staff feel confident to do their work, understand the roles and responsibilities of staff from the agencies they are working with, and have a sense of working together for the 'good of the community'. A comprehensive joint agency training programme is likely to be beneficial. In one of the case study areas, GPs learn about policing, for example.[lix] One manager summarised the views of several practitioners we interviewed; they recognised that the value-added of joint working occurs when those delivering services are able to work across organisational boundaries, and as a consequence to work in different ways:

"I suppose the basic principles of what works well are having people within different organisations, statutory or voluntary, who are really prepared to work across those organisational boundaries and take some risks, and do things differently." NHS Health Improvement Manager

Another manager gave an example of how cooperative working led to joint social care and health commissioning through the local district housing office, and how this enhanced joined-up working and had better outcomes for clients. The healthcare clients were seen as the same as the housing department's clients:

'For me, if you've got an elder with a variety of health and care issues who's in social housing, actually the person who is probably physically closest is the Housing Office in the decentralised form. I was always arguing that what you could have done is you could have been able to empower that housing provider to be the single point of entry and referral, and if necessary, were people willing to pool

budgets at that housing level so that somebody could actually, the idea of a housing officer being able to 'commission' care services in partnership with their care partner for that tenant. Because the reality of it is, the housing officer saw these people more than anyone else because they could do the home visit, they were on the estate and all the rest of it. ' Senior NDC Manager

5.2.7 A willingness to learn

A key mechanism that underpins how changes in organisational and working cultures can occur within and across organisations is a willingness to learn. This approach is, however, dependent on organisational cultures that promote and support learning, encourages experimenting with new ideas and values learning from mistakes.[ix]

Practitioners who are willing to listen to residents develop a better understanding of local people and their communities, and are better informed about community issues. Such information can feed into commissioning and community engagement strategies. One manager explained the value of this process:

'So we were starting to feed backwards, like Mrs M had her blood sugar tested, she's had a heart condition, but actually what was really at the heart of concerns was she was extremely stressed because her teenage kids had been excluded from school. And what that led to was, well actually why can't we start putting these people in contact with this other strand of work we had around learning mentors or street-based youth workers? And we started to see that if you approached somebody on their health and well-being ...is that people would actually reveal other stresses in their lives that you're actually thinking, well, actually we could probably assist with that as well. So it became a way of engaging people to learn more about them, them learn more about us so that we can actually then offer them other services.' Senior NDC Manager

5.2.8 One repeat user target for all agencies and groups

We suggest that integrated working will be easier to achieve if all agencies and community groups work towards the same target or performance indicator and that this is repeat users. For health services treating illness and emergencies – GPs and accident and emergency services – and for police, youth offending teams, social services and responses to truanting and exclusions from schools, the aim would be to reduce repeat users. For other activities such as attending courses, exercise on prescription initiatives, clinics for babies and young children, and physical activities, the aim would be to have regular attendance and therefore high numbers of repeat users would be considered as a success.

Given that available resources are limited, and shrinking, focusing practice on repeat users is an attractive strategy. It invests in those with most health and social problems and encourages sustained healthy living. It also encourages agencies to develop a system of cross-referrals and to meet the one performance target, agencies will be motivated to plan integrated responses to individual's and families' multiple problems, thereby responding to them as 'whole people'.

Reducing repeat users is already a familiar performance measure for accident and emergency services and for the police. Furthermore, local strategies have incorporated, for example, a reduction in re-offending by young people[lxi] and a reduction of repeat incidents of domestic violence.[lxii]

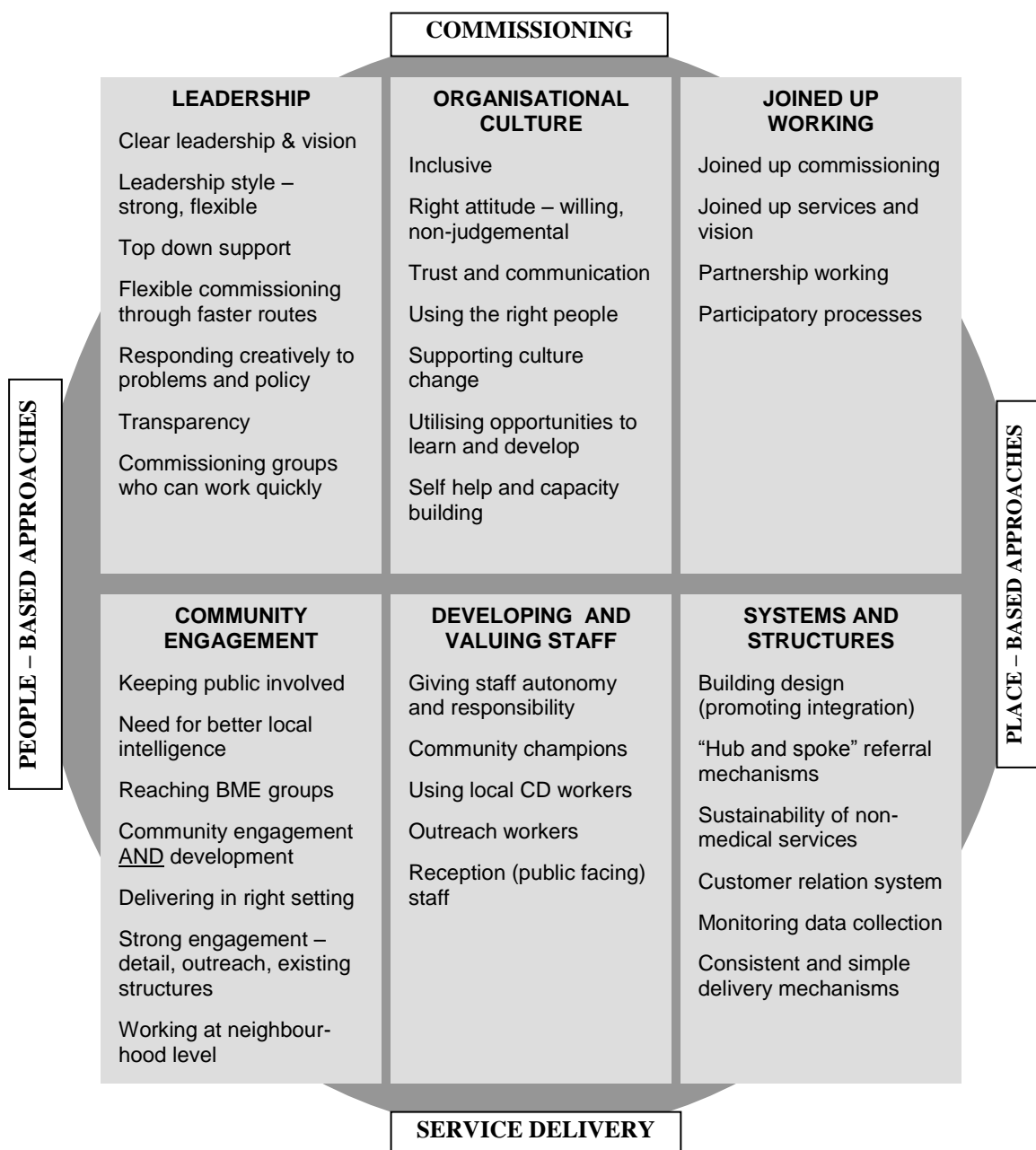*5.2.9 Routine checking of outcomes with baseline updates and routine feedback from residents*

A baseline is important as it enables all partners to assess the outcomes and impact of their actions and to reflect on remaining problems and how they may be addressed. It also enables partners to asses their progress towards achieving longer term goals. Creating routine feedback loops between service providers and residents are essential for developing and maintaining services and activities that are relevant, for delivering services sensitively, and to enhance and develop existing skills and attributes within the community.

The contents of a baseline study, we suggest, are best decided on as a joint exercise consisting of service providers, community members and researchers.

5.3 Summary of key health promotion organisational structures and activities

Since the focus of this study is on health, we have highlighted some themes pertinent to the effective organisation of health services to indicate 'what works'. The diagram below summaries the key health themes associated with effective commissioning and service delivery, which arise in particular from the practice case study and are incorporated into the models described above.

__Figure 1__[lxiii]: Themes associated with effective commissioning and service delivery to promote health and reduce inequalities in socially disadvantaged urban areas

COMMISSIONING

PEOPLE – BASED APPROACHES

PLACE – BASED APPROACHES

LEADERSHIP

Clear leadership & vision

Leadership style – strong, flexible

Top down support

Flexible commissioning through faster routes

Responding creatively to problems and policy

Transparency

Commissioning groups who can work quickly

ORGANISATIONAL CULTURE

Inclusive

Right attitude – willing, non-judgemental

Trust and communication

Using the right people

Supporting culture change

Utilising opportunities to learn and develop

Self help and capacity building

JOINED UP WORKING

Joined up commissioning

Joined up services and vision

Partnership working

Participatory processes

COMMUNITY ENGAGEMENT

Keeping public involved

Need for better local intelligence

Reaching BME groups

Community engagement AND development

Delivering in right setting

Strong engagement – detail, outreach, existing structures

Working at neighbour-hood level

DEVELOPING AND VALUING STAFF

Giving staff autonomy and responsibility

Community champions

Using local CD workers

Outreach workers

Reception (public facing) staff

SYSTEMS AND STRUCTURES

Building design (promoting integration)

"Hub and spoke" referral mechanisms

Sustainability of non-medical services

Customer relation system

Monitoring data collection

Consistent and simple delivery mechanisms

SERVICE DELIVERY

6 Key issues specific to 'Stratford City'

Findings from our research suggest that there are some issues which are of particular significance for Stratford City if it is to become a healthy place. These issues are discussed in this section and include:

6.1 Creating an optimal context for a healthy place: identifying a larger 'Stratford City'

As described earlier we constructed two models, which are hypotheses, to generate explanatory information to enable practice principles to be extracted from research findings. These practice principles or generative causal mechanisms are transferable and form the basis for developing practices that can be used in different contexts.[lxiv] However, the practice models are more likely to be more effective and have better outcomes in some contexts rather than others. Figure 2 below outlines the larger Stratford City 'footprint' which, on the basis of research findings, is a preferably geographical area to create a healthy place.

In East London where there is a convergence strategy to address health inequalities we propose that a larger area, as shown below, is identified as 'Stratford City'. The reasons for this are: to use the Olympic site and the legacy of the Games to promote healthy living in an area where the existing residents have poor health; to integrate existing residents with incoming new residents to establish and retain a balanced community of social, affordable and private housing and families from all tenure types; to address the potential problem of the Athletes' Village becoming an exclusive area dominated by professions who only have a transitory interest in the village.

Our proposed area for 'Stratford City' integrates existing communities with the new developments in what we have termed the 'Green Legacy Footprint' and is a 'green' area which can be used on foot, by bicycle, skateboard or canoe. This area is defined on three sides by natural barriers: the A12 dual carriageway to the north and west, and in the south the railway line from Bromley-by-Bow to Plaistow through West Ham. The eastern extent is less easy to define, but has been positioned broadly along the A11 and B164 as representing a likely limit to walking and easy cycling interaction with the Olympic Park facilities.

Information about the existing population shows that residents are ethnically and culturally diverse, tend to be younger adults (16 to 34 years old), some of whom have children. An increasing number of families, particularly with secondary school aged children, have moved into this area over the last five years and live in housing association and rented accommodation. Pensioners living in the area are likely to be living in relative poverty. Residents tend not to have formal qualifications and are usually employed in semi-skilled manual and unskilled work.

Data suggest that the existing population would benefit from a health promotion programme; economic and social disadvantage is above the London average, there is a tendency for the type of residents living in this area to smoke and shop in cheaper supermarkets, and rates of smoking, obesity and use of mental health services are all above the London average. The young age of residents, including young people, give added relevance to a healthy living initiative for 'Stratford City'.[lxv]

Figure 2: The Stratford City 'Green Legacy Footprint' area. Note: a real image has been rotated with north to the bottom to aid depth perception of buildings and topography. © 2010 Google – Imagery © 2010 DigitalGloge, GeoEye, Infoterra Ltd and Bluesky, Getmapping plc, The GeoInformation Group.

6.2 Re-naming

Similarly, we recommend that consideration is given to re-naming particular areas as names are contextually significant, particularly where social mixing is identified as a typical problem and promoting social equality and integration are mechanisms which can

address health inequalities. Re-naming is important for integrating existing and new communities, for addressing the potential problem of the Athletes' Village becoming an enclosed community where income polarisation may cause health and social problems within the village, and for outsiders a small area named as a 'City' portrays the image of an exclusive place. This can fuel resentment and undermine community relations in the wider Stratford area. A place name that includes 'City' is likely to exacerbate these potential difficulties. However, place-naming is likely to be decided by the owners of the developments as part of their marketing strategy.

The Athletes' Village is situated in the Olympic Park and is part of the area identified as Stratford City, which incorporates zones 1-7 on the masterplan and includes the new international railway station running from west to east across the centre of the site, with mixed tenure housing to the north of the station and a retail and commercial development to the south. Our proposals in this study fit well with the key principles of the masterplan which include place-making, connectivity, efficiency and identity. The masterplan also has a clear open space strategy with easy access to the Olympic and Lea Valley parks. However, to integrate the Athletes' Village into the existing area as recommended in the section above, we suggest that the planned mixed community is named to give it a neighbourhood identity and similarly, the retail and commercial area is named to give it a neighbourhood identity and the name Stratford City is given to the wider area, although a consultation exercise that allows existing residents to decide on a name could be a useful exercise to foster place-making and attachment to the area.

To contribute to the image and reputation of Stratford City as a healthy place, giving the new polyclinic a name which includes 'healthy living centre' would also be beneficial.

6.3 Making a good start

A clear finding from our research was the importance of making a good start by having clear delivery structures in place with the necessary capital and revenue funding to realise plans. The following factors will contribute to a good beginning:

6.3.1 Local commissioning and integrated working across boroughs
A joint health unit with local authority staff, NHS staff, and community organisations from Newham, Tower Hamlets, Hackney and Waltham Forest which will integrate planning, commissioning, implementation and evaluation for regeneration and health, similar to the New East Manchester model, and take forward a healthy place agenda. Area-based

commissioning and a pooled budget would facilitate joint planning and integrated service delivery. The following table summarises what systems and structures support the delivery of health services:

Table 1[lxvi]: Systems and structures to support commissioning and delivery of services to promote health

System/structure	Details
Using the "Hub and spoke" model for delivery and referral	Can facilitate joined up, non-siloed partnership working between NHS health services and other services relevant to health - essential for tackling wider determinants of health.
	'Roaming' hub e.g. healthy life-style check can bring services to community settings (e.g. mosques, football matches) making services "easier to reach".
	Hub and spokes need to be flexible so that spokes can refer to other spokes, as well as the hub referring to spokes.
Building design (promoting integration and well-being, involve community in the design)	Include space for 'non-medical' and community facilities.
	Communicate a message of "self-worth" to staff and users ("It's light, it's bright, it's welcoming. It gets praised for its aesthetics and I think that, in an area of deprivation, is what's needed").
Sustainability of non-medical services	Important for 'low-level' mental health problems.
	When these services are seen as fundamental for improving health rather than as 'add-on extras' long-term funding more secure.
IT systems	Right software and systems need to be in place from the beginning.
	All stakeholders need to be able to enter and access information (e.g. GPs, commissioners, third sector).
Monitoring data collection	Collating evidence to support a service requires continual monitoring, and also considering how to capture soft or unexpected outcomes.
	A lot gets missed because it is not necessarily a direct impact, it is a 'soft' or unexpected outcome', the right questions are not asked or insufficient data is gathered to provide conclusive evidence.
Consistent and simple delivery mechanisms	Consistent delivery includes consistent style, time, venue, publicity to ensure that over time people learn about it, it becomes trusted and also develops into referral pathways from other service providers e.g. GPs .
	Consistency and continuity enables, politically, ties to develop e.g. GPs becoming aware of services for referral.
	Simplicity in accessing and understanding the service is also very important.
	Successful element is simplicity, visual action and direct association.

6.3.2 A confident and committed multi-professional group of service providers

The experience of the East Manchester project is that improving health outcomes in disadvantaged areas is complex and challenging, and that it is difficult to achieve tangible improvements in health and wider-health determinants even over a 10 year period. The commitment and energy of staff delivering the East Manchester urban

renewal programme is impressive, but these efforts can be undermined by short term contracts, unwanted secondments, and rapid staff turnover can hinder the delivery of programmes.

6.3.3 Ready-to-use facilities and services

An absence of available services quickly gives a new place a poor reputation and once it is stigmatised, market-rate families and services are not attracted to the area and a balance of housing tenures is hard to achieve. The importance of having health and public services in place before new residents move in was emphasised. The current arrangements for Stratford City are that health facilities and other services can utilise section 106 funds according to the rate of resident occupancy. However, studies have found that services and facilities should be available for residents to use immediately they arrive.[lxvii] An awareness of possible unintended consequences was also highlighted in our study; for example, an existing GP moved into new health facilities in Greenwich Millennium Village and his patients stayed with him, making fewer places available for new residents. In both Greenwich and Manchester, accessibility of health services was variable, with limited accessibility to dentists, for example.[lxviii]

6.3.4 One organisation with management responsibilities for all residents in the Athletes' Village

Research has found that in planned mixed communities, like the Athletes' Village, having one organisation and one place where all tenants go for assistance and to make complaints is valuable. If the same organisation is responsible for responding to all residents' difficulties and complaints, tenure prejudice may be less likely to occur and residents are likely to have higher levels of satisfaction.

6.3.5 Activities to promote social integration led by community development and outreach health engagement workers

The experience of planned mixed communities is that residents do not organically or naturally come together to create a friendly place and that the social mixing which is particularly beneficial for those living in social housing does not occur. The employment of a community development worker can 'bridge the social divide' and promote community participation through activities, a newsletter and the provision of information about local community groups and services. A worker can contribute to a positive beginning for new residents and integrate existing and new residents. The role of community development workers is also to enhance the qualities and skills of local

people and, at the same time, advocate on their behalf and facilitate relationships between 'the community' and professional organisations.

Social mixing is most likely to occur amongst children. Running child-centred activities is likely to be one way of achieving social interaction[lxix] and the planned extended school hours in the Athletes' Village may increase social interaction between social classes, if it has high attainment levels to attract market-rate families.[lxx] A community worker could facilitate social mixing in community centres, at the schools, in parks and open spaces by organising family orientated activities, for example.

Similarly, even though the polyclinic may be a state-of-the-art building, it cannot be assumed that its users will naturally socialise. Receptionists have a key role in creating a 'friendly place' and the use of the building for community meetings can create a friendly environment. Nor can it be assumed that being a former Olympic site will facilitate social networking and better social relations.

Our research findings consistently show that proactively engaging residents and community development work are necessary, and that starting these activities to create a healthy place in the broader 'green footprint' area of Stratford is likely to facilitate the process of integrating new residents with existing residents. The following table outlines factors related to successful and meaningful engagement.

Table 2[lxxi]*: Factors related to successful and meaningful community engagement*

Factor	Details
Aligning community engagement more closely with community development	Building relationships, outreach, and capacity building to raise residents' aspirations and self-esteem.
	Important for sustainability: "we just hold the door open or just help them through the door so that they can then improve their life prospects".
Having a clear purpose or 'end game' for the community engagement	Prevent "community engagement for engagement's sake," with success judged solely in terms of "if they kept turning up that was good".
	Link 'end game' to building capacity and empowering members of the community to engage with services.
Setting up structures and processes for ongoing engagement as opposed to 'one-off' engagement	The 'hub and spoke' model for service delivery adopted by NDCs provided opportunities for ongoing engagement and further intelligence gathering through the referral system.
	Working at the neighbourhood level as well as borough-wide.
Using outreach workers and community members to go 'deep' into communities and produce better local intelligence	Delays in finding out about "changes on the ground" could be shortened by improving local intelligence.
	Use of community development workers or community members could shorten delay, especially in estates where no dedicated services were in place.
Ensuring that community engagement is inclusive of 'harder to reach groups'	To be inclusive, community engagement needs to follow several steps: segmenting the community, recognising and understanding potential barriers to engagement within different segments, and developing appropriate engagement strategies to overcome these barriers.

Community development and outreach health engagement posts could be funded through a pooled budget managed by a joint health delivery unit, and use funds from the community development trust which has a £1million endowment fund provided by section 106 funds, and which is linked to the physical building of the polyclinic and its community facilities. Trust funds can be used as soon as residents move into the Athletes' Village. Funds for community engagement work prior to 2014 will require other sources of funding.

6.3.6 Awareness of the high risk of tenure prejudice

The possibility of tenure intolerance and prejudice arising in the Athletes' Village is real. All the conditions are present that cause the problem; high land values and high housing prices which result in polarised income gaps between private and social tenure residents. In a location that is attractive, buyers who wish to invest in property buy-to-let and this can create a social imbalance in the community. It has been decided to have a concentration of social housing, in particular blocks of flats instead of 'pepper-potting' social housing. Social tenants will therefore be easily identifiable as a 'separate' social

group. Tenure prejudice can be exacerbated when there are perceptions that service charges are high. Service charges create an expectation of high levels of cleanliness and orderliness and a 'right' to complain. Research has found that these situations can create health and social problems, including higher levels of violence as an expression of feeling 'put down' and humiliation.[lxxii]

7 Research and evaluation

There are various ways to monitor and assess the progress of the Stratford City initiative. These include: establishing a baseline study and routinely updating the information in order to assess the extent to which health outcomes are being achieved; an action learning research approach whereby researchers work with practitioners to enable them to articulate problems and to improve problem-solving; a formative evaluation to assess progress towards achieving process outcomes; and a summative evaluation of impacts.

We recommend that the approach to research and evaluation incorporates the values described in the proposed models; that research is iterative, collaborative – including statutory agencies, community groups and residents as partners, builds on the skills of residents by training them as community researchers, and is integrated into the initiative by submitting joint delivery agencies and university funding applications for research and evaluation.

Alice Sampson, Centre for Institutional Studies & Team UEL co-ordinator
Angela Harden, Professor of Community and Family Health, Institute for Health and Human Development.

[i] For the appendices see full report. See appendix 1 for the review of literature on health and regeneration, appendix 2 for a review of planned mixed communities and health, appendix 3 for a review of well-being and mental health, appendix 4 for the Greenwich Millennium Village and New East Manchester Case studies, appendix 5 for the health practice case study and appendix 6 for statistical information on the case studies and the Stratford City 'green legacy footprint'.

[ii] The UEL research team comprises of researchers from: the Centre for Institutional Studies, Alice Sampson, Hipolina Joseph and Jane Stokes; Institute of Health and Human Development, Angela Harden, Patrick Tobi, Kevin Sheridan, Faye Adams-Eaton, Shahana Lais, & Gail Barrow-Guever; Geo-Information Studies Centre, Allan Brimicombe and Yang Li; and Health Psychology, Ilona Boniwell. We would particularly like to thank our UEL colleagues John Lock and Oona Scott for their support and helpful comments on earlier drafts of the report. We would also like to thank the members of our steering group for their helpful, supportive and insightful contribution to this study; Jane Connor, Mary Clegg, Fiona Parry and Monica Thomas.

[iii] See appendix 3.

[iv] See appendix 1.

[v] See appendix 2.

[vi] Marmot, M. (2009), *Fair Society, Healthy Lives. Strategic review of health Inequalities in England post 2010.* www.ucl.ac.uk/marmotreview

[vii] See Olympic and Paralympic Legacy Strategic Regeneration Framework. Response of the Marmot team. April 2010.

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xviii See reports written by researchers at the Centre for Institutional Studies on Stratford City Challenge and Single Regeneration Budget initiatives. For example Fearnley, R. (1999) Stratford City Challenge: Final evaluation, CIS commentary 82, Centre for Institutional Studies, University of East London and other reports at www.uel.ac.uk/cis
Also see appendix 4 and NEM which has a long timeline before health outcomes are expected to change. Surveys show that attitudes towards smoking, drinking and sedentary lifestyles are beginning to change but there is still a 'lag' in behaviour changes.

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xxiii For the findings summarised in this box see appendices 1 & 2 & 3.

xxiv See appendices 1 & 2 in particular.

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xl See appendix 3.

xli Appendix 3 and Marmot, M. (2009), *Fair Society, Healthy Lives. Strategic review of health Inequalities in England post 2010.* www.ucl.ac.uk/marmotreview

xlii See appendix 3.

xliii See appendices 3, 4, & 5.

xliv See appendix 3.

xlv See appendices 4 & 5.

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l See Sampson, A. (2010) 'Young people and performing arts as a route to social inclusion'. End of AHRC award report. Centre for Institutional Studies, University of East London.

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lv See appendices 2 & 4.

lvi The Registered Social Landlord is Triathlon which is a consortium consisting of two social landlords, East Thames Group and Southern Housing Group and a private developer First Base. Triathlon is the owner and manger of the affordable housing.

lvii See appendix 2.

lviii See appendices 1, 2 4 & 5.

lix See appendix 4.

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lxv see appendix 6.

lxvi See appendix 5.

lxvii See appendix 4.

lxviii See appendix 6.

lxix See appendices 1, 2, & 4.

lxx See appendix 2.

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Appendix 1

A review of the literature on the impact of urban regeneration and health
Prepared by Marcello Bertotti and Angela Harden

1.1. Introduction

This review draws on existing systematic and other types of reviews on the topic of urban regeneration and health and selected primary research evaluating key urban regeneration initiatives. The review covers the international literature but has a particular focus on studies from the UK and Europe[1].

1.2 How might urban regeneration bring about changes in health?

Much urban regeneration aims to address socio-economic deprivation through improving living conditions and economic opportunities. Based on the wealth of epidemiological data linking socio-economic deprivation to poor health, they have been used extensively in the UK as part of a strategy to improve health and reduce inequalities. The hypothesis is that interventions which aim to alleviate socio-economic deprivation will lead to improved health (Thompson, 2008). Urban regeneration is also informed by a 'wider determinants of health' model (Dahlgren and Whitehead, 1991). Initiatives have made an explicit attempt to alter these wider determinants of health, such as employment, housing, education and income, as well as more traditional efforts to promote health life-style changes and improvements to health service provision.

Urban regeneration is a term that means different things to different people, ranging from large scale activities that promote economic growth to neighbourhood interventions that improve quality of life. The English Department of Communities and Local Government recently defined regeneration as "a set of activities that reverse economic, social and physical decline in areas where market forces will not do this without support from government" (DCLG, 2008). Another recent definition highlights that regeneration should not be simply equated with physical regeneration but should involve "a wider set of actions intended to: increase economic activity and employment; improve business confidence; deliver better educational outcomes; enhance skills; achieve greater levels of community safety; and improve environmental quality" (Equally Well, 2008).

Conceptual work to explore the mechanisms by which urban regeneration may bring about improvements in health is very limited and reports on specific urban regeneration initiatives rarely make explicit the mechanisms by which health gains are thought to occur. Atkinson et al. (2006) could only infer the following links from their review of nine urban regeneration initiatives:

- In programmes which include investment in the creation of employment opportunities, absence of paid employment is linked to poor mental health and life chances, especially for ethnic minorities;
- Crime reduction activities are linked to health via fear of crime as a source of stress;
- Improvements in the physical environment are linked to better quality of life and health for children, as they encouraged exercise and decreased danger posed by derelict and dangerous land.

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[1] Reviews were identified by systematic searches of the Cochrane Library, the Campbell Library, The EPPI-Centre website and its Database of Promoting Health Effectiveness Reviews (DoPHER) held at the Social Science Research Unit at the Institute of Education, University of London and DARE, the systematic review database held by the Centre for Reviews and Dissemination at the University of York.

Egan *et al.* (n.d. unpublished paper) argue that the relationship between regeneration and health is likely to be of three different types: direct, influence or contribution. Examples of a direct impact of regeneration on health include preventing asthma by making homes damp free, or increasing children's risk of injury by moving families to new homes near busy roads. In an influence relationship, regeneration has an indirect impact on health via an intermediate step such as behaviour change. For example, improving people's kitchens may encourage residents to spend more time preparing and cooking healthier food, or improving the quality of the neighbourhood encourages more people to walk. In the contributions model, it is the collection of regeneration actions which impact on health. Some of these actions will have a direct impact, others an influencing impact via intermediate step(s). For example, a range of initiatives and a favourable economic climate reduce health inequalities and lead to residents of disadvantaged areas enjoying the same level of health as residents of more affluent areas.

1.3 Do urban regeneration initiatives bring about improvements in health?

1.3.1 Evidence from systematic reviews

Despite the powerful argument outlined above regarding the potential of urban regeneration to improve health through impacting on the wider determinants of health, there is very little consistent empirical evidence of impact except for the direct impact of housing improvement on health. Thompson et al. (2001) conducted exhaustive searches dating back to 1887 and found 18 studies that studied the effects of housing improvements on health. The majority of the 18 studies found improved health outcomes as a result of the housing improvements. Studies of the effects of re-housing, refurbishment and relocation showed improvements in mental health illness episodes and self-reported physical and mental health. Improvements in respiratory symptoms were also found as a result of energy efficiency measures. The authors did note methodological problems such as small sample sizes and a lack of control groups as a limit to the reliability of the evidence. This review is currently being updated and more recent higher quality studies show similar positive effects. For example, a recent study from New Zealand showed promising effects of non-polluting, more effective home heating (e.g. heat pump, wood pellet burner) on the health of children with asthma (Howden-Chapman et al., 2008). Lung function did not improve significantly but symptoms of asthma were reduced, as were days off school, healthcare utilisation, and visits to a pharmacist.

The most comprehensive synthesis of evidence to date on regeneration initiatives, which include a wider set of actions that go beyond physical improvements in housing, reveals a more mixed picture and highlights a rather thinner evidence base (Thompson et al., 2006).

The findings suggest the following effects:

- Health impacts – rarely assessed, conflicting findings (5 evaluations)
- Employment – modest positive impact (10 evaluations)
- Education – modest positive impact (6 evaluations)
- Housing quality – rarely assessed (1 evaluation)
- Income – rarely assessed (3 evaluations)

The regeneration programmes reviewed are shown in Table 1.

Table 1 Urban regeneration programmes analysed by Thomson et al. (2006)

Urban Programme 1969–1980s about £274m/year	Grant based programme to deal with areas of special social need through supplementation of existing programmes covering economic, environmental, employment and social projects.
Urban Development Corporations (UDC) 1981–1998 £2120m	Property and economic regeneration to attract inward investment.
Estate Action 1985–1995 £1975m	Housing led regeneration, addressing both improvements to physical aspects of housing, as well as housing management.
New Life for Urban Scotland (New Life) 1988–1998 £485m	Comprehensive multi-agency regeneration programme to improve housing, environment, service provision, training and employment for local people in four areas.
Small Urban Renewal Initiatives (SURI) 1990–2003 £160m+	Housing led regeneration to widen housing choice, improve quality of housing and the local environment, improve economic prospects and lever public and private funding.
City Challenge 1992–1998 £1162.5m	Comprehensive multi-agency regeneration to improve quality of life of residents in run down areas.
Single Regeneration Budget (SRB) 1995–2001 £5703m + £20301m from the private sector	Comprehensive multi-agency regeneration through initiatives on employment, training, economic growth, housing, crime, environment, ethnic minorities and quality of life (including health, sport, and cultural opportunities).
Regeneration Partnerships (now known as Social Inclusion Partnerships (SIPs)) 1996 £52m	Coordinated approach to tackle and prevent social exclusion and demonstrate innovative practices. Main activities focus on education and training, and initiatives to reduce poverty, crime, and promote employment, enterprise, empowerment and health

Overall, the authors of the review conclude that regeneration programmes have had a small positive impact across a range of key socio-economic determinants of health. However, these have not been compared with national gain on similar indicators, and it is not clear whether other changes might have influenced the gain in these regeneration programmes. For instance, there was no indication whether the evaluations had included a control group to compare impacts between areas benefiting from the regeneration programmes with areas that had not. The authors argue that these conclusions are not, however, a reason to abandon the pursuit of a healthy urban policy, but a reason to adopt more realistic expectations of what it can achieve within given resources and timescales, and to build in better evaluations.

For example, expectations may be too high around the extent to which increases in employment opportunities will result in improvements in health. Here, it is important to consider the quality of employment as fundamental in determining health outcomes rather than employment per se. Whilst individuals outside employment might be stressed, have little self-confidence, and a poor quality of life, employment in poorly remunerated jobs, with little flexibility, might increase rather than reduce stress (Crisp et al., 2009). In terms of impacts on health, expectations need to be matched to the level of spend on health relative to other aspects and the relative emphasis given to health within the programme. As Atkinson et al. (2006) found, only a small number of urban regeneration programmes included health as a focus, and of those that did, the level of spend was tiny. For example, in the 'Single Regeneration Budget,' health was one of 10 funding themes, but only 0.26% of the total expenditure for the scheme went into improving health services.

1.3.1 Evidence from other local and national evaluations

We considered evidence from a number of evaluations including New Deal for Communities, Sure Start, and the Central Stepney Single Regeneration Budget. We focus in detail here on the findings of the national evaluation of the New Deal for Communities (NDC) and Sure Start.

a) New Deal for Communities

This is the most recent urban regeneration initiative to have been implemented in the UK and the full results were not available for inclusion in the review by Thompson et al. (2006). The NDC aimed to improve outcomes across a range of themes, including housing and the physical environment, worklessness, crime, health, and education. Unlike other urban regeneration schemes, the NDC had a significant emphasis on health. In terms of its ambitions for health, it aimed to:

- support families, mothers and children to give a good start in life and break the intergenerational cycle of ill health;
- engage communities and individuals;
- prevent illness and provide effective treatment and care;
- address the underlying determinants of health.

New Deal for Communities is one of the most important neighbourhood renewal programmes ever launched in England. Its primary function is to 'reduce the gaps between some of the poorest neighbourhoods and the rest of the country.' There are 39 NDC areas and each area typically houses about 9,800 people. 'Partnerships' are formed in each area to implement approved 'Delivery Plans', each of which has attracted approximately £50 million of NDC Programme investment. The total cost of the 10 year Programme is of the order of £2 billion. The vast majority of NDC projects and expenditure was allocated on the renewal of physical infrastructure.

The NDC is based on the premises that deprivation is caused by a range of interconnected problems. Thus, neighbourhood renewal can be pursued by a strategy based upon a holistic approach and the improvement of health plays a crucial role in this. The role of employment, housing and education in terms of addressing health inequalities or the determinants of health is not the central focus of the development of the NDC, but an indirect outcome of the actions of partnerships to act to tackle problems of worklessness, housing and education considered here. In relation to health, specifically, the NDC interventions have been designed to address three key sets of problems, including:

- high rates of illness, low birth weight and perinatal and premature deaths;
- life-style issues – smoking, physical activity, low levels of fruit and vegetable consumption, substance misuse, etc;
- poor services and problems around access.

Local partnerships were responsible for the design of strategies and delivery plans. The average size of such partnerships was 22 and community representatives represented the majority number in 24 of the 39 NDC partnerships, reflecting the strong emphasis of the NDC on community engagement. In addition, a major focus was placed upon facilitating cooperation between local bodies involved in regeneration in a joined up approach to regeneration. It is not clear what role the community has played in the NDC. Whilst NDC strongly emphasised community involvement, it was less clear the extent to which such involvement would be able to influence the design and implementation of projects on the

ground. It needs to be borne in mind that "*statistical evidence does not yet generally point to there being positive relationship between this scale of community engagement, on the one hand, and positive outcomes or enhanced spend, on the other*" (CRESR, 2005; p. 281).

In terms of NDC projects focused on health, most (34) focused on health promotion (diet, exercise, health and well-being) followed by projects aiming to reduce death rates and increase life expectancy (29). Health improvements have occurred as a result of the NDC but these have not been consistent across all health outcomes (Table 2).

Table 2: Summary of evidence from NDC

Indicators	Change 2002–2008			
	NDC	Comparator	National	Change
	%	%	%	
proportion of residents feeling their own health was not good	-4	-3	-2	Positive change
proportion of people who felt that their health had got worse in the previous 12 months	-2	1	5	Substantial positive change
long standing limiting illness	-2	-2	-2	Reduced but not in relation to comparator and nationally
Mental health index (SF36)	4	-3		Very significant positive change
Eat five portions of fruit or veg every day	-3	-1		Negative change
Smoke cigarettes	-5	-3	-4	Moderate positive change
Do not exercise for 20 minutes or more	2	0	-2	Negative change

Source: Pearson et al (2010)

The most recent evaluation of health outcomes in NDC areas (Pearson et al 2010) concludes that 'there has been broadly positive, but modest, change in health outcomes, NDC areas. However, this has not always been greater than that experienced nationally or in other similarly deprived communities' (p.9; Pearson et al 2010). Large variations across partnerships were also documented in this report.

However, if other domains that have an impact on health are considered, NDCs are generally outperforming the comparator areas, particularly in relation to positive neighbourhood level changes, satisfaction with their area in relation to comparator areas. In terms of **worklessness,** NDC areas have performed better than comparator areas in terms of improving employment (net change 3.1%) and economic activity (net change 1.1). Satisfaction with **housing** and the surrounding area are also significant, particularly in terms of the latter (e.g. satisfaction with the area, area improvements, and lower lawlessness and dereliction rates). Perception of **crime** has also improved significantly with large positive changes in perceived safety, and greater satisfaction with the police, although interestingly, actual victims of crime have declined in line with other areas. More people have taken on training and **education** in NDC areas, and satisfaction with primary and secondary school is also higher than control areas.

The total expenditure of the NDC between 1999/2005 was about £827m. Less was spent on health (£148m), than for any other theme (11%). Spending was only marginally smaller than for worklessness and crime, but was less than half of that allocated to Housing and the physical environment. Moreover, it is also significant that health recorded one of the

lowest matching funding ratios; therefore, the overall expenditure on health was rather poor.

b) Sure Start

A key aim of Sure Start (SS) has been to enhance the life chances of young children under five and their families by improving services in areas of high deprivation. The programme was introduced in six waves between 1999 and 2003 and, at its maximum, operated in over 500 neighbourhoods, giving it access to 400,000 children – a third of under-fours living in poverty (Meadows and Garber, 2004).

Some of the key elements of the programme are as follows:
- area based with all children and their families living in a prescribed disadvantaged area;
- each SS Local Programme (SSLP) has extensive local autonomy concerning how to fulfil its mission with a common broad framework of services;
- Services are tailored to meet local needs, but also maintain a number of core services including, outreach and home visiting; support to families and parents; support for good quality play, learning and childcare; primary and community healthcare; and support for children and parents with special needs.

The promotion of health and reduction in health inequalities was a key theme early in the design of SS. However, Halliday and Asthana (2007) conclude that the initial focus on health was marginalised in favour of supporting parental employment. National targets relating to child health disappeared from the SS programme in 2001. This was mainly explained by the need of the programme to demonstrate rapid and tangible improvements, but it is at odds with the evidence that it can take years for the effects of early years' interventions to fully manifest themselves in terms of improving health outcomes.

The large national evaluation of Sure Start (NESS 2008) was based on interviews with 9,000 3-year-olds and their families in 150 SSLP who were initially studied when the children were 9 months of age. These children/families were compared at nine months and three years with a comparator group. The research revealed a variety of beneficial effects for children and families living in SSLP areas when children were 3 years old. In particular, SSLP children showed a **better social development**. Parenting showed benefits associated with **less negative parenting** while providing their children with a **better home learning environment**. However, a prior survey carried out by NESS (2008) reached a different conclusion: most disadvantaged 3-year-old children and their families (i.e. teen parents, lone parents, workless households) were doing less well in SSLP areas, while somewhat less disadvantaged children and families benefited (dual parent families, working households). Thus, there is **evidence to suggest that SSLP has worked for the least disadvantaged groups**, according to this prior evaluation. However, it is difficult to gauge the significance of these rather modest impacts, because early childhood interventions do not necessarily have immediately measurable effects (Gray and Francis, 2007).

Despite some of the positive effects noted above, there were problems in achieving child health goals: neither the initial low birth weight nor the emergency admission targets were met and were both removed (Halliday and Asthana, 2007). Overall reach figures were also disappointing. Those who used services often used several and reported satisfaction with them. But services offered at traditional times and in conventional formats did not reach many fathers, black and minority ethnic families and working parents. Providers found barriers to attracting 'hard to reach' families difficult to overcome. Few programmes demonstrated proficiency in (1) systematically monitoring,

analysing and responding to patterns of service use, or (2) rigour in measuring the impact of treatments. Multi-agency teamwork, including effective ways of sharing information and clarity about the cost effectiveness of deploying specialist and generalist workers strategically, proved difficult to manage and operate (Anning et al, 2007).

1.3.2 Evidence from studies of previous Olympic or mega-sporting event cities

A trawl of previous studies has revealed that little evidence is available in relation to the impact of the Olympic Games on health, except for the emphasis placed upon physical activity via engagement in sport. Some sources (LERI, 2007) have shown that The Games do **encourage greater engagement in sport**, but there is no evidence available to assess how long this 'effect' lasts.

Whilst there are an obvious number of benefits from holding the Games or major sporting events in terms of image, inward investment, tourism during the Games and after, job creation in the construction and creative industries, there is also agreement in the literature that there is little evidence that the Games benefit the local population (Vigor et al 2004; LERI, 2007). A number of studies (LocumConsulting, 2006; PWC, 2005) look at the potential opportunities and estimate impact from the Games. However, only very few offer a methodologically sound evaluation of the impact after the Games have taken place.

LERI (2007) looked at the impact of four Olympic and Paralympic Games (Athens, Sydney, Atlanta and Barcelona). In terms of **employment**, new jobs are created prior to the Games in construction specifically. Evidence for the Olympics leading to the creation of local employment opportunities is limited in all four cities. Volunteering and skills have been somewhat enhanced (Sydney), but it is not clear to what extent these lead to permanent jobs and the quality of such jobs. Jones and Stokes (2003) examined the effectiveness of the volunteering scheme developed for the Commonwealth Games in East Manchester. A pre-volunteer programme (PVP) was created to address the employment gap between East Manchester and other areas of Manchester. Only a small proportion of volunteers who graduated from the programme found a place as volunteer for the CWGs, because of various issues that the research could not uncover. Out of the 160 people who graduated, 21 found a job (13%) in various retail and sport related occupations. The authors conclude that the level of employability has risen through the PVP scheme and needs to be seen in that light, i.e. a step towards paid employment.

The development of new Games-related infrastructure in two cities (Tokyo and Seoul) has led to improvements in water sanitation and control of water pollution, as well as the construction of 389 new public parks (Tokyo). In Barcelona, an infrastructure created for the Olympics was converted into a Primary Care Centre within the Catalan public health network in 1993. This includes a rehabilitation centre and an outpatient emergency service management centre.

1.3.2 Evidence from European regeneration initiatives

Cadell et al. (2008) evaluated the impact of urban regeneration in Lille and Rotterdam. The regeneration and the evaluation did not have a direct focus on health, but aimed to tackle the wider determinants of health.

a) Lille (Roubaix)

In Lille, the focus of the regeneration was on Roubaix, an industrial town 15 kilometres from the centre of Lille. Like many large industrial towns in Britain, Roubaix experienced serious decline and deprivation following the collapse of its main industries. The key rationale for the regeneration was to tackle problems of unemployment due to the

closure of manufacturing companies, particularly in the textile industry. The need to promote cohesion and quality of life was seen as being rooted in the difference between rich and poor, and this also contributed to create stress and ill health.

A strong partnership between different stakeholders was a key characteristic of the programme. The regeneration programme was run by Lille Métropole Communauté Urbaine (LMCU). LMCU is made up of 85 municipalities whose councils appoint an assembly with 170 members and is responsible for strategic planning and investment, including public transport, economic development, environmental services and urban regeneration (which it shares with the individual cities). LMCU had strong decisional autonomy, and the national government used Lille as a pilot for the development of other regeneration policies to be adopted in other French cities. So there was strong national as well as regional and local support for the development of the Roubaix area. LMCU has a much bigger investment capacity than individual municipalities, with resources coming from local taxes and central government grants. It now has an annual budget of almost £1.5 billion and a staff of over 2,000.

The strategy for the regeneration of Lille is mainly based on the renewal of the textile industry, a telecommunications centre, and a cultural quarter. Business investment has been attracted by providing five year free business rate to companies locating in the area in exchange for their focus on employing local residents. Similar initiatives have been adopted in the UK with the Enterprise Zones, but such schemes have not linked benefits for companies to local employment, which seems to be crucial in tackling local problems of unemployment.

The redevelopment necessary to bring back retail into the centre of Roubaix was financed by a public-private partnership where the main key actor was a state owned bank (Caisse des Dépôts et Consignations). This helped the centre to attract visitors from outside to spend money in local shops, but it also created new public spaces and improved the public transport system.

b) Rotterdam

In Rotterdam, the focus of the regeneration was on Kop van Zuid (Southern Headland), which is a peninsula on the south bank of the River Maas directly opposite Rotterdam's city centre. It covers some 125 hectares and used to be an important port area with docks, a shipyard and a terminal for ocean-going liners, but all these activities closed down when the port moved downstream to the mouth of the river during the 1960s and 1970s, and Kop van Zuid was abandoned. Further to this, the area is poorly linked to the city centre as the river acts as a barrier to the easy flow of people to and from central Rotterdam. The area is mostly inhabited by immigrants. It has traditionally been an area of low educational achievement and high unemployment, and used to have a very poor image, which made it difficult to attract commercial and private housing investment.

The regeneration had social, economic and physical goals. Its aim was to change Rotterdam as a whole, not just to transform an abandoned port area. Above all, it aimed to change the image of the city to outsiders (particularly business investors and enterprising people), and to change the image of a large part of the city to existing residents of Rotterdam. In particular, two reasons were seen as key: first, to enable the city to physically develop and attract young professional employed and develop the knowledge economy; second, to tackle the longstanding problems of unemployment and social exclusion

The regeneration was led by Rotterdam City Council which had a clear idea of the way that the city should develop and the contribution that Kop van Zuid could make. The plan for the regeneration of the area was underpinned by the following strategy:

- linking Kop van Zuid, and the suburbs to the south of it, directly to the city centre (Erasmus Bridge, a new metro station and the extension of Tramplus, the city's high quality tram service);
- creating a lively and attractive mixed-use district (with offices, residential, leisure and educational facilities) in Kop van Zuid;
- insisting on high quality of design in all buildings and throughout the public realm;
- re-using existing landmark buildings wherever possible;
- developing a programme of 'Mutual Benefit' to ensure that residents of the poorer areas next to Kop van Zuid benefited from the scheme.

Key changes in the city included a number of large infrastructural developments, including two university colleges with capacity for 10,000 students. Furthermore, office space and a more mixed housing market were pushed forward. The transport system experienced a considerable transformation. A tram extension and the building of underground tunnels for railway lines and the development of a ferry service on the river resulted in Kop van Zuid being only a few minutes from the city centre. This attracted a large number of higher income people to live in the area, contributing to rebalancing the social profile, and rising property values are encouraging existing residents to stay.

Rotterdam was cited as one of the leading examples of urban renaissance by the Urban Task Force, and it won recognition as European Capital of Culture in 2001. Unemployment fell from 17% in 1991 to 6% in 2005 and the population of the city is slowly rising again. Much of the new employment has been created in the north-west of the city (towards the airport) and many of the jobs in Kop van Zuid are in organisations that have relocated there from other parts of the city. Concerns over the future of local immigrant communities were taken on board by including local neighbourhood associations in the project organisation, and a Mutual Benefit programme was developed to help channel as many as possible of the jobs generated by the development to local people and to improve the economies of the surrounding areas.

The successful redevelopment of Kop van Zuid has encouraged new investment in other parts of the south of the city, which almost certainly would not have gone ahead without it, and this is likely to continue in the future. For example, local housing corporations (which have recently been allowed to operate in the private, as well as the social, market) are now developing higher quality housing in poorer neighbourhoods, which means that local people can move to better housing without leaving the area altogether. This not only helps to promote a sense of 'belonging' to an area, but will over time also help to create more 'balanced' communities.

Fewer direct jobs during the regeneration were created for local residents than originally anticipated (Berg et al., 2003). In particular, very few construction jobs were filled locally. In part, this was due to the over-supply of labour at the time and to the lack of relevant skills among the people of Feyenoord.

1.4 Barriers and facilitators to success

Although empirical evidence of the impact on health is mixed (or not studied), there are plenty of lessons on the barriers and facilitators for successful implementation of urban regeneration initiatives which may maximise the potential for health impact:

- Ensure that expectations for health improvement are realistic, given resources and timescales. Improvements in health outcomes may not appear for many years so

health indicators or improvements in the wider determinants of health need to be monitored.

- Acknowledge that the benefits of investment in priority areas may not automatically reach the wider community.
- Making the mechanisms or routes, through which health impacts are expected to be made, explicit.
- Areas in receipt of assistance may be stigmatised, which increases rather than reduces social exclusion.
- The importance of having clear agreement on health outcomes and indicators from the beginning and remaining committed to achieving those outcomes.
- Different groups are likely to value different outcomes. There is evidence to suggest that local communities place less emphasis on health but value an emphasis on the wider determinants of health.
- Staffing and associated problems such as short term contracts, unwanted secondments, inadequate accommodation and rapid turnover have all hindered delivery of urban regeneration programmes.
- Involvement of health professionals and managers from the outset. This helps to ensure that health remains on the agenda.
- Close involvement of residents and residents' organisations in the planning and implementation of the regeneration programmes.
- Ensure, where minority populations are concerned, that full account is taken of cultural issues and linguistic differences.

The literature we reviewed also identified barriers and facilitators for delivering new services to promote health within disadvantaged areas:

- Taking a holistic rather than a siloed approach
- Build on the strength of existing services and use creativity to set up new services
- Sustainable governance, management and leadership to manage the complexities of multi-agency teamwork
- A welcoming, informal but professional ethos
- An emphasis on empowering residents
- Responding to community priorities
- Early identification and targeting of those in need of specialist services
- Recruiting, training and deploying providers with appropriate qualifications and personal attributes.

Based on the experiences of urban regeneration in Rotterdam and Lille, facilitators for urban regeneration more generally include:

- Having a strong focus on changing the image and reputation of the area by creating cultural spaces capable of attracting the attention of the media (e.g. creating a fashion quarter, restoring historic buildings). In time, this will bring in investment, employment, and higher income people to buy houses.
- Introduction of 'street mediators' to discourage anti-social behaviour.
- Involving the community in creating a sense of local identity.
- Devolved power to the consortium running the regeneration and greater tax-related incentives for local authority cooperation with business (this may be more difficult to achieve in the UK).
- Shared vision and clear leadership with national as well as local support for the regeneration.
- Initial public sector infrastructural investment is important in order to show the commitment of the government to the business sector.
- Recognition that benefits need to be shared by nearby deprived communities.

1.5 Conclusions

There is strong epidemiological evidence linking health to living conditions, and economic and educational opportunities. However, there is remarkably little evidence on the impact of urban regeneration initiatives on health, including the impact of previous Olympics. This may not be because urban regeneration has no impact on health. Health impacts from these types of interventions are difficult to evaluate and have not traditionally been studied. What we do know is that improvements in the physical condition of housing can improve health and that wider regeneration initiatives which focus on economic development can have positive impacts on employment and housing. The most recent study from the UK evaluating the effects of the largest UK-based urban regeneration initiative – New Deal for Communities – suggests some positive impacts on health indicators, including mental health.

The experience of running large scale urban regeneration initiatives captured in the evaluations and distilled in this literature review suggests the following three principles that might be applied to the Olympic-related urban regeneration going on in Stratford.

- Develop a theory of change for the Olympic-related urban regeneration in relation to improvements in health. As well as being useful in its own right, it will help to ensure a shared vision across the partnership responsible for delivering the Olympic legacy. It will also help to keep health on the agenda.
- Maximise the 'place-making' opportunity offered by the Olympics in order to improve area reputation.
- Be aware of, and build in strategies to counteract, the potential for negative and unintended consequences of the Olympic-related urban regeneration, in particular around the exclusion of local residents.

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Appendix 2
A review of the literature on the impact of mixed communities on health
prepared by Angela Harden, Shahana Lais and Gail Barrow-Guevera

2.1 Introduction

This review draws on reviews, theoretical work and primary research evaluating 'mixed communities'. Like the review on urban regeneration, the review covers the international literature but has a particular focus on studies from the UK[1]. It also has a particular focus on planned *new* mixed communities rather than those which have grown to be mixed over time, and a focus on the health effects of mixed communities. What are mixed tenured communities and what is their appeal?

2.2.1 Definitions

The term 'mixed' in 'mixed communities' has been used by academics, policy-makers and practitioners to refer to mixing on a wide range of dimensions, including the socio-demographics of residents, such as age, employment status and income; types of buildings (e.g. housing, retail, work); types of housing (e.g. flats, family homes) or types of land (green spaces, water features). Often, mixing housing tenures (e.g. owner-occupied and social housing) is used as a proxy for mixed communities and mixing housing tenures are used as a mechanism to achieve a mix of residents with different socio-demographic characteristics, particularly income (Tunstall and Fenton, 2006). The focus on housing tenure and income can overlook other aspects of mixing such as type of household (single person, couple or family) which may be important in achieving truly socially balanced communities.

2.2.2 Hypothesised benefits

Creating neighbourhoods with a mix of housing tenures in order to create socially balanced communities has been central to recent urban regeneration policy initiatives, designed to tackle the problems of social exclusion in concentrated areas of disadvantage. Mixing tenures is considered to be a way to 'dilute' concentrated areas of disadvantage by attracting residents with higher incomes and aspirations to these areas. This in turn is hypothesised to bring about positive gains in economic, social and health outcomes at both the area level and the individual level for existing residents. In the UK, there is wide support for mixing tenures from central and local government, housing associations and independent housing organisations. Mixing tenures is usually part of a wider regeneration strategy which includes upgrading housing stock, improvements to the physical environment and new public and leisure services.

We identified a range of anticipated benefits from mixed communities in the literature. This ranged from very general specifications such as 'increased life chances' and 'reducing social ills' to more specific benefits such as improvements in social cohesion and social interaction, gaining employment and (less often) improvements on health indicators, such as life limiting illness or mortality. Silverman et al. (2006) usefully

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[1] We searched exhaustively on 13 bibliographic databases. Some of these databases covered literature from a wide range of social sciences (e.g. Social Science Citation Index) whilst others were topic specific (e.g. Urbaline). On each database we used a wide range of terms for 'mixed communities' including "mixed tenure", "tenure mix", "social balance", "mixed neighbourhoods" and "public-private". We also searched the ESRC research register and the publication list of the Joseph Rowntree Foundation. We identified a total of 2117 potentially relevant citations. These were screened to identify reviews and discussion papers on mixed tenured communities and research evaluating the impact of mixed tenured communities with a UK focus. Full reports were obtained for potentially relevant citations and these were re-screened for relevance. Our final set of 55 studies contained discussion papers, reviews, cohort studies and evaluations of one or more mixed tenured communities.

summarise the likely benefits of mixed communities according to the source from which the benefits arise: (i) the resources which go into creating the mixed tenured community and (ii) the greater interaction between different social groups. Benefits arising from the former include improvements in housing quality and the physical features of the neighbourhood environment, well supported public services and facilities, an improved reputation for the area, long-term stability with fewer residents leaving the area, and fewer residents with motivation for criminal and anti-social behaviour. Benefits arising from the latter include exposure to aspirational peer groups for existing residents, more cultural and social capital to shape continued improvements in services and access to more advantaged networks.

2.2.3 Pathways and mechanisms to improved health

The hypothesised pathways and mechanisms from mixed tenured communities to improved life chances for residents are complex, and it is rare to see such pathways and mechanisms explicitly articulated in the research literature or policy documents (Beekman et al., 2001; Lees, 2008; Tunstall, 2006; Tunstall and Fenton, 2006; Van Ham and Manley, 2009; Wood, 2002). The clear articulation of these pathways is, however, very important for the development, implementation and evaluation of mixed tenured communities. In line with other reviews, we found very few reports that had dedicated any space to outline how a mixed community might achieve positive benefits. Notable exceptions to this were Communities and Local Government (2009) and Graham et al. (2007). The first of these is discussed in detail in the next section. Graham et al. (2007) outline a number of ways that mixed tenured communities could be linked to improved health outcomes:

- Improvements in the quality of the physical environment and improvements to health services may impact directly on health or indirectly through reductions in levels of stress;
- Improved image of the area may impact on health via improvements in self-esteem;
- Health may also improve via role-modelling of healthy behaviours from residents with higher incomes and aspirations.

Improvements in health may also arise from improved employment prospects:

- With the development of a positive area reputation, access to financial credit may improve and employers are more willing to recruit from the area;
- As a result of new employed residents moving into the area, the area loses its 'culture of unemployment';
- Existing residents benefit from new residents' networks and connections to the labour market;
- Jobs are created through expansion of service and leisure facilities.

2.2.4 An example of a theory of change

As noted above, we identified a theory of change developed for a longitudinal evaluation of the Mixed Communities Initiative (MCI) (Communities and Local Government, 2009)[2]. The MCI was launched in 2005 as a comprehensive approach to tackling areas of concentrated disadvantage, with demonstration projects in 11 areas of England. It aims to "alter population and housing mix as well as making physical, environmental and service improvements". A key underpinning assumption is that area transformation will

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[2] This report documents baseline and early findings only. The final report has not yet been published.

only be achieved by integrated housing improvements with other non-housing interventions such as education and training interventions and health improvement. The stimulation of economic development is also an explicit goal with demonstration projects expected to operate entrepreneurially and to work with the private sector. The evaluation team developed an overarching 'theory of change' for the whole MCI, emphasising the need to tailor this for each individual demonstration project (box1).

Based on interviews with a wide variety of agencies involved in the implementation of the demonstration projects and interviews with residents themselves, this explicit theory of change offers several advantages for the MCI. It will offer: a framework for the evaluation; a way to understand how individual demonstration projects might need to vary, given specific local contexts; and a means to assess the extent to which the propositions within the theory are shared or contested across the range of partners and organisations.

A theory of change for the transformation of Stratford City could help the various partners involved to articulate and agree a shared vision and action plan; align and join up the vision and action plan with other initiatives; identify funding streams; identify and overcome potential barriers to implementation; and establish a framework and infrastructure for a long-term evaluation. Pertinent questions to ask in developing a theory of change for Stratford City are: i) What is the specific nature of the problem(s) to be addressed; (ii) What remedies are needed?; (iii) What are the social and economic processes that will be triggered by these remedies?; and (iv) What outcomes will be achieved? Questions for the evaluation would be (i) Are the proposed remedies delivered?; (ii) Is there a change in processes?; and (iii) Are the desired outcomes achieved?.

Box 1: Overarching theory of change for the English Department of Communities and Local Government Mixed Communities Initiative (adapted from Communities and Local Government, 2009)

A: Nature and cause of problems
- Disadvantaged areas suffer multiple deprivation (poor housing stock, decayed environment, poor reputation, high rates of crime and anti-social behaviour)
- Limited life chances for residents in these areas (low educational attainment, low employment, poor health)
- Areas require high public expenditure
- Three main drivers of an area's deprivation: weak economic base, poor housing and environment, poor public services

B: Remedies needed
- Service improvements by themselves will not transform areas. A socially mixed population is needed.
- Market forces by themselves will not achieve this social mix.
- Long-term targeted interventions from partners from all sectors are needed to deliver 1) a more diverse and desirable housing stock and 2) improvements to facilities, services and opportunities*

C: Social and economic processes triggered by the remedies
- Remedies will lead to direct improvements in life chances of existing residents
- The area will attract wealthier residents with higher expectations and aspirations, who will impact positively on other residents and the neighbourhood as a whole.

D: Outcomes achieved
- Demand to live in the area increases and property and land values increase
- Services perform better against local and national targets
- A positive area effect takes hold and become sustainable

*These should include improvements to environmental, educational, leisure and retail facilities, high quality preventative services supporting 'at risk families', and improved connectivity to wider labour market.

2.2 Do mixed tenured communities lead to better outcomes?

2.2.1 Health outcomes

The health effects of mixed communities were rarely studied in our sample of literature (table 2.1). Graham et al. (2009), the only report to explore whether mixed communities impact on health outcomes, examined the relationship between the level of tenure mix and four indicators of what they termed 'social well-being,' using data from the 1991 and 2001 censuses. They looked at four indicators of social well-being: unemployment, long-term illness, morbidity and premature death. Overall, little support was found that mixing tenures was good for social well-being; the analysis did not identify any strong and consistent relationship between the level of tenure mixing and social well-being. However, when relationships were found, the level of mix appeared to be important, with the suggestion that to achieve health benefits, the proportion of social housing within a mixed community should be no more than thirty per cent:

> "...this study would suggest that only a wholesale dilution of the concentration of social renting (from 60% and above down to below 30%) will bring about the requisite gains attributable to mixing tenures" (Graham et al., p 57)

Table 2.1: Number of reports (N=55) that examine the health effects of mixed communities

	N	%
Considers health effects	1	2
Do not consider health effects	54	98

The 54 reports that did not consider health effects did examine effects on other outcomes, most often upon outcomes that might be considered to be related to achieving a more socially cohesive community with good levels of social interaction between residents in order for role-modelling to take place (one of the mechanisms through which mixed communities are hypothesised to achieve health effects).

2.2.2   Other outcomes

We found a substantial amount of primary research in the UK which has evaluated examples of planned new mixed communities. Examining these studies in-depth in terms of the effects of mixed communities on outcomes other than health was beyond the scope of this review. The focus of the primary studies varied considerably and most were fairly limited cross-sectional case studies, making it difficult to identify common themes and messages. We did, however, identify several reviews of national and/or international research. We summarise in detail below the findings of two of the most comprehensive of these reviews. Examining comprehensive reviews of the national and international research provides a more balanced view of evidence.

Kleinhans (2004) reviewed the evidence on the effects of mixed communities in relation to outcomes in five areas: housing quality and area reputation, neighbourhood-based social interactions, residential attitudes towards social mix, the role-model effect, and problem dilution. Some evidence was found for problem dilution (e.g. 'diluting' the concentration of disadvantaged households resulted in less burden on public services), improvements in housing quality and the physical environment of neighbourhoods (as might be expected as efforts to mix tenures usually involve upgrading housing stock and improving environments), and resident attitudes (e.g. residents identify the influx of homeowners as a social improvement). However, less support was found for improvements in area reputation, neighbourhood-based social interactions and role model effects. Studies suggested that it proved difficult to dispel an area's poor reputation, especially if the mixed communities were embedded within a wider area with a bad reputation. Social interaction between homeowners and tenants was limited by differences in life-styles and spatial separation between private and social housing in neighbourhood layout. This of course reduced the potential for any role-modelling effects to occur. The author concludes that future research should focus on other social outcomes and processes such as social control, shared or unshared norms, trust in people, as well as collective action and organisational participation of residents, rather than a pre-occupation with social interaction and role-modelling effects.

Tunstall (n.d) and **Tunstall and Fenton (2006)** review the evidence base specifically in relation to the impact of mixing housing tenures on income mix; retail and public services; employment levels; crime and anti-social behaviour; neighbourhood popularity and reputation; community cohesion; and sustainability (box 2).

2.3 Barriers and facilitators to desired health outcomes of mixed communities

One interpretation of the mixed evidence on the benefits of mixed communities is that there is a fundamental flaw in the theory of mixed communities to alleviate the effects of social disadvantage. Cheshire (2007) advocates this interpretation, arguing that the only way to tackle social disadvantage is to tackle the root causes of poverty. He argues that tenure mixing is treating the symptoms of poverty and income inequality rather than the causes. He also argues that the mixed community theory ignores the benefits of homogenous communities, such as living amongst people with shared lifestyles and cultures.

An alternative interpretation is that there has been a failure of implementation in the mixed communities engineered so far. The preceding sections have given some insight into how the hypothesised benefits of mixed communities may be better realised. Based on the studies in our review, the following points need to be considered in planning a mixed tenure community with explicit aims to improve the health of residents in disadvantaged areas:

- Provision for a range of households, including **families**, appears to be crucial. This may help to achieve sustainability in the long-term and provision for families will also facilitate social-interaction across tenures. The latter will be dependent on educational facilities (nurseries and schools) that homeowners and renters will want to send their children to. The provision of community facilities, parks and green spaces will also foster cross-tenure interactions.

- The **layout** of the community is important. There need to be plenty of green spaces and walkways to facilitate play and social interaction, plenty of shared spaces such as community centres or shared parking spaces, and social housing ideally needs to be 'pepper potted' throughout the development.

- Arrangements for **governance and management** need to be planned. Several elements need to be in place here: building in time to set up collaborative arrangements with the range of stakeholders involved in the planning and management of the mixed tenured community; flexible and robust management systems which effectively incorporate inclusive partnerships (regardless of tenure); fair and equitable allocation policies (to guard against informal selection process); planning for the long term to sustain mix; and building in evaluation and monitoring.

- Following good practice for community development such as active programmes of **community engagement**. Community forums may be organised around shared interests, such as children or gardening.

- **Avoiding too broad a mix,** such as very wealthy residents and very poor residents.

- **Actively fostering an attachment to place** to reduce resident turnover, increase pride, shared norms and values and enhance area reputation.

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Appendix 3

Mental well-being and its implications for regeneration

Prepared by Ilona Boniwell

3.1   Introduction

Well-being and happiness have been a topic of interest for many centuries, from Ancient Greek philosophy, through Post-Enlightenment West-European moral philosophy (especially Utilitarianism) to Humanistic psychology and current quality-of-life and well-being research in the social, political and economic sciences (Veenhoven, 1991). Aristotle defined happiness as a supreme good, the only value in life that is 'final' and sufficient; final in a sense that everything else is merely means to this end, sufficient in that once happiness is achieved, nothing else is needed or desired (Diener, 1993).

Currently, the field of well-being is flourishing, both in terms of increasing research output and public interest in the topic. Politicians and economists are also developing an interest in non-financial indicators of well-being and quality of life (e.g. Layard, 2005). A number of reliable measures of subjective well-being have been developed (Diener, Lucas and Oishi, 2002). In the UK, an Act of Parliament, The Local Government Act 2000, provided local authorities in England and Wales with a power of well-being, which entitles them to do anything that might achieve the promotion or improvement of the economic, social and environmental well-being of their area.

3.2   Subjective well-being: the dominant approach to defining well-being

Amongst the many concepts that have much in common with the term well-being are self-actualisation, contentment, adjustment, economic prosperity, welfare and happiness. The notion of *subjective well-being* (SWB) is a recognised substitute in research literature for the more commonly used term happiness. SWB is considered a multidimensional construct which encompasses how people evaluate their own lives in terms of both affective and cognitive components of well-being (Diener, 2000). SWB is not the only conception of well-being currently offered, but is the dominant one in psychological literature at present. In this paper, notions of happiness and subjective well-being will be used interchangeably.

Veenhoven (1991) poses the question of whether happiness can be measured objectively or only subjectively. He argues that it cannot be measured objectively because no overt behaviours are linked to happiness in a reliable manner. For example, an outgoing and friendly appearance, which is frequently observed among happy people, can also be present in unhappy people. This is probably why surveys are the main method used for studying SWB/happiness.

Subjective well-being is traditionally approached in two ways. The first focuses on *life satisfaction*, which is normally considered to represent a cognitive component of well-being (Ryff and Keyes, 1995). Life satisfaction, according to Veenhoven (1991) is "...the degree to which an individual judges the overall quality of his life-as-a-whole favourably. In other words: how well he likes the life he leads." (p.10). One feels satisfied when there is little discrepancy between the present situation and what is thought to be the ideal or deserved standard. Life satisfaction appears to be a unitary dimension, underlying satisfaction with different areas of life, which seems meaningful to people as a personality construct (Lewinsohn, Render and Seeley, 1991). Ratings of satisfaction with important domains, including self, marriage, family life, work, friends, etc have been found to be highly inter-correlated and are sometimes combined by various researchers to represent an overall life satisfaction. A number of cognitive models have attempted to

explain life satisfaction. Amongst these are comparison models that claim that people evaluate their lives on the basis of comparison between themselves and others. An elaboration of this is the 'Michigan Model', according to which, satisfaction is greater when achievements are close to aspirations (Michalos, 1985). Raising aspirations can make satisfaction more difficult as achievement may fall short of desired aspirations (Schwartz, 2000).

The second approach focuses on *affect.* The notion of affect comprises both mood and emotions that are associated with the experience of momentary events (Lucas et al, 1996). Positive and negative affect constitute the emotional side of happiness, whereas satisfaction represents the cognitive side (Ryff and Keyes, 1995). Affect is studied experimentally, using the procedures of mood-induction, through experience-sampling methodology and via self-report scales. Early studies approached the emotional side of well-being as a balance between positive and negative affect (Bradburn, 1969). Later studies showed that positive and negative affect correlated with different predictor variables (Myers and Diener, 1996), and that they are only weakly (if at all) correlated with each other (Diener and Emmons, 1984). In fact, Diener and Emmons (1984) established that the correlation between negative and positive affect was more negative with a shorter time period. The current measures tend to view affective well-being as a combination of high positive and low negative affect rather than the balance between these two variables. This finding of independence of positive and negative affect is significant for psychological interventions. Eliminating negative affect would not necessarily lead to an increase in positive affect, just as enhancing positive affect would not necessarily eliminate an underlying problem.

Even though common sense might imply that happiness would be greatest when individuals experience the maximum amount of intense positive affect and only infrequent negative affect, Diener, Sandvik and Pavot (1991) suggest that this is not the case. They show that while frequency of experience of positive affect is both necessary and sufficient for well-being, intense positive affect is not (although it can at times increase happiness amongst those who experience positive affect frequently). It appears that intense positive affect comes with the price, as it usually effects the evaluation of subsequent (usually less intense) positive experiences. Larsen and Diener (1987) also argue that intensity is of relatively little importance for the evaluation of positive affect because "extremely positive affect" is reported infrequently (only on 2.6% of days).

Although the affective and cognitive components of SWB are partly separable, they appear to correlate at levels sufficient to say that they are part of a higher order construct of subjective well-being (Lucas et al, 1996; see Figure 1 for a graphical representation).
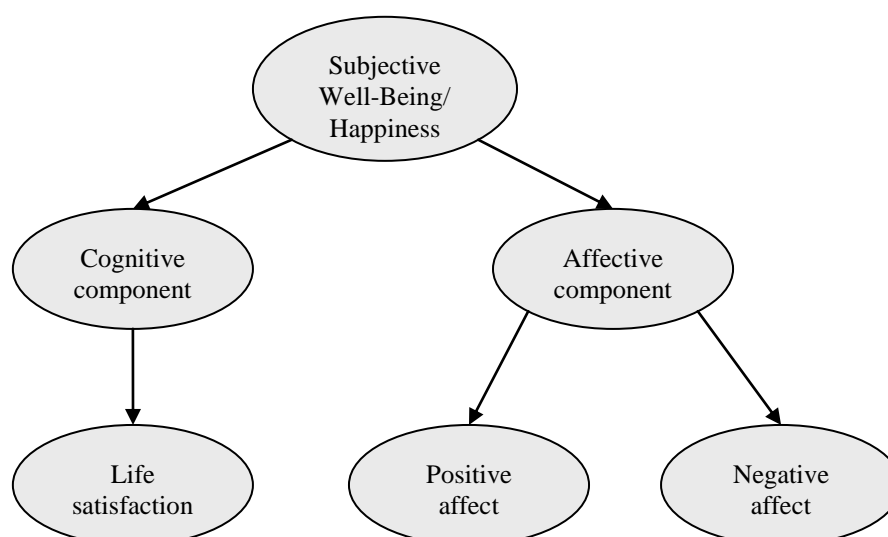
Figure 1: Affective and cognitive components of Subjective Well-Being (SWB)

3.3 Measuring subjective well-being

Early instruments used for measuring well-being were based round single-item measures, e.g. Campbell et al's (1976) "How satisfied are you with your life as a whole nowadays"? Surprisingly, they possess a degree of validity (Diener, Lucas and Oishi, 2002). However, since the partial separateness of three major factors (life satisfaction, positive affect, negative affect) was confirmed (Andrews and Withey, 1976; Lucas, Diener and Suh, 1996), multiple scales are normally used to measure the construct of well-being. A widely accepted SWB measurement technique involves summing life satisfaction with positive affect, and subtracting negative affect from the total (Schmuck and Sheldon, 2001).

The most commonly used measure of life satisfaction at present is the 5-item **Satisfaction with Life Scale (SWLS)** by Diener et al (1985). The SWLS appears to possess favourable psychometric properties, including high internal consistency. For instance, in Diener et al's (1985) original paper, test-retest reliability over two months was .82 and the alpha coefficient was .87. All scale items fell under one single factor, accounting for 66% of variance. The scale has moderately strong correlations with other subjective well-being measures (generally not exceeding .70). It also has adequate criterion validity coefficients, in terms of correlations between satisfaction with life scores as self-reported by participants and as estimated by the experimenters who interviewed them (Diener's et al, 1985). In one subsequent study, Lucas, Diener and Suh (1996) considered the discriminant validity of SWLS through the use of several methods. Their analysis showed that life satisfaction is clearly discriminable from positive and negative affect, as well as from conceptually similar constructs such as optimism and self-esteem. Another well-known measure of the cognitive side of SWB is the 4-item **Subjective Happiness Scale** (Lyubomirsky and Lepper, 1999). It has been shown to possess high internal consistency, a unitary structure, stability over time and reasonable convergent and discriminant validity. In the UK, the Depression-Happiness Scale (Joseph and Lewis, 1998) and the 29-item Revised Oxford Happiness Scale (Hills and Argyle, 2002) are also widely used, the latter being significantly more detailed than many of its American counterparts.

A review by Lucas, Diener and Larsen (2003) identifies 11 widely used measures of affect, ranging from 1- to 300-item scales. The **PANAS (Positive and Negative Activation) Scales** are the most frequently used measures of affect at present (Watson et al, 1988). It includes 20 emotion adjectives that are evaluated on a 5-point scale to indicate the amount of time respondents spend experiencing each emotion. PANAS can be

administered with different temporal instructions, ranging from "right now" and" today" to "during the past year" and "in general".

Diener et al. (1999) demonstrate that many multi-item instruments possess adequate psychometric properties, including converging with alternative measures, exhibiting good internal consistency, moderate stability and some sensitivity to changing circumstances. Schimmack, Diener, and Oishi (2002) further elaborate that people construct their life-satisfaction judgements bottom-up from accessible and relevant sources of information. These sources are chronically accessible and provide relatively stable information, due to their reliance on personality traits, which is why judgements are found to be quite stable over time.

To conclude this part, the dominant paradigm of well-being sees it in terms of cognitive and affective explanations that comprise the concept of SWB. A number of instruments to assess SWB have been developed, are widely used and are generally recommended.

3.4   Alternative approaches to defining and measuring well-being

The traditional approaches to well-being, encompassing life satisfaction, positive and negative affect, are subject to a number of conceptual criticisms, which maintain that focusing on life satisfaction and emotion gives a one-sided representation of well-being. Ryff (1989a), for example, believes that it is better to feel unhappy than not to have a purpose in life. Ryff and Keyes (1995) argue that subjective well-being research has failed to deal with the question of what it actually means to be well psychologically. They point towards the lack of debate on whether the existing measurements actually capture the richness of human wellness and happiness. They attribute this failure to the fact that life satisfaction measures were originally generated as outcomes measures, and are essentially data driven, rather than having been developed out of a clear conceptual framework.

In response to such criticisms, Diener, Lucas and Oishi (2002), the proponents of the 'traditional' viewpoint, maintain that their approach to well-being is so widespread and widely recognised because it is accessible. Respondents are evaluating their lives themselves; they are not assessing it on the basis of what someone else believes to constitute their happiness. Therefore, it is argued that this relatively simple approach to well-being allows people to convey to researchers what they feel makes their life good.

The concept of *psychological well-being* (PWB) is widely advocated by Carol Ryff and her colleagues as an alternative to subjective well-being (e.g. Ryff and Keyes, 1995; Ryff and Singer, 1998). She defines well-being as "the striving for perfection that represents the realization of one's true potential" (Ryff & Keyes, 1995, p.100). Ryff and Keyes's (1995) conception of well-being was derived from a comprehensive analysis of various approaches to happiness in different sub-fields of psychology (including humanistic and developmental psychology). They offer six components of positive human functioning which include: *self-acceptance* (positive evaluation of oneself and one's life), *personal growth*, *purpose in life, positive relations with others, environmental mastery* (the capacity to effectively manage one's life and surrounding environment) and *autonomy*. Their studies provide empirical support for this six-factor model with the emergence of a single higher factor. A philosophical analysis by Ryff and Singer (1998) also provided some support for the above-mentioned elements of well-being. Keyes, Shmotkin and Ryff (2002) hypothesised that SWB and PWB, although conceptually related, are empirically distinct conceptions of well-being. Factor analysis of the data from over 3,000 respondents confirmed that SWB and PWB are two correlated but distinct factors, and that they show a different pattern of relationships to demographic and personality variables, such as education, age and the Big Five dimensions. Many scholars treat SWB and PWB as complementary constructs and frequently use PWB measures to enrich and supplement

information obtained using SWB measures on their own. PWB Scales (PWBS) developed by Carol Ryff and colleagues range from 3 to 14 items per sub-scale and are used widely.

Recently, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS, Tennant et al, 2007) has been proposed as a viable alternative to both SWLS and PWBS. This newly developed British scale for assessing positive mental health (mental well-being) includes a 14 positively worded item scale with five response categories. It covers most aspects of positive mental health (positive thoughts and feelings) currently in the literature, including both subjective and psychological well-being elements.

Regeneration professionals may find it difficult to measure and evaluate the concept of well-being due to its complex and subjective nature. Nevertheless, despite this perception, well-being has been successfully assessed for over three decades with all measures indicated above used in the national, representative and community samples.

3.5   Correlates and predictors of well-being

This section will consider some predictors and correlates of SWB. Although correlates are often considered to be the causes of SWB, the direction of the effects is often not clear. Furthermore, variations in well-being across time have seldom been explored. Studying these variations requires longitudinal and experimental studies which are quite rare in the field. In considering the main correlates of well-being, attention will be paid to personality factors, social relationships, work and leisure, before moving onto the importance of external environment and place.

3.6   Personality factors and individual differences

Argyle (2001) emphasises that one of the best predictors of happiness is extraversion. This effect may be due to choice of more socially based and physical activities, using more positive non-verbal expressions and more socially enhancing behaviours (Watson and Clark, 1992). On the other hand, neuroticism has strong and pervasive associations with various measures of negative affect (Watson and Clark, 1992). Diener and Lucas (1999) do not consider these findings surprising as extraversion is characterised by positive affect, whereas neuroticism is consistently negatively associated with it.

Happy people tend to be *optimistic*, "look at the bright side" (the "Pollyanna" principle), have a more positive view of others, have more positive associations and employ successful coping strategies (Argyle and Martin, 1991). Another correlate of happiness is attribution style. Happy people interpret bad events as external, situational and unstable. On the other hand, they interpret positive events as internal, global and stable (Seligman, 2003). Veenhoven (1991) shows that personal characteristics common in happy people include: identity integrity, inner control, ego-strength, mental maturity, social ability, activity and perceptual openness. Diener and Lucas (1999) note that self-esteem is a stable correlate of well-being, although the direction of causality is not determined.

Taylor and Brown (1988) picture happy people as continuously engaged in the distortion of reality in three different ways: having an unrealistically positive view of themselves, an exaggerated belief of control over their lives and improbable optimism. People who are pessimistic and unhappy tend to judge things more accurately.

In their meta review on the correlates of well-being, DeNeve and Cooper (1998) examined 137 distinct personality constructs. They found personality to be predictive of subjective well-being, happiness and positive affect, but less so of negative affect. Defensiveness, trust, emotional stability, locus of control, desire for control, hardiness, self-esteem and

tension were most closely associated with SWB. When personality traits were grouped according to the Big Five traits, neuroticism was the strongest predictor of life satisfaction, happiness and negative affect, whilst extraversion and agreeableness predicted positive affect.

3.7   Social relationships

Social relationships appear to be the greatest single correlate of well-being (Argyle, 2001). Campbell et al (1976) demonstrated that family life and marriage (which are a part of social relationships) show the highest independent effect on overall satisfaction.

Spending time with friends is associated with the highest level of positive affect. The experience sampling study by Larson (1990) showed that people feel happiest when they are with friends, followed by being with family and being alone. Furthermore, satisfaction with friendships has been shown to correlate with life satisfaction at the level of about .30 to .40 (Costa et al, 1985). However, only close (with high level of self-disclosure) and personal friendships appear to be of importance, not the number of friends or the mere process of socialising (Wheeler et al, 1983).

The process of being in love heads the list of sources of positive emotions (Argyle, 2001). While the positive affect associated with love declines (though not disappears) over time, people in close personal relationships have a higher level of life satisfaction than those who are single, widowed, separated or divorced (Inglehart, 1990). A number of studies have shown that cohabiting people are on average less happy than those who are married (Inglehart, 1990; Stack & Eshleman, 1998). However, this finding is likely to be culture dependent (Diener et al, 2000).

Yet it is not merely the fact of being married that predicts happiness, but the quality of marriage (Russell & Well, 1994). The factors that influence satisfaction with marriage include instrumental satisfaction (financial security and sharing of domestic tasks), emotional satisfaction (social support, intimacy and sex), and companionship in leisure. Marriage also seems to act both as a buffer against and as a means of overcoming mental and physical health problems. For instance, married people are 5.5 times less likely to be admitted to mental hospitals (Argyle, 2001).

Marriage leads to an increase in SWB, which is rapid at first but then sinks. Nevertheless, it does not return to the starting point but stays at a higher level than before. Marriage, therefore, changes the set point of SWB even though the change is not large. Other findings indicate that people who are going to get divorced are unhappier three years prior to the event while those who are going to get married show a higher level of SWB five years in advance (Diener, 2000).

Families are the source of both positive and negative affect. As far as the satisfaction with life is concerned, children have a zero effect on the happiness of their parents, although they do have an effect on the meaningfulness of one's life (Veenhoven, 1994). Furthermore, having young (under-five) and adolescent children leads to a decline in marital happiness (Walker, 1977).

Diener and Seligman (2002) in their study of exceptionally happy people (upper 10% of 222 college students) found only one main difference between the happiest and the rest of the students. The very happy people had a rich and fulfilling social life. They spent the least time alone, had good relationships with friends and had a current romantic partner. They did not have less negative and more positive events, nor did they differ on the amount of sleep, TV watching, exercise, smoking, drinking, etc.

Social isolation, on the other hand, can lead to misery. However, intimate relationships are not the only answer. According to McMillan and Chavis (1986), sense of community can serve as an antidote. It comprises four elements: (i) membership (feeling of belonging and relatedness); (ii) influence (one matters to other people and can make a difference to the group), (iii) integration and fulfilment of needs and (iv) shared emotional connection (sense of shared history, places, time, symbols and experiences).

Citizen participation has been identified as another means of enhancing well-being. It has been defined as "involvement in any organized activity in which the individual participates without pay in order to achieve a common goal" (Zimmerman & Rappaport, 1988, p.726). Advantages of participation include: increased social support, buffering against stress, increases in confidence and skills, diversion from anti-social behaviour, development of responsibility and sense of positive citizenship , as well as increase in subjective and collective well-being (Kagan, Castie & Stewart, 2005).

3.8   Work and leisure

It appears, on the basis of comparison between various international, American and British-based surveys, that between 30 and 40% of people really like their jobs, a similar percentage are satisfied, while 25-30% are not (Argyle, 2001). It is hardly surprising that satisfaction with work is related to satisfaction with life (Warr, 1999) and that both have been found to have an effect on each other, although life satisfaction shows a greater effect (Headey & Wearing, 1992; Seligman, 2003). Some show that pay does not have a strong relationship with job satisfaction, while good relationships and work content do (Clark, 1998). The nature of the job seems to have a curvilinear relationship with well-being according to Warr (1999). His *vitamin model* of employment proposes that some of the features of work (pay and physical conditions) increase well-being to a point where it can no longer be affected by these factors, similarly to the function of vitamins C and E. Other features – opportunity for control, skill use, job demand, variety, environmental clarity and opportunities for interpersonal contact – act as vitamins A and D; in that too much of these can actually decrease well-being. Warr (1999) demonstrates that greater employee well-being is significantly associated with better job performance, lower absenteeism, reduced probability of leaving an employer, and the occurrence of more discretionary work behaviours.

Job satisfaction is adversely affected by role-conflict, such as conflicting demands of work and family. This role-conflict is largely manifested in dual-career families and is especially detrimental for young women with children working over 25 hours a week (Haw, 1995; Zuzanek, 2004).

Jahoda (1981, 1982) argues that work provides people with five categories of experience essential for well-being: time structure, social contact, collective effort or purpose, social identity/status and regular activity.

Unemployment has a strong negative effect on all aspects of happiness, including positive affect, negative affect and life satisfaction. Unemployment affects mental stability, physical health, self-esteem, feeling of control, leisure patterns, social contacts, not to mention financial situation, etc. Retirement, on the other hand, despite sharing some features with unemployment (such as the actual absence of employment), is associated with very different outcomes in terms of well-being. The well-being of the retired is, on average, greater than that of those at work (by up to a quarter of standard deviation) but that differs, depending on the nature of the previous employment and on the level of income of the retiree (Argyle, 2001).

Leisure (especially sport, exercise and belonging to leisure groups) shows significant positive correlations with positive affect, with mental and physical health and, to a lesser extent, with life satisfaction (Argyle, 2001). Csikszentmihalyi and Mei-Ha Wong (1991) demonstrate that the highest level of happiness is reported when respondents are in the flow state (when high skills are matched with high challenges).

Physical activity specifically is considered the most reliable predictor of well-being. Not only does it reduce anxiety and stress, the risk of hypertension, of type 2 diabetes, heart disease, insomnia, obesity and probability of dementia, it also improves cognitive functioning (Lyubomirsky, 2008; Babyak et al, 2000). However, it has been suggested that unsafe, 'unwalkable' urban areas, which lack greenery and are dominated by traffic, tend to discourage physical activity participation, whist inclusive, accessible environments encourage walking, cycling and other activities (CABE, 2009).

3.9   Other correlates and predictors of well–being

Perhaps surprisingly, some demographic factors do not show a relationship with well-being. For example, women and men report similar levels of well-being. Although women experience more depression than men and report more negative affect, they also report more frequent and more intense experiences of positive affect and life satisfaction, thus arriving to a similar level of well-being to men. (Diener et al, 1999). This finding holds constant across many studies. The only gender differences in well-being have been found with regard to faith (strong faith increases happiness more for females than males), living in a country with a high quality government (this increases well-being more for females), and some cultures (females are happier than males in Asia and some non-Asian developing countries) (Helliwell & Putnam,2005). Education has a very weak relationship with SWB, although it is stronger in poorer nations (Diener et al, 1999).

A commonly held view that money can buy happiness (most people think that a little more money would make them a little happier, Myers, 2000), is not supported by evidence. Wealthy people are only somewhat happier that poor people, but this correlation is very low once the basic needs are met (Heady and Wearing, 1992; Myers, 2000). Social class has some effect (independent of money) on happiness through lifestyle differences and better coping methods (Argyle, 2001). Education has a very weak relationship with SWB, which is stronger in poorer nations (Diener et al, 1999).

Although self-rated health shows moderate correlations with SWB (at 0.32, Okun & George, 1984), when health is rated by others (e.g. doctors), the correlation drops (to 0.16). This indicates that it is a subjective construal of one's health that is associated with subjective well-being. Long-term, although some adaptation is possible, physical health problems have a negative effect on subjective well-being (Diener et al, 1999). Specifically, Lucas (2007) used longitudinal analyses to study well-being of people with disabilities in two large-scale nationally representative datasets. He found that not only do people take an emotional hit around the time of their severe disabilities, but their well-being levels tend to stay lower than before. People with severe disabilities and unable to work make little emotional recovery.

A number of large-scale studies have shown significant correlations between SWB and religion, which appears to provide psychological and social benefits such as meaning in life, collective identity, social support and assistance in major life crises (Diener et al, 1999; Myers, 2000). These findings, however, are based on studying a particular religious perspective, namely Christianity. It is unclear whether these can be generalised to other religions such as Buddhism or Islam, and especially to spiritual beliefs that are not necessarily embedded in a particular religious tradition.

3.10 External environment

3.10.1 Natural environment, health and well-being

A substantial body of evidence shows people prefer natural to built environments (Ulrich, 1983; Knopf, 1987; Kaplan & Kaplan, 1989; Hartig, 1993), and this is recognised in the economic literature as higher prices for properties in a natural setting (Anderson & Cordell, 1988; Luttik, 2000).

Time spent in a natural environment may contribute to subjective well-being by providing opportunities to cultivate interpersonal relationships. People are more likely to socialise if they have green spaces in their neighbourhood, resulting in stronger social ties (Kuo, Sullivan, Coley, & Brunson, 1998), and community gardening is associated with better social interactions and a stronger sense of community (Dunnett & Qasim, 2000; Schmelzkopf, 1995; Mackenzie et al, 2000). Kuo et al (1998, p. 843) write: "We found that the more vegetation in a common space, the stronger the neighbourhood social ties near that space – compared to residents living adjacent to relatively barren spaces, individuals living adjacent to greener common spaces had more social activities and more visitors, knew more of their neighbours, reported their neighbours were more concerned with helping and supporting one another, and had stronger feelings of belonging."

Scholars in ancient Greece and Persia remarked on the stress reducing effects of viewing vegetation and water (Cooper-Marcus & Barnes, 1999; Ulrich, 2002), and empirical research confirms this phenomenon, which is likely to explain our preference for natural environments (van den Berg, Koole & van der Wulp, 2003).

Hartig and colleagues (Hartig et al, 1996; Hartig, Mang & Evans, 1991; Hartig et al, 1997; Hartig et al, 2003) found that viewing natural rather than urban scenes led to subjective well-being benefits, such as stronger increases in reported happiness and positive emotion and stronger decreases in negative emotion. Hartig's studies also found that exposure to a natural environment increased attentional capacity, and in children, this effect is manifested as a reduction in Attention Deficit Hyperactivity Disorder (Faber Taylor, Kuo & Sullivan, 2001; Kuo & Faber Taylor, 2004).

Conversely, exposure to degraded environments seems to reduce subjective well-being – for example, living in areas of high air and noise pollution is associated with lower life satisfaction (Welsch, 2006; van Praag & Baarsma, 2005).

Community gardening is associated with aesthetic appreciation of the local environment (Dunnett & Qasim, 2000; Schmelzkopf, 1995), and gardening programmes for older people have led to increased feelings of self-worth, purpose in life and happiness (Mackenzie et al, 2000; Barnicle & Midden, 2003),

People have reported flow experiences in a forest environment, as well as feelings of awe (Williams & Harvey, 2001). Similarly, Farber and Hall (2007) found that vast natural scenery and wildlife were associated with feelings of awe, excitement and pleasure. Arnould and Price (1993) studied transcendent experiences while water rafting, and found that participants were moved by communion with nature, time away from their everyday responsibilities and immersion in places of natural beauty. They also reported a sense of connection with others in their party and personal growth. Meanwhile, Kaplan and Kaplan (1995) found that the primary sources of enjoyment for gardeners were feelings of peacefulness and tranquillity, followed by fascination with nature.

Stringer and McAvoy (1992) found that being in a wilderness environment tended to heighten an individual's sense of spirituality, and participants in a qualitative study

(Frederickson & Anderson, 1999) described meaningful experiences prompted by complete immersion in a wilderness, an awareness of the sheer power of nature and interactions with the other people who shared the experience.

A feeling of connectedness or oneness with nature seems to be a common thread to these transcendent experiences of nature. Mayer and Frantz (2004) found a small but statistically significant correlation between connectedness to nature and life satisfaction. Some people who reported transcendent experiences in the Alaskan wilderness said these experiences made them reflect on how the Arctic is preserved and how human uses and environmental protection are balanced (Farber & Hall, 2007).

Individuals differ in the extent to which they feel part of nature (Mayer & Frantz, 2004), and this may also be true of cultures: the view that humans are superior to and separate from nature is embedded in Western values (White, 1967). Extensive research shows that feelings of connectedness are a precondition for helping behaviours (Piliavin, Dovidio, Gaertner & Clark, 1981; Cialdini et al, 1997; Schulz, 2000), so this view of humans as separate makes it easier to damage the environment without experiencing distress (Roszak, 1995).

Two studies by Mayer and Frantz (2004) and Schultz et al. (2004) found that connectedness with nature correlated with environmental attitudes and self-reported environmental preservation behaviour. Connectedness with nature was also associated with concern about the environment for its own sake (biospheric concerns), rather than due to the negative effect environmental damage might have on other humans (altruistic concerns) or on participants themselves (egoistic concerns). Mayer and Frantz (2004) also found that connectedness with nature was correlated with low consumption, and spending more time outdoors. The latter could reflect people who feel connected to nature choosing to spend more time outdoors – or more interestingly, could indicate that one's connection with nature can be enhanced by spending more time outdoors. Taking a life course approach, Wells and Lekies (2006) found that adults who spent time in green spaces as children tended to exhibit more environmentally-friendly attitudes and behaviours.

Natural environments provide a pleasant location for physical activity (Humpel, Owen & Leslie, 2002). Exercising in landscapes with natural elements maximises reductions in blood pressure and increases in self-esteem and mood (Pretty et al, 2005), and longitudinal research on 2,000 participants found that regular gardening halved the risk of developing dementia (Fabrigoule et al, 1995).

There is also evidence that viewing natural rather than urban scenes contributes to health by raising our ability to withstand pain, reducing blood pressure and speeding post-operative recovery, as well as reducing physiological signs of stress such as skin conductance and muscle tension (Diette et al, 2003; Miller, Hickman, & Lemasters, 1992; Ulrich, 2002). Not surprisingly, degraded natural environments – such as those with high levels of air pollution – are bad for physical health (Johnston et al., 2006).

3.10.2 Built environment, health and well-being

Until relatively recently, little attention has been paid to contextual factors and their impact of well-being, yet as early as 1995, Halpern talks about built environment as a potential source of influence on human psychology via its link to stress. Indeed, several elements of the physical and built environment have been found to be linked to poor mental well-being, such as high-rise living, graffiti, damp, and noise exposure (Evans et al, 2000; Ouis, 2001). Some even argued that good housing can be seen as fundamental to general health and well-being (Barton, Grant & Guise, 2002). Chavis & Wandersman

(1990) claim that the built environment plays a key role in fostering a sense of community and in influencing participation in local neighbourhood life. Halpern (1995) also talks about the significance of aesthetics or liking the look of where one lives and highlights the importance of residents' involvement in the planning process.

Overall, systematic reviews of the association between the physical environment and mental well-being have concluded that there are modest associations between elements of the built environment and psychological health (Evans, 2003). However, a longitudinal Scottish Health, Housing and Regeneration Project (SHARP) study indicates that merely changing housing, e.g. through relocation, is unlikely to improve health and well-being outcomes (Kearns, et al, 2008). Evans and Long (2000), drawing on the example of Housing Association Trusts (HATs), also demonstrate that devoting a lion's share of resources to housing investment may be insufficient to tackle some deeper-rooted social and economic problems associated with deprivation.

A conceptual model put forward by Chu, Thorne and Guite (2004) suggests five environmental domains that are most likely to promote a sense of well-being in urban areas: (i) control over the internal environment; (ii) quality of housing design and maintenance; (iii) presence of valued 'escape facilities'; (iv) crime and fear of crime, and (v) social participation.

A recent study of Greenwich residents assessed the impact of the physical and urban environment on mental well-being. It identified twelve significant factors, but concluded that the most important factors that are not confounded by others included: (i) neighbour noise, (ii) sense of over-crowding in the home and escape facilities such as (iii) green spaces and (iv) community facilities (e.g., libraries and community centres), and (v) fear of crime and harassment (feeling unsafe to go out in the day or night) (Guite, Clark, Ackrill, 2006).

The negative influences of neighbourhood noise, overcrowding (resulting in the lack of privacy) and traffic have also been highlighted by Stokols (2003). However, he also talks about positive environmental factors, including aesthetic quality, environmental clarity and manageability, as well as comfortable interior design of buildings.

Ellaway and Macintyre (1996) studied health-related behaviours of residents in four diverse, socially contrasting neighbourhoods in Glasgow. Their investigation showed that, after controlling for the effects of gender, age, social class and household income, residents' behaviour relating to diet, smoking and exercise were directly affected by the particular neighbourhoods in which they lived. Residents living in the more affluent neighbourhoods were most likely to eat healthy food, least likely to eat unhealthy food or smoke, and most likely to exercise. The authors suggested that places have certain environmental characteristics – such as the availability of healthy foods, health-affirming services, community norms and so on, which influence health behaviour, either by the presence or absence of 'cues for action' (Janz & Becker, 1984).

The above evidence can be taken to suggest that despite moderate importance of good housing and other aspects of the build infrastructure, these need to be addressed in conjunction with more psychological aspects of human relationships with their environment when one's aim is to improve well-being of local residents.

An important variable connecting the build and lived environment and our psychological enmeshment with it is referred to as *sense of place*. Curtis and Rees Jones (1998) define it as "the meaning, intention, felt value and significance that individuals or groups give to particular places" (p. 86). Sense of place refers to the feeling of attachment or belonging to a physical environment, such as a place or neighbourhood, and the sense of personal

and collective identity that comes from this sense of belonging (Jacobs, 1995; Rivlin, 1987). Rivlin also talks about the connection between place attachment, the development of local connections and roots linked to a person's personal history, and feelings of comfort and security. In the UK, the Young Foundation carried out several case studies around the enhancement of the sense of place in South Tyneside and Manchester. These suggest that "understanding the nature of peoples' sense of place or belonging – what makes them feel attached to their neighbourhood – is a useful starting point when engaging and empowering communities and will help develop an understanding of what creates a vibrant, civic culture" (Hothi, 2007).

3.11 Characteristics of a "mentally healthy" town – making the most of regeneration opportunities

Dickinson (2005) describes how, traditionally, urban regeneration concentrated on land, premises, communities, the economy and the environment. Recently, however, the attention shifted from focusing on merely the physical and economic aspects of regeneration towards "softer", often psychology-related factors: "Regeneration is not simply about bricks and mortar. It's about the physical, social and economic well-being of an area; it's about the quality of life in our neighbourhoods" (ODPM, 2003, p.3). A combination of insights from psychology, sociology and other related fields of study, in conjunction with some policy literature, have informed the formation of a broader perspective on the characteristics of a "mentally healthy town" presented below and potentially achieved via the regeneration process. These characteristics follow from the literature outlined above, supplemented by additional searches on regeneration and well-being.

3.11.1 High social capital

Much of the above review has focused on the importance of relationships for individuals' well-being (e.g. Argyle, 2001, etc). In sociological literature, the notion of *social capital*, defined at the level of a local area as connections with local networks and good relationships with neighbours and other people in the locality, is frequently quoted as one of the core indicators of quality of life and well-being (Putnam, 2000).

Helping each other, generalised trust, a sense of inclusion, taking part in local organisations, social cohesion, shared norms and values, social solidarity, social control, social networks and a feeling of belonging to each other through a common identity are all aspects of good social relationships and a strong social capital. Better neighbourhoods – in particular, those characterised by concentrations of a well-educated population, homeowners, more traditional family structures, longer-standing residents, good community and social infrastructure, good services and low problem concentration – are usually more likely to have higher levels of social capital (Humphreys, 2007). Woolrych and Sixsmith's (2008) study indicates that feelings of community identity, developing and maintaining social relationships are aspects included in residents' own definitions of well-being in regeneration areas.

Humphreys (2007) suggests that strategies to develop social capital in regeneration-undergoing communities could include investment in good quality local services, community infrastructure (e.g. meeting places, local shops, amenities), and initiatives to produce a good social mix in residential areas and opportunities for interaction across social groups. Such opportunities for more interactions with neighbours and other local area residents can be achieved through street parties, picnics, sales and other local events not targeted at particular ethnic minorities.

3.11.2 Sense of place and local pride

Closely related to social capital is the sense of place, otherwise referred to as local pride, community spirit and place attachment. It captures the emotional bond that develops between a person and their environment (Woolrich and Sixsmith, 2008). Place attachment reflects the expectations people hold as to where and how they plan to live their lives in the future (Altman, 1993). When cherished places, spaces, and settings are destroyed or irrevocably changed beyond our control, people feel a sense of loss and grief (Read, 1996), similar to that felt at the loss of a personal relationship which was expected to last (Altman, 1993). Although aesthetic factors are important in the development of local pride (CABE, 2009), the atmosphere, capture of the community character and social intimacy can be more profound (Woolrich and Sixsmith, 2008).

Creating the sense of place may be difficult, especially for the outsiders, for the new cannot simply replace the old. What is ugly and unimportant from a perspective of a planner, may hold meaning or positive identification for the residents. So whilst there may be some universal guidelines, such as managing and maintaining places in such a way as to make them look cared for (CABE, 2009), this process needs to be bottom-up and organic, based on the involvement and participation of local people (Humphreys, 2007). The following two characteristics of a mentally healthy town build on this point.

3.113 Sense-making

People have a strong drive to 'make sense' of or interpret their environment. In a process called gestalt, we strive to see how different parts can form a harmonious whole, seeking legibility and comprehension. According to Butterworth (2000), we prefer environments that allow us to make sense of them and facilitate involvement and interaction. Psychologically, this enables us to develop environmental mastery or the capacity to effectively manage one's life and surrounding environment (Ryff and Keyes, 1995).

Although initially, people tend to evaluate spaces and built environment for their overall, affective impact rather than for specific detail, this is only the first stage. Rapoport (1982) felt that insufficient attention had been paid to the meaning that users derive from their interaction with the built environment. He stated that designers and planners often clash with users over intended meaning and purpose. Designers tend to focus on the perceptual (manifest) features of built forms, whereas users or inhabitants tend to view the same structure in associational terms (i.e., connected to a particular memory, associated with a specific task or function). He stated that for users, feelings of personalisation and relevance of the environment are critical for their satisfaction. Users need to decorate or personalise their habitat (house or neighbourhood), which ultimately become more important than the architectural features. To enable sense-making, community cafes and other participatory data gathering exercises can be held to understand the attitudes of the amenities users, to study the latent function of designs and to see how the new designs can connect with the cultural heritage of local residents. As a simple example, a question can be raised regarding what type of coffee bar can attract Stratford residents of different ethnicity (e.g. Starbucks, a pub, a traditional teashop, a European style café, etc.).

3.11.4 Amenities and opportunities for participation and control

A long tradition of psychological research maintains the importance of choice and autonomy for subjective well-being. For example, the *self-determination theory* (SDT), developed by Ryan and Deci (2000) postulates the existence of three inherent psychological needs – competence, autonomy and relatedness – which, when satisfied, enhance motivation and well-being and, when limited, impact on well-functioning. In Ryff and Keyes' (1995) model of *psychological well-being*, autonomy is one of its core

component parts. At a local level, autonomy can be seen as participation, feeling able to influence decision-making and exercise some control over the regeneration process. Unfortunately, in practice, the process and outcome of regeneration is largely controlled from the "outside". Drawing on the example of research conducted in a New Deal for Communities area of the North-West of England, Woolrich and Sixsmith (2008, p.6) find "little evidence to suggest that planning and decision-making responsibilities were being shared between regeneration professionals and local residents". This is despite the ownership and engagement in community places being one of the four most important elements of well-being for local residents.

Evans and Long (2000) suggest that in order to succeed, urban regeneration processes must operate in equal partnership with local residents, public bodies, voluntary and private sectors. Provision of attractive and accessible civic centres or use of existing infrastructures for the purposes of bringing local communities together can be the first step in this direction.

3.11.5 Sense of safety

Whilst there is no clear consensus on, and a relatively limited attention to, the importance of safety for well-being in the psychological literature, studies of naïve definitions and perceptions of well-being (e.g. Boniwell & Henry, 2007) indicate the importance of perceived safety for the general public.

Fostering the sense of safety can be achieved through organised activities in parks and public places, good street lighting, avoiding blank frontages and positioning windows to overlook public routes and spaces. Further suggestions also include security-conscious designs, tighter tenants' agreements, clear processes for exchange of information with police and improved youth facilities (CABE, 2009; Evans and Long, 2000). On a more psychological level, challenging residents' perceptions concerning fear of crime and safety can be achieved through bringing together different communities in workshops, public discussions or through local celebrations.

3.11.6 Green spaces

The natural environment, health and well-being section above was used to address questions pertaining to the value of green spaces in depth. Whilst there is no doubt as to the value of greenery for personal well-being, creating new green parks in highly populated urban areas can be troublesome. Solutions include encouraging more trees and planting wherever possible to improve air quality and provide shade in the summer; creating greenery in unconventional places like roofs or pocket parks and providing hanging baskets. Existing parks need to be made into safe, well-managed green spaces encouraging play and outdoors enjoyment (CABE, 2009).

3.11.7 Leisure and physical activity opportunities

Not only does exercise increase well-being directly, it has been demonstrated to lastingly improve mental health problems. Babyak et al. (2000) compared three groups of depressed patients. The first group was prescribed anti-depressants, the second group aerobic exercise, and the third a combination of the two. Independently of the treatment regime, most of them had improved four months after taking part. Unexpected results came six months later when 38% of those recovered patients from the first group relapsed into depression. 31% of the third combo group went back to ill health, but only 9% of those who only did exercise became depressed again.

Existing literature suggests that physical activity needs to be encouraged through every possible means. Safe and aesthetically pleasing trails can be used to promote walking and cycling. Locating attractive staircases in convenient places would also encourage walking and reduce the use of lifts and escalators (CABE, 2009). Investing in subsidised ice-skating rinks and gyms, bicycle routes, free hire bicycles, open tennis and other outdoor sports courts, dance studios, children's play areas and more could further encourage participation. A combination of characteristics one, two and four may also give rise to local initiatives, such as running groups or active picnics.

3.11.8 Opportunities for creative pursuits

Creative industries or major cultural projects have been repeatedly suggested as the panacea of urban regeneration, cited as having social and economic benefits in local contexts, and as being a vital element of integrated urban and regional regeneration strategies (Florida, 2002; Parkinson & Bianchini, 1996). Jayne (2004, p. 203) states "There has been a large amount of 'boosterism' in discussions about the role that the creative industries can play in urban and economic regeneration over recent years". He proceeds to illustrate the failure of investment into creative industries in Stoke-on-Trent to impact the wider regeneration of the city. Evans (2005) further points out that even when research on the arts and urban regeneration has featured in academic articles, this often tended to be limited to descriptive and uncritical case studies. Having carried out a comprehensive literature review on the impact of major cultural projects, he concludes the evidence of their sustained impact to be limited: "Where evidence is emerging, distributive effects and regeneration objectives, as now defined, are generally underachieved - or they are not sustained" (p. 975).

There are, however, challenges to this position. For example, from Johnson (2006) who talks about having to develop a broad conception of creative capital in order to assess the impact or value of creative industries on confidence, image, individual well-being and social cohesion.

Nevertheless, even if evidence is inconclusive with regard to creative industries and large-scale cultural projects, there seems to be a better consensus regarding small-scale and often home-based engagement with various crafts (ranging from painting, sewing, cooking and flower arrangement through to DIY). These appear to have a beneficial effect on mood, physical and mental health, self-efficacy and self-actualisation (Mason, 2005). These activities can be enhanced by formal and informal training opportunities, as well as by creating opportunities for voluntary community-led groups to form and evolve.

3.11.9 Personal growth opportunities

Drawing on the earlier discussion of the differences between hedonic and psychological well-being, one factor of the latter captures their main dissimilarity – personal growth. Whilst subjective well-being is primarily oriented towards feeling good and contented with one's life, personal growth as a sub-set of psychological well-being is oriented towards breaking the homeostasis in order to achieve a qualitatively different level of functioning.

In the context of urban environment, Butterworth (2000) recommends that the environment needs to contain sufficient complexity and even mystery to invite further exploration. In the context of providing local opportunities for personal growth, these may result from closer school-university and college-university partnerships, as well as other opportunities for informal training and participation.

In Australia, VicHealth's (1999) Mental Health Promotion Plan documents research identifying several major influences on mental health, in particular social connectedness, freedom from violence, and economic participation. Specifically, economic participation is seen as a function of access to work and engagement in meaningful activity, education, adequate housing, and money. It can be argued therefore that opportunities for personal growth may lead to individuals engaging in education or meaningful activity, resulting in better housing and money. Dickinson (2005) concurs with the above by suggesting that the level of educational attainment and work-related skills that may have an effect on employment opportunities.

3.11.10 Psychological capital

In their study on urban regeneration in a disadvantaged area in South Manchester, Rogers et al. (2008) identified several themes arising from lay perceptions of locality adversity, mental health and quality of life. Amongst these themes, local residents identified their reliance on personal coping strategies to manage adversity. In talking about well-being, psychological literature is vast on the identification of personal characteristics enabling individuals to 'bounce back' in situations of stress and hardship. A concept that brings a number of these characteristics together is the so-called *psychological capital*.

Luthans et al. (2007, p. 3) define psychological capital as 'an individual's positive state of development characterized by: (1) having confidence (*self-efficacy*) to take on and put in the necessary effort to succeed at challenging tasks; (2) making a positive attribution (*optimism*) about succeeding now and in the future; (3) persevering toward goals and, when necessary, redirecting paths to goals (*hope*) in order to succeed; and (4) when beset by problems and adversity, sustaining and bouncing back and even beyond (*resiliency)* to attain success.'

Psychological capital can be developed by short training sessions in both classroom and field settings and electronically through the internet. Suggested interventions include: providing opportunities for mastery and successful experiences, providing positive feedback, interventions to improve the psychological and physiological well-being of people in employment, such as the provision of on-site exercise and wellness programmes, family friendly benefits (e.g. childcare facilities), informal social activities and gatherings, etc (Luthans et al, 2008). It is also advisable to include interventions directly impacting any of the components of psychological capital, e.g. resilience. As the first step, the area needs to be assessed for existing schemes of this type, such as the Newham Resilience Initiative, running in several local secondary schools.

To conclude, ten characteristics of a "mentally healthy" town have been suggested and discussed above. These included: (1) social capital, (2) sense of place, (3) sense making, (4) amenities and opportunities for participation and control, (5) sense of safety, (6) green spaces, (7) leisure and physical activity opportunities, (8) opportunities for creative pursuits, (9) personal growth opportunities and (10) psychological capital. Whilst every effort has been made to identify their unique features, it needs to be acknowledged that, in reality, some of these may overlap. It further follows that some of the interventions to increase the prevalence of these characteristics may and would impact on more than one of them.

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Appendix 4

Greenwich Millennium Village and New East Manchester case studies

prepared by Hipolina Joseph and Alice Sampson

Summary of findings: lessons for Stratford City

'**Getting it right from the beginning**... **you never recover from a bad start'** was most forcefully emphasised. *Actions which enable this to occur include*:

A strategy which embeds health into all aspects of urban renewal – transport, education, worklessness, etc – and a programme of work that explains the importance of health, and how health services, including budgets, work to all partners and stakeholders.

Improving understandings between health practitioners and planners; seconding a planner to a strategic health department and to the regeneration agency responsible for the delivery of the Stratford City project are recommended actions.

Securing capital and revenue funding in advance to ensure that services are in place prior to residents moving in.

Building high quality health facilities and involving local people in their design to create community pride, to demonstrate that service users and health practitioners are valued, and to signify the importance of health.

Prioritising healthy living and health promotion as well as a health inequalities agenda and involving a range of sports and leisure organisations to develop a programme of activities.

Using the Games to secure private investment and to improve local employment opportunities.

Having a strong community development and engagement programme in place and having local people as partners involved in all aspects of the initiative.

Avoid getting 'bogged down' in complaints which creates a negative environment to live and work and focus on creating a friendly place.

Putting in place a system of integrated governance which allows all tenants and residents to have the same point of contact for issues related to cleanliness, safety and behaviour, and one organisation responsible for housing and grounds maintenance across the whole site.

'**Getting it right from the beginning**...**and focus on long term goals'** was also emphasised. *This can be achieved by*:

Strong management focused on outcomes and which keeps local people well-informed.

Partnership arrangements which engender inclusion and are committed to achieving health outcomes that will take years to be realised.

Ongoing and proactive actions by practitioners and residents are required to bring about and maintain healthy living.

Routine collection and collation of data to assess progress towards health improvements with agreed indicators to measure progress, using the information to improve performance by adapting the programme of work to prioritise those with the greatest needs, and to keep the focus on health outcomes, both in the short and long term.

Training and nurturing a skilled workforce to achieve low staff turnover and practitioners who are able to bring diverse professionals and local people together.

Responding to challenges

A number of challenges were identified that require proactive action from practitioners and these include:

Understanding that strategies are 'too high a level' for practitioners who prefer operational and pragmatic guidance.

Creating opportunities for social mixing amongst all residents and tenants in ways which build tolerance, trust and respect.

Paying careful attention to attracting and retaining market-rate families to create and maintain a 'balanced' community.

Ongoing community development to foster tolerance and to promote social mixing, as well as encouraging healthy life-styles.

Being aware that high class state-of-the-art sporting facilities may bring prestige and status to an area and attract investment, but clear plans to ensure local people use the facilities are necessary.

Appreciating that changing cultural attitudes and mindsets towards adopting healthy life-styles will be difficult to bring about and changes will be incremental and take time to achieve.

Create a place which people living, working and visiting talk about positively.

4.1   Introduction

In this appendix, health and health-related issues are discussed with respect to two existing planned mixed communities. The purpose of the fieldwork in these two sites was to identify key lessons learnt for those with responsibilities for the development of Stratford City.

In this appendix, the site selection process is described, the research tasks and analysis of the data and the findings from the Greenwich Millennium Village (GMV) case study and from New East Manchester (NEM) are then presented. Each case study describes the history of the area, development plans and anticipated and actual outcomes, where information is available. The focus of the case studies is on the lessons learnt for Stratford City.

4.2   Site selection

The selection criteria for case study areas were: a planned community with mixed tenure housing and at least five years old, situated in an urban area, with a mix of old and new residents. A review of possible case study sites was undertaken using the internet and

knowledge of the research team.[1] Additional criteria were then added to refine the search to ensure that the selected sites had as many features as possible in common with Stratford City. These included: new build on a brownfield site surrounded by existing socially and economically disadvantaged communities, and a mixed tenure housing area with features that included a health centre, an eco park, leisure and sporting facilities, supermarkets and shops, and that it is integrated with public transport.

An additional criteria was to select one site in London and the best option was considered to be Greenwich Millennium Village (GMV), and to select a site which had a clear sporting legacy and it was decided that New East Manchester (NEM) was selected.

4.3 The research

4.3.1 Data collection and analysis

Information was collated from a wide range of documents including reports and research papers and policy documents. Interviews were also conducted with 16 key personnel from the agencies involved in the regeneration and development of GMV and EM and included representatives of health, local authority planning, property developers and landowners, housing association, sports and leisure organisations.

Key personnel were selected for interview according to their expertise and involvement in developing GMV and NEM. Their names and details were found using original planning documentation and minutes of meetings. A snowballing technique was also used to identify those who were, and are, involved in the development of these sites. At the end of each interview, the interviewee was asked who they thought was informative and well-placed to respond to our questions about what lessons could be learnt for the Stratford City development.

The experience of carrying out the research in the two sites was quite different. In London, there was a reluctance to participate in the research and we had no response from key personnel including senior health practitioners and local councillors, and some interviewees had limited knowledge about what the Village is like now, and there is a dearth of research and evaluation studies upon which we could draw. It appears that GMV is no longer a showcase place and it receives little attention. This experience is in contrast to Manchester which has extensive secondary data and numerous academic studies, baseline studies; in 2007 the Research Institute for Health and Social Change at the Manchester Metropolitan University (MMU) published a comprehensive impact study, for example.[2] The selected interviewees were willing to participate, were helpful, and eager to share their experiences and ideas. They seemed genuinely interested in the Olympics and the outcomes for Stratford City. They all spoke animatedly and passionately about their work and their involvement in the EM regeneration. The sense of pride and accomplishment was obvious.

Eighteen interviews were recorded and subsequently transcribed. The analysis included tabulating the responses based on the main questions in the interview schedule. This produced a very useful matrix which summarised the various responses and from which the findings were extracted to inform this report.

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[1] Shahana Lais undertook the initial search and facilitated the selection of the two case study sites. We would also like to thank Jane Stokes who was a member of the case study research team and who undertook the initial Greenwich Millennium Village research.

[2] Woolrych R., et.al., (2007), 'The Impact of Regeneration on the Well-being of Local Residents: The Case of East Manchester', Research Institute for Health and Social Change, Manchester Metropolitan University, Manchester.

4. 4   Greenwich Millennium Village (GMV)

Overlooking the River Thames, close to a main arterial road which passes through the Blackwell Tunnel and a main road to the south, GV is situated in the southerly part of Greenwich Peninsular.
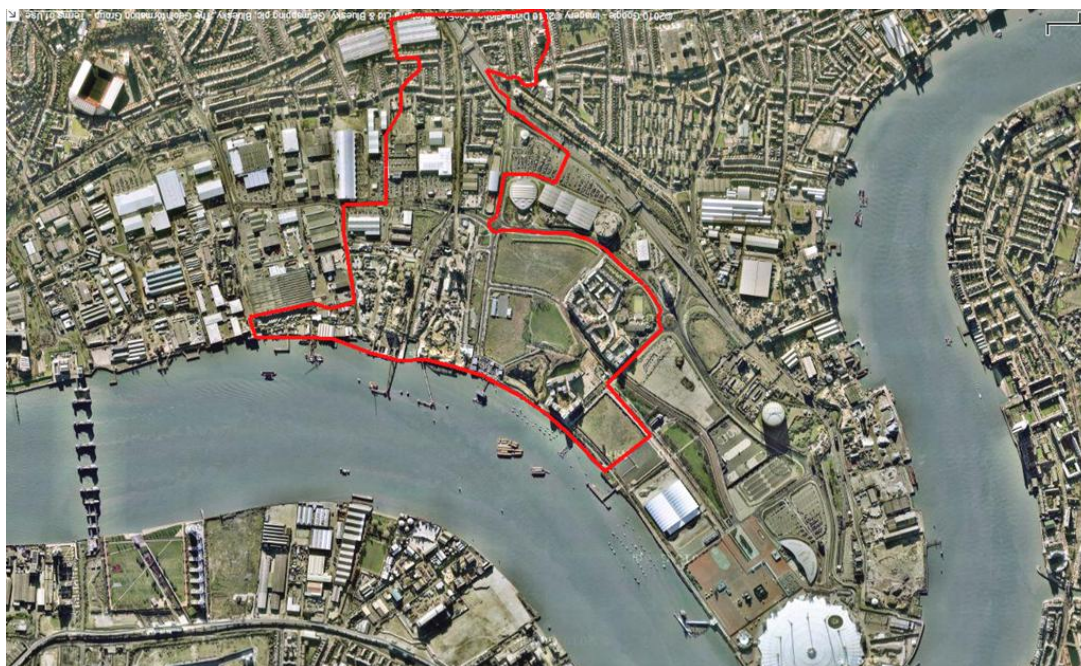
Note: The LSOA containing Greenwich Millennium Village. Note: a real image has been rotated with north to the bottom to aid depth perception of buildings and topography. © 2010 Google – Imagery © 2010 DigitalGloge, GeoEye, Infoterra Ltd and Bluesky, Getmapping plc, The GeoInformation Group.

4.4.1 Vision and plans

GMV is part of the Greenwich peninsula brownfield site and comprises 44 acres. It was conceptualised as an innovative and state-of-the-art development which represents progress and symbolised the new millennium in a similar way that Stratford City is part of a great sporting event that is designed to foster local and national pride. Further housing, retail and commercial development is planned, as well as a secondary school and college which is almost completed. Thus, a full provision of education and many employment opportunities are available on the peninsular for residents to learn and work locally.

The Village is close to the southern banks of the river Thames and has a primary school with a nursery and extended opening hours and which shares a site with a health centre. This complex is situated at the heart of the Village. Nearby is a 14 screen cinema, supermarket and two superstores, a hotel, yacht club and the O² entertainment complex, formerly the Millennium Dome. GMV is well-served by public transport which includes six bus routes and is within walking distance of North Greenwich underground station and a riverbus service.

The GMV masterplan specifies 1377 dwellings (298 houses and 1079 maisonettes and flats) and outline planning permission identifies that 266 will be affordable housing; 60 shared ownership and 42 rented flats/maisonettes and 14 shared ownership and 150

rented houses (just under 20%).[3] Section 106 funds are used for the affordable housing provision. The plans state that 'the overall aim of the scheme is create a sustainable urban environment that fosters an inclusive sense of community amongst the people who live and work there…. [and] this is to be achieved by the use of careful design, modern building materials and techniques and a strong community management organisation.'[4]

GMV has similar characteristics to the planned Stratford City with its environmentally-friendly design which incorporates the use of low-energy schemes, an emphasis on cycling and walking with routes linked to London-wide networks, and the creation of a natural environment with an ecology park and a lake. GMV is also managed by a private company.

GMV is considered to be a good example of where planning has contributed to sustainable development through its use of energy efficiency housing, including a combined heat and power plant that generates electricity on site providing heating for houses, and a good example of 'joined-up' planning as the Village is integrated into the wider development framework.[5] It has also been argued that the design of GMV has high levels of visual and social connectivity within the site, as well as having good links to the wider area, and high levels of accessibility which encourages the use of public spaces that is socially inclusive and fosters feelings of security.[6] Each home is also connected via a computer terminal to the internet and enables residents to talk to the estates office, who can disseminate information about events and meetings in the Village, and enables residents to communicate with each other, as well as having implications for home-working and taking training and education courses.[7] Thus, GMV reflects the vision of the architects, summarised as: 'Greenwich Riverside should not only be a showpiece of brilliant design and technical solution but a true expression of the ideals about respect for human dignity, equality and freedom we foster in our democratic society'.[8]

4.5   Health: initial developments and subsequent practices

In 1997 the challenge of regenerating Greenwich peninsula, the site of the largest gas works in Europe and a former manufacturing site for chemical, steel, soap and munitions industries, was started by the landowners, English Partnerships. They ran a competition to find a development team to create an exemplar sustainable new community for the new millennium. The winning consortium included Countryside Properties and Taylor Woodrow in conjunction with Moat Housing Association and Ralph Erskine Architects. The remedial work on the site removed any health hazards associated with living on a brownfield site.

The design of GMV attracted national political attention and John Prescott, Deputy Prime Minister, insisted that a Health Centre should be incorporated into the planning. Known as 'John Prescott's baby,' the Health Centre, both the site and building, was paid for by English Partnerships. They then offered the centre for lease at market value to the Health Service, with the condition that there was a provision for a common management structure for the health centre and primary school. The school hall was to be used as a

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[3] In 2004 12% was affordable. However, there are few family sized homes, including 14 private ones, with over 80% of the homes with one or two bedrooms (E. Silverman, R. Lupton and A. Fenton (2005) *A Good Place for Children? Attracting and Retaining Families in Inner Urban Mixed Communitie*s, published for Joseph Rowntree Foundation by the Chartered Institute of Housing. See page 41).

[4] Greenwich Local Authority, Planning and Development Committee, 'Development of the Millennium Village, Greenwich Peninsula': 8th October 1998: page 2.

[5] C. Gossop (undated) 'More Sustainable Planning – Experience from England'.

[6] Maghsoudi, M (2007) 'The Survey of the Urban Space: New pattern. A case study of Greenwich Millennium Village, London, UK' *Environmental Sciences*,4,3: 21-10.

[7] R. Hawley and R. Handkinson (2001) 'Homes for the New Millennium: New technology and innovation at Greenwich Millennium Village', *Ingenia*, 8, London: Royal Academy of Engineering.

[8] Ralph Erskine in Greenwich Millennium Team 'Greenwich Riverside: new ways of living for the 21st Century' Volume 1. Undated.

community facility in the evenings and at weekends. The centre provides a range of health services including clinics for babies and young children. In the current Greenwich Strategic plan, provision has been made to increase the 'spoke' services of the health centre to provide additional services.[9]

A minimum of 15% of the total housing stock was planned to meet full mobility standards and this provision was to be distributed though out the Village. The design of the Village is intended to promote healthy living with limited parking provision to discourage car use, and a pedestrianised centre, cycle routes and walking paths to encourage exercise. The ecology park and natural landscape are designed to contribute to residents' sense of well-being. Whilst there is a healthy life-style infrastructure, there are currently no health promotion schemes specifically for GMV and none outlined in health strategy documents, although a private health spa and café will soon open in the retail area of the Village. Statistical data presented in appendix six indicates that there are higher levels of smoking and binge-drinking and lower levels of eating fruit and vegetables, but a lower proportion of obese residents in the Millennium Village area compared to the average for London. This suggests that designing a healthy physical environment is not sufficient to guarantee healthy outcomes.

4.6   Lessons for Stratford City

The following issues were identified by those who participated in the research as relevant to those planning the Stratford City development. They include:

4.6.1 Getting it right at the beginning; it is difficult to recover from a bad start.

The importance of involving health practitioners at the early stages of planning and getting the 'right things in the right place at the right time' was repeatedly emphasised by those interviewed for this research. Numerous examples were given where health professionals were not included at early stages of planning and how a lack of understanding about how NHS and PCT budgets work caused subsequent problems. It was emphasised how a bad start is difficult to recover from and examples were given of planned communities which quickly got a bad reputation and then struggled to get rid of the stigma, making it difficult to attract market-rate residents, retail businesses, GPs and other services. To avoid such a situation occurring, challenges include:

Fostering better understanding between health and spatial planning agencies: Improving communication between these two agencies to integrate spatial supply and demand for services, and to build in flexibility to accommodate changing services and demands, was considered to be a priority. Difficulties encountered when working together include health staff not knowing how their own organisation works, a lack of understanding of the constraints within each sector, particularly about contractual and financial arrangements, and a lack of shared language which leads to misunderstandings. As a result of these difficulties, the following has occurred: health centres have been proposed too close to each other, a health centre designed with rooms which are unsuitable for counselling and are not flexible enough to accommodate new services. Whilst joint working has improved, those who were interviewed for this study identified recurring problems and mistakes with new developments arising from inadequate partnership working. The common practice of using consultants to advise and to generate ideas was felt to contribute to these problems; strategies and 'high level' thinking were thought to be too removed from the everyday practical realities of practitioners delivering health services.

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[9] Greenwich Teaching Primary Care Trust, Commissioning Strategy Plan: 2008/09 – 2012/13.

Ensuring that capital build such as health facilities, community buildings and schools are co-ordinated with revenue funding: being able to deliver services immediately to residents, as soon as they moved in, was considered to be essential. A concern of health professionals was that the health centre would end up as a liability. To ensure that the centre was ready to provide services when residents moved in, health professionals persuaded a GP working from nearby premises to move to the new health centre and to take on the lease of the building, because the health authority was unable to advertise for a new GP as there was already sufficient GP provision within the borough. Many of the GPs existing clients wanted to remain on his list, in part they were attracted by the new facilities, leaving fewer places available for new residents. It proved impossible to attract a dentist to the health centre to occupy the room with a reinforced floor for a dentist's chair. There was an x-ray room but no capital funding was available for an x-ray machine, for example. A nearby local primary school was closed and children were transferred to the new school that shares a site with the health centre. Having fully serviced buildings ready for new residents was thought to be important for creating positive feelings towards the Village, and that securing advanced capital and revenue funding was essential for this to happen, but that this had been very difficult because it was '*not within the usual rules*'. To obtain funding, it is usually necessary to demonstrate that there are already patients on waiting lists and that they have particular health needs. In 2006, data show that it was difficult for residents to access dentists and pharmacies, suggesting that after six years, residents did not have easy access to some health services.[10]

Raising the profile of health promotion: it was felt that promoting health was neither a priority for health professionals nor planners, even with the *Choosing Health* agenda, and that the policy framework for strategic integration to promote health lacks clarity for planners. Whilst planners have a duty to create conditions for healthy communities, this was not a planning policy on health, and it was felt to be '*ambiguous*'. Further, the 'absence of disease' was thought to be a low priority for health professionals and health promotion remains a small part of the budget of health services, as borne out by a recent King's Fund report.[11] One interviewee who participated in our research felt that the 'health inequalities agenda' was the lowest priority for both planners and health professionals. Health Action Zones were one initiative designed to address health inequalities through health promotion, and one reason for their disappointing performance was thought to be their failure to make any lasting changes to working relationships between agencies.[12] It was felt that integrated working was best achieved where working arrangements were more formally integrated. Examples of good practice to support integrated working were given where planners were seconded to PCT strategic health commissioning departments. In this situation, planners are able to inform and influence the approach of health professionals towards spatial planning, to encourage their involvement at the initial planning phase and to learn from health professionals. Furthermore, a 'healthy' agenda is different to agencies responding to illness and this involved bringing together different partners; leisure and sport, and the Ramblers' Association, for example.

Other issues related to '*getting it right at the beginning*' are:

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[10] See appendix six. By 2010 this situation may have changed but data are not available to assess the accessibility of services.
[11] King's Fund (2010) 'A high-performing NHS? A review of progress 1997-2010'. Summary. Published by the King's Fund, London.
[12] L. Bauld and K. Judge, eds., (2002) *Learning Lessons from Health Action Zones*, Bodmin: Aeneas.

- Health promotion was thought to be a good use of section 106 with schemes to encourage exercise, healthy eating, and so on; however, there is no such provision in section 106 for GMV.
- New residents are often attracted to a place because it is new and a challenge is to maintain the attractiveness of a place like Stratford City after the initial surge of interest and when it is no longer 'new'.
- Considering place-making when allocating social tenants to a new development was considered to be important, and that tenants with pro-social behaviour contribute to developing a positive reputation for a new community.
- No health outcomes were set for GMV. Current health strategic plans do not identify GMV as a place requiring special health promotion attention and outcomes are measured borough-wide.
- The lack of a longitudinal assessment of GMV as an innovative and pioneering initiative was thought to be a wasted opportunity. Examples of good practice in other similar areas were identified, including New East Manchester where residents' surveys are repeated to identify the impact of health outcomes and wider determinants of health.

4.6.2 Ongoing community development.

One wider determinant of health is the extent to which residents feel part of a community, make friendships and have an emotional attachment to where they live.[13] The design of the Village with its pedestrianised squares, its shared courtyards, informal spaces by the river and lake, and community buildings were intended to foster social interaction and create 'gossip groups and social spaces'[14] to establish a 'meaningful inclusive community'.[15] There has, however, been no research which has systematically assessed the impact of the design on social inclusivity, belonging, or health.

Initially, a community development worker was employed by the developer to encourage community ties by connecting new residents to the Village and its surrounds and to each other to bridge the social and class divide found in planned mixed communities. The part-time worker had a small activities budget and produced a newsletter, and helped organise social activities and consultations with residents. Initially, the developer also contributed financially to start a parent and toddlers' group and to raise funds for the school.

Currently, there is no community development worker and the absence of a cohesive community was commented upon by interviewees. This is manifest in several ways; there is a view that in some blocks of flats, residents rarely see their neighbours and feel isolated, there is no playground to provide a meeting place for parents and carers with young children, and when there are community meetings, social problems and complaints rather than events which foster positive attitudes and positive community experiences are discussed. The main positive community events are festivals and fairs held at the ecology park to celebrate holidays. However, several of those interviewed thought that GMV was '*not a friendly place*'.

It appears that there is a growing divide between a vocal group of market-rate residents and those living in social housing. Some residents are concerned about the value of their properties and have complained to the local member of parliament and councillors. They

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[13] See appendix 3 on well-being.
[14] See http//:www.urbandesigncompendium.co.uk/greenwichmilleniumvillages. [accessed 13th April 2010].
[15] Greenwich Local Authority, Planning and Development Committee, 'Development of the Millennium Village, Greenwich Peninsula': 8th October 1998: page 45.

complain about social tenants who they claim are too noisy, regularly have arguments and commit domestic violence crimes in their flats, and behave unacceptably in communal areas and lifts by leaving litter, being drunk, having fights, and allowing their children to run up and down the stairs. The private company meets regularly with the Registered Social Landlord (RSL), tenants are sign-posted to local authority services such as the anti-social behaviour team and parenting classes, and some families have been evicted. From the perspective of the local authority, who are responsible for many very disadvantaged neighbourhoods in the borough, GMV is managed by a private company, and the scale and seriousness of the problems on GMV do not justify the expenditure of additional, and limited, local government resources.

4.6.3 Appropriate governance:

GMV Ltd was set up as joint venture company to oversee the site's development and long term management. The GMV management company is hired by the developers and a local councillor is a member of the board. The private on-site management company is responsible for housing and grounds maintenance across the whole site, for running the 'concierge' system, which provides a single point of contact for residents who have problems with cleanliness, safety and social behaviour. Staff monitor CCTV cameras and walk round the estate. Where there are problems, a member of staff meets with residents and staff regularly meet with the Registered Social Landlord (RSL) to discuss any concerns that arise about those living in social and affordable housing. A research study found that these arrangements, with a single on-site company for all residents, was more responsive to social problems than in, for example Britannia Village, London Borough of Newham, also a planned mixed community where a private management company is responsible for only maintaining private areas. This has created a social divide with more litter and graffiti near social housing and fewer residents feeling safe than in GMV.[16]

There is a cross-tenure residents' association and a sub-group of the association which is run by social tenants for social tenants.

4.6.4 Putting in place a baseline study and measuring health improvements:

A benchmark study was undertaken with European funding by an organisation with an energy remit.[17] The initial data were collated in 2007 using planning and construction documents. The benchmark study is due to be repeated in 2012. It is centred on assessing the sustainable design efficiency of the site and has a set of technical innovation targets for primary energy, construction standards and water consumption, all of which are designed to be energy saving. They include, for example: construction cost with a target to reduce costs by 30% by recycling site waste, including plasterboard and metals; a reduction in water consumption by 30%, using efficient devices in the home and recycling grey water; primary energy, an 80% reduction by using the combined heat and power facilities.[18] The selected targets reflect the use of the latest technology to reduce construction and development costs and to create an environmentally sustainable community. Neither health targets nor any social or community indicators were incorporated into this benchmark study. The London Wildlife Trust, for example, were disappointed that no ecological survey of pre-existing flora and fauna was undertaken prior to the remediation work.[19] No one involved in the initial stages of the GMV

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[16] See Silverman et al 2005: pages 35 -50.
[17] Secure (undated) 'Benchmark Study: Greenwich Millennium Village', European Sustainable Urban Development projects.
[18] Hawley, R. and Hodkinson, R. (2001) 'Homes for the new millennium: new technology and innovation at Greenwich Millennium Village', *Ingenia*, 8, London: Royal Academy of Engineering.
[19] Greenwich Local Authority, Planning and Development Committee, 'Development of the Millennium Village, Greenwich Peninsula': 8th October 1998: page 27.

development we talked to for the research was familiar with other baselines studies, either at the inception of GMV or subsequently.

4.7 Current challenges

There are a number of issues which have emerged from the research which are discussed more extensively in appendix 1 and 2 of this report. One issue which underpins how GMV works as a community is that GMV is a private development with affordable and social housing, which raises questions about how far it is possible to influence private companies who are driven by profits. A study conducted in 2004 found that 25% of the private housing was bought to invest,[20] and this further drives a desire to ensure that GMV is well managed and maintains a good reputation so that investors can maximise the return on their investments. It is in this context that the following issues have been raised in our research:

4.7.1 Property values and social mixing:

One consideration which has been instrumental in driving forward the planned mixed communities agenda is the persistence of social and economic disadvantage where there has been repeated social interventions and large scale capital expenditure. An alternative approach to the problem of improving areas of concentrated poverty has been to create mixed housing tenure communities. A presumption is that those who are economically and socially disadvantaged will benefit from living in an area with mixed tenure housing; social tenants will be less concentrated in an area which is not stigmatised, will benefit from better housing and living in an environment where they will learn pro-social behaviour from middle class young people who are not involved in anti-social or criminal behaviour, and the opportunity to mix socially across class will raise their aspirations and improve their chances of finding employment.[21] Such assumptions rely on mixed communities being attractive to market-rate families and for meaningful social mixing to occur between residents. The 'urban village' design of GMV is intended to provide these opportunities by facilitating social interaction and community participation amongst residents. In this way, social inclusion is to be achieved through tenure mix.[22]

In some parts of GMV, the process of social mixing between residents has been impeded by a lack of friendliness and has broken down in some blocks of flats where there are market-rate households and social tenants living side-by-side. The reasons for a rise in intolerance and tenure prejudice include a pronounced income gap between market-rate residents and those in social housing. Since GMV was built, property prices have risen steeply and two bedroom flats can be bought for between £300K and £400K in a location with easy transport connections to the City, nationally and internationally, which is attractive to high earning professionals.

Income inequality has been identified as a source of social stress, poorer mental health and increased levels of violence, and this is most evident in planned mixed communities where higher earners live in close proximity to those out of work and with low incomes.[23] These potential problems can be exacerbated when market-rate households and those living in affordable housing are preoccupied with maintaining the value of their properties, which can decrease due to litter and antisocial behaviour. Each tenant also pays a service charge, which is perceived as high (between £26 and £40 a week) and for

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[20] See Silverman et al 2005:page 42.

[21] Lupton et al (2009), 'Evaluation of the Mixed Communities Initiative Demonstration Projects'. London: Communities and Local Government. See pages 21-27.

[22] See Silverman et al 2005: page 40.

[23] R. Wilkinson and K. Pickett (2009) *The Spirit Level: Why Equality is Better for Everyone*. London: Penguin.

which high levels of cleanliness and orderliness in private and public spaces are expected. When these expectations are not met, complaints are routinely made to the management company and some residents complain to councillors and the local member of parliament. The complaints are invariably about social tenants who are not thought to respect their properties and, as a result, they are often blamed for disturbances and litter problems. Complaints can, of course, be reasonable and there is a clear complaints procedure in place. However, it was thought that complaints made by market-rate households living in GMV were often about low levels of nuisance and noise which are tolerated in other planned mixed communities. As a result of the low levels of tolerance, meetings between agencies get '*bogged down*' with responding to complaints, and this has prevented planning for positive events and activities to encourage and facilitate social mixing and community development.

4.7.2 Maintaining a 'balanced' community:

A national study found that market-rate families were attracted to GMV principally because of its outdoor space and environment, for its architecture, its urban lifestyle and its mixed tenure.[24] Retaining families to maintain a 'balanced' community has been more of a challenge. It seems that children mix socially at primary school and then market-rate families move on once their children reach secondary school age. The high value of the flats makes it possible to buy homes with gardens in areas where there are high performing schools and colleges. A lack of strong attachment to GMV also makes parents and carers more inclined to plan to move out once their children get older.[25] Young people living on the estate are therefore more likely to live in affordable or social housing. These social processes run counter to some fundamental belief that informed the GMV development that a mix of dwelling types and sizes, which caters for a range of housing needs, 'should encourage the development of mixed and balanced communities in order to avoid areas of social exclusion.'[26] However, further and more systematic research is required to find out if those living in affordable and social housing on GMV have more life chances and enjoy better health as a result of their move to the Village.

4.8   New East Manchester

4.8.1 Introduction

The second case study is located in East Manchester (EM). East Manchester is situated immediately east of Manchester City Centre and was at the centre of the Industrial Revolution. It was the industrial workshop of the world with a thriving manufacturing industry on which the city's and whole country's wealth was based. However, 1968 onwards marked the beginning of the decline of the manufacturing industry, including the closure of Bradford Colliery[27] and the EM based Johnston & Nephew[28], plus a number of other manufacturing establishments which employed local people. This trend continued throughout the 1970's, and with these factories employing different generations of the same families, the socio-economic effects were visible. This was followed swiftly by the election of Margaret Thatcher in 1979, a period which saw the most radical changes in the British welfare state and was characterised by a fast changing political landscape, stringent economic conditions, high unemployment and high inflation. The knock-on effect of these factors saw most of the industries within the area either shut, collapsed or moved out. In the 10 years leading up to 1985, the area

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[24] See Silverman et al 2005: page 45.
[25] Silverman et al 2005.
[26] Greenwich Local Authority, Planning and Development Committee, 'Development of the Millennium Village, Greenwich Peninsula': 8th October 1998: page 29.
[27] Bradford Colliery shut down in 1969 resulting in 1,600 men becoming unemployed overnight.
[28] J & N was one of the biggest wire exporters in the world and the biggest employer in the area, employing thousands of men and women.

experienced a 60% employment loss.[29] This period was also characterised by successive economic recessions and increased competition from global markets.

This once thriving area encompassing 1900 hectares[30] became a huge brownfield site and one of the most deprived areas in the country. In the late 1980s to early 1990s, EM was characterized by poorly used open space; poor quality derelict industrial sites; extensive social, economic and physical decline; 13% population loss; 20% of housing stock vacant and negative equity. This inevitably caused a collapse in the housing market; low skills base and poor education; poor health and health facilities; high crime rates; and poor community and retail facilities. The economic base of EM was very fragile with 52% of the population receiving benefits.

The area has been home to a number of local regeneration projects including the EM Initiative from 1982-1989; the EM local action team and EM development strategy in the early to mid 1990s. EM has also benefited from the Central Manchester Development Corporation (CMDC), which was a central government regeneration agency that worked in partnership with the city from 1988-1996 and attracted £350m investment into central Manchester.[31] However, the current EM project is the largest regeneration challenge the city of Manchester has ever faced. Although national initiatives aimed at socio-economic development existed and were delivered at city and neighbourhood level, these initiatives, such as Sure Start, New Deal for Communities, Single Regeneration Budget, Health Action Zone, Sports Action Zone, Education Action Zone, were unable to achieve sufficient physical, social and economic improvements.

East Manchester is, however, a prime site for regeneration. Manchester City is strategically located at the heart of the UK, and serves as the gateway to the North both by road and rail. EM is served by Piccadilly train station located in the city centre. The Manchester City Football Club (MCFC), Sportscity, and all the major sporting facilities that form part of the legacy of the Commonwealth Games, are just a short journey from Piccadilly train station. EM is also served by four major arterial roads, all with very good access to the Manchester Orbital motorway – the M60. They are the A62, A662, A57 and A635. Despite the relatively close proximity to the city centre and the M60, parts of EM still remain isolated due to inadequate transport links. Between spring 2012 and winter 2014, Metrolink plans to complete ongoing works to extend the current Piccadilly-Draylsden service to Ashton-under-Lyne which will serve Sportcity, and represents the highest transport infrastructure investment in EM.[32] This new link will increase the potential for investment, growth, and economic activity, as well as making EM a more desirable place to live and to work.

4.9 New East Manchester Regeneration Ltd. (NEM)

In 1998, in an effort to ensure a consistent and sustainable approach to development and regeneration, the New East Manchester Regeneration Ltd. (NEM)[33] was set up by the Manchester City Council. NEM[34] was one of the first Urban Regeneration Companies to be established and is a partnership between Manchester City Council, The Homes and

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[29] www.neweastmanchester.com
[30] www.neweastmanchester.com
[31] Mace, A., et al. (2007), *New East Manchester: Urban Renaissance or Urban Opportunism?,* London, Routledge
[32] Strategic Regeneration Framework 2000 - 2008
[33] Although it is set up and owned by the Manchester City Council, NEM Ltd. is a private Limited Regeneration Company whose work is directed and overseen by a Board of Directors. It operates as the business face of the council.
[34] Although the name of the regeneration company is the East Manchester Regeneration Ltd. and the geographical area is New East Manchester, both are commonly referred to as NEM. Consequently, as both the company and the geographical area are being discussed here, for distinction, NEM will always refer to the regeneration company – East Manchester Regeneration Ltd- whilst East Manchester-EM – will always refer to the geographical area.

Communities Agency, North West Development Agency (NWDA) and the communities of EM.[35] NEM works closely with developers Urban Splash Ltd., and their broad objective is 'to lead the physical regeneration of the area, co-ordinate and integrate social/community and economic initiatives and market and promote the area to new businesses and residents ensuring a sustainable future.'[36]

As shown in the map below[37], NEM's regeneration programme area is physically large and diverse, which comprises a series of discrete and interlocking neighbourhoods and communities, including Openshaw, Higher Openshaw, Clayton, Ancoats, Miles Platting, Lower Medlock Valley, Cardroom, West Gorton, Ardwick, Aston Canal Corridor, Beswick.[38]
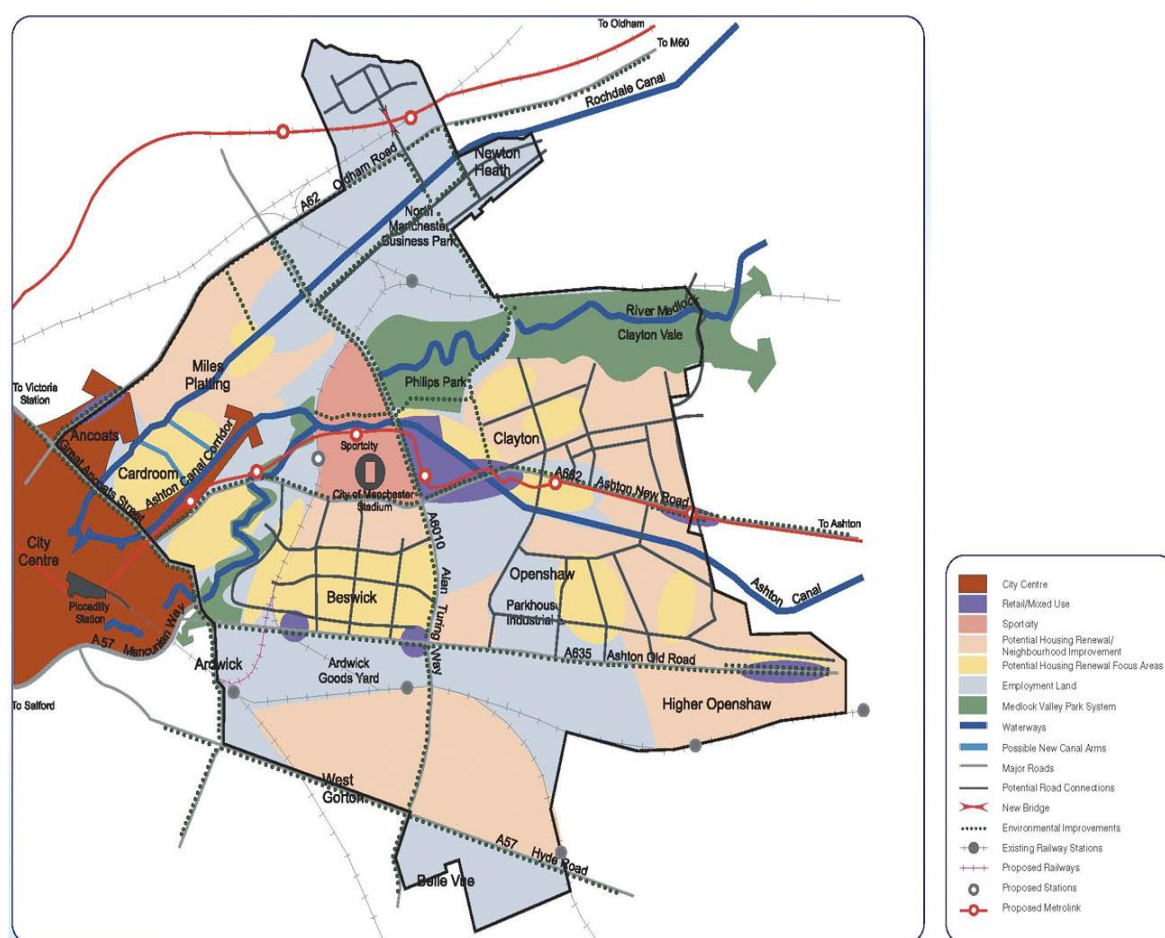
Source: NEM Strategic Regeneration Framework 2000 - 2008

[35] www.neweastmanchester.com
[36] www.neweastmanchester.com/introduction
[37] NEM's Stretegic Regeneration Framework 2000-2008
[38] NEM's Strategic Regeneration Framework 2000-2008. See also figure 1 in section B of this appendix.

One of the first priorities of NEM was to develop a Regeneration Framework which was published in 1999 after extensive consultation with all stakeholders, including local residents. In this framework, NEM's aims and objectives were outlined. The framework recognises the importance of addressing wider determinants of health such as educational attainment, worklessness and low income, and acknowledges that these factors will take a long time to address satisfactorily.[39] The original framework identifies four broad long term goals for NEM:[40]

1) to act as custodian of the vision and regeneration framework and ensure the highest standards;
2) to co-ordinate a wide range of regeneration programmes with different boundaries, remits, timetables, and resources;
3) drive forward major new physical developments – the new town centre, private sector housing programme, strategic environmental and public realm improvements;
4) market EM by raising its profile and building a private sector investment base.

Two objectives underpin the framework, linking the initiative's social and economic ambitions. The first was creating sustainable communities and an environment that was attractive and friendly to live and work in, where local communities benefited from job creation, high quality facilities and long term viability. The second was to maximise its contribution to the economic competitiveness of both Manchester and the northwest region.[41] Within these two objectives, NEM identifies specific roles which included developing and implementing the Regeneration Framework for EM in partnership with others; lead the major strategic physical regeneration of the area; co-ordinate, integrate and oversee the design and delivery of a range of special initiatives underpinning NEM's regeneration programme; secure public and private sector resources to deliver the comprehensive, long-term programme of regeneration; focus mainstream public services and funding more effectively and based on the needs and aspirations of residents, stakeholders and new investors in NEM's vision for the regeneration of EM.[42]

In implementing their vision and plan, NEM works with a number partners to achieve their targets which include:

1) Increasing the population of EM from 60,000 to 90,000
2) Construction of 12,500 new homes
3) Comprehensive improvement and modernisation of 7,000 existing homes
4) Development of a 160 hectare new business park
5) Creation of over 10,000 new jobs in the area
6) Completion of the Sportcity complex of world-class sporting facilities in the heart of the area.
7) Development of an integrated public transport system incorporating Metrolink, rail, bus and car transport, as well as pedestrian and cycling provision
8) Raising educational attainment in EM schools to above the city average

It is beyond the remit of this study to outline all the initiatives undertaken by NEM, as our focus is on health. However, the following account gives an insight into the types of initiatives NEM have put in place to address high levels of unemployment, which is a wider determinant of health.

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[39] Benzeval M., et. al., (2000), Evidence on the Relationship between Low Income and Poor Health: Is the Government Doing Enough?, UK, Institute of Fiscal Studies
[40] NEM 'The new town in the City' - Interim Evaluation of NEM (Parkinson et. al.pp. 3-4)
[41] NEM 'The new town in the City' - Interim Evaluation of NEM (Parkinson et al.: pages 3-4).
[42] NEM 'The new town in the City' – Implementation plan 2006/07.

Since 2005, NEM established the Regeneration Assistants project, which is an accredited training programme that helps local people access jobs in regeneration through a route that combines work-based experience to gain skills, practical knowledge and qualifications. Occasionally, in partnership with Jobcentre Plus, and a variety of other employers through the Local Employer Partnership, NEM host a jobs event –'Jobcity' – which is always very well attended. A number of employers from the public, private and third sectors participate and in summing up after one such event, NEM remarked[43] 'the feedback from employers and from those seeking work has been very positive, which demonstrates the value of the event in helping to match local people with local jobs. It is particularly encouraging to see so many local residents taking positive steps towards finding employment.' The latest of these events was held in February 2010.[44] In addition, there is the NEM Economic Programme which is 'a progressive package of support designed to reduce worklessness and increase job creation by working with NEM residents and the local business community to achieve sustainable growth in the economy.'[45]

In 2007, a leading industry magazine named 'Regeneration and Renewal' held a special ceremony in London to commemorate the first ever Regeneration and Renewal Awards. There, NEM was named the Regeneration Agency of the Year and also won the top award in the training category for the Regeneration Assistants project. [46]

In September 2008, in partnership with The Manchester College and Manchester Solutions Ltd, and funded by New Deal for Communities and the NWDA, NEM opened a new Construction Training Centre in EM. The centre aims to equip learners with the relevant skills to secure employment in the construction industry. It offers training in a real working environment in courses such as plastering, kitchen and bathroom fittings, carpentry, joinery and groundwork. Together with one private and one third sector partner, local people are also offered a free welding course at the Manchester College of Arts and Technology. [47]

4.9.1 Sporting facilities

After hosting the 2002 Commonwealth Games, EM is now home to some of the country's most advanced and world-class sports facilities where some of the best sports people undergo training and provide coaching. The 48,000 seat capacity stadium is home to Manchester City Football Club and is at the centre of a large leisure complex known as Sportcity. The national velodrome is nearby. In keeping with the planned legacy, the facilities are available to local residents who use them alongside sporting heroes and champions. Some of the ways in which the facilities are made available to the community include conferences, social and community functions such as wedding and funeral receptions, schools, senior citizens social meeting, physical training including exercise by prescription.

4.9.2 Planned mixed community

EM is a planned mixed community and one challenge for NEM has been to reverse the population decline and to attract a greater number of shared and homeowners into the area. Between 1951 and 2001, the population of EM declined 61% from 164,633 to 64,459, and has since started to increase. The NEM's 2008 residents' survey found that

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[43] This remark was made by Eddie Smith – Chief Executive of NEM.
[44] www.neweastmanchester.com.
[45] http://www.neweastmanchester.com/projects/job_training_skills/
[46] www.neweastmanchester.com
[47] NEM annual report 2008-2009

27% of the respondents had moved into the area since 2003 and that nearly half the residents had lived in the area over twenty years.
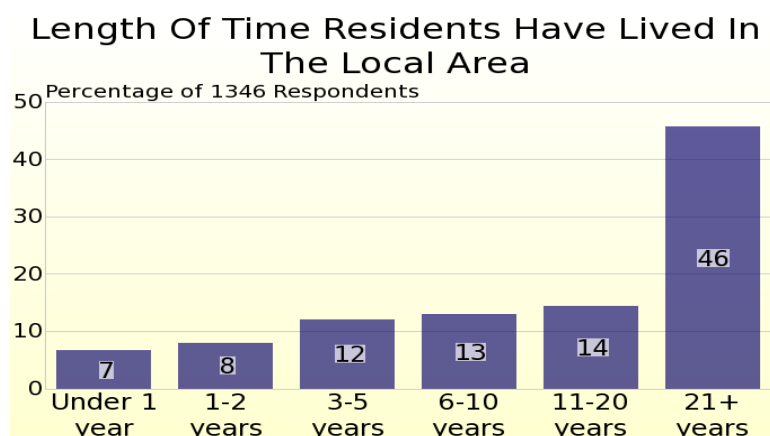
Source: NEM's 2008 Residents' survey

There has, however, been little change in housing tenure between 1998 and 2008. In 1998 and in 2008, the residents' surveys found that owner occupiers were 35% and 34% respectively and in 2008, two thirds rented their property mainly from Housing Associations and the local Council.[48]

The current 2008-2018 SRF proposes that by 2025, 24,000 additional new homes will be built to meet their intention to increase the population to between 90,000 and 100,000 by 2018.[49]

4.9.3 Employment and worklessness

Between 1971 and 1997, employment fell in Manchester by 26%,[50] with a steep 62% decline in employment in the manufacturing sector.[51] NEM have worked hard to improve employment opportunities, not only for existing residents but also for those who move into the area. They have a target to create 10,000 new jobs in the area. NEM have facilitated the establishment of bigger retail chains including ASDA Wal-Mart, Matalan and Next, employing 218, 51 and 41 local people respectively. At the time of completion, the 180,000sq feet ASDA Wal-Mart supermarket was considered the biggest of its kind in Europe.[52] Gregg's bakery completed and opened its new £16 million North West Headquarters in EM preserving 300 jobs in the local area.[53]

Available data show, however, that many challenges remain:

- The profile of businesses remains micro with a significant number operating below the VAT threshold;
- The proportion claiming Job Seekers' Allowance is consistently above the Manchester and national averages. Even though there was a reduction in EM and

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[48] NEM residents' survey.
[49] NEM baseline study 2008 – figures based on analysis of data provide by GEOMATICS and Leeds University.
[50] From 344,739 jobs in 1971 to 254,550 jobs in 1997.
[51] Mace A., et.al.. (2007).
[52] http://www.neweastmanchester.com/introduction/achievements/
[53] NEM annual report 2008-2009

Manchester in 2007, the trend still remained the same, with EM 5.7%, Manchester 3.7% and the national figure at 2.4[54];

- More than one third of working-age residents claimed a non-working benefit in 2008, the majority of whom were 'inactive benefits'. These benefits do not oblige the recipient to look for work, although a small growth in the proportion of working-age residents re-engaging in work has been observed[55];
- There are a small number of neighbourhoods which have almost half of working age adults not in employment[56];
- There is evidence of a churn effect as many of those who gain employment do not remain employed for sustained periods.

It is within this context that achieving a healthy workforce is particularly challenging for NEM and its partners. The establishment of the Manchester Community Health, Manchester Mental Health and Social Care Trust, the Manchester Joint Health Unit, along with a number of other health initiatives is testament to Manchester's commitment to achieving healthy outcomes for EM's residents.

4. 10 Health

4.10.1 Strategic approach

Health services in Manchester are provided by NHS Manchester and the jointly funded Joint Health Unit (JHU),[57] which is a special initiative responsible for strategic planning and partnership working for health improvement and tackling health inequalities.[58] Health facilities were firmly integrated into the initial planning stages. Interestingly, NEM's Strategic Regeneration Framework has specific sections dedicated to education, housing, community, transport and so on, but not to health. This is because health is perceived as an overarching issue relevant to all aspects of regeneration and it has therefore been embedded into all sections of the strategic plan. The fear was that if health was included as a separate section, it would be excluded from the planning and implementation of activities such as education, transport and community.

Healthy outcomes were an integral part of the initial planning and since EM was an old manufacturing area, the available land was extremely polluted. Extensive remedial work had to be undertaken on the site to decontaminate and remove any health hazards associated with living on a brownfield site. Section 106 funding was used to complete these tasks.

4.10.2 Baseline study

NEM routinely conduct baseline studies of key characteristics that are relevant to the strategic plan and include physical, social, economic, environmental and health status issues.

The first baseline study found that health in EM was very poor, comprising of high mortality, high morbidity, obesity, low life expectancy, high conception rate amongst pre-16 years old, poor dental health, high incidences of low and high level mental illnesses, and high rates of alcohol abuse and smoking and corresponding diseases. A significant proportion of the population were claiming disability/incapacity and other sick related allowances and benefits and it was concluded that the EM area was 'the unhealthiest in

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[54] Department of Work and Pensions
[55] NEM baseline study 2008
[56] NEM Strategic Regeneration Framework 2008-2018
[57] The Joint Health Unit is funded by the Manchester City Council and NHS Manchester
[58] www.manchester.gov.uk

the country'. In response to these findings, NEM identified a number of factors and principles that would address the health issues. These include:

1) Getting buy-in from all stakeholders and engaging them from the outset
2) Conducting repeat baseline studies
3) Partnership working and taking a multi-agency approach
4) Joint recognition of the issues and a shared approach to addressing the problems
5) Engaging local residents at all levels in the implementation of the regeneration programme
6) Adopt a holistic approach to health by encouraging local residents to lead healthy life-styles and by organising health promotion activities

Despite all their efforts, achieving positive health outcomes remains a challenge that reflects a nexus of issues comprising of decades of unemployment and worklessness, poor health, low incomes and low educational attainment. Teenage conception saw a steady increase between 2001 and 2004, with a rate that was significantly higher than Manchester as a whole and the average for England.[59]

NEM includes questions in the baseline study on respondent's perception of their health and compares health status over time. Perceptions of health and well-being can be subjective and vary, findings on self-rated health should therefore be interpreted cautiously. 2001 census data was analysed by NEM staff[60] and 59% of EM residents thought that they were in good health and 25% thought they were in fairly good health. However, 15% thought that they were not in good health, which was significantly higher than nationally, with 1% reporting that they did not think that they were in good health. The findings from NEM's own survey conducted in 2008 found, in response to a question on *rating of health during the past 12 months*, that 42% of respondents reported their health as 'good', 29% report their health as 'fair' and 23% reported 'poor' health.[61] [62] These findings from the local survey suggest that self-rated perceptions of poor health were higher than the census data and that self-reported health has declined rather than improved. Whilst these findings indicate that perceptions of poor health remain well above the national average, the apparent increase in poor health may be interpreted positively; they could indicate a great awareness about health issues and this might be the first steps towards adopting a healthier life-style?

4.11 Lessons for Stratford City

A number of issues were identified by research participants as relevant for planning the Stratford City development. All the research participants agreed that the regeneration of the Stratford City area could learn a great deal from the Manchester experience. The following issues were identified as being particularly relevant:

4.11.1 'Getting it right at the beginning; it is difficult to recover from a bad start': Central to the EM case is *'getting it right at the beginning'* and ensuring that *'the right people are engaged at every level and at every step of the process.'*

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[59] NEM baseline study 2008.
[60] 3 years after NEM was established.
[61] NEM Perceptions report 2008.
[62] For comparison of the responses between the national census and NEM local survey on the same question; the census' 'good health'; 'fairly good health' and 'not good health' is compared to 'good'; 'fair' and 'poor' respectively.

It was repeatedly emphasised how difficult it was to recover from a bad start. Interviewees emphasised three factors in particular that enabled a positive beginning; involving all partners strategically and operationally in planning by adopting an open and inclusive approach which recognised 'the community' as equal partners and encouraged integrated working through work placements and secondments, for example; community engagement and community development; and designing high quality health facilities which were 'fit for purpose' for health practitioners, that fostered community pride and feelings of being valued.

Those interviewed for the research emphasised the importance of giving as much thought to strategic plans as to pragmatic, operational and logistical aspects of the programme. The interviewees attributed much of their initial strategic and operational success to '*getting buy-in from all stakeholders*' and '*involvement and commitment from partners*'. At the earliest opportunity, NEM staff Identified and worked with partners who shared their vision and created a working environment where joint-agency working engendered new, innovative and efficient ways of working. This multi-agency approach also raised an awareness of partners' individual plans; for example, other partners already had similar plans but with a different emphasis or priority, the plans of others could adversely affect the regeneration programme, whilst the work of others was complementary. It was thought that the strong management of the East Manchester programme, from the beginning, was able to bring together all the relevant partners and to persuade them of the value of participating in the large scale regeneration initiative. Engaging partners at each stage of development in a way that was meaningful to, and clearly understood by, them and an open and inclusive approach as exemplified by the use of secondments; for example, from the inception of the initiative, a senior partner from the developers was seconded to NEM's office, thereby integrating physical planning into the programme, were considered to be effective actions. These actions contributed to an approach where '*everybody is singing off the same hymn sheet, everybody being involved, everybody wanting it to be a success.*'

A strong belief about the importance of working with local people and considering residents as a key partner also underpinned NEM's approach to joint working. From the outset, consideration was therefore given as to how best to engage and work with local people as a community partner. All the agency partners agreed, for example, that '*overwhelming residents and service users with large numbers of professionals creates disengagement,*' and NEM staff and partners worked sensitively with local people to build their skills and confidence, enabling them to participate as equal partners. From the outset, they believed that it was imperative to ensure the community understood the development as '*not being done to them but being done for them or rather with them*' and that they were '*part and parcel of not just the games but the legacy of the games*'. A NEM manager explained that the '*the best people to work with are those who live in the local community.*' As a result of valuing the involvement of local people, the importance given to community engagement cannot be overemphasised. As one interviewee expressed it; '*engagement, engagement, engagement with the community from the outset*'.

NEM staff learnt that 'getting it right' included having an ongoing community development plan. An important aspect of the plan is to:

'*empower communities to be active partners capable of taking control of their own destiny, give them space, confidence and support to develop*' and to '*encourage collective community activities that help meet outcomes*'.

Policies which have arisen from this approach include avoiding gentrification by implementing the 'Right to Remain/Right to Return' policy. Existing tenants were given

temporary housing during the initial infrastructural developments and could exercise their right to remain/return to their homes once the development was completed.

With respect to community engagement and community development and improving health outcomes, NEM have been, and remain, mindful about how best to engage with local people and have adopted a flexible approach to improve the take-up of health services: *'it is essential to make sure that there is a power balance, which creates an environment where choices can be made; for example, residents do not always have to go to services, services can go to them; a health talk does not have to be held at a health centre, it could be at a park or a local food market which may be more attractive and less intimidating, thus resulting in better attendance.'* To achieve this, the importance of employing staff with skills to instil an ethos of co-operation within agencies and promote the co-ordinated delivery of services, was repeatedly emphasised. One interviewee summed up the views of several interviewees:

'engage skilled people who know how to work in partnership at the highest level, so that they will drive a culture of working in partnership on the ground, because it's the way it works on the ground that really, really can make a difference.'

A key factor which created a positive start was, according to research participants, to ensure the high quality of buildings for health services and to ensure that the design teams, the architects and health professionals worked together towards designing buildings that met high architectural standards and provided an environment which met the requirements of the medical professionals and services, such as room sizes and logistics that enabled them to provide high quality services efficiently. As one manager observed:

'*The building should be part of the design brief, so the people working there feel proud and happy to work there and similarly the people visiting it.'*

Putting in place high quality health facilities complements and reinforces community health promotion work. By involving local people in the design of buildings, they are *'kept informed and engage at every stage and of every change,'* and this ongoing communication *'breeds a sense of belonging and inclusion,'* thereby creating a positive environment where the message of health can be transmitted and understood. This dual approach was summarised by a manager as one which emphasised: *the importance of health, the importance of well-being, and making sure that the facilities provided are second to none.'*

Nevertheless, an analysis of accessibility to GPs, dental practices and to a pharmacy indicated relatively poor accessibility for these health services for many local people.[63]

4.11.2 Health should be firmly embedded in all aspects of the programme:

NEM avoided health being a stand-alone project, as it was thought this would create opportunities for other areas such as infrastructure, education and housing to regard health issues as peripheral. They ensured that health took a holistic/well-being approach and was an overarching theme which concerned all areas of the programme. Staff also worked with agencies to ensure that there was a good understanding of the work of health and regeneration professionals and the implications of their work for each sector including education, transport and community development. At all levels and from all partners, there was an unflinching focus on outcomes with a shared awareness of what they are, and how best they can be achieved. It is recognised that healthy outcomes are strongly correlated with health status and other indicators such as low incomes, low

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[63] See appendix six.

educational attainment and unemployment. Addressing these indicators are therefore embedded into their plans to improve health outcomes.

4.11.3 Using the Games to engage with the private sector:

In East Manchester, the Games provided motivation which was 'a *catalyst for the programme development and implementation'*. The Games facilitated a link with commercial partners which enabled them to contribute by creating employment opportunities and providing goods and services. Particular attention was given to supporting and promoting local business to contribute to health outcomes, for example, providing healthy food.

4.11.4 Clear focus on outcomes; the significance of baseline studies and using the findings to inform practices - 'get indicators and monitor outcomes over time':
NEM believe if one is setting out to make changes, it is vital that there is an awareness of the starting point and then to routinely chart changes in indicators to measure progress. The initial baseline study provided data on the health status of the population which informed policy-making and service provision. The findings were used to prioritise health services and '*target services to areas with the biggest need.'* Information was also collated on the local area to ensure that the new developments were sensitive to its local history and heritage.

Interviewees recognised that baseline studies have their limitations, especially on a subject like health which may be considered intrusive by some respondents, they may use different judgements when self-rating their health status and may not be completely honest in their responses. For example, with the high rate of sick/disability benefit claimants in EM, and some claimants being in receipt of benefits for extended periods, they may report their health as worse than it actually is, out of fear that their benefits may be affected.

Whilst the shortcomings of collating reliable health status information for a baseline study were acknowledged, it was felt that the benefits outweighed the limitations and that the direction of the East Manchester regeneration initiative has, and continues to benefit from the findings of baseline and evaluation studies. Interviewees stressed that the research kept a focus on achieving longer term goals and on outcomes and impact, and that this influences how partners work together. They argued that partnership working is successful where agencies collaborate in the interests of the initiative rather than promoting one's own agency. One manager summarised this perspective as follows:

'it is not about doing things to take credit, it is about thinking of what can be done to support in order to achieve the desired outcomes.'

4.11.5 Changing mindsets is a challenge- 'be aware that change, and particular significant cultural and lifestyle changes take time':
Some aspects of NEM's strategy have been successfully implemented, ranging from the physical regeneration to the involvement and inclusion of local communities. However, achieving some of their desired outcomes, in particular health indicators, remains a challenge. This is due, in part, to well-established cultures and mindsets which require changing for NEM to realise their vision. The following example illustrates the types of challenges faced by those working towards achieving improved health outcomes which require changing deep-seated attitudes and beliefs. One interviewee discussed the difficulties of responding to increasing teenage conception and recalled a meeting with parents of teenage girls where one parent remarked *'I had my first child at 15 and I am fine, so why can't my daughter if she wants to'*. The interviewee thought that this particular attitude was representative of other parents present at the meeting. Thus, for

some residents teenage pregnancy is not considered to be a social problem and therefore they see no reason to encourage girls and young women not to become teenage mothers.

4.12 Challenges

There are a number of challenging issues which have emerged from the research and the following sums up the issues which are most relevant to the development of Stratford City:

4.12.1 Regenerating a brownfield site:

One of the major issues which had to be considered was the decontamination of the land to make it fit for purpose. This process was criticised by practitioners and other commentators as a 'waste of money' which could have been spent otherwise. The extent of the contamination was contested and it was felt that the large amount of funding, using section 106 funds, could not be justified. The expense of the decontamination process was so great that there was nothing left for community and social infrastructure projects.

4.12.2 High staff turnover and restructuring of the NHS and PCT:

Research participants felt that the rate of progress has been hindered by high levels of staff turnover. Staff from NEM, council, and the Joint Health Unit, seem to *'move around a lot'* and *'this was not always managed in a way that kept disruption to a minimum'*. The restructuring of the North, Central and South Manchester PCTs into NHS Manchester also had a detrimental effect on some of the programmes and plans, as new staff did not necessarily work with the same priorities.

4.12.3 *East Manchester as a private development with affordable and social housing*:

Although NEM plans to build 24,000 new mixed tenure homes by 2015, currently the majority of households are social housing. Although below the national average, and despite policies intended to prevent gentrification, house prices have seen a significant increase in recent years, whilst household incomes have only increased modestly. Mirroring the national trend, these price rises have had an impact on low income households seeking to enter the property market and impacts badly on younger residents aspiring to purchase their own home. Indeed, the 2008 baseline study estimated that private renting accounts for about 30% of households in EM,[64] with young people in their twenties without children being over-represented in this category.

An important element of creating a planned mixed community and for long-term sustainable population growth is to focus on the family housing market. However, attracting market-rate families has proved to be difficult, although the Housing Market Renewal funding scheme has provided a major boost to NEM's plans to attract families and means that NEM can: *'continue to utilise the single greatest asset that it has, namely space, to attract families into housing built to lower densities than those promulgated by the new urbanists in central government.'[65]* In addition to housing quality, school performance will be a key factor for attracting families. Since schools in EM are under-performing across a range of measures, securing improvements in educational performance remains a challenge for NEM.[66]

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[64] NEM Strategic Regeneration Framework 2000-2008
[65] Mace A., et.al.. (2007)
[66] Mace A., et.al.. (2007)

4.12.4 Progressing from community engagement to improvements in life-styles:

Underpinning community engagement is a view that *'residents do not always have to go to services, services can go to them,'* and practitioners have proactively attended the football stadium on match days, to parks, local food markets and even to betting shops to deliver health advice and to promote healthy living.

Research participants thought NEM had done very well in engaging with the community, keeping the community well-informed, and at the heart of their strategy. However, the findings from the 2008 survey illustrate some difficulties encountered encouraging young people to adopt healthy life-styles. It seems that NEM's engagement with the community has not necessarily lead to changes in behaviour. For example, in the 2008 perception survey, when asked the question *'what factors need to be tackled/improved to improve residents' quality of life',* the two responses with the highest percentages refer to facilities for young people. 40% wanted facilities for young people in the evenings, and 35% wanted facilities for young people at weekends. Interestingly, 17% said that they wanted sports and leisure facilities. Thus, it seems that the sports facilities in EM's Sportcity[67] which are among, if not the best in the country[68] are considered by a significant minority of local people to be inappropriate for young people to use in the evenings or at weekends for activities or for sport. It was beyond the scope of this research to find out the reasons for these responses, but there may be issues of suitability, availability, and cost. Either way, this mis-match between meeting the demands of local young people for leisure and sports facilities and the presence of prestigious internationally acclaimed sporting venues in the local area raises issues for Stratford City about how best to enable local people to use the high quality facilities to improve their health and well-being.

Another example of how progressing from community engagement to healthy living is difficult to achieve is the continued prevalence of smoking and obesity, despite regular health promotion activities.[69] Yet there are promising improvements in decline in the rate of claimants of income support, although the relative poverty in retirement is increasing. The lessons for Stratford City are clear, that achieving healthy life-styles through health promotion and by addressing the wider determinants of health will take time and dedication.

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[67] http://www.sportcity-manchester.com/pages/arena.asp

[68] They include, for example, the English Institute of Sport, Sportscity Fitness Studio, National Squash Centre, Regional Tennis Centre, Manchester Velodrome, Manchester City Football Club to name a few. Additionally, there are a number of health related fitness activities including family oriented activities such as the EM walk.

[69] See appendix six for information that shows, for example, a higher proportion smoking and with obesity than Manchester as a whole, but less binge drinking than the Manchester average.

Appendix 5

Commissioning and service delivery to promote health and reduce health inequalities in socially disadvantaged urban areas
Prepared by Kevin Sheridan, Faye Adams-Eaton, Patrick Tobi and Angela Harden

5.1 Rationale and aims

The first two case studies carried out for this research project were geographically defined new mixed income communities. This third case study was defined by examples of practice and innovation in promoting health and reducing health inequalities in socially disadvantaged urban areas. The 'case' was health governance and sub-units of the case were drawn from programmes and services in different geographic locations. Two broad aspects of governance were examined: commissioning and service delivery. Through discussions among the research team, expert advice and a rapid scan of the literature, the following criteria were used to identify potential cases:

1. Beneficiary community similar to Newham's – i.e. in terms of socio-demographic and cultural characteristics, levels of deprivation, and urban location
2. New Deal for Communities (NDC) area with new developments and mixed housing
3. Good practice or innovation in commissioning or service delivery
4. Significant amount of upstream (i.e. health promotion) activity
5. Presence of a newly built or integrated health facility
6. Good examples of community engagement

5.2 The case study areas

From among the candidate areas meeting the criteria above, five sites were selected for inclusion in the case study – three were NDC areas: Haringey (Bridge NDC in Seven Sisters); Bristol (Barton Hill NDC); and North Fulham (NFNDC), the fourth was the Mindfulness Based Cognitive Therapy service delivered by NHS Forth Valley in Scotland, and the fifth was the Tower Hamlets Partnership Participatory Budgeting project, 'You Decide!'. A brief description of each site is provided below.

5.2.1 Hammersmith and Fulham North Fulham NDC

The North Fulham NDC houses a population with a strong mix of socio-economic groups – a traditional white working class community with sizeable BME communities, including a growing number of refugees and asylum seekers. Although the bulk of housing locally is either council or housing association-owned, house prices in the owner-occupied sector are high, reflecting the affluence of the areas immediately surrounding the NDC. The North End Road market represents an important element in the local economy and local culture. This unit of the case study was based around the commissioning and delivery principles employed by the 'Health Theme' manager for the NDC, who has a track record of delivering successful and innovative services to mixed community housing, particularly within the White City Estate.

5.2.2 Haringey: The Bridge Seven Sisters NDC

This NDC area combines late 19th century terraced housing with a series of council estates, and contains Seven Sisters tube station, linking to Central London and, via Tottenham Hale, Stansted Airport. Just over 50% of households are in local authority accommodation, 30% in owner occupation and 11% in private rented accommodation, many of which are now in poor condition and in use as short-let accommodation to

refugees and asylum seekers. Although predominantly residential, the area includes a small industrial estate and run-down retail centres along Seven Sisters and St Ann's roads, and is above all characterised by its diversity, with only 30% of the population claiming white British origin. The NDC has supported the opening of the Healthy Living Centre and this unit in our case study focused primarily on the set-up, structuring and day-to-day delivery of activities in the centre.

5.2.3 Bristol – Barton Hill NDC

The Bristol 'Community at Heart' NDC stretches eastwards from the city centre at Temple Meads through an area of mixed industrial and residential land uses. Crossed by major rail, road and water ways, the area offers a mix of housing tenures. Traditionally a white working class area, it has become more mixed with a BME (particularly Somali) community presence. As a result of the NDC and its community engagement, this area now benefits from a new health care centre building which has a number of services running from it. This unit of the case study examined the community engagement elements of the NDC and the health care centre structure and set-up.

5.2.4 Tower Hamlets Partnership Participatory Budgeting project

Participatory budgeting directly involves local people in making decisions on the spending and priorities for a defined public budget. The Tower Hamlets 'You Decide!' project began in January 2009 and in the first four months ran eight events, across which 815 residents spent almost £2.4 million. The money was from the central council budget and was spent on additional mainstream council services. The main reasons for using a model of participatory budgeting were to: a) improve perceptions and performance of local services; b) develop proper participation within the community; and c) generate social capital. At each event, the residents who attended were informed about the services on offer, had an opportunity to deliberate about the services with other members of their community and then had the chance to decide which services should be purchased. Subsequent to the events, the Local Area Partnership (LAP) Steering groups – made up of residents, councillors and service providers – had a large say in how the service should be operated on the ground and also a role in monitoring that service going forward. 'You Decide!' is intended to improve the level of involvement and engagement among Tower Hamlets residents in all walks of life, and not just in relation to council services. This includes the joining of voluntary organisations and local associations as well as encouraging involvement in politics.

5.2.5 NHS Forth Valley Mindfulness service delivery

There has been growing interest in mindfulness based services within the NHS, and mindfulness has been recommended by a recent Young Foundation report. Mindfulness (or a mindful approach) has to do with paying attention in a particular way: on purpose, in the present moment, and non-judgementally. The approach has been shown to be effective for the treatment of depression in the form of Mindfulness Based Cognitive Therapy, and for cardiac patient recovery. There has been considerable input into providing mindfulness based services from a range of health workers within the central and southern belt of Scotland and more recently within Wigan. Initial enquiries suggest that it is important that delivery of these projects occurs in a mindful way, including considerations around timing, training and ongoing practice to ensure quality of outcomes for patient care and staff well-being. This unit of the case study examined the delivery of mindfulness based services, focusing in particular on the capacity of the mindfulness approach to develop the providers themselves and transform staff working.

5.3 Data collection and analysis

Desk based information and 19 semi-structured interviews with key informants were used to collect data. The interviews were facilitated by a topic guide developed by the research team. This focused on three areas of service commissioning and delivery: context (e.g. characteristics of the area and services), mechanisms/processes (e.g. planning and resources, who was involved) and outcomes (e.g. service take-up, monitoring and evaluation) – and sought to elicit views on what worked well, what didn't work so well and why. Table 6.1 shows the health governance issues discussed in each case location

Table 6.1: Programmes and health governance issue(s) examined in each location within the case study.

Location	Programme/service	Health governance issue(s)
Hammersmith and Fulham: North Fulham NDC	NDC	Commissioning and delivery principles
Haringey: The Bridge Seven Sisters NDC	Healthy Living Centre in the NDC	HLC delivery
Bristol: Barton Hill NDC	Healthy Living Centre in the NDC	Community engagement - HLC delivery
Tower Hamlets Partnership Participatory Budgeting Unit	You Decide!	Community engagement - participatory budgeting
NHS Forth Valley	Mindfulness service delivery	(Mentally healthy) service delivery

Interviews were recorded, transcribed and thematically analysed. Analysis of the data was aimed at understanding what needs to be in place for effective commissioning and service delivery to promote health and reduce inequalities in socially disadvantaged urban areas.

5.4 Findings

Across the five areas of the case study, six connected themes emerged from the data collected; they were: a) Leadership; b) Organisational culture; c) Joined-up working; d) Systems and structures; e) Community engagement; and f) Developing and valuing staff. Figure 5.1 depicts the themes, and the sections that follow describe the themes in more detail.

Figure 5.1: Themes associated with effective commissioning and service delivery to promote health and reduce inequalities in socially disadvantaged urban areas

COMMISSIONING

6.1.1

PEOPLE – BASED APPROACHES

PLACE – BASED APPROACHES

LEADERSHIP

Clear leadership & vision

Leadership style – strong, flexible

Top-down support

Flexible commissioning through faster routes

Responding creatively to problems and policy

Transparency

Commissioning groups who can work quickly

ORGANISATIONAL CULTURE

Inclusive

Right attitude – willing, non-judgemental

Trust and communication

Using the right people

Supporting culture change

Utilising opportunities to learn and develop

Self help and capacity building

JOINED–UP WORKING

Joined-up commissioning

Joined-up services and vision

Partnership working

Participatory processes

COMMUNITY ENGAGEMENT

Keeping public involved

Need for better local intelligence

Reaching BME groups

Community engagement AND development

Delivering in right setting

Strong engagement – detail, outreach, existing structures

DEVELOPING AND VALUING STAFF

Giving staff autonomy and responsibility

Community champions

Using local CD workers

Outreach workers

Reception (public facing) staff

SYSTEMS AND STRUCTURES

Building design (promoting integration)

"Hub and spoke" referral mechanisms

Sustainability of non-medical services

Customer relation system

Monitoring data collection

Consistent and simple delivery mechanisms

SERVICE DELIVERY

Evidence from the NHS Forth Valley Mindfulness service emphasised the central role of leadership in successful service delivery. Mindfulness Based Cognitive Therapy (MBCT) began as an 'internally' developed project that was championed by a leading clinician who brought the commissioning director on board. It was implemented in response to the growing trend for more non-pharmacological options for the treatment of depression, as well as increasing staff and user group interest. It also meets key priorities around better management of long term conditions. The team serve the whole health board, which is split into north and south, and have one of the smallest staff to client ratios in Scotland, calling for innovative practice in managing waiting lists.

Top-down support for the approach from senior managers was seen as vital to ensure buy-in from other departments and professionals, allowing creative, ambitious and new ideas to be considered. They then helped to drive that culture change and forward thinking among middle level senior managers, while the other staff worked to get the project moving. Leadership filters through to all staff, so a strong style is required, one

that is flexible, willing to take creative risks and be ready for unexpected outcomes, trusting of the team to take the service forward at the right pace. Top-down support has gradually become very strong, and this appears to be a main strength that has opened up opportunities for other staff to attend training, taster sessions and top-ups.

Another area of impact was identified in the creative way the leadership responded to problems and policy. Decisions and actions in response to problems, local needs or policy implementation that are decided through partnership input, clear communication and strong ambitious leadership can lead to innovative and creative solutions. This is reflected within a willingness to learn and understand the local environment and community and adapt systems accordingly.

5.5   Organisational culture

The culture of the organisation in terms of relationships between staff, and between staff and service users, is important in fostering trusting and competent working environments. In the Mindfulness service, staff found that a strong team identity and creating 'non-hierarchical' relationships with service users encouraged more effective service delivery. The team involved have to work well together and constant communication and updating to all involved is extremely important.

Offering a service that is wholly inclusive allows everyone, including all staff, colleagues and residents to actively benefit and 'champion' the project. From a professional perspective, this encourages learning and staff development across departments. For the community, just knowing you can be involved dramatically increases satisfaction rates. Continual feedback and opportunity to shape and be involved in the service, offers an opportunity for learning and development for the staff, community and the service designers, leading to continual improvements.

Tackling prevailing cultures that resist change is important, particularly those held by professionals that do not value or are not used to listening to 'local knowledge,' or do not consider individuals to be able to take responsibility for their recovery or behaviour change. As one NHS Health Improvement Manager noted:

> *"I think you do have to have at some level a real desire for change and to improve things for people. You need people who are non-judgemental and who are prepared to listen and have empathy and understand and be able to see things from other people's perspective, and understand that their experience of life right from the age of nought may be very, very different from yours and that's why they're acting in the way they are, or why they experience things in the way they do.....[staff need to] recognise the fact that actually you might be an expert on, I don't know, delivering a dietician service, but there are people in Barton Hill who are expert on what it's like to live in Barton Hill."*
> NHS Health Improvement Manager

Shifting this culture would include moving away from the 'quick-fix' attitude held by some professionals and managerial staff. New services take time to deliver. It requires appropriate, experienced and supervised staff – not just training from a textbook. Clients and workers also need to be treated with honesty and respect and be given ongoing updates; this can demand a whole new way of working with 'client' groups, and staff require training and more opportunities to engage with clients.

5.6   Joined–up working

Joined-up and partnership working were mentioned frequently during the interviews. Interviewees were convinced, however difficult, that this was essential to the effective delivery of health services, health promotion, and in tackling the wider determinants of health and health inequalities. It was generally seen that health issues, and the wider determinants of health cross a lot of departmental boundaries, e.g. social care, housing,

employment, leisure and so on, and so it would make sense to have joint plans and actions, not only at the top of organisations but also at the frontline, bringing together shared visions, multi-disciplinary skills, budgets, shared data and other resources.

> *"And a part of that quite clearly is working in partnership with others to make sure it's not just about a health model, it's broader than that. So, clearly, working with local authority, independent sector etc. to try and bring an integrated way forward that gets all stakeholders involved."*
> NHS Commissioner

The Healthy Living Centres (HLCs) in the NDC areas, and in turn the communities they served, benefited from professionals from different sectors sharing a joint vision and working together under one roof, or within one area. They were able to cross-refer and the clients were able to see, sometimes literally, what else was on offer. It was felt that new staff in the HLCs or the target area, in whatever capacity, sector or organisation, should be inducted into the shared vision and understand from day one what other services were on offer in the hub or area. In some cases, interviewees called for tenancy agreements to include participation and partnership working in them.

However, existing institutional models and cultures often raised high barriers to operationalising effective partnership. GPs, in particular, were seen as difficult to work with, mostly due to the time they had to devote. For example, in the NDCs, GPs had difficulty keeping up-to-date with the range of service provision in their area. They were unsure whether services were still available for referral.

> *"When you start to silo activities and services and departments, you don't meet the needs of the service users primarily. I would say you go so far but people aren't siloed in themselves, so why would they need to be siloed in terms of what their needs are? So the idea is that it's a service user centred approach, whereby we recognise that these people are made up of many different parts, and it's ease of access, it's reducing those barriers. And actually what our job is to do is to try and make that joined-up working work very hard at that. So that if somebody comes in and accesses GPs and they say "Actually I'm really having difficulty with my housing or benefits, but I could really do with some support around that and it's making me feel quite low and I'm not sleeping and I'm anxious," they can very readily get referred on to our Branching Out programme and get the support that they need. And, to me, that's a great way of joined-up working so that then we don't have a problem with the doctor going "Well, here's some antidepressants, I'll see what I can do. Here's a telephone number of somebody you can talk to." Actually what people need is a direct referral. And so it simplifies those access (issues) … and reduces the barriers. And it's recognising that people are made up of many different component parts but they're still one person so we should be able to offer one service with lots of activities within that service that fit with that individual."*
> NDC Health and Well-being Manager

Other NDC interviewees noted problems engaging health colleagues in projects around worklessness to promote mental health *("'Hang on a minute, we're not in the work business, we're in the well business")* and problems at the top, in terms of the perceived problem of giving away resources and power with joint management.

Joining social care and health commissioning through the local district housing office was also seen as an excellent way to progress joined-up working. The health care clients were seen as the same as the housing department's clients.

> *"For me, if you've got an elder with a variety of health and care issues who's in social housing, actually the person who is probably physically closest is the Housing Office in the decentralised form. I was always arguing that what you could have done is you could have been able to empower that housing provider to be the single point of entry and referral, and if necessary, were people willing to pool budgets at that housing level so that somebody could actually, the idea of a housing officer being able to 'commission' care services in partnership with their care partner for that tenant. Because the reality of it is the housing officer saw these people more than anyone else because they could do the home visit, they were on the estate and all the rest of it."*
> Senior NDC Manager

5.7   Systems and structures

In the course of the interviews, participants talked about the systems and structures that were in place to support commissioning and delivery of services and reflected on those aspects that were the most (or least) supportive (table 5.2).

The three NDC areas operated with variations of a "hub and spokes" model. Such a model has been proposed in the NHS Newham Commissioning Strategy Plan. In this model, the "hub" in the network is usually a large health centre which offers a range of services as well as managing the overall network. The "spokes" refer to other services in the network (e.g. GP practices, dentists, pharmacies).

In Bristol and Haringey NDCs, the "hub and spokes" model was broadly similar to that specified above. The hubs were large health centres (called 'Healthy Living Centres'). These centres offered a range of medical and non-medical services and professional skills under one roof. These included GPs, dentists, pharmacies, midwives, arts projects, youth projects, yoga, complementary health, employment advice, home energy advice and so on.

In North Fulham, the hub wasn't setting specific but was based on a roaming MOT Health Check called 'Lifestyle Fridays'. In the latter case, settings followed footfall, so stalls etc were set up in schools, GP surgeries, pubs on match days, community organisations, markets, mosques, even betting shops. This set up was based on the idea of taking health services out into the community or as one Senior NDC Manager noted: "Get out into their space, adapt to their context and the outcomes may be better'".

Table 5.2: Systems and structures to support commissioning and delivery of services to promote health in socially disadvantaged urban areas

System/structure	Details
Using the "Hub and spoke" model for delivery and referral	Can facilitate joined up, non-siloed partnership working between NHS health services and other services relevant to health - essential for tackling wider determinants of health.
	'Roaming' hub e.g. healthy life-style check can bring services to community settings (e.g. mosques, football matches) making services "easier to reach".
	Hub and spokes need to be flexible so that spokes can refer to other spokes as well as the hub referring to spokes.
Building design (promoting integration and well-being, involve community in the design)	Include space for 'non-medical' and community facilities.
	Communicate a message of "self-worth" to staff and users ("It's light, it's bright, it's welcoming. It gets praised for its aesthetics and I think that, in an area of deprivation, is what's needed").
Sustainability of non-medical services	Important for 'low-level' mental health problems.
	When these services are seen as fundamental for improving health rather than as 'add-on extras' long-term funding more secure.
IT systems	Right software and systems need to be in place from the beginning.
	All stakeholders need to be able to enter and access information (e.g. GPs, commissioners, third sector).
Monitoring data collection	Collating evidence to support a service requires continual monitoring, and also considering how to capture soft or unexpected outcomes.
	A lot gets missed because it is not necessarily a direct impact, it is a 'soft' or unexpected outcome', the right questions are

	not asked or insufficient data is gathered to provide conclusive evidence.
Consistent and simple delivery mechanisms	Consistent delivery includes consistent style, time, venue, publicity to ensure that over time people learn about it, it becomes trusted and also develops into referral pathways from other service providers e.g. GPs. Consistency and continuity enables politically ties to develop, e.g. GPs becoming aware of services for referral. Simplicity in accessing and understanding the service is also very important. Successful element is simplicity, visual action and direct association.

As noted above, having a range of medical and non-medical services and professionals under one roof in the healthy living centres was seen as very positive in enabling joined-up, non-siloed partnership working. This was seen as especially key in relation to health promotion:

> *"To have these things in one place... for one, the idea is that it facilitates partnership work between GPs especially but NHS professionals and the third sector community health promotion organisation. And notoriously it's hard to develop those relationships, especially with GPs, but to have them actually in the building does help facilitate that."* NDC Health and Well-being Manager

The non-medical services were seen as crucial for alleviating the vast array of low level mental health issues that presented. They offered an alternative for GPs (and community members) to drug therapies and fostered a sense of community. Non-medical staff were also reported by interviewees to be seen as more approachable, more informal, less preachy, and less rushed than the clinical staff.

Designing buildings fit for purpose, with "well-being" as their central design feature, with flexibility to grow and adapt to new demands, with space for non-medical activities and organisations and community facilities, appears to be a strong message from all interviewees. Thought should be put into how buildings will be designed and used, and involve as many different stakeholders as possible in that process. Above all, they should be welcoming and exude well-being, and a message of "self-worth" to their users. One interviewee noted how a well-designed building could have a positive impact on staff and the local community:

> *"I think the building of such an attractive, well-built centre where schoolchildren had been involved in doing floor tiles, and people had been involved in choosing all kinds of things and colours, and having input into it, it has a massively positive effect on the community, just by its sheer existence. You can walk in there and people feel, gosh, this is in my community and we're worth it. We're better than the horrible hut that the GPs were in before that we had to put up with."* NHS Health Improvement Manager

Whilst most interviewees saw the benefits of partnership between 'medical' and 'non-medical' services (e.g. arts projects, befriending schemes), one of the major barriers was the lack of sustainability in terms of funding for the 'non-medical' services. When these services were seen as fundamental for improving health rather than as 'add-on extras,' funding was more likely to be sustainable. Strong leadership and greater recognition for the benefits of these services were thought to be crucial.

Having the right communications framework and IT systems in place from the beginning was seen as very important to most interviewees. When this happened, it was a great aid to referral, commissioning, and GPs. Where there were barriers to this, it caused great frustration. The lesson is that the right software and systems should be in place from the beginning. They should be designed to allow all stakeholders to be able to enter and access information – this includes commissioners, GPs, and third sector service providers.

5.8   Community engagement

All interviewees saw community engagement as essential for the commissioning, design and delivery of appropriate and accessible services that the community really wanted and needed. Community engagement was seen as a precursor to planned interventions, but was also seen as an ongoing activity, especially within the "hub and spoke" referral models developed within the NDC areas. Hence, there were two types of engagement with the community occurring – one as part of the overall initiation of plans and one as part of the ongoing activities. All the NDC areas carried out extensive community engagements before and shortly after NDC status was granted. This involved various events in the area culminating in reports and strategies. In Haringey, the CE was initially community led, but when the community's demands were not fulfilled, support fell off. In Bristol, the CE seemed more successful. Analysis of reflections from interviewees on what worked well and what did not, revealed several factors related to success (table 5.3).

Table 5.3: Factors related to successful and meaningful community engagement

Factor	Details
Aligning community engagement more closely with community development	Building relationships, outreach, and capacity building to raise resident aspirations and self-esteem.
	Important for sustainability: "we just hold the door open or just help them through the door so that they can then improve their life prospects."
Having a clear purpose or "end game" for the community engagement	Prevent "community engagement for engagement's sake" with success judged solely in terms of "if they kept turning up that was good."
	Link 'end game' to building capacity and empowering members of the community to engage with services.
Setting up structures and processes for ongoing engagement as opposed to 'one–off' engagement	The "hub and spoke" model for service delivery adopted by NDCs provided opportunities for ongoing engagement and further intelligence gathering through the referral system.
	Working at the neighbourhood level as well as borough-wide.
Using outreach workers and community members to go 'deep' into communities and produce better local intelligence	Delays in finding out about "changes on the ground" could be shortened by improving local intelligence.
	Use of community development workers or community members could shorten delay, especially in estates where no dedicated services were in place.
Ensuring that community engagement is inclusive of 'harder to reach groups'	To be inclusive, community engagement needs to follow several steps: segmenting the community, recognising and understanding potential barriers to engagement within different segments, and developing appropriate engagement strategies to overcome these barriers.

The importance of better alignment between community development and community engagement ran through all discussions around community engagement. Interviewees spoke about empowerment and "co-production": getting the community involved right from the start, building their capacity, using local knowledge and expertise, and using expert patients and community members who could become mentors and trainers to lead health promotion activities themselves.

A community development approach was used in the Bristol NDC, where community engagement was seen to be more successful. Employing community workers and volunteers from various communities was seen to lead to commissioning and delivery design that was more responsive to the needs on the ground, rather than driven by top-

down mandates on the issues that are important. As the Health and Well-being Manager noted:

> "It isn't a tick box and often these initiatives come down from some government thing that they've figured out that that's actually the way to do it. And so everything changes and then you get another set of things coming at you and then it changes again and you get another set. Well, it's slow and steady here and driven by the community and not by public health initiatives that come out of the NHS top driven health." NDC Health and Well-being Manager

Community engagement in this model involves giving something back to community members (e.g. taking information and services from the NHS out to the community), as well as drawing on their local intelligence and expertise. This 'give and take' perspective informed ideas around 'incentivising service users' to take part in health and well-being projects. This might involve rent reductions or free entry into credit union schemes. As one interviewee noted, the use of incentives may make community engagement more successful; "They've actually got a benefit so they want to give something back, rather than just saying 'Will you come and talk to us about stroke services?'".

The importance of being inclusive was emphasised by a majority of interviewees but there was a difficulty in engaging with a number of groups. Interviewees recognised that they had not always got community engagement right in the first stab but adapted and learnt to draw in all parts of the community. Particular groups, for example certain ethnic minority groups, were excluded at first because of oversight, or the inability of the engagers to understand the barriers to these groups' engagement. For example, it was only through initial and ongoing engagement with the members of the Somali community in Bristol that a successful mental health and drugs project could be set up and delivered. A shared language around mental health was established and initial cultural misunderstandings were overcome[1].

5.9   Developing and valuing multi–professional staff

Delivering upstream health promotion, the wider determinants agenda and reducing health inequalities pose challenges for health services. As already noted above, new types of partnerships and new types of staff are required, together with a shift in organisational culture and attitudes. Interviewees emphasised the need for good staff development to support these shifts. Management style was championed when it gave staff autonomy and responsibility. This involved supporting staff and giving them the freedom to explore new ideas, make things happen and develop their own abilities. This level of autonomy signified a trusting working environment that enabled staff to genuinely push something forward, rather than just chasing targets.

Interviewees spoke about the importance of having and valuing diverse and less traditional types of staff. Having within the team staff who are "more community

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[1] The NDC involved were running a programme around 'low-level' mental health problems. An immediate barrier identified for the community engagement was the fact that the Somali community does not have a word for depression. Another factor that was thought to be a barrier was that the staff were all 'White British'. After some research, done together with members of the Somali community, it emerged that Somali men were being overlooked in terms of mental health as women were generally seen by health visitors via antenatal and postnatal care. Further assessment of men's needs suggested that: *"actually seeing a white British man who isn't part of the Somali community is probably a good thing because they don't want somebody in the Somali community to know that they have mental health problems or drug problems or sexual dysfunction problems or whatever it is, because it is quite a small community."*

focused," such as community development workers, outreach workers and community champions, was felt to lead to a more "holistic service" in which staff have "more time to spend with people" in order to better understand what barriers people face in say, giving up smoking or trying to lose weight. Reception staff were also recognised as having an important role. Having a welcoming, accessible and aesthetically beautiful building was important but not enough. Reception staff can welcome or scare off service users. Yet they are often the least qualified, poorest paid, and under pressure.

"Then there was a bit of a resentment from the reception staff that they were having a difficult time and nobody really understood how hard it was. So there was a lot of work that needed to happen with that sort of group, that they couldn't… we couldn't make it happen, we could only sit in meetings with the Practice Manager and say 'This would be really good. These are the kind of issues and these are some of the things we could do to address it.' But we couldn't just get hold of it and do it, really. And we had a lot of frustrating meetings where the Practice Manager would agree to it and then obviously would go back to receptionists who'd say, 'We can't do that,' or who would be very bolshy about it and then she wouldn't see it through. So they were difficult… " NHS Health Improvement Manager5.10
Conclusion

This case study has highlighted a number of closely interacting themes in the commissioning and service delivery process that appear important to implementing services to promote health in socially disadvantaged urban areas. These are leadership, organisational culture, joined-up working, systems and structures, community engagement, and developing and valuing staff. Within each theme, a number of specific elements were identified and described.

Neighbourhood interventions can be targeted at different levels: for instance, directly on the people living in the community, relationships between community residents and service providers, or improving the physical infrastructure of an area. There has been much discourse about which approaches can more effectively deliver improvements to people's health and the question is not an easy one to answer. Poverty, unemployment and other material and social deprivation are often spatially concentrated, and intuitively targeting these factors would seem to be the most effective way to intervene. This is the approach taken by housing and economic regeneration programmes. But the recent literature suggests a shift away from purely physical interventions to more integrated approaches. In particular, there has been greater emphasis on interventions that increase the capacity of local communities through community development, employment and education initiatives.

The themes emerging from this case study are consistent with an integrated approach and suggest that both people and place-based factors are important in effective commissioning and service delivery to promote health. Within the context of the case study, people are represented not just by the beneficiary community residents but the service commissioners and providers. Designing an effective service for a new development will clearly need to approach all of these issues holistically and in a joined-up way.

Appendix 6
Health and well-being profiles of areas using official statistics

Prepared by Allan Brimicombe and Yang Li

6.1   Introduction

The purpose of this Appendix is to present the official statistics that have been used in this study to understand the nature and trends in the *demographic* and *health* characteristics of the surrogate sites at Greenwich Millennium Village and Beswick & Clayton (East Manchester), and to provide an initial baseline for the Stratford City area. The data are presented and discussed under twelve headings in the same format for all three areas. There are limitations to this type of analysis, which are discussed below in a methodological note. Key factors are the scale and configuration of geographies used for reporting official statistics, which do not allow micro analysis of individual developments, such as the Millennium Village. Also, there is an inevitable lag in the publication of official statistics, so for the most part this Appendix considers the trend from 2001 (the last Census) to about 2008. Stratford City is a new construction where the first residents will not move in until after the London 2012 Games. In order to determine a baseline for this as yet to be inhabited area, we have drawn upon the fourth legacy promise which is "To make the Olympic Park a blueprint for sustainable living". As a sustainable community, Stratford City will require to interact and integrate with surrounding areas, which we have termed the 'Green Legacy Footprint'. Constructing a baseline on this basis has its limits if the residents that will move in are expected to be of a different demographic, either intentionally at the planning stage, or through market forces acting on the value of the properties and the availability of mortgages or other financing. We would therefore recommend a sample survey of these new residents, once sufficient numbers have moved in, as they will not be captured in the 2011 Census.

6.2   Summary

The three study areas are all associated with development/redevelopment of residential areas, adjacent to facilities built for mega-events. However, Greenwich Millennium Village would appear to most resemble the development scenario of Stratford City, in that they are both new residential developments on former industrial brownfield sites, rather than redevelopments of existing residential areas. All areas are experiencing a population increase as a consequence of the growth in the number of residential units. Greenwich Millennium Village and the 'Green Legacy Footprint' area are dominated by bands B and C, whilst Beswick & Clayton are still predominantly band A. With regard to the physical environment, the percentage area given over to private gardens is well below the respective regional averages. Beswick & Clayton and the 'Green Legacy Footprint' are better endowed with green space and open water which for the latter will improve with the completion of the Olympic Park. We have no data on land given over to allotments, but an inspection of the aerial imagery showed no major areas given over to allotments to compensate for the lack of private gardens. The trend is towards smaller household units with the growth in one child families, and fewer families with larger numbers of children. For Greenwich Millennium Village in 2006, it can be estimated that about 75% of the population comprised of singles and couples without children.

Greenwich Millennium Village closed the deprivation gap to come from above the London average in 2004 to below in 2007. Beswick & Clayton has not closed the gap with Manchester as a whole. Greenwich Millennium Village has a low rate of benefit claims compared with London as a whole, but with a growth trend. Beswick & Clayton has much higher, though declining, rates of benefit claimants than Manchester as a whole. The trend in declining rates may simply be an artefact of growth in base population.

Noticeable in all three areas is the high rate of pension credits from at least a third to nearly two-thirds of all pensioners living in relative poverty.

Life expectancy at birth is rising for both males and females in all three areas, but remains below their respective regional figures, without significantly closing the gap. All three areas are higher on smoking, lower on the consumption of fruit and vegetables. Greenwich Millennium Village is higher on binge drinking, and lower on obesity. Hospital episode data for coronary heart disease, cerebrovascular disease and cancers for Greenwich Millennium Village oscillate but in 2008 are near the London average. The five year trend for the 'Green Legacy Footprint' shows improvements over the London rates, (though the rise in coronary heart disease has simply been overtaken by the rising London rate), and perhaps shows a slightly more optimistic picture than for Greenwich Millennium Village. Data on use of mental health services is by borough and only for 2008/09. Greenwich shows much higher uses of these services than, say, Newham, though all three areas are above their regional rates.

6.3 What lessons can be drawn from the trend in official statistics for Stratford City?

At a very simplistic level, population will rise with the increase in the number of residential units and therefore so will the demand for local services in health, education, recreation and so on. Brownfield sites of the nature of Greenwich Millennium Village and Stratford City tend not to have nearby facilities to draw on, and unless specific provision is made, inequalities of accessibility to services will arise. Clearly, the life-style and health profiles will tend to relate to the demographic of those that take up residence. Few assumptions can be made about this, as either the population in the surrounding areas take advantage of the availability of new housing and move in, leading to no significant change in the local demographics, or a different demographic group moves in because of the market determined affordability of properties. In the 'Green Legacy Footprint' area, there are already two contrasting demographic types; one with comparatively high incomes (I24), and another with low incomes (I33; the bottom quartile nationally). *We would therefore recommend a sample survey of the new residents be undertaken once sufficient numbers have moved in to Stratford City.* Developments of the size envisaged may help to reduce overall deprivation levels locally (as is evident in Greenwich Millennium Village), but any ripple effect to neighbouring areas is hard to predict. Nevertheless, from the data it seems likely that:

- life-style characteristics relating to smoking, obesity and healthy eating will be worse than the London average;
- the rate of pensioners on pension credits (i.e. in relative poverty) will be high, with knock-on health effects;
- rates of hospital episodes for key diseases in the population as a whole will be around the London average;
- demand for mental health services will be above the London average for both males and females.

6.4 Methodological Note

The area profiling and/or the determination of baselines from administrative data and official statistics require the use of administrative geographies that are the means of reporting statistical data. Administrative geographies are nested hierarchically with increasing resolution (Figure 1). A Local Authority area (Borough, District, Metropolitan District or Unitary Authority) is subdivided into Wards. These are further subdivided into Middle Super Output Areas (MSOA), then into Lower Super Output Areas (LSOA) and finally into Output Areas (OA) and are the smallest units at which official statistics, such

as the census, are reported. Postcode geographies do not sit comfortably with administrative geographies. Whilst OA are designed for the reporting of data on about 300 residents (125 households), they can be too small for health data, where either small numbers can give rise to issues of confidentiality or where the sample size for the data collected is not representative for such a small area. Consequently, a considerable amount of longitudinal statistics, able to show trends, is reported only at LSOA or above with some health data reported only at MSOA or above. Moving to higher level geographies means an aggregation of characteristics across a broader area, and any marked diversity at a local level gets averaged out and lost. Therefore, for areas of interest that are smaller than an LSOA, it becomes difficult to ascertain the characteristics and trends of that area. This is the case, for example, with Greenwich Millennium Village, where official statistics are a mixture of this new development and the well established residential areas of Westcombe Park of a different character. In brownfield sites such as Stratford City, where currently there are no residents in a development that is under construction, the characteristics of the existing LSOA only reflect some established residential areas that are included at the edge of the LSOA. Constructing a baseline, therefore, needs to take a view of the surrounding areas, but this has its limits if the residents that will move in are expected to be of a different demographic. It would therefore be advisable to sample survey these new residents, once sufficient numbers have moved in.
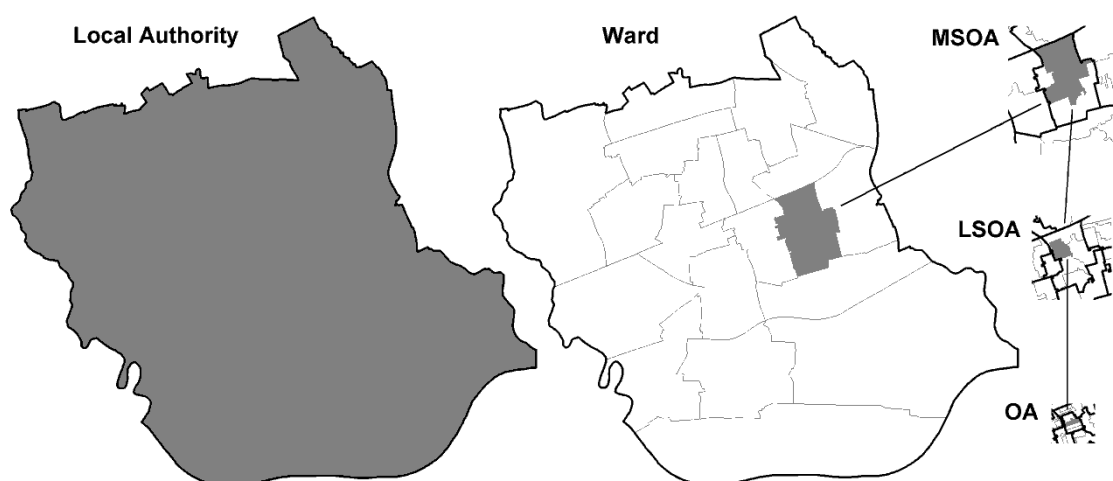
Figure 1: An example of the hierarchy of administrative areas from Local Authority down to census Output Area (OA)

Demographic data. The 2001 UK Census of population has probably been, in metropolitan areas, the Census to become out-of-date the fastest. Demographic data from 2001 only reflects an historical situation. It has therefore been necessary to identify data that has been updated on an annual or biennial basis in order to adequately inform this study. There is an inevitable lag in the release of official statistics and thus the most recent available for this study have tended to be 2008, particularly at sub-Ward level.

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Accessibility to health services. Geographical Information Systems (GIS) have been used to calculate levels of accessibility to specific health services (GP, dental practice, pharmacy).

The technique for doing this is explained in relation to the East Manchester study area as illustrated in Figure 2.

(a) road network for relevant LSOA study area

(b) location of postcode centroids in the area

(c) shortest routes from each postcode to GP

(d) averaged accessibility by Output Area
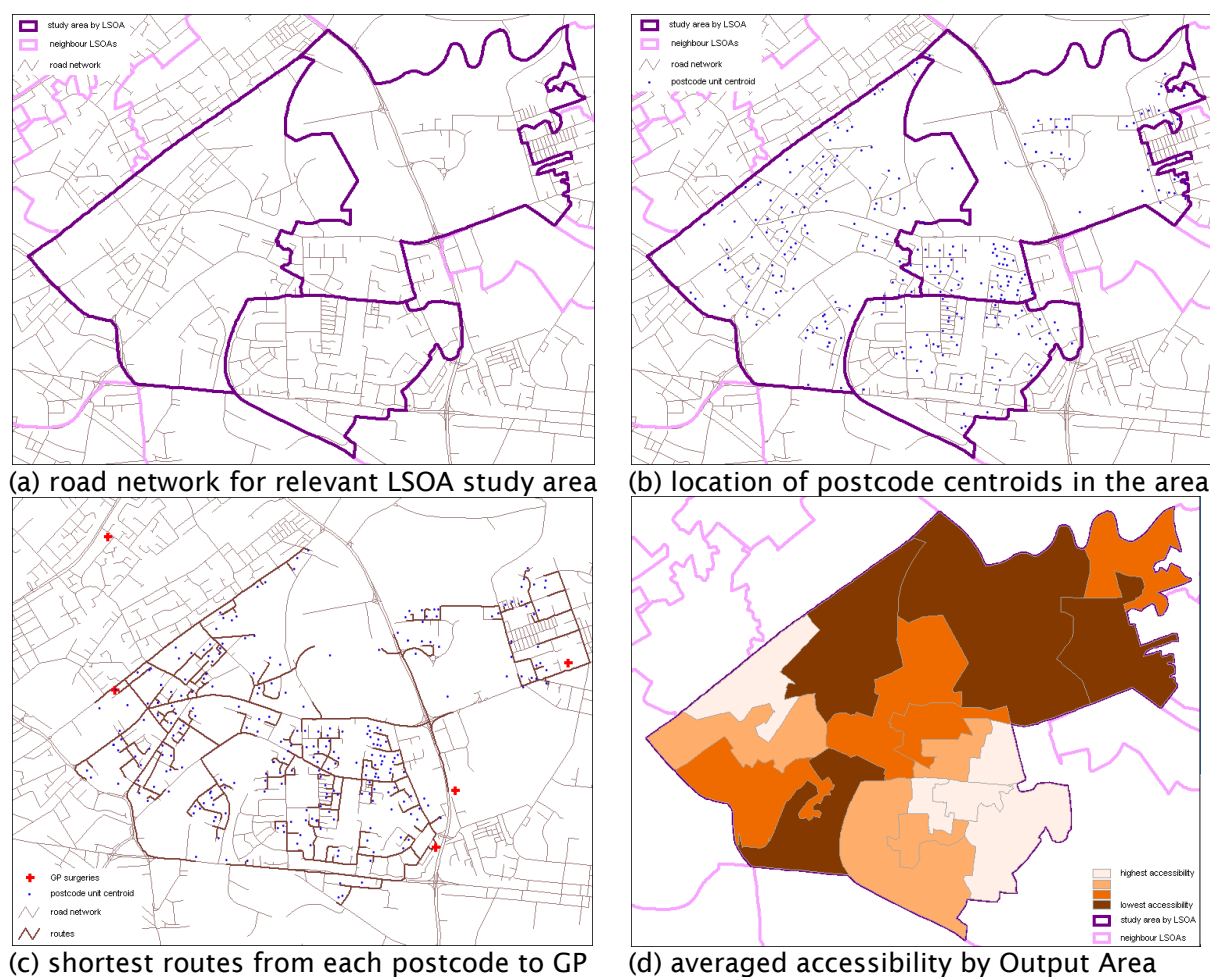
Figure 2: Method for calculating accessibility to specific health services.

The desired goal is to establish a relative measure for each Output Area (OA) that reflects the accessibility of specific health services for an OA's residents. For this, we use the road network, postcodes and the locations of the health service to be accessed. We have done this for GPs, dental practices and pharmacies. 2009 data on GP surgeries and the week time equivalent (WTE) number of GPs at each surgery has been supplied by the relevant PCTs. Data on the location of dental practices and pharmacies has come from ONS compiled data for 2006. Not just the health facilities within a study area as defined by LSOA are used, but also included are health facilities within the surrounding areas as the nearest facility for a particular postcode may be outside the study area. Using GIS, the shortest distance from each postcode centroid (centre point) along the road network to, say, a GP surgery is calculated (Figure 2(c)). All road segments are treated equally and the analysis does not take into account those that might be public transport routes. The distances for each postcode are weighted by the number of residential delivery points within each postcode (as a proxy for relative population size). For the GP data, these are further weighted by the WTE of GPs at each surgery. The postcode values for accessibility are then averaged for each OA and presented as a relative accessibility map (Figure 2(d)).

6.5 Greenwich Millennium Village

This is a surrogate area from which to understand the possible development of Stratford City. This was a brownfield site in proximity to the Millennium Dome (O2). Residents first

moved into the new development in 2001. The area is within a single LSOA: E01001663 (Figure 3).
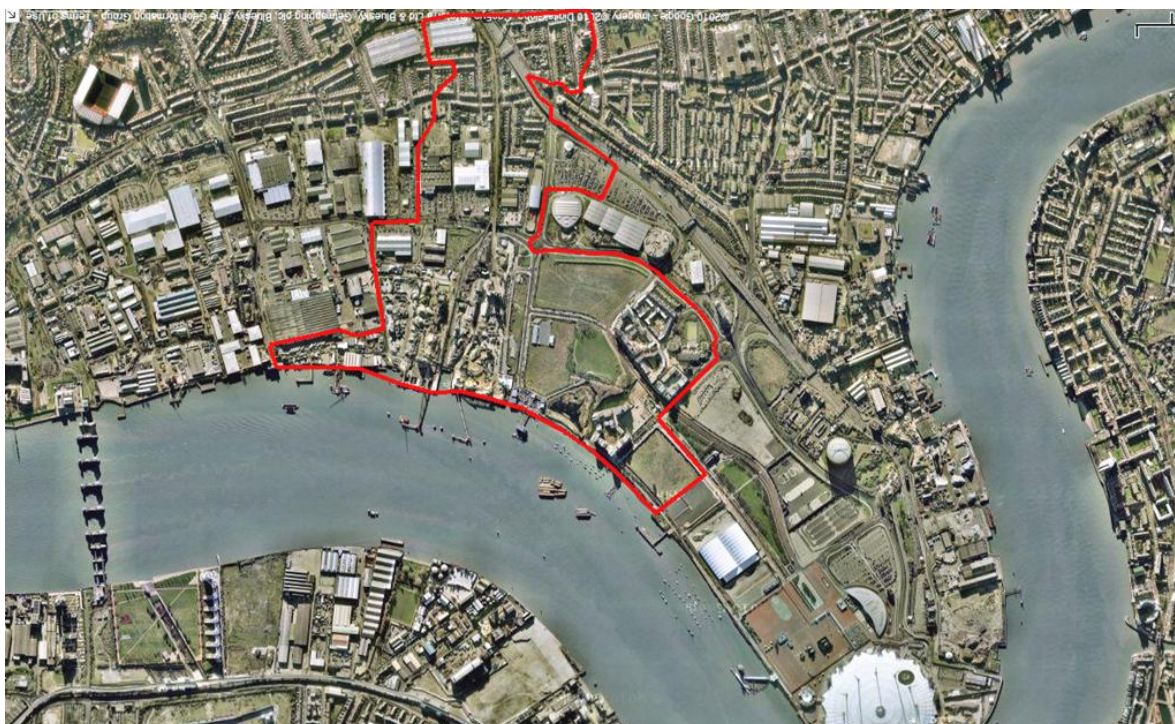
Figure 3: The LSOA containing Greenwich Millennium Village. Note: aerial image has been rotated with north to the bottom to aid depth perception of buildings and topography. © 2010 Google – Imagery © 2010 DigitalGloge, GeoEye, Infoterra Ltd and Bluesky, Getmapping plc, The GeoInformation Group.

Social Marketing Classification

The People & Places classification (Beacon Dodsworth Ltd) shows this LSOA to be classified as H25 (Working Singles). A pen portrait of this group is:

H25 Working Singles: Working Singles are youths and young adults aged between 16 and 34, who are mainly single workers. There are some instances of co-habiting within this Branch. Working Singles has a mixed ethnic population and include those from China, Africa, Asia and Eastern Europe. Working Singles are most likely to live in rented accommodation, though some also live in housing association properties. Living space is generally small, and flats and bedsits are common types of home. Some will have no central heating and have to share bathroom facilities. Working Singles are a mobile population and tend to move house after a year. These households are unlikely to have a car. Working Singles do have an interest in politics, but are very unlikely to read any type of newspaper. They tend to be smokers and they prefer to shop at the cheaper supermarkets such as Aldi and Lidl. In their working lives, Working Singles are well qualified, and work in managerial or professional roles. The women of this Branch are also very likely to work. Public transport is the most popular way of commuting to the workplace. As these young adults are likely to be in their first jobs, incomes fall into the third quartile[1].

This pen portrait needs to be balanced by the fact that the LSOA incorporates two distinct sets of housing areas: the Millennium Village in the north and the Westcombe Park area in the south.

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[1] First quartile is topmost 25%, second quartile is the 25% above the median, third quartile is the 25% below the median, fourth quartile is the bottom 25%

ONS MYE population
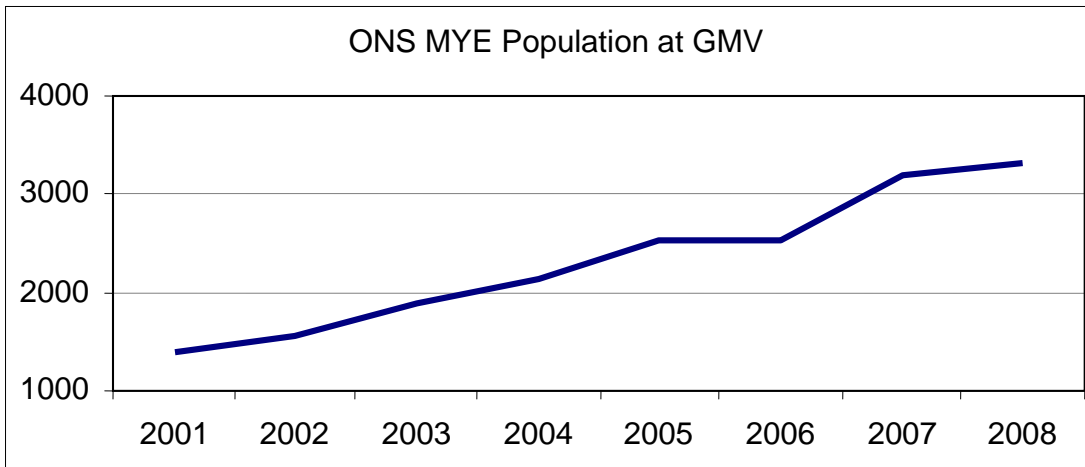
Population has increased over the period 2001-2008 by 139% from 1,386 to 3,311residents.

Dwelling stocks by council tax band
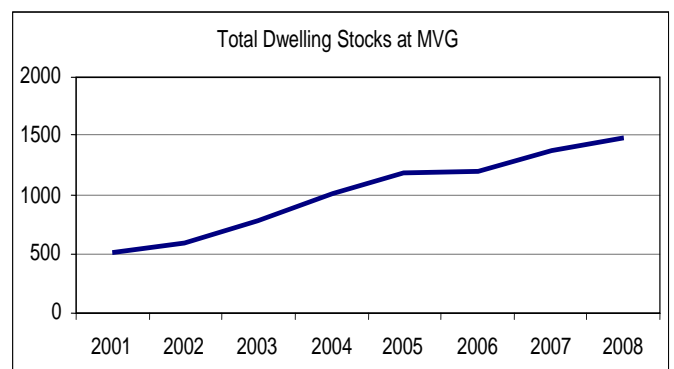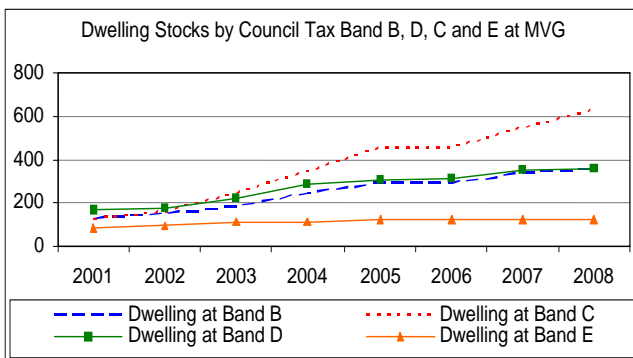
Total dwelling stock has increased over the period 2001-2008 by 186% from 518 to 1,471 units. Most of this increase can be attributed to the Millennium Village. The increase in dwelling stock corroborates the population increase. Bands A to E have all increased, with high growth in Council Tax bands B, C and D; the highest growth being in band C (410%).

Families with children
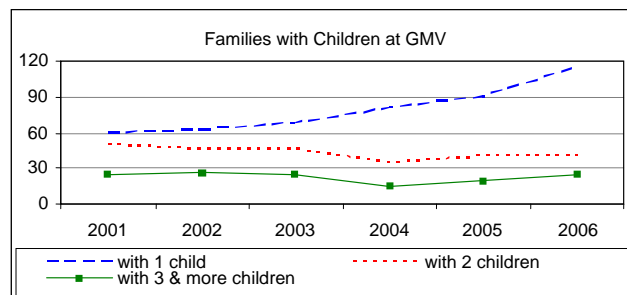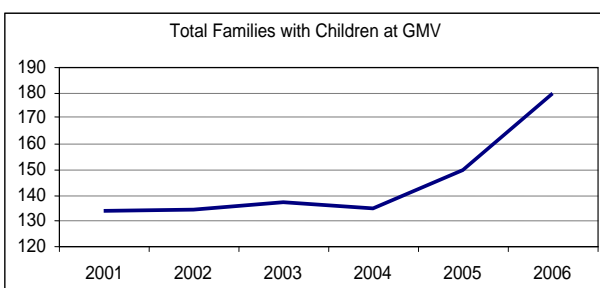
Families with children grew sharply from 2004 to 2006 (33%). This will have been for the most part single child families. Families with larger numbers of children are fewer and are generally declining. The numbers of families with children are comparatively small, from which it can be deduced that in 2006 about 75% of the population comprised of singles and couples without children. This fits with the profile from the social marketing classification.

Schools Census
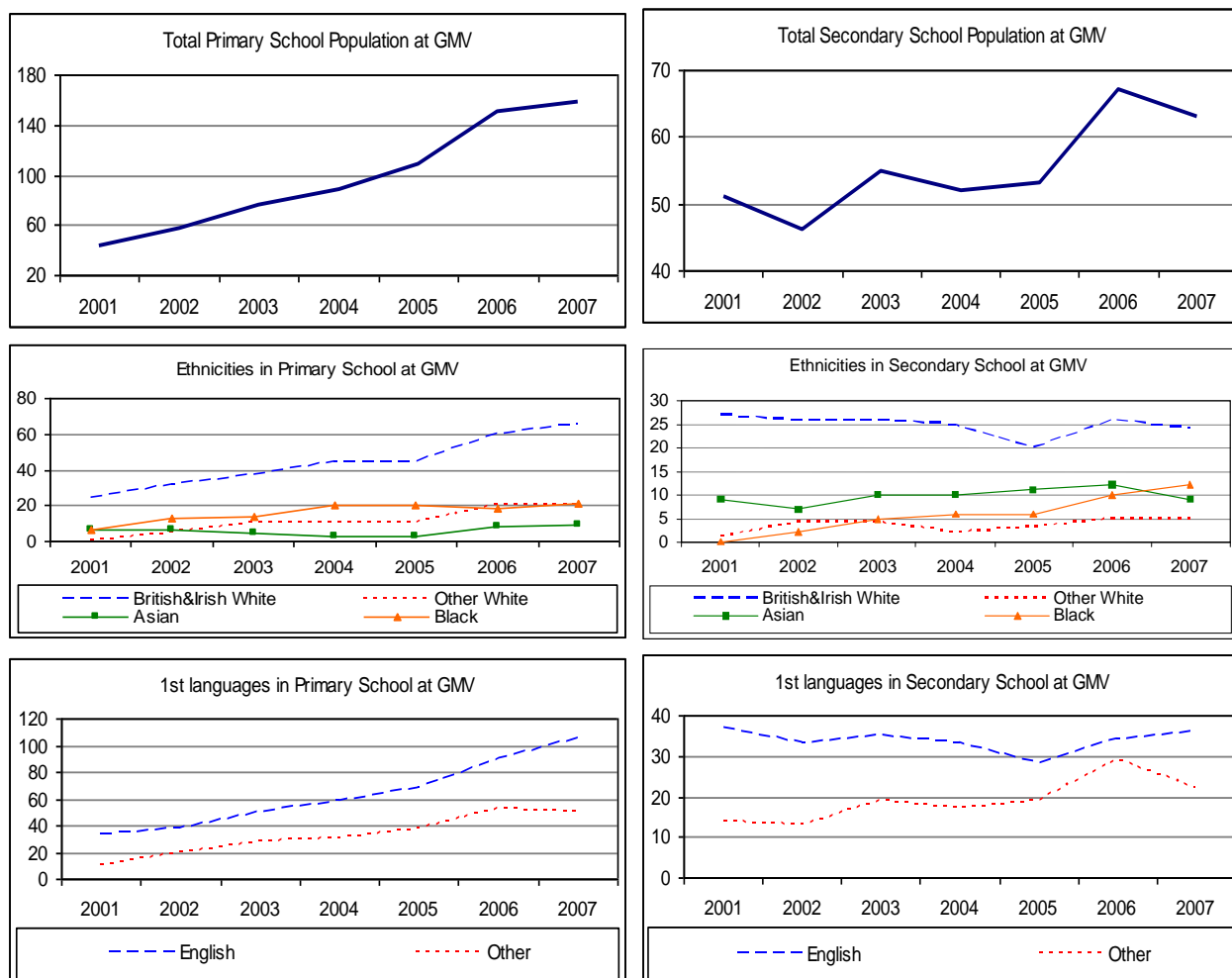
In line with the increase in the numbers of families with children, so the number of primary school children resident in the LSOA has been increasing (by 249% to 159 children in 2007). Secondary school children have increased slightly. Most of the increase in primary school children has been British and Irish White with English as the dominant first language. This would suggest that relatively fewer ethnic minorities have moved into the Millennium Village.

Deprivation

	IMD Score		Health Score	
	2004	2007	2004	2007
LSOA	26.56	21.68	0.23	0.00
London	24.58	25.96	-0.04	-0.01

IMD scores between 2004 and 2007 are not strictly comparable, but the trend is worthwhile looking at in comparison to the rest of London. This shows the level of overall

deprivation falling from being just above the London average in 2004 to being below in 2007. The health score within the IMD would suggest some improvement between 2004 and 2007 but remaining above the London average, though the gap is closing.

Physical environment (percentage of area covered, 2005)

| | **Buildings** | | **Open Space** | | |
	Domestic	Non-Domestic	Gardens	Green space	Water
MSOA	4.0%	8.8%	5.1%	22.0%	8.9%
London	8.7%	4.7%	23.8%	38.2%	2.8%

On the whole, the quality of the physical environment does not appear to be as good as for London as a whole. There is a higher mix of domestic and non-domestic land use with a much smaller proportion of land given over to gardens and formal green spaces. The higher percentage of water surface is due to being adjacent to the Thames.

Benefits claimed
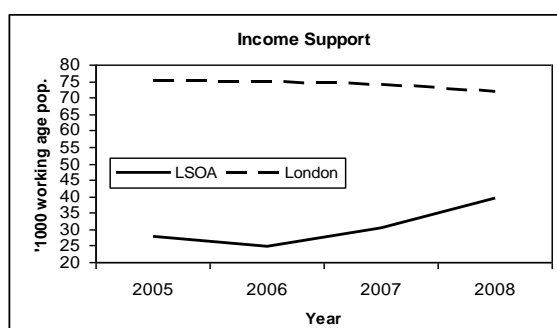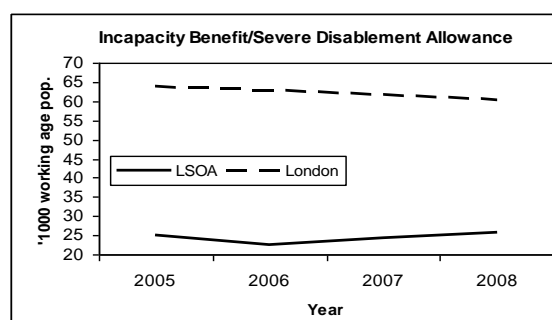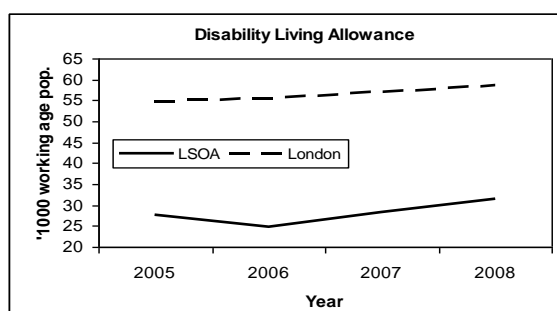
Levels of benefits claimed are well below the rate for London as a whole but have tended to increase from 2006 to 2008. The rate of disability living allowance has increased in parallel with the rest of London, but incapacity benefit/severe disablement allowance and income support have both risen, whilst overall, London has fallen slightly. The rise in the rate of income support (and therefore relative poverty) would seem to be at odds with the general direction of change in the Index of Multiple Deprivation. The rate of pension credit has oscillated, but stood at the overall London rate in 2008.

Life Expectancy at Birth

		2004	**2006**	**2008**
Greenwich	Male	74.5	75	75.45
	Female	80.1	80.7	81.71
London	Male	76.4	77.4	78.2

| Female | 81.1 | 82.0 | 82.7 |

Life expectancy at birth is available at Borough level and may not necessarily reflect actual levels in the Millennium Village. In general, the Borough lags behind London as a whole, slightly more so for men. Life expectancy on the whole has been rising in line with the trend for London.

Healthy Living (Model-based, 2005)

	Smoking	**Binge Drinking**	**Obesity**	**Fruit & Veg.**
MSOA	29.1%	16.2%	15.4%	25.7%
London	23.4%	12.8%	18.3%	29.8%

This one-off set of figures for the MSOA would suggest less healthy living than for London as a whole. There are higher levels of smoking and binge drinking and lower levels of eating fruit and vegetables. The proportion of obese residents on the other hand is below London as a whole.

Hospital Episodes (all finished admissions)
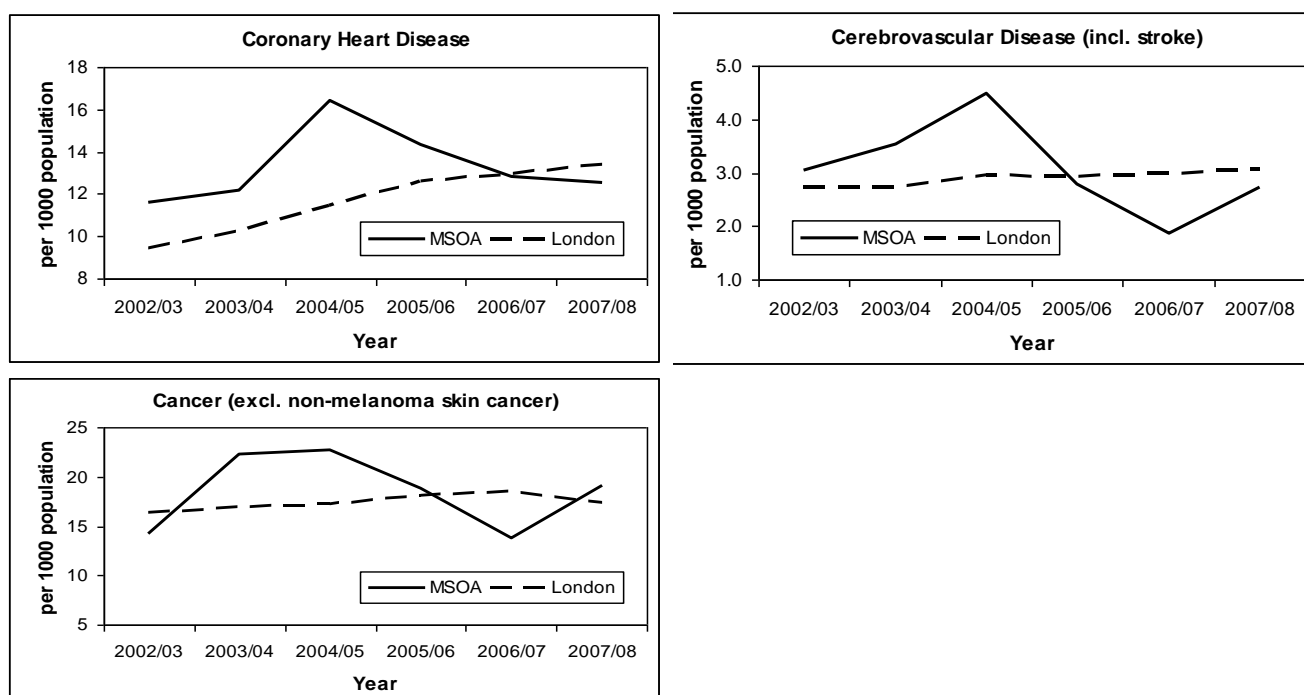
The rate of hospital episodes for key diseases is by 2007/08 near or below the London rate in the case of coronary heart disease, as much because the rate for London has been rising consistently since 2002/03. Nevertheless, the rate of hospital episodes for the MSOA seems on the whole to have improved from a peak in 2004/05.

Use of Mental Health Services (2008/09)

per 1000 age group population

		All	**Age 18–35**	**Age 36–64**	**Age 65+**
Greenwich	Male	32.6	43.9	43.2	49.3
	Female	35.8	45.1	41.3	64.9

London	Male	23.8	27.6	30.9	41.1
	Female	27.2	31.0	30.9	54.4

This one-off set of figures is for the Borough. It shows that the rate of use of mental health services within Greenwich is much higher than for London as a whole, across all age groups. For ages 18 to 64, there is not much difference between the rates for males and females. The much higher rate for females over the age of 64 most likely reflects the onset of various forms of dementia with the longer life expectancy.

Accessibility to health services
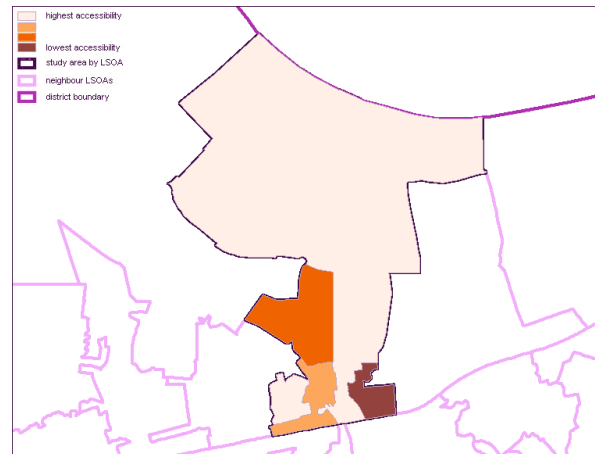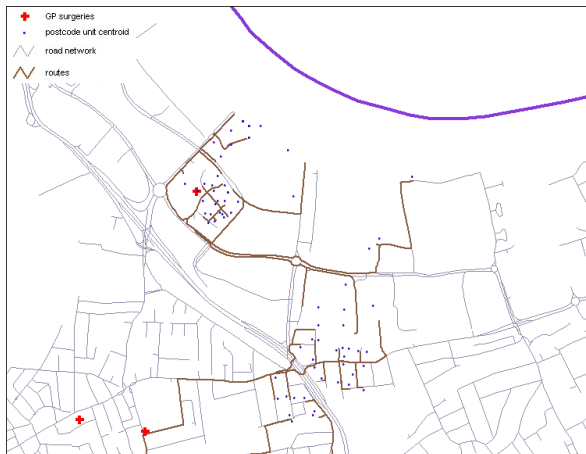
Accessibility to a GP (average 702m, max 1274m)
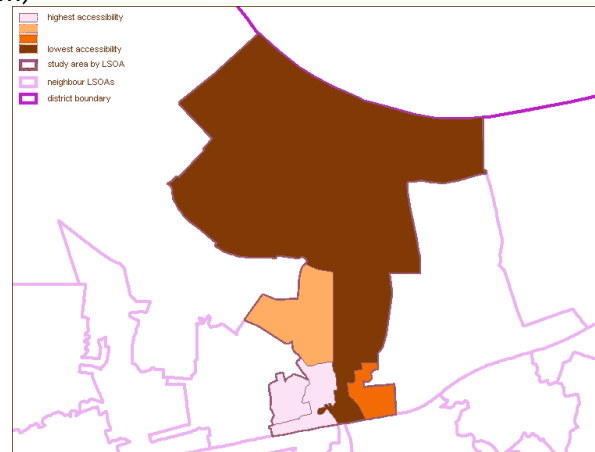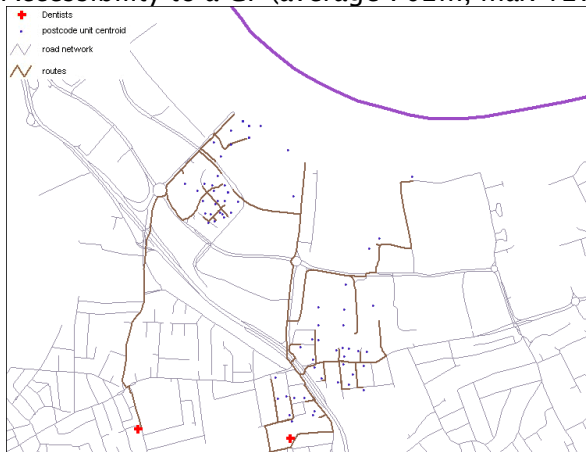
Accessibility to a dental practice (average 1096m, max 1595m)
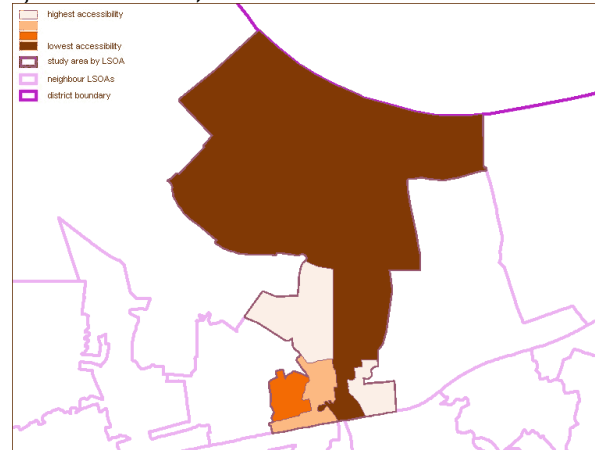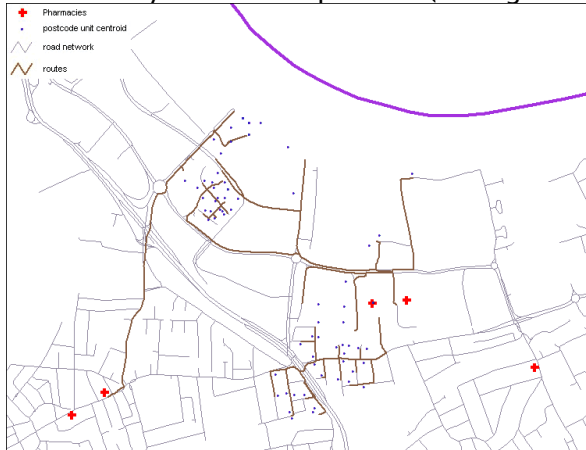
Accessibility to a pharmacy (average 955m, max 1481m)

The accessibility analysis for the Millennium Village is limited to some extent by the size and shape of the OA within which it sits. A GP surgery is located within the Millennium Village, providing ready access to primary care. However, from the data available (2006), there are no dental practices or pharmacies near the Millennium Village, giving it poor accessibility to these services (though in the case of pharmacies, services have recently been provided). This low level of relative accessibility for some services arises because the development of the Millennium Village has been sited well away from existing residential and shopping centre developments (where dental practices and pharmacies tend to be sited), and will not attract these private sector services unless there is a sufficient population threshold to provide enough demand.

Beswick & Clayton, East Manchester

This is a surrogate area from which to understand the possible development of Stratford City. This was an existing housing estates residential area, within which brownfield sites were used for the Commonwealth Games facilities. This area comprises three LSOA: E01005095, E01005096 and E01005105 (Figure 4).

Figure 4: The combined LSOAs for Beswick & Clayton, East Manchester. Note: aerial image has been rotated with north to the bottom to aid depth perception of buildings and topography. © 2010 Google – Imagery © 2010 DigitalGloge, GeoEye, Infoterra Ltd and Bluesky, Getmapping plc, The GeoInformation Group.

Social Marketing Classification
In the People & Places classification (Beacon Dodsworth Ltd), E01005095 and E01005105 are classified as M40 (Cramped Flats), and E01005096 is classified as M38 (Hard to Let). These represent 64% and 36% of the 2008 population of the area respectively. Pen portraits of these groups are:

M40 Cramped Flats: Cramped Flats contain many young adults aged between 16 and 24.These adults are single workers or single parents, as many have young children. This Branch also contains a diverse ethnic mix, which includes Blacks, Chinese, Africans and those from the Caribbean, India, Pakistan and Eastern Europe. Cramped Flats households are purpose built flats that belong to the council or local housing association. Accommodation is very small, households are very poor, and often do not have central

heating. Overcrowding is common in these households. Cramped Flats households are very unlikely to have a car. These adults tend not to be interested in politics and some will read tabloid newspapers such as the Sun and the Mirror. They tend to be smokers and do their grocery shopping at cheaper supermarket chains, such as Aldi and Lidl, as well as at Asda. In their working lives, Cramped Flats do not hold any qualifications, and tend to work in semi-skilled manual and unskilled jobs, as well as routine and semi-routine occupations. However, unemployment is very high in this Branch, as are incidences of long term illness. Incomes fall into the fourth quartile.

M38 Hard to Let: Hard to Let is made up of a mix of pensioners and young adults. The young adults are aged between 16 and 24 and tend to have children and are mainly lone parent families. Many households are made up of singles, including many lone pensioners. Hard to Let households are based in council or housing association property and are generally small. These homes are in purpose built flats, though some also live in terraced housing. Hard to Let households are often very poor and do not have a car. These adults are not interested in politics, but are very keen readers of tabloid newspapers, such as the Sun or the Mirror. They are also very likely to smoke and tend to do their shopping at Asda. In their working lives, Hard to Let adults do not have qualifications, and work in semi-skilled manual and unskilled jobs, as well as routine and semi-routine occupations. Many take public transport to get to work. However, there is a very high level of unemployment in this Branch. Incomes fall into the fourth quartile.

ONS MYE population
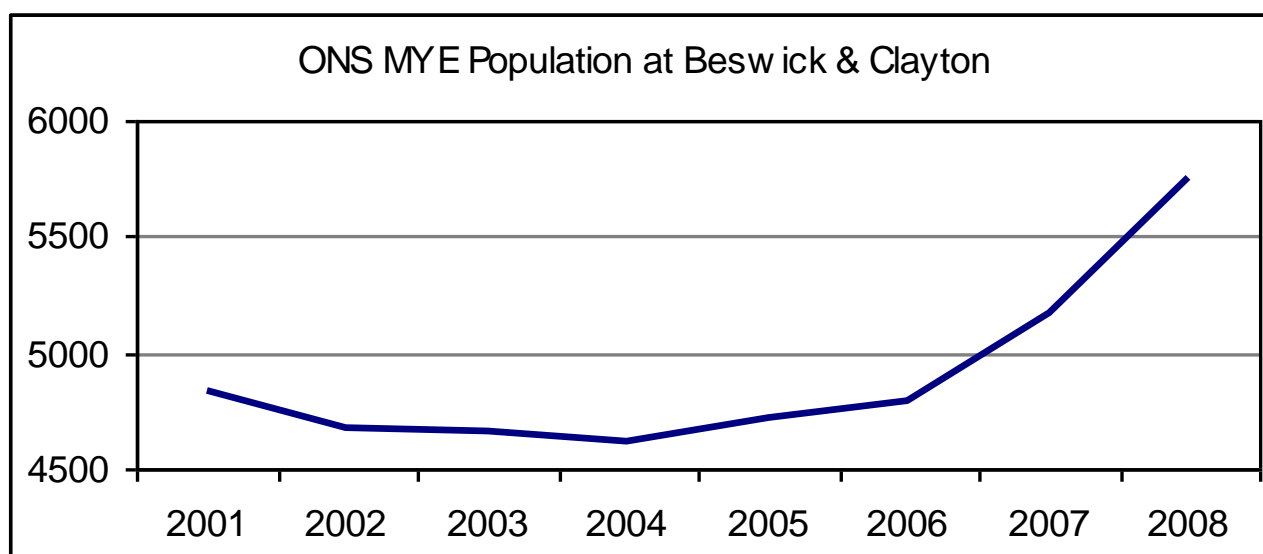
Population figures show a fall to a minimum in 2004 with a subsequent increase of 24% by 2008 from 4,620 residents in 2004 to 5,749 in 2008. The fall in population to 2004 may represent decanting, due to demolitions prior to redevelopment. This is borne out by the trend in housing stock over the same period.

Dwelling stocks by council tax band

Total Dwelling Stocks at Beswick & Clayton

Dwellings by Council Tax Band at Beswick & Clayton
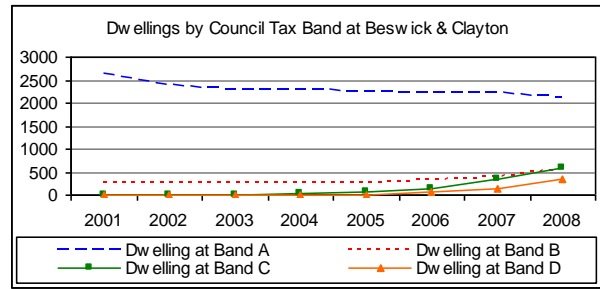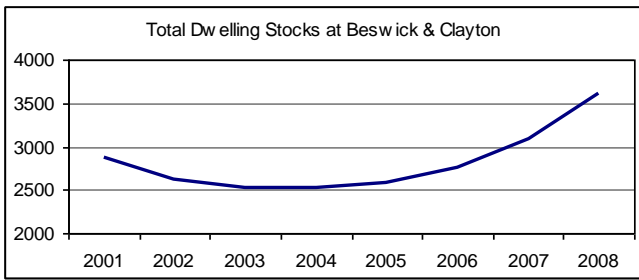
Corroborating the population trend is the change in the size of the dwelling stock which follows the same pattern. The number of dwellings has increased by 42% since 2004 with 3,604 units in 2008. The number of band A dwellings has fallen by 20% since 2001 (though remains by far the largest category – 58% of dwelling stock in 2008) with the largest increases in bands C to E. Bands D and E were negligible in 2001 but represent 26% of the dwelling stock by 2008. This indicates a considerable transformation in the housing stock over a 7 year period.

Families with children

Total Families with Children at Beswick & Clayton

Families with Children at Beswick & Clayton
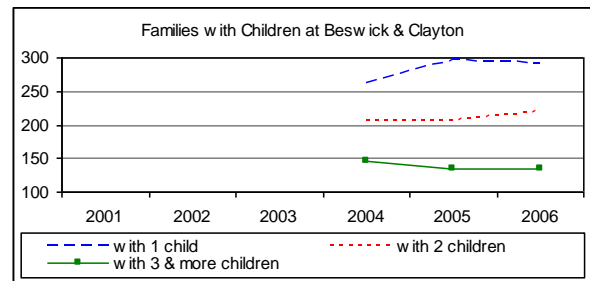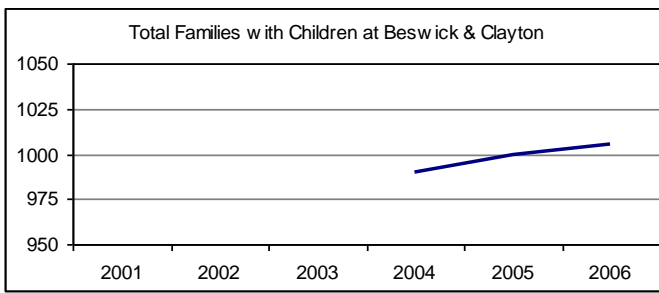
Numbers of families with children increased from 2004 to 2006 (1.5%) with the largest growth in single child families (12%). Larger families with three or more children declined.

Schools Census

Primary School

Secondary School

Total Primary School Population at Beswick & Clayton

Total Secondary School Population at Beswick & Clayton

Ethnicities in Primary School at Beswick & Clayton

- – – British&Irish White .... Other White
- —■— Asian —▲— Black

Ethnicities in Secondary School at Beswick & Clayton

- – – British&Irish White .... Other White
- —■— Asian —▲— Black

1st languages in Primary School at Beswick & Clayton

- – – English .... Other

1st languages in Secondary School at Beswick & Clayton

- – – English .... Other

The period 2001 to 2007 showed a marked decline (-9%) in primary school children living in the area. Given that ethnic minority primary school children were increasing and that the main decline is in White children and children with English as a first language, without evidence for a corresponding move into secondary education, this would seem to characterise residents that are leaving the area. The overall suggestion from the trend in secondary school children is that families with children moving into the area seem to have older children.

Deprivation

	IMD Score		Health Score	
	2004	2007	2004	2007
LSOA	77.76	72.06	2.21	2.33
Manchester	47.75	44.69	1.49	1.40

The deprivation scores for Beswick & Clayton are very much higher than for Manchester as a whole. Whilst the gap for the overall IMD scores remains about the same for 2004 and 2007, there is evidence for a widening gap in the health score.

Physical Environment (percentage of area covered, 2005)

| | Buildings | | Open Space | | |
	Domestic	Non-Domestic	Gardens	Green space	Water
MSOA	5.0%	7.4%	7.4%	35.8%	1.7%
Manchester	8.0%	6.0%	15.4%	1.4%	1.0%

Whilst the mix of domestic and non-domestic land uses for the MSOA is slightly worse than for Manchester as a whole, this may well reflect the presence of the sports facilities in the neighbourhood rather than any industrial areas. Green space is much higher than for Manchester as a whole suggesting the potential at least for a good physical environment.

Benefits claimed
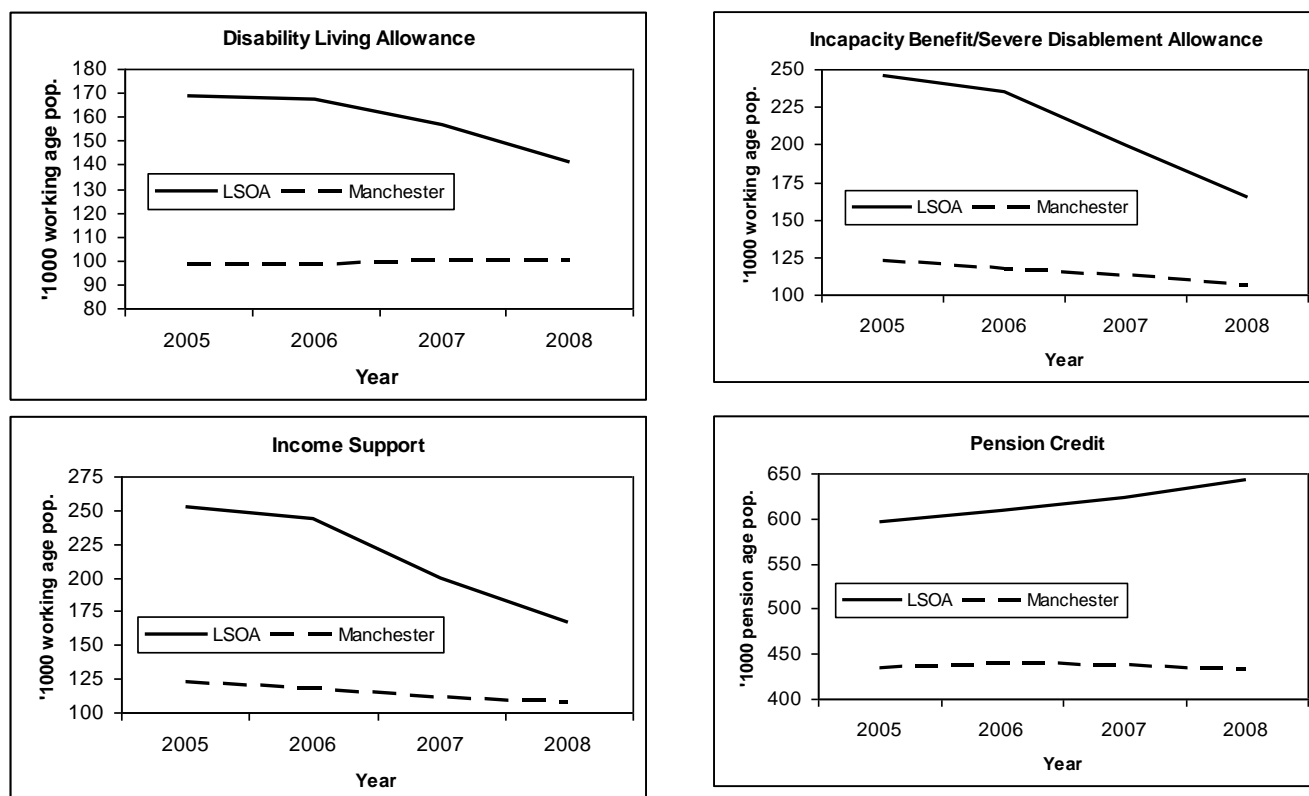
The overall trend is for the rate of benefit claimants to decline overall and more quickly than for Manchester as a whole, except for pension credits. In other words, the decline in the rate of claimants of income support would suggest relative poverty amongst those in employment appears to be declining, but that the numbers in relative poverty in retirement are increasing. However, the apparent decline in the rate of income support, disability allowance and incapacity benefit could simply be an artefact of the rising base population diluting the rates. The rate of Jobseekers' Allowance, though falling over the period, is nearly twice as high as for the rate for Manchester as a whole, suggesting endemic unemployment.

Life Expectancy at Birth

		2004	2006	2008
Manchester	Male	72.3	73.0	73.8
	Female	77.9	78.6	78.9

		2004	2006	2008
North West	Male	75.1	75.8	76.3
	Female	79.7	80.3	80.6

Life expectancy at birth is available at District level and may not necessarily reflect actual levels in Beswick & Clayton. Whilst life expectancy in Manchester is rising, it lags behind the wider region in which it sits.

Healthy Living (Model-based, 2005)

	Smoking	Binge Drinking	Obesity	Fruit & Veg.
MSOA	52.3%	26.7%	28.5%	14.2%
Manchester	33.8%	28.4%	25.8%	21.5%

This one-off set of figures for the MSOA would suggest an overall less healthy life-style in Beswick & Clayton, compared with the whole of Manchester. There is a higher proportion of smoking and obesity, and significantly lower consumption of fruit and vegetables.

Hospital Episodes (all finished admissions)
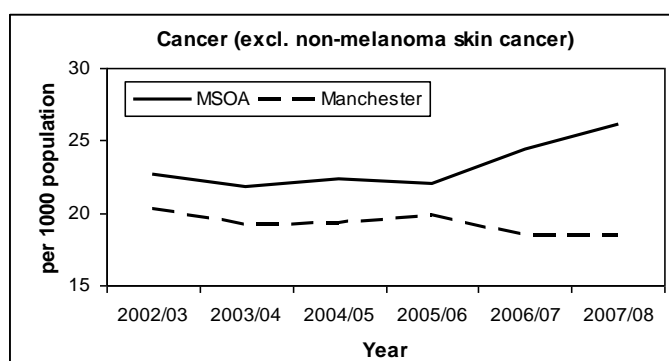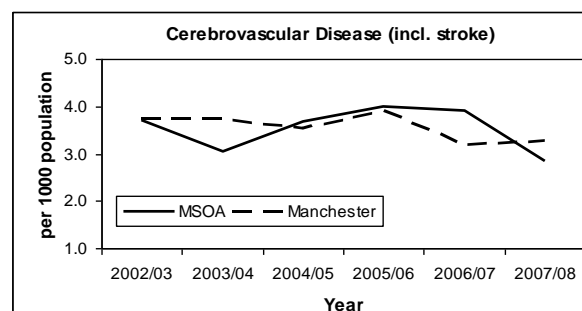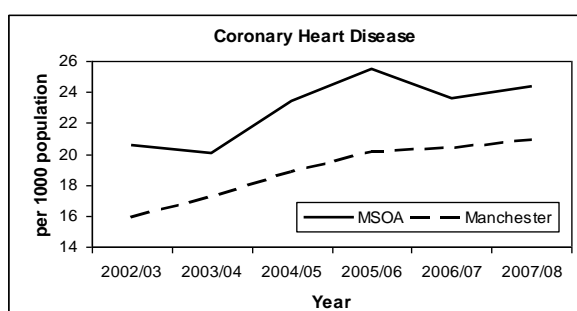
The rate of hospital episodes for key diseases at MSOA level shows a varied picture. The rate for coronary heart disease in higher than for Manchester as a whole, and is increasing roughly in pace with the trend for Manchester. The rate for cerebrovascular diseases appears stable and about the same as the rest of Manchester. The rate for cancer, on the other hand, sharply diverges from the Manchester trend after 2005/06. This is disquieting, given the rise in base population during this period.

Use of Mental Health Services (2008/09)

		per 1000 age group population			
		All	Age 18-35	Age 36-64	Age 65+
Manchester	Male	25.6	22.3	41.9	46.6
	Female	28.4	24.2	40.8	59.8
North West	Male	21.1	28.0	24.8	36.3
	Female	23.9	26.6	23.3	51.1

This one-off set of figures is for the Metropolitan District and may not be representative of Beswick & Clayton. The rate of mental health problems amongst the younger population of Manchester is low compared to the region and is in stark contrast to the older age groups in Manchester.

Accessibility to health services
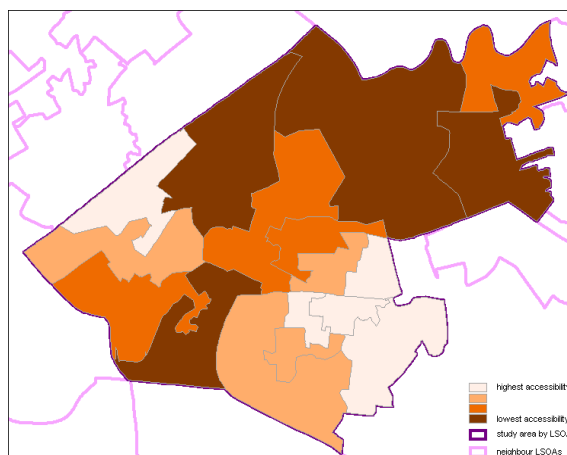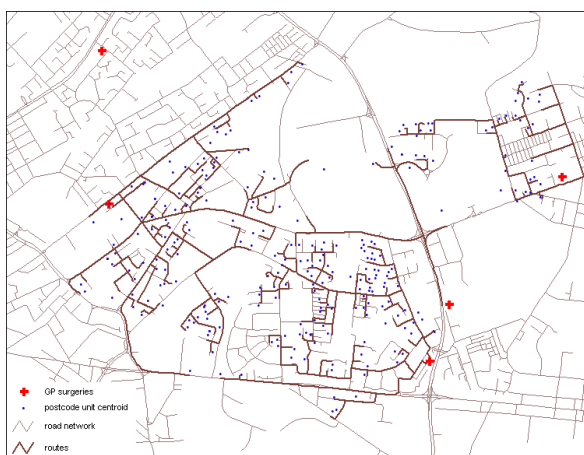
Accessibility to a GP (average 792m, max 1361m)
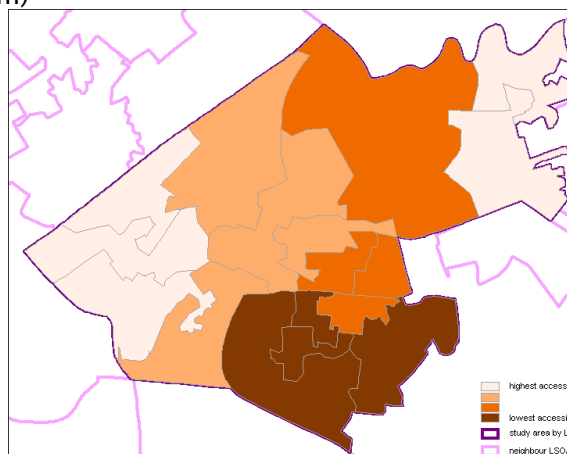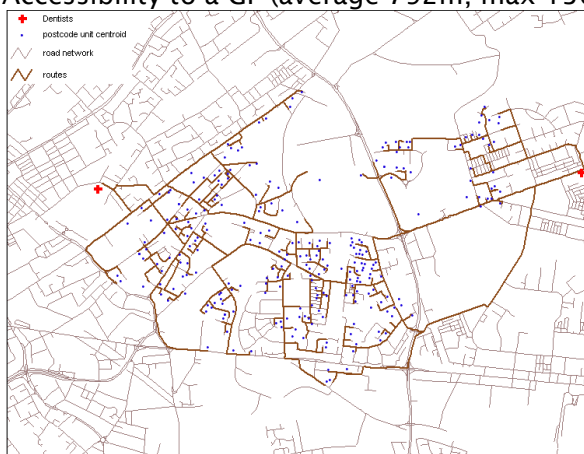
Accessibility to a dental practice (average 1462m, max 2398m)
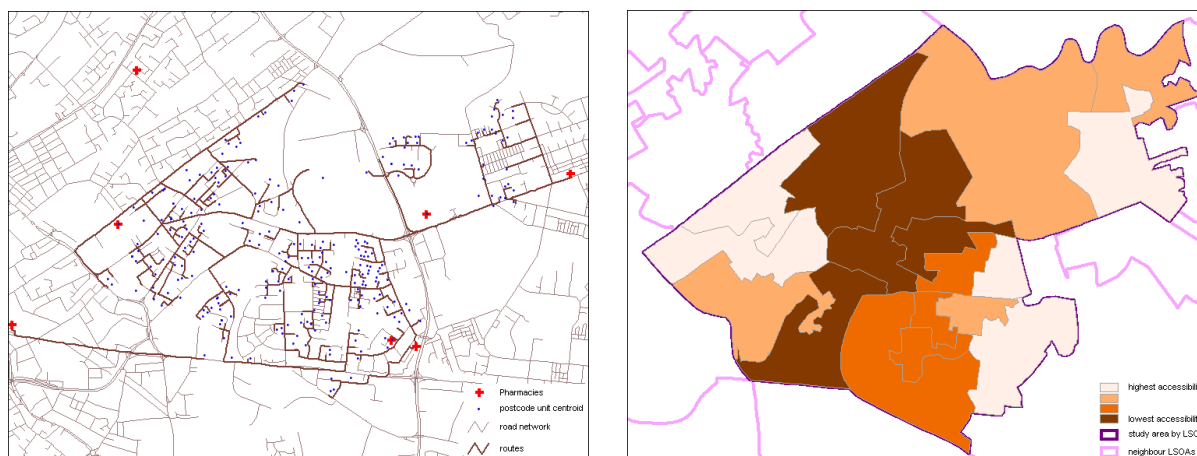
Accessibility to a pharmacy (average 815m, max 1475m)

Nearly all the health services being considered are to be found outside the estates on main roads and/or in local shopping centres rather than within the estates themselves. This leads to relatively poor accessibility in the heart of the study area. Only two dental practices are servicing the area, at an average distance of about 1.5km from any residential postcode.

Stratford City – 'Green Legacy Footprint'

The Stratford City is a new construction where the first residents will not move in until after the London 2012 Olympic and Paralympic Games, as they will be athletes' accommodation during the event. In order to determine a baseline for this as yet to be inhabited area, we have drawn upon the fourth legacy promise, which is "To make the Olympic Park a blueprint for sustainable living". As a sustainable community, Stratford City will require to interact and integrate with surrounding areas, what we have termed the 'Green Legacy Footprint'. This area is defined on three sides by natural barriers: the A12 dual carriageway to the north and west, and in the south, the railway line from Bromley-by-Bow to Plaistow through West Ham. The eastern extent is less easy to define, but has been positioned broadly along the A11 and B164, as representing a likely limit to walking and easy cycling interaction with Stratford City and the Olympic Park facilities (Figure 5). The Green Legacy Footprint area roughly corresponds to the residential areas included within the Olympic Co-ordination Zone.

Figure 5: The Stratford City 'Green Legacy Footprint' area. Note: aerial image has been rotated with north to the bottom to aid depth perception of buildings and topography. © 2010 Google – Imagery © 2010 DigitalGloge, GeoEye, Infoterra Ltd and Bluesky, Getmapping plc, The GeoInformation Group.

This area comprises 21 LSOA, the majority part being in Newham, but also encompassing parts of Waltham Forest, Hackney and Tower Hamlets. The 2011 UK Census of population will add important new data to the baseline presented below - the data will likely be released in 2013, when new residents are already beginning to occupy Stratford City – and, as suggested above, should be supplemented by a sample survey of these residents, as soon as they are of sufficient number.

Social Marketing Classification

In the People & Places classification (Beacon Dodsworth Ltd), 63% of the population in this area is classified as I33 (Multicultural Key Workers), 28% is classified as I24 (Cultural Enterprise), 5% as E08 (Urban Professionals) and 4% as G17 (Aspiring Streets). I33 and I24 are contrasting demographics. Pen portraits of these two main groups are:

I33 Multicultural Key Workers: Multicultural Key Workers are the less affluent Branch of the Multicultural Centres Tree. As you would expect, it is a very culturally diverse Branch, and includes Buddhists, Hindus, Jews, Muslims and Sikhs. The Branch also includes Blacks, Chinese, Indians, Pakistanis, Bangladeshis and Africans, as well as those from the Caribbean, Asia and Eastern Europe. Multicultural Key Workers are mostly families and

students, and include a lot of younger adults aged 16 to 34. Parents are generally aged between 16 and 34, though some are aged between 35 and 54. Households are generally large. Multicultural Key Workers' households are generally housing association accommodation, and many also live in council owned and rented accommodation. Much of the accommodation is small, being terraced housing, flats or bedsits, and some homes have no central heating and shared bathroom facilities. Multicultural Key Workers' households are very unlikely to have a car. This Branch is not interested in politics and reads tabloid newspapers, such as the Sun and the Mirror. Multicultural Key Workers tend to smoke and do their grocery shopping at cheaper supermarket chains, such as Aldi and Lidl. In their working lives, Multicultural Key Workers tend not to hold qualifications, and many work as semi-skilled manual and unskilled labour, as well as in routine and semi-routine occupations. Many work in the manufacturing industry, and take public transport to get to their place of work. Incomes fall into the fourth quartile.

I24 Cultural Enterprise: Cultural Enterprise is the richer Branch of the Multicultural Centres Tree. This Branch is very ethnically diverse, and contains those of different religions, such as Buddhists, Hindus, Jews, Muslims and Sikhs. This Branch also includes Blacks, Chinese, Indians, Pakistanis, Bangladeshis, Africans, those from the Caribbean, Asia and Eastern Europe. Cultural Enterprise is made up mostly of youths and young adults, and includes many students. Young families, where the parents are aged between 25 and 34, are also a feature of this Branch. Cultural Enterprise households are generally large ones, and they live in rented and housing association accommodation, or council owned property. This accommodation is generally small, and whilst there is some semi-detached housing, it is generally terraced housing, flats and bedsits. These households may not necessarily own a car. Cultural Enterprise is quite interested in politics and reads broadsheet newspapers. Doing the grocery shopping at Sainsbury's is very popular. In their working lives, Cultural Enterprise adults are generally well qualified, with the young adults working in higher managerial or professional positions. Some also work as semi-skilled manual and unskilled labour, and some work in service distribution. Manufacturing is a popular industry to work in. Public transport is the main way by which Cultural Enterprise adults commute to the workplace. Incomes fall into the first quartile.
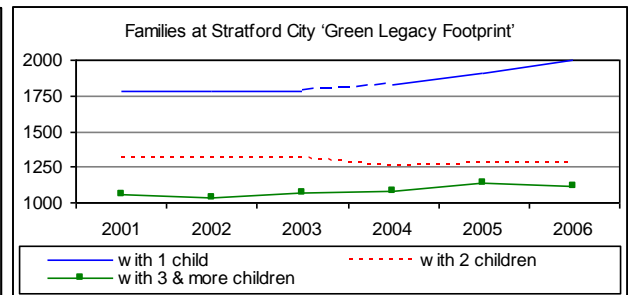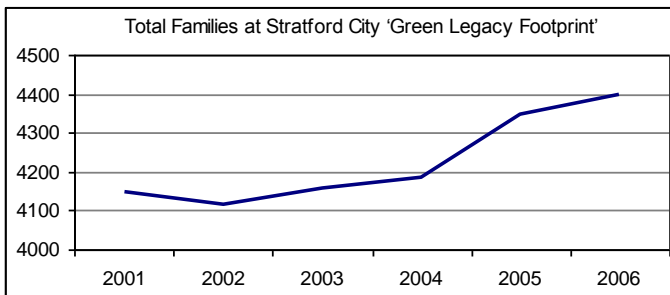
ONS MYE population
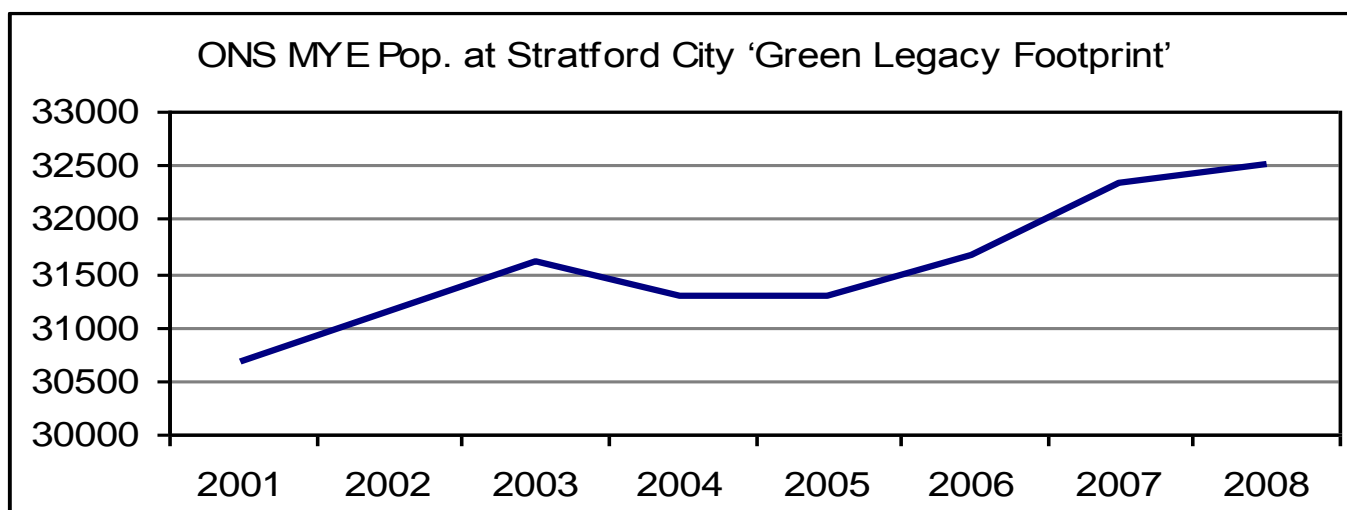
Population has risen in the period 2001-2008 by 6% from 30,674 to 32,517 residents.

Dwelling stocks by council tax band

Total Dwellings at Stratford City 'Green Legacy Footprint'

Dwellings by Tax Band at 'Green Legacy Footprint'
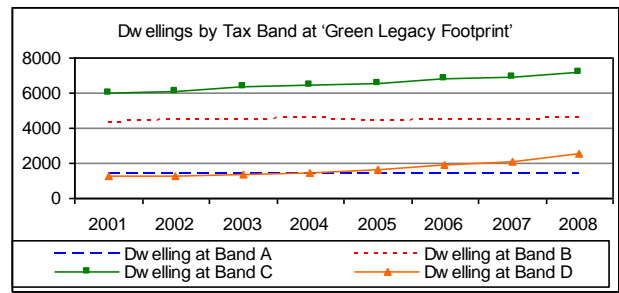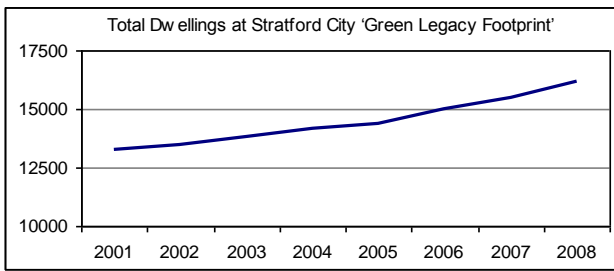
Dwelling stock has risen in the period 2001-2008 by 22% from 13,249 to 16,183 units. The majority of units comprise of bands B and C (28% and 44% respectively). There has been an increase in the stock for all bands with the fastest growth in bands C, D and E.
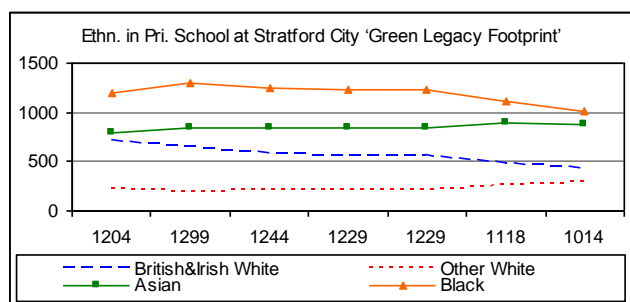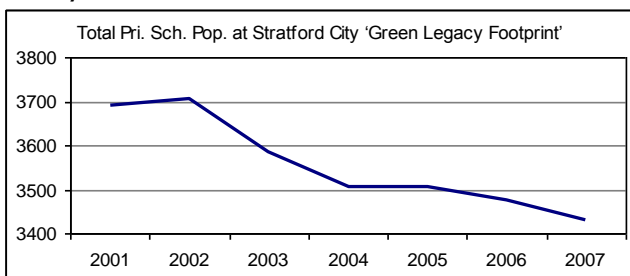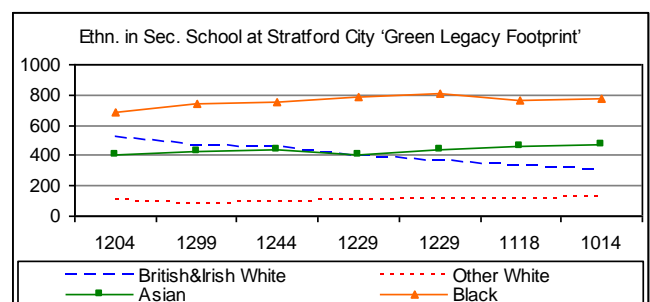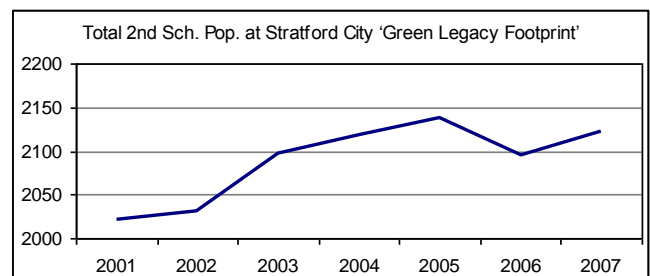
Families with children

Total Families at Stratford City 'Green Legacy Footprint'

Families at Stratford City 'Green Legacy Footprint'

For the period 2001-2006, there was a 6% increase in the number of families with children, from 4,147 to 4,400. The largest category is single child families (45% in 2006). Fastest increase has been in single child families (12%), followed by families with three or more children (5%). The number of families with two children fell.

Schools Census

Primary School

Total Pri. Sch. Pop. at Stratford City 'Green Legacy Footprint'

Ethn. in Pri. School at Stratford City 'Green Legacy Footprint'

Secondary School

Total 2nd Sch. Pop. at Stratford City 'Green Legacy Footprint'

Ethn. in Sec. School at Stratford City 'Green Legacy Footprint'

131
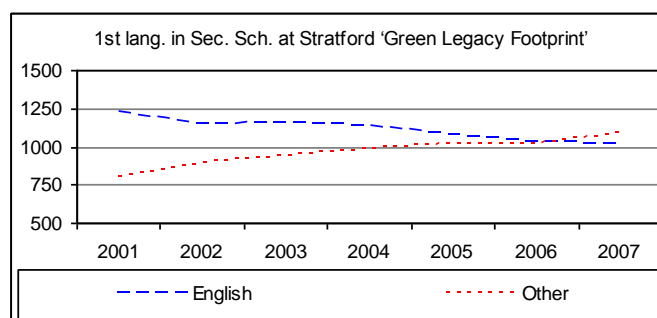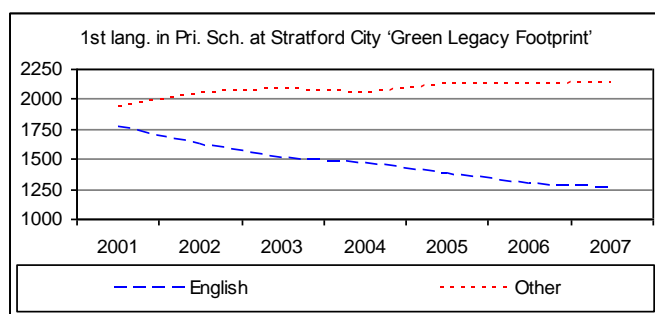
The 7% decline in primary school children in the period 2001-2007 is matched by a 5% increase in secondary school children, and would suggest an overall ageing of the youth population out of primary into secondary school without replacement at primary school level. At both levels, there is a continued decline in White pupils with English as a first language and in 2007 they were a minority group attending primary and secondary school.

Deprivation
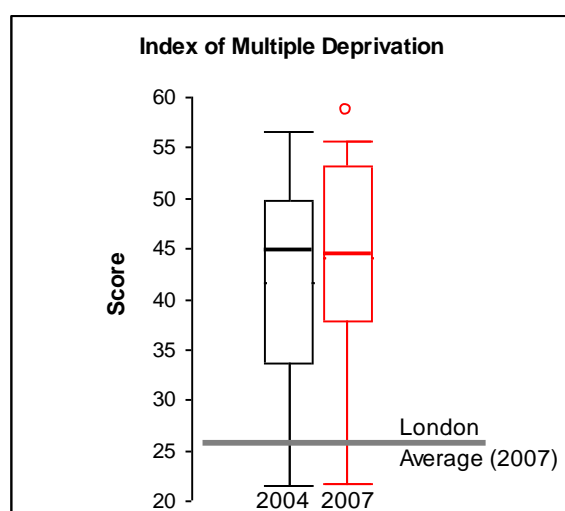
IMD scores between 2004 and 2007 are not strictly comparable, but the boxplot representations of the LSOA within the Green Legacy Footprint allow some trends to be discerned. The two sets of boxplots show that for most of the LSOA in the area, deprivation is well above the London average. For the overall IMD, the median remained the same in 2004 and 2007 but that the interquartile range (the middle 50%) moving upwards with greater levels of deprivation. For the health dimension there appears to be little change between 2004 and 2007 and all LSOA are above the 2007 London average.

Physical environment (percentage of area covered, 2005)

	Buildings		Open Space		
	Domestic	Non-Domestic	Gardens	Green space	Water
MSOA	7.3%	12.0%	9.0%	21.3%	3.6%
London	8.7%	4.7%	23.8%	38.2%	2.8%

The mix of domestic and non-domestic land uses at the MSOA level shows a higher proportion of non-domestic buildings compared with London as a whole. This reflects the

number of commercial and industrial buildings in this lower end of the Lea Valley, much of what is now the Olympic Park having been brownfield industrial land. The proportion of gardens is well below London as a whole, as is green space, but that will change with the completion of the Olympic Park. This is an urban environment in transformation.

Benefits claimed.
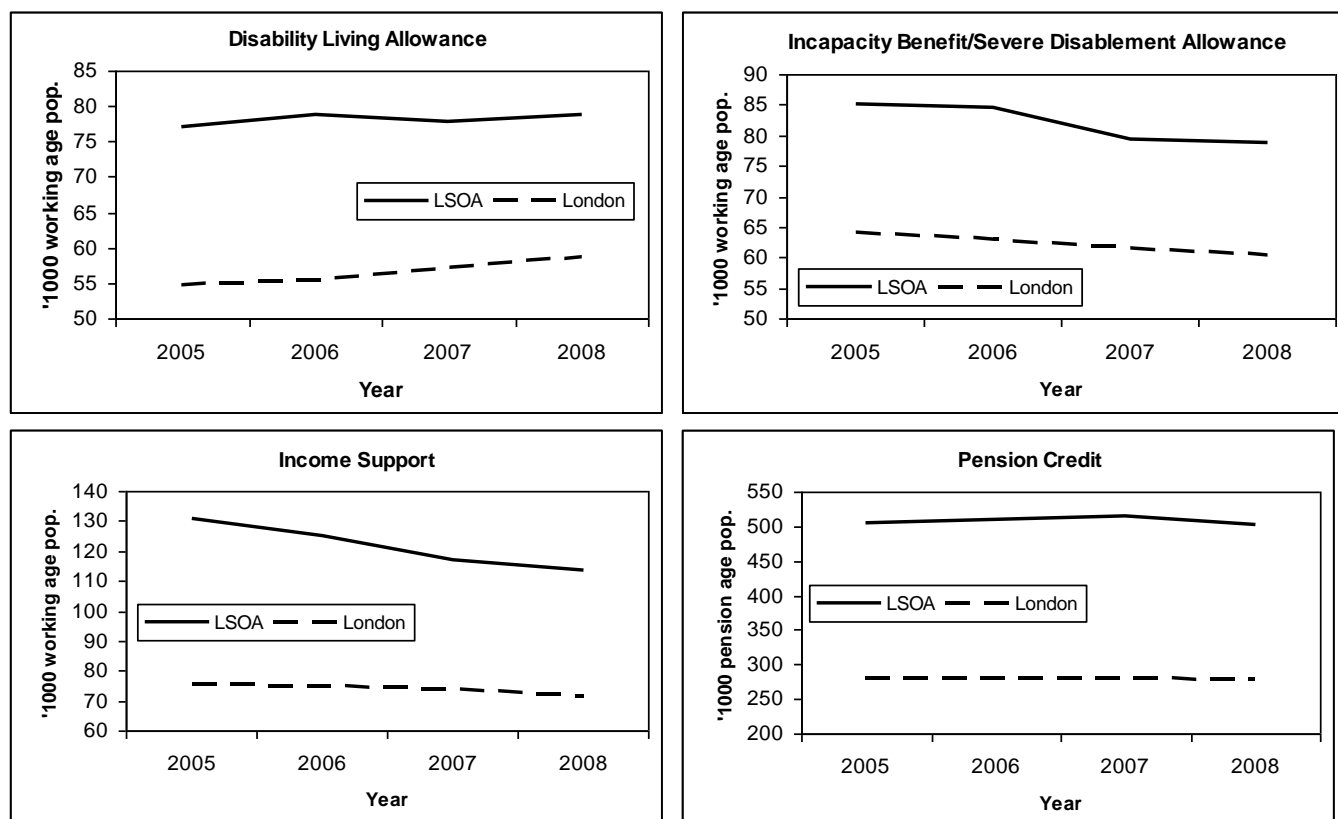
The rate of benefit claimants is well above London as a whole, but is steady or in decline for the period 2005-2008. Nevertheless, half the pension age population is on pension credit, indicating retirement in relative poverty, twice the London rate.

Life Expectancy at Birth

		2004	2006	2008
Newham	Male	74.4	75.0	75.8
	Female	78.8	79.4	80.4
Tower Hamlets	Male	73.8	75.2	75.3
	Female	79.2	80.2	80.4
Hackney	Male	74.6	75.0	75.9
	Female	80.8	81.7	82.2
Waltham Forest	Male	74.9	75.3	76.5
	Female	79.9	80.7	81.2
London	Male	76.4	77.4	78.2
	Female	81.1	82.0	82.7

Life expectancy at birth is available at Borough level and may not necessarily reflect actual levels in the Green Legacy Footprint. The largest part of the area falls within

Newham. Life expectancy for both males and females in Newham is below the London average, though it is increasing in line with the London average.

Healthy Living (Model-based, 2005)

	Smoking	Binge Drinking	Obesity	Fruit & Veg.
MSOA	28.5%	11.1%	21.2%	24.5%
London	23.4%	12.8%	18.3%	29.8%

This one-off set of figures for the MSOA would suggest that healthy life-styles are not that much different from London as a whole, with slightly more smoking, slightly higher obesity and less consumption of fruit and vegetables.

Hospital Episodes (all finished admissions)
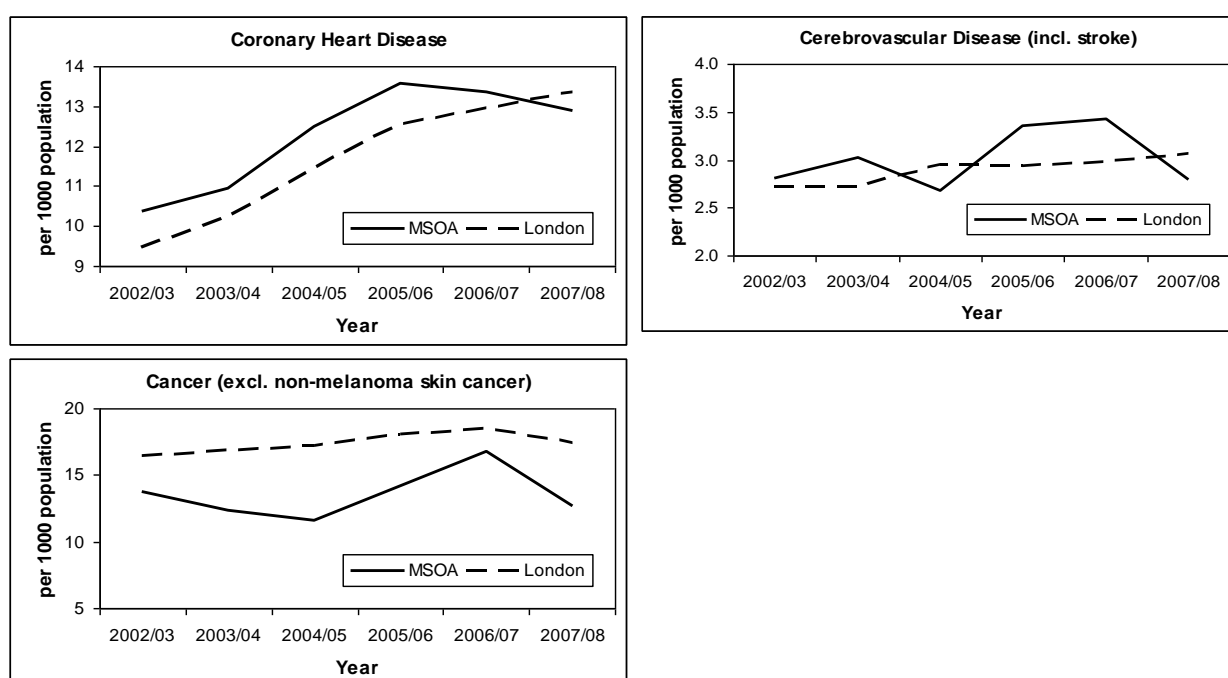
The MSOA data shows that in 2007/08, the rate for coronary heart disease was below that of London as a whole, only because overall, the rate for London had grown faster. In the two years 2005/06 to 2007/08, the local rate started to drop after a number of years of increase, whereas London continued its upward trajectory. The rate for cerebrovascular disease has oscillated over the five year period, but has stayed roughly on track with the overall rate for London. The rate for cancer is consistently below the overall rate for London

Use of Mental Health Services (2008/09)

| | | per 1000 age group population | | | |
		All	Age 18-35	Age 36-64	Age 65+
Newham	Male	25.0	32.0	34.6	48.6
	Female	30.8	37.2	41.2	65.9
Tower Hamlets	Male	26.5	33.8	36.9	39.0
	Female	28.9	37.6	35.6	50.0
Hackney	Male	25.9	28.2	35.7	53.4
	Female	30.7	35.3	41.0	63.4
Waltham Forest	Male	29.0	38.6	39.5	40.6
	Female	33.7	44.6	41.0	54.6
London	Male	23.8	27.6	30.9	41.1
	Female	27.2	31.0	30.9	54.4

This one-off set of figures is for Boroughs and may not be representative of the Green Legacy Footprint. The largest part of the area falls within Newham. For all age groups, the rates are slightly higher than for London as a whole. One noticeable rate for females aged 36-64, is much higher than the rate for males within the borough and in comparison to the gender age group for London as a whole. This feature is repeated in Hackney and Waltham Forest but has the greatest contrast in Newham. The much higher rate for females over the age of 64 most likely reflects the onset of various forms of dementia with longer life expectancy, but is much higher in Newham than for London as a whole.
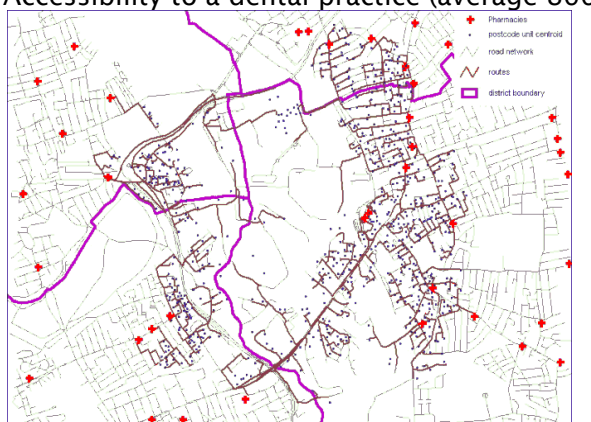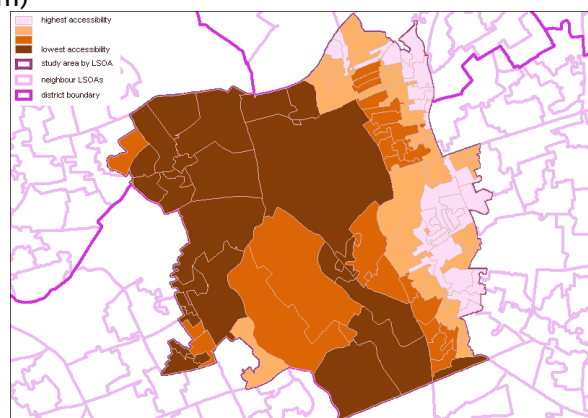
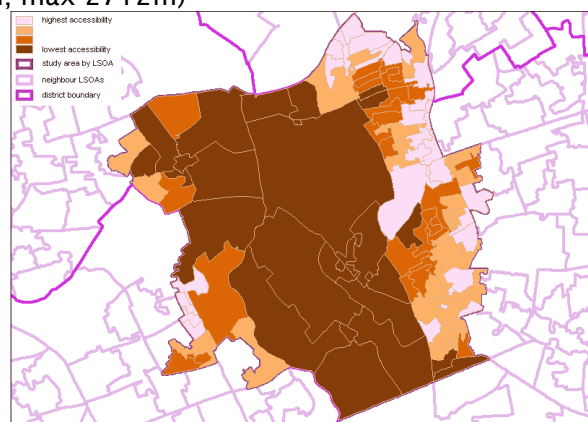*Accessibility to health services*
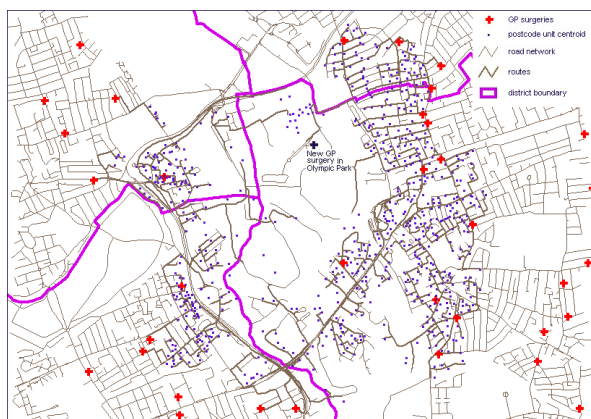
Accessibility to a GP (average 491m, max 1957m)
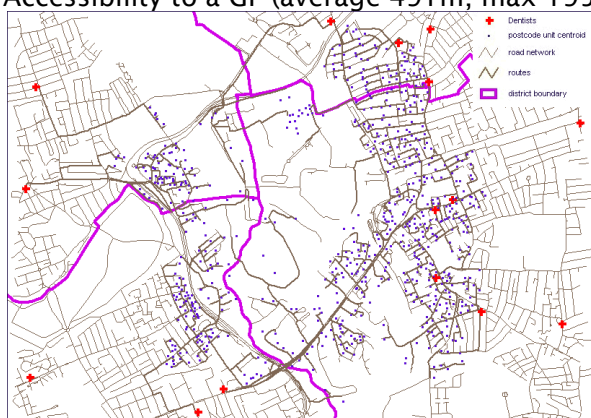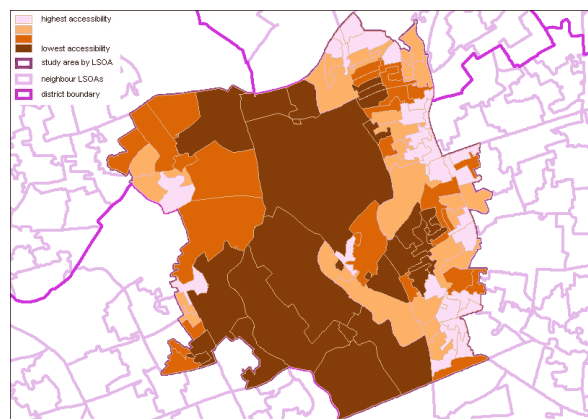
Accessibility to a dental practice (average 866m, max 2712m)

Accessibility to a pharmacy (average 534m, max 2286m)

The accessibility analysis takes account of existing health facilities. Although we are aware that a polyclinic will be located in Stratford City, we are not aware of how many WTE GPs will be based there. Also, whilst one might assume that a pharmacy may open in the new shopping mall, there is currently no confirmation of this. As one might expect from a brownfield site with few residents, the Stratford City site and the areas along the Lea Valley and across High Street (A11) in the south have least accessibility to health services. Of the existing residential areas, Hackney Wick has relatively low accessibility to dental practices and to pharmacies. There is clearly an opportunity for the Stratford City development to close some of these gaps in the north of the area and provide equality of accessibility.