journeys that are involved and therefore reducing physical pollution for doing that, but the other point I would make, which is ... about social impact: if you put a large entertainment complex, including a casino, in the centre of a town, you will suck huge amounts of money out of the leisure economy in that town; and this goes against the principle of trying to ensure that casinos, in as far as they displace economic activity, do so from a wide area of relative affluence and concentrate the new spend in areas of relative disadvantage. That is the best way of dealing with the economic redistribution policy. I think that is something which not only is undesirable in itself, but will clearly lead to all sorts of objections from all sorts of businesses to downtown casinos.

5.9 Policy 3D.1 provides the criteria for Development Plan Documents (DPDs) to strengthen the wider role of town centres. The Greenwich Peninsula and the site for the Wembley development are not town centres so this policy is not in conflict with 3D.1.

5.10 The most straightforward reason for a likely positive relationship between geographical proximity and problem gambling rates appears to be availability (i.e. allowing more frequent gambling), which has been shown to lead to increased problem gambling prevalence (221). Increasing ambient gambling, i.e., access and availability to gambling has deleterious effects on health. Non-ambient gambling are those forms that are less convenient to access and require forward planning to participate in (e.g. an out of town Regional Casino located away from residential areas). A recent Price Water House Coopers (219) report on the Newcastle casino development states that 'Stakeholders consulted and international research agree that the risk from non-ambient gambling is considerably less than that associated with ambient gambling. Building a Regional Casino in a non-ambient environment is therefore key in terms of minimising the risk of problem gambling' (219).

5.11 As Professor Peter Collins notes in the parliamentary select committee (220)

> As far as I can tell from reviewing the evidence which is in my submission, convenience is the single greatest spur to increase problem gambling. The reason for that is that problem gambling is a disorder of impulse control, consequently people are likely to engage in problem gambling behaviour more if temptation is regularly put in their way when they are not expecting it.

Gambling: Problem and pathological

5.12 The impacts on health and well-being of 'addictive' behaviours such as tobacco smoking, alcohol consumption and drug use are increasingly well-established and well-researched. Less widely researched is the issue of problem gambling, most likely to be expressed in the context of mental health, and often linked with other dependencies (222).

5.13 There is no universally agreed definition of problem gambling. Most adults who gamble do so responsibly, but a small minority display problems which meet diagnostic criteria. According to the British prevalence survey published in 2000, the proportion of the adult population who display problems is 0.6 per cent or 0.8 per cent, depending on which diagnostic method is used. In some cases the problems are very severe, leading to devastation in the lives of the gamblers and those around them.

5.14 The most recent comprehensive assessment of problem gambling in the UK was the Gambling Prevalence Study carried out in 2000. This suggested that the rate of problem gambling was 0.8% of the adult population based on the South Oaks Gambling Screen measure. Although it is likely that this rate will have increased, due to the increase in internet gambling and new innovations such as fixed odds betting terminals (FOBTs), it is still provides the most accurate baseline position.

5.15 Whilst problem gambling is generally viewed as a continuum (223), in its most extreme form it has been viewed as an addiction, and hence it has been medicalised. In 1997 pathological gambling was included in the International Classification of Diseases (ICD9) coding, and thus recognised as an official psychiatric disorder (listed under Disorders of impulse control). A substantial body of the current research into problem gambling follows the medical model, based within the discipline of psychology.

5.16 From a public health perspective, individuals who experience gambling-related difficulties, but would not meet a psychiatric diagnosis for pathological gambling, are of as much

concern as pathological gamblers because they represent much larger proportion of the population. The prevalence of problem and pathological gambling has been shown to double in communities within a 10-mile radius of a casino (224;225). Low socioeconomic status has also been found to be a significant risk factor for current problem gambling and probable pathological gambling. (225;226).

5.17 At present the impacts of problem gambling on health and well-being follow two, not-unrelated, pathways.

5.18 The first is within mental health, where studies demonstrate relatively high rates of depression, schizophrenia, life-threatening behaviour and suicide among problem gamblers.

- An epidemiological study based in St. Louis, USA found significantly elevated odds ratios (risk) for major depression and schizophrenia in problem gamblers, alongside suicidal tendencies (222).
- DeCaria et al (227) also observed high rates of a wide range of mental health problems in problem gamblers.
- In 2002, 10% of users of an established telephone helpline for problem gambling in New Zealand reported considering suicide, with 30 of the 4,655 clients having attempted suicide in the past year (228).
- More women than men reported loneliness and isolation in connection with the development of a gambling habit, the majority of respondents reported significant family histories of gambling problems and alcohol dependenc e(229).

5.19 The second pathway relating to co-dependence on alcohol means that it is often difficult to explore problem gambling as a separate issue.

5.20 'Problem gambling' refers to patterns of gambling behaviour that compromise, disrupt or damage health, personal, family or vocational pursuits (230). The individual gambler is most likely to feel the most severe effects, but these can impact on close family members, friends and workplace colleagues. The gambling process can often take priority over other commitments and everyday routines, and where the gambling is sustained over many hours, the gambler will neglect eating and sleeping, resulting in poor physical health (231). Problem gamblers report poor self-related health, and high rates of depression, anxiety and stress (232). A study of pathological gamblers (229) noted that 15.4% of the women and 13.2% of the men reported stress or anxiety as a trigger for gambling. The mean annual percentage incomes lost as a result of this gambling were 83.2% for women and 54.3% for men, though it should be noted that these respondents were at the extreme of the gambling spectrum.

Casinos and problem gambling

5.21 The relationship between casinos and problem gambling is complex. This is especially so in the UK where there is no other super casino on which to base the projections. In general, studies have concluded that problem gambling is related to the availability of gambling. These studies reflect a range of countries (eg. Australia and the US), different gambling cultures and a range of legislative, regulatory, planning and social circumstances .

5.22 We must be wary of directly applying the relationships seen elsewhere to the UK, and London, context.

5.23 There is a significant volume of internationally published research which examines the social costs of gambling with particular reference to health and other personal and interpersonal issues. There are however, very few studies that differentiate casino driven health impacts from those which might accrue from a general increase in gambling in all forms. Moreover, it is becoming widely recognised that gambling, like alcohol, is not a homogenous product: the social impacts of gambling vary depending on the type of gambling concerned - this will also apply to different types of gambling within any particular casino.

5.24 Whilst it is likely that problem gambling will cause a slight increase in the prevalence of poor mental, physical health, these effects should be taken in context. Two points must be borne in mind:

- firstly, it is clear that, where the health and social problems do manifest themselves with problem gamblers, it is unlikely that problem gambling will be the sole root cause; and,
- secondly, other forms of gambling, such as internet based gambling and less regulated gambling, will also be contributing to any increase in the overall rate of problem gambling and, therefore, to associated negative health impacts.

5.25 At a local level, however, there are concerns that locating a large number of gaming machines close to neighbourhoods (particularly those that rank highly in the IMD index) will bring about health problems locally. As Professor Peter Collins (220) notes in his response to the parliamentary selection committee

... high prize machine gambling is the form of gambling most liable to be abused and most likely to increase the incidence of problem gambling. This is because the combination of rapidity of play and the possibility of winning substantial amounts of money makes it comparatively easy, both physically and psychologically, for gamblers to gamble more than they originally intended or can realistically afford; other things being equal, the introduction of high prize machine gambling will lead to an increase in problem gambling;

5.26 The potential effect of a casino on social cohesion has also been highlighted in local authority areas such as Brent by local stakeholders such as the PCT and multi-faith forum (233). Casinos are an emotive and controversial topic and it is clear that some religious and faith communities have extremely negative perceptions of casinos and wish to resist attempts to develop such a facility in proximity to their places of residence. A similar point was made by Sir Peter Hall in his oral evidence to the Joint Committee on the Draft Gambling Bill in relation to the conflict between residents and users of the casino (220).

So, despite the laudable aim of government to have everything mixed up and the housing next door to pubs, clubs and gambling, I think in practice there can be very, very negative effects from these uses in the juxtaposition which would have to be looked at

5.27 It is not possible to quantify or cost the extent of the impact on social cohesion but the fear of creating or exacerbating community tensions is a genuine one.

5.28 There have been studies that show a positive correlation between casinos in a community and an increase in the number of persons suffering from problem and pathological gambling (234). A pre-post test study of the social and economic effects of five casinos on four Ontarian communities found a 1.5% to 2.5% increase of probable pathological gamblers in the local communities (234). Two studies by John Welte and colleagues showed that the prevalence of problem gambling declined significantly as socioeconomic status increased (225;235;236) .

5.29 The 2002 study revealed that African Americans, Hispanics and Asians were more likely to be problem gamblers than Whites (235). The 2004 study (225) examined the effect of community disadvantages and gambling availability on gambling participation and pathology. The significant finding of this study is that the presence of a casino within ten miles of a respondent's home was positively related to problem and pathological gambling. Specifically, respondents to the survey who lived within ten miles of a casino had double the rate of problem and pathological gambling compared to those who lived further than 10 miles from a casino.

5.30 Table 1 examines the implications of this finding for people living within a 10-mile radius of the Greenwich Peninsula location. Table 1 shows an approximate estimate of the adult population living within this 10 mile radius. Figures for the adult population were taken from the census counts for 2001. Boroughs that fall mostly outside the 10 mile radius are not counted.

Table 1 Estimate of problem gambling in 10 mile radius surrounding Greenwich Peninsula

LB Borough	Adult population*	Number of problem gamblers once regional casino established**
Barking and Dagenham	116,973	1,404
Bexley	218,307	2,619
Camden	155,767	1,869
City of London	6,335	76
Greenwich	156,972	1,884
Hackney	145,221	1,743
Islington	136,007	1,632
Kensington and Chelsea	158,919	1,907
Lambeth	204,079	2,449
Lewisham	184,968	2,220
Newham	164,791	1,977
Redbridge	175,830	2,110
Southwark	184,016	2,208
Tower Hamlets	140,421	1,685
Waltham Forest	160,822	1,930
Total	2,309,428	27,712
All London	*5,389,908*	

* 18 years and older

** calculated at 1.2% ie twice the proportion of 0.60% according to the lower estimate of the BGS

5.31 If we accept the findings from the Welte and colleagues 2004 study Table 1 shows that more than 27,000 people will exhibit problem and pathological gambling. This is an increase of more than 13,850 problem gamblers. This 10-mile radius includes some of the most deprived areas with London.

5.32 This underestimates the potential number of people who may be affected: it is based on the 2001 census population counts, it uses the lowest estimate of the baseline prevalence of problem and pathological gambling and it excludes London boroughs and local authorities outside Greater London that do not fall wholly within the 10-mile radius. On the other hand the calculation assumes equal ease of access to the Greenwich site. The Thames may act as a barrier, and a deterrent, to travel from north of the river.

5.33 The 2004 study conducted by the RIGT (224) found

> ... it can be anticipated that legislation and policies that significantly enhance access to electronic gaming machines, casino table games and other continuous gambling forms will generate increases in problem gambling and related flow-on costs to families and communities. Risk profiles are also likely to change, with disproportionate increases among women and some other population sectors including ethnic and new migrant minorities. Problem gambling may also move 'up market', becoming somewhat more evenly distributed throughout socioeconomic strata and age groups.

5.34 A report by EDAW for LB Brent (237) and a report by Hall Aitken (238) each state that our understanding of the causes and effects of casino-driven problem gambling is limited by the lack of research which isolates the impact of casinos and components within casinos. Research in a UK context draws predominately on overseas evidence and is generally over-reliant on assumptions. General trends from the evidence do emerge:

- **Gender** Males more prone but rates in women catching up - women likely to have shorter gambling careers but develop problems at faster rate.
- **Age** The young are seen as the most likely to develop problems - 18-35 year olds at greatest risk - also adolescent gamblers most likely to develop problems.
- **Education** Conflicting results - majority point towards slight relationship between lower educational attainment and problem gambling.
- **Marital Status** Single people are deemed to be most vulnerable - especially separated/divorced - although this may be more of a consequence than a cause.
- **Employment Status** Unemployed and manual/lower occupational groups most vulnerable.

- **Household components** Single-person households.
- **Income** Lower income most vulnerable as they spend a higher proportion of their income on gambling than higher income groups.
- **Ethnicity** Conflicting results although majority point towards higher vulnerability for immigrant and minority populations; also those who do not speak English at home; and Chinese immigrants often most prone.
- **Geography** Proximity to casino generally seen as a major contributor; also most deprived neighbourhoods most vulnerable.

Casinos and economic regeneration

5.35 Para 3.236ii of the London Plan states that casinos (particularly those in the 'Regional' category) are likely to have significant scope to provide regeneration benefits listed as including employment and training, support for regionally important developments or strategic priorities and transport improvements.

5.36 The national and international evidence is equivocal about the scope casinos have to provide regeneration benefits (236).

5.37 A unique quasi experimental study by Costello et al (239) examined the health effects of a rise in income via the development of a casino within a deprived American Indian reservation in the United States. The study found positive psychopathological health impacts such as reduced behavioural problems amongst children; and improved self-reported health – particularly anxiety, depression and physiological health.

5.38 It concluded that these were generated by moving individuals and their families out of poverty. However, the mechanisms responsible for these health changes were primarily psychosocial. Incomes had marginally increased above that of welfare benefits levels; however, it was proposed by the authors that the positive health changes were due to the fact that formerly unemployed individuals had obtained employment within the casino. While this employment provided an income it was the employment that was considered most important, in that it enabled individuals to feel socially included and integrated, provided a structure and purpose to their lives, provided autonomy and control and role models for their children.

5.39 However, Pricewaterhouse Coopers (219) state in their report on the Newcastle casino development that

> ... in our experience of similar proposals by casino operators suggests that a significant proportion of casino jobs created could be entry level positions with limited requirements for specific skills or qualifications.

5.40 In the case of a regional casino they state that 50-60% of the jobs created will not require any qualifications. In Section 5.2.1 of the main SA report the SA team note that temporary, unskilled employment does not promote social inclusion and may lead to adverse health impacts.

5.41 As a potential mitigation measure PWC recommend that

> ... local education and training agencies and the casino operator work together to maximise the training benefits of a Regional Casino and enhance the development of skills to facilitate progression to higher level positions within the casino operation (219).

5.42 In assessing the significance of these impacts a number of points should be borne in mind (219)

- Gambling is not a homogenous product and the social impacts arising from each type of gambling will differ and this applies to different types of gambling within casinos.
- The extent of the social impact is determined to a considerable degree by the type of licensing and regulatory framework adopted. Security and access policies clearly have a role to play in controlling the social impact of casinos.

5.43 Hall Aitken in their recent analysis of the social and economic impacts of regional casinos (238) note that there will be a significant number of jobs created by a casino, both long and short-term, but:

- many of these are likely to be displaced from elsewhere in the leisure sector; these jobs will not necessarily match the needs of the local population; and
- there is strong evidence to suggest that many of the jobs will go to migrant workers.

5.44 In the late 1980s Atlantic City in the US was a run-down large-scale seaside resort. Large-scale resort casinos were seen as being the means of regenerating the city and turning round its declining fortunes. The city authorities had high hopes for the impact of the investment and expected that an economic renaissance would follow the first casino. However these 'regeneration benefits' did not transpire for Atlantic City (238). The New Jersey Governors Advisory Commission on Gambling 1988 saw the warning signs early on:

> ... it is clear that retail businesses and retail employment in Atlantic City have continued to decline despite the presence of gambling, and that rampant speculation has rendered the redevelopment of vast parts of Atlantic City difficult if not impossible.

5.45 There is no compelling evidence that suggests the 'Atlantic City effect' will follow a large regional casino in the UK. But there is a clear risk that it could. On the basis of international evidence, Hall Aitken conclude that many existing and competing businesses would be blighted or undermined by the presence of a regional casino. Significant numbers of businesses and neighbourhoods may be affected.

5.46 Three key findings from the Hall Aitken (238) report are that:

- the estimates of economic benefit from a regional casino development are both optimistic and potentially misleading;
- the social costs of regional casino development are potentially high and, for most locations, would outweigh any economic benefit; and
- the proposed regional casino will, on balance, undermine government targets on neighbourhood regeneration.

5.47 In line with the policies in chapter 3A of the London Plan it is important to be cognisant of the views of local residents who will be most affected by the development. Survey research (233) has recently been carried out by the Brent Borough Council to explore the implications of a Regional Casino for the LB Brent. This study included a survey of residents: while 30% of the residents believed that a casino would provide enhanced employment, 79% of the residents surveyed said they would not take up the employment opportunities created by the casino development and 54% were 'strongly opposed' to a casino being located within Brent. Local stakeholders such as the Primary Care Trust and the multi-faith forum also expressed concern. It is clear that some religious and faith communities have extremely negative perceptions of casinos and wish to resist attempts to develop such a facility in proximity to their places of residence. It is impossible to quantify or cost the extent of the impact on social cohesion but the fear of creating or exacerbating community tensions is a genuine one.

5.48 The casino development is intended to be of social and economic benefit to local residents in terms of access to employment, however if residents are unwilling to take up these jobs then the purpose of the casino as a mechanism driving regeneration will be hindered or more specifically local rates of economic activity / unemployment will not be reduced.

Impact on problem gambling rate

5.49 Based on economic assessments of increased revenue, experience from overseas and studies looking at the implications of the new UK legislation, there is little doubt that the number of gamblers and the amount gambled will increase. One report identifies an estimated 62-fold increase in expenditure on hard gaming slot machines once the new legislation is introduced (240).

5.50 The results of international research vary on this subject, although we have seen above that on balance, there may be a positive correlation between geographical proximity and problem gambling rates.

5.51 However, not all studies have shown a relationship between gambling opportunities and the prevalence of problem gambling. A different study of Nevada carried out in 1998 indicated it may have the lowest rates of problem gambling in the US (cited in Welte, source 225).

Also when Windsor Casino, Ontario was opened no increase in the local rates of problem gambling were noted (241)

5.52 Casino operators argue they have little incentive to generate revenue from problem gambling in their casinos. However, the range of research indicates that problem gamblers account for a significant proportion of gaming revenues.

5.53 A further fundamental question to consider is whether casinos have an incentive to proactively reduce problem gambling. Three factors appear to be at play, the first an incentive to address problem gambling, the second and third being disincentives.

5.54 Susan Fisher (242) provided evidence that the UK casino industry is sustained by regular gamblers among whom the prevalence of problem gambling is relatively high. Whilst regular (i.e. at least once a week) casino visitors made up only 7% of all casino patrons they were extremely active, accounting for 63% of all casino visits. The prevalence of problem gambling in this group was 15%.

5.55 Other international evidence supports this view, with the research data outlined in the table below indicating that casinos generate a significant proportion of their revenues from problem gamblers.

5.56 As Fisher concludes in her research paper:

They [UK casino operators] may therefore see it in their enlightened self-interest to assist with patron research, as a first step toward the minimisation of problem gambling on their premises. On the other hand, if patron research demonstrates that their revenue is drawn primarily from a small proportion of regular patrons, among whom the proportion of problem gamblers is high, they will be forced to make difficult and possibly radical decisions about where the future of their business lies.

5.57 International benchmarking shows that spending on problem gambling in the US, Canada, Australia and New Zealand is considerably higher, in both per capita and per estimated problem gambler terms, than the £3 million proposed for the UK (243). GamCare and Gordon House, for example, have each stated that they would be able to spend £10 million and that additional funding is needed to increase the availability of treatment services and to raise awareness of the services that already exist. Other UK charities have also been noted in the press arguing they need further resources.

5.58 As PWC note in their report for the Newcastle City casino development:

'Given the risk of insufficient national funds to address problem gambling in the UK it would appear especially important for Local Authorities to ensure that they do not 'own' the risk of addressing potentially very significant problem gambling costs. Embedding the principle of a variable financial contribution from any Regional Casino operator, sufficient to mitigate social impacts, will therefore be vital'.

5.59 PWC (219) recommend the following:

Embed a variable operator contribution to address social risks in any licensing arrangements. Local borough councils should ensure that social impact risks, particularly the high risk and uncertain area of problem gambling, are 'owned' by the casino operator.

Recommendations

5.60 The following recommendations are based on recommendations made by the London Assembly and by independent consultants and were made to the London Plan policy authors.

- Any applications for new regional casinos must recognise their potential negative, and differential, impact on populations within a 10-mile radius. As part of the application, the developers should publish a clearly defined action plan to mitigate any negative side-effects. We further recommend that the action plan should be monitored by the Boroughs and enforced by the Gambling Commission.
- The local education and training agencies and the casino operator work together to maximise the training benefits of a Regional Casino and enhance the development of skills to facilitate progression to higher level positions within the casino operation. This

will help to offset potential negative effects of temporary and unskilled employment and to promote opportunity for socially inclusive employment.

- Embed a variable operator contribution to address social risks in any licensing arrangements. Local borough councils should ensure that social impact risks, particularly the high risk and uncertain area of problem gambling, are 'owned' by the casino operator and that costs are not borne by NHS organisations and the borough council.

5.61 Each of these recommendations was considered by the policy authors and the policy on casinos was amended accordingly.

6. Notes from consultation workshop

Introduction

6.1 On Wednesday 5th July 2006, the Greater London Authority hosted a workshop for the SA of the further alterations to the London Plan. There were approximately 40 participants. The list of participants is provided on page 58. Prior to the workshop participants were sent a briefing paper on health issues associated with the alterations to the London Plan and an evidence base.

6.2 The purpose of the workshop was to

- Support participants in considering key policy alterations relevant to health, in the light of the existing evidence and on the basis of stakeholder knowledge, by:
    - providing an overview of the contents of the *draft Further Alterations to the London Plan* and the development process underpinning it; and
    - briefing participants on key aspects of the existing evidence on the health impacts associated with the draft Strategy.
- Enable participants to share their own experiences and knowledge on equal terms, through structured group discussions.
- Identify ways in which changes in the *draft Further Alterations to the London Plan* support health, and ways in which the alterations could be strengthened, and to use this information to shape clear and practical recommendations to inform the final Strategy.

6.3 The workshop started with a brief introduction and an outline of Sustainability Appraisal and Strategic Environmental Assessment and health. Jane Carlsen then described the purpose of the further alterations. Ben Cave then described how the workshop would be run. The slides from the presentations have been circulated. The timetable of the workshop is shown below. The participants split into groups. Each group was facilitated and the participants were asked to focus on prioritising the significant health effects.

Time	Who	What
10.15		Tea & Coffee
10.30	Ben Cave	Introduction & welcome
10.40	Jane Carlsen	What are the *Further alterations to the London Plan*?
10.55	Ben Cave	What does this mean for health and wellbeing?
11.05		Coffee
11.15		Facilitated small group work
12.15	Ben Cave	Feedback
12.25		Facilitated small group work – Recommendations
12.45	Ben Cave	Feedback, next steps, evaluation forms and close

6.4 A workshop for the London Sustainable Development Commission was held on 11th July 2006. The initial findings from these workshops were discussed with London Plan policy authors on Wednesday 12th July 2006. The full SA report was discussed. Many issues were raised including the powers of a spatial plan. There was general support for the messages coming from the workshops but also a request for clearer wording in the recommendations. Clarification was requested on some points.

A note on the *Diamond Nine* approach

6.5 The SEA Directive stipulates that *significant* effects on human health should be identified. The focus of the workshop was on identifying the significant effects of the alterations.

6.6 Diamond Nine helps to get discussion going, draw out people's views on priorities ... and draw on different stakeholders values, knowledge and experience to reach consensus.

6.7 Facilitators were provided with detailed briefing. Participants were asked to individually identify their top 2 or 3 most significant effects. Working as a group they were asked to stake their claim on which they think gets the top spot ... (and later the other positions) and to 'argue' why until consensus is reached (ie consensus being 'the choice that all may not agree with but can live with').

6.8 The note takers attempted to capture the rationale/key reasons the group give for the ranking of the effects.

6.9 This is not a scientific process of research but an exercise to encourage participants to focus in a short time. Many participants felt uneasy about losing particular issues. We will take note of all issues as we write the next iteration of the SA report.

Analysis

6.10 In the next section we provide the notes from the small group discussions. We look at the issues chosen as 'top three' significant impacts in the bullet points below. The 'top nine' from each group are shown in a table on page 59*ff.*

- Reducing health inequalities received strong support from each of the groups. How would this be prioritized, achieved and measured?
- Economic growth and economic development received support in the context of community growth or community benefit.
- *Access* to all that London can offer for all Londoners was the first choice for one of the groups. This group explicitly used a very wide definition of *access* and included access to physical, environmental, social and economic opportunities and access to services.
- Implementation was cited as an important issue. This delivery theme was picked up by other groups in the questions about targets, indicators for the health inequalities objective.
- Climate change was mentioned by one group. It was also cited as being of a different magnitude and thus worthy of support above and beyond this Diamond Nine process.

Next steps

6.11 We welcome comments on these notes and corrections where we have omitted things or interpreted the issues incorrectly. We will use the workshop discussions to guide us as we write up the next iteration of the SA report.

6.12 Please send comments on this document to Ben Cave at ben.cave@caveconsult.co.uk by Monday the 14th August 2006.

Small group discussions

Comments from group facilitated by Ben Cave, BCA

6.13 A question was raised about the decision of the SA/SEA to focus only on the significant effects of the alterations. Jane Carlsen explained that the original London Plan went through a full SA and Examination in Public. This SA/SEA focuses on the alterations. The SA might identify areas where the alterations have had knock-on effects on policies which are currently unchanged.

6.14 When considering how to rank the nine significant effects the group stated that the public health impacts of climate change are enormous and of a different magnitude, both geographical and temporal, to many of the other changes under consideration. The group strongly supported the initiatives on climate change but has not prioritised them, in this exercise, as they appear to be secure, and central to the alterations.

6.15 There was a discussion about the difference between the economic development agenda and the skills, worklessness and child poverty agenda. Economic development was ranked higher in the diamond nine as the group felt that this was a more clearly spatial policy. Each is linked to the other.

6.16 A spatial plan guides change. Some polices will be spatial and some will be aspatial.

6.17 The group felt that it was positive to include an objective on health inequalities. There was concern that it was not clear which policies in the altered Plan require health inequalities to be addressed. If health is a cross-cutting issue then the objective on health inequalities should have been in the original Plan. Its inclusion now suggests that a wider review needs to take place.

6.18 The group wanted health inequalities to be more explicitly addressed throughout the Plan: the group acknowledged the difficulties of doing this.

- How should this be shown? The matrix approach, used in the original London Plan, was felt to be too complicated and not to add much.
- Targets and indicators were recommended – especially targets.
- Need to find a way to make policies geographically specific.

6.19 Economic development: extract maximum social benefit from economic development. This term was favoured over worklessness and skills as it is more spatial. Jobs, and facilities and infrastructure for jobs, need to be provided where there is most need. We need to support the supply side and not the demand side of the equation. In Outer London there is a gap between provision and need.

6.20 Housing: provision of affordable housing. Again important to extract maximum possible social benefit.

6.21 What is the definition of affordable housing?

- Note: Policy 3A.6 (p57) provides a definition of affordable housing. This policy has been updated: intermediate housing is now defined as being affordable by households on incomes of less than £49,000. The previous limit was £40,000.

6.22 There are two stages of development: construction and operation. Operation brings the benefits – usually to a larger and wider population. Construction: localised adverse effects.

6.23 The London Plan is implemented by local authorities through their Local Development Frameworks.

Diamond Nine

Significant health impact	Notes
1. Reducing health inequalities	tackling social exclusion
2. Economic development	
3. Housing	
4. Worklessness, skills and child poverty	
5. Increasing physical activity	
6. Olympics legacy	
7. Ensuring access to modern health facilities embedded in a social infrastructure	Mitigating the impact of major developments *eg* Olympics construction Impact of wider development
8. Mental health	Accessible open spaces for all: younger and older and disabled Londoners – link to mental health
9. Airport development	

Comments from group facilitated by Nannerl Herriot, RPHG, DH

6.24 Olympics and Paralympics. There was a discussion about how although Olympic were recognised as a good thing there would be disruption to local communities (who are also some of most deprived) for the next 5 to 6 years.

6.25 Challenge of economic growth the impacts on communities and issues of how growth is distributed; if it is not managed it can increase inequalities.

6.26 Need to build social capital in new and existing development

6.27 Integrating infrastructure for new and existing communities through development

6.28 Housing (affordable/healthy/resource efficient) and mixed use developments

6.29 Land-use issues (regeneration/redevelopment/contaminated land/noise)

6.30 Addressing 'health deserts' – areas of deprivation and poor health without access to services and facilities. Identifying areas that are bad for health in a range of ways could allow cross sectoral activities to address 'health' issues in targeted areas.

6.31 Issues of play deprivation in London and impacts on health

6.32 Obesity in children – related to poverty and security issues - potential to use green space and play to tackle 'obesity time bomb'.

6.33 Increasing use of green space for health promotion purposes – as Olympic legacy?

6.34 Emphasis on social inclusion and reducing socio-economic inequalities

6.35 Diversity and equalities (i.e. Access to services and reducing health inequalities)

6.36 Transport and accessibility issues

6.37 Transport and related energy/air quality/climate change issues

6.38 Encouraging modal shift in transport and the problem of transport capacity, what happens if there is not capacity to shift people onto other forms of transport?

6.39 General issues relating to climate change need to sort this out because of the long term impacts.

6.40 What to do with waste – health impacts due to environmental contamination from various waste disposal options and transportation of waste

6.41 Safety and security – fear imposes limits on play/interaction/mobility etc

6.42 Safety and security in terms of urban design issues and terrorist threats.

Diamond Nine

Significant health impact	Notes
1. Balancing economic growth with 'community growth' to maximise local benefits.	tackling social exclusion
2. Integrating communities (new and existing) in development to maintain social capital.	Planning infra-structure so that it is a tool for improving health, locating schools/hospitals/green space etc.
3. Climate change	key driver in all policies, needs to be mainstreamed.
4. Energy	health implications not always understood as part of the rationale for introducing efficiency measures
5. Waste	important to make the link between waste and health to help reduce the amounts produced.
6. Transport	accessibility to services, capacity, mobility.
7. Security – terrorist threats and local fear of crime	Mitigating the impact of major developments *eg* Olympics construction Impact of development
8. Harnessing the potential of green spaces for improving both physical and mental health.	Accessible open spaces for all: younger and older and disabled Londoners – link to mental health
9. Olympics and Paralympics	link to all the above. Legacy effects for community facilities, use of green space, encouraging sports and exercise etc.

Recommendations

6.43 Generally support addition of objectives 2 and 4 – but would like to see greater emphasis on community benefit throughout the plan.

6.44 Suggest a way to measure community benefit – other than putting a price on social infrastructure/community facilities – some kind of community satisfaction measure? Need to have a target that can be used to monitor the impact of the plan and the big issue of whether it is benefiting community.

6.45 Action on monitoring development and growth to enhance community benefit.

6.46 Commitment or reference to integrating new and existing communities – social infrastructure (serving both communities) specifically within objective and policy could be an effective way to achieve this integration?

6.47 Reference to use of S106 funds to support community development (e.g. investing in community development trusts, which can e.g. do local community development activity).

Comments from group facilitated by Nicky Conway, FfF

6.48 Access

- Physical, economic and locational access which leads to social access/acceptability.
- Better access to housing, jobs, health services, transport, environmental benefits and open space.
- Reduce travel times to work (and the environmental impacts/modal shift)
- Improve physical opportunities for all Londoners e.g. disabled and sensually impaired as well as physically able particularly through making walking and cycling a pleasant and safe experience.
- Need for wider access beyond town centres.
- Equitable access, ensure interplay of housing, transport, jobs and location to prevent exclusion and proximity to homes

6.49 Health Inequalities

- Strengthen commitment to monitoring inequalities and link back to evidence base and emerging strategies.
- Lifestyle issues e.g. food access, alcohol misuse and gambling.
- Need monitoring and strengthening of application.
- Protect against administration change.
- Suspect too economically driven.

6.50 Implementation

- Extend the reach of the Plan beyond boroughs to maximise its influence and through:
- planning processes and decisions; use of and access to evidence; interaction with other GLA plans (address through other strategies such as health inequalities, housing and transport etc and need to ensure that it directly influences them especially those coming up for review)
- Should have clear set of implementation principles (use planning as enabling rather than restrictive device)
- Always link back to ongoing work and knowledge base.
- Use signposting methods to further support
- Create LP implementation helpline! Too much supporting documentation won't get used, need direct help.
- Make targets public to inspire people to actually meet them (as alternative to extending requirement of boroughs to other public bodies as unlikely to have powers to do this)
- High levels of community engagement/spirit essential (engage them in reviewing impact on inequalities, LDFs etc). Inspire, which won't necessarily happen through formal processes
- Positive messages and proactive showcasing of what can be done.
- Local influence for strategies and use of neighbourhood examples.
- influence those who are investing in new infrastructure e.g. NHS and other developers,
- proactively engage them to take on board policies
- Should encourage establishment of a multi-disciplinary task force of agencies and communities where carbon reduction is the main focus of joint working
- LDFs key vehicle

- Build on the local planning mechanisms to develop means of ensuring delivery at sub-regional framework

6.51 Affordable and accessible workspace

- Ensure community provision e.g. thing often holding back community arts is lack of workspace
- Sustainable local zones
- Adequate childcare

6.52 Crime and Community

- Address the fear of crime – this is what prevents people from participating more than crime itself
- Links back to sufficient access to key services and open space and therefore tackle exclusion
- Link to health, evidence base and needs of diverse groups.
- HIA recommendations, bringing excluded groups back in. Direct impact on access to opportunities and services.

6.53 Improving streetscape design

- such as pedestrianisation, street clutter. This should apply to existing as well as new areas.
- Safety and security must be addressed.
- Mixed use key, not just concentrations eg. clubs and should be cross-generational (town centres often home of the young, especially at night). Local shops should exist as well as supermarkets. Apply mixed use to localities e.g. high streets not just applying to town centres.

6.54 Environmental inequalities

- Issues of air quality, liveability and environmental equity

6.55 Olympics

- Will LP be published in time to really influence Olympics?
- Should acknowledge much wider impact it will have on infrastructure/facilities across London, not just Lea Valley e.g. social housing
- Opportunity to look positively at Lea Valley
- Use as test case for how other developments could take place
- Olympics site as test base for LP and as a source of evidence about what works.
- What happens to the spaces left from dismantling?
- LP targets and proposals to be considered in development
- Need to ensure flexible future use of site buildings from development

6.56 What about the flood plain?

Comments from group facilitated by Grant Pettitt, GLA

6.57 Important to address health inequalities across the region – need accessible health care for all

6.58 As a term health inequalities is not specific enough though

6.59 The main issues that the group thought were important with regards to health were: housing (affordable and density), open space and play space, fear of crime, access, social infrastructure, employment, health inequalities and objectives

6.60 It was thought that it was important to have explicit objectives around health and health inequalities and then have targets to address those objectives

6.61 There were concerns over how to deliver 'healthy housing' and what the term actually meant

6.62 There is a great need to consider teenagers in the London Plan and facilities need to be provided for them e.g. concrete skate parks, as at the moment they seem to be omitted from the plan. Otherwise they will just reclaim public space and conflicts could arise

6.63 It is also important that play spaces accommodate all age ranges therefore different sorts of facilities have to be provided to suit different needs

6.64 Need more informal spaces for children of all ages to play in – the built environment does not accommodate children, its to car orientated

6.65 It is important to look at issues in an integrated way e.g. housing

6.66 However there is a danger that these new mixed use developments could turn into the slums of the future

6.67 Access should be considered as it helps reduce social exclusion

6.68 Affordability is important in relation to housing

6.69 Link between planning and the market

6.70 The plan encourages people to live where they work, however this does not always work – decentralisation is key and has been shown to work in other countries

6.71 It was pointed out that new towns for commuters were built in the UK, but were not overly successful

6.72 Could have different centres though in the suburbs e.g. major metropolitan centres and encourage more people to live there

6.73 Performance indicators and monitoring are vital in measuring the success of the plan – links to recommendations that can be made

6.74 Planning for leisure is an important issue, as the number of bars can affect the level of crime and disorder

6.75 Joint working is important to deliver the policies outlined in the plan

6.76 Affordable housing is important but need to ensure that it goes to the right people which at present is not always happening

6.77 Need to ensure affordable housing is as good as other housing

6.78 Housing association should be encouraged to ask for larger units – need more planning obligations to ensure this happens

6.79 Mayor will get more housing powers soon – be able to make more of a difference

6.80 The public sector needs to be able to buy into the London Plan – needs to link with LDFs

Diamond Nine

Priority	Comments
1	Health inequalities - mental health, crime and disorder, inter-relationship
1	Health and health inequality - target/measure: different levels
1	Health and health inequality - objective: regionally, sub-regionally, borough, neighbourhood
1	Health inequality - housing/homelessness, waste, Olympics, trees and woodlands
2/3	Design - integrated design principles driven by virtuous cycles. If choose one - housing standards, mixed communities, mixed affordability
2/3	Design - interrelationships between infrastructures, transport, housing development
2/3	Housing - providing affordable housing (promotes social inclusion & positive health benefits); mixed housing developments (aspirational and affordable); housing strategy for first time buyers
2/3	Housing - affordable living: unable to keep cool in summer and warm in winter - link to climate change
2/3	Housing - improvements in quality, housing mix to meet the needs of population, meeting needs of homeless & overcrowded households, providing affordable housing

Priority	Comments
4/5/6	Housing - overcrowding esp council & RSL, disproportionate impact on BME communities, low income, homeless (health and education effects); polarisation (impact on health inequalities); development of new units and increased density - amenities (shops, transport, youth facilities, leisure opportunities, space etc) to ensure sustainability
4/5/6	Housing density may result in mote high rise developments. It is questionable whether these meet the needs of families e.g. opportunity for physical activity/play
4/5/6	Play space - need for 'concrete' play spaces for skateboaders/BMX riders; build in facilities to learn about risk (not design out risk completely)
4/5/6	Play space - the requirement for play strategies from LAs have potential to impact on physical activity and social cohesion; concerns that in high density developments the range of play opportunities will not cover a range of age groups and needs. Also maintenance & security issues.
4/5/6	Access to services - health, transport, education; access to amenities - open spaces, shops (esp. food). Housing alone will not satisfy the health and wellbeing needs of the population
4/5/6	Food access/retail - support actions in the Plan that cover food access - workers/farmers markets; convenience shopping; situating retail in town centres; associated improvements to transport
4/5/6	Social networking affected by poor infrastructure - access to transport , cycle paths/footpaths, play areas for children/teenagers
4/5/6	Social infrastructure - supporting and creating communities; meeting basic needs for health care etc; providing access to services; reducing inequalities
4/5/6	Access - improving mobility of the population; reducing barriers to travel; improve affordability; increasing modal choice (transport)
7/8	Physical activity - linked to sedentary lifestyles, obesity, CVD; promote more sustainable forms of transport; promote use of green and open space; safe 'aesthetic' environments (design, security)
7/8	Open space encourages physical activity; play space for children; can aid integration in an area (local meeting point for communities); place for people to relax and de-stress; safety issues important
7/8	Fear of crime/insecurity - impacts on mental wellbeing; increases social isolation; increases perception of crime
7/8	Employment - hotels, hospitality and business services growth - potential impact of increasing inequalities through low pay and longer working hours

Workshop participants

6.81 40 people from 27 organisations attended the workshop. They are listed below in alphabetical order.

Andrew Attfield .... Barts and the London NHS Trust
Robert Barr .... South West London
Ian Basnett .... North East London
Neil Blackshaw .... NHS Healthy Urban Development Unit
Peter Carey .... London Borough of Camden
Jane Carlsen .... Greater London Authority
Lucinda Carter .... London Development Agency
Ben Cave .... Ben Cave Associates
Roger Chapman .... Government Office for London
Jane Connor .... LB Newham
Nicky Conway .... Forum for the Future
Amanda Cranston .... South West London
Helen Davies .... Health Policy
Alison Dickens .... Haringey Civic Centre
Muge Dindjer .... Greater London Authority
Jenny Douse .... Redbridge PCT
Peter Durrans .... Sport England
Evelyn Gloyn .... London Borough of Ealing
Paul Gocke .... London Development Centre
Nannerl Herriott .... Public Health Group
Robie Kamanyire .... Health Protection Agency
John Levy .... North West London
Caroline Lowdell .... North West London
Estella Makumbi .... LB Ealing
Frances Mapstone .... Policy Support Unit, Greater London Authority
Catherine Max .... London Health Commission
Rebecca Morgan .... Ben Cave Associates
Jonathon O'Sullivan .... Islington PCT
Grant Pettit .... Greater London Authority
Paul Plant .... Public Health Group
Ian Sandford .... Islington PCT
Aideen Silke .... London Development Agency
Sharon Smith .... CIEH London Regional Policy Officer
Rebecca Smith .... Greater London Authority
Drew Stevenson (attended part only) .... Greater London Authority
Emma Synnott .... London Sustainable Development Commission
David Taylor .... Greater London Authority
Dr Ute Navidi .... London Play
Justin Varney .... Public Health Group
Rhiannon Walters .... Walters Public Health

Summary of Diamond Nine

	BC	NH	NC	GP
1	Reducing health inequalities	Balancing economic growth with 'community growth' to maximise local benefits.	Access	Health inequalities - mental health, crime and disorder, inter-relationship
2	Economic development	Integrating communities (new and existing) in development to maintain social capital. Planning infra-structure so that it is a tool for improving health, locating schools/hospitals/green space etc.	Health Inequalities	Health and health inequality - target/measure: different levels
3	Housing	Climate change – key driver in all policies, needs to be mainstreamed.	Implementation	Health and health inequality - objective: regionally, sub-regionally, borough, neighbourhood
4	Worklessness, skills and child poverty	Energy ☺– health implications not always understood as part of the rationale for introducing efficiency measures.	Affordable and accessible workspace	Health inequality - housing/homelessness, waste, Olympics, trees and woodlands Design - integrated design principles driven by virtuous cycles. If choose one - housing standards, mixed communities, mixed affordability
5	Increasing physical activity	Waste – important to make the link between waste and health to help reduce the amounts produced.	Crime and Community	Design - interrelationships between infrastructures, transport, housing development Housing - providing affordable housing (promotes social inclusion & positive health benefits); mixed housing developments (aspirational and affordable); housing strategy for first time buyers
6	Olympics legacy	Transport – accessibility to services, capacity, mobility.	Improving street scope design	Housing - affordable living: unable to keep cool in summer and warm in winter - link to climate change
7	Ensuring access to modern health	Security – (terrorist threats and local fear of	Environmental inequalities	Housing - improvements in quality,

	BC	NH	NC	GP
	facilities embedded in a social infrastructure	crime).		housing mix to meet the needs of population, meeting needs of homeless & overcrowded households, providing affordable housing Housing - overcrowding esp council & RSL, disproportionate impact on BME communities, low income, homeless (health and education effects); polarisation (impact on health inequalities); development of new units and increased density - amenities (shops, transport, youth facilities, leisure opportunities, space etc) to ensure sustainability
8	Mental health	Harnessing the potential of green spaces for improving both physical and mental health.	Olympics	Housing density may result in mote high rise developments. It is questionable whether these meet the needs of families e.g. opportunity for physical activity/play Play space - need for 'concrete' play spaces for skateboaders/BMX riders; build in facilities to learn about risk (not design out risk completely)
9	Airport development	Olympics and Paralympics – link to all the above. Legacy effects for community facilities, use of green space, encouraging sports and exercise etc.	What about the flood plain?	Play space - the requirement for play strategies from LAs have potential to impact on physical activity and social cohesion; concerns that in high density developments the range of play opportunities will not cover a range of age groups and needs. Also maintenance & security

	BC	NH	NC	GP
				issues. Access to services - health, transport, education; access to amenities - open spaces, shops (esp. food). Housing alone will not satisfy the health and wellbeing needs of the population