Public Document Pack

Health and Wellbeing Board

Date: **TUESDAY, 1 APRIL 2014**

Time: **1.45pm**

Venue: **COMMITTEE ROOMS, WEST WING, GUILDHALL.**

Members:
Revd Dr Martin Dudley (Chairman)
Deputy Joyce Nash (Deputy Chairman)
Ade Adetosoye
Jon Averns
Dr Penny Bevan
Superintendent Norma Collicott
Dr Gary Marlowe
Simon Murrells
Sam Mauger
Vivienne Littlechild
Gareth Moore
Angela Starling
Deputy John Tomlinson

Enquiries: **Natasha Dogra tel.no.: 020 7332 1434**
Natasha.Dogra@cityoflondon.gov.uk

Lunch will be served in the Guildhall Club at 1pm

John Barradell
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES OF ABSENCE**

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **MINUTES**
To agree the minutes of the previous meeting.

For Decision
(Pages 1 - 8)

4. **SIGNAGE REVIEW**
Legible London presentation by Iain Simmons.

For Information

5. **TERMS OF REFERENCE**
Report of the Town Clerk.

For Decision
(Pages 9 - 12)

6. **HEALTHWATCH CITY OF LONDON UPDATE**
Report of the Chair of Healthwatch City of London.

For Information
(Pages 13 - 16)

7. **CCG 5 YEAR STRATEGIC PLAN**
Report of the NHS City and Hackney Clinical Commissioning Group.

For Information
(Pages 17 - 28)

8. **CCG INVESTMENT PLAN**
Report of NHS City and Hackney Clinical Commissioning Group.

For Information
(Pages 29 - 36)

9. **JSNA UPDATE REPORT**
Report of the Health and Wellbeing Policy Development Manager.

For Decision
(Pages 37 - 180)

10. **INFORMATION REPORT**
Report of the Health and Wellbeing Executive Support Officer.

For Information
(Pages 181 - 190)

11. **DEVELOPMENT DAY UPDATE**
Verbal update by Health and Wellbeing Policy Development Manager.

For Information

12. **BETTER CARE FUND**
Report of the Assistant Director, People.

For Decision
(Pages 191 - 196)

13. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

14. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

15. **EXCLUSION OF PUBLIC**
MOTION - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act.

For Decision

Part 2 - Non Public Reports

16. **NON PUBLIC MINUTES**
To agree the non-public minutes of the previous meeting.

For Decision
(Pages 197 - 198)

17. **NON PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

18. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE BOARD AGREES SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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HEALTH AND WELLBEING BOARD

Friday, 31 January 2014

Minutes of the meeting of the Health and Wellbeing Board held at on Friday, 31 January 2014 at 11.00am

Present

Members:
Revd Dr Martin Dudley (Chairman)
Deputy Joyce Nash (Deputy Chairman)
Ade Adetosoye
Jon Averns
Dr Penny Bevan
Simon Murrells
Vivienne Littlechild
Gareth Moore

In Attendance
George Gillon CC
Neil Roberts (NHS England)
Janine Aldridge (City Healtwatch)
Anna Garner (City and Hackney Clinical Commissioning Group)

Officers:

Natasha Dogra	-	Town Clerk's Office
Neal Hounsell	-	Community and Children's Services Department
Farrah Hart	-	Community and Children's Services Department
Lorna Corbin	-	Community and Children's Services Department
Simon Cribbens	-	Community and Children's Services Department
Maria Cheung	-	Community and Children's Services Department
Emma Goulding	-	Community and Children's Services Department
Derek Read	-	Department of the Built Environment
Ruth Calderwood	-	Markets and Consumer Protection
Greg Williams	-	Public Relations Office

1. **APOLOGIES OF ABSENCE**
   Apologies were received from Deputy Tomlinson, Angela Starling, Norma Collicott and Sam Mauger

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
   There were none.

3. **MINUTES**
   RESOLVED: That the minutes of the previous meeting be agreed as an accurate record.

Matters Arising:
The Town Clerk informed Members that Vivienne Littlechild's apologies had been received at the previous Board meeting.

4. **AIR QUALITY PRESENTATION**

The Chairman welcomed Dr Iarla Kilbane-Dawe, Par Hil Research Ltd, to the meeting to present a report regarding air pollution in London. Dr Kilbane-Dawe informed Board Members that:

Air pollution was highly localised - exposure increases rapidly with proximity to sources. Exposure is strongly determined by individual's routes or home environment.

Dirty vehicle motors and fuels reduced air quality - diesel is very polluting, but some fuels are cleaner and/or cheaper: petrol, LPG, CNG, EVs. Engine standards proven ineffective, the taxis are especially bad, but quality of evidence is low.

Vehicle motion caused pollution - moving vehicles and heavier vehicles generate PM10 by wearing down vehicle parts and road surfaces.

Inefficient buildings and dirty heating systems caused pollution - building design was often driven by appearance rather than energy efficiency, causing waste. Biomass systems emit extremely high air pollution levels

In response to queries from Members, Dr Kilbane-Dawe advised the following:

- Cyclists and drivers were mostly likely to be affected by poor air quality.
- Air pollution caused by Crossrail building work was higher in certain areas, however research did show that construction sites spread less pollution if they were sprayed down regularly.
- Hackney carriages used diesel fuel ineffectively and the design of the vehicles caused the taxi to emit a large amount of pollution.
- Research showed that coating road surfaces did impact on air quality, as less dust was sprayed into the atmosphere.
- Air quality underground had not been researched, however due to the high dust levels and lack of ventilation it was highly likely that the air quality would be poor.
- It was necessary to involve Public Relations Officers from the offset to ensure that the public were receiving messages about how to protect themselves against air pollution.
- A joined up approach would be necessary to tackle this problem; Committee reports due to be considered by Streets and Walkways Sub Committee may benefit from consultation with the Health and Wellbeing Board Members.
- The public smartphone 'App' had been launched which informed the public of less polluted ways of travelling to their destination.

5. **AIR POLLUTION REPORT**

The Committee received the report of the Environmental Policy Officer, Markets and Consumer Protection regarding air quality in the City. Members noted that

many City policies support action to reduce air pollution and the City Corporation had an Air Quality Strategy outlining action that is being taken. An assessment had been undertaken, by independent consultants, to consider what additional action the Health and Wellbeing Board could take to support a reduction in air pollution, leading to an improvement in the health and wellbeing of City residents and workers.

The assessment suggested that the Health and Wellbeing Board could act to reduce air pollution by considering the scale of the problem, appraising the air pollution benefits of City policies, helping identify important areas for action, embedding knowledge, providing guidance and encouraging the commissioning of information and other services.

The Board noted their role in the assessment of the health needs of the local population in order to inform and guide the commissioning of health, well-being and social care services within the City. Officers informed Members that this was done through the Health and Wellbeing profile, and had historically been completed in conjunction with Hackney Council. The City utilised a public consultation event as the prioritisation framework to identify those issues which would form the priorities in the Health and Wellbeing Strategy. Through public consultation, air pollution was ranked as the third highest public health concern for City residents. Prioritisation is supported by the evidence reviewed for this report.

RESOLVED: That Members requested Officers to:
• conduct a rapid Health Impact Assessment on the Local Implementation Plan of the Mayor's Transport Strategy, similar to the one carried out on the Local Plan.
• assess the air quality implications of the proposals contained within the Area Enhancement Strategies and identify which urban enhancement interventions were the most beneficial from a public health perspective.

6. **COMMUNICATIONS STRATEGY UPDATE**

The Committee received a verbal update from Public Relations Officers who informed the Board of the following:

- Key Officers had met to discuss the very wider range of possibilities there might be for communications in general, ranging from mass-marketing down through to individual briefing of key stakeholders, and including internal communications so that Officers across the City Corporation, for example, know about the Board
- Officers had also liaised with Hackney's with whom good contact had been established
- Officers informed Members that they two more meetings scheduled for 10th and 24th February to map the actual stakeholders and group ideas into a rough draft communications work priorities plan for those stakeholders.
- Officers had established a master Health and Wellbeing Board page on the website that signposts people to key information: www.cityoflondon.gov.uk/HWB

Members noted that the Chairman of Policy and Resources Committee would be hosting a Health and Wellbeing Board Breakfast Briefing on 20th May 2014, which all Members were encouraged to attend.

7. **JOINT STRATEGIC NEEDS ASSESSMENT UPDATE**

The Committee received a verbal update from of the Director of Public Health, and Members noted that the Joint Strategic Needs Assessment had almost completed it's refresh. The Assessment had produced a high quality of census data and showed that the life expectancy in London was higher than other areas. As a quarter of City workers were smokers this issue needed to be tackled urgently.

8. **HEALTHWATCH CITY OF LONDON UPDATE**

The Committee received the report from an Officer of Healthwatch City of London. Members noted that Healthwatch had begun establishing working relationships with the major health providers - Homerton University Hospital, and the hospitals comprising the Barts Health Trust, the East London Mental Health Trust, the City and Hackney Clinical Commissioning Group (CCG) and UCL Health Partners, as well as having planned visits to University College Hospital this year.

In response to a query from Members it was noted that the Corporation had been very helpful in assisting with access and representation on committees such as on the Adult Advisory Group and Safeguarding Group, and their support had been appreciated by the staff team.

The draft priorities for 2014 would be agreed at the Healthwatch Board Development day in January and circulated for consultation in February. After input from Members the priorities would be finalised in February 2014. The future reports would identify progress on the priorities agreed by the membership of Healthwatch City of London, and any urgent items that were identified as part of the routine work of the organisation.

Members were concerned about the low response rate to the survey. Members suggested that the survey should be more interactive to capture as many opinions as possible. Suggestions included visiting GP surgeries to speak with patients after their appointments and advertising the online survey via notice boards including those at the Barbican Centre and Golden Lane Estate. Members requested that the aggregate results be reported back to the Board and NHS England.

In response to a query from Members it was noted that promoting the use of the '111' emergency number was not the responsibility of the Board, as it was an NHS service, and not a key responsibility of Health and Wellbeing Boards.

Members agreed that although the report format was good, it may be useful to have two separate reports in future; one for the Health and Wellbeing Board to

consider important issues, and the other for the Health and Scrutiny Sub Committee to consider scrutiny issues.

9. **BETTER CARE FUND**

The Committee received the report of the Assistant Director of People. Members noted that the Government had announced an Integration Transformation Fund, known as the Better Care Fund, which would give £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. The fund pulled together some existing monies from various grants and gives a small additional pot to develop a more seamless approach between Health and Adult Social Care.

Members noted that funding must be used to support adult social care services in each local authority, that also had a health benefit and it will be a condition of the funding to demonstrate how it would make a positive difference to social care services. Another condition of the funding was that the local authority agrees with its local health partners how it was best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards would be the natural place for discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

A plan proforma would be drafted between the local authority and the CCGs that would be party to the plan. A draft plan must be submitted by the Health and Wellbeing Board to the Local Government Association (LGA) and NHS England by the 15th February 2014 with a final submission at the beginning of April.

A consultation event was held with Healthwatch on the 12th December 2013 on the areas where we think we need to concentrate in delivering services in the future. The plans that will be drawn up will directly reflect the views of our service users, partners and providers taken from the consultation event.
The four key areas are:

- Care in the right place at the right time
- Looking at 24/7 care, reablement and other local services
- Joined up care
- Looking at how we work better with partners to make a seamless service for our users
- Quality of life
- Looking at how we can make things better for people who live in the City
- Caring for Carers
- Looking at how we can support the carers to continue in their caring roles

Members noted that the City of London Corporation would receive an initial allocation of funding to support the transformation in 2014/15 of £41k, with £819k to be allocated in 2015/16. The £819k comprised £775k of BCF funding,

£17k Disabled Facilities Grant funding and £27k Social Care Capital Grant funding. Most of this money comes from existing allocations that we would receive for Social Care. A plan for how the Better Care Fund would be used must be signed off by the Board in April 2014, for implementation in April 2015.

In response to a query from Members it was noted that there would be a number of implications arising from this fund and the proposals that would emerge. It would change the funding streams to Adult Social Care with the creation of one fund that comprises the Carers Grant, Disabled Facilities Grant, CCG reablement funding and transformation funding.

RESOLVED: that Members agreed to a consultation workshop for Members of the Health and Wellbeing Board on the Better Care Fund in early March.

10. **PUBLIC HEALTH CONTRACTS**

The Committee received the report of the Commissioning and Performance Manager. Members noted the proposals for the commissioning of public health services for 2014/15, and the level of funding the City of London Corporation (CoLC) would receive in 2014/15. The proposals were:

- A full review of the Substance Misuse Partnership;
- A full review of the sexual health services;
- A full review of the community engagement role in the Portsoken Ward;
- A full review of the NHS Health Checks contracts and providers;
- A full review of mental health prevention and promotion services;
- The termination of some services under the LB Hackney SLA that are not performing for City residents or workers;
- The extension of all remaining contracts in order for redesign of service (where necessary) and procurement.

The Board noted that from April 2013, public health functions and related funding transferred from Primary Care Trusts (PCTs) to local authorities. Local authorities had a duty to take appropriate steps to improve the health of their population, funded through a ring-fenced grant, and had taken the lead for improving the health of their local population and reducing health inequalities.

RESOLVED: That Members:

- Approved the proposals to decommission the identified LB Hackney lead contracts.
- Approved the waivers to extend the identified contracts by one year, with three month break clauses for 2014/15.
- Approved the waiver for the Boots contract for 2013/14.
- Agreed the requirement to delegate authority to the Town Clerk and Chairman and Deputy Chairman of the Community and Children Service's Committee.

11. **WORKERS HEALTH CENSUS**

The Committee received the report of the Executive Support Officer, providing an analysis of new Census 2011 data on the workday population, and an

update on current workplace health activities that were taking place within the City of London Corporation.

New Census data indicated that the workday population of the City of London was 56 times higher than the resident population, and aged mainly between 20 and 50 years of age, with a higher proportion of males than females.

The majority of City workers either rented privately or own their own dwelling with a mortgage or loan. Many City workers are highly qualified. Around a third of City workers are migrants, and the population was relatively transient. Most City workers perceived themselves to be "in very good health"; however, their current health behaviours may be storing up problems for later life.

Population density in the City was 3,024 per km2 with the usual residents and amounted to 1,242.6 per km2 with the workday population. A total of 360,075 people surveyed by Census 2011 gave a workday location within the City, of whom 359,455 represented those aged 16 and above.

The Mansion House had been booked as a venue for the Workplace Health conference; press releases and invites had been distributed; the website (www.businesshealthy.org.uk) was live, and social media was promoting the workplace health agenda in the City. The Chairman of the Health and Wellbeing Board would also host a special dinner prior to the conference, to further emphasise the City's commitment to workplace health and wellbeing.

Members noted that because the event was being held at the Mansion House, numbers were restricted to a maximum of 150, so "open access" registration for those who have not received a personal invitation was limited.

The content of the conference was currently being formalised – the following speakers were confirmed: Duncan Selbie (PHE) Dame Carol Black (PHE) and the Lord Mayor, Fiona Woolf CBE. The conference would also feature a panel discussion session, for different kinds of businesses to speak about the benefits and issues around workplace health that they have encountered.

12. **HEALTH AND WELLBEING BOARD INFORMATION REPORT**

The Committee received the report of the Executive Support Officer Local regarding the following:

- CityAir App
- City of London Local Plan
- City Health and Wellbeing Library
- London Healthy Workplace Charter
- Fixed Penalty Notice (FPN) Stop Smoking Service Rebate Initiative
- Homelessness Strategy
- Late Night Levy
- Drinksmeter
- City and Hackney CCG Social Prescribing Pilot Project
- Events
- Health Services

- Social Care and Health inequalities
- Mental Health
- Sexual Health
- Environmental Health
- Health and Wellbeing Board Guidance
- Public Health Guidance/Tools
- Global Comparisons

13. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
There were none.

14. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
There was none.

15. **EXCLUSION OF PUBLIC**
MOTION - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act.

16. **COMMISSIONING AND PERFORMANCE REPORT**
The Committee received the report of the Commissioning and Performance Manager.

17. **NON PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
Members raised one non-public question.

18. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE BOARD AGREES SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
There was none.

The meeting ended at 1:10pm

Chairman

Contact Officer: Natasha Dogra tel.no.: 020 7332 1434
Natasha.Dogra@cityoflondon.gov.uk

Committee: Health and Wellbeing Board	**Date:** 1st April 2014
Subject: Terms of Reference of the Health and Wellbeing Board	Public
Report of: Town Clerk	For Decision

Summary

Background
At the meeting on 6th November 2013, the Health and Wellbeing Board approved their current terms of reference. Board Members asked Officers to submit a report to a future meeting regarding Board membership and other organisations who could be consulted for their views on reports and research considered by the Board. The attached Terms of Reference set out the provision for allocating co-opted Members and allowing named substitute members to attend in their place as follows:

Co-opted Members
The Board may appoint up to two co-opted non-City Corporation representatives with experience relevant to the work of the Health and Wellbeing Board.

Substitutes for Statutory Members
Other Statutory Members of the Board (other than Members of the Court of Common Council) may nominate a single names individual who will substitute for them and have the authority to make decisions in the event that they are unable to attend a meeting.

The terms of reference of the Health and Wellbeing Board are attached as an appendix to this report for your consideration.

Recommendations

Members are asked to approve the revised terms of reference of the Board as set out in Appendix 1.

Attachment
Appendix 1 – Revised Terms of Reference

Contact:
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Email:Natasha.Dogra@cityoflondon.gov.uk

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HEALTH & WELLBEING BOARD

1. **Constitution**
   A Non-Ward Committee consisting of

   - three Members elected by the Court of Common Council (who shall not be members of the Health and Social Care Scrutiny Sub-Committee)
   - the Chairman of the Policy and Resources Committee (or his/her representative)
   - the Chairman of Community and Children's Services Committee (or his/her representative)
   - the Chairman of the Port Health & Environmental Services Committee (or his/her representative)
   - the Director of Public Health or his/her representative
   - the Director of the Community and Children's Services Department
   - a representative of Healthwatch appointed by that agency
   - a representative of the Clinical Commissioning Group (CCG) appointed by that agency
   - a representative of the SaferCity Partnership Steering Group
   - the Environmental Health and Public Protection Director
   - a representative of the City of London Police appointed by the Commissioner

2. **Quorum**
   The quorum consists of five Members, at least three of whom must be Members of the Common Council or officers representing the City of London Corporation.

3. **Membership 2014/15**

   2 (2) Gareth Wynford Moore, *for two years*
   2 (2) Vivienne Littlechild J.P., *for three years*
   2 (2) Joyce Carruthers Nash, O.B.E., Deputy

   Together with other statutory and non-statutory Members of the Board.

   Co-opted Members
   The Board may appoint up to two co-opted non-City Corporation representatives with experience relevant to the work of the Health and Wellbeing Board.

4. **Terms of Reference**
   To be responsible for:-

   a) carrying out all duties conferred by the Health and Social Care Act 2012 ("the HSCA 2012") on a Health and Wellbeing Board for the City of London area, among which:-

i) to provide collective leadership for the general advancement of the health and wellbeing of the people within the City of London by promoting the integration of health and social care services; and

ii) to identify key priorities for health and local government commissioning, including the preparation of the Joint Strategic Needs Assessment and the production of a Joint Health and Wellbeing Strategy.

All of these duties should be carried out in accordance with the provisions of the HSCA 2012 concerning the requirement to consult the public and to have regard to guidance issued by the Secretary of State;

b) mobilising, co-ordinating and sharing resources needed for the discharge of its statutory functions, from its membership and from others which may be bound by its decisions; and

c) appointing such sub-committees as are considered necessary for the better performance of its duties.

5. **Substitutes for Statutory Members**
Other Statutory Members of the Board (other than Members of the Court of Common Council) may nominate a single names individual who will substitute for them and have the authority to make decisions in the event that they are unable to attend a meeting.

Committee(s):	Date(s):
Health and Wellbeing Board	1 April 2014
Subject: Healthwatch City of London Update	**Public**
Report of: Chair Healthwatch City of London	**For Information**

Summary

The following is Healthwatch City of London's regular update report to the Health and Wellbeing Board. At the last meeting 30th January, Members suggested that Healthwatch's updates be split to reflect activities more relevant to either the Health and Wellbeing Board, or to the Health and Social Care Scrutiny Board, who also receive updates. These changes have been reflected in this report.

This update covers the following points:

- Healthwatch City of London priorities for 2014/15.
- Evidence session with the London Assembly Health Committee

Recommendation(s)

Members are asked to:

- Note this report, which is for information only

Main Report

Background

1. The recent focus of Healthwatch City of London has been on agreeing and consulting on our priorities for 2014/15 and in developing our mission statement. Since our last report in January we have established, through intelligence from resident and worker feedback, the areas of health and social care that have been highlighted as important. Our priorities have been agreed by the Healthwatch City of London Board and are currently out for consultation with our members and stakeholders. These are presented in the summary below.

Current Position

2. The Healthwatch City of London board agreed, after a vote at the last board meeting that the preferred mission statement is:

"Shaping the best quality health and social care now and in the future for all in the City of London."

With a strapline and acronym of:

Community **I**nvolvement **T**ransparency **Y**our City

3. Healthwatch City of London submitted its first monitoring report on 27 February for the first period April to December 2013 and will submit the next report in May 2014.

4. Detailed below are some activities which have taken into account member feedback from the last two months.

Healthwatch City of London Priorities for 2014/15

5. After discussion at the board development day and agreement at our board meeting Healthwatch City of London has agreed the following priorities which have been circulated to stakeholders for comment. Each priority is linked to the Health and Wellbeing Board Strategy and the CCG strategy.

6. The four priorities agreed for consultation are:

    - Public Health and Community Services
    - Mental Health
    - Dementia
    - Integrated Care

Evidence Session with the London Assembly Health Committee 6 March 2014

7. Chair of Healthwatch City of London, was invited to give evidence to the London Assembly Health Committee to represent the views of local Healthwatch in London. The main purpose of this meeting was to discuss the reforms for health service provision and public health as set out in the Health and Social Care Act 2012. The evidence provided by the Chair covered the following areas:

Whether the 2012 health and social care reforms were working

8. From a Healthwatch perspective the opportunity to provide the user voice for all people from birth to older people was welcome. Often families cannot be pigeonholed when it comes to health and wellbeing as one person in a family's condition will impact on other family members.

9. The opportunity to represent the user voice on the health and wellbeing boards was a real opportunity to bring the user voice into the general policy and decision maker discussion.

10. The Chair mentioned in relation to the City that **having housing in the same portfolio as social care was beneficial** as often the two impact on each other and this is an advantage unique to the City.

11. The Chair also mentioned that the Barbican residents meeting, which brought senior people in the corporation together with local residents, was a good example of **user involvement**.

12. Other points raised by the Chair at the meeting:

    - The importance of investment in long term preventative care
    - The need to take a cross rail approach to investment in preventative care
    - The need to focus on pharmacies for health and wellbeing advice

- The Chair also emphasised the need to use plain language instead of jargon when speaking to the community about health and social care

Conclusion

13. The Chair will report back on items raised in this report in the next report to the Health and Wellbeing board. This will include the results of our current consultation on our priorities and mission statement and information on current activities.

Appendices

n/a

Samantha Mauger
Chair of Healthwatch City of London

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Committee(s):	Date(s):
Health and Wellbeing Board	1 April 2014
Subject: 5 year strategic plan on a page	**Public**
Report of: NHS City and Hackney Clinical Commissioning Group	**For Information**

Summary

NHS City and Hackney Clinical Commissioning Group (CCG) have submitted the attached first draft 5 year strategic plan to NHS England. The plan will be iterated and consulted on through March and April 2014, with final submission in June 2014.

The current draft of the plan outlines our vision, clinical objectives and interventions and how we will manage and monitor progress. Further individual slides provide more detailed information on reducing premature mortality, reducing emergency admissions, our urgent care system, transforming primary care services, safe high quality hospital services, addressing mental health needs and how we will respond to other things we have been told.

Recommendation(s)

Members are asked to:

- Note the report;
- Provide any initial feedback through the course of the meeting, noting that there will be further and more formal routes of consultation commencing shortly, with the HWB and other local partners and patients.

Appendices:

- Plan on a Page;
- Quality Premium 2014/15.

Paul Haigh
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City and Hackney Clinical Commissioning Group

Plan on a Page

1

Our vision for the City and Hackney health economy is:

- Patients in control of their health and wellbeing;
- A joined-up system which is safe, affordable, of high quality, easy to access, eliminates patient waste and improves patient experience;
- A collaborative approach to reducing health inequalities and premature mortality and improving patient outcomes;
- Getting the best outcomes for every £ we invest through an equitable balance between good preventative services, strong primary and community services and effective hospital and mental health services which are wrapped around patient needs;
- Services working efficiently and effectively together to deliver patient and clinical outcomes and providers in financial balance.

2 OBJECTIVE:

4 INTERVENTIONS:

OBJECTIVE	INTERVENTIONS
Reduce premature mortality	Focusing on cardiovascular, liver & respiratory diseases and cancer, commission our providers to deliver: • Earlier diagnosis and treatment; • Social prescribing and integrated preventative services; • Patients supported and empowered to embrace lifestyle changes which will impact on their health.
Reduce emergency admissions	Use the Better Care Fund to: • Ensure services and providers are working in unison to deliver patients' care plans and the system wide metrics we have set; • Achieve better support and quality of life for people with long term conditions and mental health problems.
Transform Primary Care Services	Commission the GP Federation to ensure capacity and capability to: • Deliver proactive services to support integrated care in the community for those who are vulnerable or at risk; • Maintain our demand management work; • Ensure good access to high quality and equity of primary care provision, improving patient satisfaction; • Ensure patients see primary care as their first port of call in and out of hours.
Safe high-quality hospital services	Support Homerton Hospital to deliver: • Strong 7 day DGH services, meeting all performance standards, benchmarked best practice and achieving good outcomes; • Services aligned to patient pathways across primary care and specialist services, ensuring minimal impact on DGH services and patient outcomes from redesigned specialist service models; • Improved patient experience and satisfaction.
Address mental health needs	• Commission access to fast professional care and support to maintain recovery and independence; • Support primary care development and education to deliver more community based provision and parity of esteem.

5

Overseen by:

- Shared senior system leadership to define our ambitions, oversee delivery of objectives and implementation and impact of plans;
- Alliance contracts to align individual organisational and service responsibilities within a clear performance framework;
- Patient and clinical leadership of all initiatives;
- Transparency, bottom up engagement and honesty in line with our values.

3

Measured by:

- User, clinical and process outcomes for each service, contributing to and delivering system outcomes;
- KPIs across aligned contracts and tracking system -wide changes in activity and spend;
- Financial balance maintained and all providers remain viable and without significant performance concerns.

City and Hackney
Clinical Commissioning Group

Reducing Premature Mortality

WHY?

- We have worse mortality than London and the rest of England:
- CVD mortality rate is 89 deaths per 100,000 locally compared to 66 across England and cancer mortality rate is 142 deaths per 100,000 compared to 122 nationally.
- Life expectancy in males is 1.6 years lower in C&H than in England (with 3 years gap between the most and the least deprived in C&H).
- Our patients have told us they want more support, help and education to manage their conditions.
- 59% of people locally feel supported to manage their LTC compared to 69% nationally.

WHAT?

- We are investing £2m in a comprehensive programme to commission our GP practices to identify and diagnose patients at extended risk and to initiate treatment and management;
  - This will focus on people with, or at risk of, cardiovascular, respiratory or liver diseases;
- We will also commission our practices to offer an extended consultation on initial diagnosis, train our practice staff in improved consultation skills to ensure care plans are agreed with each patient and ensure more peer education and support is available for patients;
- We are commissioning a greater focus at Homerton Hospital on supporting and managing people with Long Term Conditions to join their work up with what our practices are doing. This includes introducing new services for people with LTCs to ensure these focus on improving quality and outcomes, (staff to review care plans when people are in hospital, improve communication about changes to care plans, link up patients with community education and support) and ensuring outpatient and diagnostic services will complement the work of our practices;
- We are investing a further £600k to extend our social prescribing scheme so that more GPs can refer more patients to healthy living and wellbeing interventions in the community and that our patients have better knowledge of the support available to them;
- We are working with our Local Authority Public Health commissioners to link up our plans as their work on tackling obesity, alcohol and smoking can make the biggest impact on reducing premature mortality;
- By spring we will develop a programme with our GPs, patients and partners to work out how we can improve early diagnosis of cancer and reflect the recent recommendations in the report of the Health in Hackney Scrutiny Committee.

City and Hackney
Clinical Commissioning Group

Reducing Emergency Admissions

WHY?

We have increased our focus on emergency activity as we want people to be cared for safely at home wherever possible and the new Better Care Fund gives an added impetus to this.

We appear to perform relatively well compared to London and the rest of England on the number of emergency admissions per 1000 people (on average 1950 emergency admissions per month). 17% of these admissions are in the over 75s and our rate of emergency admissions in the over 75s per 1000 people is greater than across London. Whilst we are ambitious to make improvements we don't believe there is scope to safely reduce these by more than about 2%.

Although this initiative won't save us significant amounts of money we believe it will make a difference for our patients in the quality of care and services they receive and in minimising unnecessary hospital stays.

WHAT?

- Our newly commissioned reablement and intermediate care service starts this spring which is a joint service between Homerton and social care and is aimed at providing one point of access and a rapid response to care for people safely in their homes;
- We have also commissioned a new £600k service in conjunction with our GPs and the London Ambulance Service called Paradoc which ensures a GP and paramedic can respond to an urgent call, visit the individual and ensure that there is support and care available to keep them at home and avoid having to go to hospital;
- We are also investing over £3m on commissioning our practices to identify vulnerable and at risk people to develop care plans with the individual patients and put these in place ,and undertake regular proactive home visits. We are investing in more staff in Homerton and our other community providers to ensure that they can wrap their staff and services around what our GPs are doing to ensure that strong clinically led multidisciplinary teams are delivering the agreed care plans of our patients;
- We are investing in an Observational Medical Unit at Homerton A&E to quickly treat patients referred by GPs with certain conditions and we are also commissioning a range of consultant advice lines and urgent clinics coupled with rapid access diagnostics so GPs can get a quick diagnosis and put a care plan in place for someone in the community;
- From the spring our practices, GP out of hours provider, and Homerton Hospital will be able to see the medical records that each has about our patients. This will really help improve care for people who present at Homerton or to CHUHSE as emergencies to make sure they get the right support.

Alongside all of this we already have a wide range of commissioned services which are all focused on helping people to be cared for in their home environment and these will become the focus of our Better Care Fund.

In association with our fellow commissioners of adult social care in our two Local Authorities we will use the Better Care Fund to support our providers to work together really effectively to care for as many people as possible in the community in line with their care plans, improve the hospital discharge experience and reduce any delays ,and support more people to die outside a hospital setting if that is what they want.

Whilst the Better Care Fund has a national focus on adults, locally we are also looking at emergency admissions for children to Homerton and have commissioned an expansion to the children's community nursing team to support more children and their parents in the community and support earlier discharge. We also want to develop a programme with Homerton to look at whether their community services for children could do more to avoid hospital admissions and manage more children at home. Over the next year we will have a particular focus on asthma and on supporting our practices to identify children at risk so that they can put In place the necessary support and care plans.

City and Hackney
Clinical Commissioning Group

Our Urgent Care System

WHY?

As well as our work on emergency admissions we are maintaining our focus on the wider urgent care system for our patients, recognising that at the moment a higher proportion of our residents access A&E for urgent care than elsewhere in London.

We are fortunate that locally the Homerton delivers really strong A&E performance for sick people but we need to ensure we have a good wider urgent care system both in and out of hours which meets the needs of our patients and that our patients see primary care as their first point of contact for all non-emergency issues both in and out of hours.

WHAT?

Last year we commissioned our new out of hours GP service from a new local GP led social enterprise - CHUHSE - and already have seen more people use the service. Over the next year:

- We will be investing in four practices across City and Hackney to open at the weekends and later in the evening to improve GP access for our patients;
- We are commissioning Homerton to help people who are using A&E and don't have a GP to register with a local GP and plan to extend this service to Hackney Service Centre so that more local people can register with our GPs;
- We have commissioned our GP out of hours provider to have community nurses working alongside them to provide more holistic care for our patients overnight and at weekends;
- We will be working with our Urgent Care Programme Board to think about how we could redesign the current PUCC service at Homerton to better meet the urgent care needs of our patients;
- We will be launching a big local campaign on how to access urgent care services, encouraging people to see their GP as their first port of call in and out of hours, and how to register with a GP.

City and Hackney
Clinical Commissioning Group

Transforming Primary Care services

WHY?

Many people believe that the current model of primary care needs to change and adapt to better meet the needs of people in the 21st century.

Locally we are fortunate to have a good range of well performing practices that have been commissioned to offer a range of expanded services to support our patients and take forward our plans.

However we aren't complacent.

Our patients told us that they wanted a GP out of hours service they knew about and had confidence in - we addressed this and now have a new service run by local GPs.

Our patients are telling us that they are struggling in some cases to get access to primary care and are going to A&E to seek help, even when their practice is open and that there are differences between what different practices offer.

WHAT?

Our 44 member practices are developing a Federation. The precise model is still under discussion across the GP provider community but their plan is to create a GP-led not for profit umbrella organisation which can provide help and support to practices with the delivery of services and will give other local providers one organisation to talk to who can represent practices as we try to ensure the integration of local services. For commissioners we hope it will enable us to enter into contracts with one organisation who will ensure that all our patients can access the services we are commissioning from primary care and ensure uniform high quality standards and outcomes - we will be exploring this approach over the course of the next 12 months and how this progresses will help inform the delivery of our strategy in the medium term.

We will be commissioning the following new services from primary care:

- Extended evening and weekend opening hours in response to patient feedback;
- Duty doctor service to respond to urgent requests for support from patients and other providers;
- Identification of vulnerable older people, development and agreement of care plans, proactive home visiting service;
- Identification and early diagnosis of people at risk of coronary heart disease, respiratory disease and liver disease including access to support, advice and education and longer initial consultations;
- Managing people with mental health problems;
- Seeing each woman during her pregnancy and after delivery to ensure that her needs are being met;
- Focusing on proactively reviewing all children and ensuring that care plans are in place with a specific focus on the management of asthma and ensuring support is available to children and their families;
- Ensuring high quality prescribing practice.

Our GPs have also worked really hard over the last six years with consultants at Homerton Hospital to improve care for our patients, eliminate waste and make care as seamless as possible. We will be maintaining this focus through our clinical leadership work with Homerton, our Planned Care Board and our consortia by developing more pathways and improving access to diagnostic investigations .

City and Hackney
Clinical Commissioning Group

Safe high quality hospital services

WHY?

We want to make sure that the experience of our patients when they have to go into hospital is first class and that services are safe and of high quality.

Most of our patients use Homerton Hospital and we are fortunate that it is efficient with good standards and outcomes.

Patients have told us that they would like to see better join up between hospital services and primary care and a reduction in waste in hospital - wasted appointments where there isn't the information available to treat them, duplicate tests, poor communications.

These issues seem to be more of a problem at non-local hospitals - people are broadly complimentary about the services at the Homerton but feel that they have more to do around addressing feedback from patients and staff attitudes.

WHAT?

We will continue to work with Homerton to ensure that it stays a high performing organisation and that it can meet any new quality or performance standards which are introduced and can meet the challenges of ensuring great services seven days a week.

The three main areas of work for us over the next year are:

- Supporting the work which Homerton is doing to improve patient experience in some areas - particularly care of the elderly and post natal care - and linking up with the views of our patient and public involvement groups, Healthwatch, our GPs and other stakeholders to ensure that concerns are being addressed and patient satisfaction and empowerment is core to how Homerton - and other providers - design and deliver their services;
- Making sure that we are working with clinicians at the Homerton to monitor, investigate and learn the lessons from complaints, incidents, outbreaks of infection and any avoidable deaths;
- Working with our colleague CCGs to understand the implications of emerging models of specialist care commissioned by NHSE. We want to ensure that we have integrated pathways from presentation in primary care to hospital treatment and need to make sure that the NHSE reviews of specialist service provision across London do not worsen access, outcomes or quality for our patients nor destabilise any local services and pathways.

City and Hackney
Clinical Commissioning Group

Addressing Mental Health needs

WHY?

Our population have high mental health needs:

- 50% of all women and 25% of all men are affected by depression at some point in their lives;
- 4-5% of people have a diagnosable personality disorder;
- People with schizophrenia are likely to die 15-25 years earlier than others;
- Dementia affects 5% of all over 65s and 10-20% of the over 80s.

We appear to spend more money on mental health services than elsewhere in England and so we need to ensure that every £ is really addressing the mental health needs of our patients and really improving outcomes.

WHAT?

- We are just commissioning a new service at Homerton to ensure a rapid assessment of people with mental health problems in the hospital wards and in A&E and to help support safe and rapid discharge;
- As part of our work on parity of esteem, we have also transferred the management of some patients with mental health problems to primary care. Our clinicians have now agreed to take a further step - discharging more patients over the next twelve months and reinvesting the savings in an extended primary care mental health service;
- We are working with our Local Authority Public Health commissioners to align the health and wellbeing and prevention services they commission with our CCG plans;
- We are investing in community provision for dementia sufferers and their carers and are commissioning all our providers to increase the rate of diagnosis of dementia and ensure that advice and support is available to people diagnosed and their carers;
- We are investing in a training programme for community staff to recognise the symptoms of psychosis in order to enable swifter referrals;
- We will make sure that every patient with mental health problems has a recovery plan which has an introduction to benefits and employment support;
- We are continuing to commission shorter waiting times for psychological therapy assessment and treatment services and will commission an extended range of interventions.
- We have recently published a Joint Framework for CAMHS services to improve outcomes and promote early interventions.

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Clinical Commissioning Group

Responding to other things we have been told

WHY?

Our patient and public involvement groups who work with our practices and with our Programme Boards are an incredibly rich source of useful and powerful information about what we need to change and why.

We also spend a lot of time listening to the views of our 44 GP practices - they are in direct contact with our patients every day, work with local services and have a great understanding of what's actually happening "on the ground".

WHAT?

So we are making lots of other changes - which don't fit neatly into the other headings but are just as important if we are to meet our vision of making a difference for our patients.

We will:

- Spend about £500k to commission a range of innovative ideas to respond to what our patients told us needed to change at our “Call to Action" event last November. We are currently developing the ideas with our patient representatives and working out how best to commission them. Once we have our list we will let you know what we are doing and why;
- Improve the way that wound dressings for our patients are provided and managed in the community. We think there is a lot of waste and duplication and the current service isn't as responsive to the needs of our patients as it ought to be;
- Commission a better spread and availability of diagnostic tests for patients in the community - blood tests, spirometry, ECG amongst others;
- Commission a new community based service to test people for glaucoma and monitor the results which should result in fewer trips to hospital for check ups;
- Improve the way that people with pain and those needing joint surgery are cared for and treated - we think we could really streamline the pathway and better join up services so our patients don't need as many trips to hospital, provide much better information to our patients, and improve overall quality and satisfaction;
- Continue to develop and review pathways with Homerton for a range of conditions to maximise the role of our practices and improve patient information;
- Develop a new pathway for the antenatal care of vulnerable women and work with colleagues to develop an improved offer for our 0-5 year olds.

Quality Premium 2014/15

Total value to CCG: £5 per head of population @ 280,000 = £1.4million

Measure 1: Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people

- Target: 3.2% reduction between 2013 and 2014 calendar years
- Current data: PYLL is higher than London and England, and has been steadily decreasing in Hackney since 2008 but large increases in the City of London in 2012 and 2010 has caused the rate across City and Hackney to remain the same level
- Value: 15% of quality premium = £210K

Measure 2: Improving access to psychological therapies (IAPT)

- Target: Increase access rates to IAPT (proportion of people with anxiety/depression accessing IAPT) by 3% (from current baseline of 15%
- Current data: Access rates have sharply increased from 5% to 15% across the last 2 years, but are now running at capacity providing for that 15%
- Value: 15% of quality premium = £210K

Measure 3. Avoidable emergency admissions

- Target: Reduction/0% change/remain below 1000 admissions per 100,000 population across 4 measures:
  - unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults);
  - unplanned hospitalisation for asthma, diabetes and epilepsy in children;
  - emergency admissions for acute conditions that should not usually require hospital admission (adults);
  - emergency admissions for children with lower respiratory tract infection.
- Current data: Very low rates for these 4 indicators: 1140 admissions per 100,000 population. Have independently verified this data using HES, still unclear why such low rates.
- Value: 25% of quality premium = £350K

Measure 4. Friends and Family Test

- Target: Agree plan for addressing issues from FFT in 2013/14; Achieve these actions; Achieve reduction in negative responses from FFT; Achieve improvement in average score and reduction in negative responses for locally chosen metric: Inpatient survey
- Current data: Low response rates for FFT and inpatient scores lower than London or England (A&E scores higher than London or England).
- Value: 15% of quality premium = £210K

Measure 5. Improved reporting of medication-related safety incidents

- Target: Increase level of reporting of medication incidents at chosen local provider: ELFT
- Current data: Very low levels of reporting historically (in bottom quartile of all MH trusts: 9.9 incidents per 1000 bed days compared to MH trust median of 23 per 1000 bed days; April-September 2012) but improving over 2013/14
- Value: 15% of quality premium = £210K

Measure 6. Further local measure

- Target: Increase % of people diagnosed with diabetes within the last year referred to structured education, to 25%
- Current data: 5.4% from 2011/12 diabetes audit
- Value: 15% of quality premium = £210K

Where a CCG does not deliver the identified patient rights and pledges on waiting times, a reduction of 25 per cent for each relevant NHS Constitution measure will be made to the quality premium payment.

	Target threshold for 2014/15	**Current performance**
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	90.9% (Apr-Nov 13)
Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	95%	*NHS England has not yet supplied the Provider/CCG mappings that will be derived from HES figures for A&E waits all types.*
Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer	100%	94% (Oct 13)
Category A Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes	75%	76.5% (Apr-Oct 13)

Committee(s):	**Date(s):**
Health and Wellbeing Board	1 April 2014
Subject: Investment Plans	**Public**
Report of: NHS City and Hackney Clinical Commissioning Group	**For Information**

Summary

The Clinical Commissioning Group (CCG) Board met on Friday 28th February 2014 and agreed the attached. This outlines an exciting range of new services and initiatives we are commissioning to improve care for our patients, using CCG investment of nearly £18m to tackle important local issues identified by our patients and our clinicians.

The paper outlines the process we have gone through and we were delighted to have the input of our Healthwatches and of Public Health to help us reach our decisions.

We wanted to share this with you and would be happy to provide you with any more information on this, or on specific initiatives.

Recommendation(s)

Members are asked to:

- Note the report.

Appendices:

- Investment Plans presentation.

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INVESTMENT PLA NS

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CONTEXT

- At the September 2013 CCG Board meeting it was agreed to establish a Prioritisation Sub Committee to consider investment proposals developed by CCG Programme Boards to take forward CCG commissioning plans
- The members of the Sub Committee are
  - Jamie Bishop (Chair); Christine Blanshard; Clare Highton; Gary Marlowe; Paul Haigh; Philippa Lowe; representatives from Hackney and COL Healthwatch; Ash Paul (LBH Public Health consultant)
- The Sub Committee met on 6 December 2013
  - At this meeting an initial sift of proposals was undertaken, reviewing these using a prioritisation framework to assess impact
  - Agreed that initiatives should deliver CCG outcomes and improve quality, innovation or deliver recurrent commissioner savings
  - The Sub Committee agreed further work was needed to address these points and feedback was given to Programme Boards

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- The Sub Committee met again on 7 February
  - At that meeting revised proposals were considered and it was agreed to
    - Endorse investment in 2014/15 of £9.8m with a further £7.2m year 2 spend in 2015/16 – details outlined in the Appendix
    - Ask the CCG Chair, Chief Officer and Chief Finance Officer to take delegated responsibility to endorse final service specifications and contractual arrangements
- A report will be made available to the Board in September to update on implementation
- The Clinical Executive Committee will review impact of each scheme by Programme Boards in May/June 2015

- It is noted that the Sub Committee should meet again in April/May to consider any further investment proposals (given that some were deferred as needing more work)

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FRAMEWORK

- The Prioritisation Sub Committee agreed the following framework for investment
  - Approved initiatives would be funded for 2 years on a non recurrent basis to ensure that impact of the schemes can be assessed
  - All initiatives to be implemented with a contract with the lead provider covering
    - A clear service specification outlining clinical, process and patient outcomes expected to be delivered
    - KPIs by which performance will be assessed and payment made
    - Each initiative to have “impact markers” – ie where commissioners expect to see reductions in spend.
  - All proposed contracts with practices as providers are subject to the scrutiny of the CCG Audit Committee

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SUMMARY OF INVESTMENTS

OBJECTIVE	SUMMARY OF SCHEMES AND YEAR 1 SPEND
Reducing premature mortality	Long term conditions contract to increase prevalence and treatment – 950k Extension of Social Prescribing project – 605k Extension of Homerton COPD team – 143k
Empowering patients	People in control patient education programme - £310k – subject to revised business case in April Innovation fund to take forward public Call to Action priorities- £400k
Improving urgent and emergency care	PARADOC – GP and paramedic home visiting service – 615k Extended access and duty doctor arrangement in practices – 1825k Additional out of hours centres – 20k Non clinical navigators in A&E – 285k Community nursing support to out of hours service – 163k
Improving care in the community	Proactive home visiting service to vulnerable patients – 788k Integrated care and support to vulnerable patients – 1500k Supporting provider collaboration to reduce emergency admissions - 700k Medical reviews during pregnancy to identify at risk women -250k Identifying and supporting vulnerable children and tackling asthma – 820k Commissioning a community glaucoma screening service -200k Improving wound management services -100k
Improving hospital services for people with Long term conditions	Pulmonary rehabilitation for people with heart failure – 35k
Improving mental health services	Transferring more MH patients to community care and commissioning enhanced support – 70k (project management to implement a proposal which is expected to be cost neutral)
Improving prescribing	A range of initiatives to improve prescribing practice -553k

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Committee(s):	Date(s):
Health and Wellbeing Board	01 April 2014
Subject: JSNA update report	**Public**
Report of: Health and Wellbeing Policy Development Manager	**For Decision**

Summary

In September 2013, members of the Health and Wellbeing Board agreed the proposal to refresh the Health and Wellbeing Profile (shared with LB Hackney) and to produce a JSNA City Supplement. The two draft documents have been produced in parallel and contain a number of new findings relating to City and Hackney residents; and other City populations.

As the Health and Wellbeing Profile is a data refresh document, it does not require consultation; however, the JSNA City supplement is a new document and should undergo a period of public consultation.

Recommendation(s)

Members are asked to:

- Note the refreshed Health and Wellbeing Profile dataset
- Approve a period of public consultation for the JSNA City Supplement, with the final draft coming to the next Health and Wellbeing Board for sign-off on 30th May 2014.

Main Report

Background

1. In September 2013, members of the Health and Wellbeing Board agreed the proposal to refresh the Health and Wellbeing Profile (shared with LB Hackney) and to produce a JSNA City Supplement

Current Position

2. The two draft documents have been produced in parallel and contain a number of new findings. Please note: the JSNA City Supplement is in a draft format, and still requires proofreading and harmonisation of tables and figures.

Health and Wellbeing Profile (shared with LB Hackney)

3. The aim of the statistical update was to ensure that the data within the existing Profile was accurate and that the narrative and text remained as relevant as possible. This work has now been completed by LB Hackney, with extensive input from the City's officers.

4. There are areas that have seen significant additional information published; for example, population data from the Census 2011. In addition, the adult social care landscape has undergone significant changes.

5. The demographic data shows that the population of City and Hackney continues to grow, particularly in working age people, but the number of over 65's is expected to rise the fastest in the next 25 years. Fertility rates continue to decline while life expectancy rates continue to rise. Accordingly demand for adult social care services will continue to increase.

6. A wide range of health outcomes and risk factors in the area are shown to be linked to deprivation, age, gender and ethnicity.

7. There are a number of trends of interest, which will need to be scrutinised further and accounted for within delivery planning.

8. In particular, consideration will need to be given where members of the HWB do not have accountability or resources for delivery, for example immunisations and vaccinations.

9. The key trends arising from shared City and Hackney data are:

- Immunisation rates for children in Hackney and the City have been improving steadily, with marked improvements over the last year.
- Flu vaccination uptake remains high, in comparison with London.
- In 2012/13, the caseload for Open Doors work in Hackney and the City showed an overall decrease in the number of street sex workers supported by the service.
- GP recorded obesity in adults has fallen slightly again, but this remains higher than London as a whole.
- There was an outbreak of measles in December 2012 and marked increase in cases of pertussis (whooping cough).
- Reported sexually transmitted infections (STI) and HIV incidence remains high compared to England.
- There are reports of increases in child dental decay and local research highlights high rates of decay and poor mouth hygiene in adults.
- There has been a small decrease in breast cancer screening coverage
- Childhood obesity in state school students remains high.

- New data suggests that 25% of City and Hackney residents are smokers. This is the highest rate in London. A survey in 2012 also found that 25% of City workers smoked.

10. It should be noted that this review did not include an update to Section 2: Society and the Environment. Along with some other sections, these will be updated as part of a full refresh of the Health and Wellbeing Profile to begin this year.

11. The document can be read and accessed at: http://www.hackney.gov.uk/jsna.htm

12. In addition in-depth needs assessment for alcohol, substance misuse and mental health are currently being prepared, which will report separately to the HWB upon completion.

JSNA City Supplement

13. The JSNA City Supplement has been produced to give an overview of the health needs of the key populations in the City, including those communities not covered by the Health and Wellbeing profile.

14. Selected key findings are as follows:

Residents

- The City's resident population is projected to grow slowly in the upcoming decades, with those aged 65 and older projected to contribute the most to the growth.
- Almost 40% of City residents are migrants.
- The City's residents are predominantly White and speak English as their main language.
- There are relatively few families and few births in the City. The majority of households in the City are single person.
- Of children and young people aged 0-19 in the City, 43% are from Black and minority ethnic (BME) backgrounds.
- Children in the City have excellent early years provision and perform very well in primary school.
- Local figures identify that 21% of children living in the City of London are in low-income households. Previous national figures calculated that 19% of children in the City live in poverty.
- 22.3% of primary school children are eligible for and claiming free school meals.
- The City has a very low rate of fuel poverty.
- Unemployment is a significant contributor to poor health and wellbeing. There are discrepancies in unemployment in working-age residents between the different housing estates in the City.

- Unpaid carers provide vital support to vulnerable people in the City, and it is important that they receive appropriate support.
- The profile of residents using treatment services has changed from unemployed homeless drug misusers to those who are in stable housing and employment who have an alcohol problem
- Life expectancy is expected to remain high amongst City residents: incidences of age-related health problems such as reduced mobility, dementia and social isolation, as well as the need for additional support and care, are likely to increase.
- Adult social care in the City has been modernised, and most users of adult social care are happy with the service they receive.
- Introduction of the Better Care Fund may enable better joined up working between healthcare and social care services.
- 20% of City residents are registered with GPs outside the City – this has implications for how cross-border health services are provided.
- Deaths from all cancers and from premature cancer are well below the average for London, and premature deaths have fallen markedly over the last 6 years.

City workers

- The workday population in the City is 56 times higher than the resident population.
- City workers have a male-dominant and younger age profile (20-50 years old) compared to the resident population.
- City workers are a transient population and about a third are migrants.
- Most City workers perceive themselves to be in “very good health”; however independent reports suggest that alcohol, smoking and mental health remain major risk factors.
- Low paid migrant workers are at greater risk of poor health due to decreased access and increased costs to care.
- Between 2001 and 2012, the City of London saw the biggest increase in employees across 983 areas in London (36%) with Finance remaining the dominant sector in the City
- The majority of City workers (two thirds) are university graduates, which is twice than the London average.
- City workers smoke more than the London average. Quitting rates amongst City workers are relatively successful (50%).
- Alcohol misuse amongst both male and female City drinkers is considerably higher than national averages. Young white males are the predominant alcohol misusers.
- Over a fifth of City workers report suffering from depression, anxiety or other mental health conditions with a third reporting that their job causes them to be very stressed on a regular basis.
- The younger age profile of City workers also puts them at greater risk of sexually transmitted infections and for drug misuse.
- The City has been working to promote workplace health within the Square Mile and to develop support for businesses to achieve this. The City has commissioned research and initiated a business network.

- Many City workers, particularly those in lower-paid sectors and roles, find it hard to access primary care services, as doing so requires taking time off work for appointments.
- One-third of City workers would choose to register with a GP near to work rather than near to home, if they were allowed.
- Musculoskeletal, respiratory and mental health problems are the major health conditions identified by City workers.
- It is likely that many City workers have caring responsibilities.

Rough Sleepers

- The City has the sixth highest number of rough sleepers in London
- Rough sleepers in the City are predominantly male and the majority are between 20-50 years of age.
- About half of the rough sleepers are British nationals and the remaining come from Eastern Europe.
- Over half of the rough sleepers have alcohol problems and mental health problems, and almost a third have drug problems.
- The City provides a wide range of services to help rough sleepers leave the streets, and has received several awards for innovation in this area.
- Rough sleepers are particularly vulnerable to smoking, alcohol misuse, substance misuse and sexually transmitted diseases, and may encounter barriers to accessing services for these health issues.
- Rough sleepers tend to have co-morbidities, and are likely to use A&E much more than the general population.
- Rough sleepers are particularly vulnerable to infectious diseases, for example, tuberculosis.
- In the City, GP registration for rough sleepers is a priority. Rough sleepers can register with two local GPs practices.

General

- Over nine in ten residents, workers, executives and businesses are satisfied with the City as a place to live, work and to run a business.
- Health based targets for air quality are not being met. Air quality is a challenge in the City due to its central location and the vast transport network catering to the large daytime worker population. The City has been responding with initiatives to improve air quality and to reduce the population's exposure to air pollution.
- Increases in cycling in the City have been accompanied by an increase in traffic casualties. The City is urgently reviewing options for reducing road danger.
- The City is mainly covered by office buildings and lacks green space. Many cultural assets are available to residents and City workers. Despite this, social isolation may be an issue.
- Crime rates in the City are falling overall; however, some categories of crime are increasing.

- The majority of City workers and residents are either homeowners or rent privately, with both groups showing fewer social housing tenants than the national average.
- The City has a new responsibility for coordinating and implementing work on suicide prevention; however, as very few people in the City are residents, there is a limit to what can be done locally.
- 23.7% of incidents reported to the City police were alcohol related or connected to licensed premises.
- More women than average do not participate in the recommended levels of physical activity (both residents and non-residents).
- There is a potential to expand services in pharmacy to meet local health needs. Many residents use community pharmacists which are located outside the City; however, pharmacies can also be used to deliver services to City workers.
- The City has a vibrant voluntary and community sector, as well as a time credits scheme, which help to strengthen and build communities.

Proposals

15. Public consultation has been ongoing throughout the process of producing both the City Supplement and the Health and Wellbeing Profile. Now that both documents are in draft format, a series of stakeholder events are currently being organised to engage with communities in Hackney and the City.

16. As the Health and Wellbeing Profile is a data refresh document, it does not require extensive consultation; however, the JSNA City supplement is a new document and should undergo a period of public consultation.

17. It is proposed that the draft version of the JSNA City supplement be circulated to stakeholders for comment and consultation, before bringing the final draft of the JSNA City supplement to the HWB on the 30th May.

Implications

18. The Health and social Care Act 2012 ("2012 Act") amends the Local Government and Public Involvement in Health Act 2007 ("2007 Act") to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs through the Health and Wellbeing Board.

19. s.116 of the 2007 Act (as amended by section 192 of the 2012 Act) requires a local authority and each of its partner CCGs to prepare JSNA and JHWS. Section 116A (as inserted by section 196 of the 2012 Act) provides that these functions are to be exercised by the Health and Wellbeing Board. Although the NHS Commissioning Board (NHSCB) is not a core statutory member of Health and Wellbeing Boards it must participate in JSNAs and JHWSs. The Health and Wellbeing Board also has a duty to involve the public in the preparation of the JSNA and JHWS.

20. The 2012 Act provides that the preparation of the JHWS and JSNA are functions of the Health and Wellbeing Board and so they are not executive functions.

Conclusion

21. The City of London has a duty to prepare JSNA and to involve the public in this process. The Health and Wellbeing Board is making good progress in this respect, and will have two very useful documents at the end of this process, which will form a valuable body of intelligence for informing commissioning.

Appendices

- Appendix 1 – City and Hackney Health and Wellbeing Profile (JSNA data update, January 2014) (www.hackney.gov.uk/jsna)
- Appendix 2 – JSNA City Supplement

Background Papers:

City and Hackney Health and Wellbeing Profile – 5th September 2013

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City of London Corporation

City Supplement

Health and Wellbeing Profile

Joint Strategic Needs Assessment

Document Control

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Acknowledgement

We would like to thank the public health team at the London Borough of Croydon for their innovative approach to JSNA, which has been instrumental in shaping this document.

1. Background

City and Hackney Joint Strategic Needs Assessment (JSNA)

The City of London has a statutory duty to conduct Joint Strategic Needs Assessment (JSNA). It is a process which examines the health and wellbeing needs of the people in the locality. The City currently conducts Joint Strategic Needs Assessment with the London Borough of Hackney, as we share a health budget, and much of our data is currently aggregated with Hackney. This joint document is published as The Health and Wellbeing Profile.

JSNA brings together detailed information on local health and wellbeing needs and looks ahead at emerging challenges and projected future needs. The JSNA is an on-going, iterative process, led by Public Health and involving The City of London Corporation (Children and Community services), City and Hackney NHS Clinical Commissioning Group (CCG), City of London HealthWatch, the voluntary and community sector and other partners.

The City Supplement - A City Digest

This City Supplement is the first report to pull together all data that is available and disaggregated, specific to the City's population. This includes evidence from the City and Hackney JSNA, as well as from any independent reports commissioned by the City to inform the health needs of the City's population.

The City and Hackney Health and Wellbeing Profile was refreshed in January 2014. Although this refresh has met the statutory minimum requirement, it does not provide all the information required to commission local services in the City, nor does it provide a complete sense of the City as a separate place to Hackney.

As a result, this City Supplement has been produced to provide a City focused health and wellbeing profile, as requested by the City of London's Health and Wellbeing Board.

What the City Supplement is used for[1]:

- To supplement the City and Hackney JSNA, to provide a City focused picture of the health and wellbeing needs of the City of London (now and in the future) covering residents, workers and rough sleepers.
- To inform decisions about how the City designs, commissions and delivers services, and also about how the urban environment is planned and managed.
- To improve and protect health and wellbeing outcomes across the City while reducing health inequalities.
- To provide partner organisations with information on the changing health and wellbeing needs of the City of London, at a local level, to support better service delivery.

[1] *LB Croydon* (2012)

- As the evidence base for the Joint Health and Wellbeing Strategy, identifying important health and wellbeing issues for the City, and supporting the development of action plans for the priorities named in the strategy.

The social determinants of health

Social determinants of health are "the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment."[2]

The beginning of every chapter summarises Key Findings from the needs assessment. This is followed by Recommendations based on evidence and Questions addressing challenges for commissioners.

Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are some of the factors that affect the health of individuals and communities. Similarly, good education, public planning and support for healthy living can all contribute to healthier communities.

The Health map

Barton and Grant and the UKPHA strategic interest group (2006) developed a health map which shows how individual determinants including a person's age, sex and hereditary factors are nested within the wider determinants of health. The health map (below) places people at the centre, but sets them within the global ecosystem which includes:

- natural environment
- built environment
- activities - such as working, shopping, playing and learning
- local economy - includes wealth creation and markets
- community - social capital and networks
- lifestyle

These are the social, economic and environmental determinants of health.

[2] Raphael, 2004 'Social Determinants of Health: Canadian perspectives', Toronto, CSPI.

The health map above challenges the notion that health is the domain of the NHS and brings it squarely into the arena of local government. In fact many would argue that the health sector has a relatively minor role in addressing inequalities and the social determinants of health. The majority of local government services impact upon or can influence the conditions in which people live and work and, to a certain extent, the life chances of individuals.

Health in All Policies

Health in All Policies is a collaborative approach that integrates and articulates health considerations into policymaking across sectors, and at all levels, to improve the health of all communities and people.

As shown above, public policies at all levels have health impacts which need to be accounted for. The Health in All Policies (HiAP)[3] approach aims to improve the accountability of policy makers for health impacts at all levels of policy making, by taking into account the health and health-system implications of decisions across sectors; seeking synergies; and avoiding harmful health impacts, for better population health and health equity.

Incorporating health considerations into policies across all sectors is challenging and, even when decisions are made, implementation may be only partial or unsustainable. One public health think tank[4] suggests the following characteristics to achieve successful collaboration:

- Identify shared goals
- Engage partners early and develop relationships

[3] Ministry of Social Affairs and Health, Finland (May 2013) Health in All Policies: Seizing Opportunities, Implementing Policies.
[4] Association of State and Territorial Health Officials. http://www.astho.org/HiAP/?terms=health+in+all+policies

- Define a common language
- Active the community
- Leverage funding

The JSNA process takes a collaborative approach between different partners for identifying health needs and seeks to establish a common language for intervention. It can be considered the first step in establishing groundwork for a health in all policies approach.

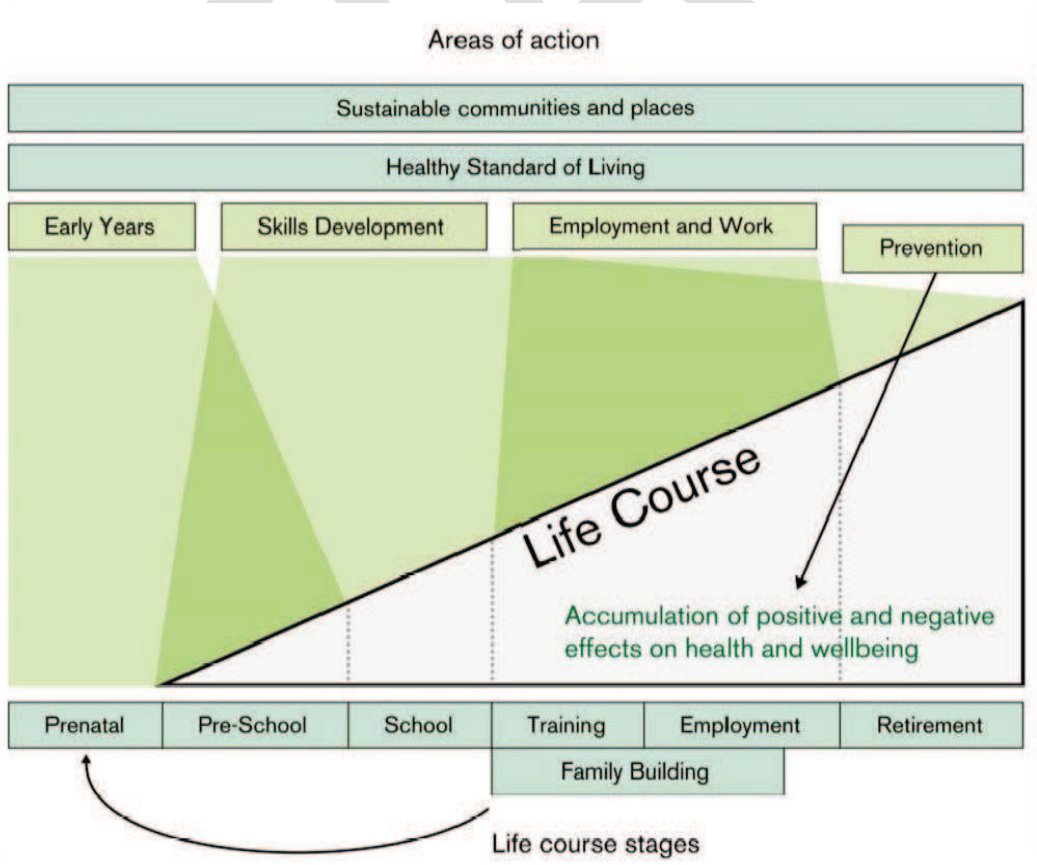
Life Course Approach

A complementary way to view the effects of social determinants of health is in a temporal approach rather than spatial.

This is the approach taken by the Marmot Team in their 2010 report on health inequalities in England: **Fair Society, Healthy Lives**.

- It takes the broadest view of the factors that affect health but describes these principally in terms of the life course, set in a context of sustainable communities and healthy standards of living.
- A particular emphasis is given to the beginning of this story: action to reduce health inequalities must start before birth and be followed through the life of the child. The top recommendation of the report is that every child should be given the best start in life.
- The report also identifies the many opportunities through school and education, working life and older life to minimise adverse health impacts and maximise positive impacts.

Figure 1.1 Areas of action and intervention across the life course



Format of the City Supplement

The City Supplement incorporates both a spatial view of health and wellbeing, beginning with population profile and socio-economic context and a life-course view, moving from the needs of infants, children and young people to the needs of adults and older people.

These two ways of describing health and wellbeing needs together provide a comprehensive view of the issues that need to be considered when planning for the protection and improvement of the health and wellbeing of the people of the City of London.

The City Supplement follows the structure of the Life Course Approach with chapters beginning with community and early life through to later life. [5] Below is a brief overview of the topics covered in each section:

Section	Definition	Topic Areas
Community Life	Influences on health and wellbeing occurring through our environment	Community cohesion and neighbourhood attachment, air quality, transport, green spaces, noise pollution, leisure and cultural facilities, climate change, crime and safety
Early Life and Family Life	Most aspects of health and wellbeing from birth up to age 18. Followed by aspects relating to families	Young people's policy context, demographics, education and training, poverty and deprivation, families and households, maternity
Working Age	Aspects of health and wellbeing relating to those aged between 16 and 65	City's economy, jobs within the City, education and qualifications, unemployment and out-of-work benefits, workplace health, sexual health, smoking, physical activity, alcohol, substance misuse, carers, disability, mental health
Later Life	Over 65 years of age	Older people, end-of-life care Life expectancy, infectious disease, chronic disease
Healthy Living	Health outcomes and usage of health and social care services	Health services, disease prevalence social care services and usage, voluntary and community service assets

[5] *LB Croydon* (2012)

Limitations of the dataset

To paint a clearer picture of the City's needs, aggregated figures reported as joint City and Hackney have been omitted from this report.
For a full overview of figures including those that are aggregated see the City and Hackney JSNA.

Resident data

City resident-specific data has always been challenging to obtain and report due to small numbers, which makes it difficult to compare to local and national indicators. Historically, health specific data has been aggregated with Hackney due to pooled budgets. This is a challenge for the City, as without the disaggregated figures it is difficult to decipher if the trend observed truly represents the City population or is mainly a reflection of Hackney.

City worker data

In October 2013, a new release of Census 2011 data estimated the population and characteristics of the workday population across England and Wales. This Census intelligence is the first of its kind, and is of particular importance to the City of London, since the workday population is 56 times higher than the resident population. Two independent reports have also been commissioned to gain insights into the health needs of City Workers – *The Public Health and Primary Healthcare Needs of City Workers*, and *Insight into City Drinkers*.[67]

Rough sleeper data

The main source of data for rough sleepers in the City comes from the CHAIN database. The CHAIN (Combined Homelessness and Information Network) database is commissioned and funded by the Greater London Authority and managed by Broadway. Research into rough sleeper health needs has also been recently conducted by NHS North West London.

For more information on data sources and a detailed explanation of data limitations, please see Appendix 1.

[6] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[7] Insight into City Drinkers, 2012

2. The City's Geography

Lower Super Output Areas (LSOAs) are statistical regions with an average population of 1,500 that are used for local area statistics. The City is comprised of six Lower Super Output Areas. Unlike most local authorities, the City's electoral wards are smaller than its LSOAs (shown below in red)

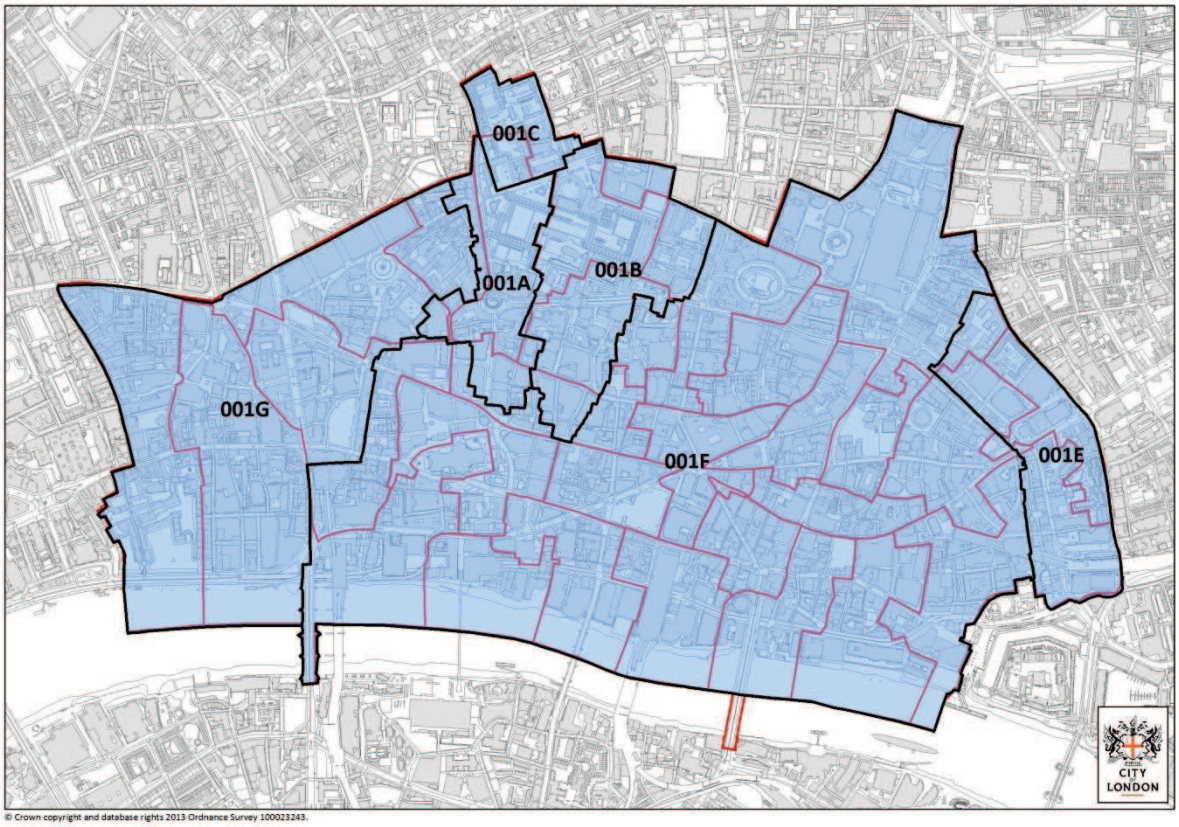


Figure 3.2 Map of the City of London showing Lower Super Output Areas in black and ward boundaries in red

Four of the City's LSOAs broadly correspond to particular residential populations in the Barbican, Golden Lane and the Portsoken estates; whereas the other two represent a slightly more dispersed population (see Figure 2.2)

LSOA	Broad electoral ward	Major populations
001A	Aldersgate	Barbican West
001B	Cripplegate, south	Barbican East
001C	Cripplegate, north	Golden Lane Estate
001E	Portsoken	Mansell Street and Middlesex Street Estates
001F	Rest of City	Queenhithe and Carter Lane
001G	East Farringdon and Castle Banyard	City West and the Temples

3. The City's Population

The first step in a needs assessment is to define the population under investigation.

Understanding the structure of the population and the way demographics change – including such characteristics as age, gender, disability and ethnicity - forms the basic intelligence on which many commissioning decisions are made.

In the City there are three populations with distinct health needs. They are the residents, City workers and rough sleepers.

Look for subtitles marked City workers or Rough sleepers throughout the report where more in-depth evidence or data exists for further analysis.

Key Findings

Residents

- The City has a small population that is projected to grow slowly in the upcoming decades
- Those aged 65 and older are projected to contribute the most to the growth, increasing rapidly in the next decade. (For more information on their health needs - see section "Later Life")
- Almost 40% of City residents are migrants.
- The City's residents are predominantly White and speak English as their main language.
- There are relatively few children in the City.

City workers

- The workday population in the City is 56 times higher than the resident population.
- City workers have a male-dominant and younger age profile (20-50years old)
- City workers are a transient population and about a third are migrants.
- Most City workers perceive themselves to be in "very good health" however independent reports suggest that alcohol, smoking and mental health remain major risk factors.
- Low paid migrant workers are at greater risk of poor health due to decreased access and increased costs to care.

Rough Sleepers

- The City has the sixth highest number of rough sleepers in London
- Rough sleepers in the City are predominantly male and the majority are between 20-50 years of age.
- About half of the rough sleepers are British nationals and the remaining come from Eastern Europe
- Over half of the rough sleepers have alcohol problems and mental health problems, and almost a third have drug problems.

Recommendations

- Commissioners and strategy leads will want to be confident that all new and existing strategies and commissioning decisions take account of changes in the City demographics

anticipated over the next 10 years. New and existing services will need to adapt to meet the needs of our changing population.

Questions for Commissioners

- How can the City plan its services to meet the health and other needs of the rapidly expanding older population?
- What is being done to tackle the alcohol, smoking and mental health risk factors for City workers?
- How can commissioners enable the tackling of the risks of poor health to low paid migrant workers?
- How can commissioners progress integrated health and housing care for rough sleepers?

RESIDENTS

Population size and age profile

The City's resident population is growing slowly. The 2012 mid-year estimate in the City was 7,604 which is an increase of 3.1% compared to the figure in 2011.

Table 2.1 presents the populations in five-year age bands, with population pyramids for the area in Figure 2.1 There are a particularly small proportion of children in the City.

The geographical spread of age groups in the population is shown in Figure 2.2-5. School-aged children are located in the most eastern part of the City, Portsoken. The working age population is generally spread throughout the City except in the north and eastern parts. Populations of older people are more heterogeneous, with particular concentrations in the northern and eastern parts of the City.

Table 3.1 **Estimated population of the City of London by five-year age group: ONS 2012 mid-year estimates**

Age	Population
	The City
0–4	297
5–9	205
10–14	165
15–19	231
20–24	495
25–29	949
30–34	826
35–39	622
40–44	663
45–49	598
50–54	504
55–59	470
60–64	473

65–69	363
70–74	263
75–79	192
80–84	155
85–89	86
90+	47
All ages	7,604

Figure 3.1 Population of the City of London by five-year age group and gender (ONS 2012 mid-year

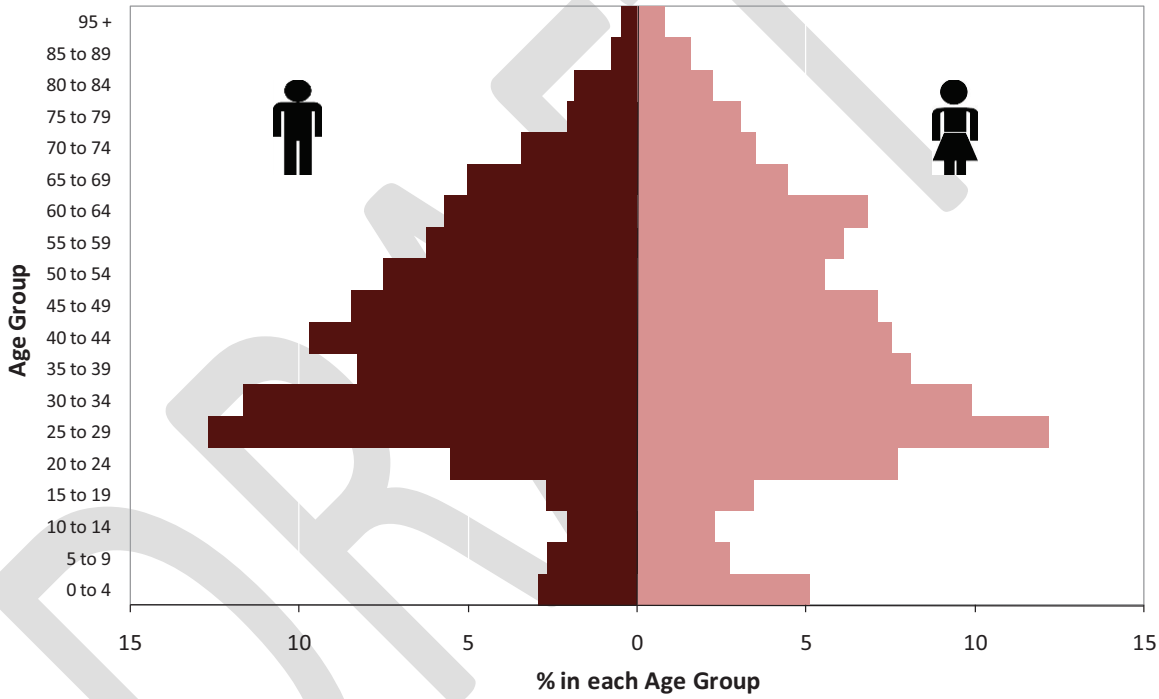
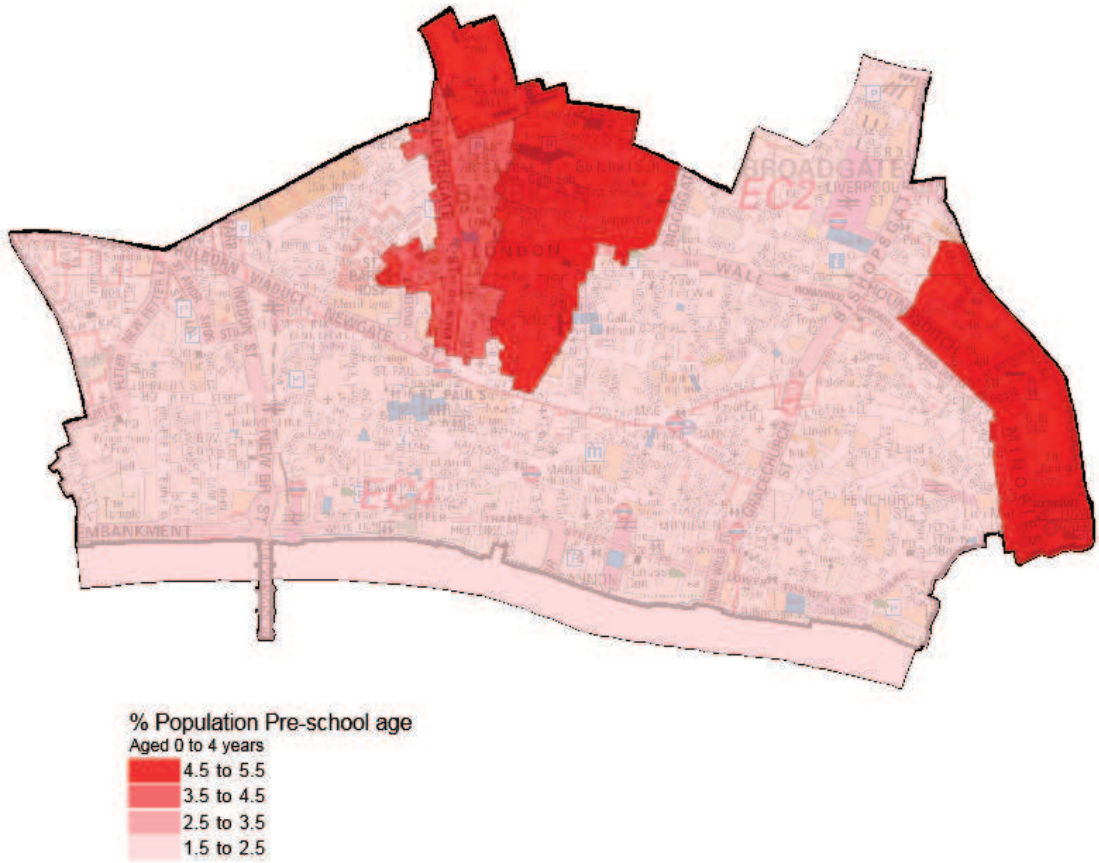
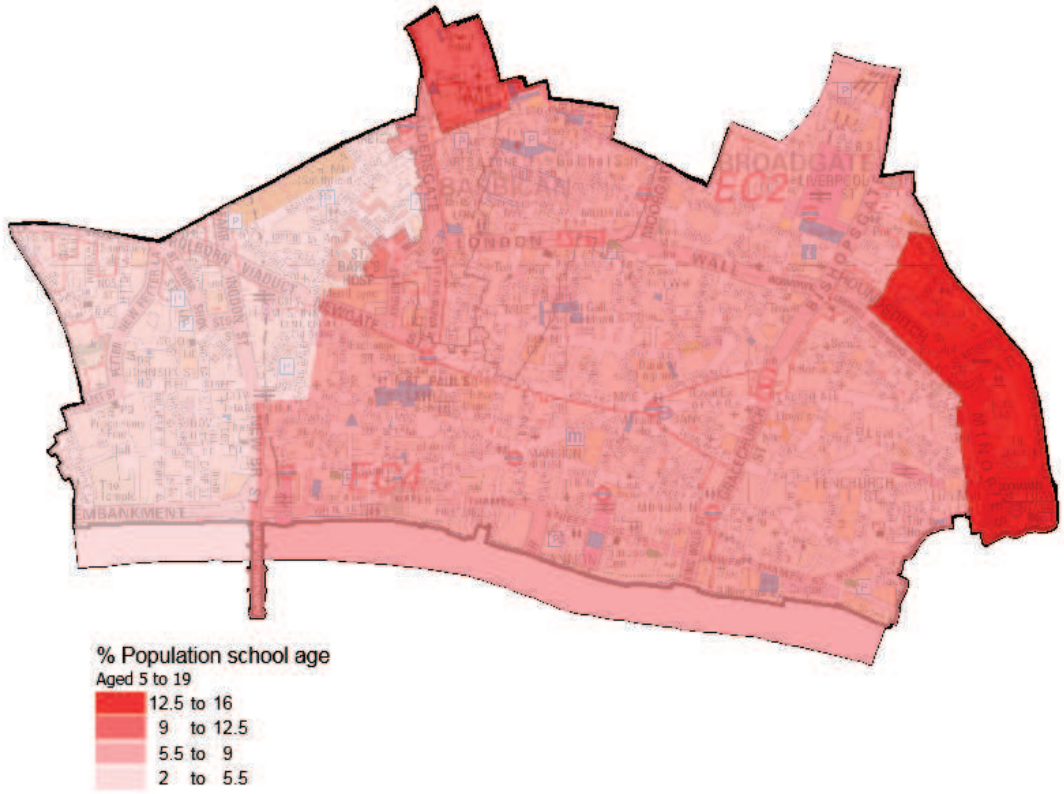


Figure 3.2 Geographical age structure: percentage aged 0-4



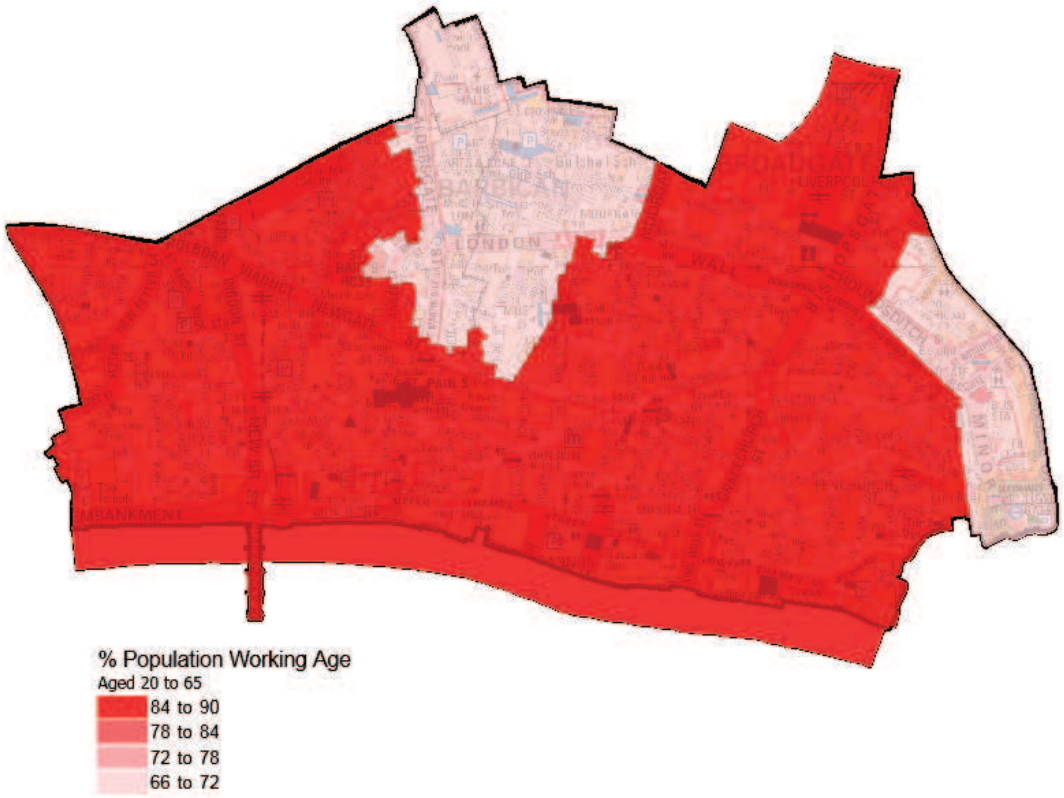
Source: ONS 2012 mid-year estimates

Figure 3.3 Geographical age structure: percentage aged 5-19



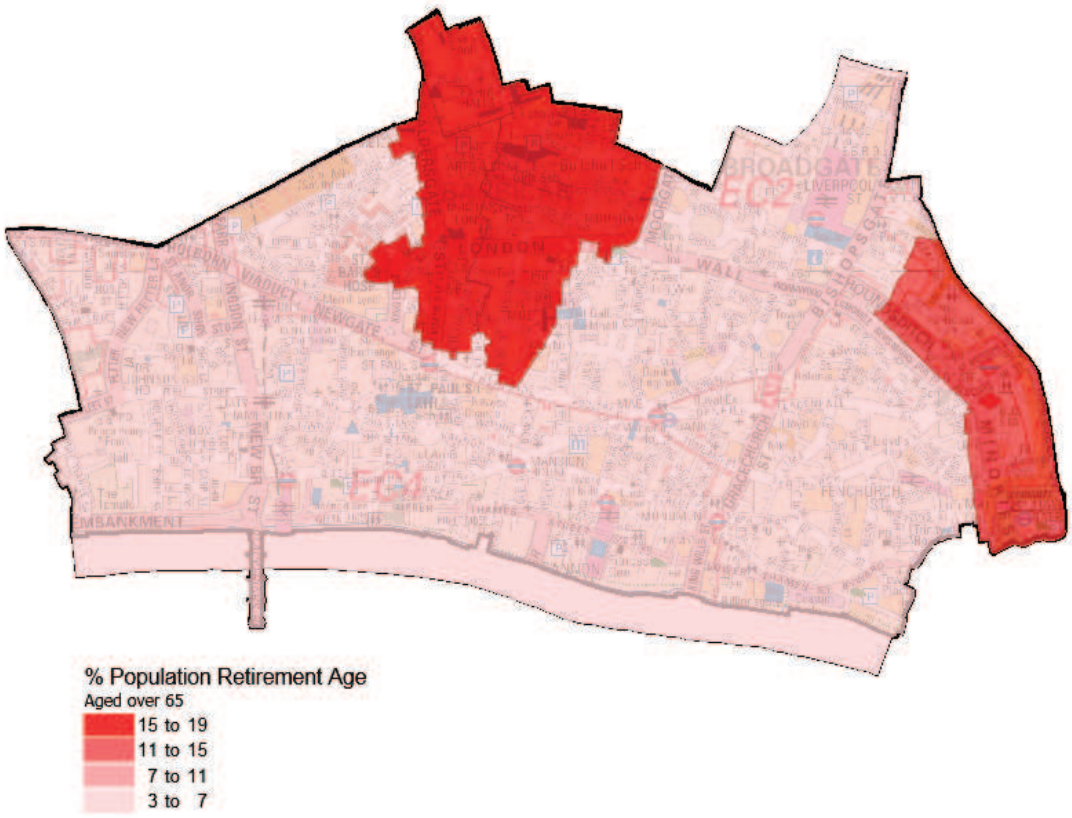
Source: ONS 2012 mid-year estimates

Figure 3.4 Geographical age structure: percentage aged 20-65



Source: ONS 2012 mid-year estimates

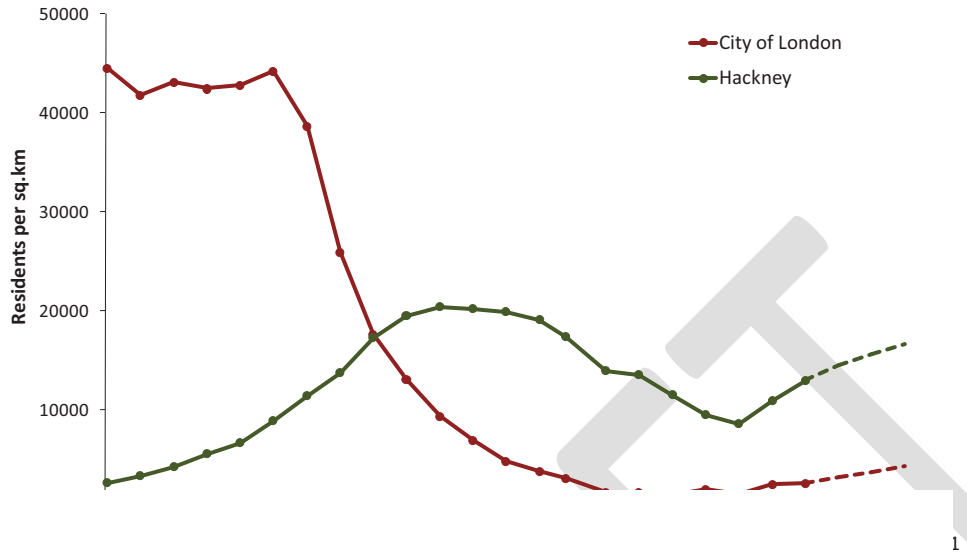
Figure 3.5 Geographical age structure: percentage aged over 65



Source: ONS 2012 mid-year estimates

Population density

Figure 3.6 Historical and projected population density in the City of London



Source: Greater London Authority (GLA)

The 2011 Census estimates the population density to be 2,552 residents per km^2 in the City of London. These remains historically low though the current trend is rising (**Figure 2.9).** However, the population density is greater than this when including residents occupying a second home in the City. The 2011 Census estimated 1,370 persons who are resident elsewhere in the UK as well as in the City. Including these increases the population density to 3,024 residents per km^2.

The majority of the City's land is in office use, with housing occupying a small proportion of land. Thus residential densities in the City, as seen in the north (Figure 2.10) are very high, as the majority of housing schemes are multi-storey with little or no outdoor space or car parking.[8] However, density by the number of persons per household remains low (Figure 2.11).

[8] City of London Local Development Framework, Core Strategy: Delivering a World Class City, Affordable Housing Viability Study, May 2010

Figure 3.7 Population density: number of persons per hectare

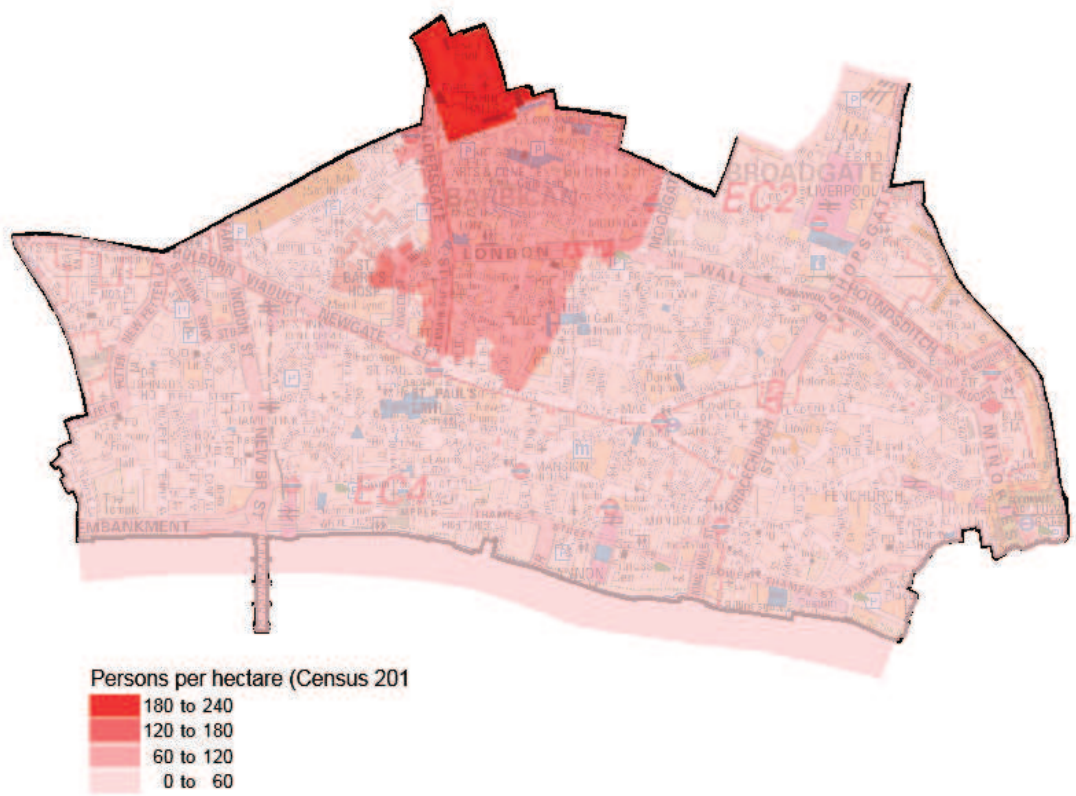
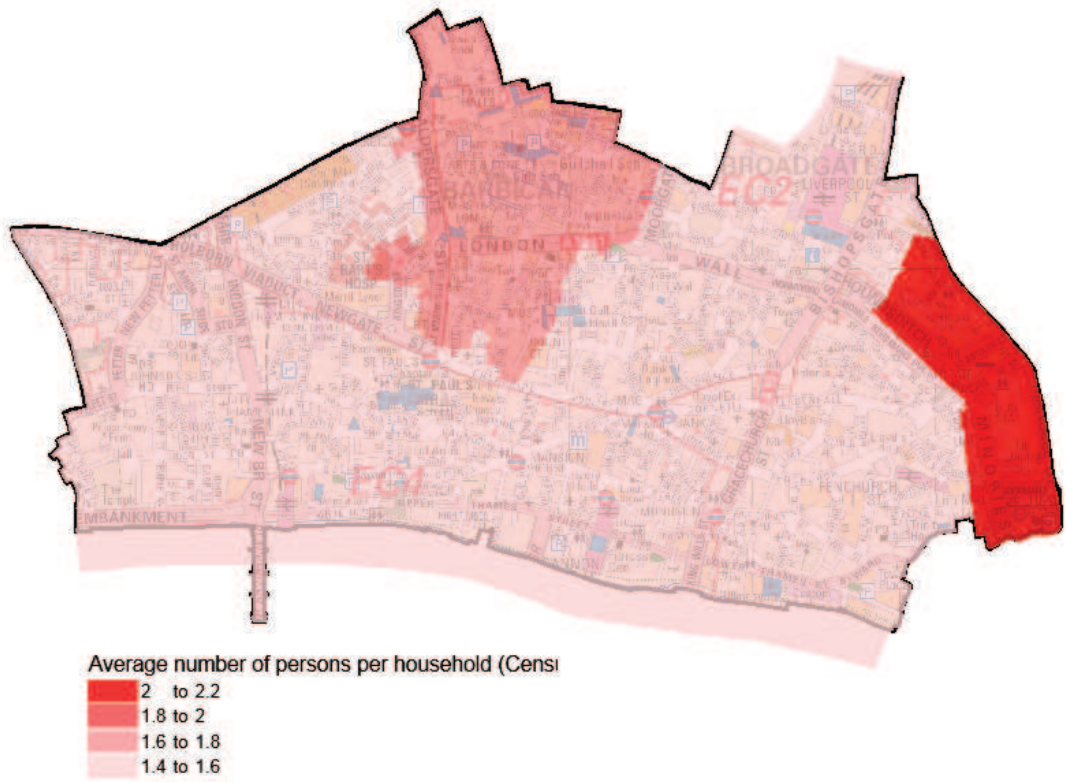


Figure 3.8 Population density: number of persons per household



Population change and migration

ONS estimates show that the City's population is growing slowly. The City's population is subject to migration from within the UK and internationally, with large numbers of migrants moving in and out of the City. This is likely to reflect the working-age population who come to the City of London for a specific job or employer. ONS estimates are rounded to the nearest 100, which are not entirely helpful in the City context. In future JSNA publications, it is envisaged that more accurate births and deaths data will be available.

GLA estimates project that the City's population will grow from 7,600 in 2012 to 9,200 in 2037. The majority of growth will be in the working age and aging population; however the number of older people is projected to increase more rapidly in the near future. For more detailed population estimates and projections, see Appendix 2

Table 1.5 Components of change in population estimates 2011-12 (numbers rounded to nearest 100)

	The City	
	Number	%

Mid-2011 population estimate	7,400	
Natural change		
Live births	+100	+0.8
Deaths	–0	–0.5
Net natural change	+0	+0.3
Migration		
International migration: in	+700	+9.4
International migration: out	–500	–6.6
UK internal migration: in	+900	+11.5
UK internal migration: out	–900	–12.1
Net migration	+200	+2.3
Mid-2012 population estimate	7,600	

Source: ONS

Of the 2011 Census population, 2,700 (37%) were born abroad, with 44% of these resident for 10 or more years. Main countries of origin are recorded in Table 1.8.

Table 1.8 Top 20 countries of birth for residents of the City born outside the UK

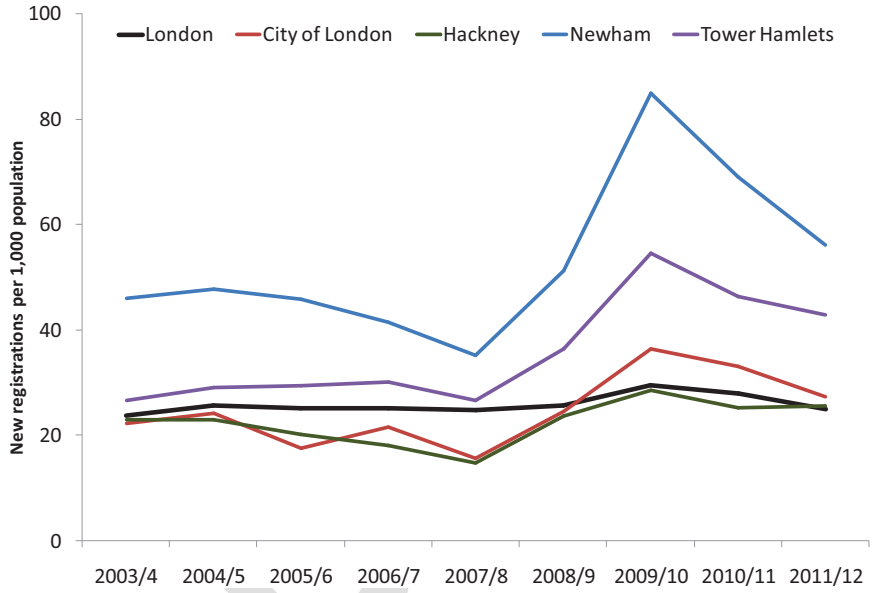
City	
Country of birth	**% of population**
United States	2.8
France	2.0
Australia	1.9
Germany	1.6
Ireland	1.5
India	1.4
Italy	1.4
Bangladesh	1.3
China	1.3
New Zealand	1.1
Hong Kong	1.0
South Africa	1.0

Spain	1.0
Canada	0.9
Japan	0.7
Greece	0.7
Malaysia	0.7
Russia	0.7
Colombia	0.7
Poland	0.6

Source: 2011 Census

There was a decrease in new GP registrations for people previously living abroad. This indicator captures most migrants and their dependents, but excludes those who do not register with a GP, including short-term economic migrants and those who have access to private health insurance services.

Figure 1.9 New GP registrations of people previously living abroad per 1,000 population, 2003-12



Source: ONS

Ethnicity

White populations are particularly concentrated in the City There are concentrations of people of Asian ethnicity in the east of the City, and overall very few black and people who identify as mixed origin.

Table 1.9 Proportions of population in broad ethnic groups in the populations of the City

Ethnicity	City
	% of population
White	78.6
Black	2.6
Asian	12.7
Mixed/multiple	3.9
Other	2.1

Source: 2011 Census

Table 1.10 Proportions of population in main (>1%) narrow ethnic groups in the populations of the City

Ethnicity	City
	% of population
White British	57.5
Black African	1.3
Black Caribbean	0.6
Turkish/Turkish Cypriot	0.2
Asian Indian	2.9
Asian Bangladeshi	3.1
White Irish	2.4
Asian Chinese	3.6
White Polish	0.5

Source: 2011 Census

See Appendix 3 – Ethnicity for more information.

Religion

The City is diverse area, with a wider range of religious identities than England as a whole (Table 1.11).

In the City, 45.3% of residents identify as Christians, with 34.2% having no religion. The next largest religion is Islam, with 5.5% of residents, followed by 2.3% who are Jews and 2.0% who are Hindus. Buddhists make up 1.2% of City residents and Sikhs 0.2%.

Since the previous Census, the proportion of the population identifying as Christian has reduced by around 10%, while the proportion identifying as having no religion has increased by roughly the same amount.

See Appendix 4 - Religion for more information.

Table 1.11 Proportions of population by religious identification in the populations of the City

Religion	City	London	England
	% of population	% of population	% of population
Christian	45.3	48.4	59.4
No religion	34.2	20.7	24.7
Muslim	5.5	12.4	5.0
Not stated	8.8	8.5	7.2
Jewish	2.3	1.8	0.5
Buddhist	1.2	1.0	0.5
Sikh	0.2	1.5	0.8
Hindu	2.0	5.0	1.5
Other religions	0.4	0.6	0.4

Source: 2011 Census

Languages

In the City, residents speak English as their main language (82.9%), with most others speaking different European languages (11.2%). South Asian languages are spoken by 2.1% and East Asian languages by 2.5% (Table 1.12).

Most of those who do not speak English as their main language do speak English well or very well (15.8% in the City) which is higher than the national figure (6.1%). In the City 1.4% stated that they do not speak English well or at all which is the same as the national figures.

The main individual languages spoken in the City are shown in Table 1.13.

Table 1.12 Proportion of respondents' main language groupings in the populations of the City

Language	City % of population
English	82.9
Other European languages	11.2
East Asian languages	2.5
South Asian languages	2.1
Other languages	1.3

Source: 2011 Census

Table 1.13 Proportion of respondents' main languages widely spoken (>1%) in the populations of the City

Language	City % of population
English	82.9
French	2.2
Spanish	1.8
Bengali	1.6
German	1.2
Italian	1.1

Source: 2011 Census

See Appendix 5 – Languages for more information

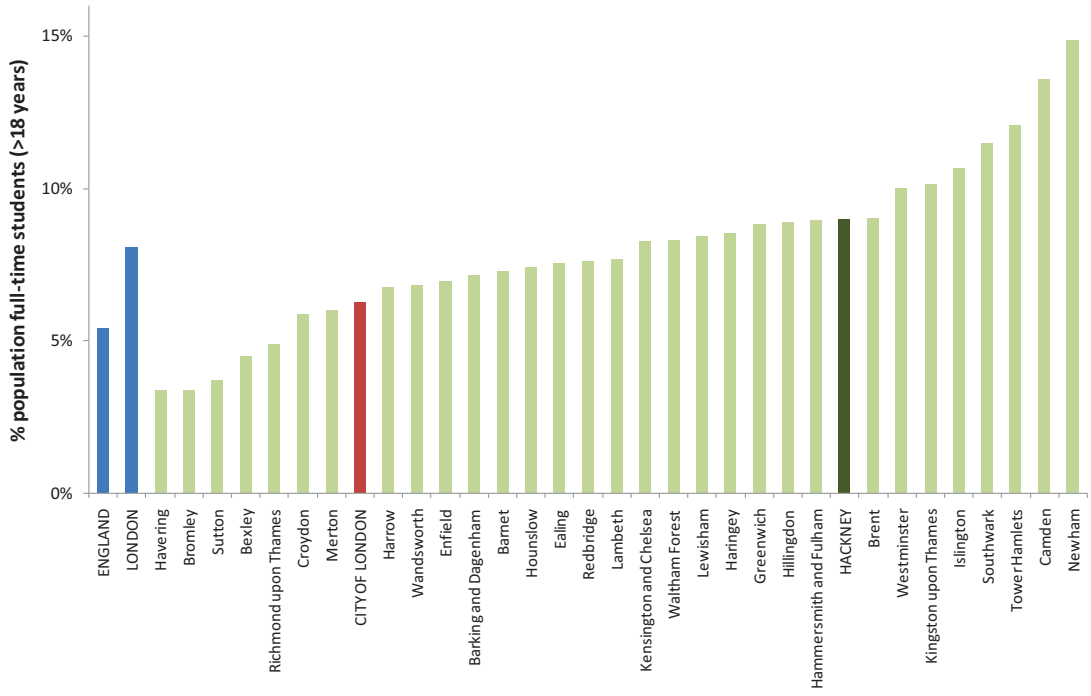
Overall Health

Most City residents consider themselves to be in good or very good health (88% of all residents). However around 1 in 8 households have a disability or suffer long-term health problems. This is less than in London or elsewhere nationally, but there are variations in health between neighbourhoods. These patterns of health inequalities reflect the patterns of relative social and economic deprivation in the City. Poor health is more prevalent in the Portsoken and Golden Lane areas where ill-health and disability affects around 20% of households. Many of these have a physical disability, are frail elderly or suffer with mental health problems and are most likely to require specialist forms of housing or adaptations and support services to help them to remain living independently in their home.

Students

The 2011 Census was carried out on 27th March 2011. On this date, 400 (6.2%) of those in the City reported themselves to be full-time students, over the age of 18. This is lower that the London figure (8.1%) and is close to the England figure of5.4% – see Figure 1.14. It should be noted that students are a particularly mobile population, and this figure will vary widely across the academic year.

Figure 1.14 Proportion of students in population by borough (2011 Census)



Carers

See Working Age section for detailed information on carers.

Travellers and Gypsies

The 2011 Census records that fewer than five residents of the City of London described themselves as Gypsies or Irish Travellers.

CITY WORKERS

Overall, the findings from the Census 2011 are consistent with previous independent reports. New insights not previously available are the age and sex profile by year, religion, housing tenure (see housing section), education, residency and passport designation of City workers.

Population Density

Population density in the City is 3,024 per km^2 with the usual residents and amounts to 12,426,000 per km^2 with the workday population. A total of 360,075 people surveyed by Census 2011 gave a workday location within the City, of whom 359,455 were aged 16 and above.

Age and Sex

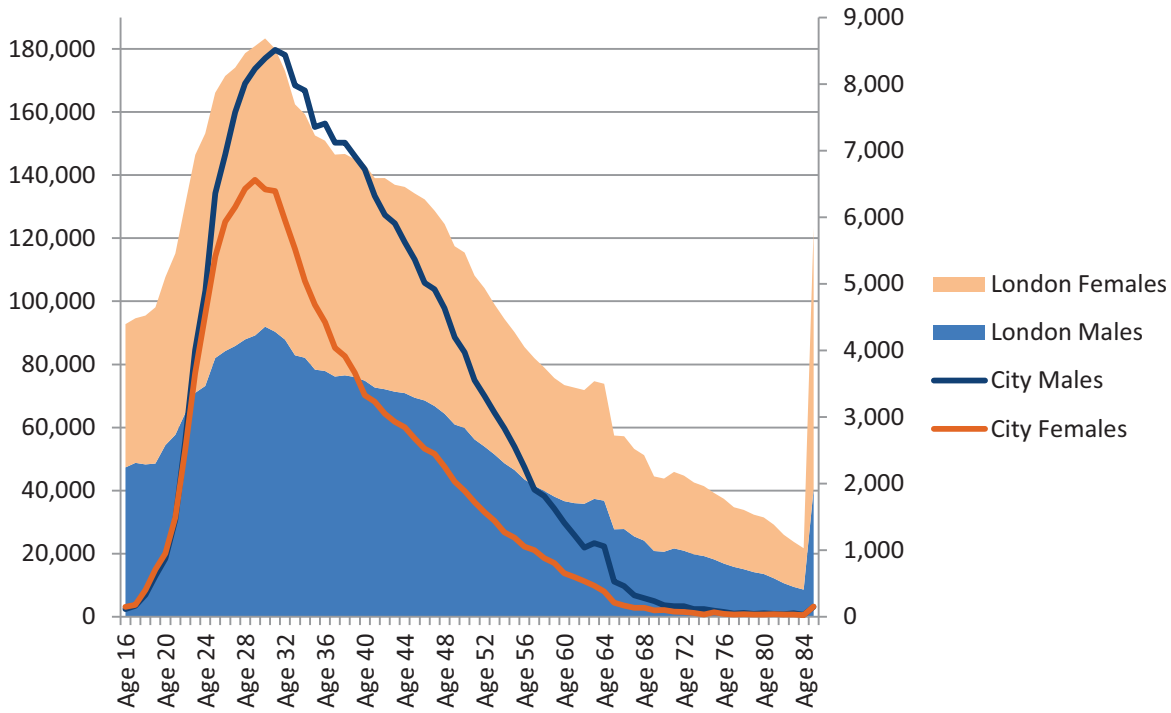
City workers are mainly aged between 20 and 50 years of age. Most women working in the City are aged between the mid-20s to mid-30s; whereas men are aged between the mid-20s to mid-40s. There are over a third more male (220,265) than female (139,813) daytime City workers, which is the reverse trend of that seen across London (Figure 3.9).

The younger age and male dominated profile of City workers is consistent with findings from previous independent reports, and is likely influenced by the male-dominated finance and insurance industry representing a large portion of the work force[9][10]. City workers tend to be healthier because they are younger than the general adult population. Health from this point forward is largely determined by factors related to their lifestyle – such as smoking, alcohol consumption, levels of physical activity and diet.[11]

Although female workers are proportionately fewer in numbers than male workers in the City, their health needs should not be overlooked and may be unique. For example, *Insights into City Drinkers* indicated that both female and male City workers drink higher amounts than national averages, suggesting that women in the City may in part drink more because they have been influenced by a wider 'social norm' of heavy drinking in the City.[12] This may also apply to other health needs affecting female City workers surrounded by a predominantly male working population.

[9] ibid
[10] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[11] ibid
[12] Insights into City Drinkers, 2012

Figure 3.9: Profile of City and London Workers by sex and age

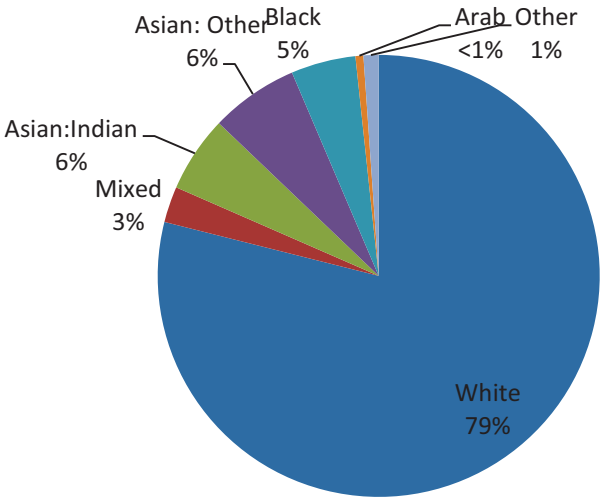


Ethnic Group

The ethnic profile of City workers overall reflects the London profile – see figure 3.10. The majority are white (79%), a relatively large proportion of Asians are Indian (6%) while the remaining Asians represent another 6%. 5% are black, 3% mixed, and less than 1% are Arab. This is consistent with previous independent reports on City workers.[13][14]

[13] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[14] Insights into City Drinkers, 2012

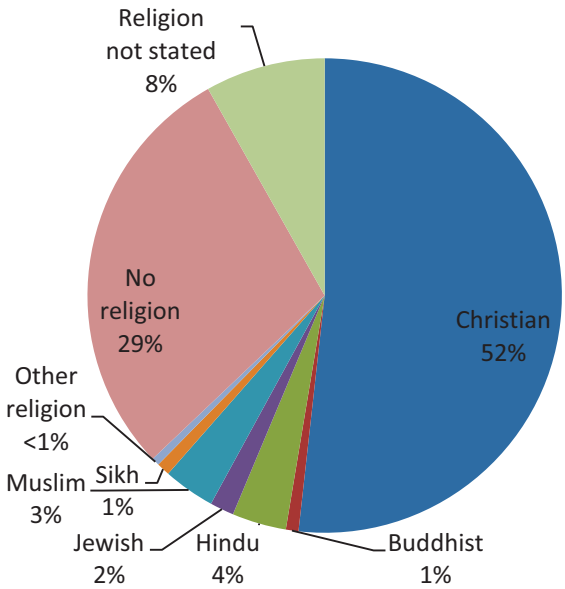
Figure 3.10: Ethnic Profile of City workers



Religion

The religious profile of City workers is broadly representative of that across London and England – see figure 3.11. Half of City workers are Christian while another third have no religion. 4% are Hindu, 3% are Muslim, and 2% are Jewish. Sikh and Buddhists represent 1% each. Nationally, there is a greater portion of Christians (59%), and across London there are more Muslims (12%) then seen amongst City workers.

Figure 3.11: Religious Affiliation of City workers



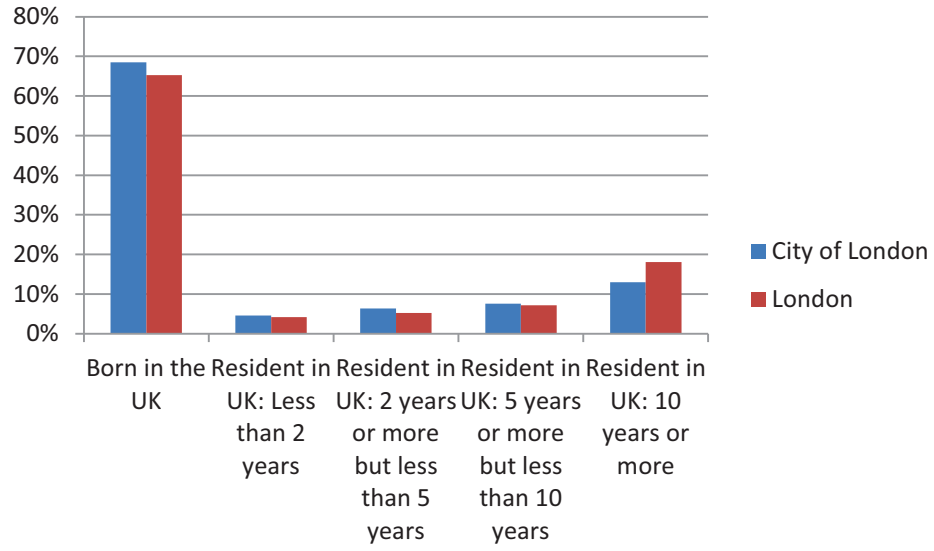
Residency

The majority of City workers are born in the UK; or are in short term residence, both of which are slightly higher than the London average. 68% of City Workers are UK born and a remaining 17% of City workers are short term residents of less than 10 years. Taken together, a third of all City workers are migrants.

Most migrants are healthy, young people... Risk factors most relevant to migrant City workers' health include language and cultural differences, stigma, discrimination, social exclusion, separation from family and socio-cultural norms, as well as administrative hurdles and legal status.

Migrants tend to travel with health profiles, values and beliefs, reflecting their community of origin. Such profiles and beliefs may have an impact on the health of and usage of health services by migrants.[15]

Figure 3.12: Residency of City workers



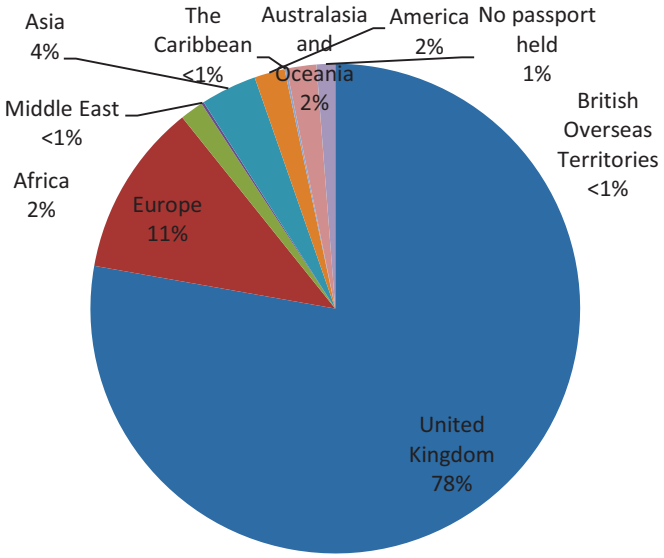
Passport Designation

Of all passport types, 78% of City workers have UK passports. See figure – 3.13 Of all non-UK passports, one third are from EU countries according to the March 2001 EU membership, (Germany, France, Italy, Portugal, Spain and others); and 10% are from the EU accession countries that joined from April 2001 to March 2011 (Lithuania, Poland and Romania). Another 9% is represented from Southern Asia, Ireland and Australasia each; and 7% from North America. Access and entitlement to free NHS treatment is dependent upon the length and purpose of residence in the UK, and not one's nationality. In addition to the common health risks for migrant health detailed above, non-UK nationals encounter some reduced social security and protection, even as residents in the UK.

[15] WHO 2010, Health of Migrants – the Way Forward

For both UK citizens and non-UK citizens, NHS hospital treatment is accessible and is free at the point of need, for example at A&E, however charges apply to both groups where subsequent treatments are necessary and the patient has been admitted to the hospital. There is some discrepancy in registering with a GP for non-UK citizens, as GP practices are not legally bound to accept non-UK citizens.[16] The decision is ultimately at the discretion of the practice, which may prove a barrier to access. Even when registered with a GP, non-UK citizens must pay out of pocket for dental treatments and prescription drugs.[17] Thus, non-UK citizens have some extra administrative barriers and fees than compared to UK nationals. It is worth noting that a considerable portion of City employers offer private healthcare, which may fill some of these gaps in protection. Those most at risk of being impacted are the low paid migrant workers who are not covered by private healthcare, and the low paid UK workers who are entitled to free NHS treatment but cannot access these services due to long or inconvenient work hours.[18] (For more information, see section on – Health Services)

Figure 3.13: Passport designation of City workers



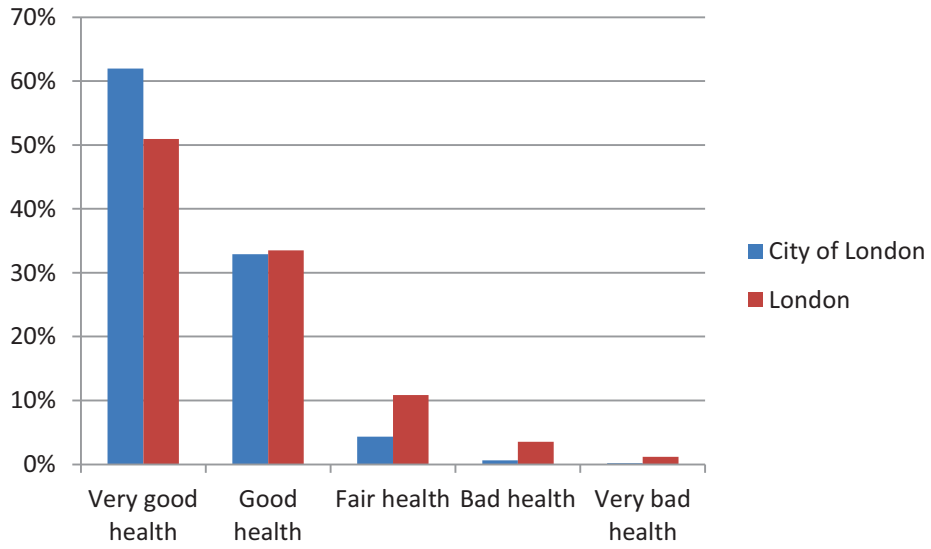
Overall Health

Most City workers perceive themselves as having 'very good health' (62%) (Figure 3.14) which is higher than the London average of 51%. This perception is consistent with the findings from the 2012 independent survey on The Public Health and Primary Healthcare Needs of City Workers[19]. However this is most likely related to their age and particular migrant profile, coupled with selection effects (i.e. the City offers demanding jobs that tend to attract healthy people).[20] Additionally a combined tendency for being highly educated and earning a higher income is associated to better health outcomes.

[16] Citizens Advice Bureau 2013, NHS charges for people from abroad
[17] Citizens Advice Bureau 2013, NHS charges for people from abroad
[18] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[19] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[20] The Public Health and Primary Healthcare Needs of City Workers, May 2012

Despite this, there is strong evidence that amongst City workers, there is a culture of long working hours and feeling stressed regularly, coupled with heavy alcohol consumption, and smoking, which may lead to future health problems.[21] For more information, see lifestyle and behaviour, and mental health in Working age.

Figure 3.14: Self perceived overall health of City workers



Source: Census 2011

[21] ibid

ROUGH SLEEPERS

Rough sleeping is the most acute and visible form of homelessness, and an issue that remains a challenge within the City of London. Those that find themselves homeless on the streets are intensely vulnerable to crime, drugs and alcohol and at high risk of physical and mental illness, and premature death. Many people will come to the streets with complex personal issues, some have limited entitlement to services or connection to areas far from where they are sleeping rough, and some are resistant to and refuse the support that is available to them. For those that remain sleeping rough, the aim of returning to a stable life in their own home becomes harder to achieve the longer they call the streets their home.

Population size

On average, approximately 20-25 people sleep on the streets of the City of London every night. The City has the sixth highest number of rough sleepers in London after Westminster, Camden, Lambeth, Southwark and Tower Hamlets[22].

In 2012/13, a total of 284 people were seen sleeping rough in the City by outreach teams[23].
Of these people, 112 (39%) were new to the streets, another 112 (39%) were longer term rough sleepers who had been seen both in the reported year and in the year before, while 60 (21%) were those who had returned to the streets after a period away.

Sex, Age and Ethnic Origin

The rough sleeper population in the City is overwhelmingly male – 94% of those seen in 2012/13 were men – and 85% were aged between 26 and 55 years of age, with a further 11% aged over 55. The majority of those seen, 57%, where British nationals, with the bulk of the remainder coming from Europe (predominantly Eastern European countries) – see Figure 2.13.

Overall Health

Rough sleepers have high needs relating to alcohol, drugs and mental health. In 2012-13, 46% of rough sleepers in contact with services in the City had alcohol problems, 30% had drug problems and 45% had mental health problems (with many having more than one of these problems). See more – in rough sleeper, Healthy life section

Rough sleepers are generally in much worse health than other homeless people[24]. National estimates show that the homeless population consumes about four times more acute hospital services than the general population, costing at least £85m per year[25]. Rough sleepers access A&E seven times more than the general population, and are more likely to be admitted to hospital as an emergency, which costs four times more than elective inpatients[26].

[22] CHAIN Street to Home report 2012/13
[23] CHAIN Annual Report for City of London 1st April 2012 - 31st March 2013.
[24] Bines W (1994). *The health of single homeless people*. York: Centre for Housing Policy. For full references on the health of rough sleepers see NHS City and Hackney: *Health and Housing in Hackney and the City*, 2010.
[25] Brodie et al (2013). *Rough sleepers: Health and healthcare*. London, NHS North West London.
[26] Ibid

Rough sleepers have an increased prevalence of health issues including chronic chest problems, tuberculosis, skin complaints and mental ill health. These are often compounded by substance misuse. Rough sleeping is linked with premature death, with rough sleepers having an average life expectancy of 43.

Despite this, rough sleepers can face barriers to accessing services due to attitudes, service models, inability to register with a GP, a lack of knowledge of services, a lack of continuity of care, transiency, lack of local connection and cost.

Figure 2.13. Nationality of rough sleepers in City of London 2012/13 (Broadway)

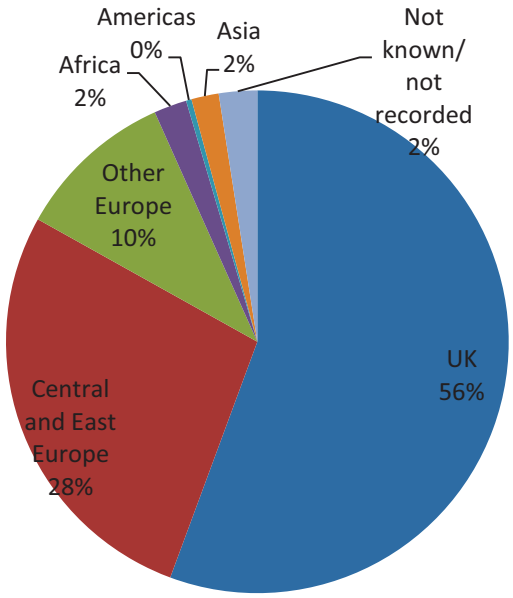
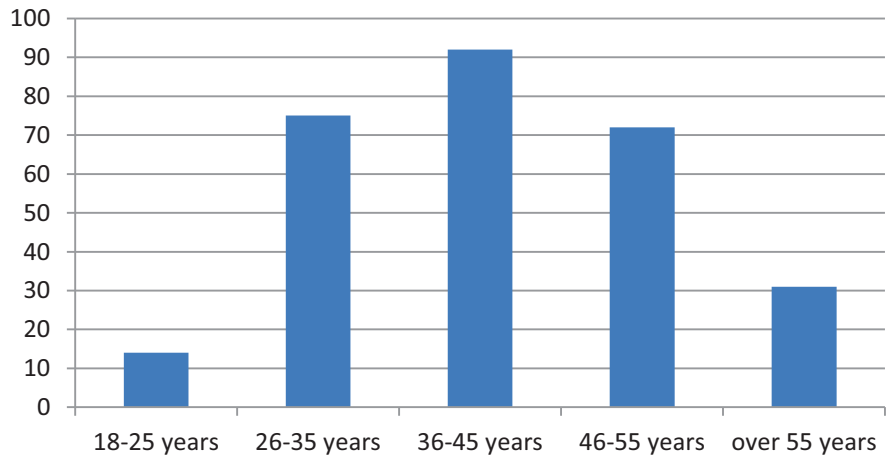


Figure 2.14. People seen sleeping in the year, by age 2012/13



4. Community Life

Our surroundings and how we interact with them are an integral part of our wellbeing. The importance of community and societal factors as determinants of health has been recognised for thousands of years.

The World Health Organisation, in its ground-breaking definition of health, states:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [5]

Our health and wellbeing are influenced by both the physical environment itself (i.e. our housing, transport, access to green spaces and air and water quality) and the people and networks within these communities. Although harder to quantify than aspects of the built and natural environment, issues such as community cohesion, social isolation, trust and fear are also important determinants of wellbeing.

Key Findings

- Over nine in ten residents, workers, executives and businesses are satisfied with the City as a place to live, work and to run a business
- Health based targets for air quality are not being met. Air quality is a challenge in the City due to its central location and the vast transport network catering to the large daytime worker population. The City has been responding with initiatives to improve air quality and to reduce the population's exposure to air pollution.
- Increases in cycling in the City have been accompanies by an increase in traffic casualties. The City is urgently reviewing options for reducing road danger.
- Housing is a key determinant of health. Housing and homelessness will continue to be a growing challenge in coming years. The City has begun responding by aiming to build a more resilient community, a priority linked in the housing strategy.
- The City's space is mainly covered by office buildings and lacks green space. Many cultural assets are available to residents and City workers. Despite this, social isolation may be an issue.
- Crime rates in the City are falling overall; however, some categories of crime are increasing
- The majority of City workers and residents are either homeowners or rent privately, with both groups showing fewer social housing tenants than the national average
- The City has a very low rate of fuel poverty
- The City provides a wide range of services to help rough sleepers leave the streets, and has received several awards for innovation in this area

Recommendations

- Air quality cannot just be addressed locally, as it is heavily impacted by activities in surrounding areas. It will be important to work together with neighbouring local authorities and London to achieve improvements in air quality.
- As space in the City is limited, planning developments have a significant impact on the health of residents and workers in the City. Conducting Health Impact Assessments on major projects will help to ensure health impacts have been considered and incorporated.

Questions for Commissioners

- How do commissioners plan to work with other bodies to improve air quality?
- How can commissioners enable services to support the City's aspirations to build more resilient communities

Quality of Local Area

Community cohesion and neighbourhood attachment

Results from a local survey, published in May 2013[27] reported that satisfaction with the City as a place to live, work and to run a business remains high, with over nine in ten residents, workers, executives and businesses satisfied with the local area in this respect. Residents are the group most likely to be "very" satisfied. Satisfaction amongst businesses has increased by nine percentage points since 2009. The survey reported the perception of City workers, City residents, City businesses, and senior City executives.

Workers and businesses were most likely to see the location of the City and the ease and convenience of getting to the City as its good points. Areas for improvement in the City from both City workers and businesses cite traffic congestion, poor parking, building/roadworks and the expense as downsides to working in the City.

The City scores well on all the indicators of satisfaction and participation in civil society, shown in Table 2.1. City residents see traffic congestion and pollution as in need of improvement, followed by road and pavement repairs, affordable decent housing, parks and open spaces and shopping facilities.

Table 2.1. National indicators of strength of civic society and satisfaction with local area, 2008

	The City	London
People who believe people from different backgrounds get on well together	92%	76%
People who feel that they belong to their neighbourhood	59%	52%
Civic participation in the local area	26%	17%
People who feel they can influence decisions	42%	35%
Overall satisfaction with local area	92%	75%
Participation in regular volunteering	24%	21%
Environment for a thriving third sector	24%	21%

Transport

The City of London is situated at the heart of London's extensive public transport system. Seven of the 11 underground lines in London, and the DLR, serve the City via 13 underground stations. There are seven mainline rail stations, four of which are major rail termini. Fifty-two bus routes use the City's streets as part of their itinerary. There are also various commuter coach services and river boat services which operate from piers at Blackfriars, London Bridge and Tower Hill.

[27] City of London Corporation Polling 2013

The City of London has a public transportation accessibility level rating of 6b (the highest level), indicating excellent accessibility. However, because most of the numerous visitors, students, workers and residents travel to and from the City by public transport, these services can be overcrowded and congested.

The residents of the City take an average of 3.4 trips per day of which the majority (56%) are on foot. Those who use public transport tend to use the Underground. Cycle use by residents is low (Table 2,2) but there has been a significant overall increase in cycling in the City in recent years due the popularity of commuter cycling and the Mayor's bike hire scheme. Currently the City of London provides public cycle parking facilities for 6,761 cycles. There are an estimated 4,663 spaces within buildings in the City. This total provision of 11,424 spaces is 31% of the estimated demand of 37,000 spaces. Under the bike hire scheme there are 36 bike docking stations in the City accommodating approximately 900 bikes.

Pedestrian flows are high at certain times during the week. With an estimated 368,000 workers, 16,000 students and about 8,870 residents walking in the City, pedestrian facilities can be inadequate at peak times. The City is therefore actively pursuing opportunities to provide enhanced facilities for pedestrians such as wider footways and pedestrian areas through a programme of Area Enhancement Strategies.

The increase in cycling in the City has unfortunately been accompanied by an increase in traffic casualties. In 2011, 49 people were seriously injured on the City's roads and a further 360 were slightly injured. This is an increase on 2010 when 41 people were killed or seriously injured and 339 people were slightly injured. In 2011 vulnerable road users accounted for the vast majority of the 49 seriously injured (pedal cyclists 47%, pedestrians 24%, motorcyclists 27%, vehicle occupants 2%).

The Public Health Outcomes Framework identifies the City of London as having a very high rate of deaths and serious injuries on the roads; however, this statistic is based on the total number of incidents that occur in the City (including both workers and residents) divided by the City's resident population. This shows an error in the calculation methodology, as it uses different populations to calculate the rate.

The City has started an urgent review of options for making the City safer for all road users, particularly cyclists and pedestrians whose numbers are expected to continue to grow. The first stage was the adoption of the City's Road Danger Reduction Plan at the beginning of 2013. This sets out an action plan containing a series of measures such as street safety audits and more focussed education, training and enforcement which taken together are intended to reduce casualties. A 20 mph speed limit for the whole of the City of London was approved in September 2013 and is to undergo public consultation in early 2014.

The second strand of the Road Danger Reduction Plan is to work with the Mayor of London to help realise his 'Vision for Cycling in London'. The Mayor is making £913m available for cycle improvements (£400m over the next three years) and intends to implement a Central London Grid of cycle routes. The Grid will comprise Superhighways with a high level of segregation between cyclists and other traffic on strategic routes such as Upper and Lower Thames Street and 'Quietways' on side streets with lower traffic levels.

For more information on road casualties, see Appendix 6 - Road casualties

Table 2.2. Residents' trips by mode of transport 2007/08 - 2009/10 (TfL)

	Trips per	Walk	Cycle	Bus	Under-	Rail	Motor	Taxi/

	person per day				ground		car/cycle	other
Hackney	2.0	37%	5%	30%	6%	3%	17%	1%
City of London	3.4	56%	0%	5%	17%	5%	16%	1%
Tower Hamlets	2.3	42%	2%	17%	14%	2%	21%	2%
Newham	2.4	39%	1%	15%	12%	2%	30%	1%
London	2.5	31%	2%	15%	7%	4%	39%	1%

Road casualties

In the City, 58 people were killed or seriously injured on the roads in 2012, an increase of 18% on the previous year. With smaller numbers in the City, there is even more year-on-year variability in this data. (Figure 6.5)

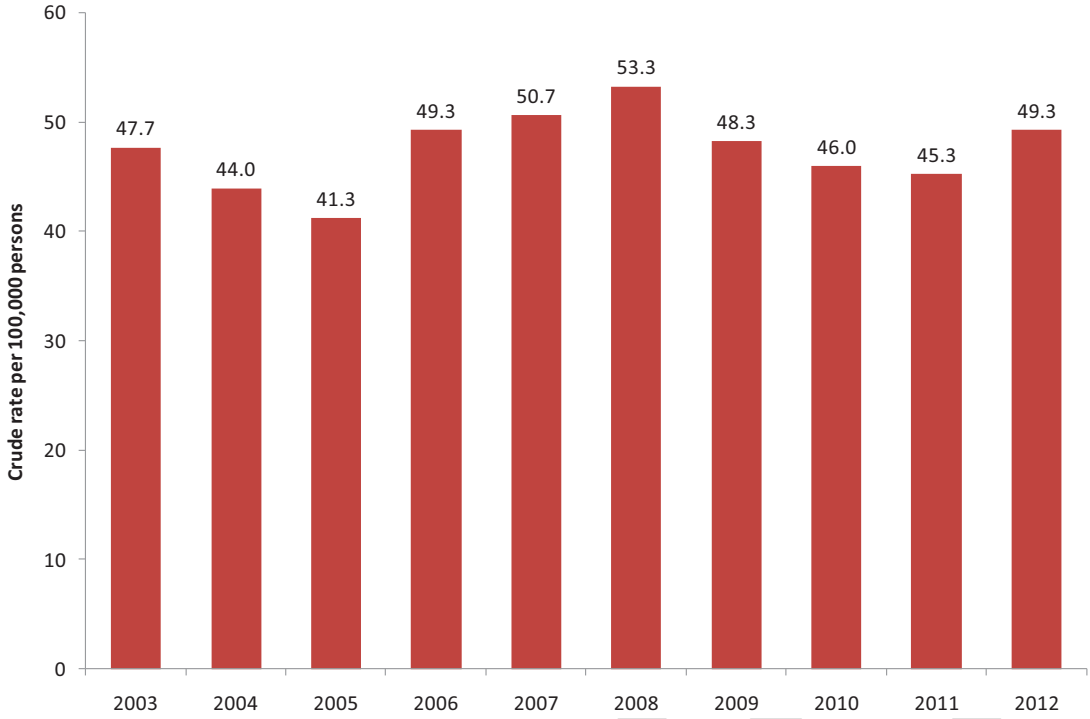
Given the smaller numbers involved, there is even more year-on-year variability in this data in the City. Since 2003, the long-term trend on a three-year rolling average shows a generally consistent number of casualties (Figure 6.6).

The unusual resident population in the City make it inappropriate to present the road casualty figures in direct comparison with those for neighbouring boroughs.

Table 6.5 Road casualties by road user type, 2012 (Dept for Transport)

	City of London (N=58)	London (N=3022)	England (N=21,630)
Pedestrian	33%	44%	31%
Pedal cycle	45%	23%	16%
Motor cycle	16%	21%	22%
Car	3%	16%	35%
Bus or coach	3%	3%	1%
Van / light goods	0%	1%	1%
HGV	0%	0%	1%

Figure 6.6 Three-year rolling average of killed or seriously injured casualties in the City, 2003-12 (DfT)


Crude rate per 100,000 persons
60
50
40
30
20
10
0
47.7
44.0
41.3
49.3
50.7
53.3
48.3
46.0
45.3
49.3
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012

Green Spaces

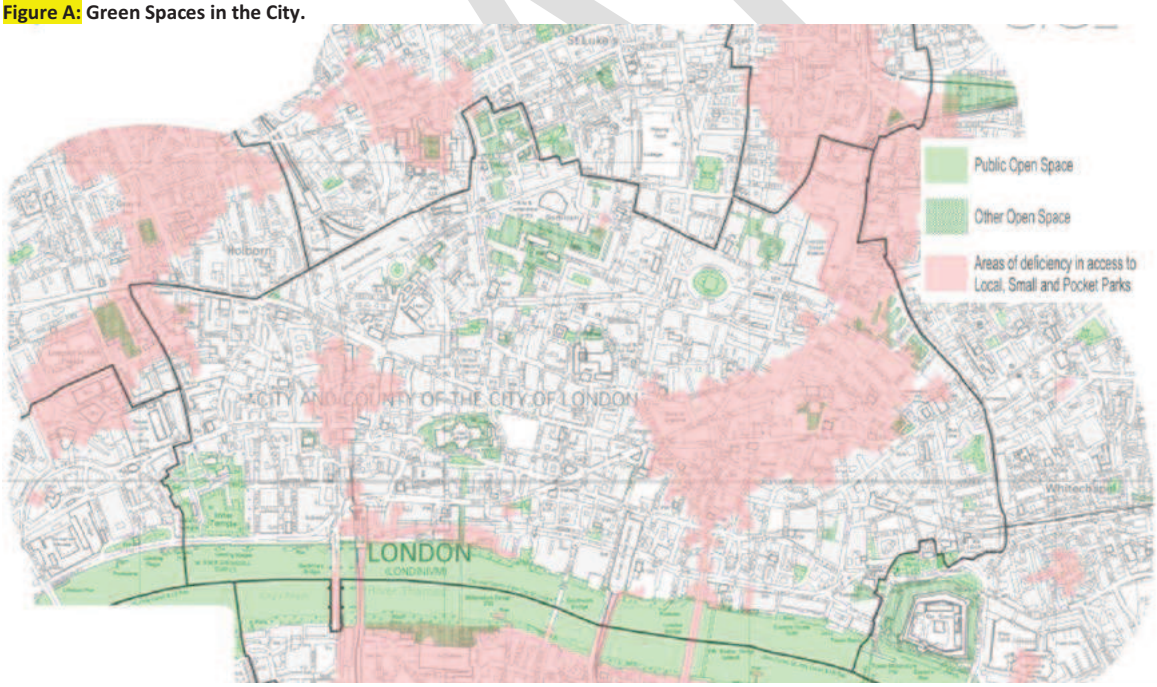
Open spaces in the City of London are an important resource for residents, workers and visitors. A survey of the large daytime population in 2012 found that 86% use the City's public gardens regularly, with 36% visiting at least once per week. Almost all users (79.4%) rate these spaces as good or very good[28].

As at 31st March 2012, the City of London was found to have 32.09 hectares (320,900 square metres) of open space (this does not include land closed due to construction works)[29]. In the City, 71% of all space that is openly accessible to the public is deemed appropriate for disabled access.

The City's Open Space Strategy aims to encourage healthy lifestyles for all the City's communities through improved access to open spaces, while encouraging biodiversity[30]. Given the constraints on land in the City, the City of London Corporation focuses on improving the quality of the limited open space available and where possible, also seeks to identify opportunities to increase provision of green space. One such way is by seeking to maintain a ratio of at least 0.06 hectares of high quality, publicly accessible open space per 1,000 weekday daytime population. Figure A shows the green spaces in the City of London where the pink areas are defined as area of deficiency in access to local, small and pocket parks[31].

In the City, there are 5.2 hectares (51,800 square metres) of parks and gardens, of which 88% are open to the public. This space, separate from classified civic and market squares, provides accessible high quality opportunities for informal recreation and community events.

Figure A: Green Spaces in the City.



(Better Environment, Better Health, a GLA Guide to London Boroughs, London Borough of City of London 2013)

[28] City Gardens Visitor Survey 2012
[29] Open Space Audit Report, April 2013
[30] Open Space Audit Report, April 2013
[31] Better Environment, Better Health, a GLA Guide to London Boroughs, London Borough of City of London 2013

Eleven of the open spaces within the Square Mile are Sites of Metropolitan, Borough or Local Importance for Nature Conservation due to their importance for wildlife. The Open Spaces Department works with residents, local schools and volunteers to maintain these important sustainable assets, as well as delivering a range of opportunities for education and healthy lifestyles.

In 2012, the City's gardens won Gold and category winner in the London in Bloom competition, as well as gold awards in a number of individual disciplines. Bunhill Fields won both a Green Flag Award and a Green Heritage Award, and received Grade One status on the national Register of Parks and Gardens.

The Aldgate Project

The Aldgate gyratory lies on the eastern edge of the Square Mile. Following the adoption of the Aldgate and Tower Area Strategy in 2012, the City proposes to introduce two-way traffic on Aldgate High Street, Minories, St Botolph Street and a section of Middlesex Street. These changes will enable a new public space to be provided between Sir John Cass's Foundation Primary School and St Botolph without Aldgate Church. A smaller public space is also planned for the southern end of Middlesex Street.

The project aims to make Aldgate feel safe, inviting and vibrant by:
- enhancing safety for road users
- improving cycling routes
- improving pedestrian routes and connections
- introducing more greenery
- creating a flexible public space for events, leisure and play
- improving lighting

The City is working with the London Borough of Tower Hamlets and Transport for London in developing these proposals. The Mayor of London's Cycling Vision and Transport for London's (TfL) Better Junctions programme have contributed to the proposals to provide cyclists a less intimidating and higher quality experience as they move through the area.

Health and wellbeing benefits of this new space include reduction in noise, air pollution, as well as increased pedestrian and cycling space.

Noise Pollution

Excessive noise seriously harms human health and interferes with people's daily activities at school, at work, at home and during leisure time. It can disturb sleep, cause cardiovascular and psychophysiological effects, reduce performance and provoke annoyance responses and changes in social behaviour.[32]

The City of London received 1075 complaints about noise in 2013/14 from both residents and businesses. These concerned a range of sources, but were predominantly related to construction sites, street works and entertainment venues.

[32] WHO Regional Office for Europe, Noise.

The City's Noise Strategy was adopted in 2012 and an action plan is currently being implemented. This brings together in one place the different strands required to maintain or improve the City's noise environment. It addresses the following: new developments, transport and street works, dealing with complaints, and tranquil areas. It is hoped this will contribute to the health and well-being of the City's communities and support businesses by minimising or reducing noise and noise impacts.

The Public Health Outcomes Framework reports a very high percentage of the City's population is affected by noise; however, this statistic is based on total noise complaints (including those from both residents and businesses) divided by the resident population, and so uses two different populations to calculate the figure.

Leisure facilities

Golden Lane Sport & Fitness (formally known as Golden Lane Leisure Centre) has been open since January 2012. The centre runs programmes and memberships aimed at engaging the wider community such as City workers, residents and children. There are currently over 1100 prepaid members who regularly use the centre, and approximately 2000 casual pay-and-play uses per month. This core use is in addition to school and after school swimming lessons; various clubs and courses ranging from taekwondo, gymnastics, netball and tennis; and the continuation to develop sports activity programmes through the Community & Sports Development team.

The high land values and density of existing buildings in the City mean that space for new development of sports facilities is limited, and often comes at a significant premium. Therefore the Sports Development team uses the City's landscape which provides an environment that is conducive to active travel, walking, jogging, cycling, running, and participating in activities such as Street Gym (where the landscape is the equipment). A number of sports programmes and activities have been held in unconventional City spaces, such as the dance floors in bars and on the streets, that aim to engage with City workers and residents who cannot afford to access the large number of private gyms in the City.

The table below demonstrates the accessibility of facilities for sport and physical activity in the City of London. It shows which facilities are accessible by private members, those which are bookable by the public and those which offer full public access.

TableXX: Facilities in the City by membership accessibility.

Facility Type	Private	Bookable	Public	Total
Artificial / Turf pitches (ATPs)	1	-	-	**1**
Gyms /Fitness Centres	29	1	1	**31**
Parks and open Spaces	-	-	39	**39**
Playgrounds	-	-	6	**6**
Squash Courts	5	-	-	**5**
Sports Halls	3	1	2	**6**
Swimming Pools	13	-	1	**14**
Tennis Courts	-	1	2	**3**
Total	**51**	**3**	**51**	**105**

(Source: City and Hackney Healthy Weight Strategy: Facility Audit, Active Places Power)

Targeted services

A range of targeted programmes have been designed specifically for those who are most inactive and/or with specific health conditions that could be improved through physical exercise. These include a range of activities and health advice which is on offer for workers, residents and families to adopt a healthier lifestyle. In January 2013 the City of London piloted an "Exercise on Referral" scheme. Following its success, the programme was launched in March 2013.

Young at Heart

Young At Heart is a City-led programme offering opportunities to people over the age of 50 to improve their physical and mental health, fitness and wellbeing through physical activities, health seminars, wellness events and free quarterly health checks and advice. Now in its 8th year, the scheme has engaged over 700 individuals in activities including gentle exercise, line dancing, short mat bowls, swimming, gym workout, chair-based exercise, Pilates, ballroom dancing, table tennis and guided walks. The programme also offers social aspects and events such as back correction workshops and nutrition talks.

City of Sport

City of Sport is a project launched in 2011 aimed at lower paid and inactive City workers. The calendar of events includes training sessions with fully qualified coaches in fencing, Pilates, Zumba, badminton, table tennis, swimming and tennis. It offers 14 hours of quality coaching per week to increase participation in sport on a pay-as-you-go basis to breakdown access barriers. The programme was awarded the Inspire Mark by the London Organising Committee of the Olympic Games.

Cultural facilities

Libraries, museums, theatres and art galleries deliver many benefits for local communities, promoting education and learning, creativity and personal development, and greater identification and belonging for residents and workers within their locality. They also offer an opportunity to communicate with users about health and wellbeing through embedded programmes and marketing and media opportunities.

Research into personalised budgets in adult social care has highlighted the likely increase in demand for cultural and leisure services from people receiving personal budgets. Such mainstream services are likely to pay an important role in helping people socialise, meet new people, go out and engage in specific activities like art and music[33].

Libraries

The City of London has five major libraries at the Barbican, the Guildhall, Shoe Lane, City Business Library and the new Artizan Street Library and Community Centre (replacing the former Camomile Street Library). Several of these libraries are designated as being of regional or national importance. For example, City Business Library provides its users with access to a wide range of financial and business data and runs a full programme of events to support business start-ups and sole traders; the Guildhall Library specialises in the history of London and the City, and holds significant

[33] Wood C: Personal Best, DEMOS, 2010

collections including those of many Livery Companies, the Stock Exchange and Lloyd's of London; and the Barbican Library houses a specialist music library which is a centre of regional importance excellence and holds an international award for excellence.

The libraries in the City also provide for local communities with a wide variety of services and learning resources. Some services and programs offered include community language collections, help and advice sessions, ESOL and self-help classes, a toy library and an extensive programme of work with local schools, nurseries and children. Others include Rhymetime, and Stay and Play sessions for under 5s with their carers at all lending libraries, and also a Read to Succeed reading scheme, which partners children with trained volunteer reading mentors at Barbican and Artizan Street Libraries. An evaluation of services offered to families in the City in 2011 found that libraries are the most used services and the most valued[34]. The great majority of City residents (85%) use the City's public libraries and are members of at least one City Library (75%). 33% of City workers and 11% of people living and working outside of the City hold membership at a City Library. The Barbican and Barbican Children's libraries attribute 35% and 20% of visitors from all categories respectively.

All libraries take health and wellbeing information provision very seriously and offer for loan a wide variety of self-help books. Additionally, libraries are a good source of public health leaflets and information and offer customers the opportunity to participate in regular health-related events and activities.

Museums and Theatres

Museums in the City include the Museum of London, the Clockmakers' Museum, the Bank of England Museum and Dr Johnson's House. Galleries include the Guildhall Art Gallery and the two art galleries at the Barbican centre. The Barbican also houses a concert hall, two theatres and three cinemas, and presents a variety of world class calibre performing and visual arts.

Every year the City of London spends over £80m on its culture and leisure services, including everything from libraries, open spaces, and street scene to arts institutions, festivals, museums, galleries, ensembles and the Guildhall School, one of the UK's leading conservatoires. In addition to the many other attractions surrounding the Square Mile, City arts festivals and institutions regularly attract over 10 million visitors annually.[35]

Satisfaction is very high for libraries (93%), museums/galleries (87%), and theatres/concert halls (85% satisfied) in the City[36]. In 2011, 94% of service users agreed that the City's libraries, archives, and Guildhall Art Gallery offered appropriate and accessible learning opportunities both for citizens, and community groups, whilst 99% of parents, carers, and teachers agreed that the City's libraries, archives, and Guildhall Art Gallery services and activities contributed to the enjoyment and achievement of children and young people through increased participation in a broad range of high-quality activities.

[34] City Family Festival Life Survey, 2011
[35] City of London Cultural Strategy 2010-2014
[36] Public Library Users Survey (PLUS) 2010

Air Quality

Air pollution in urban environments, even at the relatively low levels in London, is recognised as a threat to human health, warranting further action to reduce air pollution over coming years.

At the levels found across London, and in the City, it is a significant cause of disease and death, especially heart disease and lung cancer, but also respiratory disease and asthma. Department of Health figures suggest it may be as much as the fifth highest cause of death in London, ahead of communicable disease, passive smoking, alcohol abuse, road accidents and suicide[37]. As pollution particles pass into the blood and travel throughout our bodies they inflame many organs, and there are now associations with Alzheimer's and Parkinson's diseases, Type 2 diabetes, cognitive impairment and learning problems in children[38]. Air pollution disproportionately affects the elderly, poor, obese, children and those with heart and respiratory disease, but it has effects on everyone exposed to it to some extent.

The Public Health Outcomes Framework identifies the City as having the highest fraction of mortality attributable to particulate air pollution – this is based on modelled estimates, using the air quality readings in the local area.

Source and levels of air pollution in the City

Air pollution is made up of gases and very tiny particles that are not visible to the naked eye. The main source of air pollution in the City of London is diesel vehicles.

Air quality is monitored in the City and this data compared to health based targets. The targets for small particles (PM10) and nitrogen dioxide are not being met. Levels of tiny particles, PM2.5, also need to be reduced. At busy roadsides in the City, the annual average level of nitrogen dioxide is around three times the target. Figure x shows the annual average levels of nitrogen dioxide across the City.

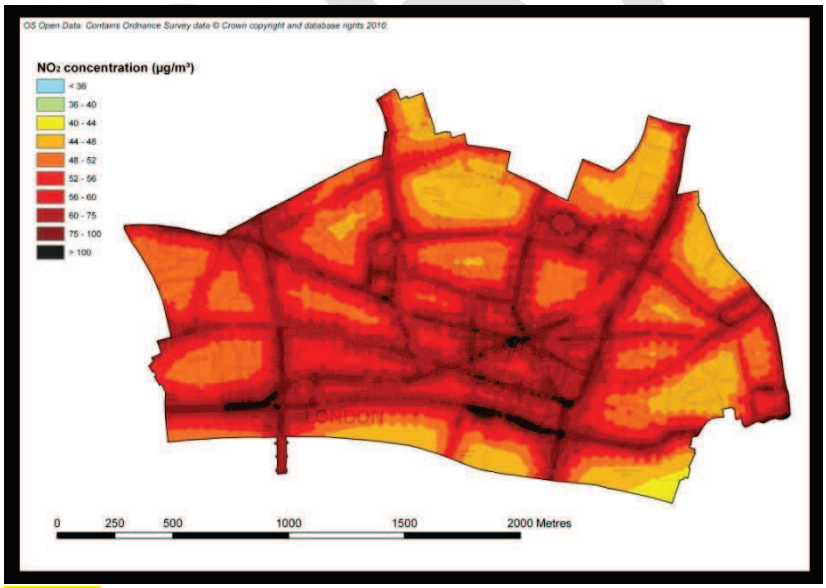


Figure x Annual Average Concentrations of nitrogen dioxide across the City.

[37] Report to the City of London Health & Wellbeing Board on Air Pollution, 2014. Iarla Kilbane-Dawe & Leon Clement, Par Hill Research Ltd

[38] The City of London Air Quality Strategy 2011

Improving air quality

The City published an Air Quality Strategy in 2011, which outlines plans and programmes to improve air quality in the Square Mile. The City is implementing a number of actions to reduce emissions of pollutants. Key areas are:

- Reducing emissions of pollutants from the City's own vehicles and buildings
- Taking action to reduce pollution from idling vehicle engines by requiring drivers of parked vehicles to turn their engines off
- Gaining the support of City businesses to reduce pollution through the CityAir programme
- Using planning policy to help improve local air quality
- Controlling emissions of pollutants from construction and demolition sites
- Considering air quality in traffic management decisions
- Working with the Mayor of London, other London Boroughs and the government to improve air quality across London
- Encouraging and rewarding action by other organisations through the annual Sustainable City Award, the Clean City Award and the Considerate Contractors Environment Award.
- Reducing emissions associated with taxis by improving taxi ranks and encouraging taxi drivers and the public to use them
- The City also monitors air quality to assess levels of pollution and measure the effectiveness of plans and policies to improve air quality.

Reducing exposure to air pollution

Despite many programmes in place to improve air quality, pollution levels in the City can be high in certain weather conditions. The City of London Corporation provides information in a number of ways to help people who spend time in the City to reduce their exposure. Additional initiatives include:

- Working with Barts Health NHS Trust to provide information directly to patients that are vulnerable to poor air quality, as well as improving air quality around Barts' hospital sites across London
- Working with Sir John Cass School to help the children to understand urban air quality and improve air quality around the school
- Producing and promoting a smart phone app, CityAir, to help people reduce their exposure to pollution across London
- Monitoring air quality with City residential communities to increase their understanding of how pollution varies in urban areas, and what can be done to reduce exposure

Climate Change

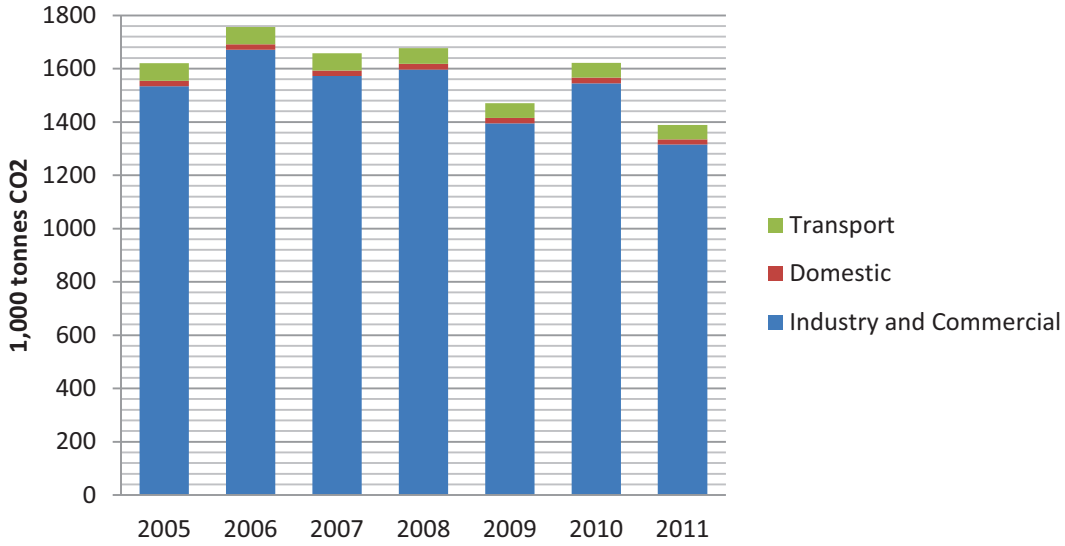
Climate change in the City

In the City, carbon emissions overwhelmingly come from commercial buildings (Figure 2.6).
The overall level of carbon emission fell by 13.7% between 2010 and 2011 from 1,621,700 to 1,388.800 tonnes CO_2[39].

[39] Department of Energy and Climate Change, AEA, Local and Regional CO2 Emissions Estimates for 2005-2011 plus, subset data of CO2

Per capita CO_2 emissions are not relevant in the City due to the small resident population.

Figure 2.6 Sources of carbon dioxide emissions in the City, 2005-2011 (AEA)



Crime and Safety

Crime affects the health of individual victims and the communities within which they live and has an impact on local health services. Perceptions of the incidence of crime and feelings of personal safety can have widespread effects on the way we live. Fear of crime can be a debilitating experience for many people.

In 2008, almost all City residents said they felt safe when outside in the local area during the day, and over four in five felt safe after dark. Residents viewed drunkenness and rowdiness in public places as the biggest local anti-social behaviour issues, followed by noisy neighbours, teenagers hanging around on streets, and rubbish and litter[40].

Policy on crime and community safety in the City is overseen by the Safer City Partnership. The 2013/14 priorities of this partnership are:

- Anti-social behaviour
- Domestic abuse
- Reducing re-offending
- Night-time economy issues
- Fraud and economic crime
- Counter terrorism
- Civil disorder

The most common reported crime in the City is theft, which includes shoplifting, pedal cycle theft and theft from a person.

[40] *Assessing the City of London's performance. Results of the Place Survey 2008/09 for the City of London Corporation and partners.* Ipsos Mori/ City of London Corporation, 2009.

From 2011/12 to 2012/13 overall crime in the City fell by 9.5% (586 offences). Despite this overall decrease there were still increases in some crime categories (violence against the person with injury, rape, personal robbery, non-dwelling burglary and public disorder) however even in these categories, crime levels remain comparatively low in the City.

The City's night-time economy has grown over recent years, with a large number of people now visiting the City specifically to socialise in the evenings. There have been significant changes around the opening hours and licensing of venues, particularly with regards to alcohol licensing and smoking legislation. Whilst the night-time economy can be a source of income and employment in the City, it also has negative effects, in the form of violence, noise, and other anti-social behaviour.

In 2012/13 there were 140 domestic abuse incidents reported in the City. Of these, 118 were reported to the City of London Police and 22 were reported to other agencies (City of London Corporation, City Advice).

Deprivation

In 2010, the City of London was ranked 262 out of 326 boroughs, with 326 being least deprived[41]. However, there is considerable variation between wards. Clear socio-economic differences remain between the Mansell Street and Middlesex Street estates in Portsoken and the wealthier Barbican estate in the northwest of the City.

Housing

Housing tenure has been consistently found to be associated with morbidity and mortality, with health outcomes worse among those who live in social housing. Tenure is often a reflection of socio-economic factors and advantage which are also determinants of good health and well-being. However, factors such as the physical quality of housing and its local environment (such as damp, overcrowding, crime and poor amenities) may also determine poor health outcomes independent of factors such as income.

The City, like much of central London, has a housing stock polarised between very high cost owner-occupied or private rented housing and social rented housing. Despite its small residential population, the City faces key challenges including overcrowding, housing affordability and homelessness, particularly rough sleeping.

The City's Housing Strategy 2014-19 includes a priority to support vulnerable groups within their communities with the aim to build more resilient communities. Prevention, promoting independence, and earlier intervention are central to the approach and focuses on the following vulnerable groups and issues of inequality:

- To prevent homelessness
- To tackle rough sleeping
- To support living for people with disabilities
- To support older people
- To intervene early to reduce inequalities and tackle deprivation

[41] Resident Deprivation Index 2010, City of London, Planning and Transportation

Housing stock and households

As it is primarily a business district, the City has an unusual housing and household profile. The City of London Core Strategy (September 2011), which sets out the planning strategy, divides the major planning areas into five Key City Places (Figure 2.3). Study Areas indicate the spatial concentration of housing units. The majority of the City's units - 3,718 units (61.3% of the total) are located in the North of the City. This is due to the presence of large concentrations of dwellings, particularly at the Barbican Estate (2,069 units), Smithfield (736 units) and Golden Lane (651 units). The Key City Places of Aldgate, Thames & Riverside, and the Rest of the City are areas of mixed land use, while Cheapside, St. Paul's and the Eastern Cluster are Key City Places focused upon business activity and have the lowest number of units. 50% of dwellings in the City have two or fewer "*habitable rooms"*, with 20% having only 1 habitable room[42].

Housing tenure

There were 6,064 dwellings in the City of London as of the 31st of March 2011. The largest type of household tenure in the City of London is privately rented accommodation, which makes up 36% of all households. This is greater than seen in both Greater London, and England and Wales.

Household tenure with a mortgage in the City of London (17%) is significantly lower than Greater London (27%), and England and Wales (33%). There are a relatively high percentage of households in the City of London that are 'rent free' 5%, compared to 1% in Greater London and England and Wales. This could be explained by residents living in company owned flats. Figure 2.4 shows the visual comparison in housing tenure compared to Greater London and England and Wales.

There are three social housing estates, two of which are owned or managed by the City of London Corporation, with the majority of the rest of the residential accommodation either owner occupied or privately rented. Overall, 83% of dwellings are owner occupied or privately rented, and 16% are social rented

In the City, more than 50% of households comprise of one person, which is significantly higher than the profile for Greater London and England and Wales, both of which are approximately 30%. Within the City, 12% of households comprising of one person are of pensionable age as of the 2011 Census.[43]

The City of London has a very high percentage of households with no children (80%). The number of households with dependent children is very low: 10% of all households.
[44]

Figure 4.1. Dwellings in the City of London, March 2012

[42] City of London, Housing *info*, March 31 2011. *The term "habitable room" refers to any room within a housing unit, apart from a bathroom, kitchen or hallway.*
[43] *For these purposes, Pensionable age refers to 65 years old and older, although by definition Pensionable age is anywhere between 61-68 years of age.*

[44] [7] City of London, Residential Population, Households, Census 2011

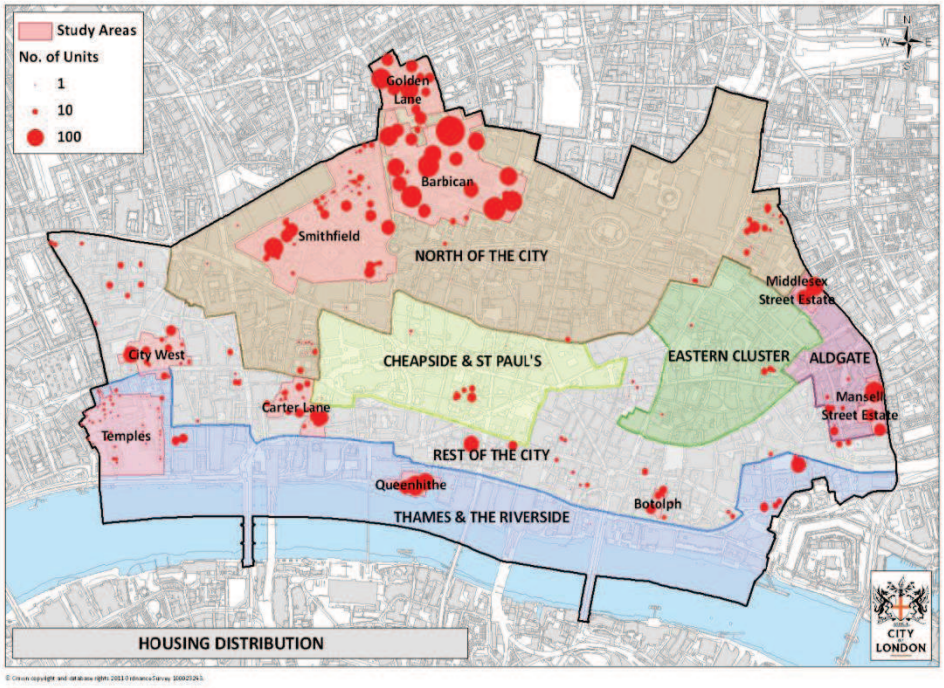
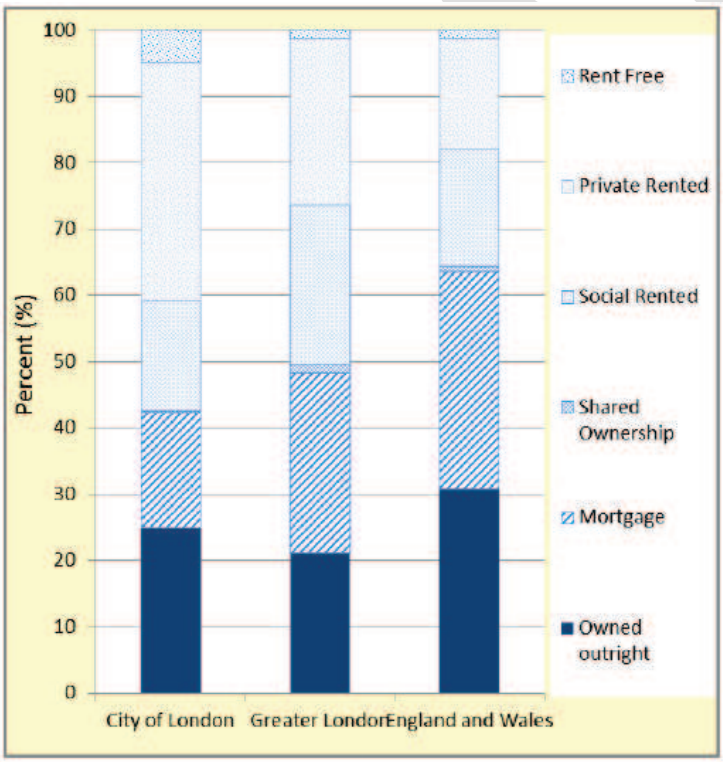


Figure 2.4 – Household Tenure, Census 2011



City Workers

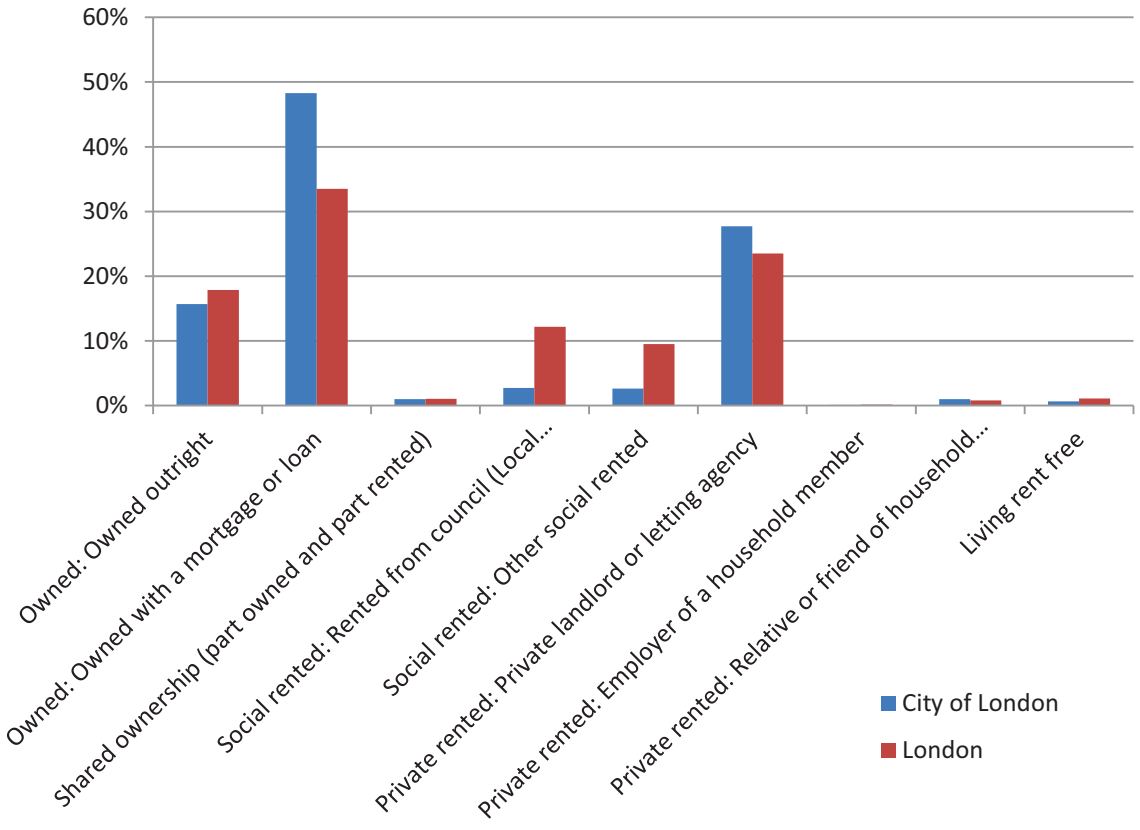
The new Census data has provided an opportunity to present the housing tenure amongst daytime City workers. 48% of City workers own property with a 'mortgage or loan' which is notably higher than the London average of 33%. Another 28% live in privately rented property, which is slightly

higher than the London average. A very small proportion of City workers live in social rented homes (3% rented from council and another 3% from other social rented sources).

The pattern of housing tenure overall can be seen as consistent with the average income profile of City workers, that is, the City of London has the highest average weekly wage of all districts in the UK.[45] Thus, the low percentage of workers in social housing is to be expected. Although private renting can offer some of the poorest housing quality and overcrowding, in the City the proportion of renters affected by this may be diminished, since those with above average earnings would be able to afford better living standards amongst the rented options.[46] Despite this, there remain City workers not in the higher income profile, for example those working in retail which would also most likely feed into the 'private rented' category.

The relatively large portion of 'private renters' may be reflective of the transient nature of the population. This may affect health by increasing the chance of gaps occurring in health records from moving GPs. Finally the large proportion of home owners with a 'mortgage or loan' is also predictable in this population who on average are earning higher than average incomes early in their career.

Figure 4.2: Housing Tenure of City workers



[45] BBC 2012, Average earnings rise by 1.4% by £26,500 by April says ONS
[46] Scottish Government 2010, Review of literature on the relationship between housing and health

Housing standards

Poor housing conditions can affect health in a variety of ways. They are associated with increased incidence of infections, respiratory disease, asthma, heart disease and hypothermia. Poor housing conditions can also increase depression, stress and anxiety. The World Health Organisation identified the main significant hazards associated with poor housing conditions as poor air quality, tobacco smoke, poor temperature, slips, trips and falls, noise, house dust mites, radon and fires.

Since 2000 there has been a clear government focus on improving the quality of the existing social housing stock nationally. This focus recognises that well maintained homes that meet a minimum standard of decency are fundamental to the health and wellbeing of individuals and the community. The standard set – the Decent Homes Standard – requires social homes to be in a reasonable state of repair, have reasonably modern facilities and services, and provide a reasonable degree of thermal comfort.

The City met its Decent Homes target by 2010, with the exception of Great Arthur House, a listed tower block on Golden Lane Estate, where progress has been slowed by the building's listed status. The City has agreed with the GLA that work on Great Arthur House will be completed by 2015, and more broadly continues to improve the condition of its housing assets through programmed works to meet and maintain decent standards.

Fuel poverty

The level of fuel poverty in the City is relatively low and has been relatively stable since 2006, despite rising energy costs. It is estimated that 163 households (3.4%) in the City need to spend more than 10% of their household income to heat their home to a comfortable standard.

In 2013, the definition of fuel poverty was changed. According to the government's new definition, a household is said to be in fuel poverty if:

- they have required fuel costs that are above average (the national median level)
- were they to spend that amount they would be left with a residual income below the official poverty line

According to this new definition, 120 households in the City (2.5%) are in fuel poverty.

Both methodologies identify LSOA 001A (Aldersgate) as being the area with the highest rates of fuel poverty. However, all areas in the City are below the national average of 11% fuel poverty.

Overcrowding

Around 1 in 3 of all households in the City live in accommodation lacking one or more rooms. In terms of demand for social housing, 326 of the households (218 applicants and 108 existing tenants) on the City's housing register are overcrowded. Overcrowding has implications for health and child development and impacts disproportionately on certain sectors of the population, such as black and minority ethnic households. Overcrowding can also contribute to family breakdown, noise nuisance and perceptions of anti-social behaviour, especially where people live in close proximity with neighbours.

Homelessness

In 2012/13, the City took 37 applications from households who were homeless or at risk of homelessness. This level of applications has increased markedly in the last two years, and is set to continue at this level in 2013/14. Of those that applied for assistance in 2012/13, 20 were both homeless and in priority need and the City accepted a duty to secure settled accommodation for them.

The City also provided temporary accommodation to 25 households who were either homeless applicants pending a decision on their case, or those to whom the City had a duty to house and were awaiting an offer of settled accommodation. The City is rarely able to provide temporary accommodation within its boundaries, but for the majority, temporary accommodation stays are less than six months in duration.

Advice services commissioned by the City provided assistance to 19 people at risk of homelessness in 2012/13. In addition, the City Housing Needs and Homelessness teams provided advice and assistance to prevent or end the homelessness of a further 51 households.

Rough Sleeping

The City funds Broadway to provide outreach to rough sleepers in the City, and arrange accommodation through links with hostels. They also refer rough sleepers to No Second Night Out and No-one Living on the Streets, which are both rapid assessment and response services for rough sleepers who are new to the streets; and intermediate-term rough sleepers who wish to move away from living on the streets. The City also supports the Middle Street Hostel with financial support and funding a part-time support post.

The City has developed innovative accommodation and service models to support its most entrenched rough sleepers off the streets. Working with St Mungo's, the City has developed a new model of hostel accommodation for long-term rough sleepers, whose needs are distinct from those who are more transient or chaotic. The accommodation, known as The Lodge, breaks away from the traditional model and approach of a hostel, to offer hotel style accommodation. In doing so, The Lodge has succeeded in engaging, accommodating, and supporting a client group that would not have otherwise been.

Some long term rough sleepers remain resistant to support from services. In 2010 the City of London's outreach team piloted a new way of working with this group, focussing on personalisation. The project moved away from the standard model of outreach, to provide longer term, more intensive engagement, and the offer of a personal budget to enable flexible and creative approaches. The project was developed and is delivered by Broadway, a London based homelessness charity commissioned to provide outreach in the City. To date the project has succeeded in engaging 27City rough sleepers and accommodating 26. In 2011, the project was rolled out Pan-London and the City of London, in partnership with Broadway, received the Andy Ludlow award for the work.

The City of London has recently introduced new "pop-up hubs", in association with Broadway and the local churches, which take the form of a five-night intensive support facility, staffed by a multidisciplinary team. These hubs provide an opportunity for those sleeping rough at the time to

engage with a number of key services, all in the same venue, to help them find the support they need to leave the streets.

5. Early Life and Family Life

This section covers key aspects of the health and wellbeing of children and young people aged from birth to school leaving age (i.e. ages 0 – 18 years). It also deals with matters relating to family structure, and maternity.

Influences on health and wellbeing begin before birth. Our development, the environment we grow up in and the behaviours and attitudes we take on in our early years impact on our health and wellbeing for the rest of our lives. As an individual gets older, the influences of their education, socialisation, peer pressure and support, and the difficult transition from adolescence to adulthood become more important.

Key Findings

- There are relatively few families and few births in the City. The majority of households in the City are singles persons.
- Of children and young people aged 0-19 in the City, 43% are from Black and minority ethnic (BME) backgrounds
- The City has a good record of caring for looked-after children
- Children in the City have excellent early years provision and perform very well in primary school.
- In the City's one maintained school, 100% of school pupils participate in at least 2.5 hours of organised physical education per week.
- Local figures identify that 21% of children living in the City of London are in low-income households. Previous national figures calculated that 19% of children in the City live in poverty.
- 22.3% of primary school children are eligible for and claiming free school meals

Recommendations

- It will be an important period to monitor evidence based outcomes in children, in order assess the impact of recent policy and service provision changes.

Questions for commissioners

- How are commissioners preparing for the transfer of public health responsibility for 0-5 year olds transferring to local authority in October 2015?
- 43% of children and young people are from BME backgrounds. How can commissioners ensure that these young people and their families are supported effectively and are receiving appropriate services to meet their needs
- Are commissioners and commissioned services fully utilising the City's resources to support families out of poverty?

Young People

Local policy context

The Children and Young People Plan 2013 (CYPP) reflects the City's ambition to use the power of partnerships and multi-agency working to improve outcomes for all children and young people with a particular focus on preventative services. The CYPP is a strategic plan that supports service planning and delivery against seven key priority areas. These are:

- Stronger Safeguarding
- "Early Help"
- Children's Workforce Development
- Healthy Living
- Achievement and Learning
- Partnerships
- User Engagement

The City's Education Strategy 2013-15 also sets out a vision which is:

To educate and inspire children and young people to achieve their full potential.

Four key themes from the strategy define the City Corporation's approach to education:

- A commitment to creating a family of schools from its schools portfolio, which will have a shared culture and a common ethos
- To improve the governance and accountability frameworks of the education offer
- It recognises the role the City Corporation can play in its outreach provision across London and seeks to strengthen this offer
- Finally it confirms the City Corporation's commitment to providing pathways to employment and bridging the gap between education and employment, making use of the livery and business links within the Square Mile

Population

Demographics

The population data from the 2011 Census projects that there are 269 primary age (4 - 10) and 147 secondary age (11 - 16) children living in the City of London out of an estimated 843 total of 0 - 19 year olds[47]. Of the 843 young people aged 0 – 19 years, 361 (43%) are from Black and minority ethnic (BME) backgrounds.[48]

The City's Resident Insight Project recorded that in November 2012, there were 898 young people aged 0 – 19 years resident in the City, of whom 604 were aged 0 – 9 years and 294 were aged 10 – 19 years. Out of these 898 children and young people, 21% were identified as living in low income homes, i.e. homes with a low income supplemented by benefits.[49]

[47] ONS mid-year estimates for 2013
[48] Primary Education in the City of London, Annual Report 2013
[49] Ibid.

At the age of 11, when children leave the state primary school, it becomes harder to track their whereabouts in terms of schooling. Although around 18 children per year register to attend state maintained schools outside the City, it is not known whether these children remain City residents as they grow into older teenagers. Additionally, it is not known whether other children, who do not register, are going on to attend private schools outside the City, or whether the whole family is moving out of the City, and becoming a resident in another borough with more suitable housing for teenagers.

Disabilities

There were fewer than 10 children and young people with disabilities known to the City in 2013. The City's Special Education Needs and Disability (SEND) Strategy 2013-17 describes the City's strategy for children and young people aged 0-25 years with SEND. A disability register is also currently under review.

Looked-after children

The City has a good record of caring for looked-after children. All looked-after children in the City have stable placements and accommodation.

There were fewer than five children (aged 0 – 16) looked after by the City of London in 2012/13.[50] In the City, all the children who had been looked after for at least 12 months as of March 2013 had up-to-date health checks, immunisations, dental checks and health assessments. This maintains the 100% record of the previous year.

No resident children of the City of London were made subject to a court order, adopted or accommodated in 2012/13.[51]

Table 5.1 Number of children looked after by the local authority, 2009-2013

	City of London
2009	**15**
2010	**15**
2011	**10**
2012	**5**
2013	**5**

Physical activity

In the City's one maintained school, 100% of school pupils participate in at least 2.5 hours of organised Physical Education per week. They also have access to further physical activities if they so choose, through playtimes (up to 4 hours per week) and afterschool clubs (up to 4 hours per week).

[50] City of London Corporation, *Safeguarding Children Annual Report*, 2012/13
[51] City of London Corporation, *Safeguarding Children Annual Report*, 2012/13

Education and training

Schools

The City of London has one maintained primary school and three sponsored City Academies in neighbouring boroughs. It also supports three independent schools based in the City.

The one maintained primary school is Sir John Cass's Foundation Primary School with Cass Child & Family Centre, the City's one children's centre. Primary aged children attend Sir John Cass and a small number of schools in Islington, Camden and Westminster. Secondary age children attend a range of schools which includes Islington secondaries and schools in other neighbouring local authorities, including Tower Hamlets and Hackney.

The City currently funds fewer than 5 children to be educated in provision other than mainstream local authority education. Of the pupils attending the one maintained primary school, many of whom do not live in the City, 68% (971) are from Black and minority ethnic (BME) backgrounds.

In terms of youth 'not in employment, education or training', numbers in the City are too low to report with accuracy.

Primary School performance

In the City, 75% of eligible children aged five achieved at least 78 points across the Early Years Foundation Stage (2012), with at least six points in each of the scales in personal, social and emotional development and communication, language and literacy. These results are the second highest in the country and the highest in London.

The 2011 Ofsted inspection of City of London Corporation children's services found that all provision for early years education and childcare was good or outstanding, and that for children under the age of five, provision for early years education was outstanding. Achievement at age five was found to be well above average and continues to improve far more quickly than it does nationally. Sir John Cass's Foundation Primary School's most recent Ofsted inspection was in April 2013, when it was deemed to be outstanding in all aspects.

Attainment to Higher Education

The number of young residents (age 18-24) entering their first year of study either part-time or full-time in their first or undergraduate degree at a UK higher education institution has been decreasing over the five-year period from 2007/08 – 2011/12 (Figure 5.1). In the 2010/11 academic year, of those who completed their higher education in the same year, within six months, 33% were in full-time employment, 16.7% were in part-time employment while and 11.1% were self-employed. 22.2% however were not employed and not looking for employment while only 5.6% were unemployed and looking to be employed. [52]

[52] City of London: The higher education journey of young residents, July 2013

Figure 5.1 Young residents progressing to higher education 2007/08 - 2011/12 (HESA)

Apprenticeships

Apprenticeship is about helping young people fulfil their potential through personal and social development. Apprenticeship programmes can help tackle youth unemployment by helping to match skills demanded by employers and those available amongst the population, especially young workers.

The City of London Corporation provides a free apprenticeship placement service to support businesses in employing young people starting their careers. School leavers aged 16-18 who are unemployed are eligible.

This service gives candidates a first experience of the workplace whilst boosting employer performance. The programme supports apprenticeships within the Corporation, as well as with recognised names in banking, insurance, property and many other sectors.

Child poverty and deprivation

According to previous national figures, 145 City children (19%) were living in poverty in 2010. This figure was calculated using the relative poverty measure, and defined as the proportion of children living in families in receipt of out-of-work benefits or tax credits where their reported income is less than 60% of the median income.

In July 2013, the Resident Insight Project identified a total of 960 children living in the City of London, of whom 21% (197) were in low-income households (defined as being in receipt of low-income-based benefits). Because these two figures have different definitions, they are not directly comparable. Of the 197 children

The City of London Corporation will be conducting a new Child Poverty Needs Assessment in 2014.

This will be used this to review the delivery and targeting of services to better meet families' needs.

living in low-income households, 76 were in workless households (39%), with the remaining 61% in working households. This reflects the national figures, where the majority of all children growing up in poverty (63%) have at least one parent or carer who is in work.[2] This is an increase from 2000–01, when nationally 51% of poor children on the relative low-income measure were from working households.

Although the Resident Insight Project does not identify particular concentrations of child poverty in the City, there is likely to be a higher rate in areas of social housing around Portsoken and Golden Lane.

Free school meals

In the City of London, 22.3% of primary school children were eligible for and claiming free school meals. This is lower than the level in London and inner London, but just over 5% higher than the national average. There is one maintained primary school in the City, Sir John Cass's Foundation Primary School, and no maintained secondary schools. Of the children attending the school, 22% are entitled to free school meals.[53] 73 out of 1,428 children at this school are City residents aged 3–11.

Table 5.1 Free school meals in state-funded primary schools

Location	% eligible for and claiming free school meals
City of London	22.3
Inner London	31.9
London	23.7
England	18.1

Early years support

Local estimates from the Resident Insight project found that there are 364 children aged 0–4 currently residing in the City of London, of whom 79% are registered with the early years system Synergy Connect.

44 of the 364 children live in a home with a low income; 82% of this group are registered with the children's centre system and 26 are regular users of the centre.

27 of the 364 children live in a home where workless benefits are being claimed; 74% of this group are registered with the children's centre system and 26 are regular users of the centre.
There were 2,635 visits to the John Cass Children's Centre in the period April to August 2013. Of these, 42 visits were related to targeted family support.

The number of City of London children and families requiring statutory social care interventions is low compared with other local authorities. Very few children (six) were subject to a child protection plan in the City of London in 2012/13.[54]

[53] School Census 2013
[54] City of London Corporation, *Safeguarding Children Annual Report*, 2012/13

Youth Services

In 2012, youth services changed from being provided in house to being a commissioned service. Since 1 April 2013 the City of London's Youth Services have been delivered to 10 – 19 year olds (to 25th birthday for those with special needs) by Commissioned Providers. There are five strands of youth services for the City run by three service providers who took over contracts in April 2013. The services contracted are: the provision of Information Advice and Guidance, Universal Youth Services, Targeted Youth Services, Youth Participation and Client Caseload Management Information System. The changes are expected to improve outcomes based results and offer better value for money.

Children and Adolescent Mental Health Services

The mental health provision for children and adolescents in the City is provided jointly with Hackney. As at 2013/14 the services encompassed the following:

- Community Child Psychology Services
- Specialist Child and Mental Health Services
- Integrated Clinicians in Young People's Services

S came into care five years ago. Before coming into care, S had witnessed several incidents of violence between her mother and her mother's boyfriend. She was engaging in unsafe play and displayed aggressive behaviour towards adults and other children. She was referred to anger management services to help her come to terms with her past experiences.

Accessing the service

When concerns arose about S, the carer and social worker discussed these with CAMHS who were willing to see her.

S was seen by CAMHS for individual sessions and her carer was also offered support to help her deal with her behaviour effectively. An improvement in S's behaviour was observed, for example, she previously displayed anger outbursts however, this behaviour has now ceased both in school and at home. She has been given strategies to deal with her emotions in a more appropriate way and she has been observed to do this effectively by her foster carer and social worker. In discussions with her therapist and with the foster carer and social worker, it was felt that S could cease her sessions and they did; her progress was then reviewed with a meeting held with her foster carers, CAMHS worker, social worker and S. All were in agreement that she had made significant progress and that she should be discharged from the CAMHS service. Should it be necessary, it was made known that she could be referred in the future.

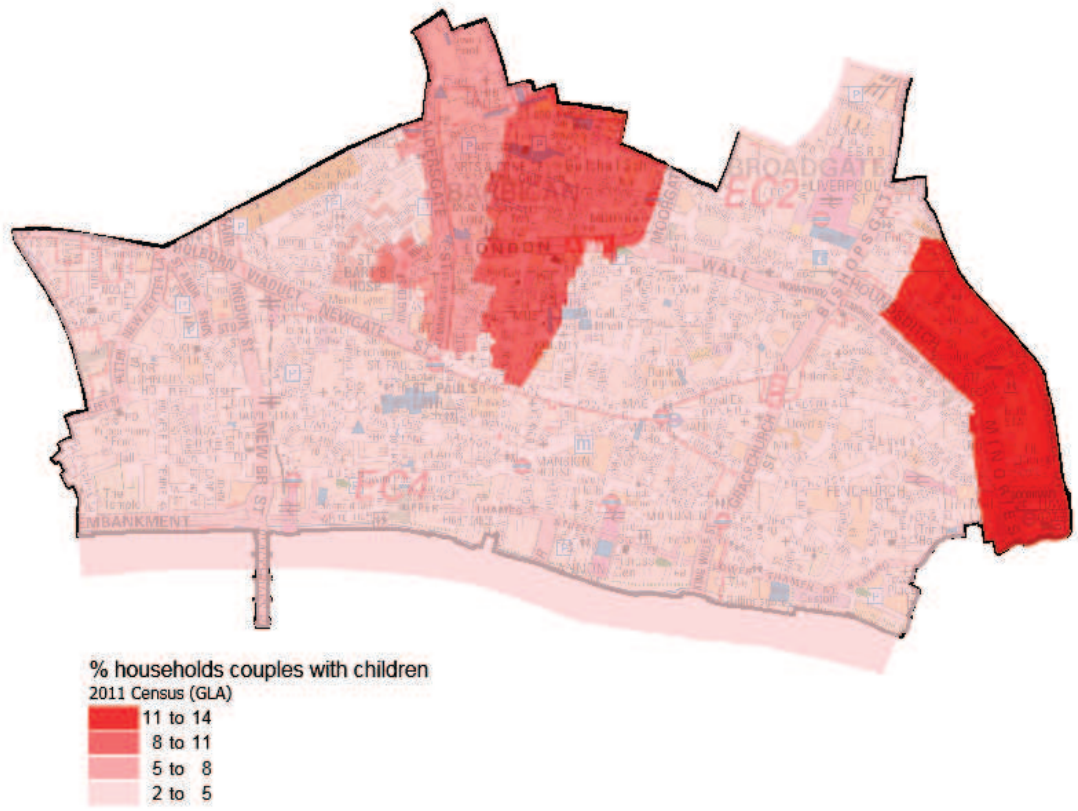
The Child and Adolescent Mental Health Service Framework 2013-15 outlines the vision for the development of emotional health and wellbeing, and Child and Adolescent Mental Health Services including an action plan with measurable outcomes aligned with wider national policy.

Families and households

The type of housing available in the City is not particularly suited to family life, particularly for older children. For example, 50% of accommodation in the City is two bedroom or smaller. Additionally, there is only one state school in the City, which is for primary aged children only. Despite this, there are some families in the City of London, with particular concentrations in the areas around Barbican, Golden Lane, Mansell Street and Middlesex Street.

The 2011 Census includes detailed information about household structure within the City. Single persons are the predominant grouping (60%) seen throughout the City. (Fig 1.13 A-E, See Appendix 7). Almost 30% of households in the north are couples without children. "Others" which mainly include shared housing, are concentrated in the east in Mansell Street and Middlesex Street Estates. Couples with children are mainly concentrated in the east with some in the north.

Figure 1.13A Household structure in the City: percentage of couples with children



For more information on family structure, see Appendix 6 - Road casualties

In the City, 58 people were killed or seriously injured on the roads in 2012, an increase of 18% on the previous year. With smaller numbers in the City, there is even more year-on-year variability in this data. (Figure 6.5)

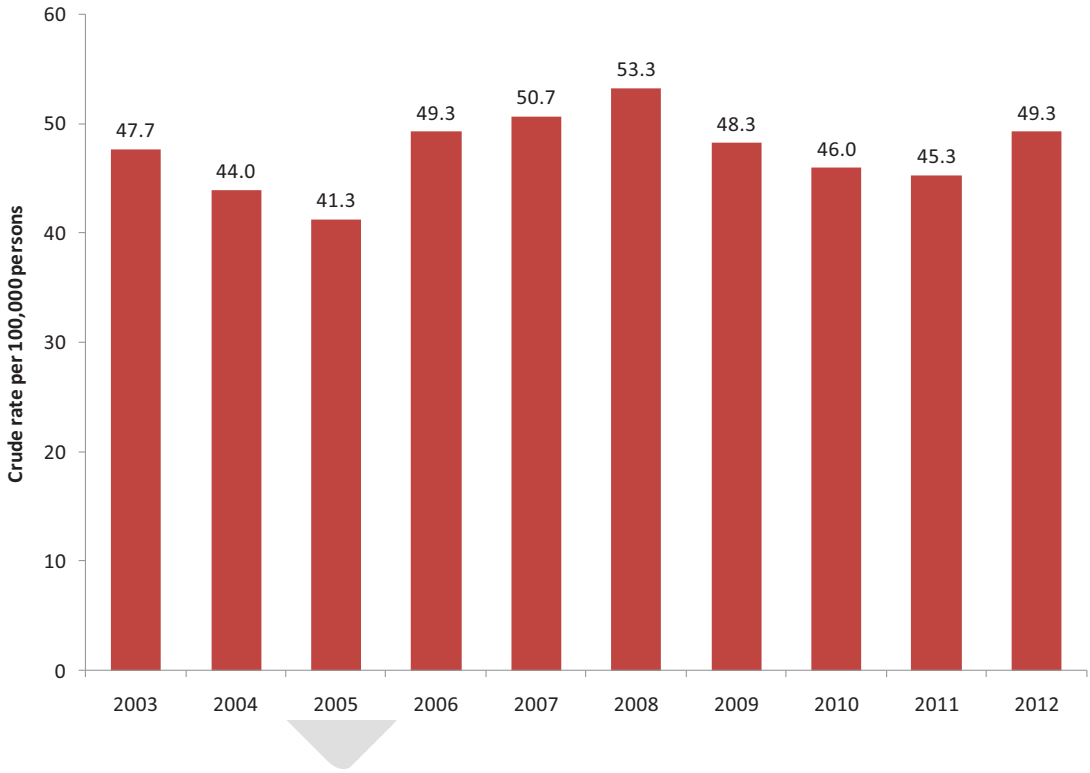
Given the smaller numbers involved, there is even more year-on-year variability in this data in the City. Since 2003, the long-term trend on a three-year rolling average shows a generally consistent number of casualties (Figure 6.6).

The unusual resident population in the City make it inappropriate to present the road casualty figures in direct comparison with those for neighbouring boroughs.

Table 6.5 Road casualties by road user type, 2012 (Dept for Transport)

	City of London (N=58)	London (N=3022)	England (N=21,630)
Pedestrian	33%	44%	31%
Pedal cycle	45%	23%	16%
Motor cycle	16%	21%	22%
Car	3%	16%	35%
Bus or coach	3%	3%	1%
Van / light goods	0%	1%	1%
HGV	0%	0%	1%

Figure 6.6 Three-year rolling average of killed or seriously injured casualties in the City, 2003-12 (DfT)



Maternity

Smoking and pregnancy

In 2010/11 none of the pregnant women resident reported being smokers at time of delivery.

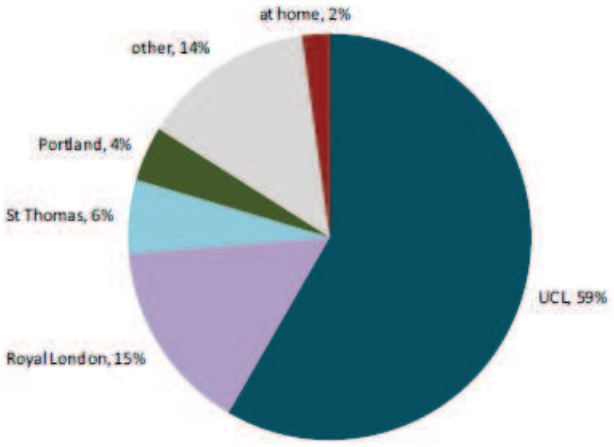
Antenatal care

Over the six months from April to September 2011, 21 women from the City booked for maternity care. Three quarters had booked by the 12th week.

Place of birth and delivery method

Between January 2010 and October 2011, 98% of births to City residents took place in hospital, mainly at UCL and the Royal London

Figure 5.8. Place of birth of babies born to mothers in the City Jan 2010 - October 2011 (hospital data)



Terminations

The abortion rate for City residents in 2012 was 11.7 per 1,000 women, which is much lower than the national and London averages.

Breastfeeding

In 2010/11 all babies born to City mothers were recorded as initiating breast-feeding and continuing breast feeding at 6-8 weeks.

6. Working Age

Those of working age, particularly men, tend to be the group least likely to engage with traditional health professionals. This is one of the many reasons that make the workplace a key setting for the promotion of health and wellbeing.

The nature of the work undertaken and the culture of the employing organisation can have both positive and negative effects on health. For example, most jobs offer opportunities to network with others, give structure and bring meaning to life, and offer an income. Many jobs, however, are now largely sedentary, contracts can be short or insecure, and unhealthy amounts of stress and pressure can be placed on individuals in a society which has some of the longest working hours in Europe.

According to the WHO Life Course Approach, functional capacity peaks in early adulthood.[55] Thus early adulthood is a critical period for intervention which can have a springboard-effect to alter subsequent life-course trajectories, with implications for health in older life. [56] Healthcare needs in this group tend to relate to specific short-term issues, for example, flu symptoms, as well as services aimed at reducing the rate of decline by reducing unhealthy lifestyle behaviours. Maintaining functional capacity, for example through supportive working conditions and options for starting family-work life balance are equally important to this age group. [57]

Key Findings

- The City has a new responsibility for coordinating and implementing work on suicide prevention; however, as very few people in the City are residents, there is a limit to what can be done locally.
- 23.7% of incidents reported to the City police were alcohol related or connected to licensed premises
- More women than average do not participate in the recommended levels of physical activity (both residents and non-residents)

Residents

- Unemployment is a significant contributor to poor health and wellbeing. There are discrepancies in unemployment in working-age residents between the different housing estates in the City.
- Mental health data for residents is limited to those registered in the Neaman practice.
- The City recognises the important contribution that carers make to population wellbeing and have developed support for carers as well.
- Unpaid carers provide vital support to vulnerable people in the City, and it is important that they receive appropriate support.
- The profile of residents using treatment services has changed from unemployed homeless drug users to those who in stable housing and employment who have an alcohol problem

[55] A Life Course Approach to Health, WHO 2000
[56] ibid
[57] The Public Health and Primary Healthcare Needs of City Workers, May 2012

City workers

- Between 2001 and 2012, the City of London saw the biggest increase in employees across 983 areas in London (36%) with Finance remaining the dominant sector in the City
- The majority of City workers (two thirds) are university graduates, which is twice than the London average.
- City workers smoke more than the London average. Quitting rates amongst City workers are relatively successful (50%).
- Alcohol misuse amongst both male and female City drinkers is considerably higher than national averages. Young white males are the predominant alcohol misusers.
- Over a fifth of City workers report suffering from depression, anxiety or other mental health conditions with a third reporting that their job causes them to be very stressed on a regular basis.
- The younger age profile of City workers also puts them at greater risk of sexually transmitted infections and for drug misuse.
- The City has been working to promote workplace health within the Square Mile and to develop support for businesses to achieve this. The City has commissioned research and initiated a business network.
- It is likely that many City workers have caring responsibilities

Rough sleepers

- Rough sleepers are particularly vulnerable to smoking, alcohol misuse, substance misuse and sexually transmitted diseases, and may encounter barriers to accessing services for these health issues.

Recommendations

- As alcohol, smoking and mental health risk factors are closely linked, it is important to continue tackling these issues concurrently and comprehensively in order to be the most effective in improving health outcomes. Provision should consider the needs of all three populations; the residents, City workers and rough sleepers.

Questions for commissioners

- What are commissioners doing to tackle unemployment levels in the City?
- How are commissioners adapting the substance misuse treatment and prevention services that are available to residents in line with the change in profile of those needing the services?
- How can commissioners prevent the alcohol misuse and mental health issues that are associated with City workers?
- What are commissioners doing to increase smoking quitting rates for City workers?
- How are commissioners ensuring that services for integrated to ensure holistic health support for rough sleepers?
- In conjunction with the 'Communities' chapter, how can commissioners support organisations to build the resilience of City residents, including encouraging a greater takeup of physical exercise?

Economic participation amongst residents

In the City, 77% of the resident population is of working age[58]. The population is too small for reliable estimates of economic activity to be made.

The Public Health Outcomes Framework identifies sickness absence amongst City residents as very high; however, this is based on survey data that drew upon an extremely small sample from the City, and therefore is unreliable. The PHOF does not give a sickness absence figure for City workers, which would have been a useful indicator for the City's Health and Wellbeing Board.

Unemployment and out-of work benefits

Unemployment is bad for health. Unemployed people, particularly those who have been unemployed for a long time, have a higher risk of poor physical and mental health. Unemployment is linked to unhealthy behaviours such as smoking and drinking alcohol and lower levels of physical exercise. The detrimental health effects of a long period of unemployment can last for years.

In September 2013, only 4.8% of the working age residents of the City of London were claiming Job Seekers Allowance (100 people). The proportion of City residents claiming Incapacity Benefit is also relatively low at 2.3% (140 people).

It is likely, however, that there are distinct differences between people living in estates within the City. The Resident Insight Database has indicated that 7% of households with children have no-one working, and that 10% of children live in a workless household. A survey of the tenants of Golden Lane and Middlesex Street estates found significant levels of unemployment among working age adults: 40% of respondents were either job seekers or not actively seeking work, including 16% who were unable to work because of long-term sickness or disability.

The City of London Corporation is currently concentrating efforts to tackle worklessness particularly in the wards of Portsoken and Cripplegate, which have the highest levels of unemployment in the square mile. An employability project part-funded by the City of London and the European Social Fund (ESF), City STEP, aims to place residents from these wards into sustained employment during 2014.

Table 2.10. Key benefits claimed by residents of City of London, May 2013. Percentages are of working age population (NOMIS/DWP)

	The City		London
	number	%	%
Job Seekers Allowance	100	1.7%	3.9%
Incapacity Benefit and ESA	130	2.3%	5.5%
Lone parents	-	-	1.5%
Carers	20	0.3%	1.0%
Others on income related benefits	10	0.1%	0.4%
Disabled	30	0.5%	0.8%

[58] NOMIS 2011

Bereaved	10	0.1%	0.1%
Key out of work benefits	240	3.2%	10.9%

Adult Learning

There is growing evidence of associations between participation in various types of adult learning and improvements in wellbeing, health, and health-related behaviours. These benefits can be particularly strong for those people who left school without any qualifications, as well as older people. The Marmot Review identified lifelong learning as one of the key interventions to reduce health inequalities.

Participation in adult learning may reduce the risk of developing depression, and may also encourage other healthy behaviours, such as participation in exercise. There is a strong relationship between participation and self-reported life satisfaction and/or psychological wellbeing, and some studies also show that participation in adult learning can help older people to retain verbal ability, verbal memory, and verbal fluency[59].

The City of London Adult Skills and Education Service aims to provide high quality, responsive lifelong learning opportunities to City residents and workers of all ages by facilitating, a vibrant, world class, urban learning community at the heart of the capital.

Many varied people participate in lifelong learning courses in the City of London each year, with more than fifty different subjects taught at locations across the whole Square Mile including community centres, libraries, primary schools, children's centres, a college as well as the Museum of London and Guildhall Art Gallery. There were over 2000 learners participating in 223 courses.

Jobs within the City

ONS reported 353,800 employees in the City of London in 2012.[60] Between 2001 and 2012, the City of London saw the biggest increase in employees across 983 areas in London. In 2001 there were a total of 259,500 people working in the City and by 2012 this figure had risen to 353,800. This is the highest number of employees of all years in the dataset and between 2011 and 2012 alone it gained 26,300 employees. This represents an increase of 36% in just over a decade (Figure 6.1).[61]

Employment trends show that the Financial sector remains the dominant sector in the City (41%). A steady increase in employment levels since 2008 has seen Professional and Estate remain a considerable industry in the City, comprising 27% of employment. Other sectors combined make up almost a third (32%) of employment in the City, the most significant of which is Administrative and Education which accounts for 15% of City employment (Figure X).

[59] British Academy (2014) If you could do one thing…" Nine local actions to reduce health inequalities
[60] Office for National Statistics, Small and large Firms in London, 2011 to 2012
[61] Alasdair Rae, Under the raedar, Employee Growth in London 2001 to 2012

Figure 6.1 Change in number of employees working in London between 2001-2012

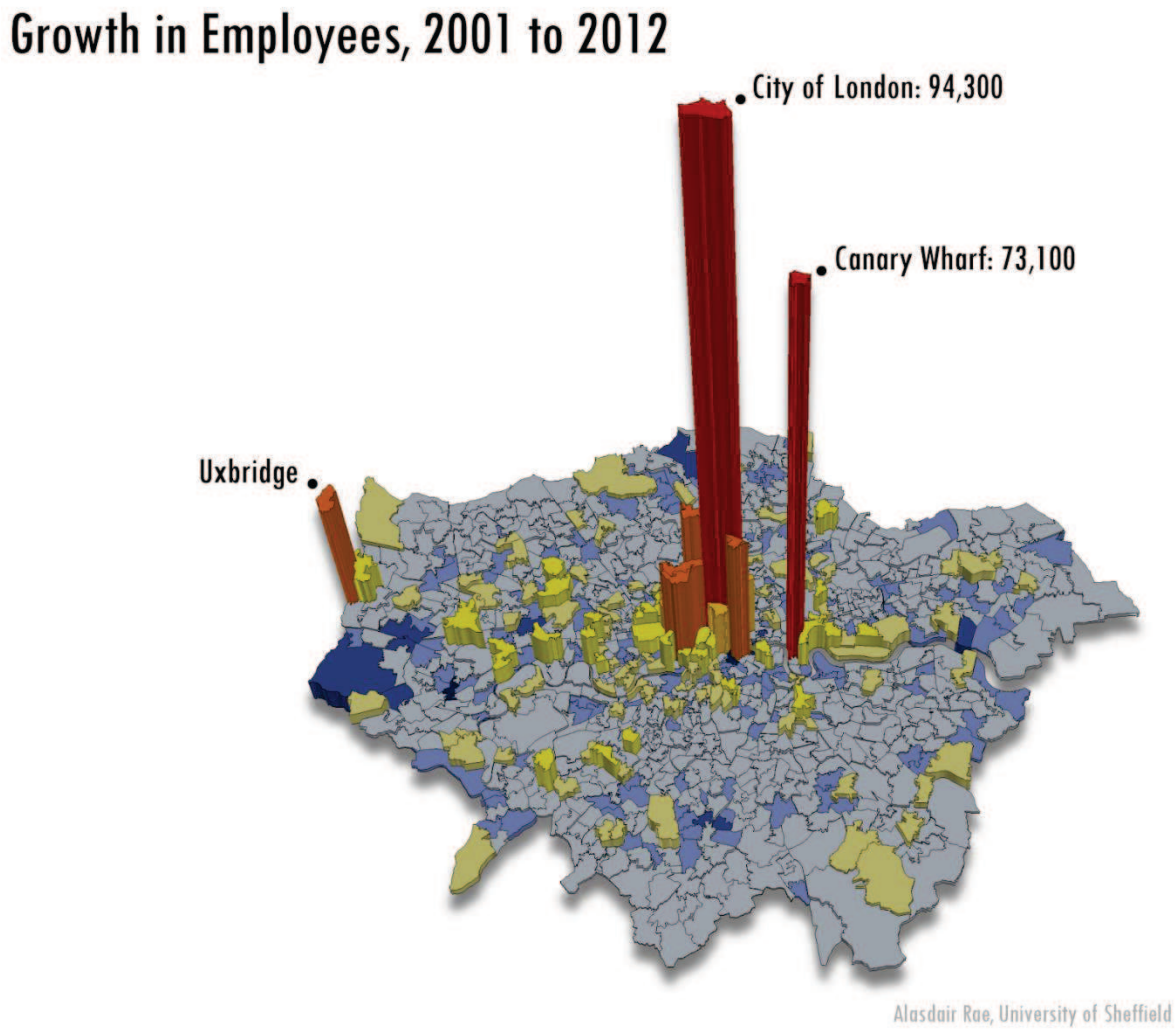
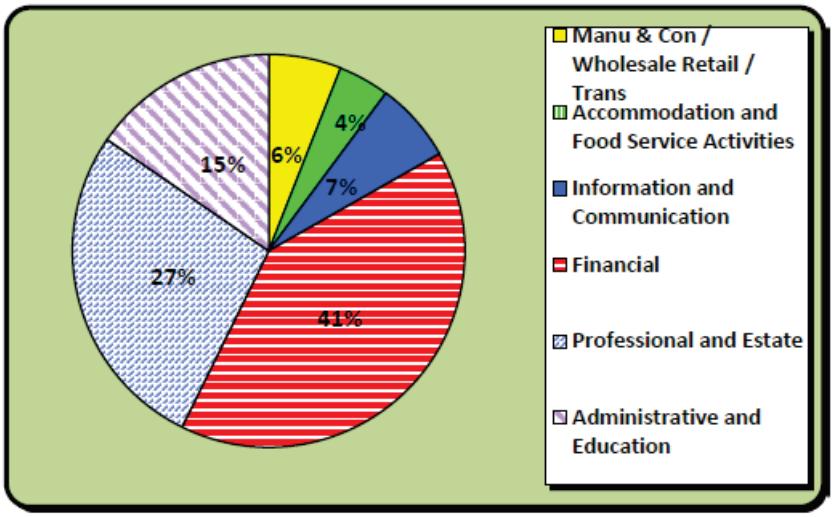


Figure X: Employment by industry in the City, 2011 (BRE)



There are distinct gender differences within the occupation profile of jobs within the City. Management and senior official positions are more likely to be occupied by men. Administrative and personal services jobs are more likely to be occupied by women[62] (Figure 2.20).

Figure 2.20.Employment within the City: occupations by sex, 2010/11 (Labour Force Survey)

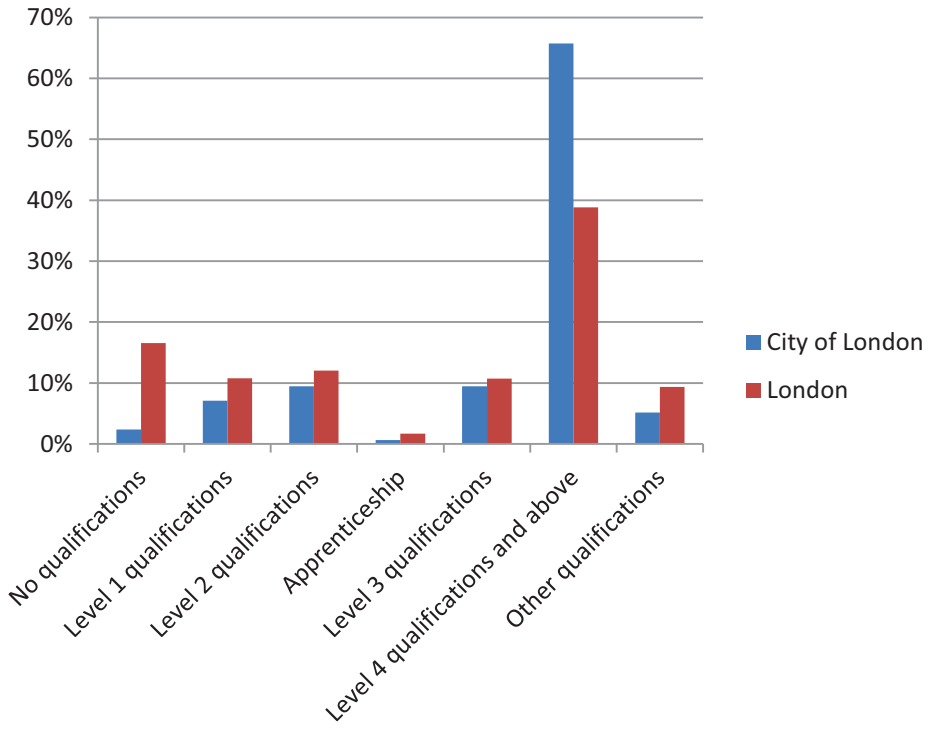
Education and qualifications

City Workers

Two thirds of City workers have at least a level 4 qualification which exceeds the London average by 27%. The qualifications levels are based on the Qualification and Credit Framework where level 4 and above is obtained at university level, and includes certificates of higher education through to doctorate degrees.[63] The greater proportion of level 4 qualifications is consistent with the representative work sectors traditionally seen in the City – that is, mainly of the financial and insurance sector (37%) and the associated professional services (18%), which require a level of higher education.[64] Education, along with income and housing tenure all have enduring associations with health, over time and across different diseases.[65] The increased proportion of a highly educated working population is consistent with greater incomes and increased home ownership.

[62] Labour Force Survey 2010/11
[63] Accredited Qualifications 2012
[64] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[65] Health Development Agency 2004, health inequalities: concepts, frameworks and policy

Figure 6.2: Highest Level of Qualification



Workplace Health

Improving the health of adults of working age is a national public health priority. Workplace health is an essential component of the UK government strategy to tackle health inequalities and increase healthy life expectancy[66]. Working age ill-health is estimated to cost the UK economy over £100 billion a year. In 2011, a total of 131 million days were lost because of sickness absence in the UK[67].

The City of London Corporation is committed to supporting and promoting The City as the world leader in international finance and business services. The City of London Corporation, has set out its intent to establish the City as the world's foremost 'healthy workplace setting' for the people who commute into the City on a daily basis. Current evidence suggests public health interventions in the workplace can deliver considerable benefits to the City itself as well as the wider health and social care economy. For City businesses, public health interventions that address behavioural risk factors (for example, poor diet, excessive alcohol consumption, physical inactivity and smoking) can play a significant role in improving employee physical health and mental wellbeing; improving workplace productivity and output; improving staff retention and recruitment; and reducing sickness absenteeism.

The City of London was chosen as a pilot area for the London Healthy Workplace Charter, which is an initiative developed by the Department of Health, which is now run by the GLA. The Healthy Workplace Charter is an accredited scheme for employers to demonstrate their commitment to workplace health. This scheme is being used within the City of London Corporation, to demonstrate

[66]. DH 2011, Healthy Lives Healthy People a Public Health Strategy www.phe.co.uk

[67]. Office for National Statistics 2013, Sickness Absence in the Labour Market, April 2012, http://www.ons.gov.uk/ons/dcp171776_265016.pdf

the Corporation's commitment to addressing these issues for our own staff. The City Corporation

Business Healthy Conference

In March 2014, the City held an inaugural conference on workplace health. This conference brought together key decision makers from the business world, to improve awareness of the link between healthy workplaces and improved business productivity. The conference also aimed to start a dialogue about how to shift workplace health from a "health and safety" focus to holistic wellbeing, including tackling stress and mental health in modern workplaces.

has set the ambitious target of reaching the Excellence standard of the Charter.

The City of London Corporation has also commissioned and published a piece of research on best practice in workplace health, looking at national and international examples and comparing this to current practice within the Square Mile. It is hoped that this research will be used by organisations in the City to inform and further improve their workplace health activities.

The City is also in the process of establishing a network of businesses within the City, the Business Healthy Circle, to share best practice on workplace health and to provide a business-led response to workplace health issues within the City.

Lifestyle and Behaviours

Smoking

Prevalence

Residents

Among City residents, there is currently no robust data for smoking prevalence, although patients registered with the Neaman practice have low rates of current smoking (as disclosed to their GPs) of around 15%, which is lower than the average for London.

City workers

A survey of City workers[68] reported that 24.7% of respondents were smokers, representing approximately 91,000 people. This was above the average for both London (17%) and England (20%) in that year. Of the respondents who reported smoking, about 15.1% smoked regularly and 9.7% were occasional smokers.

Rough Sleepers

Research suggests that rough sleepers have very high smoking rates, with surveys showing that around between 80-90% of homeless people sleeping rough are smokers[69]. It is likely that smoking is a contributing factor to the poor health of rough sleepers, but that rough sleepers find it much harder to access smoking cessation services that more advantaged people take for granted.

[68] *The Public Health and Primary Healthcare Needs of City Workers*, PHAST and City of London, 2010
[69] HDA (220$0 Homelessness, smoking and health

Quitting

In the City, 1,145 people set a quit date in 2012/13 and 606 (53%) went on to be successful four-week quitters. Table 3.2 describes the quit rates across different population subgroups. The majority of those accessing quitting services were **City workers** rather than **residents**, of whom most were in managerial or professional roles. However, quit rates were slightly higher among the smaller numbers of people in intermediate professions, those not employed and those aged 60 or over. Quit rates were lower among 18 to 34-year-olds and the white British/Irish population.

Table 3.2 People not smoking four weeks after quitting: absolute number and percentage quit rate by population subgroup in the City, 2012/13 (Source: DoH)

Population group	Number of four-week quitters	Percentage quit rate
Gender		
Male	352	53%
Female	254	52%
Age		
18–34	255	49%
35–44	202	55%
45–59	128	59%
60+	16	64%
Ethnicity		
White British/Irish	461	53%
White other	50	54%
Black	19	58%
Asian	35	47%
Mixed	29	54%
Work/socio-economic status		
Not employed	20	57%
Employed: managerial/professional	471	52%
Employed: intermediate professions	9	56%
Employed: routine and manual	35	52%

Smoking cessation support services

A total of 16 pharmacies in the City are signed up to deliver Level II smoking cessation support services as detailed in figure 8.2.

These pharmacies have also been branded with the local 'Quit Here' branding in order to raise the profile of the service. In 2012/13, 64% of smokers accessing support to give up smoking in the City did so through their local pharmacy.

In 2012/13, the pharmacy-led service performed well. Although it fell short of its target (by just two quitters), its overall quit rate of 51% greatly exceeded the Department of Health recommended minimum quit rate of 35%. Its carbon monoxide validation was exceptionally high at 97% (the Department of Health minimum standard is 80%).

87% of the pharmacies achieved or exceeded the minimum recommended quit rate; although overall there was a slight decrease in the number of four-week quitters compared with the previous year. These follow the national trends of decrease alongside the introduction of e-cigarettes. However, the quit rate increased from 44% to 51%, which suggests that the quality of stop smoking services in pharmacies is increasing.

The profile of smokers who access the pharmacy stop smoking services in the City continues to mirror the profile of the City working population as a whole. 56% of smokers accessing the service are male; they are predominantly white British (76%); and 83% work in managerial or professional occupations.

Level III specialist services are for patients who require longer term, more intensive support. These include patients who: have more than three serious failed quit attempts; smoke within an hour of waking; have chronic diseases (COPD, coronary heart disease, diabetes, hypertension and/or stroke); have multiple illnesses; or have psychiatric problems.

The specialist Level III service runs a range of clinics across the City. These include both weekly drop-in clinics and workplace clinics that are run on an ad hoc basis. The Level III service exceeded its 2012/13 target (108%) and achieved a 61% quit rate, with 87% of quitters carbon monoxide-validated. The population accessing the Level III service is very similar to that accessing the pharmacy service: 68% are white British and there are more men than women quitting through the service (65%). When the data is broken down by socio-economic status, the majority of people accessing the service are from managerial and professional occupations (67%). However, routine and manual workers make up 14% of the smokers accessing the Level III service. This is considerably higher than the pharmacy service, where routine and manual workers make up only 4% of the total number of smokers accessing the service.

The Queen Mary service has a team of health psychologists who are able to provide a more intensive level of support and who are trained in behaviour change. They are therefore able to provide a more appropriate service for routine and manual workers, who often have higher levels of dependency.

Physical activity

Sport and physical activity among adults

Sport England's Active Peoples survey (April 2012/April 2013, Published June 2013) states 38.2% of resident adults take part in sport and physical activity in the City of London (At least one 30 minute session of moderate intensity activity per week), compared to a London average of 36% and a national average of 35%.

A local survey conducted with both residents and non-residents in the City revealed that the non-participation rate amongst females is above the national average at 29%, compared to 19% by males.

There are also high non-participation rates amongst people with a disability at 34% (national average 25%). Encouragingly, 58% of measured participants did all their sport inside the Square Mile and 69% of City workers surveyed said they would like to do more sport. Respondents said that if the location was convenient, for example, during lunchtimes, then their activity would increase. 32% of those who would like to do more sport were specifically interested in swimming.

Alcohol

Levels of alcohol consumption

Synthetic estimates of alcohol consumption in 2012 by **City residents** suggest a slightly higher level of risk than the average for London (Table 3.3). Compared to the previous year, there seems to be variable trend in risk. The number of individuals who 'abstain' has decreased, but those deemed at 'increasing risk' has also reduced compared to the previous year. This may be linked to the ethnic profile of City residents.

City Workers

A review on City drinkers (**workers in the City**) published January 2012 reported the prevalence of alcohol misuse in 2011 amongst City drinkers to be a significant issue as summarised in table 3.3. 33.4% of City drinkers are at an increased risk of alcohol-related harm, compared to 20.1% nationally.[70] These drinkers are not yet necessarily experiencing alcohol-related harms, but are increasing their risk of health and social problems. 12.4% of City drinkers were drinking at a higher risk level compared to 3.8% in the national population, or 8% as the London average[71]. Higher risk drinkers are already experiencing alcohol-related harms and many have some level of alcohol dependency.

The scores are derived from the Alcohol Use Disorders Identification Test (AUDIT), a validated health screening tool developed by the World Health Organisation. The full 10 question AUDIT identifies respondents into one of four main categories from 'lower risk' to 'possible dependence' (Table XXB). Alcohol misuse in the City may in part also be attributed to a complex range of factors such as higher average wealth, high pressured or risk based work environments, a culture of entertaining clients and high use of public transport.

Alcohol misuse amongst both male (56.2%) and female (34.1%) City drinkers is considerably higher than national averages (33.2% men and 15.7% women)[72]. Young white males are the predominant alcohol misusers.

Table 3.3 Estimates of alcohol consumption of City Residence and City Drinkers by DH risk categories, 2011 and 2012[73][74][75]

	Abstain (%)		Lower (%)		Increasing (%)		Higher (%)		Source
	2011	2012	2011	2012	2011	2012	2011	2012	

[70] Insight into City Drinkers, 2012
[71] Insight into City Drinkers, 2012
[72] Insight into City Drinkers, 2012
[73] NWPHO Local Alcohol Profiles for England, 2012 refresh
[74] Insight into City Drinkers. 2012
[75] Adult Psychiatric Misuse Survey 2007

City residents	19%	14%	50%	70%	22%	22%	8%	9%	*NWPHO*
City workers	-	-	-	-	33%	-	12%	-	*City Drinkers Insight*
London	24%	22%	52%	73%	16%	20%	8%	7%	*NWPHO*
National	-	-	-	-	20%	-	4%	-	*APMS 2007*

Table XXB AUDIT categories by score range

AUDIT SCORE	LAY CATEGORY	MEDICAL CATEGORY	COMMENT / SUMMARY
0-7	Lower risk	Lower risk	Includes abstainers – unlikely to experience alcohol-related harm
8-15	Increasing risk	Hazardous	Drinking above the guidelines therefore increasing the individuals risk of alcohol-related health or social problems
16-19	Higher Risk	Harmful	Regularly drinking (on most days) at least twice the recommended guidelines. Already likely to be experiencing alcohol-related harms
20+	Possible dependence	Possible dependence	Dependence may be mild, moderate or severe. Loosely defined as a strong desire to drink and/or difficulty controlling alcohol use

(Source: Insight into City Drinkers, 2012)

Health impacts of alcohol

The annual alcohol attributable death rate in the **City's resident** population is 49.6 deaths per 100,000 men and 2.3 per 100,000 women (age-standardised rate). This makes the City the second lowest rate in the country for women. However, it should be noted that rates in the City can jump dramatically due to the low resident numbers. Alcohol-attributable hospital admissions are also very low in the City's resident population (Table 3.4). There were 17 individuals in contact with structured alcohol treatment in 2012/13, 40% of whom completed treatment successfully.

Table 3.4: Alcohol attributable hospital admissions for men and women in the City in 2012/13, compared with London average, and national rank, where rank 1 is best[76].

The City			London
	Rate per 100,000 standardised	National rank (out of 354)	Rate per 100,000 stand'd

[76] North West Public Health Observatory, Local Alcohol Profiles, 2011.

Men	969.7	7	1535.9
Women	289.0	1	810.9

City Workers

Alcohol-related problems in City workers may be disproportionately social rather than health harms compared to national averages. Health-related problems were less reported than social or behavioural related problems (e.g. injury or remorse)[77].

Crime and anti-social behaviour

The London Ambulance Service (LAS) dealt with 26 calls in the City regarding alcohol overdoses or accidents in the 2012/13 year, with 18 (69%) of these coming from the Bishopsgate area. This is an increase on the previous year when there were 22 alcohol-related calls.

During 2012/13 the City of London Police was notified of 5,454 incidents, of these 1,292 (23.7%) were alcohol related or connected to licensed premises (public houses, night clubs and wine bars). 178(32.1%) were deemed violent offences and 1,013(26.7%) acquisitive offences.

In general, alcohol-related offences happen after 7pm (Monday to Friday) and fall off by midnight. Specifically, on Thursday, Friday and Saturday, offences are likely to happen through the night until 4am. 957 (74.1%) offences occurred between Thursday and Sunday, with 679 (52.6%) occurring between 6pm and 2am on those days. There were 175 arrests for drunkenness offences, and 121 arrests for Road Traffic offences relating to breath tests (failure to provide, positive and refusal)

Substance misuse

Prevalence of drug use

Local research gathered via the Project Eclipse initiative in night-time venues across the City appeared to show that cocaine was the major drug being confiscated and deposited in amnesty bins, and showed that over half of the patrons were also working in the City. National data shows the 'prosperous urban' demographic tend to use more drugs than other groups, including cocaine.

Health impacts of drug use

Between April 2007 and March 2013, there were 36356 incidents related to ambulance callouts in the City of London, with 304 (0.8%) flagged as being drugs related. 48% of the incidents were to individuals under 35; 56% were for males and 41% were for females (with 3% not recorded).

Emerging trends in drug use

Residents

[77] Insight into City Drinkers, 2012

The City's treatment services have always been used by predominantly more males than females and this is consistent with services across England. Predominantly clients are of British nationality. The majority of individuals who use the City's services are not parents, and at least 18% of the client population is not heterosexual.

In 2011/12 there were no clients who had 'wages' as an income source; this has now changed in 2012/13. In previous years the majority of individuals using treatment services were street homeless or in unstable accommodation. The reverse is now true with the majority being in stable accommodation with no housing problem. This change goes in hand with the increase in those who are employed and the increase in those with a primary alcohol problem.

Treatment and engagement

Residents
Twenty-four individuals entered the treatment system in 2012/13 adding to the 17 who were already in treatment on the 1st April 2012. It is encouraging that the highest number of referrals was self-referral; the second highest group of referrals came from GP's. These were predominantly for those who had a primary alcohol problem.

In 2012/13, 11 people received structured drug treatment through the City of London Substance Misuse Partnership. Of these, 9 were opiate and/or crack users. The overall proportion of those leaving treatment successfully in the City (23%) is higher than national levels (15%) and none of those who left successfully returned to treatment; however numbers in treatment and associated successful completions are decreasing.

Harm reduction

Residents
Prevalence of Hepatitis C in injecting drug users is around 50% nationally. Prevalence of Hepatitis B in injecting drug users is around 17% nationally. The prevalence estimate of current injecting drug users in the City is 17. Public Health England estimates there are 77 people infected with hepatitis C in the City of London, of whom 64 are current or previous injecting drug users. In 2012/13 the needle exchange was used by 23 people, with a total of 266 packs given out. Hepatitis C testing is offered to all new clients who currently inject or have a history of injecting. In 2012/13 the uptake of testing was 88%, compared to 73% nationally

Sexual Health

Sexually Transmitted Infections (STIs)

89 acute STIs were diagnosed in **residents** of the City of London in 2012 (81% in males and 19% in females). This equates to a rate of 1,201 per 100,000 residents (1,742 for males and 519 for females). Fluctuations in the rates of diagnosis and reinfection within the City from one year to another are not significant due to the small absolute numbers and low population baseline.

Chlamydia screening

Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. Public Health England recommends that local areas achieve a testing rate of at least 2,300 per 100,000

resident 15 to 24-year-olds, a level which is expected to produce a decrease in the prevalence of chlamydia. Nationally between January and December 2012, 26% of 15 to 24-year-olds were tested for chlamydia, with an 8% positivity rate.

In the City coverage and diagnosis rate is well below the suggested threshold, although the numbers involved are small. The 2012 chlamydia diagnosis rate in 15 to 24-year-olds was 1,080 per 100,000. 17% of 15 to 24-year-olds were tested for chlamydia, with eight cases diagnosed (a positivity rate of 6%).

Human Immunodeficiency Virus (HIV)

In 2011, the diagnosed HIV prevalence rate in the City of London was 10.8 per 1,000 population aged 15–59, compared with 2.0 per 1,000 in England. 62 adult residents received HIV-related care, fewer than five of whom were female. Of these, 90% were white. As regards to exposure, 84% probably acquired their infection through sex between men and 6.5% through sex between men and women.

Where resident information was available, data showed that six adult residents (aged 15 and older) were newly diagnosed in 2011. All of these individuals were male and had acquired HIV through sex between men.

Between 2009 and 2011, 32% of HIV diagnoses were made at a late stage of infection. The proportion was 35% for men who have sex with men and 0% for heterosexuals. The small numbers involved mean that differences for the City are not statistically significant.

Workers

The City of London's worker population is young and is predominantly male. This group is at a higher risk of Sexually Transmitted Infection, and may be less inclined to access sexual health services in their home areas or from their family GPs.

Rough sleepers

No prevalence data on sexual health exists for City rough sleepers; however, research identifies the sexual health needs of homeless people as a key health priority, with rough sleepers suffering from high rates of sexually transmitted diseases, including HIV.

Mental health

Prevalence of mental illness

It is estimated that one in four people in the UK will suffer a mental health problem over the course of a year.[78] At any one time, it is estimated that one in six adults of working age experiences symptoms of mental illness that impair their ability to function. A further sixth of the population have symptoms (such as anxiety or depression) that are severe enough to require healthcare treatment. Between 1% and 2% of the population are likely to have more severe mental illnesses such as schizophrenia or bipolar affective disorder, which require intensive and often continuing treatment and care.

[78] The Mental Health Foundation, http://www.mentalhealth.org.uk/help-information/mental-health-statistics/

Depression

There is no data on depression among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2012/13, the crude prevalence of depression recorded by the Neaman practice was 3.4% (267 individuals).

Severe mental illness

There is no data on severe mental health conditions among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2012/13, the crude prevalence of severe mental health conditions recorded by the Neaman practice was 0.8% (69 individuals).

Suicide

Under the Health and Social Care Act 2012, coordinating and implementing work on suicide prevention is now a local authority responsibility.

The City of London has three potential population groups who are at risk of committing suicide: residents who live in the City; those who work in the City; and those who travel to the City with the intention of committing suicide from a City site, but who have no specific connection to the City.

The Department of Health recently published *Preventing suicide in England: a cross-government outcomes strategy to save lives*. Much of this strategy focuses on what primary health services (GPs) can do to prevent suicide: however, the vast majority of people in the City do not live there, and so are registered with a GP in another local authority.

The suicide prevention strategy identifies some effective local interventions as:

- Prevention – barriers, nets, etc. and providing emergency telephone numbers
- Working with planning departments and developers to include suicide risk in health and safety considerations when designing tall buildings
- Working with the media to encourage responsible reporting

Local advice services have been found to be effective in preventing suicide, as they can help with debt, bereavement and wider mental health issues. In the context of the City, Toynbee Hall provides the City Advice Service, which can provide information, advice and guidance to City residents and workers, as well as signposting to relevant health services.

City workers

21% of City workers report suffering from depression, anxiety or other mental health conditions; with, with 33% reporting that their job caused them to be very stressed on a regular basis. Those who report being very stressed several months of a year were 2.6 times more likely to identify themselves in as being 'poor health'. City workers report taking fewer than the UK average number of sick days (6.5 days per year). This suggests either that City workers are generally healthier or that they still come to work under some circumstances even when ill.

Rough sleepers

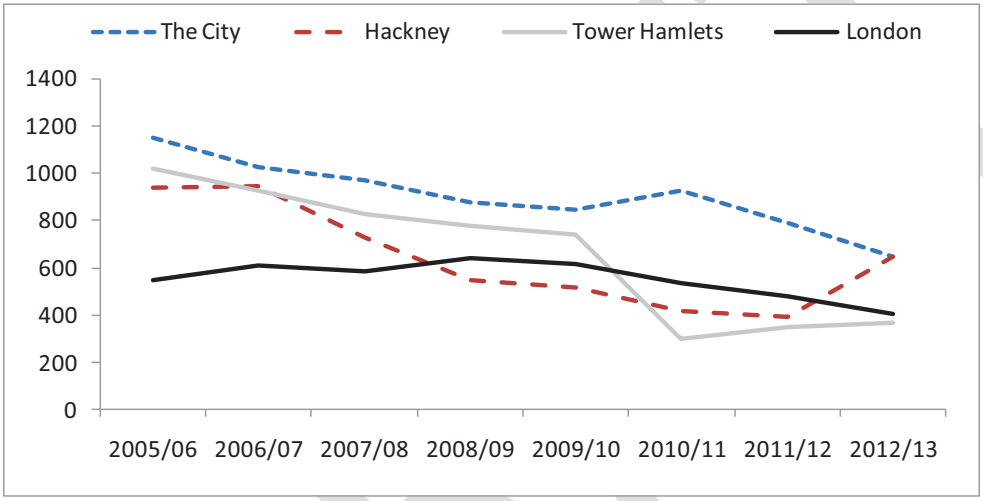
A national audit of the health and wellbeing of homeless people found seven out of 10 clients had one or more mental health need, a rate over twice as great as the general population[79]. Within the City, the CHAIN database identifies 45% of rough sleepers with a mental health issue.

Social care for people with mental health difficulties

In 2012/13 the City of London provided services to 84 adults with mental health problems, 20% of whom were aged over 65.

Based on Mental Health Minimum Data Sets for 2011/12, 89.6% of adults receiving secondary mental health services in the City lived in settled accommodation.

Figure 7.5 Number of adults (aged 18-64) with mental health problems receiving care packages per 100,000 population, 2005-13



Source: National Adult Social Care Intelligence Service (NASCIS)

[79] Homeless Link (2010) The health and wellbeing of people who are homeless: evidence from a national audit. London: Homeless Link

Carers

Support for carers

Carers are people who provide help and support to a friend or family member who, due to illness, disability or frailty, cannot manage without their support. Carers are unpaid, although they may be in receipt of benefits related to their caring role. Performing a caring role can have major implications for someone's life: young carers can suffer a loss of education and life chances; carers of working age can see their employment opportunities limited and suffer poverty as a result; and older carers are particularly vulnerable to the impact on health and wellbeing that caring for someone else can have.

Carers play a vital role in supporting family members or friends to live independently and maintain their wellbeing. However, many carers are also frail or in poor health and so may need support themselves. According to the legislation, carers have the right to request an assessment and subsequent review of their own needs. Carers can have a joint assessment or review with the person they care for, or can request a separate assessment or review for themselves. The number of carers receiving services as a result of these assessments and reviews is an indication of the extent to which a council is working with and for carers.

Case Study

G is a 59 year old woman, of White British origin. G met her partner T eight years ago and has been married for five years.

Caring Role

G is the informal carer for her partner T who suffers from a neurodegenerative condition and is dependent in all activities of daily living including being wheelchair dependent. T has some speech limitations, which means that G has to occasionally advocate T's verbal wishes for him.

Carer Needs and Support

G feels being T's informal carer can be challenging at times, feeling that she has to live a very structured life as a result. She acknowledges that being a full-time informal carer has imposed restrictions on her social life and that she has lost friends who were unable to understand her caring role.

G is no longer able to work full-time. She had a carers assessment from adult social care and was awarded a non-means tested carers individual budget to aid her in her caring role. This is in addition to the carers' allowance which is a benefit entitlement from the government. She has also been provided support by The City's Carers' Service as well as advice from City Advice.

Despite this, G feels that she has found a home since meeting T and has established roots in the City. She acknowledges that being an informal carer can be challenging at times, but feels being T's carer has been very good for her, and has enriched her life in other ways.

Carers in the City

The City Carers' Register lists 58 known carers of clients aged over 18. According to the 2011 Census,[80] 576 City residents (7.8%) have some caring responsibilities, with 121 of these carers providing over 21 hours of unpaid care per week. Although lower than the national average, this figure indicates that many people are giving care in the City who are unknown to the Carers' Register.

[80] Office for National Statistics, Census 2011

Since 2012, the City of London has commissioned its own City Carers' Service (provided by Elders Voice). Both individual and group services are offered, including access to respite care. The service is also tasked with finding hidden carers. The City Carers' Service offers outreach to carers, providing emotional support, support in accessing health and social care, and information and advice, including advice on welfare benefits. It also organises support groups with speakers on relevant subjects, outings and training sessions depending on specific need.

Crossroads is commissioned to offer planned and emergency respite to carers, while City50+ is another commissioned service which targets those aged over 50. Activities include organising coffee mornings and working as a conduit to refer people on to other services – specifically focusing on carers, dementia and reducing hospital admissions.

Full carers' needs assessments are provided based on eligibility criteria. For those with a lack of means, a means-tested carer's individual budget is available, which ranges from £150 to £3,000 per year. The adult social care service assesses the entitlement to care and support of both the carer and the cared-for.

The City of London Carers' Strategy, published in 2011,[81] recognises the significant contribution that carers make to the wellbeing of service users and residents. It sets out an approach whereby carers are able to design and direct their own support by engaging in the support plan of those they care for, and ensuring that support is tailored to their specific needs.

City workers

Due to the sheer number of City workers it is very likely that many also hold caring responsibilities. This data may become available in future Census 2011 releases.

Disability

Learning disabilities

In 2012/13 the City of London provided services to 15 clients with learning disabilities. 86.7% (13 clients) are living in settled accommodation. The number of clients with learning disabilities receiving care packages had increased in 2011 and has since remained fairly stable over the past three years. (Figure 7.8, Appendix 8)Estimates of learning disability prevalence are based on national prevalence rates with some adjustment for local demographics, which may not be reliable for the unusual profile of the City's population. Currently a Disability Register is under review which aims to consolidate a more up to date profile of disability in the City.

For more information about learning disabilities, see Appendix 8 – Learning Disabilities.

Physical disabilities

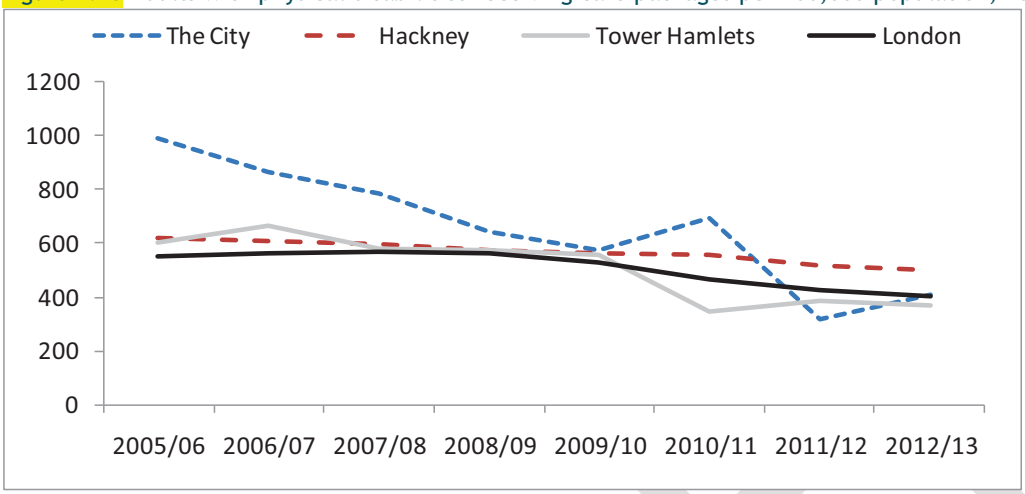
In 2012/13 City of London provided services to 113 clients with physical disabilities, of whom 80% were over 65. 56% of these clients received community-based support (home care not included).

[81] City of London Carers' Strategy, 2011

Equipment and adaptations were provided to 31 clients. Professional support was provided to 11 clients and 53 clients received direct payments to purchase their own care.

The number of people receiving on-going support from the City of London Corporation has decreased since 2005/06: a 46% drop in the rate per 100,000 population (Figure 7.18).

Figure 7.18 Adults with physical disabilities receiving care packages per 100,000 population, 2005-13



Visual impairment

In 2010/11 In the City there were 9 people on the local visual impairment register, with fewer than five registered in each category as partially sighted, blind, and deaf/blind.

7. Later Life

The health and wellbeing needs of those who are beyond working age differ significantly from those in younger groups. Most of the health behaviours, attitudes and exposures have already been established by later life. In additional, many people will already be living with one or more long term conditions.

Maintaining quality of life and preventing deterioration begin to take on more importance than preventative and behaviour change activities. Preventing social isolation and providing continued independence are also key social goals.

Key Findings

- Life expectancy is expected to remain high amongst City residents.
- The number of older people in the City is small but is projected to increase rapidly in the next decade.
- Trends show that older people wish to remain living independently in their own homes for as long as possible.
- Incidences of age-related health problems such as reduced mobility, dementia and social isolation, as well as the need for additional support and care, are likely to increase.
- The City has been adapting to the increasing demands of the aging population through increased provision in telehealth, preventing social isolation and in creating a dementia-friendly City.

Recommendations

- Provisions for the aging population should continue to meet the increasing demands projected in the upcoming decade.
- The provision of health, social care and housing will need to become increasingly inter-dependent if we are to maintain independence and good quality of life into healthy aging for our City residents.

Questions for commissioners

- What are commissioners doing to ensure that their commissioning strategy and commissioned services are prepared for the rapid increase in older people in the City and associated likely health needs?
- How can commissioners creatively consider the use of new and emerging technologies and services to support older people stay in their own home and enable residents to have varied choices for care?
- How well does the City of London Corporation know the future likely need for its social care services? A clear understanding of need is vital to enable social care services to be responsive to need and able to provide appropriate services.

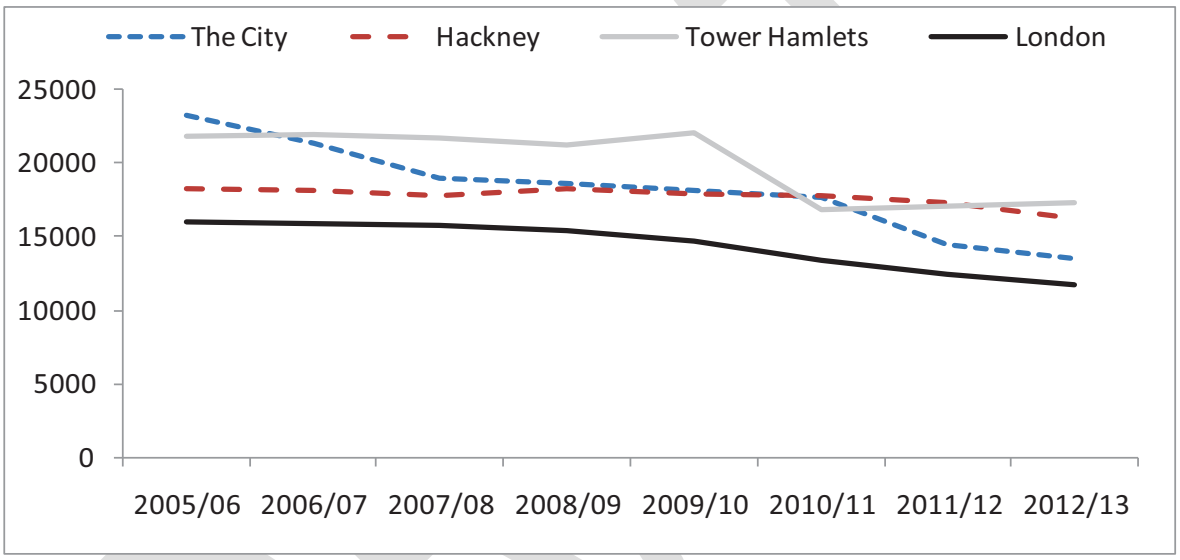
Older people

In 2012/13, the City of London Corporation provided services to 142 clients aged over 65. Of these, 90 (63%) had a physical disability, 44 (31%) had mental health problems, fewer than five had a learning disability and seven (5%) had problems with alcohol or substance misuse or were vulnerable.

Over the last three years, the number of people aged over 65 in the City receiving social care packages declined (Figure 8.1).

A survey of residents living on the Golden Lane and Middlesex Street Estates found that people on these estates have a slightly different age profile from the general profile for the City, with greater numbers of older people and high disability rates in the oldest groups[82] (Figure 7.32).

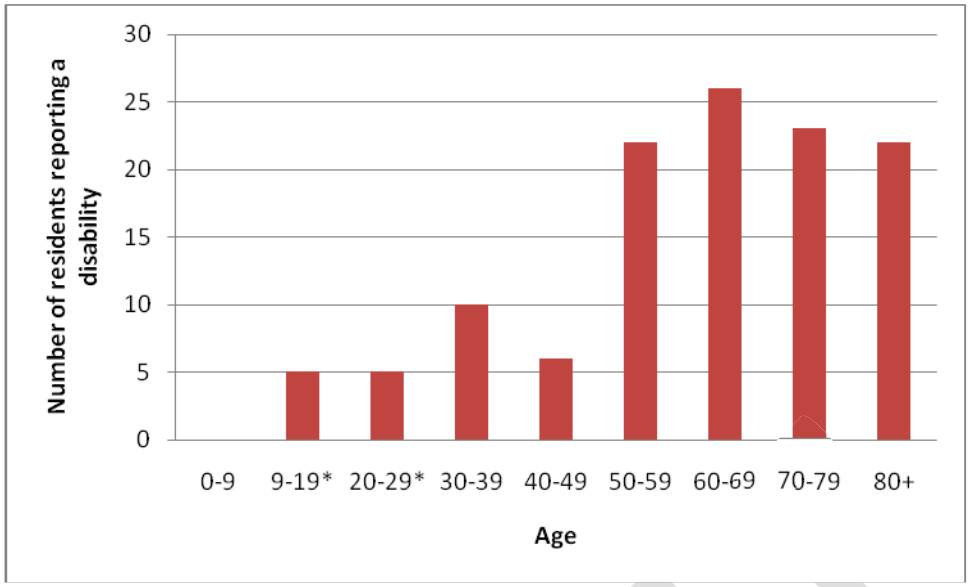
Figure 7.1 Older people (aged 65 and over) receiving care packages per 100,000 population, 2005-13



Source: NASCIS

Figure 7.32 Age and disability of tenants of Golden Lane and Middlesex Street Estates

[82] City of London housing tenants profiling, 2011



** Fewer than five individuals were reported*
Source: City of London

Life expectancy

In the City, both the male (83.8 years) and female (88.6 years) life expectancies are higher than the figures for England (78.6 years for males and 82.1 years for females) and the surrounding boroughs.

Figure 6.3 Life expectancy for males, Hackney and the City 2006-10 (LHO)

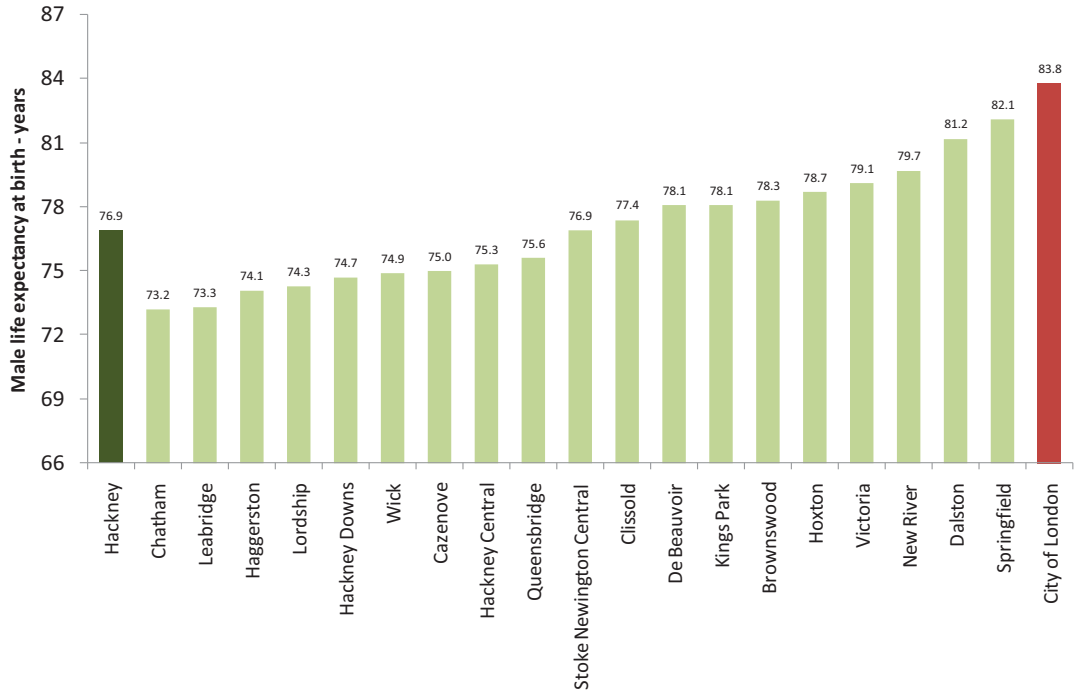
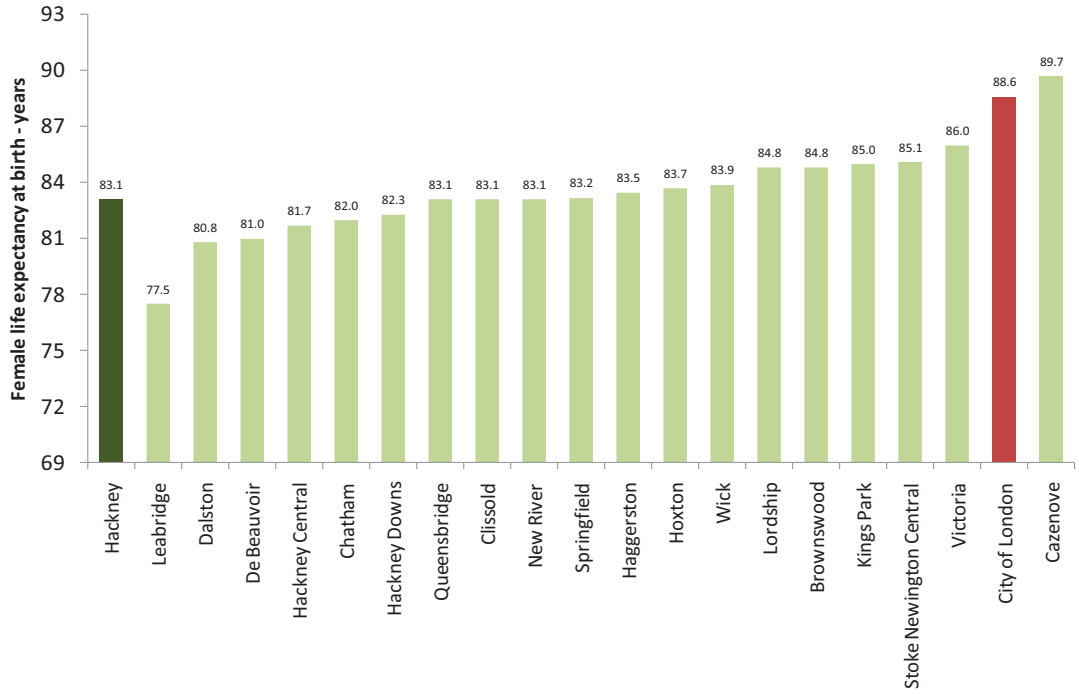


Figure 6.4 Life expectancy for females, Hackney and the City, 2006-10 (LHO)



Deaths

In 2009, 41 residents of the City of London died: 19 females and 22 males. The age-adjusted rate was 309 deaths per 100,000 residents, though this figure is very variable year-on-year due to the small number of deaths and the small population.

The premature death rate in the City is low: in 2009, 13 City of London residents aged under 75 years died. The trend is erratic due to the small number of deaths but nonetheless demonstrates a long-term decline. For more information, see Appendix 9 – Death rates.

Telecare and telehealth

Telecare and telehealth services use technology to help someone live more independently at home. They include personal alarms and health-monitoring devices. Telecare and telehealth services are especially helpful for people with long-term conditions. They can also help an individual live independently in their own home for longer, to avoid a hospital stay or put off moving into a residential care home.[83]

In the City there are approximately 107 telecare users in General Housing and 33 in Sheltered Accommodation. These figures regularly fluctuate dependent on need and demand. The call handling service receives between 60 and 110 calls per month.

The social prescribing pilot project

In partnership with City and Hackney CCG, the City and Hackney Health and Social Care Forum is developing a collaborative project, working with the London Borough of Hackney, the City of London Corporation and the Voluntary and Community Services to develop a system for social prescribing.

Social prescribing is a process whereby GPs refer patients with social, economic, emotional, practical and/or wellbeing needs (whether or not they also have identified physical or other medical issues) to a range of local support services. These might include welfare advice, befrienders, walking clubs, arts clubs and exercise groups. This process is sometimes called 'community referral', as activities and services are on offer locally and are mostly provided by the Voluntary and Community Services. A major aim of this referral system is to tackle social isolation in the elderly.

Telecare services in the City of London include a 24 hour call handling service and a Mobile Rapid Response team who can offer visits and assistance.

Loneliness and social isolation

A report from Age UK on loneliness and isolation report that 7 per cent of people 65+ in England say they always or often feel lonely. Including those who say they are sometimes lonely, the figure rises to 33 per cent. The relationship between isolation and loneliness is a complex one, involving social contact, health (physical and psychological) and mood. Both loneliness and isolation appear to increase with age, and among those with long-term health problems.[84]

Within the City, 2,472 households are single-person, with 526 of these aged 65 or above. About 58% of these over 65 residents living alone are women, and 42% are men. In the City, the recent and projected (see Appendix 2, table ___) growing aging population suggest that loneliness and social isolation may be an increasing issue. As well, anecdotal evidence from housing officers and City residents suggest that the socially isolated aging population in the City tend to be concentrated in the north of the City, and may find themselves "asset rich and income poor".

Case Study

[83] NHS Telehealth and Telecare Technology, http://www.nhs.uk/Planners/Yourhealth/Pages/Telecare.aspx
[84] Loneliness and isolation evidence review, Age UK

K is an 85 year old man, of white British origin. K is single and resides in a studio property on Golden Lane Estate. He has no surviving family or friends.

Independence and health issues

K does not cook but has meals in his local café. He has a condition that requires District Nurses to attend daily and is on a selection of medication. He has also had physiotherapy and occupational therapy input. K is otherwise reported as being independent in daily living tasks with access to a care alarm and bathing aids. K tends to finds change difficult and has declined referral to the local luncheon club, though he is visited by the Barbican mobile library.

Dementia condition and support

K has a diagnosis of dementia and paranoia and has been known to Adult Social Care for several years, since his diagnosis. K reports seeing people in his flat, and property going missing. He telephones the City of London Police regularly and is on their Pegasus system for vulnerable residents. The Police Community Support Officers and Ward Beat Officer also visit him, which enhances K's feeling of security. K's dementia is reported to be manageable in his own home environment. He is known to the City and Hackney Mental Health Team and has had Community Psychiatric Nurse input in the past. He is also visited monthly by support workers from City and Hackney Alzheimer's Society.

Dementia

There are estimated to be over 67 people in the City of London with dementia and this number is set to increase by more than 40% in the next 20 years[85]. Adult Social Care (ASC) and the GP practice have confirmed that they currently know of 15 people referred and living in the community and 5 people in nursing care but acknowledge that there may be many more people who are not formally diagnosed via primary health or who have not accessed statutory social care.

This is recognised as quite a large discrepancy; therefore the Neaman Practice is reviewing its diagnoses of patients who may have signs and symptoms of dementia as a co-morbid factor to their primary diagnosis, and are referring them to the Memory Clinic for a further assessment where necessary.

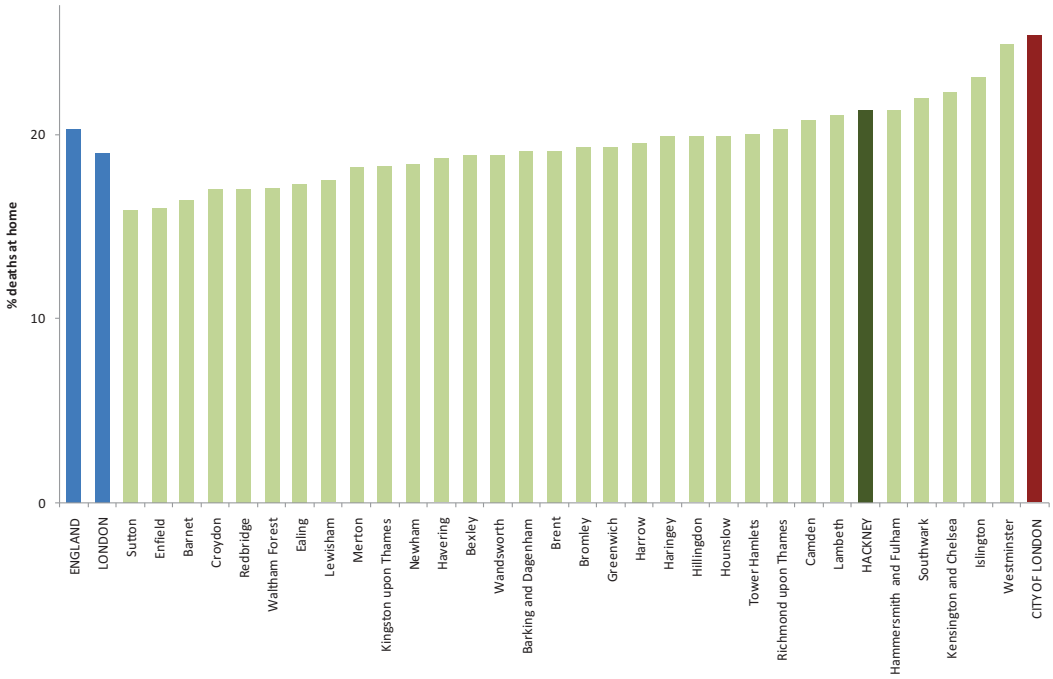
In 2014 the City committed to providing the best possible services to this particularly vulnerable group through the City's Dementia Strategy. The strategy commits the City of London Corporation to creating a "Dementia Friendly City", where residents and local retail outlets and services will develop a keen understanding and awareness of the disease and offer support in a respectful and meaningful way.

End-of-life care

In 2010/11, over a quarter of the deaths amongst residents from the City took place at home – this was the highest average across all London boroughs and higher than that for London and England (Figure 7.33). Generally, more men die at home than women.

Figure 7.33 Percentage of deaths taking place at home, 2008-10 (HSCIC)

[85] This data is derived from a synthetic estimate based on national prevalence rates and Census data.


% deaths at home
0
10
20
ENGLAND
LONDON
Sutton
Enfield
Barnet
Croydon
Redbridge
Waltham Forest
Ealing
Lewisham
Merton
Kingston upon Thames
Newham
Havering
Bexley
Wandsworth
Barking and Dagenham
Brent
Bromley
Greenwich
Harrow
Haringey
Hillingdon
Hounslow
Tower Hamlets
Richmond upon Thames
Camden
Lambeth
HACKNEY
Hammersmith and Fulham
Southwark
Kensington and Chelsea
Islington
Westminster
CITY OF LONDON

8. Healthy Life

This final section concentrates on those aspects of wellbeing which are most closely aligned with health and healthcare. It contains some information on disease prevalence, hospital utilisation and user satisfaction. It also covers services in social care, as well as the local voluntary and community services the City has to offer.

Key Findings

- There is a potential to expand services in pharmacy to meet local health needs. Many residents use community pharmacists which are located outside the City; however, pharmacies can also be used to deliver services to City workers
- The City has a vibrant voluntary and community sector, as well as a time credits scheme, which help to strengthen and build communities

Residents

- 20% of City residents are registered with GPs outside the City – this has implications for how cross-border health services are provided.
- Deaths from all cancers and from premature cancer are well below the average for London, and premature deaths have fallen markedly over the last 6 years.
- Other disease prevalence estimates for residents are currently limited to those registered at the Neaman Practice.
- Adult social care in the City has been modernised, and most users of adult social care are happy with the service they receive
- Introduction of the Better Care Fund may enable better joined up working between healthcare and social care services.

City workers

- Many City workers, particularly those in lower-paid sectors and roles, find it hard to access primary care services, as doing so requires taking time off work for appointments.
- One-third of City workers would choose to register with a GP near to work rather than near to home, if they were allowed.
- Musculoskeletal, respiratory and mental health problems are the major health conditions identified by City workers.

Rough sleepers

- Rough sleepers tend to have co-morbidities, and are likely to use A&E much more than the general population.
- Rough sleepers are particularly vulnerable to infectious diseases, for example, tuberculosis.
- In the City, GP registration for rough sleepers is a priority. Rough sleepers can register with two local GPs practices.

Recommendations

- Expanding services in the pharmacies could be an effective way to improve the health of City workers

- Better linkage of health and social care with community assets from the voluntary services has potential to relieve pressures on care services, while building a more resilient community for the City's resident population.

City workers

- It will be important to assess how primary care services for workers could be funded and resources allocated, to ensure that the level of service for residents is maintained.

Rough sleepers

- The City should continue supporting rough sleepers in accessing services, and reducing barriers. Commissioners should look to work across agencies and with other commissioners to develop models of care for rough sleepers, working across professional and clinical boundaries.

Questions for commissioners

- How are commissioners working with service providers in other local authorities to ensure equity of service provided to City residents?
- Are commissioners looking at the different locations and providers for public health services to be provided from in order to improve the health of City workers?

Chronic Disease

There is no data on chronic disease prevalence among residents of the City, except for those registered at the Neaman practice in the north-west of the area.

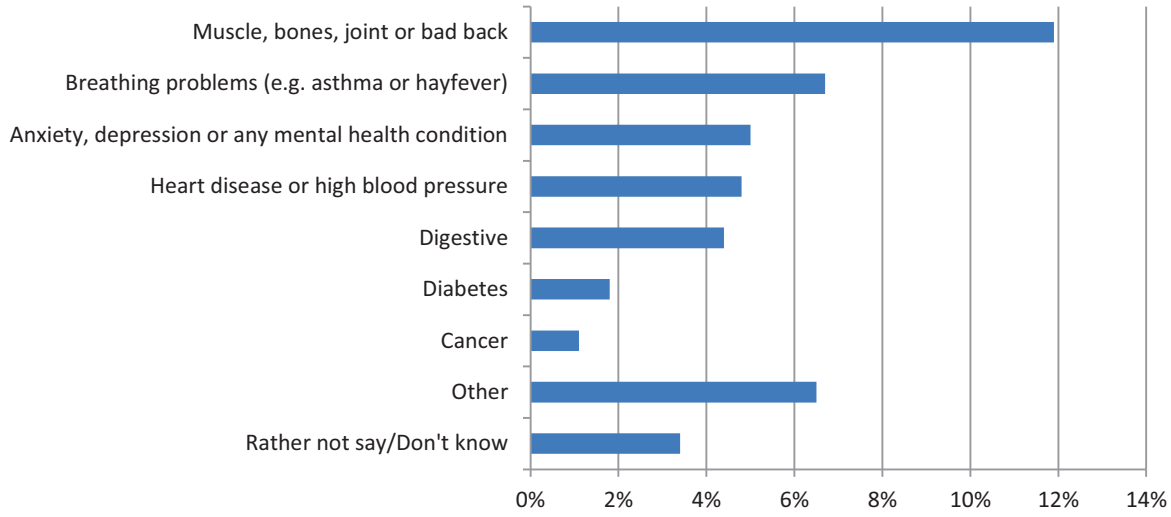
Data are available on cancer, which show that deaths from all cancers and from premature cancer are well below the average for London, and premature deaths have fallen markedly over the last 6 years.

For more information on chronic disease in patients registered at the Neaman Practice, see Appendix 10 – Chronic disease.

City Workers

When asked: "Do you have a health problem which has lasted, or is expected to last, at least 12 months?", City of London workers reported the following conditions (multiple answers possible per respondent). Musculoskeletal, respiratory and mental health problems were the most common health conditions identified. (Figure XX)

Figure XX City worker respondents to the question "Do you have a health problem which has lasted, or is expected to last, at least 12 months?"



Infectious diseases

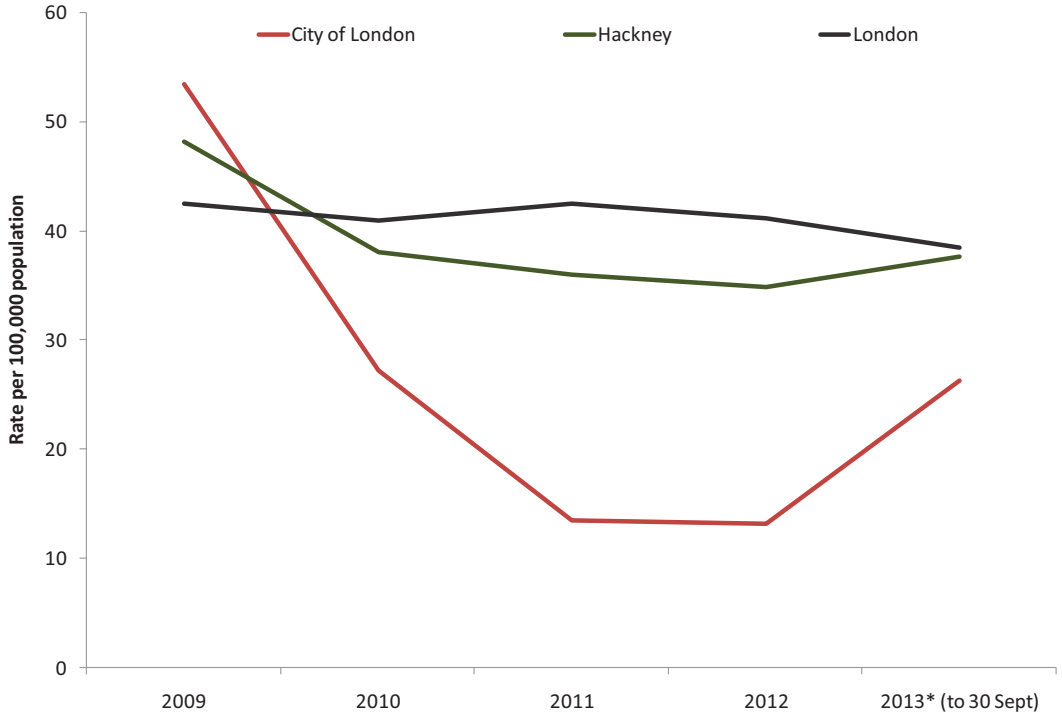
Hepatitis C

Public Health England estimate that there are 77 people infected with hepatitis C in the City of London, of whom 64 are current or previous injecting drug users. This figure is based on modelled estimates and may not reflect the City's unusual population.

Tuberculosis (TB)

The rate of TB incidence in City residents has been steadily declining over the last few years, with a small upturn in the recent year, from 74.2 per 100,000 population in 2004 to 35.7 per 100,000 population in 2012 (Figure 4.3). However, these rates are based on very small numbers.

Figure 4.3 Annual trend of TB incidence by local authority of residence from 2009-2013 (PHE)



City Workers

As discussed above, a significant number of City workers are migrants and some come from countries where TB is prevalent. The Health Protection Team at Public Health England is responsible for following up cases of TB in City workers, and ensuring that co-workers who may have been exposed to the infection are screened. City workers who are detected with TB are usually treated by health services local to where they live.

Rough Sleepers

Rough sleepers are vulnerable to TB, with some studies showing up to 15% of rough sleepers having past or active tuberculosis[86]. Compliance with treatment can be a particular issue for rough sleepers. The City's homelessness team works closely with Public Health England to manage active cases of TB in rough sleepers.

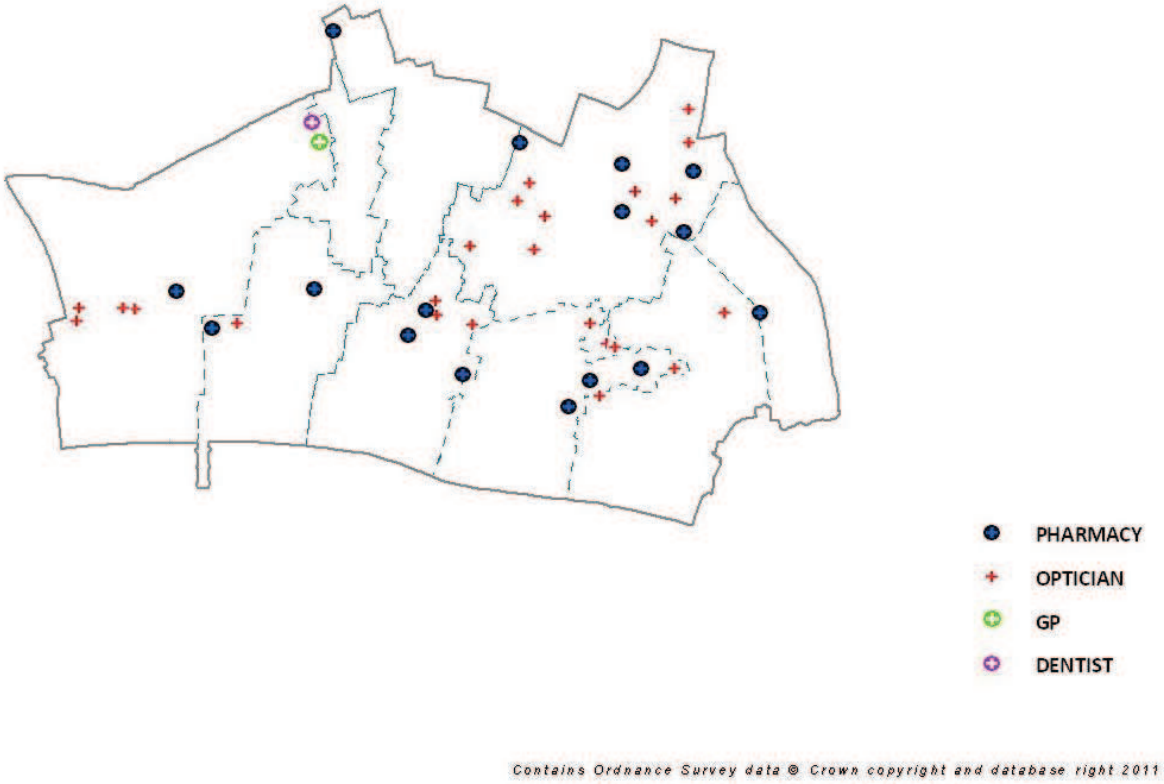
Health Services

Primary care

Primary care services include the many services provided at GP practices, dentists, pharmacists and optometrists. The geographical distribution of these services in the City is show in figure 8.4. In addition to these location-homes, optometry is also delivered in residents' homes where necessary, and GPs also offer home visits to residents.

[86] Rough sleepers health and healthcare (2013) NHS North West London

Figure 8.1 Primary care services in the City



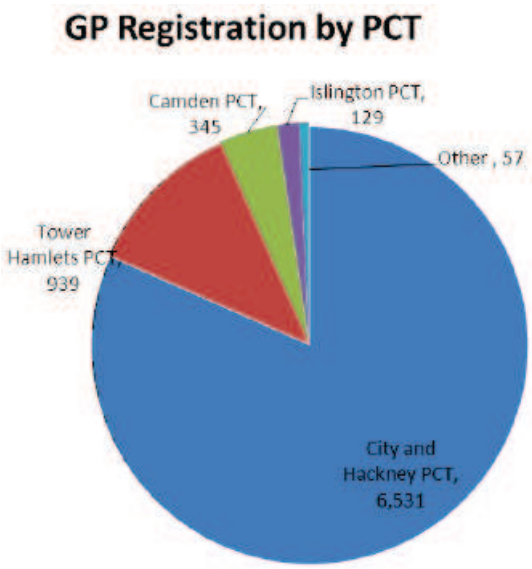
GP registrations

The majority of City residents are registered with the Neaman practice in the City of London (81%), with the second largest registration being at the Spitalfields practice in Tower Hamlets (9%) (Figure 8.1).[87] Overall, 18% of residents are registered outside City and Hackney PCT; the majority of these are registered with GPs in Tower Hamlets (12%). While the practice with the third largest registration of City residents is in Camden, only 4% of City residents are registered with a GP in Camden PCT.[88]

The Portsoken ward contains two social housing estates at Mansell Street and Middlesex Street. Some of this residential accommodation was originally in Tower Hamlets, but was transferred to the City under The City and London Borough Boundaries Order 1993. The ward's relatively recent addition to the City means that the Portsoken area's links to Tower Hamlets are still strong, and not all of the services in the area are provided by the City. The catchment area of the City's only GP practice does not cover the Mansell Street and Middlesex Street Estates, meaning that residents of these two estates must register with GPs from Tower Hamlets. A Tower Hamlets GP practice currently provides services to Portsoken residents at the Green Box Community Centre, located on the Mansell Street Estate.

Figure 8.1 GP registration of City residents

[87] *Mapping of Health Services in the City of London*, 2012
[88] *Mapping of Health Services in the City of London*, 2012



Practices with largest number of City Residents

Practice	Count of City Residents
THE NEAMAN PRACTICE	6512
THE SPITALFIELDS PRACTICE	597
ST PHILIPS MEDICAL CENTRE	206
CITY WELLBEING PRACTICE	156
WHITECHAPEL HEALTH PRACTICE	88
CLERKENWELL MEDICAL PRACTICE	80
GRAY'S INN ROAD MEDICAL CENTRE	66
ST. KATHERINE'S DOCK PRACTICE	45
Other	251
Total	8001

(Source: Mapping of Health Services in the City of London, 2012)

City Workers

City workers who are entitled to register with a GP must do so in their home locality. This means that many City workers, particularly those in lower-paid sectors and roles, find it hard to access primary care services, as doing so would require taking time off work to make the appointment.

Research conducted with City workers showed that one-third of City workers would choose to register with a GP near to work rather than near to home, if they were allowed, and 82% would choose dual registration if this were to become possible. Allowing City workers to register close to work has the potential to make services more accessible, support longer-term health needs, provide more opportunities for screening and prevention, and require less time off work to access services.

Research shows that City workers wish to access health services and clinics during early mornings, lunchtimes and evenings. The short waiting times for services at private sector clinics are seen as a distinct advantage; however, private services are only available for those who can afford them.

NHS walk-in centres around the country have higher throughputs and longer waiting times than private clinics but they are also open to all and free of charge; however the only NHS walk-in clinic in the City was closed in 2010.

Rough Sleepers

Rough sleepers can register at the Neaman Practice in the City, but most choose to register at Health E1, a specialist GP surgery for homeless people, which is just outside the City. The City's homelessness strategy has made GP registration a priority for rough sleepers.

Dental services

There are two dental practices in the City: the Barbican Dental Centre, which offers a range of private and NHS treatments, and the specialist Barbican Orthodontic Clinic, which serves children and young people aged 0–18.

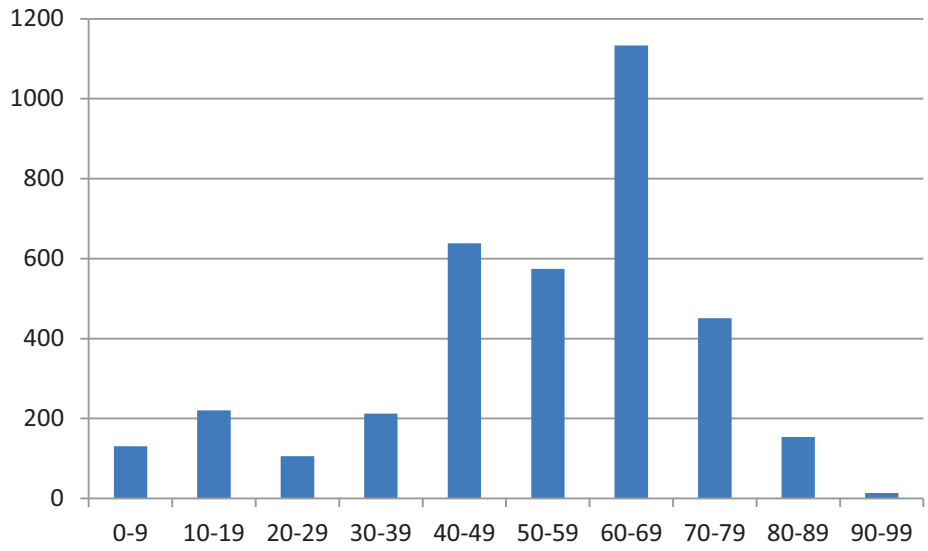
During the period April 2010 to March 2011, residents of the City of London accessed NHS dental services in the neighbouring boroughs of Hackney, Tower Hamlets, Camden and Islington. The

number of people living in the City of London who attended an NHS dental practice was 620: 557 of these were adults and 63 children.

Optometry

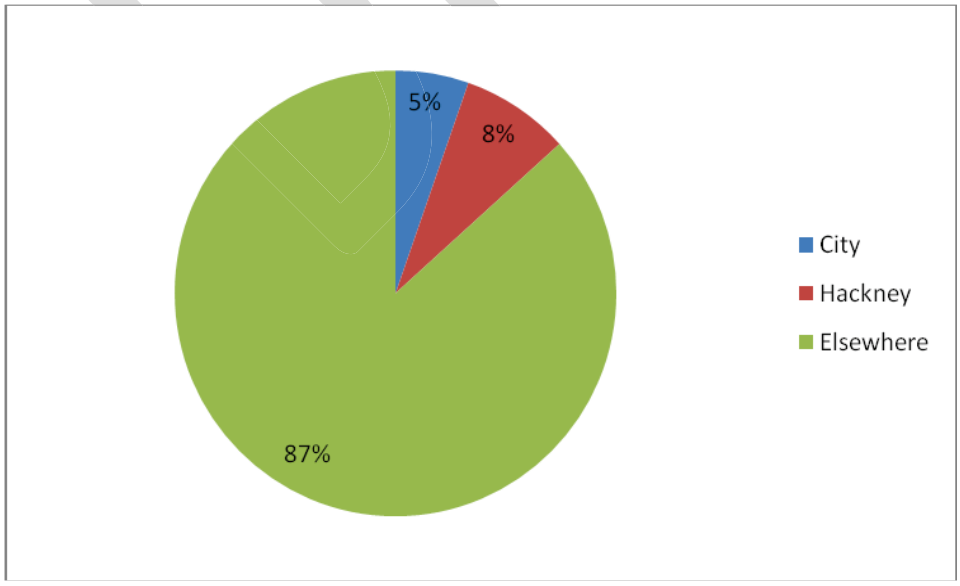
In 2009/10, NHS sights in the City were predominantly performed in the over 40's population.

Figure 8.1 Age profile of NHS sight tests performed by optometrists located in the City



In 2009/10, only 5% of reported NHS sight tests in the City were performed on City residents, with the rest being performed on non-residents, including 8% on people from Hackney (Figure 8.2).

Figure 8.2 Residency of those undergoing NHS sight tests with optometrists located in the City



Pharmacies and prescribing

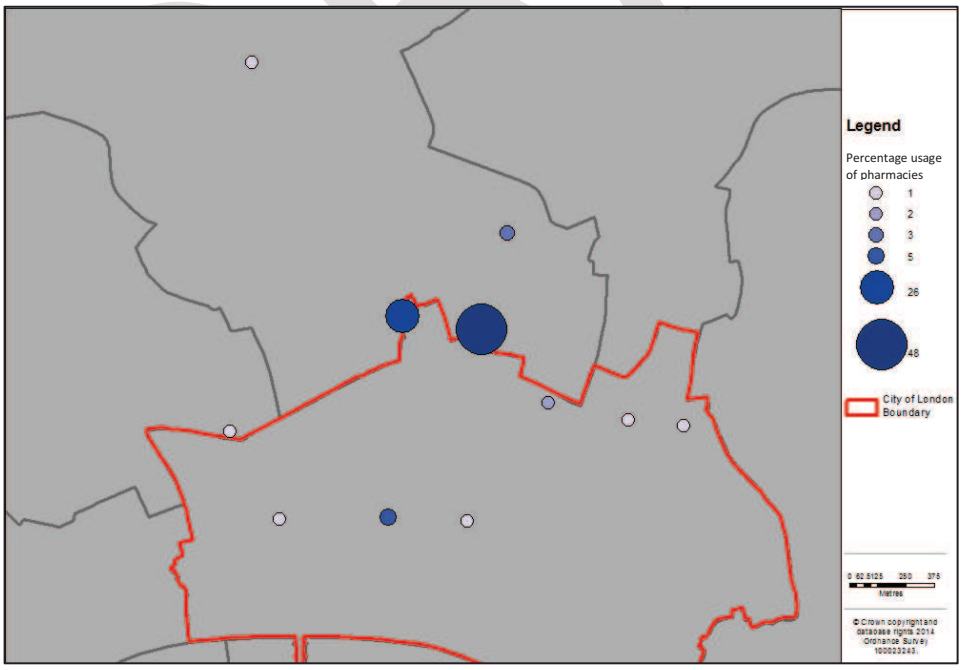
Community pharmacy has had an important role to play in reducing health inequalities through increasing access to health information, prevention and screening services as well as signposting patients to other services and supporting them to take medications. There is a potential to expand services in pharmacy to meet local health needs.

There are 16 community pharmacies in the City. Essential services include dispensing NHS prescriptions. Local enhanced services include the following:

- Chlamydia screening and treatment services, targeting young people in particular;
- Minor ailments service;
- Weight management service, designed to improve access and choice to services that help people
- manage their diet and exercise and maintain a healthy weight;
- Emergency hormonal contraception service;
- Free-dom condom distribution service;
- Drug misuse services including needle exchange and supervised consumption;
- TB treatment supervision service, supporting people with TB to adhere to therapy;
- Seasonal flu vaccination service;
- Stop smoking service

An analysis of prescriptions dispensed from the Neaman Practice between June-December 2011[89] showed the locations where prescriptions were being dispensed. As can be seen, the majority of prescriptions were dispensed from two independent pharmacies, one of which is located in Islington.

Figure 8.2 Percentage usage of pharmacies by Neaman practice patients 2011



[89] ePACT 2011

Rough sleepers

Although there is no City specific data, the healthcare utilisation and costs of rough sleepers in the City is likely to reflect patterns seen amongst rough sleepers assessed in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster.[90] The healthcare needs and utilisation patterns were found to be:

- Secondary healthcare costs are at least five times more for rough sleepers than the general population
- They access A&E seven times more than the general population
- They are more likely to be admitted to hospital as emergencies which costs four times more than elective inpatients
- They are four times more likely to attend outpatient health appointments (with DNA's removed) compared with general population
- They stay in hospital twice as long as the general population
- They have more co-morbidity. One in five rough sleepers who had contact with hospitals had three or more diseases
- Their healthcare usage increases over time
- Hospital usage is highest among 30-49 year old men and cost significantly higher than the general population
- Most rough sleepers had clinical conditions related to mental health, trauma and orthopaedics, digestive system and ophthalmology

Case Study

K is a 27-year-old male currently sleeping rough in an underpass. He was born in London and was taken into care at a young age. He was placed with 5 different foster families and started using heroin and crack cocaine at the age of 17

Housing history

K was accommodated by the City, but then evicted for a combination of arrears, non-engagement, and hoarding, despite numerous case conferences to prevent this. He was then accommodated in a hostel, but was evicted for assault in the following year.

Health issues

K's drug use in one year was estimated at £100 per day of heroin & crack on top of methadone script. He has multiple health problems and frequently attends hospital.

Other issues

There have been issues of violence and domestic abuse with his current partner but they continue to stay together. He has been a prolific beggar in the City since 2010.

Three voluntary organisations are working with him, in addition to City Outreach, Substance Misuse Partnership and the Police, but his case is extremely complex, and his behaviour persists in being very challenging.

Nearly half of those rough sleepers who attended to hospitals have attended all three (outpatient, inpatient and A&E) hospital services

[90] Rough sleepers: health and healthcare, NHS North West London. http://homeless.org.uk/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf

Social Care Services

In 2011 the City of London held a number of consultations with service users and partners on changes to the way Adult Social Care was to be delivered. In the wake of the consultations, the following changes were made;

- **Introduction of the Supported Assessment Questionnaire (SAQ),** designed to enable Adult Social Care staff to gather relevant information from individuals who may require support to maintain their independence and choice.

- **Resource Allocation System (RAS).**
  The Resource Allocation System (RAS) allocates points to propose an Indicative Individual Budget and agree a support plan, which can be managed through a Direct Payment to the service user themselves or via a third party agency.

- **Service user contributions**
  The new process requires full financial assessment and disclosure of savings, income and assets. An annual review of the Individual Budget alongside a financial reassessment is now a routine part of work with service users.

- **Adherence to the Fair Access to Care (FACS) eligibility criteria**
  The Fair Access to Care has four bands of eligibility;
  - Substantial and Critical: eligible for an individual budget
  - Low and Moderate: eligible for advice and information

- **Carers Strategy and Carers Individual Budgets**
  Carers are assessed through the Supported Assessment Questionnaire (SAQ) so that their needs are addressed. The amount of financial support offered to Carers has been increased. Those with Moderate eligibility receive an Individual Budget of £150; Substantial: an amount of £750; and Critical: £3,000.

- **A small grants scheme**
  The small grants scheme was implemented to support the formation and maintenance of community groups.
  - The scheme has provided small grants to maintain social clubs for elderly residents, as well as providing art and exercise classes for residents.

The Better Care Fund (BCF)

The Better Care Fund was announced as part of the Government 2013 spending review. It brings together separate strands of funding, providing an opportunity to transform local services to deliver better integration of care and support, and better outcomes for individuals.

The City's BCF plan was developed in consultation with service users, service providers, commissioners and the Health and Wellbeing Board. It will deliver the City's vision for:

- Person-centred care and support
- 7-day services in health and social care
- Early intervention and prevention
-Better data and information sharing to support care
- Joined up and coordinated services, and support for carers

In doing so the plan will reduce the burden on acute hospital services, by supporting people to remain in, or return more quickly to, their homes.

In 2014/15 the City of London will work with health partners to put in places the changes to deliver the BCF plan fully from 2015/16.

- **Service Directory**
  A comprehensive service directory has been created for service users, which forms a resource manual for those seeking to manage their own individual budgets.

Performance Data

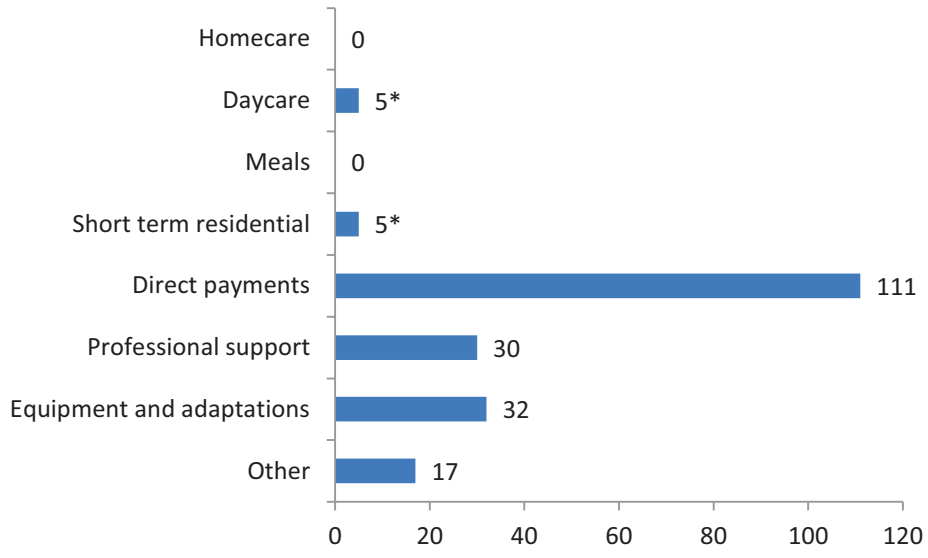
In 2011-2012 the City of London carried out the Adult Social Care User Survey for the first time. The City had an excellent response rate of 63%. Of those who responded, 83% felt that the services they received made them feel safe and secure. 74% of users felt that they have control over their daily life, and 70% of users have found it easy to find information about services.

In 2012/13, The City of London Corporation provided services to 224 people with a wide range of needs, both at home and in care homes. Approximately 84% of clients received services in the community. The majority of clients (63%) were older people, aged 65+ years. In this older age group, there were more women than men (58% vs. 42%). In the younger age group, under 65 years, there were fewer women than men (33% vs. 67%).

These clients were 88% White, 5% Asian, 3% Black and 4% of mixed or other ethnicities. Compared to the GLA ethnic profile for the City, White clients are over-represented and Asian clients under-represented in this social care client group; though the numbers are relatively small so variations do not necessarily reflect inequalities in access.

The graph below describes the range of social care services provided to City residents by the City of London Corporation in 2012/13. These services are dominated by clients receiving direct payments. Professional support and equipment and adaptations are also well represented.

Figure _____Community social care services received from City of London Corporation, 2012/13 (some clients receive more than one service)



**Fewer than 5 individuals were reported*

Direct payments

Direct payments and personal budgets are designed to give people control over their lives by providing an alternative to the community social care services commissioned by councils. They offer an opportunity to increase independence and exercise choice. However, they are better suited to some individuals than others. The City of London Corporation has a duty to make direct payments where individuals express an interest and are able to manage them, with or without assistance. Some people may request support with a direct payment to organise and pay for care, in which case it is set up and delivered in the way they wish.

In 2012/13 the City had 111 clients in receipt of direct payments and individual budgets. Of this total, 48% had a physical disability, 40% mental health needs, 8% learning disabilities and 4% has substance misuse needs or were vulnerable.

Safeguarding

In 2012/13 there were 20 alerts, 11 referrals and 11 completed referrals to the Safeguarding Adults Board. An alert is a concern that an adult at risk is or may be a victim of abuse or neglect. A referral is when an alert (following a decision made by a Manager of the Adult Social Care Team), is accepted to be a safeguarding issue and is managed through the safeguarding process. This includes referrals for City residents who are placed in residential or nursing homes outside the authority for which the City still has a duty of care. Of the 20 alerts, 6 were of residents placed outside the City.

Case Study

A is a 93 year old widower who lives alone in a City flat. He suffers from severe arthritis which restricts his mobility. He is dependent on a walking frame both indoors and outdoors and occasionally uses a wheelchair.

He was admitted to hospital having been found by District nurses, who visit 3 times a week, suffering from dehydration and confusion. He had been so confused that he did not use his pendant alarm. He was discharged back home with Reablement input and a package of care provided by an agency for evenings and weekends.

A Reablement worker visited him one morning to discover him semi-naked having struggled with dressing and personal care. Further investigation from the Reablement worker showed that he had not been given his medication over the weekend and that the carer had not logged in. The Reablement worker informed his GP regarding the medication and saw to his immediate needs before raising a safeguarding alert.

Safeguarding process

The allocated social worker arranged for care to be taken over by a different homecare agency with immediate effect. The decision was taken to suspend any future referrals to the previous agency until systems were in place to prevent a repeat occurrence.

The agency worker responsible for non-administering of medication and non-attendance was suspended pending further investigation and was to be dealt with by the agency's disciplinary procedures. The cause was identified during the investigation as the carer taking the annual leave without appropriate approval after which the agency responded with adjustments to their policies

All care staff continues to be monitored on all bookings by telephone spot-checks and the agency is also looking into other ways of monitoring workers' visits which may include telephone check-in systems. The service user has continued to have support with his new agency without incident.

The Voluntary and Community Services

There are around 350 organisations operating or based in the City, ranging from small neighbourhood groups and churches to large national charities and regional funders such as the City Bridge Trust and the various livery companies.

The way the City commissions services from the VCS, including from organisations based in the City, Hackney, Islington and Tower Hamlets, is guided by best value principles and the Local Procurement Directive.

The City's relatively small resident population and large daytime population of commuters and workers provide a unique environment for the VCS. There are many opportunities for City workers to volunteer both time and resources, particularly in the City Fringe area, and several City organisations exist to support this. For example, City Action is a free service provided by the City of London Corporation which introduces City businesses to a diverse and creative range of skills-based volunteering opportunities. These opportunities are carefully matched with the objectives and interests of employees.

The City of London Corporation is working in partnership with the charity Spice to create a Time Credits Network for the City, helping to strengthen and build communities. City of London Time Credits are a way of thanking those who give their time to their local community. They can be 'earned' by anyone who volunteers within the City of London, and 'spent' on events, training or leisure services in the local area.

Time Credits

Time Credits have been trading in the City since June 2012, and since then over 1,700 hours have been contributed by 180 people through 21 connected providers and community groups. The focus of the programme has been on developing Time Credits in the Portsoken ward, one of the most deprived areas of the City. Spice has been liaising with the commissioning team to involve users in commissioning, designing and delivering services – and in training providers to adopt the Time Credits system – and is currently working with City Gateway, CSV, Recycling, Fusion, Toynbee Hall, Artizan Street Library and Community Centre and Healthwatch. Local residents are also growing in confidence and are starting to set up more community-led groups, including gardening clubs, good neighbours' schemes, activity groups such as Zumba and sewing, and social groups for women and young people.

By encouraging more people to get involved in services, local community groups and third sector organisations, Time Credits create opportunities for individuals to learn new skills, gain confidence and raise their aspirations. By spending Time Credits, individuals can try new activities and improve their health and wellbeing. Many participants have commented that, through the Time Credits Network, they have been able to try activities they could not previously afford. As a result of their increased participation, individuals have better access to peer and community support networks, and a more positive perception of their ability to contribute to the local community.

Initial findings from our evaluation survey, carried out a year after rollout, show that 31% of people involved with Time Credits have never previously volunteered within their community. 62% feel that the scheme is helping to improve their quality of life.

Appendix 1 – Data limitations

Resident data

City resident-specific data has always been challenging to obtain and report due to small numbers, which makes it difficult to compare to local and national indicators. Historically, health specific data has been aggregated with Hackney due to pooled budgets.

Census 2011:

Resident demographic data is available through the Census 2011 however, due to the small numbers in the City, many reported figures are not statistically significant. Therefore the depth of analysis is limited.

Healthcare Service performance data:

Most of the data for health service utilisation and health outcomes reported is aggregated with Hackney. This is a challenge for the City, as without the disaggregated figures it is difficult to decipher if the trend observed truly represents the City population or is mainly a reflection of Hackney.

Social Care Service performance data:

Most Social Care data is collected from the City's Community and Children's Services team. Similar challenges exist where figures are too small to report meaningfully.

Early life and childhood data

Data covering education comes direct from the one primary school (St John Cass). Early years data is kept with the Education and Early Years or Commissioning and Performance teams in the City's Community and Children's service's department or may come from nationally monitored government sources such as the school census and early years census. Similar challenges exist where figures are too small to report meaningfully.

Housing data

Most of this data is derived from the 2011 Census and compiled by the City's Department of Built Environment.

City worker data

In October 2013, a new release of Census 2011 data estimated the population and characteristics of the workday population across England and Wales. This Census intelligence is the first of its kind, and is of particular importance to the City of London, since the workday population is 56 times higher than the resident population. Two independent reports have also been commissioned to gain

insights into the health needs of City Workers – *The Public Health and Primary Healthcare Needs of City Workers*, and *Insights into City Drinkers*.[91][92]

The 2011 Census release:

The workday population of an area is defined as "all usual residents aged 16 and above who are in employment and whose workplace is in the area and, all other usual residents of any age who are not in employment but are resident in the area". Those excluded from this workday population are:

1) Those with a place of work in England and Wales but who are not usually resident in England and Wales
2) And short-term residents.[93]

Public health and Primary Healthcare Needs of City Workers:

The City of London Corporation in conjunction with NHS North East London and the City appointed the Public Health Action Support Team CIC (PHAST) to undertake research into the current and future public health and primary healthcare needs of City workers.

The research was based on a mix of qualitative and quantitative methods, including review of existing data and a street-based and web-based survey of City workers at all levels from senior management to entry level.

Insights into City Drinkers:

This report was commissioned by the City of London Substance Misuse Partnership to gain an insight into the prevalence and nature of alcohol consumption among city workers and identify segments within the community of City workers who could be targeted with public health information about risks associated with consuming alcohol.

The report defined alcohol misuse as those identified as drinking at 'increasing' or 'higher risk' levels as identified by a validated screening tool. Alcohol misuse in itself does not infer 'problematic' drinking, though those drinking at higher risk levels are likely to be experiencing harms including possible dependency.

Rough sleeper data

CHAIN database:

The main source of data for rough sleepers in the City comes from the CHAIN database. The CHAIN (Combined Homelessness and Information Network) database is commissioned and funded by the Greater London Authority and managed by Broadway. It records information about contacts and work done with rough sleepers and members of the wider street population in London. Outreach teams, hostels, day centres and a range of other homelessness services across London access and update the system.

[91] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[92] Insights into City Drinkers, 2012
[93] Office for National Statistics 2013, The Workday Population of England and Wales: An Alternative 2011 Census Output Base

There exists City level data for basic demographics details of rough sleepers, such as age, sex and ethnicity.

Rough sleepers: health and healthcare:

This report entitled Rough sleepers: health and heathcare by NHS North West London provides the health needs evidence where detailed City specific rough sleeper needs do not exist.

Appendix 2 – Demographics

Table 1.7 Projected population age groups in the City to 2037, with percentage rise over previous five years (numbers rounded to nearest 100)

Year		The City				
		0–4	5–19	20–65	>65	All
2007	N (% rise)	300 (22.2)	600 (–0.7)	5,900 (3.6)	900 (4.4)	7,600 (3.9)
2012	N (% rise)	300 (–7.2)	600 (4.9)	5,700 (–2.1)	1,000 (10.9)	7,600 (–0.2)
2017	N (% rise)	300 (8.2)	600 (8.1)	6,000 (4.4)	1,200 (17.3)	8,100 (6.5)
2022	N (% rise)	300 (–0.8)	700 (7.7)	6,200 (2.7)	1,300 (11.3)	8,400 (4.3)
2027	N (% rise)	300 (–0.8)	700 (4.4)	6,300 (2.0)	1,500 (10.1)	8,700 (3.4)
2032	N (% rise)	300 (–0.4)	700 (0.3)	6,300 (1.0)	1,600 (13.2)	9,000 (2.9)
2037	N (% rise)	300 (0.4)	700 (–0.4)	6,400 (1.2)	1,800 (9.6)	9,200 (2.6)

Source: GLA

Figure 1.8 Intercensal population growth (NB: 2001 populations may be underestimated in some areas).

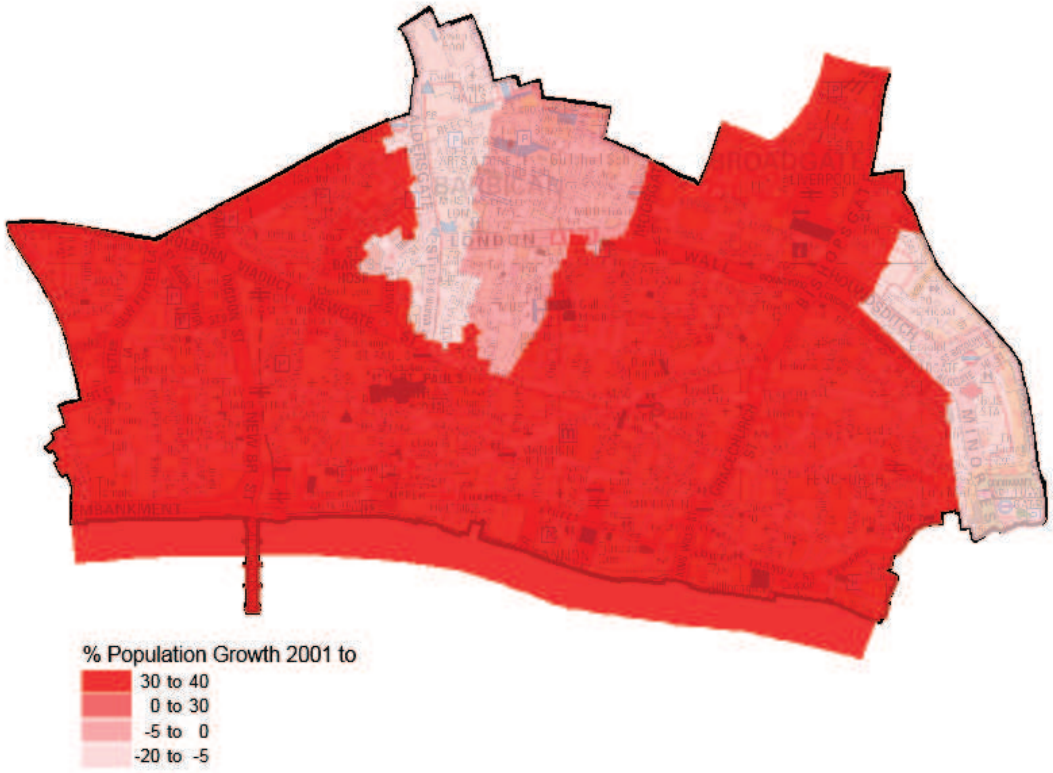
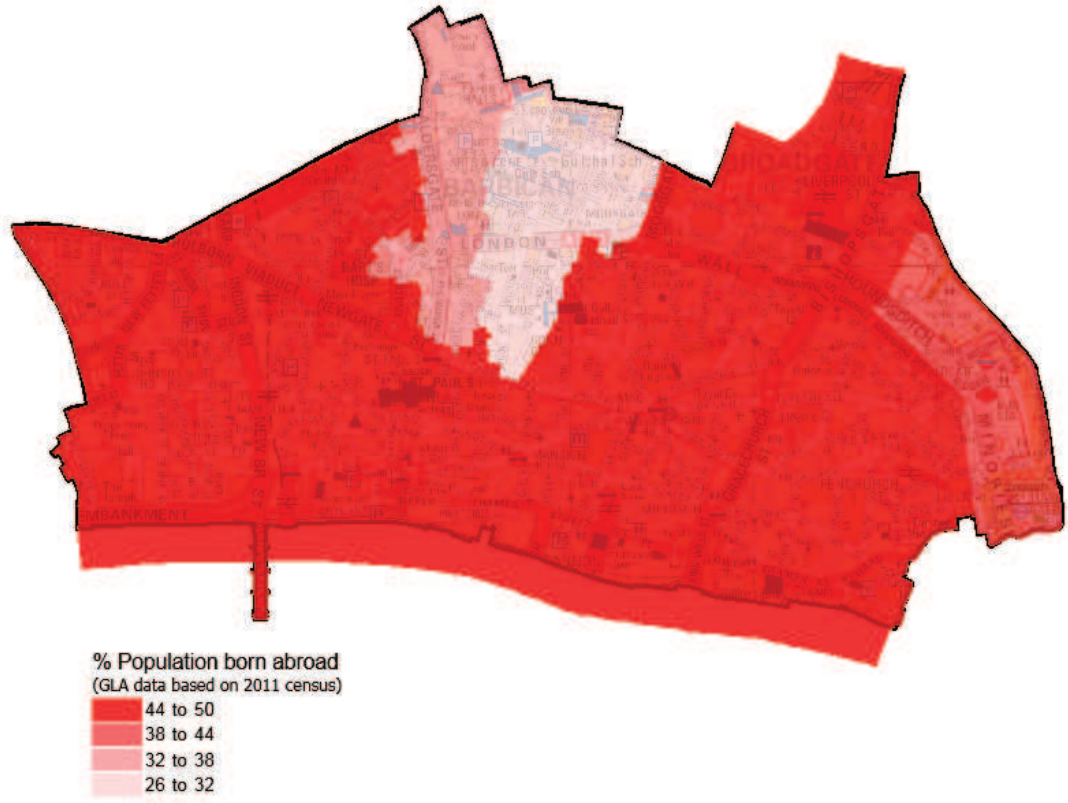


Figure 1.9 Percentage of population who were not born in the UK



Appendix 3 – Ethnicity

Figure 1.10A Ethnicity in the City: percentage of residents who are white

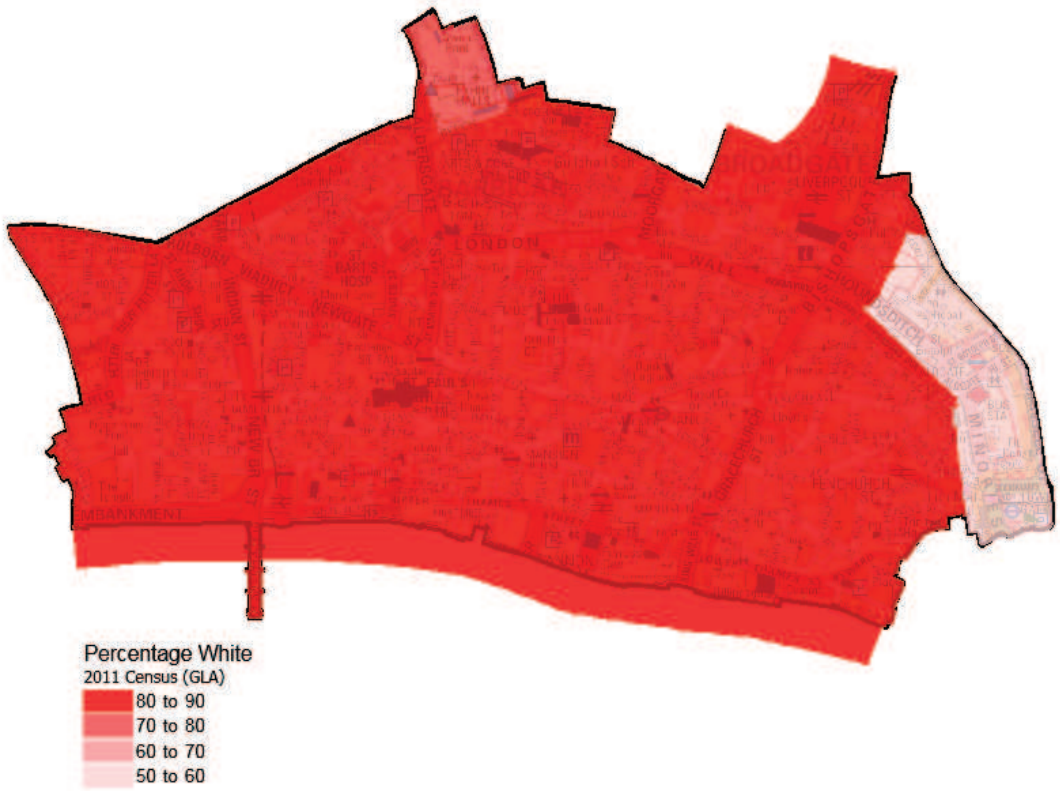


Figure 1.10B Ethnicity in the City: percentage of residents who are black

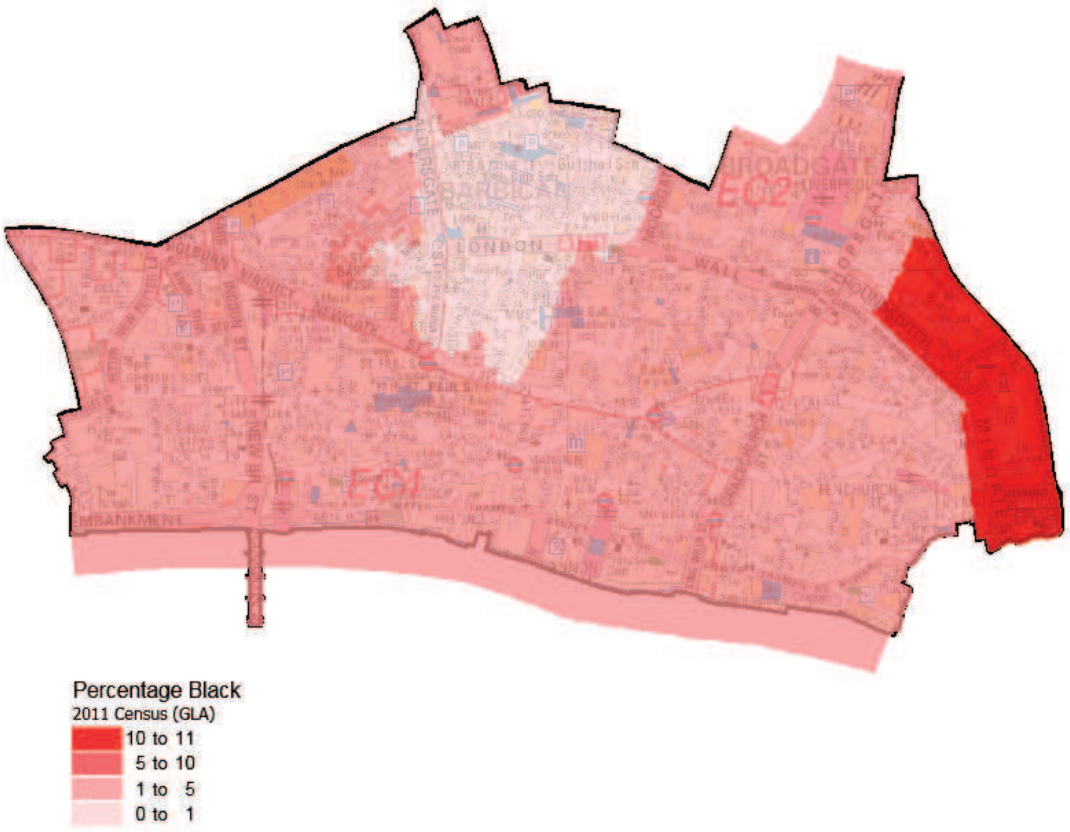


Figure 1.10C Ethnicity in the City: percentage of residents who are Asian

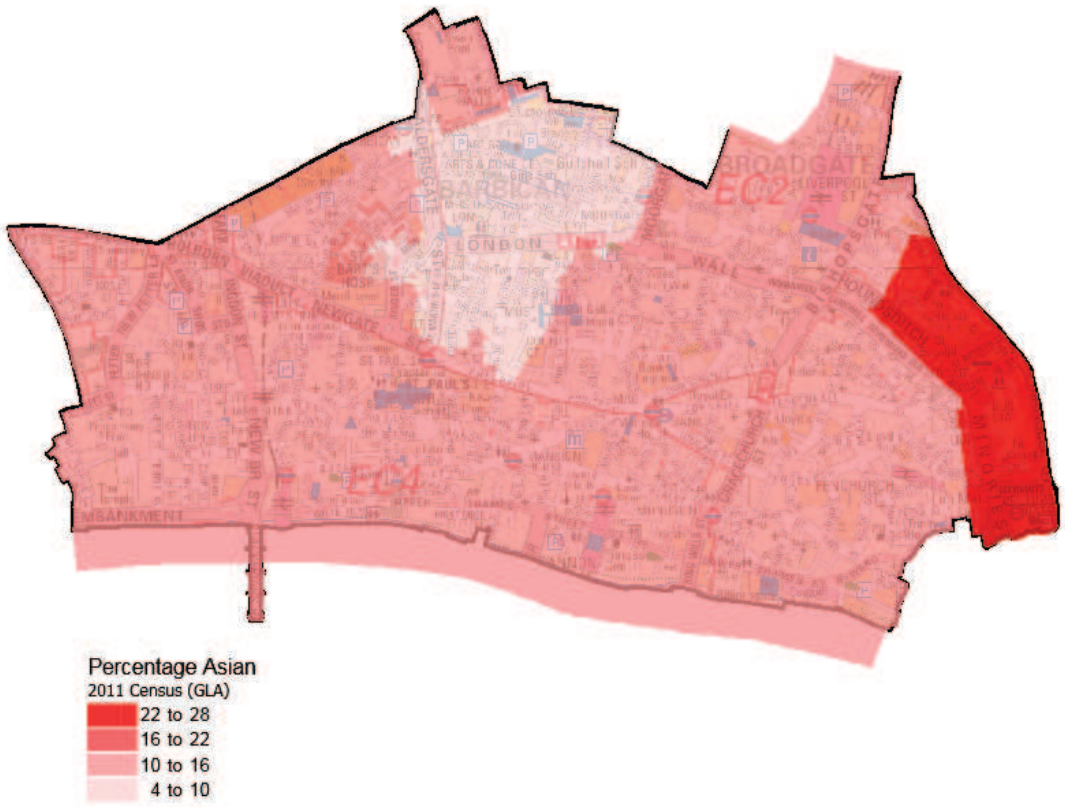
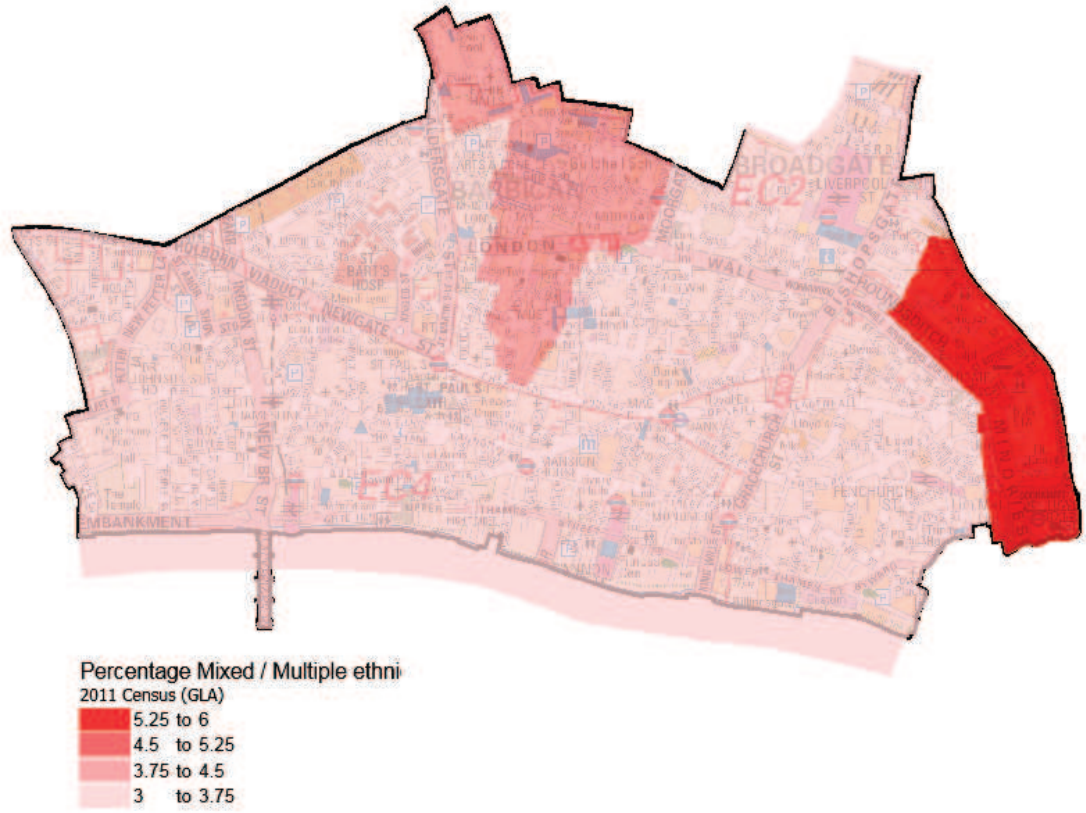


Figure 1.10D Ethnicity in the City: percentage of residents who are of mixed / multiple ethnicity



Appendix 4 - Religion

Figure 1.11A Main religions in the City: percentage of residents who are Christian

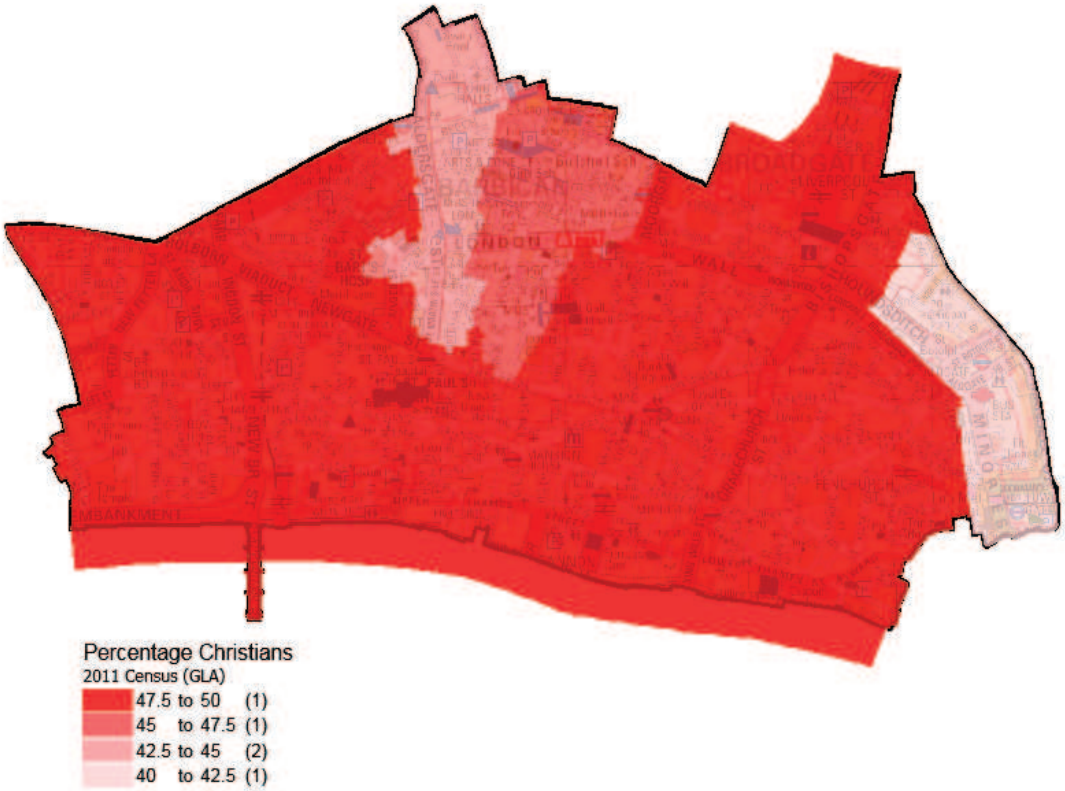


Figure 1.11B Main religions in the City: percentage of residents who are Jewish

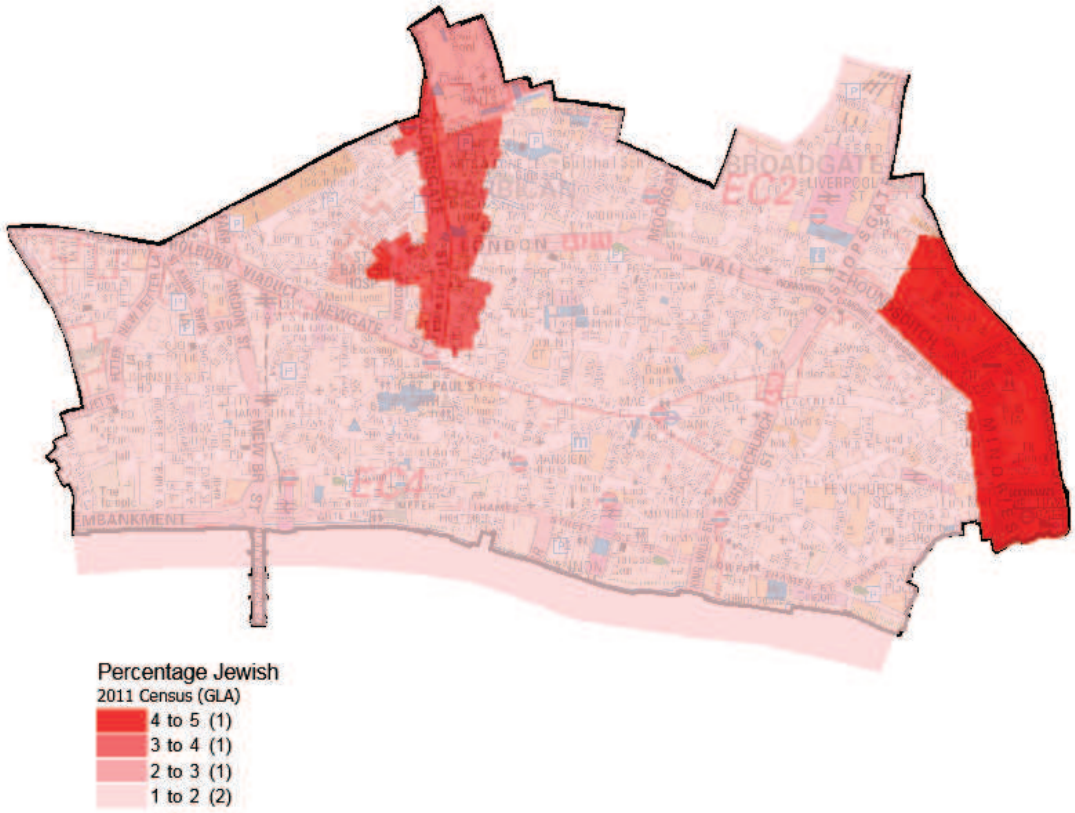


Figure 1.11C Main religions in the City: percentage of residents who are Muslim

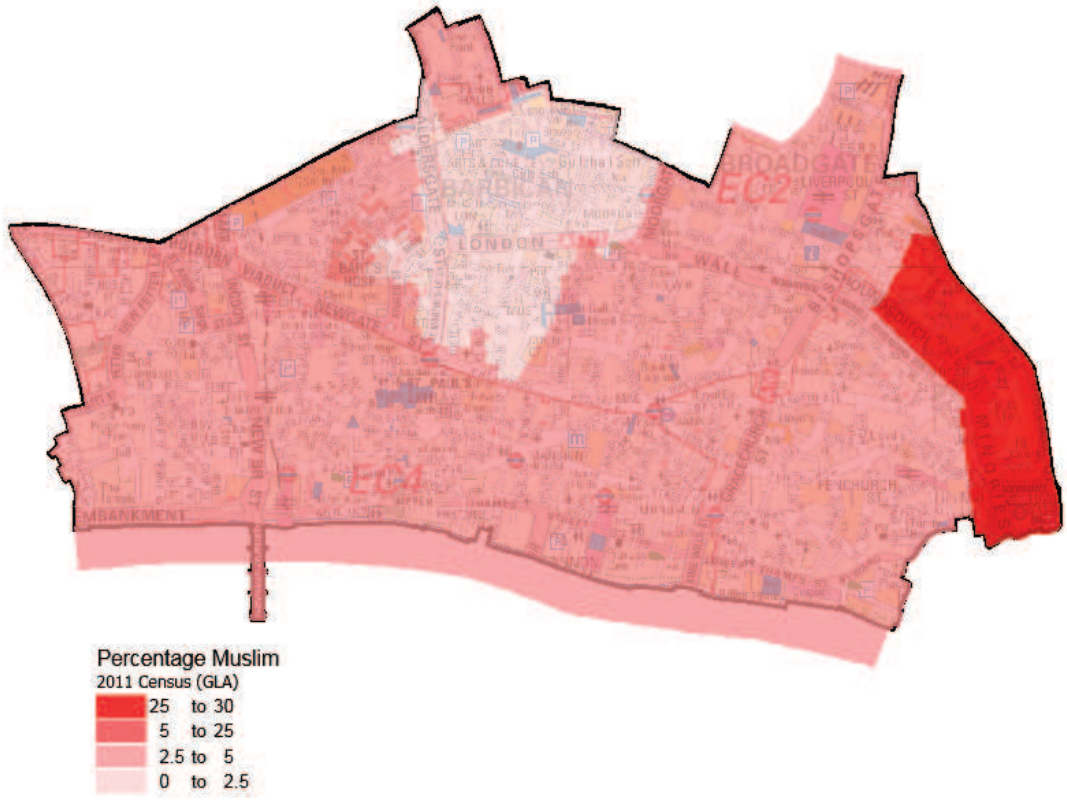
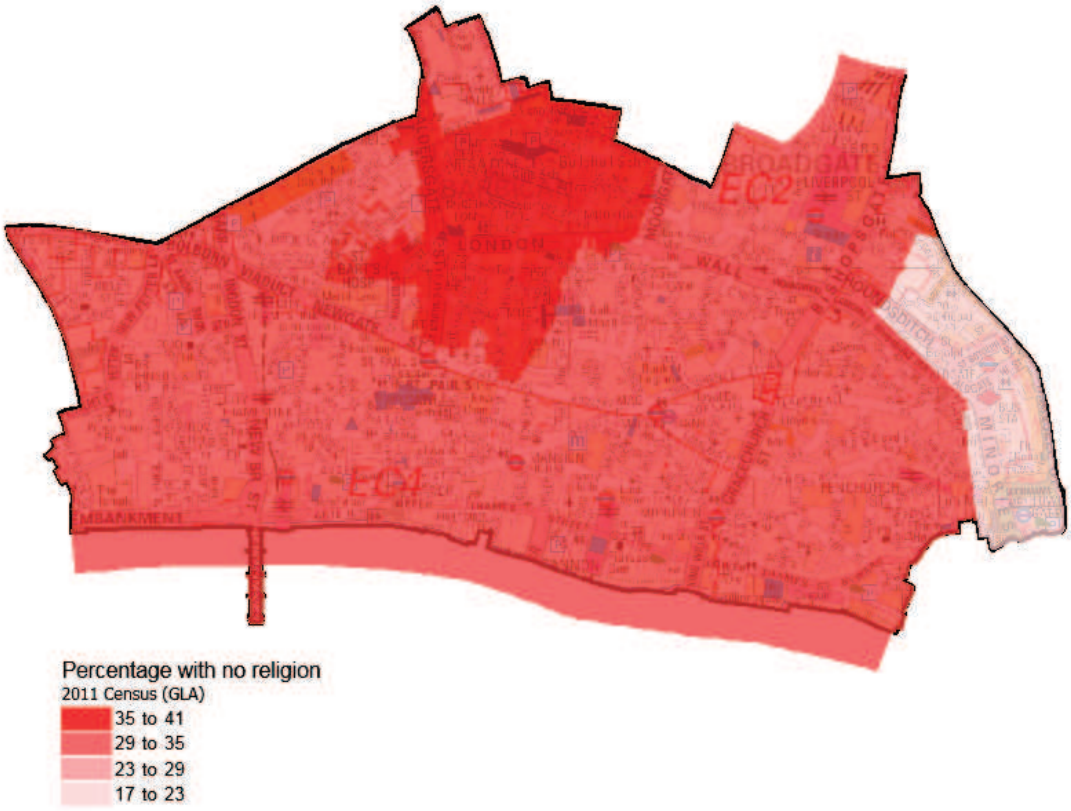
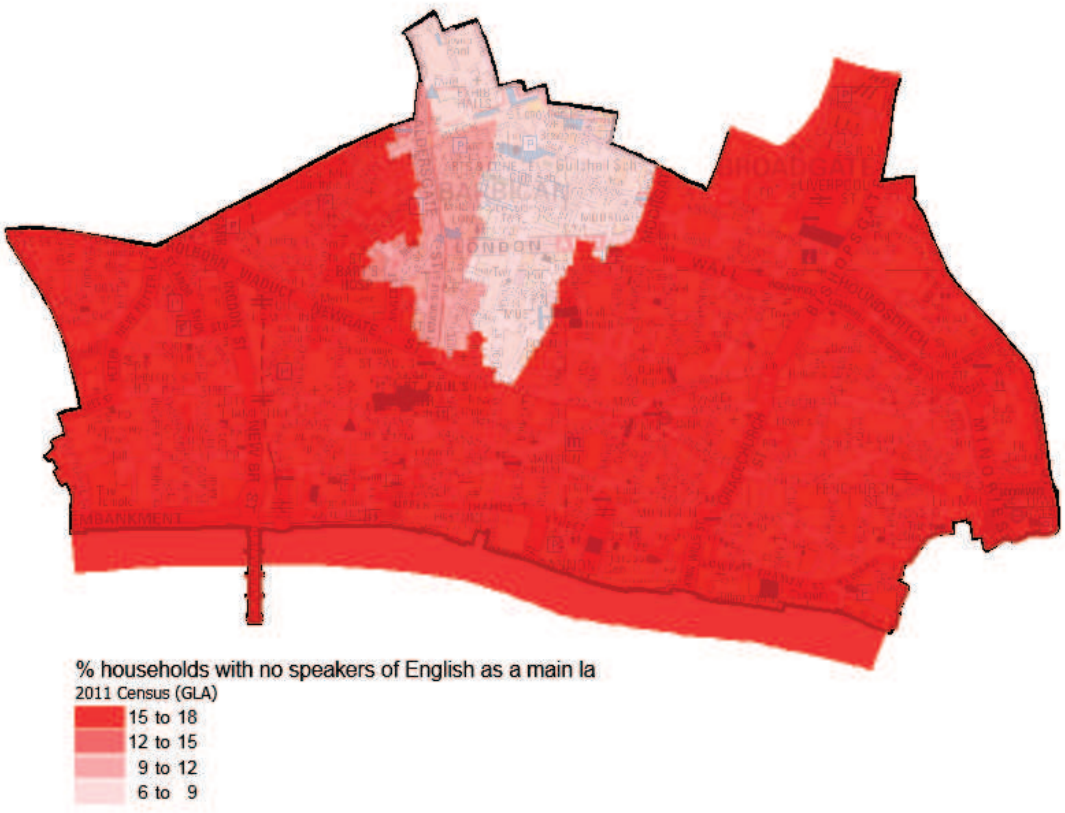


Figure 1.11D Main religions in the City: percentage of residents who state no religion



Appendix 5 – Languages

Figure 1.12 Percentage of households in the City with no speakers of English as a main language.



Appendix 6 - Road casualties

In the City, 58 people were killed or seriously injured on the roads in 2012, an increase of 18% on the previous year. With smaller numbers in the City, there is even more year-on-year variability in this data. (Figure 6.5)

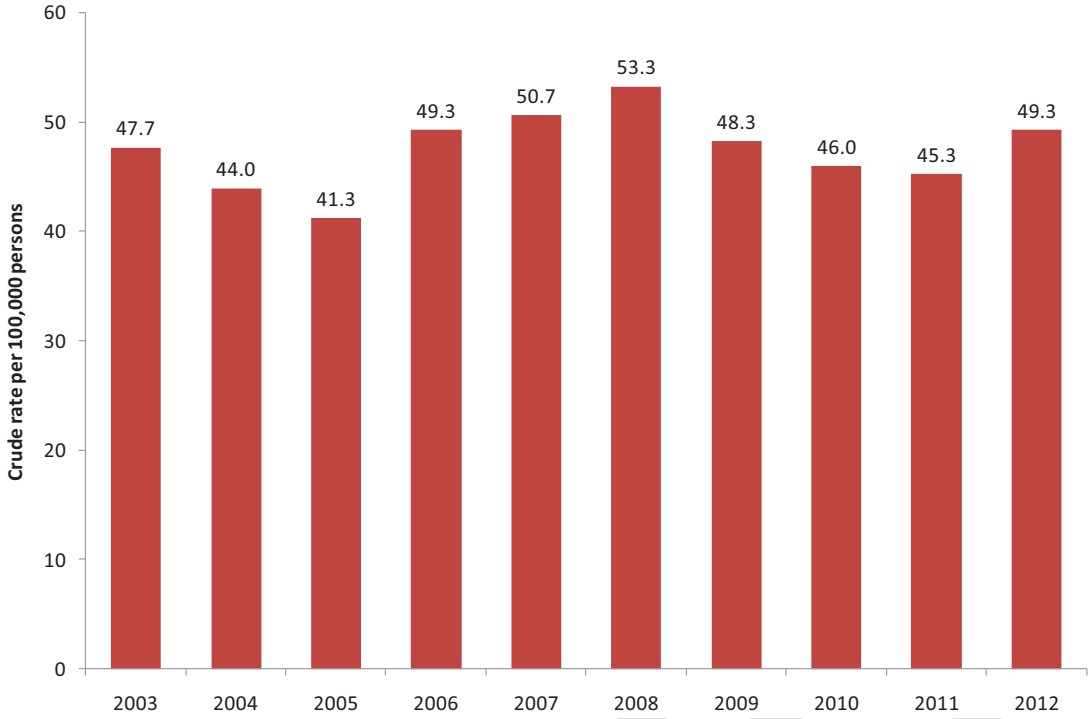
Given the smaller numbers involved, there is even more year-on-year variability in this data in the City. Since 2003, the long-term trend on a three-year rolling average shows a generally consistent number of casualties (Figure 6.6).

The unusual resident population in the City make it inappropriate to present the road casualty figures in direct comparison with those for neighbouring boroughs.

Table 6.5 Road casualties by road user type, 2012 (Dept for Transport)

	City of London (N=58)	London (N=3022)	England (N=21,630)
Pedestrian	33%	44%	31%
Pedal cycle	45%	23%	16%
Motor cycle	16%	21%	22%
Car	3%	16%	35%
Bus or coach	3%	3%	1%
Van / light goods	0%	1%	1%
HGV	0%	0%	1%

Figure 6.6 Three-year rolling average of killed or seriously injured casualties in the City, 2003-12 (DfT)


Crude rate per 100,000 persons
60
50
40
30
20
10
0
47.7
44.0
41.3
49.3
50.7
53.3
48.3
46.0
45.3
49.3
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012

Appendix 7 – Families and Households

Figure 1.13B Household structure in the City: percentage of couples without children

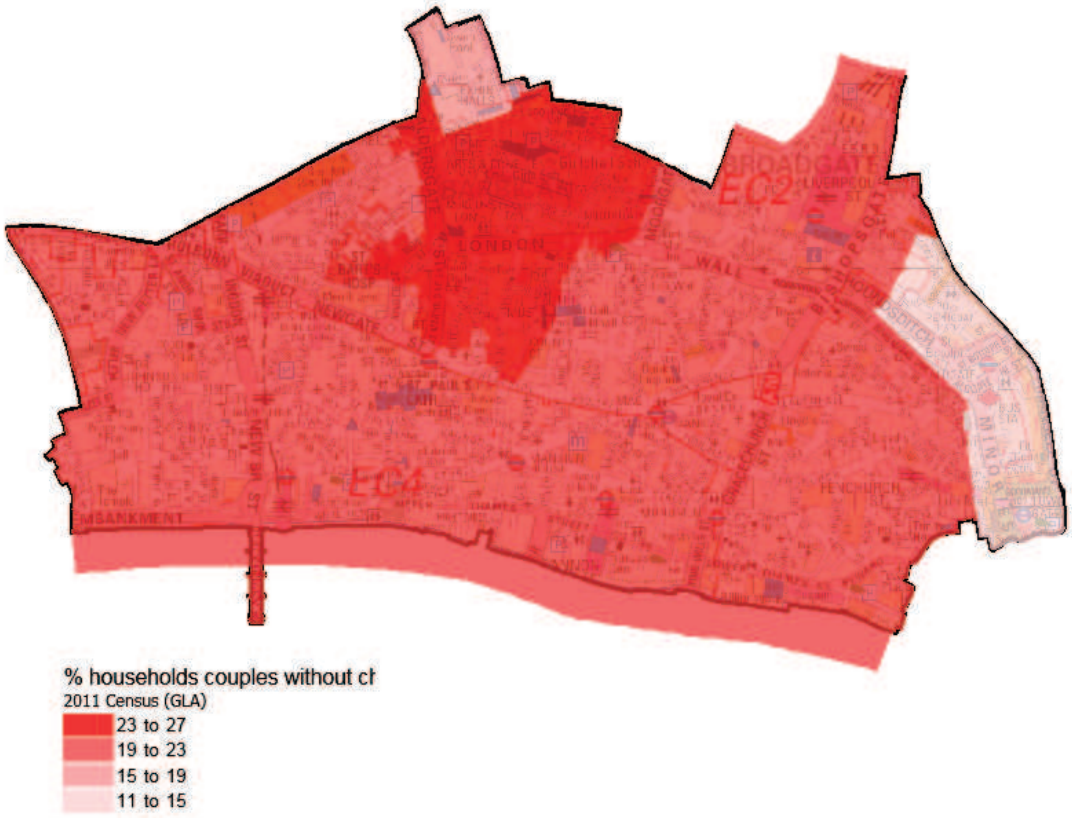


Figure 1.13C Household structure in the City: percentage of lone parent households

Figure 1.13D Household structure in the City: percentage of one person households

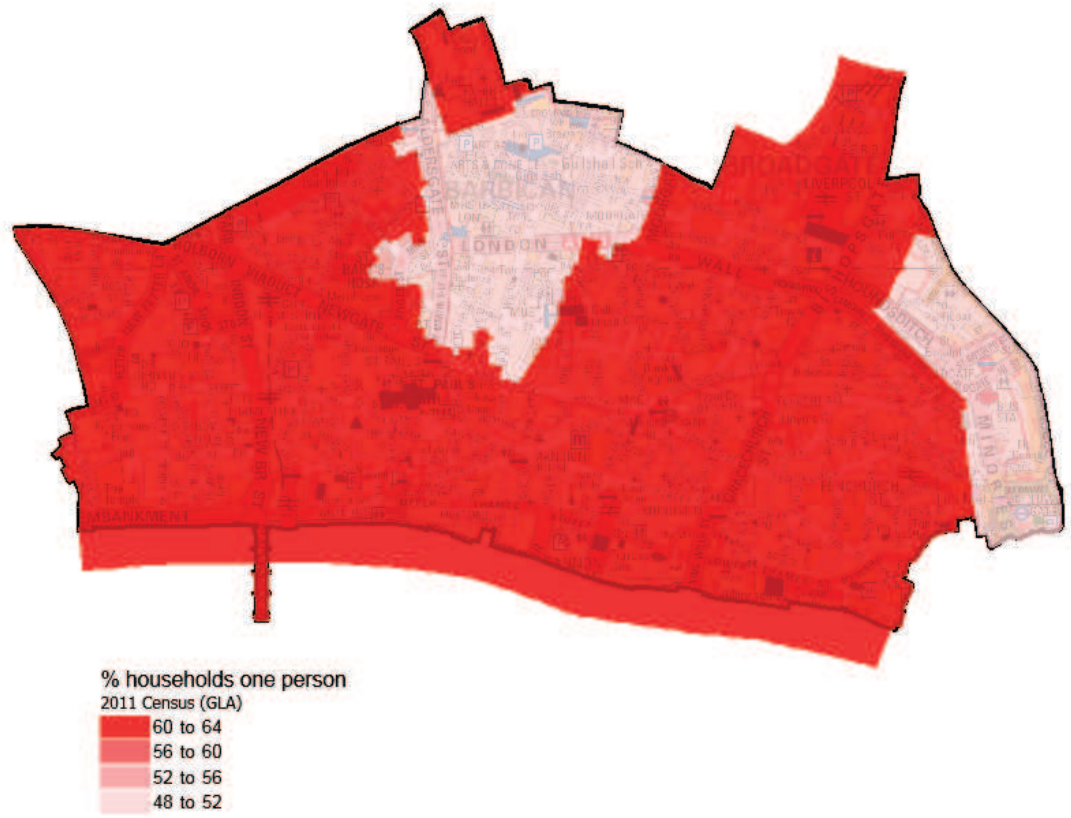
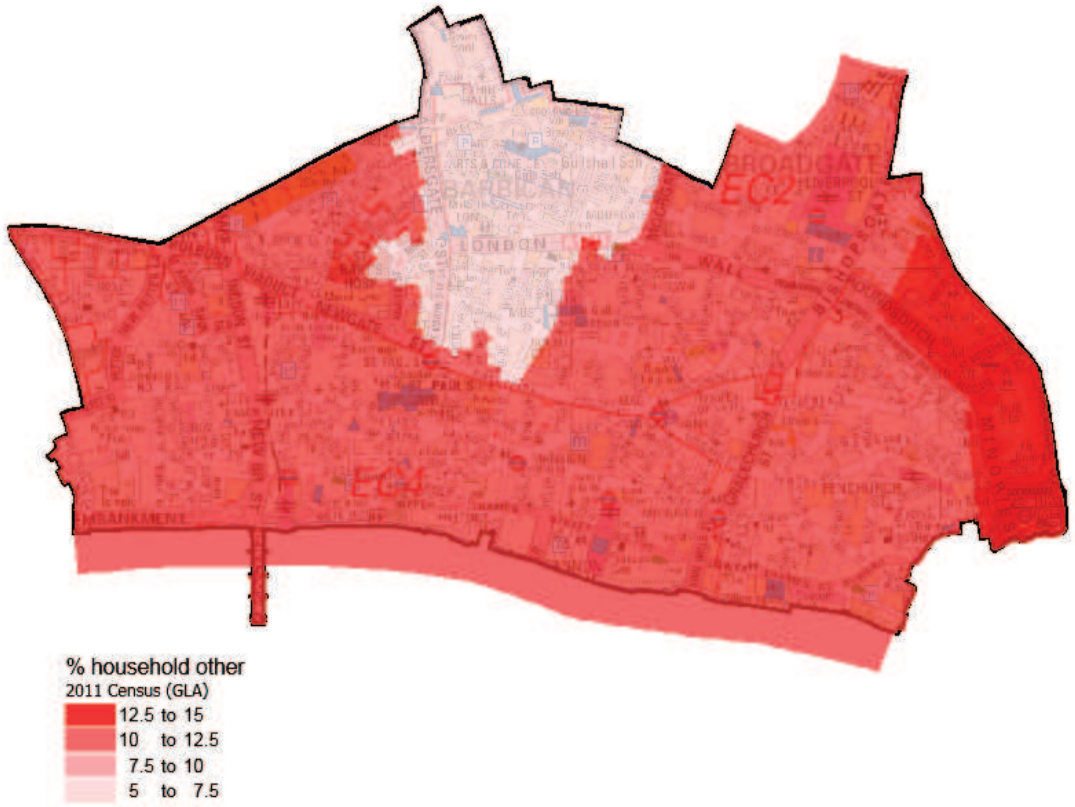


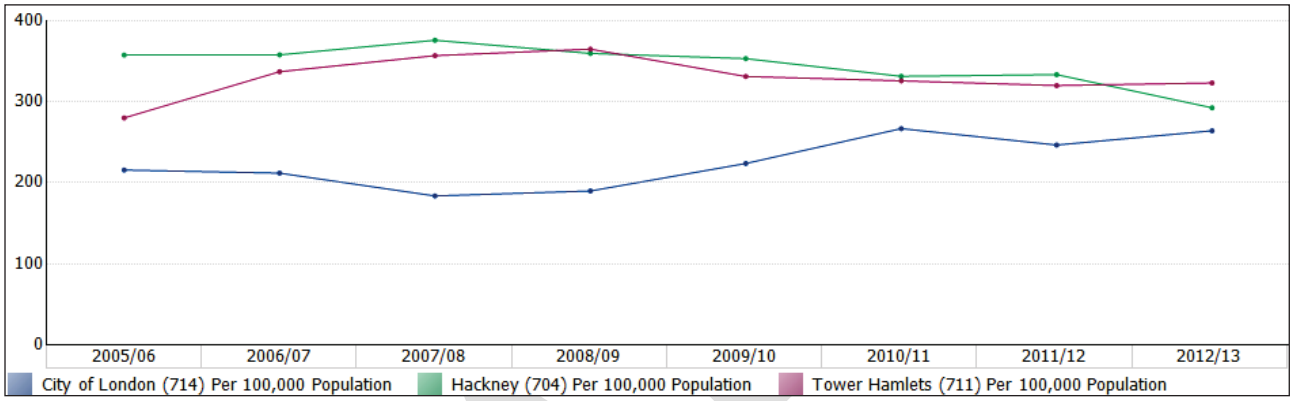
Figure 1.13E Household structure in the City: percentage of other households



Appendix 8 – Learning Disabilities

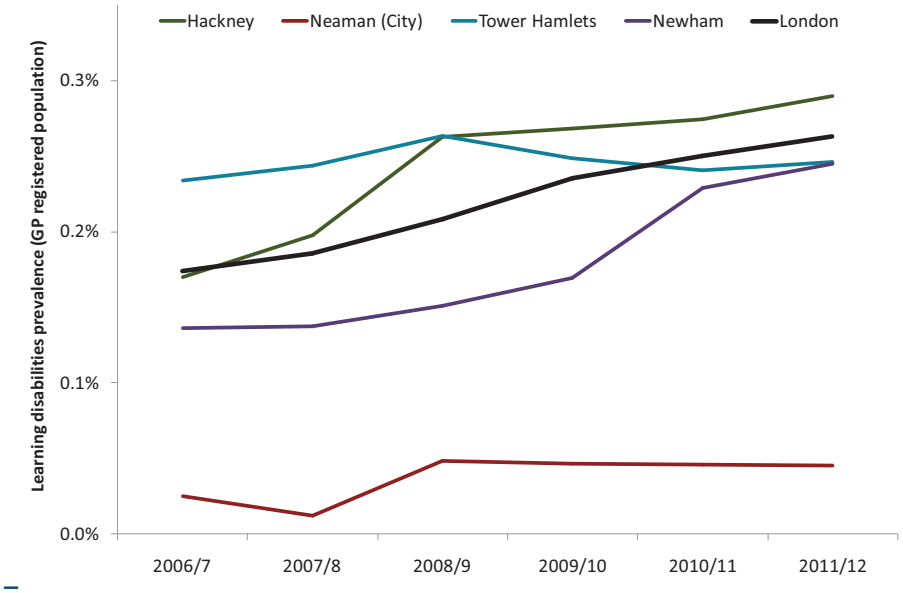
The only general practice data in the City is of those residents registered at the Neaman practice in the northwest of the City. In 2011/12, the prevalence of learning disability recorded by the Neaman practice was 0.1% (fewer than 5 individuals) (Figure 7.12).

Figure 7.8 Adults with a learning disability receiving care packages per 100,000 population, 2005-13



Source: NASCIS

Figure 7.12 Prevalence of recorded learning disabilities in GP-registered populations over time (QOF)



Appendix 9 – Death rates

Figure 0.1Age-adjusted death rates (males) per 100,000 population 2000-2009 (NCHOD)

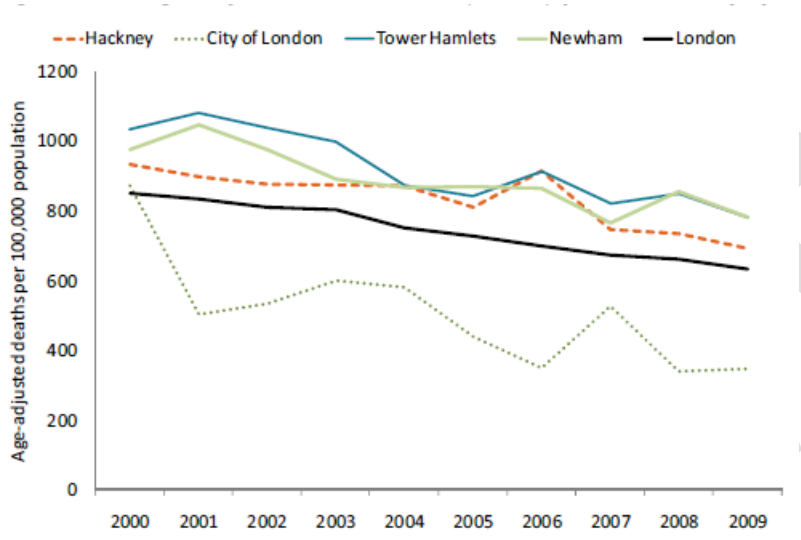


Figure 0.2 Age-adjusted death rates (females) per 100,000 population 2000-20009 (NCHOD)

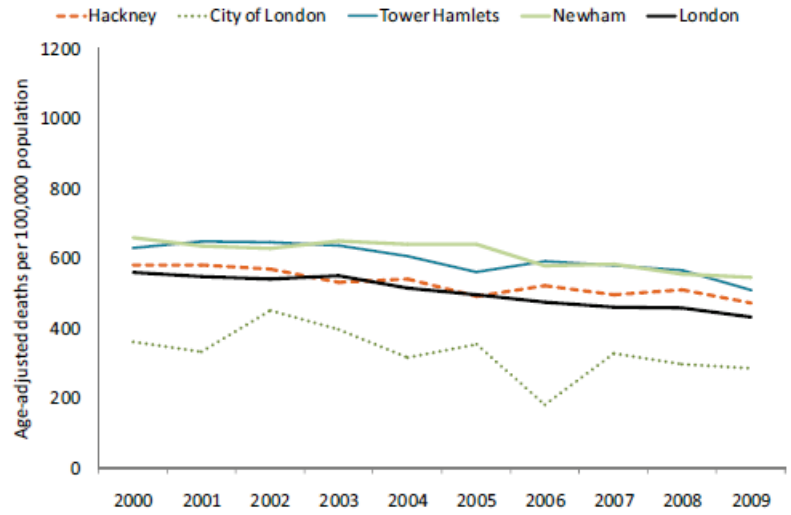


Figure 0.3Age-adjusted pre-mature (<75) death rate (males) per 100,000 people 2000-2009

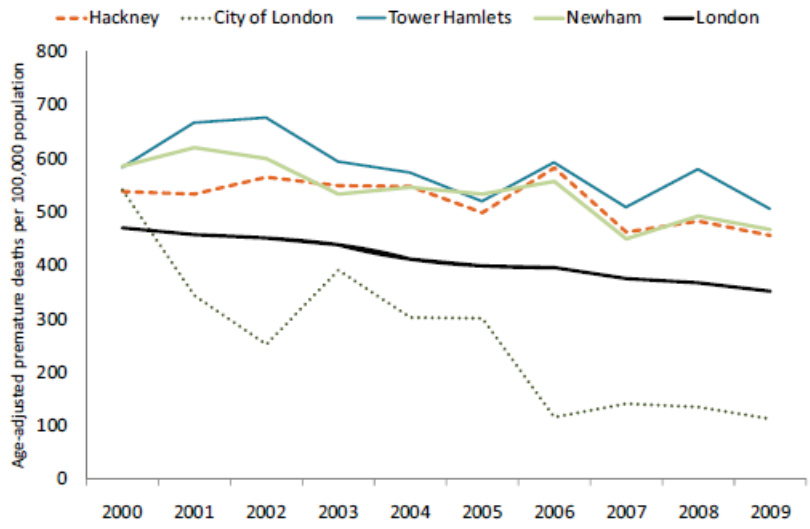
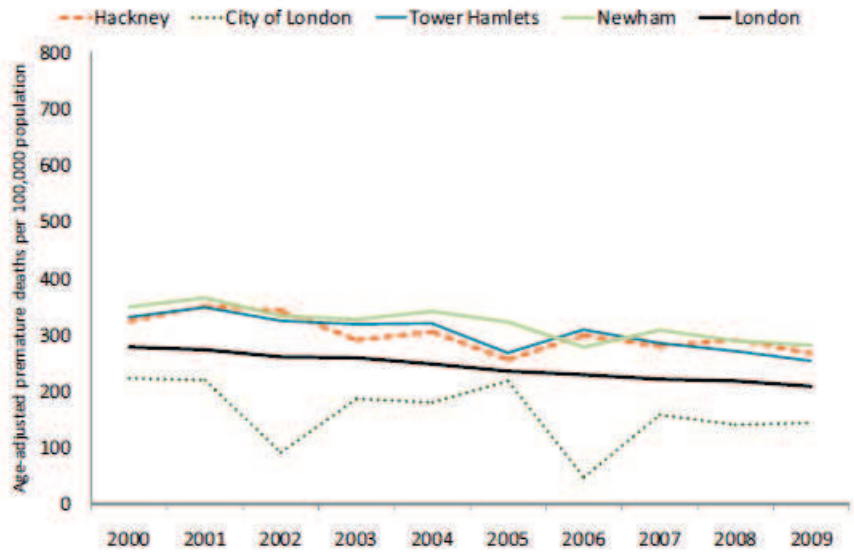


Figure 0.4Aged-adjusted pre-mature (<75) death rate (females) per 100,000 people 2000-2009



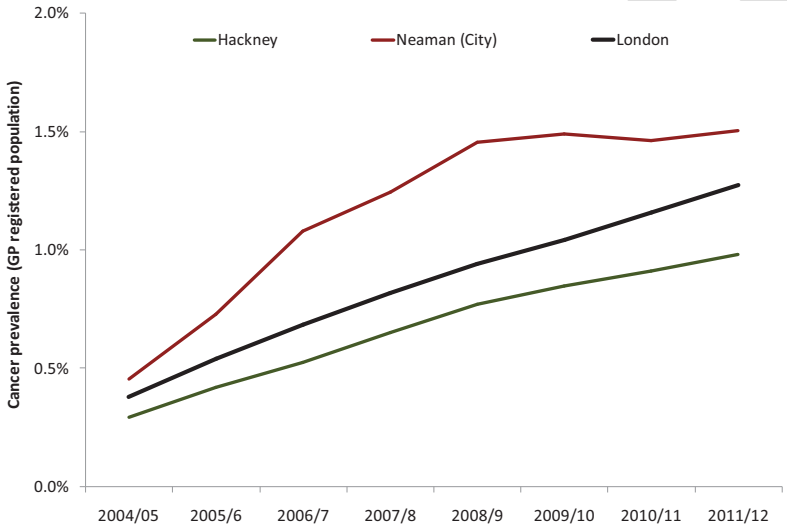
Appendix 10 – Chronic disease

Cancer

Prevalence

There is no data on cancer prevalence among residents of the City, except for those registered at the Neaman practice in the north-west of the area. In 2011/12 the crude prevalence of cancer recorded by the Neaman practice was 1.5% (134 individuals). This rate is relatively high due to the older population (rates are not age-standardised) (Figure 6.8).

Figure 6.8 Crude prevalence of cancer in the GP-registered population, 2006-12 (QOF)



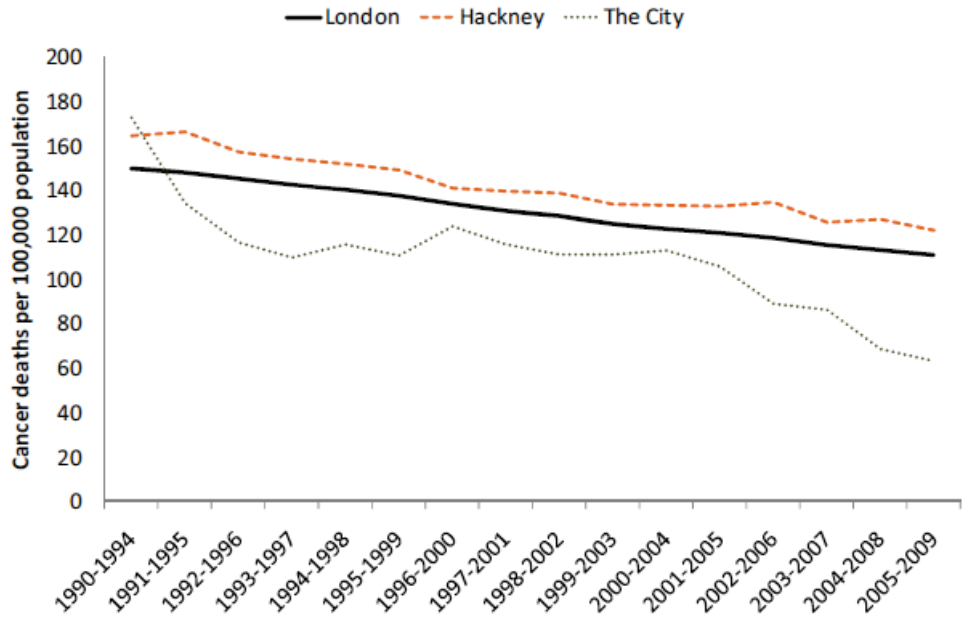
Death and survival

In the City, the annual death rate from cancer over the three years from 2007 to 2009 was an average of 15 people (43% women, 57% men). This is an age standardised rate of 128 deaths per 100,000 population per year.

Figure 6.14 and 6.15 illustrate the long-term trends in deaths from all cancers and from premature cancer (under 75 years). Both rates in the City are well below the average for London and premature deaths have fallen markedly over the last 6 years.

Figure 0.1 Long-term trend in deaths from all cancers, at all ages (Thames Cancer Registry)

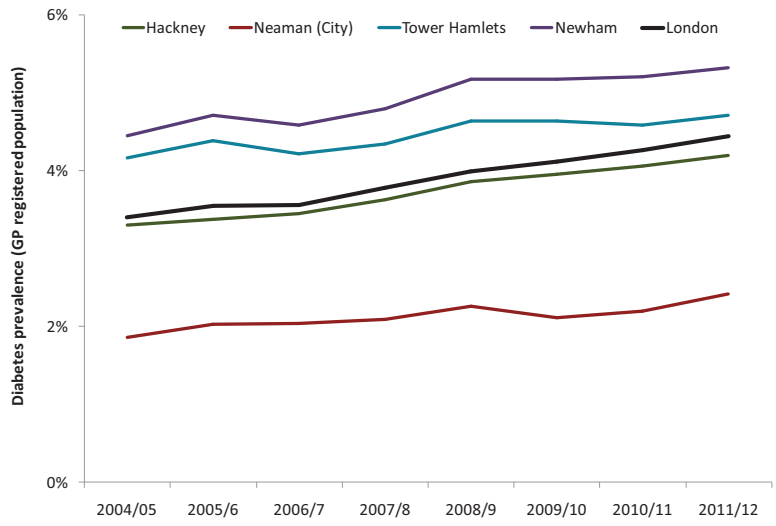
Figure 0.2 Long-term trend in deaths from premature (<75) cancer (Thames Cancer Register)



Diabetes

There is no data on diabetes prevalence among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2011/12, the crude prevalence of diabetes recorded by the Neaman practice was 2.4% (215 individuals) (Figure 6.17).

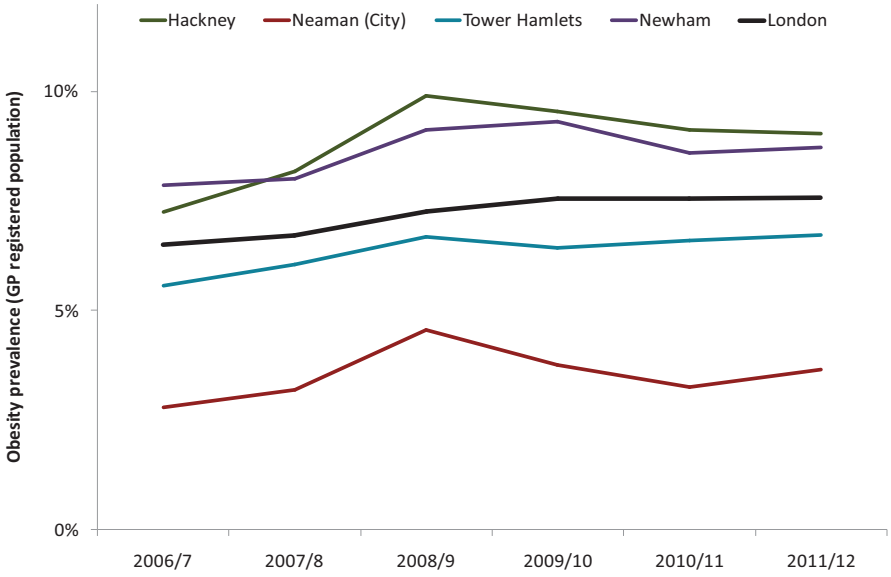
Figure 6.17 Prevalence of diabetes, 2004-12 (QOF)



Obesity

Obesity data is not available for the residents of the City, except for those registered at the Neaman practice in the north-west of the City. Around 4% of these adults are obese, which is lower than the rates for surrounding areas and London as a whole (Figure 3.9).

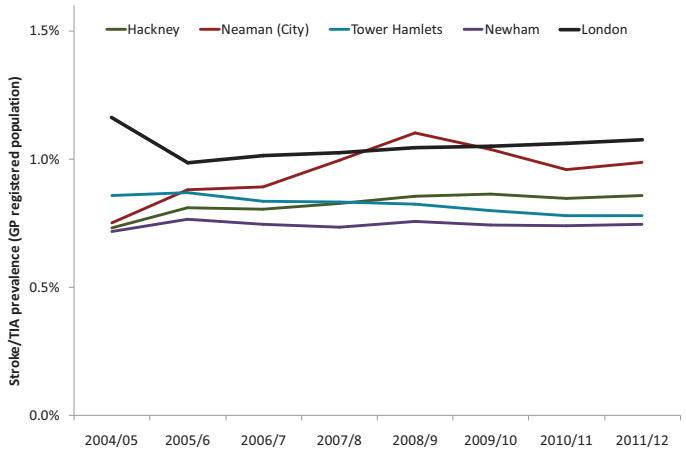
Figure 3.9 Obese adults as recorded in general practice in Hackney (QOF)



Stroke and Transient Ischemic Attack (TIA)

There is no data on stroke prevalence among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2011/12, the crude prevalence of stroke recorded by the Neaman practice was 1.0% (88 individuals) (Figure 6.22).

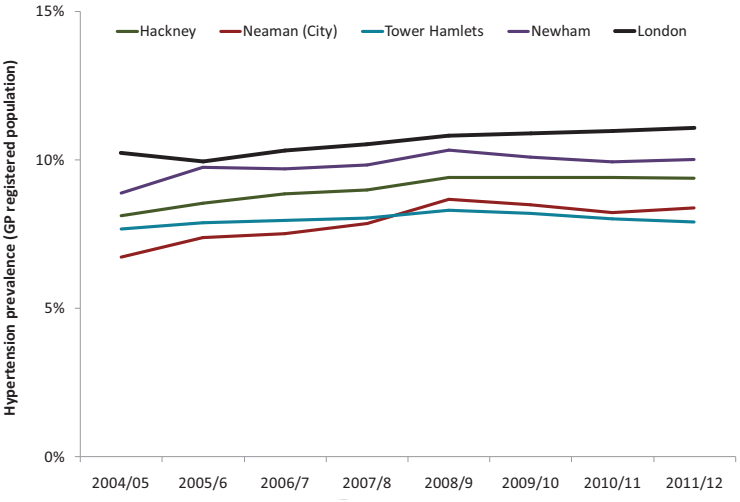
Figure 6.22 Crude prevalence of stroke/TIA in the GP-registered population, 2004-12 (QOF)



Hypertension

There is no data on hypertension among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2011/12, the crude prevalence of hypertension recorded by the Neaman practice was 8.4% (746 individuals).[94] This rate has been stable for the last four years (Figure 6.28).

Figure 6.28 Crude prevalence of hypertension in the GP-registered population, 2004-12 (QOF)



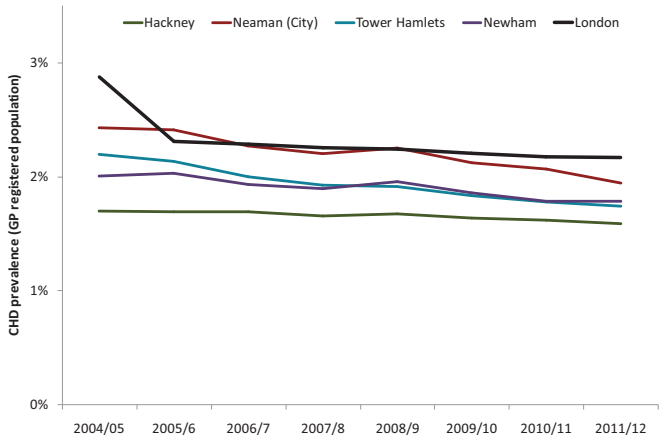
Coronary heart disease

There is no data on coronary heart disease among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2010/11, the crude prevalence of

[94] QOF data

CHD recorded by the Neaman practice was 1.9% (173 individuals).[95] This crude rate is comparable with the average for London. Prevalence has fallen slightly in the past eight years (Figure 6.34).

Figure 6.34 Prevalence of CHD in the GP-registered population, 2004-12 (QOF)



Sickle Cell Disease

There were no admissions for sickle cells disease in the City in 2010/11.

[95] QOF data

Committee(s):	Date(s):
Health and Wellbeing Board	1 April 2014
Subject: Information report	**Public**
Report of: Health and Wellbeing Executive Support Officer	**For Information**

Summary

This report is intended to give Health and Wellbeing Board Members an overview of key updates to subjects of interest to the Board where a full report is not necessary. Details on where Members can find further information, or contact details for the relevant officer is detailed within each section as appropriate.

Local updates

- Fixed Penalty Notice (FPN) Stop Smoking Service
- Riverside Strategy
- Local Flood Risk Management Strategy
- School Health and Looked After Children's Services
- Substance Misuse Partnership Review Update
- Business Healthy

Policy updates

- Health Services
- Disease Prevention
- Social Care and Health inequalities
- Substance Misuse
- Environmental Health
- Health and Wellbeing Board Guidance

Recommendation(s)

Members are asked to:

- Note the update report, which is for information

Main Report

Background

1. In order to update Members on key developments and policy, information items which do not require a decision have been included within this highlight report. Details on where Members can find further information, or contact details for the relevant officer is detailed within each section as appropriate

LOCAL UPDATES

Fixed Penalty Notice (FPN) Stop Smoking Service Rebate Initiative

1. The FPN Stop Smoking Service Rebate Initiative launched on Monday 2nd December and will run for six months. Since its launch, 67 FPNs have been issued. Take up of the initiative has been slow, with only one person accessing the stop smoking service. As a result, delivery of the initiative will be reviewed in March, with a view to extending the promotion. Currently, the initiative is only promoted at time of FPN issued. Feedback from street enforcement officers demonstrates that offenders are not receptive to the message at this point and are likely to forget the initiative once they have been fined. Therefore, the promotion of the initiative could be extended to point of payment, included in payment reminder letters, as well as promoted at educational stalls.

2. Contact officer is Gillian Robinson: 020 8356 2727

Riverside Strategy

3. The City Corporation has carried out a Riverside Appraisal of the Thames Policy Area and will be incorporating its findings into the Riverside Strategy. The aim is that the City should capitalise on its unique riverside location, sustaining the river's functional uses in transport, navigation and recreation whilst minimising the risks to the City's communities from flooding

4. Key objectives of this strategy are:
    - To provide guidance on development and public realm enhancement within the Thames Policy Area
    - To explain the impacts on development of safeguarding of sites at Blackfriars and Walbrook Wharf
    - To promote river transport and provide guidance to assist implementation of increased river transport
    - To provide guidance on improving opportunities for biodiversity on the riverside

5. The Riverside Strategy will be a Supplementary Planning Document (SPD) which provides guidance regarding the City's Local Plan policies for the Riverside area.

6. Alongside the Riverside Strategy SPD the City will be consulting on the Riverside Walk Enhancement Strategy, which focuses on how the riverside walk will be improved, making it better connected and accessible as a continuous walkway as well as a destination for people to enjoy. The vision also seeks to improve the quality of spaces and to promote the creation of new spaces for people to enjoy, to increase greenery, support biodiversity and incorporate sustainable drainage systems to combat flooding. Additionally, the cohesion and vibrancy of the riverside will be increased through development opportunities along the river front.

7. Public consultation on these documents is expected to take place in summer 2014.

8. The contact officer is Janet Laban 020 7332 1148

Local Flood Risk Management Strategy

9. Consultation on the City of London Local Flood Risk Management Strategy (LFRMS) is due to take place between 17th March and 25th April. The LFRMS identifies the current risks that the City faces from river and coastal flooding, surface water and sewer overflows and from groundwater flooding. It then focuses on the restricted areas of the City that are at risk – most of the City has a low risk of flooding – and proposes an action plan to reduce the risks still further. The nature of flood risk is such that the City needs to look beyond its boundaries and work in partnership with other authorities to implement many of the actions proposed. Within the City the development of resistance and resilience measures will provide the best protection for people and premises that are at risk.

10. The LFRMS has been subject to Equality Impact Assessment (EqIA) and Strategic Environmental Assessment (SEA) both of which have shaped the strategy making sure that it is equitable and sustainable.

11. The contact officer is Janet Laban 020 7332 1148

School Health and Looked After Children's Services

12. There was a request for an update on school nursing at the Health and Wellbeing Board Development Day held on the 21 February 2014.

13. Responsibility for commissioning a number of children's health services, including school aged health services transferred to Local Authorities as part of the transfer of Public Health on 01st April 2013.

School Health Services

14. Over the past year, Hackney has been developing a new model for school health with partners, which focuses on getting the basics right, with closer alignment to existing high quality universal services. The new model will be implemented in a measured way with key principles of the new model including maximum contact time with children, and embedding the services where children and young people are. It also allows for consolidation of other aspects of school health services through longer term commissioning plans

Health of Looked After Children Service

15. The Health of Looked After Children's Service is currently commissioned largely by London Borough of Hackney Children's Social Care, with a small

contribution from the CCG for the Designated Nurse for Looked After Children's post. This service will continue to be commissioned and will be aligned more closely with the Virtual School for Looked After Children and Children's Social Care.

16. The City of London has agreed to contribute to both services at this stage as per the current contribution to Public Health contracts.

Responsibilities

17. There are a number of key statutory responsibilities for delivery by these services:

- Ensuring all vulnerable school aged children (those on the child protection register or on a multi agency health plan, children in need or identified as having safeguarding needs) have a named nurse / health practitioner, initial health reviews and care plans
- Delivery of the National Child Measurement Programme (height and weight)
- Delivery of a school entry health check which includes hearing and vision screening
- Delivery of a health service for disabled children in special schools
- Providing Annual Health Assessments / Reviews for Looked After Children (LAC) - 6 monthly for under 5s
- Ensuring all LAC are up to date with immunisations and vaccinations
- Ensuring all LAC have access to dental health services

18. Additionally these services are encouraged to deliver opportunistic immunisations and work with other health teams to deliver school aged immunisations. This is technically the responsibility of NHS England and is being negotiated.

Commissioning Intentions

19. The new model will be implemented using a staggered approach with a focus on ensuring the statutory obligations are delivered effectively.

20. The first elements of the new services will be tendered out in an open tender process in March 2014. This will be the Health of Looked After Children's Service and a new Safeguarding School Health Service. These services will deliver on the statutory obligations for our most vulnerable children and young people as above. We are looking for these new services to be aligned to the school year, and delivering from September 2014. This tender will be for 3 years plus 2 and the current school nursing service (delivered by Homerton University Hospital Foundation Trust) will be in place until August 2014.

21. Alongside this, LBH have agreed with the Homerton University Hospital Foundation Trust that from September 2014, they will continue to deliver the National Child Measurement Programme, the School Entry Health Check (including vision and hearing screening), a small school health service for

Disabled Children in Special Schools and opportunistic immunisations. This will align delivery of the statutory elements of this service will the school year, during which time the services will be re-designed.

22. London Borough of Hackney is looking to design and tender out a full Children and Young People's Health Service, incorporating support for adolescent health needs, wellbeing and support for specific communities, to be delivered from September 2015. It is likely the components immediately above will be included in this new service.

23. The contact officer is Amy Wilkinson: 0208 356 5989

Substance Misuse Partnership Review Update

24. In March 2013 the Shadow Health and Wellbeing Board was presented with the 2013/14 Substance Misuse Partnership business plan and informed that a review of all drug and alcohol services would take place starting in April 2013.

25. The internal service review, led by the service manager, involved analysis of the 2012 drug and alcohol needs assessment, a review of all 2012/13 data and consultations with a number of partners. Alongside this process a number of meetings were held with the London Borough of Hackney, as they are carrying out a review of their substance misuse services, some of which are jointly commissioned with the City of London. The review also mapped drug and alcohol treatment pathways and funding streams within the current service.

26. In December 2013, it was agreed by the Director of Community and Children's Services that the review had reached as far as it could under the lead of the service manager, and that to continue it to the recommendations stage could lead to a conflict of interest. At this point, the review was handed over to the public health team (Public Health Commissioning and Performance Manager; and Health and Wellbeing Policy Development Manager), who have been asked to expand the review to include tobacco control and smoking cessation services, and to make recommendations for the service's future. This paper will be brought to the next Health and Wellbeing Board on 30th May 2014.

27. The contact officer is Lorna Corbin: 020 7332 1173

Business Healthy

1. On March 11th, the City hosted the Business Healthy Conference at the Mansion House. The audience included business leaders from a wide variety of City businesses, ranging from very large to SMEs, as well as representatives from Public Health England, the GLA and neighbouring local authorities.

2. The conference saw the launch of the City of London's research into Best Practice in Workforce Health, which identified how closely City firms are aligned to the evidence base for effective interventions.

3. At the close of the conference, delegates were invited to sign up for a business network, to be involved with future development in workforce health within the Square Mile. The conference was mentioned by Duncan Selbie in his Friday message, where he praised the City of London Corporation for its action on workplace health;
4. Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/291907/DS_Friday_message_14_March_2014.pdf

5. The contact officer is Farrah Hart: 020 7332 1907

POLICY UPDATES

Health Services

24. **Improving general practice: a call to action - phase 1 report**
This report contains a future strategy for commissioning general practice services. It focuses on the central role NHS England wants general practice to play in wider systems of primary care, and it describes NHS England's ambition for greater collaboration with clinical commissioning groups in the commissioning of general practice services.
- Link: http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf

25. **Bite-size guides to patient and public participation**
These guides have been developed by NHS England with partners and by reviewing good practice in each area. They aim to support CCGs and others to plan and deliver good patient and public participation.
- Link to principles for participation in commissioning: http://www.england.nhs.uk/wp-content/uploads/2014/03/bs-guide-princ-part.pdf
- Link to governance for participation: http://www.england.nhs.uk/wp-content/uploads/2014/03/bs-guide-govern-part.pdf
- Link to planning for participation: http://www.england.nhs.uk/wp-content/uploads/2014/03/bs-guide-plann-part1.pdf
- Link to budgeting for participation: http://www.england.nhs.uk/wp-content/uploads/2014/03/bs-guide-budget-part.pdf

Disease Prevention

26. **Encouraging people to have NHS Health Checks and supporting them to reduce risk factors**
This briefing summarises NICE's recommendations for local authorities and partner organisations that could be used to encourage people to have NHS

Health Checks and support them to change their behaviour after the NHS Health Check and reduce their risk factors. It is particularly relevant to health and wellbeing boards.

- Link: http://publications.nice.org.uk/encouraging-people-to-have-nhs-health-checks-and-supporting-them-to-reduce-risk-factors-lgb15

27. **Integrating behavioural health across the continuum of care**
    This guidance explains the value of integrating physical and behavioural health services and the importance of measuring integration efforts. It offers several frameworks and models to use for behavioural health integration and provides a list of strategic questions for and care system leaders to begin integrating behavioural health or to enhance current efforts.
- Link: http://www.hpoe.org/Reports-HPOE/Behavioral%20health%20FINAL.pdf

Social Care and Health Inequalities

28. **Hidden needs: identifying key vulnerable groups in data collections: vulnerable migrants, gypsies and travellers, homeless people, and sex workers**
    This report argues that the health care needs of the most vulnerable groups in society not being met because of gaps in health information and data gaps. It is aimed at data providers, healthcare professionals, commissioners and others working to improve the health of the vulnerable groups and signposts the way to good data.
- Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287805/vulnerable_groups_data_collections.pdf
- *This report may be useful as low paid migrants and homeless people are vulnerable groups in the City. In the City, migrants represent almost 40% of residents and about 30% of City workers. The City has the sixth highest number of rough sleepers in London.*

29. **How does money influence health?**
    This study looks at hundreds of theories to consider how income influences health. It identifies four ways money affects people's wellbeing: material, psychosocial, behaviour and reverse causation.
- Link: http://www.jrf.org.uk/sites/files/jrf/income-health-poverty-full.pdf

30. **Preventing loneliness and social isolation in older people**
    This briefing looks specifically at the prevention of isolation and loneliness amongst older people, with a particular focus on what practitioners in the fields of health and social care should bear in mind when working to tackle this important and growing issue.
- Link: http://www.iriss.org.uk/resources/preventing-loneliness-and-social-isolation-older-people
- *This report may be relevant as the City has a small but increasing number of older people who are more vulnerable to social isolation.*

31. **2030 vision: The best - and worst - futures for older people in the UK**
    This report provides a futures perspective on how we make the UK the best country to grow old in. It examines both the best and worst case scenarios and the rising costs associated with an ageing population.
- Link: http://www.ilcuk.org.uk/images/uploads/publication-pdfs/2030-vision-report.pdf
- *This report may be of particular importance as the City has a small but increasing number of older people*

32. **Adult social care in England: an overview**
    This report highlights the main risks and challenges as the adult social care system changes radically. It argues that the government does not know if the limits of the capacity of the care system to continue to absorb pressures are being approached and warns that major changes to the system to improve outcomes and reduce costs will be challenging to achieve.
- Link: http://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf

Substance Misuse

33. **It's about time: tackling substance misuse in older people**
    This report highlights some welcome and effective specialist service provision for older people with drug and alcohol problems, but also calls for improved services and interventions for this age group. It concludes that greater awareness of this issue is the first step to providing more effective support, with a need for specialist services that are age-appropriate and improved awareness and support in other care settings, including primary and social care.
- Link: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/ItsAboutTimeWeb.pdf
- *This report defines older people as young as 40 and older. Substance misuse, and particularly alcohol dependency, is a growing issue in the City.*

Environmental Health

34. **Under the weather: improving health, wellbeing and resilience in a changing climate**
    Changing weather patterns, more frequent extreme weather and rising temperatures have direct implications on our health, and also pose challenges to the way in which the NHS, public health and social care system operates. To help address this a toolkit has been developed to support health and wellbeing boards, and others, ensure organisations and communities are prepared for the impact of climate change and, in particular, extreme weather conditions such as heatwaves, severe cold snaps and flooding.
- Link: http://www.sduhealth.org.uk/documents/publications/Adaptation_Under_the_weather_24_02_14.pdf

Health and Wellbeing Board Guidance

35. **Local authorities' public health responsibilities (England)**
    This note sets out the main statutory duties for public health that were conferred on local authorities by the Health and Social Care Act 2012. The note includes information on public health funding; how local authorities have been spending their ring-fenced public health grants; and on accountability arrangements.
- Link: http://www.parliament.uk/business/publications/research/briefing-papers/SN06844/local-authorities-public-health-responsibilities-england

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Committee(s):	Date(s):
Health and Wellbeing Board	1st April 2014
Subject: Better Care Fund	**Public**
Report of: Assistant Director People	**For Decision**

Summary

The Better Care Fund (BCF) was introduced to Members of the Health and Wellbeing Board at its January meeting. The final BCF plan is to be submitted to NHS England on 4 April 2014.

The assurance process set out by NHS England required the submission of a draft BCF plan on 14 February 2014. This initial submission identified concerns from NHS England relating to the statistical significance of the City of London's outcomes and compliance (due to limited scale) with the recording systems put in place.

The City's officers have maintained a constructive dialogue with NHS England and agreed to submit a further draft plan on 26 March 2014 for comment.

Given this timetable, and the desire to ensure the final BCF plan addresses any issues raised through the NHS England assurance process, it is not possible to circulate the final BCF plan with the Health and Wellbeing Board document pack. The final plan will be circulated to members by noon on Monday 31 March 2014.

The BCF must be signed off by the statutory Health and Wellbeing Board. In the event that NHS England feedback is delayed, or discussion at the Health and Wellbeing Board leads to amendment or additions to the BCF Plan, it will be necessary to delegate authority to approve the plan in order to meet the deadline for final submission.

The City's BCF plan will set out how it will deliver the national conditions set by government, identify measurable improvements in performance against key metrics, and describe the proposed actions and initiatives to deliver the City's vision for better outcomes and experience for our residents. The detailed development work that will support the delivery of the City's BCF plan will take place in 2014/15 to enable full implementation in 2015/16.

Recommendation(s)

Members are asked to:

- Note the report.
- Approve the final BCF plan for submission to NHS England.
- Delegate authority to the Director of Community and Children's Services in consultation with Chairman to approve minor changes arising from discussion at the Health and Wellbeing Board.

Main Report

Background

1. The £3.8bn Better Care Fund (BCF) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. The City's BCF allocation is £776k.

2. The BCF was introduced to the Health and Wellbeing Board on 31 January 2014. The report to that meeting set out the process for developing the City of London's draft submission and the priorities it would seek to address.

Current Position

3. A draft BCF plan was submitted to NHS England on 14 February 2014 for initial feedback. Generalised feedback was given to all local authorities identifying common issues. These issues predominantly related to financial data and baseline and performance metrics.

4. On 10 March 2014, the City received specific feedback from NHS England on its submission. Their comment focussed on the outcomes and metrics delivered by the City's proposed BCF plan. Five of the six outcomes sought by the BCF plan are determined by Government, and the reporting of these requires that they are counted per 100,000 of the population. The scale of City is such that the proposed outcomes do not comply (due to their limited scale) with the performance framework set by NHS England and are rejected as being statistically insignificant.

5. NHS England has suggested the City's BCF plan is not of sufficient scale to operate in isolation and may better be delivered as part of a wider City and Hackney BCF plan. The City, and its partner CCG, strongly support the delivery of a City-specific BCF plan.

6. The City has continued to develop its BCF plan, responding both to the shared and City-specific issues raised by the initial assessment process. We have worked with the CCG, meeting on 18 March 2014, to strengthen the financial detail and outcome metrics.

7. We have agreed with NHS England to submit a further draft for comment on 26 March 2014. It is anticipated that any comments from NHS England will be received on 28 March 2014. This will allow the finalisation of the City's BCF plan on 31 March 2014. For this reason it has not been possible to circulate the final BCF plan with the document pack for the Health and Wellbeing Board.

8. The City's final BCF plan is to be submitted on 4 April 2014. The plan must be signed off by the Health and Wellbeing Board

Proposed City of London BCF plan

9. The City BCF plan seeks to deliver a vision for integrated health and social care. It will develop a bespoke locality model to meet the needs and wishes of City residents and to keep the experience of our service users/patients central to all the services the City provides.

10. Underpinning the City's BCF plan is a focus on systems that support and remove barriers to integrated care through:
    - prevention and proactive support through care planning and co-ordination
    - caring for people in the most appropriate setting, starting at home
    - supporting independence through understanding individual capabilities and needs
    - tackling social isolation, with "whole-person" approaches to wellbeing
    - using technology to develop networked, personalised health and care services, and
    - eliminating gaps, duplication and disconnects between our health and care services.

11. The City's BCF plan will deliver the national requirement to:
    - protect social care services
    - provide 7-day services to support hospital discharge
    - share data between services, and
    - provide joint assessments and an accountable lead professional.

12. The impact of the City's BCF plan will be measured against improved performance in relation to:
    - delayed transfers of care
    - emergency admissions
    - effectiveness of reablement
    - admissions to residential and nursing care
    - patient and service-user experience, and
    - effective support to carers (local metric).

    An element of the BCF payment is linked to performance and achievement of targets set against these areas.

13. The final BCF plan will include a range of actions and initiatives to deliver the outcomes sought. Improved **preventative services** will be delivered through better data sharing between health and social care providers, early identification of those who are vulnerable and at risk of ill health, social

prescribing to reduce isolation and build community resilience, and improved management of medicines to minimise the risk of adverse reaction among those who take multiple medications.

14. The plan will improve the **targeting of services** through the use of risk stratification of patients and the development of a General Practice-based case management approach for those identified. This approach will deliver an individualised care plan, practice-based coordination of care, regular scheduled home visits and one responsible named doctor to ensure continuity of care is maintained.

15. The **integration of care** pathways and services will be supported by the appointment of two joint care navigator posts with responsibility for co-ordinating services for our residents discharged from acute care. Their role will include the facilitation of services within the hospital setting to ensure a smooth transition to home and community-based services, or to other care as required.

16. The BCF plan will examine the scope for **better management of long term conditions** in the community through the provision of locality based Community Nursing services. This approach will be supported by the extension and enhance use of telecare and teleheatlh.

17. The plan also proposes a number of initiatives to **reduce acute hospital admission** including specialist provision within the community to prevent A&E admission.

18. The BCF resources will be deployed in 2015/16. The City will receive an initial allocation of funding of £41k in 2014/15 to support the implementation of the plan and the development of the proposals it contains.

Corporate & Strategic Implications

19. This report will fit with the Corporate Plan under the Key Priorities:

KPP2: Maintaining the quality of our public services whilst reducing our expenditure and improving our efficiency

KPP3: Engaging with London and national government on key issues of concern to our communities including policing, welfare reform and changes to the NHS

20. The government's agenda of closely integrating Health and Social Care is intended not only to deliver cost efficiencies, but to maximise opportunity for innovation and creating a new culture within Health and Social Care that will deliver services fit for the 21st Century.

21. Integrated care will require us to work closely with the CCGs with whom our service users engage, and with London as a whole, in order to develop our approaches.

Implications

22. There will be a number of implications arising from this fund and the proposals that will emerge. Principally, it will change the funding streams to Adult Social Care with the creation of one fund that comprises the Carers Grant, Disabled Facilities Grant, CCG reablement funding and transformation funding.

23. The intention from the Government is that CCGs and local authorities will create pooled budgets in order to facilitate integration. Given that our population is so small, having separate pooled budgets for each integration project would likely not be viable. However, there is the possibility of combining the whole fund into one pooled budget to have a City-specific pooled budget with the CCG. This would require careful management, negotiation and legal advice and would need to be one of the projects during the transition phase to test the viability.

24. If there are any joint-funded posts as a result of the fund, this would also require HR advice on management arrangements.

25. There may be a risk due to our low volumes that the City could miss out on the performance related element of the funding available as it will be difficult to demonstrate improvement (e.g. there have been no delayed discharges, so demonstrating an improvement in this area would not be possible).

Conclusion

26. The BCF provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. It is anticipated that the changes brought about by the City's BCF plan will provide locally delivered services that meet the distinct needs City residents.

Appendices

None

Background Papers:

A report introducing the BCF was presented to the Health and Wellbeing Board on 31 January 2014.

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Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**City of London Corporation**
Clinical Commissioning Groups	**City and Hackney CCG**
	Tower Hamlets CCG
	Islington CCG
Boundary Differences	**There is only one GP practice within the City, and therefore many of our residents are registered with GPs outside our boundaries and those of the CCG. We are therefore committed to working with neighbouring CCGs in order to meet the needs of our residents.**
Date agreed at Health and Well-Being Board:	**1 April 2014**
Date submitted:	**4 April 2014**
Minimum required value of ITF pooled budget: 2014/15	**£41k**
2015/16	**£776k**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£776k**

b) Authorisation and signoff

City and Hackney CCG	
Signed on behalf of the Clinical Commissioning Group	
By	Paul Haigh
Position	Chief Officer
Date	

Tower Hamlets CCG	
Signed on behalf of the Clinical Commissioning Group	
By	Jane Milligan
Position	Chief Officer
Date	

Islington CCG	
Signed on behalf of the Clinical Commissioning Group	
By	Alison Blair
Position	Chief Officer
Date	

City of London Corporation	
Signed on behalf of the City of London Corporation	
By	Ade Adetosoye
Position	Director of Community and Children's Services
Date	

City of London Health and Wellbeing Board	
Signed on behalf of the Health and Wellbeing Board	
By Chairman of Health and Wellbeing Board	Rev Dr Martin Dudley
Date	

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Provider engagement

On the 12 December 2013 Healthwatch facilitated a consultation event for the purpose of developing the City of London's BCF Plan. The event included both health and social care service providers, and service users. The consultation addressed 4 key themes:

- Care in the right place at the right time
- Joined up care
- Quality of life
- Caring for carers

Service providers were consulted with in order to develop this plan and gave their support for the key priority areas. Providers included:

- Healthwatch
- Hopscotch Asian Women's Centre
- Barbican Tuesday Club
- Crossroads Care Central North London
- City and Hackney Out of Hours AMHP Service
- Health in the City
- Toynbee Hall
- East London Foundation Trust
- Bart's Health NHS Trust
- City 50+
- Elders Voice
- City Estates
- City Health and Wellbeing Board
- City and Hackney Carers Centre

Key issues and proposals from this consultation event have shaped the formulation of this plan.

Senior managers in the City of London met with the CCG and provider hospitals in adjoining CCG areas to scope out the work that will be required to map out care pathways and to agree the need for the Joint Care Navigators (proposed new posts designed to deliver better integration of care), and have secured their agreement to work with us. We meet regularly with the City's Primary Health providers and have consulted with in developing this plan. We have also strengthened our links with Tower Hamlets and Islington CCGs as part of our commitment to ensuring better services for those residents registered outside of the CCG area, including those residents from Islington who are registered with our GP practice.

Both CCGs have signed this plan, signalling their commitment to deliver services across providers across the CCG boundaries. Work is currently ongoing to establish clear data collection in relation to our residents who are registered in Tower Hamlets (approx. 1/7th of our resident population).

The plan has been discussed with Community Nursing who were invited to participate in

our Health Scrutiny Committee to help explore with us the needs of City residents.

We have commissioned the support of a specialist consultancy (Tricordant) to develop the working arrangements to deliver integration from 2014/15 onwards so that we can deliver outcomes in the first year. This will include collaboration across a commissioning and provider landscape of 3 distinct CCGs to simplify care pathways and remove existing barriers of cross boundary commissioning in order to improve patient and carer experience.

Our Adult Wellbeing Partnership Board has partnership oversight of the delivery of the Integrated Care agenda and has a reporting structure into the Health and Wellbeing Board. Chaired by the Director of Community and Children's Services and attended by key strategic partners, it has responsibility for monitoring a number of key strategies across Health, Housing and Social Care including Dementia, Public Health Outcomes, Learning Disabilities, Physical Disabilities, Mental and Emotional Wellbeing, Carers and Homelessness amongst others, and will ensure the delivery of these strategies to support integrated care.

Senior managers from the City have also been involved in consultation events held by Hackney and by the CCG as a number of our schemes will interlink. In January 2014, the Hackney Health and Wellbeing Board invited the City to an extended development event on integrated care and support in Hackney. This was attended by 45 senior colleagues from across the statutory health and social care organisations, public health, NHS England commissioners, the VCS and Healthwatch Hackney. These included the main NHS providers in Hackney plus representatives of the GP Out of Hours provider, City and Hackney Urgent Healthcare Social Enterprise (CHUHSE), their prospective GP Provider Federation (CHUSHE+) and the Tavistock and Portman who provide some community mental health services.

The purpose of this event was to ensure collective understanding of the vision and principles for integrated care and support, reflect on the initiatives and services currently in place and to discuss further the development of the model for integrated care.

The City has its own vision and principles for the delivery of a locality-based model. However, it is essential to shape the development of Hackney services that will impact on our residents, and ensure there is access to the schemes that are being developed jointly with the CCG. Many of the pilot schemes being developed within Hackney will be mirrored in the City, but will be tailored to meet the needs of our residents. This includes the use of out of hours services and the practice based co-ordinated care.

The Neaman Practice (the City GP practice) has been part of a CCG wide clinical audit of recent emergency admissions to hospital of their patients. The learning points and reflections on alternative management arrangements and the opportunities of these integrated care proposals have been discussed both across GP practices in the City and Hackney CCG area and then collectively with the Homerton's Care of the Elderly consultants, social services, adult community nursing and reablement staff. There is strong frontline clinical engagement identifying issues and related improvements we want to make. As such and our clinicians are driving solutions from the "bottom up" - ensuring they are both relevant and locally owned.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Patient, Service user and public engagement

The City has a wide range of stakeholders whose asset base is key to the delivery of our BCF plan. Our consultation events and discussions have reached across this base, engaging our stakeholders both directly and indirectly in the development of our plan.

City of London Joint Health and Wellbeing Strategy 2013

Service users and City of London residents were key participants at the City's BCF plan consultation event facilitated by Healthwatch in December 2013. The event was structured around 4 key theme:

- Care in the right place at the right time
- Joined up care
- Quality of life
- Caring for carers

Service users and residents provided their thoughts and experiences on what worked well and what needed to improve to deliver better person centred and integrated care. There was a clear commitment from the service users to engage in and support change in local systems and services. A summary of feedback from the event is listed in the supporting documentation.

The City's Adult Advisory Group (a consultative body of service users, carers and those who have experienced hospital care locally) were also consulted (on 5 February 2014) to identify their priorities and those of local needs of residents, and identify their vision for seamless services between Health and Social Care. They offered further suggestions that have been included in this draft plan and emphasised the need to have services delivered locally within the City.

The Adult Advisory Group (AAG) meet on a quarterly basis and reports on its activity on an annual basis to the Community and Children's Services Grand Committee and the Health and Well Being Board. The group plays a key role in facilitating opportunities for service users, carers, voluntary organisations, officers and Members to help collectively shape practice and policy in Adult Social Care through a process of consultation and co-production. It reflects the City's on-going commitment to empower service users and ensure they shape our services.

The focus of the AAG includes:

- facilitating opportunities for co-produced policy and practice development;
- updating Members on the transformation of social care and the personalisation agenda;
- updating Members on consultations, guidance and legislative changes in respect of Adult Social Care at national and local level;
- updating members on key issues in relation to safeguarding adults;
- ensuring that adults and older people from socially and/or economically excluded groups are involved in the planning, development and review of services within the City of London Corporation;
- providing opportunities for the representatives of key stakeholder groups to meet together to promote information exchange, networking and disseminate good practice for example representatives from the Safeguarding Adult Board, Older People Reference Group and Commissioning.

Both the Healthwatch and City of London resident newsletters also highlighted the development of the BCF plan and invited the wider public reached by those publications to contact us with their issues and suggestions.

This breadth of consultation identified key areas of strength, and opportunities to improve integration and excellence of services within the City. Key reflections on what works well included:

- social care assessments are good and carried out well
- care and equipment needs are met quickly
- GPs, the police and housing staff have good awareness of people's social care needs and of those that are vulnerable, and they have good links with Adult Social Care services
- there are good events promoting healthier lifestyles
- the Adult Social Care Services Directory is very useful, and
- specialist services such as foot care are good.

Areas identified where the City could improve included:

- more information about where to get help and what help is available – especially in an emergency
- ensuring information should be more widely available and available to those who might be partially sighted, or for those who may need information in other languages
- providing residents and agencies with more opportunities to share information and to help shape services
- providing more services that are close to where residents live, and giving greater freedom to the choose which hospital they use
- where we provide equipment, service users want us to check if their needs have changed or if better equipment might have become available
- improving hospital discharge and avoiding delays and timing that can make it difficult to arrange care, and
- delivering support for those with dementia at an earlier stage.

This plan responds directly to our service user feedback and the priorities they raised.

Service users told us their priorities:

Service user priority	How this plan responds to the priority
Seamless services without gaps in provision or in the knowledge of people's issues, or delays in providing support or equipment	We are mapping the "care pathways" that City residents follow to make sure all of them deliver a better patient experience and better outcomes.
A single named professional to help co-ordinate care at home or on discharge from hospital, and to help navigate the way through services	We have created two new posts in our Adult Social Care team that will work flexibly with the hospitals and GPs that City residents use to co-ordinate and link-up services and improve the process of hospital discharge through the use of a single care plan that follows service users in and out of the acute system.
Information and records to be readily available to, and shared between, health and social care professionals	We are reviewing the systems that hold health and care information so that we can improve the processes of communication and data sharing. A new recording system is in place within Social Care and will be modified to include NHS identifiers. A project work stream has been established to conduct a review of IT systems and interoperability with Health. This will recommend next steps in delivering integrated systems.
Better communication between services	The new Joint Care Navigator posts will

such as GPs and hospitals – especially when you are being discharged home	facilitate discharge and provide a single point of contact for the service user between Health and Social Care
More individualised support, advice and information for carers - such as helplines, support groups, respite breaks and practical help	We are undertaking a review of the support and advice we give to carers to make sure it meets their needs. A Service Directory has been developed in Adult Social Care that is given to all service users and carers. This is being developed electronically alongside our Family and Youth Information Services. Health Services will be incorporated into the directory.
Services available around the clock	We will be enhancing our out of hours provision through the use of Paradoc and Paradoc Nursing to prevent unnecessary admissions to hospital where needs can be met by a GP or a nurse attending a City resident.
A "well-being MOT" to assess your needs and the support you need to stay well	Developing 'Care Plans' that are led by GPs, and which are developed and delivered by multi-disciplinary teams.
Support to avoid and tackle social isolation	Reviewing the work and role of the community based groups we commission to make sure they are meeting users' needs and helping us tackle social isolation and deliver better, and timelier, care and support. Social Prescribing and volunteering activities such as befriending will help to minimise the impact of social isolation as will the work around our Dementia Strategy.
Hospital discharge that is timely, has care in place whatever the day or time you leave hospital, and is not delayed by waits for medication or transport.	The new Joint Care Navigator posts will facilitate discharge and provide a single point of contact for the service user between Health and Social Care

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Report to Health and Wellbeing Board requesting a bid for s256 monies for 2	As part of the model for integrated care, it was identified that 2 posts would be

posts	integral to discharge arrangements and to provide navigators for residents being discharged from hospitals in Hackney, Islington and in Tower Hamlets. NHS England funding was secured for 18 months for these two posts amounting to £175k. JDs are currently being drafted within the intention of the posts being recruited to in 2014/15.
Project scope – Integrated Care project	Tricordant have been working closely with our colleagues in Hackney for the last 2 years on intermediate care and more recently on integrated care. We have invited them to assist us with developing our Adult Wellbeing Partnership Board arrangements and to scope the current services and the One City model for care and support.
Consultation event summary	A summary of the consultation event undertaken on the 12th December 2013 with service providers and residents and facilitated jointly by Healthwatch and the City of London. This summary sets out what our residents want from integrated care.
CCG Project scope for deep dive in relation to IT	The CCG have commissioned Tricordant to establish how our information systems can be better aligned or integrated and to review our information sharing agreements.
CCG strategic plan	The CCG strategic plans for 2 years and for 5 years.
Joint Strategic Needs Assessment (JSNA)	Assessment of the physical and mental health and wellbeing needs of individuals and communities in the City and Hackney
Joint Health and Wellbeing Strategy	Sets out the Health and Wellbeing Board's priorities based on the identified needs in the JSNA and these are included in this plan.
City and Hackney Integrated Care Stocktake report	A report to inform the development of our integrated care programme, identifying the key initiatives and projects having (or having potential for) systemic impact across services or care pathways for adults with long-term conditions and frail older people.
Homerton Hospital Review of Discharge Management	A review of discharge planning and management arrangements across both

	providers in relation to hospital inpatients to achieve better coordinated discharge planning arrangements across health and social care.
Local Annual Account 2012	The Local Annual Account sets out our vision and the changes we have made to our Adult Social Care Services in the previous year.
City Dementia Strategy	The strategy sets out the City's intentions to become a Dementia Friendly City, by engaging the community and delivering dementia awareness training. There are 10 key objectives within the Strategy.

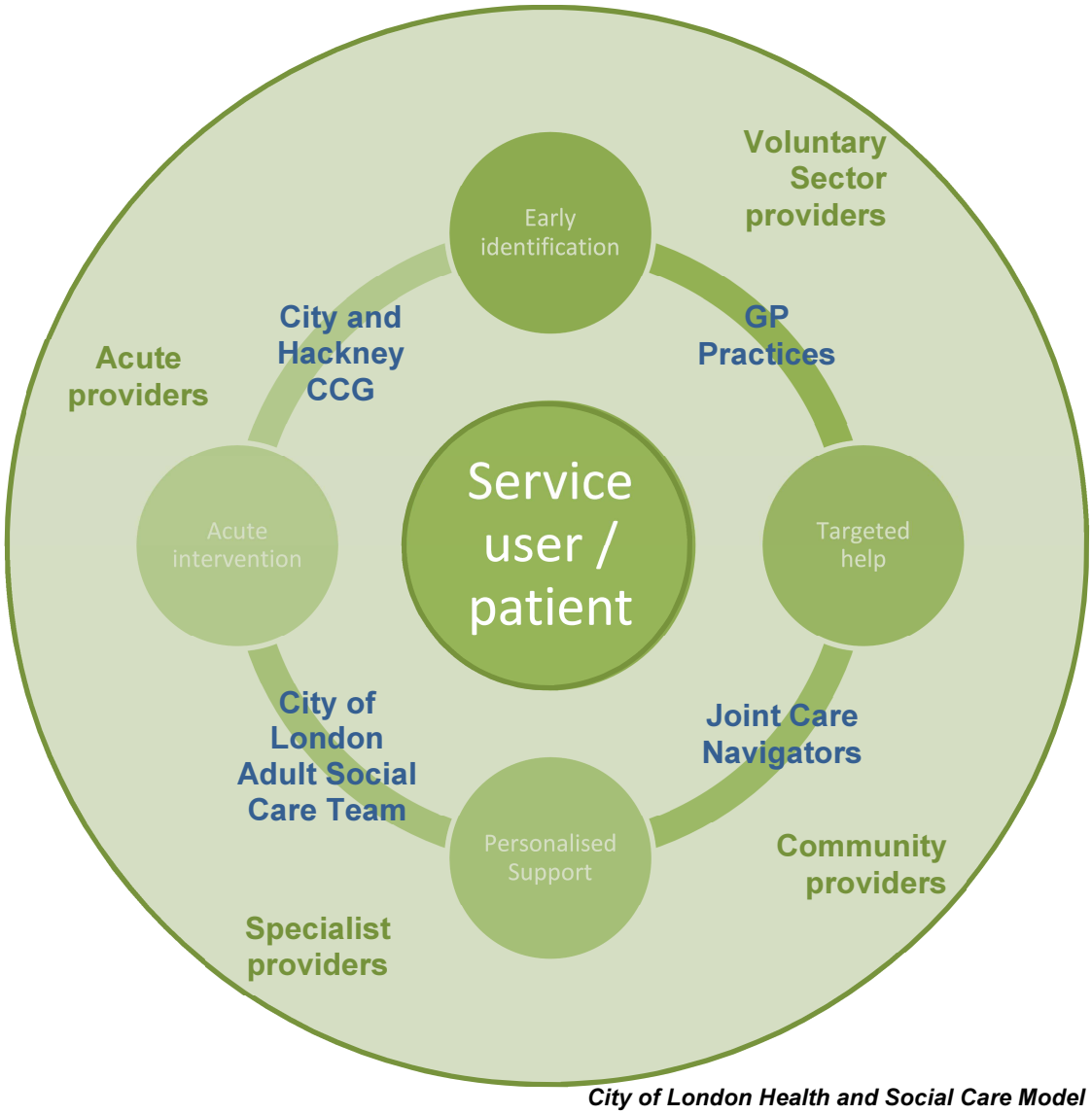
2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Vision

Our vision is:
To develop a bespoke locality model that meets the needs and wishes of City residents and to keep the experience of our service users/patients central to all the services we provide. Delivering the right services in the right place, at the right time.



City of London Health and Social Care Model 2014

Our Service Users are at the heart of our model to provide a seamless approach no matter where they are registered with a GP. There will be much more cross boundary co-operation between the CCGs and providers to enable this to happen.

The City and Hackney Commissioning Strategy fully reflects the intentions within our vision and that of Hackney in delivering integrated services responsive to the needs of patients.

Outcomes

Outcomes for service users / patients will include increasing the number of older people living healthier and longer lives in their own community. We have a low death rate in the City which means that we also have an ageing population. It is therefore important to us to manage the care needs of this older population and to respond to their needs.

Patient and service user experience will be enhanced by enhanced GP provision and the Joint Care Navigators who will 'hand-hold' service users through the health maze, meaning speedier access to services and only having to contact one key person who will act as a facilitator and which will be available 7 days a week.

Our population will feel less socially isolated and more supported by and engaged in their communities through the use of Social Prescribing which our GP practice is already applying and through enhanced volunteering opportunities, particularly through "befriending" activities.

Residential and nursing care admissions will be reduced still further through enhanced community services delivered locally.

Context of the City

The City of London is a unique area – it contains several populations in one space, with different needs and health issues. The City has a resident population of 7,400, found in densely populated pockets of the Square Mile. This resident population, found within 4,400 households, has grown slowly over last decade, but is projected to grow more rapidly to reach 9,190 by 2021. In addition to those who live permanently in the City, there are also 1,400 people who have a second home in the Square Mile. There are also 430,000 people who have jobs in the City (Nomis: Labour Market Profile 2011), as well as students, visitors and rough sleepers.

The City of London has the highest daytime population density of any local authority in the UK, with hundreds of thousands of workers, residents, students and visitors people packed into just over a square mile of urban and highly developed space.

The City of London Corporation is responsible for local government and policing within the Square Mile. It also has a role beyond the Square Mile, as a port health authority; a sponsor of schools; and the manager of many housing estates and green spaces across London.

When Public health responsibilities moved to local authorities in April 2013, the Health and Wellbeing Board of the City of London Corporation took over the statutory responsibility for undertaking the annual Joint Strategic Needs Assessment (JSNA) exploring local health needs and the Joint Health and Wellbeing Strategy

It is bordered by the London Boroughs of Hackney, Islington, Camden, Westminster, Southwark and Tower Hamlets. For health purposes, the City is formally linked to Hackney through the City and Hackney CCG. However its residents access care across three CCG areas of City & Hackney, Tower Hamlets and Islington. This creates complex care pathways.

Whilst the majority of our residents are registered with the sole GP practice in the City boundaries, it is estimated that up to 2,000 are registered with GP practices in Tower Hamlets, Islington or with private medical practices. This issue has been highlighted as particularly pertinent when trying to establish the actual care pathways and identifying which CCG is responsible for delivery of services to which patients. The current care pathway in itself has caused an inequality in the treatment of patients within the same surgeries across all three CCGs – an issue this plan will address through its delivery. Although our population is one of the smallest in the country, we recognise that the needs of our residents are as important as any other community. The City therefore acts on behalf of the residents to protect their interests – and is able to listen to and understand their needs in a way that would be prohibitive to most other authorities.

Our City Supplement of the JSNA predicts that:

- Life expectancy is expected to remain high amongst City residents.
- The number of older people in the City is small but is projected to increase rapidly in the next decade.
- Trends show that older people wish to remain living independently in their own homes for as long as possible.
- Incidences of age-related health problems such as reduced mobility, dementia and social isolation, as well as the need for additional support and care, are likely to increase.
- The City has been adapting to the increasing demands of the aging population through increased provision in telehealth, preventing social isolation and in creating a dementia-friendly City.

Source: City Supplement Health and Wellbeing Profile (JSNA), 2014

Demographics

Projected population age groups in the City to 2037, with percentage rise over previous five years (numbers rounded to nearest 100)

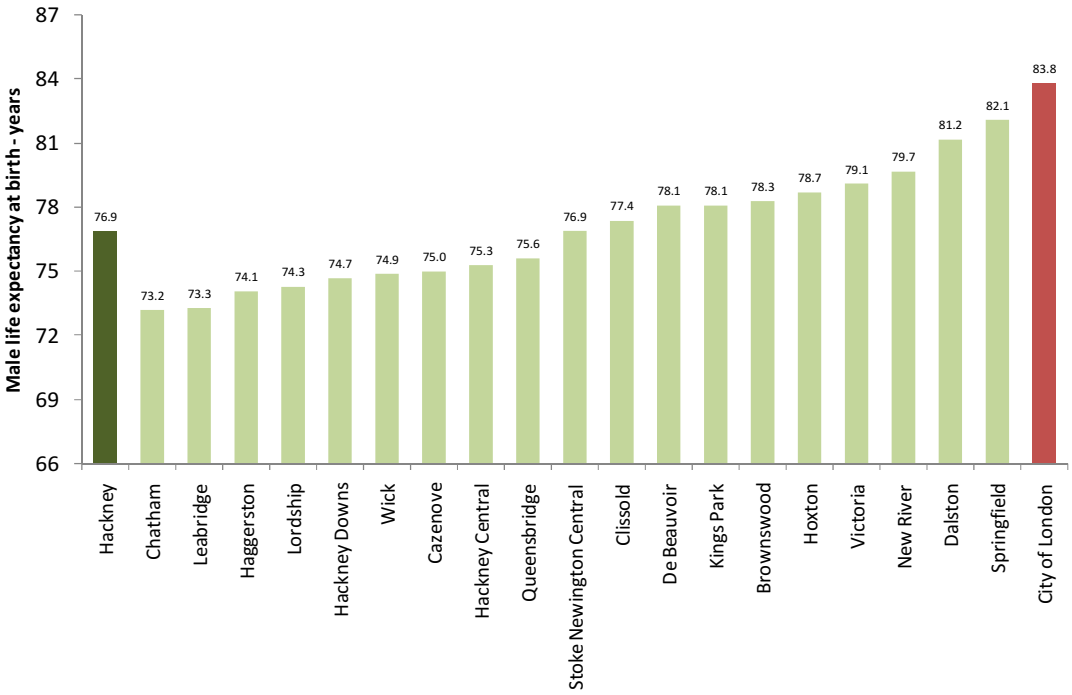
Year		The City				
		0–4	**5–19**	**20–65**	**>65**	**All**
2007	**N (% rise)**	300 (22.2)	600 (–0.7)	5,900 (3.6)	900 (4.4)	7,600 (3.9)
2012	**N (% rise)**	300 (–7.2)	600 (4.9)	5,700 (–2.1)	1,000 (10.9)	7,600 (–0.2)
2017	**N (% rise)**	300 (8.2)	600 (8.1)	6,000 (4.4)	1,200 (17.3)	8,100 (6.5)
2022	**N (% rise)**	300 (–0.8)	700 (7.7)	6,200 (2.7)	1,300 (11.3)	8,400 (4.3)
2027	**N (% rise)**	300 (–0.8)	700 (4.4)	6,300 (2.0)	1,500 (10.1)	8,700 (3.4)
2032	**N (% rise)**	300 (–0.4)	700 (0.3)	6,300 (1.0)	1,600 (13.2)	9,000 (2.9)
2037	**N**	300	700	6,400	1,800	9,200

	(% rise)	(0.4)	(–0.4)	(1.2)	(9.6)	(2.6)

Source: GLA

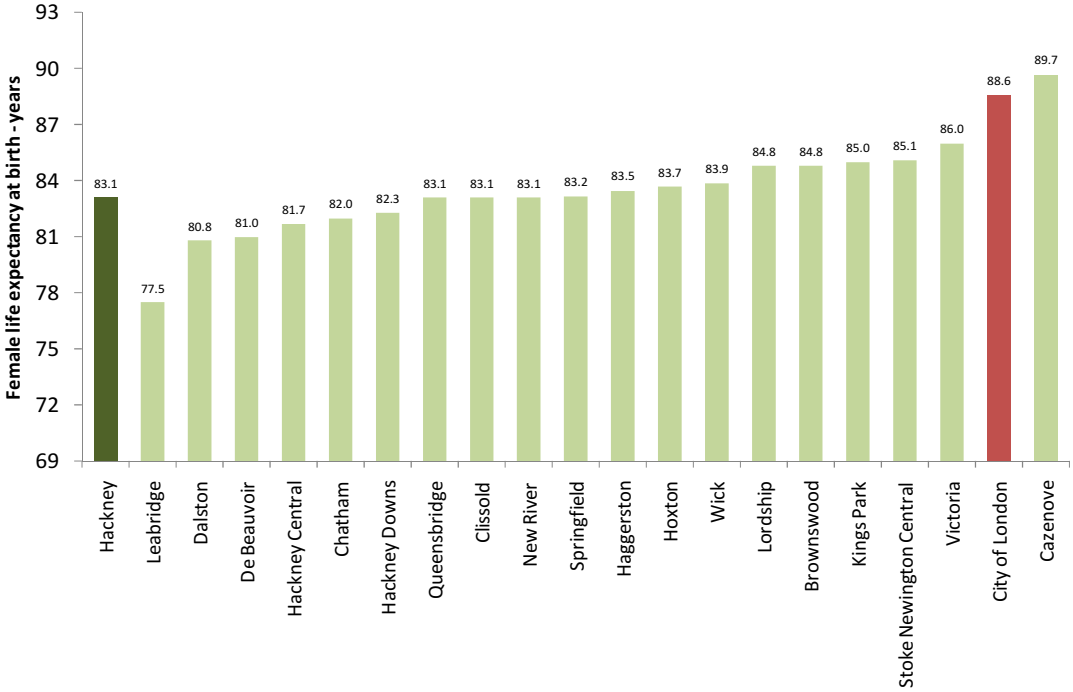
In the City, both the male (83.8 years) and female (88.6 years) life expectancies are higher than the figures for England (78.6 years for males and 82.1 years for females) and the surrounding boroughs.

Life expectancy for males, Hackney and the City 2006–10 (LHO)



Source: London Health Observatory 2010 (now Public Health England)

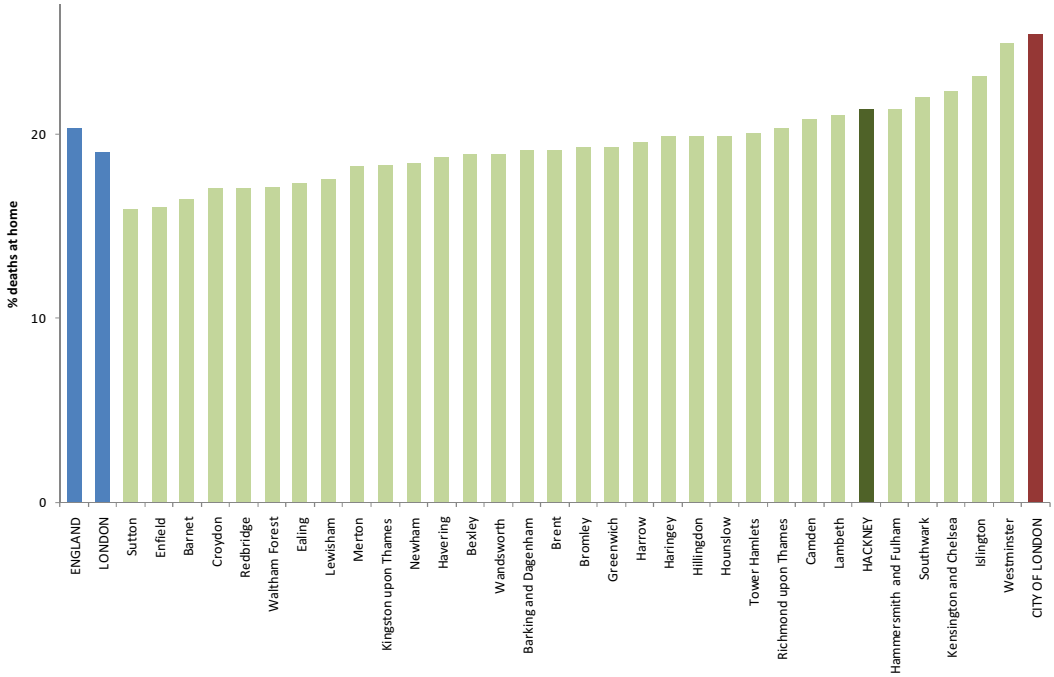
Life expectancy for females, Hackney and the City, 2006–10 (LHO)



Source: London Health Observatory 2010 (now Public Health England)

In 2010/11, over a quarter of the deaths amongst residents from the City took place at home – this was the highest average across all London boroughs and higher than that for London and England. Generally, more men die at home than women.

Percentage of deaths taking place at home, 2008–10 (HSCIC)



Source: London Health Observatory 2010 (now Public Health England)

Despite being such a small geographical area, the City of London has the fifth highest number of rough sleepers in London. Most rough sleepers are white, older males, with problems relating to alcohol and mental health.

Key Findings (JSNA)

- There is a potential to expand services in pharmacy to meet local health needs. Many residents use community pharmacists which are located outside the City; however, pharmacies can also be used to deliver services to City workers
- The City has a vibrant voluntary and community sector, as well as a time credits scheme, which help to strengthen and build communities

Residents

- 20% of City residents are registered with GPs outside the City – this has implications for how cross-border health services are provided.
- Deaths from all cancers and from premature cancer are well below the average for London, and premature deaths have fallen markedly over the last 6 years.
- Other disease prevalence estimates for residents are currently limited to those registered at the Neaman Practice.
- Adult social care in the City has been modernised, and most users of adult social care are happy with the service they receive
- Introduction of the Better Care Fund will enable better joined up working

between healthcare and social care services.

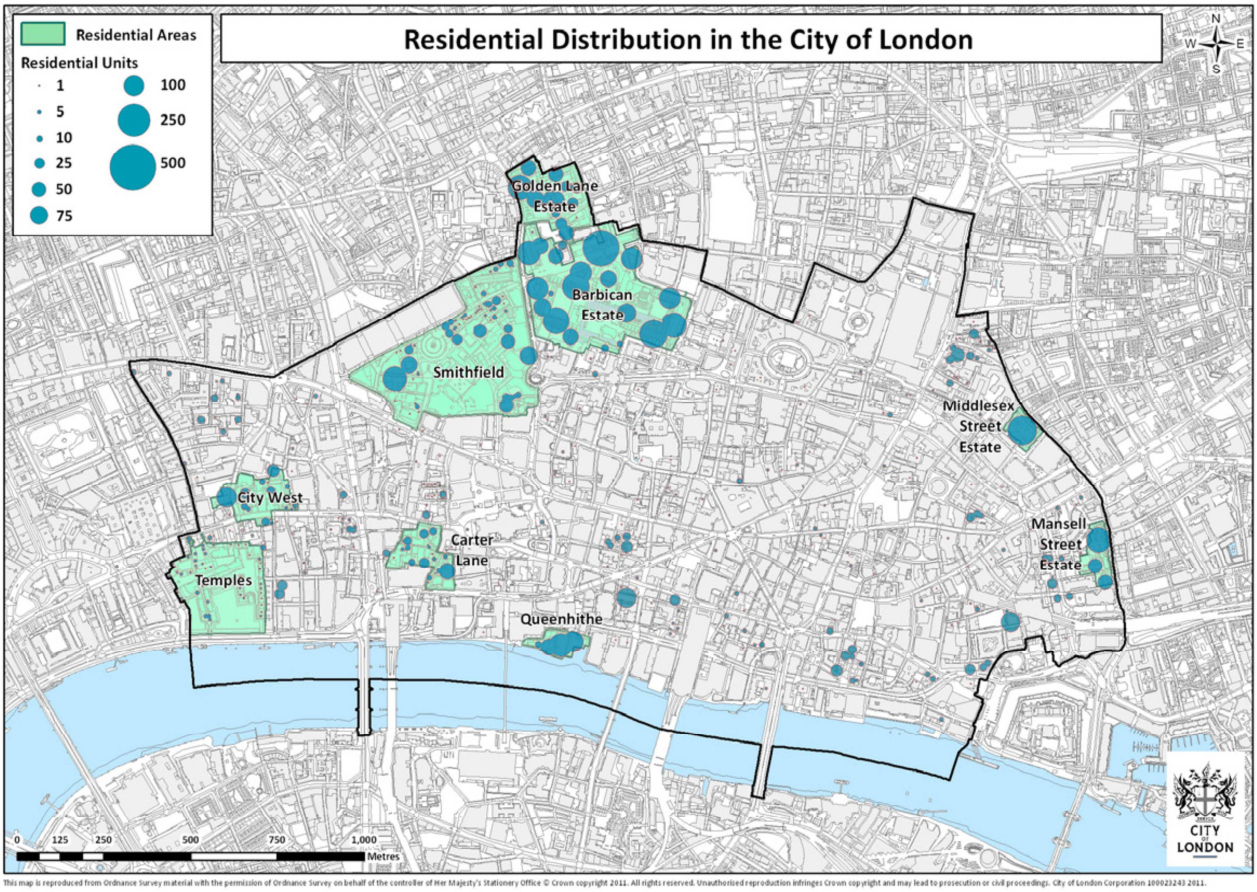
City workers

- Many City workers, particularly those in lower-paid sectors and roles, find it hard to access primary care services, as doing so requires taking time off work for appointments.
- One-third of City workers would choose to register with a GP near to work rather than near to home, if they were allowed.
- Musculoskeletal, respiratory and mental health problems are the major health conditions identified by City workers.

Rough sleepers

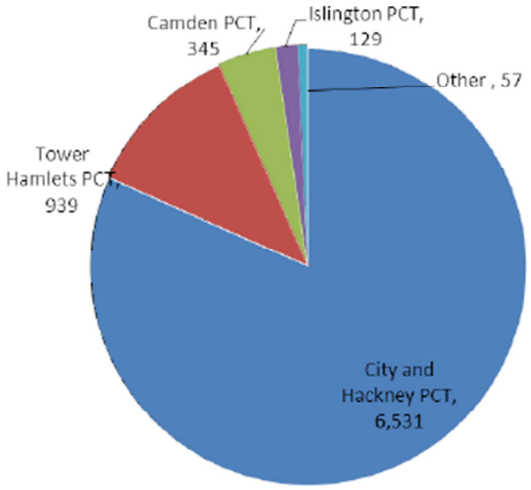
- Rough sleepers tend to have co-morbidities, and are likely to use A&E much more than the general population.
- Rough sleepers are particularly vulnerable to infectious diseases, for example, tuberculosis.

Source: City Supplement Health and Wellbeing Profile (JSNA), 2014



The resident population of the City is concentrated near its boundaries. This means that there is a natural preference of residents to register with GPs in neighbouring areas.

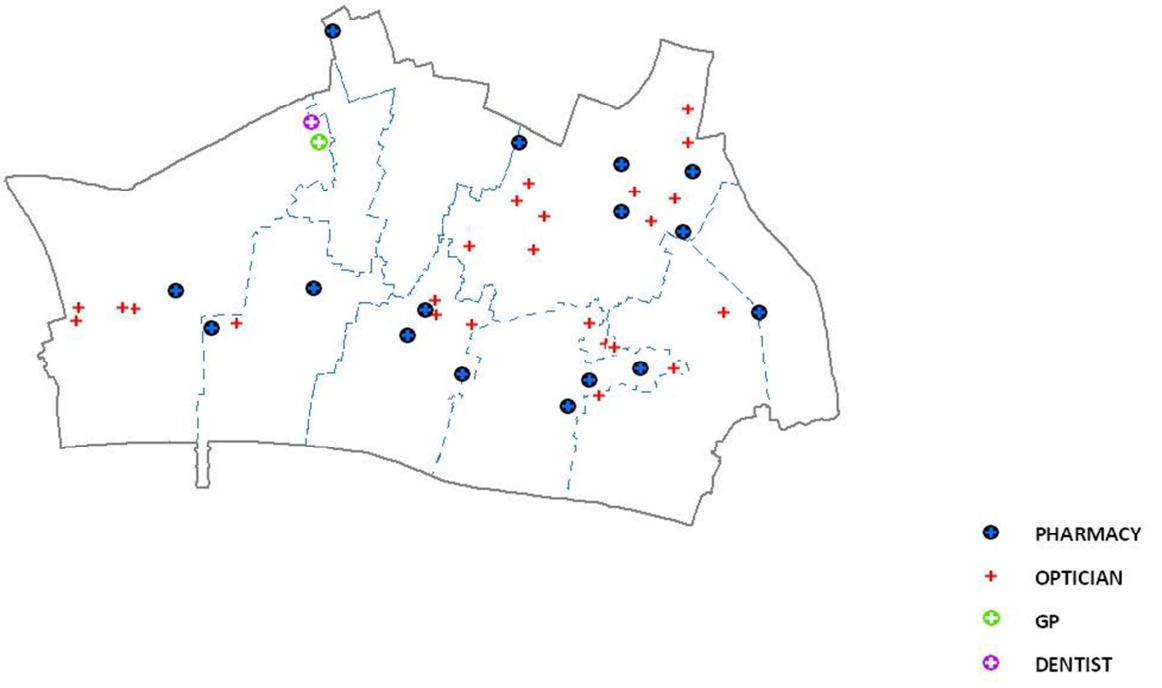
GP Registration by PCT



Practices with largest number of City Residents

Practice	Count of City Residents
THE NEAMAN PRACTICE	6512
THE SPITALFIELDS PRACTICE	597
ST PHILIPS MEDICAL CENTRE	206
CITY WELLBEING PRACTICE	156
WHITECHAPEL HEALTH PRACTICE	88
CLERKENWELL MEDICAL PRACTICE	80
GRAY'S INN ROAD MEDICAL CENTRE	66
ST. KATHERINE'S DOCK PRACTICE	45
Other	251
Total	8001

Primary care services in the City



GP registrations

The majority of City residents are registered with the Neaman practice in the City of London (81%), with the second largest registration being at the Spitalfields practice in Tower Hamlets (9%). Overall, 18% of residents are registered outside City and Hackney CCG; the majority of these are registered with GPs in Tower Hamlets (12%). While the practice with the third largest registration of City residents is in Camden, only 4% of City residents are registered with a GP in Camden CCG.

The Portsoken ward contains two social housing estates at Mansell Street and Middlesex Street. Some of this residential accommodation was originally in Tower Hamlets, but was transferred to the City under The City and London Borough Boundaries Order 1993. The ward's relatively recent addition to the City means that the Portsoken area's links to Tower Hamlets are still strong, and not all of the services in the area are provided by the City. The catchment area of the City's only GP practice does not cover the Mansell Street and Middlesex Street Estates, meaning that residents of these two estates must register with GPs from Tower Hamlets. A Tower Hamlets GP practice currently provides services to Portsoken residents at the Green Box Community Centre, located on the Mansell Street Estate.

City Workers

City workers who are entitled to register with a GP must do so in their home locality. This means that many City workers, particularly those in lower-paid sectors and roles, find it hard to access primary care services, as doing so would require taking time off work to make the appointment.

Research conducted with City workers showed that one-third of City workers would choose to register with a GP near to work rather than near to home, if they were allowed, and 82% would choose dual registration if this were to become possible. Allowing City workers to register close to work has the potential to make services more accessible, support longer-term health needs, provide more opportunities for screening and prevention, and require less time off work to access services.

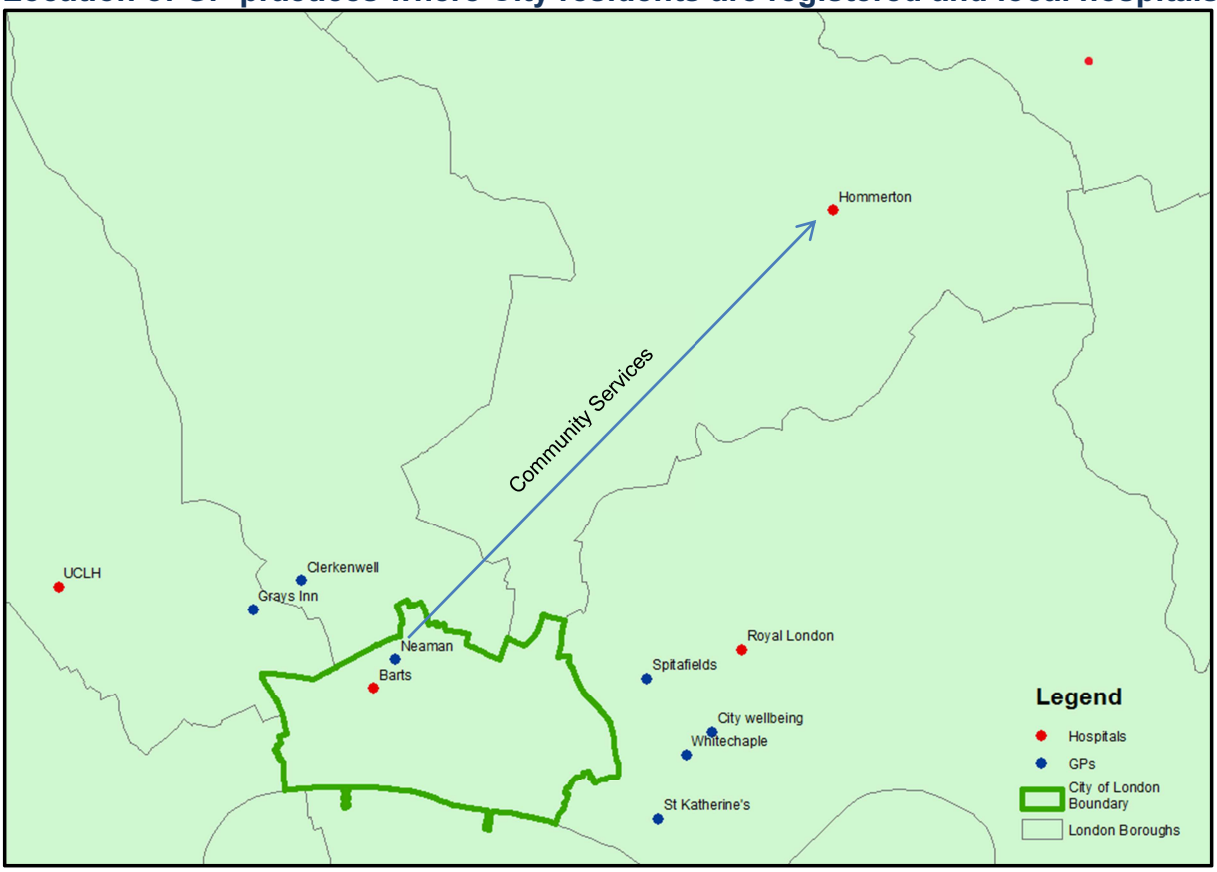
Research shows that City workers wish to access health services and clinics during early mornings, lunchtimes and evenings. The short waiting times for services at private sector clinics are seen as a distinct advantage; however, private services are only available for those who can afford them.

NHS walk-in centres around the country have higher throughputs and longer waiting times than private clinics but they are also open to all and free of charge; however the only NHS walk-in clinic in the City was closed in 2010.

Rough Sleepers

Rough sleepers can register at the Neaman Practice in the City, but most choose to register at Health E1, a specialist GP surgery for homeless people, which is just outside the City. The City's homelessness strategy has made improving the health and wellbeing of homeless people, including rough sleepers, a priority.

Location of GP practices where City residents are registered and local hospitals



Source: Hospitals and GP surgeries attended by City residents 2014.

Whilst Barts, the Royal London and UCLH are the closest hospitals for our residents both for acute and community services, they are frequently unable to access community services locally or even some acute services because of the fact that they live in the City. Planning is underway with the CCGs in Tower Hamlets and Islington as well as City and Hackney to improve accessibility of services for our residents and to map out coherent care pathways.

The Homerton Hospital in Hackney is the key acute provider for our CCG. However, many of our residents will attend or be admitted to University College London Hospital, the Royal London or the Whittington and we are therefore working closely with these providers in our considerations of integrated care. The Community Services commissioned by the CCG are provided through the Homerton.

Currently, we have arrangements where we spot-purchase many services that would be commissioned by other authorities. This gives us flexibility and the ability to provide responsive bespoke packages of care, tailored to the needs of individuals within our community within a timely manner, where other authorities might be restricted by the numbers using a particular service.

Over the last 2 years, the City has invested in an in-house Reablement and Occupational Therapy service combined with assistive technology. This has increased the number of people able to live independently at home and reduced reliance on Adult Social Care. It remains our vision, to facilitate and enable our service users to live in their own homes as

long as they are able and while it is their preferred option.

When the Better Care Fund was announced, we wanted the opportunity to be able to build on our existing bespoke models of care and support. Reliance on services commissioned by others, or partnerships in which the City is the minor party, have not served our residents well in the past nor met their needs appropriately. We are keen to explore some of the pilots being implemented by our neighbours and tailor them to meet the needs of our users.

Our Public Health work is very strong within the City and whilst we work with our 7,400 resident population, we also undertake preventative work with over 300,000 City workers who benefit from a number of projects within the City. This includes funded smoking cessation services and a late night levy to licensed premises to minimise the effects of alcohol intoxication.

We have created various 'apps' to improve health including the CityAir App which helps users to reduce exposure to areas of poor air quality and encourages people to take simple action to help improve local air quality, and preventing unnecessary ambulance call-outs for breathing related difficulties as well as longer term impacts on health relating to air quality.

The Drinksmeter and Drugsmeter apps provide feedback to individuals in relation to their own, personally-reported use of alcohol or drugs. The apps provide advice on reducing the risks associated with the use of alcohol or drugs and links to treatment and other services.

This highly effective Public Health offer within the City has wider implications for preventative health services across the country in encouraging workers in the City to live healthier lifestyles. Evidence from the Census 2011 identified a high number of young male workers. This predicts particular health issues in relation to alcohol usage and sexual health and where people may not want to attend their own local GP to discuss these issues, they are more inclined to retain their anonymity by attending services within the City.

The City also commissions NHS health checks for low paid routine, manual and retail service industry staff in the City, as many of them are unable to access primary care services during working hours in their home boroughs. The City also works in partnership with City businesses to encourage healthier working practices, as well as commissioning information and advice services for City workers.

Whilst these services are relatively new, we are monitoring their use and the impact of their use through the number of Ambulance Service call outs (and admissions) for alcohol or drug related issues within the City.

Links to other plans

There are a number of other plans that are referenced throughout the development of this BCF plan. The key plans identified as the JSNA and the city and Hackney CCG 5 year Strategic Plan form a baseline for all agreed developments. The priorities and visions within these documents enshrine the principles adopted within the BCF.

Joint Health and Wellbeing Strategy

Our City of London Joint Health and Wellbeing Strategy identified key priorities for

residents, for rough sleepers and for City Workers:

Key Health & Wellbeing Challenges

1. Residents

- Ensuring that all City residents are able to live healthily, and improving access to health services.

2. Rough Sleepers

- Working with health and outreach services to ensure rough sleepers are given the range of support they need.

3. City workers

- We want the City to continue to be the world leader in international finance and business services, and a healthy workforce is key to this.
- We want workers in the City to thrive here, and for The City of London to lead the way as an exemplar for workplace health. We want to meet the needs of all of our workers, especially those in lower-paid and non-professional positions. All kinds of people work in the City, and so we need to think about different ways to engage with them, and ensure we can keep them healthy.
- We want to work with City employers and City workers to prevent ill health, reduce sick days and improve the productivity of City businesses. It is acknowledged that many of the challenges that apply to residents also apply to workers.

These priorities are translated into action within the Joint Health and Wellbeing Strategy, the spirit of which underpins the BCF Plan.

City and Hackney CCG 5 year Strategic Plan

The City and Hackney 5 year Strategic Plan outlines the vision and key actions for the residents of City and Hackney over the next 5 years. This includes commitment to the BCF plan and to delivering a range of services that will enhance the patient experience.

Our vision for the City and Hackney health economy is:

- Patients in control of their health and wellbeing;
- A joined-up system which is safe, affordable, of high quality, easy to access, eliminates patient waste and improves patient experience;
- A collaborative approach to reducing health inequalities and premature mortality and improving patient outcomes;
- Getting the best outcomes for every £ we invest through an equitable balance between good preventative services, strong primary and community services and effective hospital and mental health services which are wrapped around patient needs;
- Services working efficiently and effectively together to deliver patient and clinical outcomes and providers in financial balance.

City & Hackney CCG 5 year Strategic Plan

Many of the schemes developed in Hackney form part of the BCF plan, however will be modified to meet the needs of residents in the City. This includes the commitment from neighbouring CCGs in Tower Hamlets and Islington to work with us in removing barriers to effective cross border working.

Preparation for the Care Bill

Much of the emphasis of this plan is developing our arrangements for the implementation

of the Care Bill. By enhancing the choice of our residents and giving them more of a voice locally, particularly in relation to how they are cared for and in developing our systems in relation to personalised budgets and deferred payments we will be in a strong position once the Bill becomes enacted.

The City has operated deferred payments for those who are admitted to residential and nursing care for a number of years. This means that we are well-positioned for the implementation of this aspect of the Care Bill

In terms of the finances around the BCF, we have modelled this on the individuals using particular services to enable us to be cost effective, and to be able to follow the service user with payments rather than paying for services that are not used by the City residents. This will help us to deliver services around the users spot purchasing relevant and timely interventions.

What changes will have been delivered in the pattern and configuration of services over the next five years?

Locality working model

By 2016/17 we will have developed, and be operating a locality working model where people are able to access resources locally and in their homes where appropriate. We want to see the City as a locality in its own right rather than it being seen as an 'add-on'.

Our Adult Social Care Team already successfully integrates Reablement, OT and Mental Health with Social Care. This gives us flexibility to be responsive to the needs of our service users and already allows us to share information between disciplines. We will use this model to integrate further with Health and with Community Nursing to ensure that service users are able to access relevant services in a responsive and timely manner by knowing who needs which services and use flexible commissioning arrangements to source services in Hackney and in Tower Hamlets and Islington or commissioning jointly with the CCGs.

This will require much closer scrutiny of the care pathways used by our residents. We are already working with our partners and stakeholders to identify and review these pathways in order to deliver a model that fits for residents whether they are registered in the City or in one of our neighbouring CCGs. This will also benefit those from our partner CCGs in understanding the care pathways of their residents registered with our GP practice. Initial findings suggested that there were system issues in relation to where residents may be referred for particular services depending on where they were registered with GPs. These are being addressed and simplified and the implementation of recommendations from this review will commence in 2014/15.

The City will be a hub for the delivery of community based services that are commensurate with the needs of our population. These services are likely to be delivered from our GP surgery.

Reducing unnecessary admissions

We will ensure that acute admissions are minimised through our preventative support, through reablement and through our services within the community. The City of London will therefore be a healthier and happier place where people are able to access preventative services locally that meet their needs and are able to retain their

independence longer and to exercise their choice of staying at home.

Joint Care Navigators will work with GPs to identify the health needs of vulnerable service users and will give advice and support to service users and to signpost them to community services where relevant to prevent the need for admissions. By having Joint Care Navigators in place we will have a much clearer indication of how we can improve our preventative work to reduce unnecessary admissions still further.

Using the Risk Stratification Tool, our GPs will identify those patients at most risk of hospitalisation and prioritise these for the development of integrated Care Plans to be discussed within the multi-disciplinary teams. This way of working will assist us to deliver packages of care and support that will prevent unnecessary admissions

Our admissions avoidance service will contribute to the reduction in the number of emergency admissions through intensive intervention and 24hour support at home for up to 72 hours over an acute period.

We have estimated a reduction in unnecessary admissions of 50% which would deliver £62k savings in the first year and £80,850 ongoing.

Recognising the importance of carers

The involvement of carers will be pivotal to our plans and their involvement in the care plans for our residents will be essential. We will demonstrate our commitment to carers through our locally devised performance measures, ensuring that they have timely health assessments themselves and that they feel that they have been listened to and involved in the development of any care plans for the person they are caring for.

We already have carer assessment processes in place and have a cohort of carers managing their own individual budgets. Carers are involved in user groups and in our Adult Advisory Group and are therefore able to directly impact service design and delivery. However, we know that historically our carers have not reported a good quality of life and are therefore committed to improving their access to services and support. We also know that key to this is the improvement of local services for the person they care for.

Our local metric of Carer-reported quality of life will be reviewed annually by our Adult Wellbeing Partnership, however underpinning this indicator will be a review of the percentage of carers receiving their own health assessments and who felt involved in discussions about the person that they care for. This will help identify whether carers need additional support in meeting the needs of the person that they care for.

The Carer's Grant has not previously been allocated directly to the City as the CCG funded a joint contract with Hackney for the delivery of Carer support. It is evident however that our carers were not accessing this service and the BCF process has allowed us the opportunity to address this issue.

Integrated data sharing

Building on the City and Hackney model, residents will be confident that they are able to 'tell their story' just once for that information to be shared and understood across health and social care. Care plans will be developed that clearly state a single named person who will guide the person through the health and social care system and who will navigate any discharges from hospital, minimising any delays and reducing the number of people having to be readmitted.

We are mid-way through a joint project between Health and Social care to review our data and information sharing arrangements and to recommend the next steps in securely managing shared data.

The outcomes of this joint review of information sharing arrangements will be presented to partners and will conclude in June 2014 with an agreement to the 'One City' information model. Our Caldicott 2 compliant Information Sharing agreement will be signed off by October 2014.

Running in parallel with this is an exercise to include the NHS identifier on all social care records to enable us to communicate using this number. This exercise will be completed by July 2014. Communication between health and the local authority using this number will commence by September 2014.

Robust data collection

Patient data is to be disaggregated from each of the CCGs to be able to form a clear picture of the residents within the City of London to enable better planning based on actual needs rather than synthetically estimated projections. This will mean that services are fit for purpose and will be effective in meeting the needs of our residents at a time and place they want or need them. We are working across the 3 CCGs to gather data relevant to the City population in order that we can analyse trends and better match provision with needs.

This work sits alongside the improvements we are already making through the creation of a separate JSNA supplement specific to the City which will enable Health and Social Care to make robust decisions on the projected needs of residents. We will be able to identify further key savings to be made in the system, by delivering services that are needed rather than contributing towards services that our residents do not ever use.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims and objectives

The key aim within the City of London will be to deliver integrated preventative services to support residents to remain within their homes and to provide support to prevent emergency admissions to hospital and to support frail older people with health problems including those with long-term conditions to promote independence. This will take a whole-system approach that is engineered at a micro-service level in order to improve pathways for individuals and therefore improving the service user experience.

We will achieve this through pulling together all of our key strategies that span health, social care and housing that affect the physical and mental wellbeing of our population and using our unique assets to respond quickly and innovatively to the needs of our population. Many of these strategies identify actions that will ultimately improve the health and wellbeing of our residents and when implemented will drive many of the changes required by the Integration agenda.

By creating the Adult Wellbeing Partnership we have a body of accountable senior officers who will ensure that our plans are delivered and who will be accountable to the Health and Wellbeing Board for the timely delivery of integration across health and social care.

We are developing a more specific Adult Service User Feedback survey to capture satisfaction with integrated services and jointly delivered services to enable us to monitor closely the difference our services are making for our residents.

Specific objectives

1. ***Joint working*:** The City has an ethos of co-production with our residents and service providers and we want to ensure that our Better Care Plans are (centrally) co-produced and monitored by our service users.
2. ***Promoting independence*:** We currently provide our own reablement and OT services which have helped residents who prefer to stay in their own home rather than going into residential or nursing care. We want to widen the scope of our service to provide greater independence and support.
3. ***Meeting expectations*:** Our Adult Advisory Group is a key driver for many of the changes in the City and for service improvement and development. Together with the GP User Group, we will ensure that our plans meet their expectations and that service users, carers and patients report better experiences of their care.

Outcome measures

Health gains for local residents

The principal health gain will be the number of people from all adult social care client groups who have fulfilling lives within their own community.

We will ensure that independence is promoted using the following assessments:

- Frequency of permanent admissions to residential and nursing homes
- Proportion of people still at home 91 days after hospital discharge into rehabilitation services
- Frequency of delayed transfers from hospital including mental health admissions
- Number of avoidable emergency admissions

We will ensure that expectations are met through:

- The Adult Service User Feedback Survey
- The Carers' Surveys
- Feedback from our Adult Advisory Group
- Regular feedback sessions facilitated by Healthwatch as part of our Annual Local Account

We will ensure that Joint working is effective using the following assessments:

- Establishment of joint governance arrangements
- Member attendance and engagement at all meetings within the governance structure
- Collation of feedback from our Adult Advisory Group and GP User Group

Additional benefits will include:

- Fewer unplanned admissions and more proactive case management
- Reduced numbers of elderly people and people with physical or mental health problems needing admission to residential or nursing care and more people using personal budgets to manage their own care
- More people having access to preventative services delivered locally within the City.

Gains for the wider system

In developing the model in the City, we want to demonstrate a system that can work for the individual as well as for the wider Health and Social Care community. Our system has reciprocal benefits for the CCGs working with us, in that we have Reablement and OT services that work particularly well. Having an enhanced service that includes Joint Care Navigators, we will be demonstrating on a small scale a personalised approach that service users across the country should expect from care integration and modelling the behaviours that are at the heart of the BCF policy.

Making changes for each individual and seeing them as a 'whole person' rather than as a list of individual medical interventions will have a bigger cumulative impact on patient experience than wide-scale policy changes.

Areas that other CCGs and areas will be able to learn from will include:

- Recognising the individual as a person rather than as a statistic
- Recognising their needs as important to them
- Delivering a real ‘customer-service’ model
- Understanding their holistic needs rather than their needs in isolation of each other
- Having a named person who can follow the service user through from before they are admitted to hospital right the way through the pathway past discharge and back to post-discharge pathway.

c) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

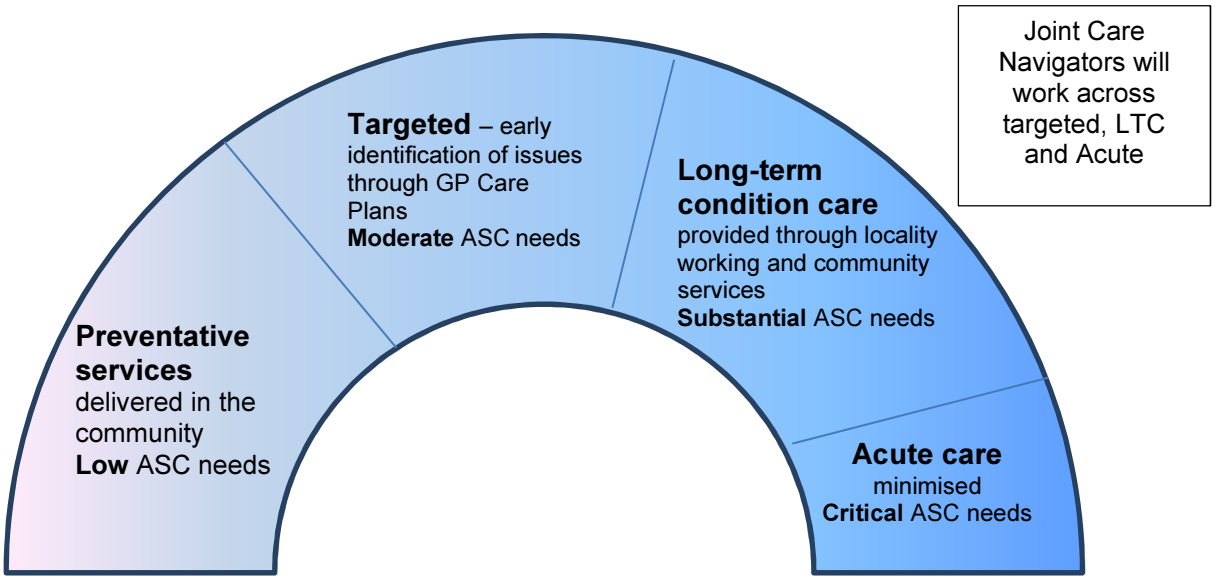
Introduction

Within the City our aim is to further develop our preventative and targeted services to reduce the numbers of people ever reaching the acute level. We currently deliver universal and preventative services through a number of activities and voluntary groups within the City which is enhanced by a Public Health offer that addresses the wellbeing of the whole resident population and that of some 300,000 City workers. This has been the focus of the City for the last 2-3 years and

Targeted services to those who may be at risk of requiring further intervention are delivered through understanding the needs of our community. Wellbeing checks for over 75s are undertaken by our GP. Early diagnosis of dementia is a key example of targeted work where we have established support groups to enable patients to maintain their independence and to regain their confidence following diagnosis.

Those with long term conditions are supported to manage their condition at home and this is supported with the use of Telecare to help prevent acute admissions. Where admission is necessary, our Reablement and OT Service and our community services manage the rehabilitation processes and offer support, minimising the chances of readmission.

Preventative services will be met within the existing budgets, however additional BCF funding has been allocated to assistive technologies, information sharing and robust data collection. This will help use to ensure that people do not formally enter the social care system and are assisted to manage their own care at home.



Preventative Services

Preventative services will be offered to all residents in order to maintain their general health and wellbeing. Many of the preventative services have been developed through our Public Health offer and are not specifically listed here. These services will enable us to identify any early need and offer support alongside our voluntary sector.

The City works very closely with our neighbour authority in Hackney, and so whilst some of the schemes within our plan link to the pilot schemes that are in development there, we are taking the opportunity to tailor these to fit the specific needs of the City in this pre-implementation year. We are also able to link to the schemes in Tower Hamlets and Islington in order to ensure smooth transition between acute and community services for our residents registered with GPs outside our CCG footprint.

The key challenge for the City is in ensuring that all of our residents are able to easily access services, regardless of where they are registered with a GP. We have started to review each of these schemes in order to assess how GPs in Tower Hamlets and Islington can access appropriate services in a timely and effective way for our residents who are registered with them. We are developing links through local network meetings to ensure that barriers to provision are minimised thereby improving patient experience.

Early identification

We have undertaken to identify residents who are at risk of vulnerability. We will use the risk stratification tool alongside our GP practice and those where our residents are registered in Tower Hamlets and Islington, to identify not only those residents who are at high risk and who are housebound, but those who are vulnerable to ensure that we can meet their needs at an early stage, reviewing potential housing needs to identify whether aids and adaptations, assistive technology or Telecare / Telemed may be required to support the resident to maintain their independence.

Information Sharing

Tricordant have been commissioned to undertake a review of the information sharing arrangements and system requirements of integrating our data through the use of improved technology. The Social Care database has recently been replaced with Framework-i which has the capability of recording the NHS identifier and already facilitates the communication between our GPs and Adult Social Care. By developing the technology and the agreements for information sharing during 2014/15, we will be in a good position for implementing step changes to the way in which we share information between the health and social care systems.

Building robust data collection

One of the workstreams will address the data issue by providing a baseline as to where City residents are registered with GPs and then to produce robust data concerning our residents so that we are able to monitor improvements. This will assist us in updating our City specific JSNA supplement and delivering a map of health and social care interactions to ensure that integration is delivered for all City residents, no matter where they are registered. It will also help us to identify gaps and forecast likely future needs.

Social Prescribing

In addition to providers within the City, we have a wealth of volunteering opportunities that has been extended by the use of a “Time Credit” scheme which has been implemented in the City.

Alongside colleagues in Hackney, we have developed a Social Prescribing scheme in the City, where residents may also be 'prescribed' to participate in social activities within the City to reduce social isolation and promote health and wellbeing. Social prescribing is targeted towards patients who repeatedly attend GP surgeries due to loneliness. Our GP surgery is primed to identify a range of support services, including welfare advice, befrienders, walking clubs, arts clubs and exercise groups. This process is sometimes called 'community referral', as activities and services are on offer locally and are mostly provided by the Voluntary and Community Services.

These activities fit within our ethos of preventing acute admissions where possible by promoting healthy lifestyles within the City and reducing the impact of social isolation. There is a worker at our GP practice and this is working well, especially in relation to dementia.

Time Credits have been trading in the City since June 2012, and since then over 1,700 hours have been contributed by 180 people through 21 connected providers and community groups. The focus of the programme has been on developing Time Credits in the Portsoken ward, one of the most deprived areas of the City. Spice has been liaising with the commissioning team to involve users in commissioning, designing and delivering services – and in training providers to adopt the Time Credits system – and is currently working with City Gateway, CSV, Recycling, Fusion, Toynbee Hall, Artizan Street Library and Community Centre and Healthwatch. Local residents are also growing in confidence and are starting to set up more community-led groups, including gardening clubs, good neighbours' schemes, activity groups such as Zumba and sewing, and social groups for women and young people.

By encouraging more people to get involved in services, local community groups and third sector organisations, Time Credits create opportunities for individuals to learn new skills, gain confidence and raise their aspirations. By spending Time Credits, individuals can try new activities and improve their health and wellbeing. Many participants have commented that, through the Time Credits Network, they have been able to try activities they could not previously afford. As a result of their increased participation, individuals have better access to peer and community support networks, and a more positive perception of their ability to contribute to the local community.

Initial findings from our evaluation survey, carried out a year after rollout, show that 31% of people involved with Time Credits have never previously volunteered within their community. 62% feel that the scheme is helping to improve their quality of life.

Medicines Management

Effective team working between patients, doctors, nurses and pharmacists will be developed to limit the risks of polypharmacy and optimise prescribing. The CCG is commissioning practice based pharmacists to work alongside each practice to support this initiative. This will particularly benefit frail elderly who are often at risk of adverse reactions and decreased adherence to treatment through prescription of multiple drug therapies.

Targeted Services

Targeted services will use the risk stratification tool to identify those residents who are at higher risk of poor health and vulnerability. These services link very closely with preventative services although they will have an element of delivering support for needs

that are greater than those of the general population. Following on from early identification, these residents are likely to have additional assistive technology requirements.

We have identified these services on the finance spreadsheet under the heading of Case Management for the Frail Elderly and Practice Based Co-ordinated Care. Joint Care Navigator work is included within Admissions Avoidance.

Case Management for the Frail Elderly

We will adopt a targeted, general practice-based proactive approach of care for vulnerable, elderly patients. General practitioners will lead the development of care plans for most of their frail and vulnerable elderly patients within the City. They will be identified using the risk stratification tool. Our goal is for each vulnerable patient to have: (a) an individualised care plan; (b) regular scheduled home visits, which typically will occur quarterly; (c) one responsible named doctor to ensure continuity of care is maintained.

General Practitioners will have overall responsibility for undertaking these care plans and will provide input into addressing the medical issues identified in the plan. They will be supported by community nurses, who will be trained to initiate the patient-centred plan and develop goals with these patients. Patients will be asked their consent for their care plan to be shared and the health information exchange system will be developed as an option for sharing care plans across organisations. It will be of particular importance to develop and share crisis plans across organisations, so that the patient, carers and responsible health and social care professionals are aware of what should happen in the case of a crisis. Care plans will be introduced in 2014-15 and we will enter into contracts with our practice to deliver this. Care planning will be supported through setting up practice based co-ordinated care as outlined below.

The City approach will see this scheme developing further throughout 2014/15 by piloting a single joint assessment undertaken by Adult Social Care and the GPs, with the GP retaining responsibility for the healthcare element of the assessment and resulting plan and the joint care navigator providing the coordination between that and the Adult Social Care responsibilities to ensure that the patient can be guided through the pathway simply.

Practice Based Coordinated Care

Our GP practice will establish practice-based coordinated care as a cornerstone of joint working, based around frail elderly patients linking with other practices in City and Hackney CCG area. It will optimise the care and clinical outcomes of individual patients by developing a care plan designed and agreed with the patient, proactively reviewing their care plans and using joint expertise available within health and social care services to develop actions based around the care plan. Multi-disciplinary case management will be crucial to the care of these vulnerable, elderly patients and agreed with the patient, carers and across team members. GPs will have central roles organising and co-ordinating care, providing the medical input to care plans. They will be supported by a multidisciplinary team of community and specialist nurses, social care staff, community mental health workers, therapists, community matrons and acute clinicians including a Care of Elderly Consultant. For City residents, the Joint Care Navigators will attend these multi-disciplinary teams to ensure that the care pathways for our residents are clearly identified within the care plans.

We follow a holistic focus that supports service users to manage their own conditions at home and become more independent and resilient rather than having a purely clinical focus on treating medical conditions. There will also be the opportunity to develop

support services for families of these most vulnerable patients, to ensure that patients and carers concerns are addressed – particularly where there is anxiety and depression and other challenging issues.

The CCG is currently aligning its contractual arrangements across the different services and providers to ensure that they are working together to achieve the same outcomes.

Developing enhanced multi-disciplinary working will enhance the creation of informal and formal professional networks. These networks will facilitate developments in clinical practice and referrals to a range of health and social care services to maintain people within their communities and will help further improve their care.

This will be supported during 2014/15 by a local incentive scheme for City and Hackney practices, which will ensure that practices are contracted to undertake care planning, proactive home visits and continuity of care for the most vulnerable frail elderly patients. This will be further underpinned by imminent changes in 2014/15 to the GMS contract, which will ensure similar proactive case management for a wider cohort of vulnerable patients (top 2% of most vulnerable) although this may be extended for City residents to include a wider cohort. Processes will be introduced to audit the quality of care plans across all practices in the City and Hackney.

We have also commissioned the Tavistock and Portman NHS Foundation Trust to support the multi-disciplinary team members to develop the skills to negotiate and implement user led care plans across the various team members and in conjunction with the patient and their families and carers.

Integrated clinical services

Homerton Hospital already provides a highly effective Chronic Obstructive Pulmonary Disease (COPD) team which provides proactive support to patients with COPD and asthma, linking closely with local practices. The team aims to avoid emergency admissions by intensive community based support, by working alongside the A&E Department and by providing proactive management to support early hospital discharge and community follow-up – this is complemented by a service commissioned from local GPs to identify patients with COPD and manage exacerbations.

This service will be integrated with our planned development of practice based coordinated care, as will other specialist community teams such as the Community Heart Failure Nursing Team and Epilepsy Team.

We are aware that similar services are in place in Tower Hamlets and have been exploring how our residents could access these services if they are registered with Tower Hamlets' GPs.

Joint Care 'Navigator' posts

We have secured funding for 18 months for the creation of 2 posts which will have responsibility for co-ordinating services for our residents as they are discharged from acute care, this will include the facilitation of services within the hospital setting so that discharge can be a smooth transition to home and community based services or to other care as required. We intend that these two posts will be pivotal in supporting the multi-disciplinary teams and in supporting Care Planning meetings led by the GPs. They will also have responsibility for facilitating discharge for our residents from hospitals outside our CCG area and have therefore included Tower Hamlets and UCLH in our discussions about the development of these posts as they agreed in the necessity of having them.

These posts will be recruited to in 2014/15 in order to effect a smooth transition to integrated service delivery in 2015/16.

We have identified from research undertaken by Age UK in Kensington and Chelsea that there are potential savings of up to £859 per referral in using these posts. We are reviewing this model to determine how it may be applied successfully within our context.

Long Term Condition and Discharge Services

Reablement Services

The City of London hosts its own bespoke Reablement Service and has been very successful in delivery of services to support effective reablement of our residents as supported by recent inspections of Reablement and have never had any fines relating to delayed discharges. We are able to deliver care services proactively due to our size and with the support of the two 'navigator' posts we expect that this will be improved still further through early identification of needs through joint care plans with the GPs. If intermediate care is required we have effective spot purchasing arrangements in place which ensures timely intervention to support rehabilitation and ensure that there are no delays in discharge.

We currently use aids and adaptations, assistive technologies and Telecare to ensure that people can stay safely in their home for longer where this is their preference and we have been able to effectively reduce the number of people being admitted to residential and nursing care following acute admissions.

Community based services

In relation to specific services, Community Nursing provision depends entirely on where the residents are registered with a GP and which CCG provides this. These are currently being reviewed alongside CCG colleagues to determine how our residents can access community based services seamlessly no matter where they are currently registered with a GP. We are exploring a resident-based commissioning model which will allow us to remove some of the current barriers in the systems and improve the integration of services provided across all three CCGs for the benefits of our residents.

Integrated Care Pathway

We are developing our integrated care pathway model that will be operational by 2015/16. This builds on the work undertaken with our neighbours in Hackney and will incorporate the GP practices in Tower Hamlets and Islington where some of our residents are registered to ensure that they are able to access services for our residents.

Mental Health

The City of London has two FTE AMHP (Approved Mental Health Professionals) social workers who cover the settled population of the City together with joint work with Broadway and the East London Foundation Trust (ELFT) CPN to support homeless people with no connection to another local authority. The AMHPs are located within the Adult Social Care Team which enhances the offer we give to our residents and serves to promote integrated working.

Dementia Care

In September 2013, the City published its Dementia Strategy which has established a City-specific approach to caring for our residents whilst tapping into the rich diversity of our community.

Synthetic estimates predicted that within the City there were up to 67 people living with

the symptoms of dementia, some of whom had been diagnosed but a large proportion of whom had no formal diagnosis. Whilst this may be a relatively small number, for those with the disease the support that they received is vital to their quality of life and their wellbeing, and the City is therefore committed to providing the best possible services to this particularly vulnerable group.

The aim of the strategy is to provide a responsive, high-quality, personalised dementia service meeting the needs of residents of the City of London. To achieve this, the strategy set out 10 objectives:

- Improve public and professional awareness of dementia and reduce stigma.
- Improve early diagnosis and treatment of dementia.
- Increase access to a range of flexible day, home-based and residential respite options.
- Develop services that support people to maximise their independence.
- Improve the skills and competencies of the workforce.
- Improve access to support and advice following diagnosis for people with dementia and their carers.
- Reduce avoidable hospital and care home admissions and decrease hospital length of stay.
- Improve the quality of dementia care in care homes and hospitals.
- Improve end-of-life care for people with dementia.
- Ensure that services meet the needs of people from vulnerable groups.

The strategy committed the City of London Corporation to creating a 'Dementia-Friendly City', where residents and local retail outlets and services would develop a keen understanding and awareness of the disease and offer support in a respectful and meaningful way. This built on the longstanding tradition within the City of caring for residents and delivering individualised packages of care and support. We already work in a quasi-integrated process by participating in multi-disciplinary meetings for those clients with Dementia.

In creating a 'Dementia-Friendly City' the Dementia Adviser gives training to businesses and to the community so that they can recognize the symptoms and be able to support this vulnerable cohort and develop a keen understanding and awareness of the disease to offer support in a respectful and meaningful way. In addition to working across the Corporation with colleagues in Housing, Museums, Libraries and Art Galleries, we have been able to engage with retail outlets, the Police and our providers.

Skills for Care has worked in partnership with the City using this model and other good practice in order to develop a safe environment for those with dementia. This included a review of signage within the City to help those with Dementia to navigate easily to and from their homes.

A 'Memory Café' is being delivered in the City provided by Age UK Camden and is growing in success.

The strategy was agreed at the Health and Wellbeing Board on 5 September 2013, with the addition of a commitment to improving signage within the City, starting with the estates managed by the Corporation. The Housing Strategy which is due to go to Committee in April 2014 reinforces the fact that within the City we can work across disciplines to achieve the same aim.

Homerton Psychological Medicine (HPM) service

The Homerton Psychological Medicine service at HUHFT is a multi-disciplinary psychiatric liaison service provided by ELFT (East London Foundation Trust), but contracted through HUHFT. Its core model is derived from evidence accrued through a 2010/11 pilot project for liaison services in Birmingham where it was known as RAID (Rapid Assessment Interface and Discharge). The key objective of this service is to improve the quality of care for patients who are admitted to hospital, who also have a mental health diagnosis, through ensuring that they receive appropriate treatment for their mental health as well as their physical health condition. This new integrated approach should also lead to improved patient experience and cost-effectiveness of hospital resources. The Birmingham model highlighted that the likelihood of readmission was 70% lower for those patients treated by the core RAID team and the average length of stay was 0.9 days shorter. The Birmingham RAID cost analysis showed the RAID model delivered 160 avoided admissions in a full year and each of these resulted in a cost savings of £2,250. The total savings from this source was estimated at £360k per year. The NHS City & Hackney model expects to deliver a similar amount of savings in the performance outcomes and improve on the service efficiency across a range of services.

All people from the City who require Mental Health input under 65 would be referred to ELFT and HPM including RAID if required.

The City of London have 2 designated consultants psychiatrists who work closely with City patients and are located in south Locality. City patients are admitted to a designated ward which is managed by these consultants.

A social worker in the City Adult Social Care team co-ordinates discharge and care.

Enhanced Primary Care Services for mental health

The CCG will continue to work with its health and social care partners to develop its primary care mental health service and an improved primary/secondary care interface. The approach is intended to improve mental and physical health and social outcomes for people with mental health problems by developing a primary care mental health service with an emphasis on healthy lifestyles and social inclusion. This approach will support better integrated working across primary and secondary care and aspires to deliver true parity of esteem for mental health patients.

Acute Services

Services under this heading are included on the Finance Template under the heading of Managing Emergency Activity and Admissions avoidance service. We have identified that based on projected performance we would be able to save £62,520 in the first year across the NHS and Social Care and £88,850 thereafter.

Managing Emergency Activity

The City and Hackney CCG are commissioning an Urgent Telephone Advice Service from an A&E consultant at Homerton and a Rapid Access Community Geriatric Clinic – both of which are available to support GPs with advice to manage patients in the community including to the Neaman Practice in the City. The Care of the Elderly Consultant is also commissioned to undertake domiciliary visits with GPs and community matrons as well as providing clinical education and leadership across the clinical community.

The CCG also commissions an Observational Medical Unit at Homerton A&E – this is a consultant led service which manages patients in line with agreed integrated pathways

across primary and secondary care and seeks to discharge patients to the community rather than admit them to hospital, even for short stays. We are working with the unit to explore whether some pathways could be delivered entirely in the community without A&E attendance. In addition, the CCG commissions a consultant geriatrician in A&E to ensure that elderly patients receive the appropriate prompt specialist geriatric input in the event of an acute admission. Improvements in this aspect of acute geriatric care are being monitored through the City and Hackney urgent care board, which monitors the proportion of elderly (over 75) patients who are assessed in the OMU by a Consultant Geriatrician and the proportion of elderly (over 75) patients who are assessed by a consultant geriatrician within twelve hours of decision to admit. There is an incentive payment in place for Homerton hospital to meet these standards, set up through the commissioning for quality and innovation payment system.

We are aware that similar services are in place in Tower Hamlets and will be exploring how our residents could access these services if they are registered with Tower Hamlets' GPs.

Admission Avoidance Service ("One City Team" model for City of London)

The creation of a Single Point of Access through the Joint Care Co-ordinator posts will play a pivotal role in identifying pathways to ensure that patients are treated in the most appropriate location thereby avoiding unnecessary acute hospital admission. In doing so the Single Point of Access acts as an interface between health and social care providers. As well as realising savings through the delivery of an admissions avoidance service, we have a duty to make sure that wherever possible, patients are treated within their own homes or as near to them as practicable

The City of London or "One City Team" will be a rapid response integrated multi-disciplinary team that provides rapid assessment and clinical support to prevent admission to hospital for up to 72 hours. Patients accepted by the One City Team would be experiencing an acute episode and deterioration in their physical well-being which, without the input of the service, would result in an acute hospital admission.

The pilot team will include a Nurse, Physiotherapist, Occupational Therapist, Social Worker and 2 Reablement officers (we are looking to commission 2 of our Domiciliary Care agencies to be part of our One City 72 hour rapid response service). The service is designed to be for people aged eighteen and over who are resident in the City of London and will offer:

- 24hr support at home for up to 72 hours over acute period
- A full assessment of health and social care needs
- Once the referral has been accepted, patients would be visited within 1-3 hours depending on their clinical need.
- Following clinical and risk assessment, a support plan of care would be agreed with the patient and their carers where appropriate to enable the patient to remain at home.
- Based on the clinical needs of the patient, the team may visit up to four times a day to implement the care plans and facilitate patient safety.
- On discharge from the service team would ensure a safe handover to appropriate services for ongoing support via provision of on individual budget together with care and liaison with the patients GP.

This service will link in closely with the PARADOC service that is being commissioned by

City & Hackney CCG as identified within their 5 year Strategic Plan.

This links with The City and Hackney CCG's 5 year Strategic Plan which identifies investment in four practices across City and Hackney to open at the weekends and later in the evening to improve GP access for our patients.

- We are commissioning Homerton to help people who are using A&E and don't have a GP to register with a local GP and plan to extend this service to Hackney Service Centre so that more local people can register with our GPs;
- We have commissioned our GP out of hours provider to have community nurses working alongside them to provide more holistic care for our patients overnight and at weekends;
- We will be working with our Urgent Care Programme Board to think about how we could redesign the current PUCC service at Homerton to better meet the urgent care needs of our patients;
- We will be launching a big local campaign on how to access urgent care services, encouraging people to see their GP as their first port of call in and out of hours, and how to register with a GP.

Source: 5 year Strategic Plan: City & Hackney Clinical Commissioning Group 2014

d) Implications for the acute sector
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

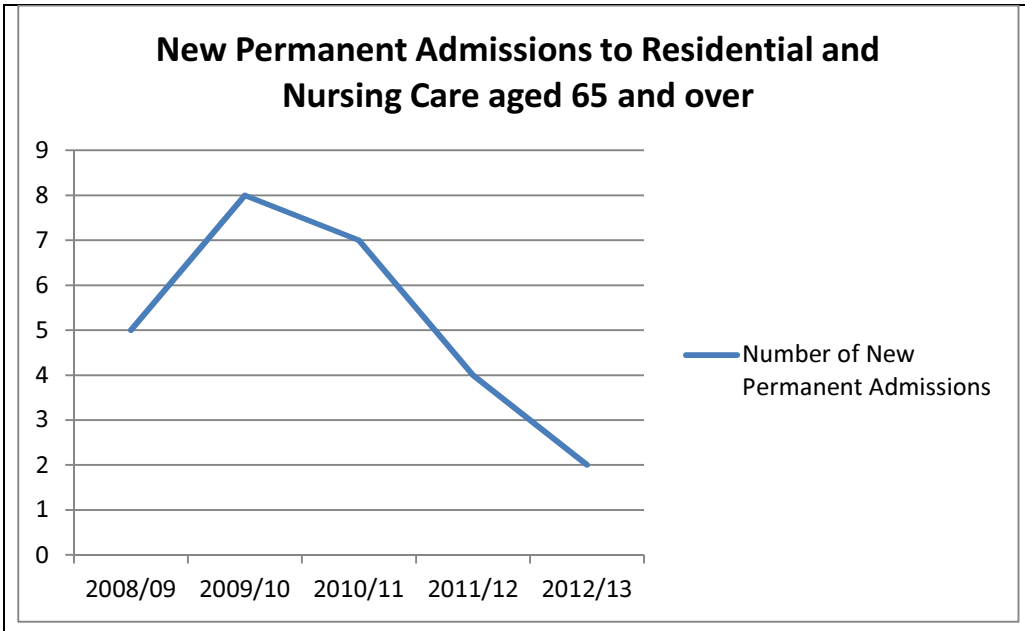
Permanent Admissions to residential and nursing care

In relation to admissions to residential and nursing care, we have already significantly decreased the number of people being admitted, increasing the domiciliary offer and helping people to maintain their independence longer. In the last year we had 4 admissions to residential care. Maintaining our trajectory of reductions, we anticipate a further 25% reduction down to 3. This has the effect of **£15k p/a** savings. (Note: these figures are not published within the ASCOF data so that individuals are not identifiable however within ASC we know the number of clients that have been admitted to residential and nursing care).

Had we not had the strategy to increase the number of people supported to live independently as long as they preferred to do so, we would have been accommodating between 7 and 10 people per year so this is an additional saving of 6 residential placements which would have cost **£219, 960** per year (based on an average cost of £705 p/w for residential / nursing care). As this was our intention long before the implementation of the Better Care Fund, we will continue to maintain a maximum of 3 permanent admissions per year (unless there are exceptions).

We have already implemented an approach within Adult Social Care that promotes the independence of our residents and through our support they are able to remain in their homes for longer and proportionally more of our residents than anywhere else in England are able to keep their wish of dying at home

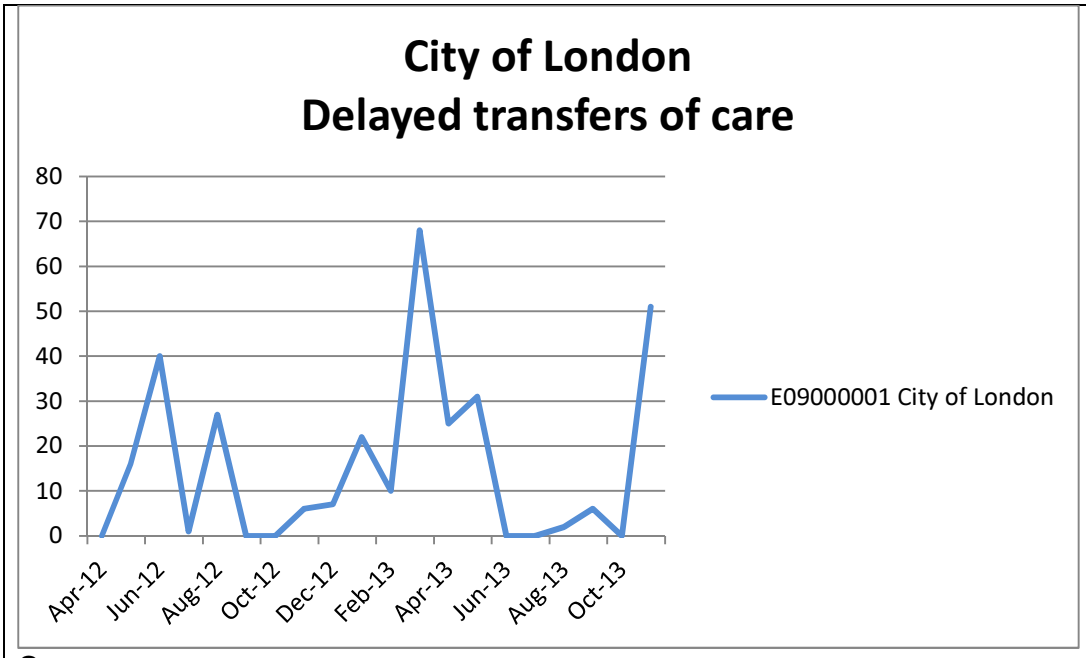
Our plans will enable more people to be able to access services locally by preference, to remain in their homes longer and prevent admissions to residential and nursing care by having locally delivered bespoke services that meet their needs. Savings will be reinvested into extending domiciliary care provision and preventative services thereby protecting adult social care which will be delivering and commissioning these services.



Reablement
In 2012/13 19 out of 22 residents were still at home after discharge from hospital into reablement / rehabilitation services giving us a metric value of 86.4%. One of the 3 residents died (and had returned home to fulfil their wish of dying at home), one was readmitted after having suffered a stroke and the third was readmitted following a fall. We have reviewed our service provision in relation to falls in order to mitigate against preventable readmissions and that is why we are confident in improving our performance to 90 – 100%. Our Reablement Service was inspected by the CQC in 2013 and received very positive feedback and with additional improvements in relation to aids and adaptations and the Joint Care Navigator, we anticipate being able to keep all of our residents at home, where readmission is preventable.

We have identified that we are technically able to achieve 100% against this target, but that due to our small numbers, one person can become an exception.

Delayed transfers of care
By managing the care of our residents at a 'micro'-level we will be able to minimise the frequency with which those with long-term conditions find themselves admitted to hospital and where they are admitted, reduce the length of stay by being prepared for discharge in advance of the admission itself. This will reduce pressure on the hospitals our residents use. In reducing delayed transfers of care from 19 days per month to 10 this would have the impact of **£11k** savings based on £250 per bed day. Estimates of savings are conservatively based solely on bed cost rather than therapy costs etc.

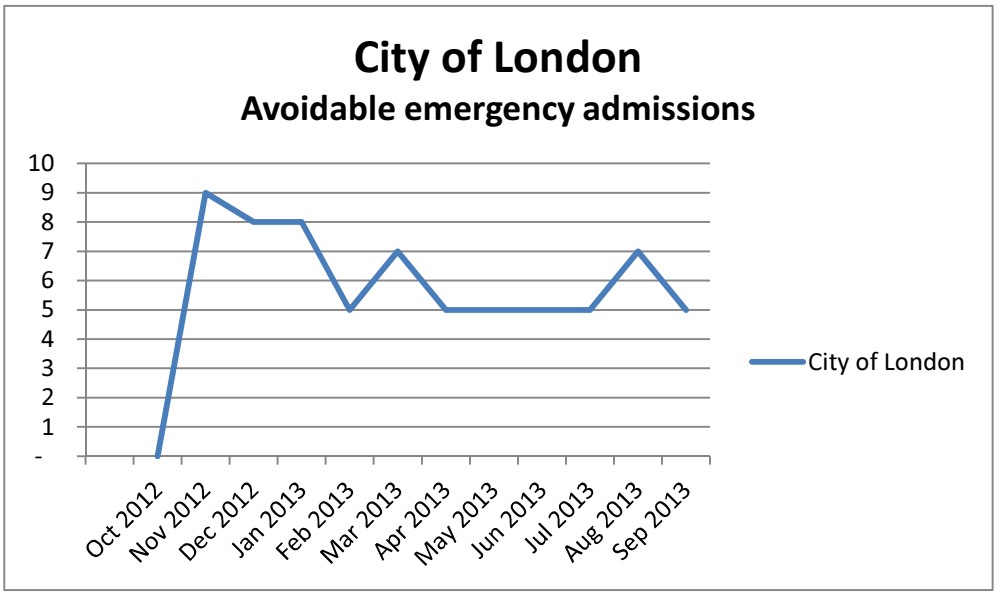


Source: Better Care Fund historic, baseline and denominator data, NHS England 2014

The Joint Care Navigator posts were agreed by colleagues in our provider hospitals in Hackney, Tower Hamlets and Islington and will improve the co-ordination and integration between health and social care, minimising the effect of bureaucracy on the discharge process and supporting the patient to successful rehabilitation at home.

Avoidable emergency admissions

Our admissions avoidance service will be the key service by which we will reduce the number of non-elective emergency admissions, furthermore we anticipate that alcohol related emergency admissions will be reduced through the preventative strategies we have put in place to support City workers. Through the development of the care navigator posts and the admissions avoidance service, we anticipate a 20% reduction in acute admissions from 39 per annum to 30. This would generate £62,520 savings in the first year followed by £80,850 recurrent savings.



Source: Better Care Fund historic, baseline and denominator data, NHS England 2014

e) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Health and Wellbeing Board will hold partners and the Adult Wellbeing Partnership to account for their part in the delivery of the plan.

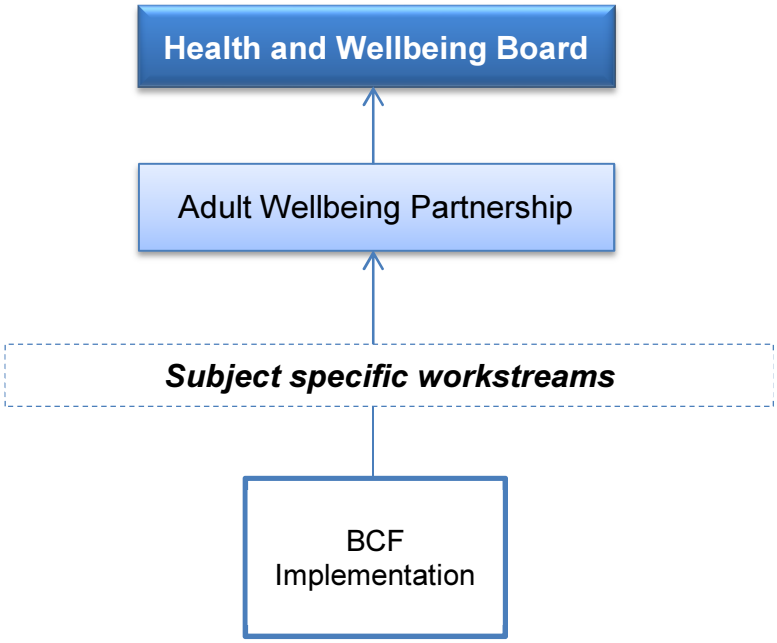
Healthwatch have assisted us in the coproduction of our plans and we ask them to consult with our residents on the impact of the changes and communicate this back to the Adult Wellbeing Partnership and the Health and Wellbeing Board.

The Adult Wellbeing Partnership monitors various aspects of the operational delivery of key strategies relating to Adult Wellbeing in the City as subject specific workstreams. The BCF plan is already being monitored through the Adult Wellbeing Partnership and progress on it is being reported through the BCF Implementation workstream.

The objectives of this group include:

- To provide strategic management oversight of the Adult Wellbeing Partnership,
- To monitor the various workstreams and performance of those workstreams through the delivery of the workplan and regular highlight reporting,
- To support the development and implementation of the action plans within the workstreams at an operational level,
- To ensure that the City of London works with partner agencies in the development of plans to integrate health and social care across the City,
- To advise the Health and Wellbeing Board on the progress of the various workstreams,
- To have oversight of key issues including resources, IT and partnership working.

In relation to pooled budget arrangements, the City will be holding the pooled budget. Further work has started in relation to defining the governance arrangements of the pooled budget which will also report through the Adult Wellbeing Partnership.



The above structure shows the reporting line between the subject specific workstream, the Adult Wellbeing Partnership and the Health and Wellbeing Board. Other subject specific workstreams include Dementia Strategy Implementation and Carer's Strategy. Our Service User Engagement Group comprises members of the Adult Advisory Group and is supported by Healthwatch. This group has been key in consulting on the BCF Plan.

The City's Health and Wellbeing Board draws its membership from the following partners:

- Elected members of the City of London Corporation*
- Officers of the City of London Corporation, including the Director of Community and Children's Services* and the Director of Environmental Health and Public Protection
- The Director of Public Health for City and Hackney*
- City and Hackney Clinical Commissioning Group*
- HealthWatch; contract awarded to Age UK*
- The City of London Police

The Health and Wellbeing Board became fully operational in April 2013, and the partners marked with an asterisk are the statutory members.

Assurance process for risk and performance

The sign-off process for this plan includes regular meetings and discussions with partners to finalise agreed processes, presentation to the City and Hackney CCG Board on the 28th March and final sign off by the Health and Wellbeing Board on the 1st April 2014.

The CCG will report performance to the Joint Commissioning Board in relation to contracts specific to the City in line with their Commissioning Strategy approach of measuring performance:

- User, clinical and process outcomes for each service, contributing to and delivering system outcomes;
- KPIs across aligned contracts and tracking system -wide changes in activity and spend;
- Financial balance maintained and all providers remain viable and without significant performance concerns.

These performance reports will be further discussed at the Adult Wellbeing Partnership which has a shared approach to performance and risk management.

Risks agreed in section 3 below will be discussed at the Adult Wellbeing Partnership meetings and form the partnership risk register which will be kept under review. Regular quarterly performance and risk monitoring reports will be considered by the Adult Wellbeing Partnership in order to manage and mitigate the operational risks prior to strategic risks being reported to the Health and Wellbeing Board.

Pooled budget governance

The BCF will be the first pooled budget arrangement between the CCG and the City. As such, governance arrangements will be agreed during the course of 2014 to be signed off at the Health and Wellbeing Board by September 2014. This allows for negotiation in

relation to performance management and monitoring. It is already agreed however that whoever holds the pool will report to a Joint Commissioning Board who are responsible for the contractual arrangements and performance reporting on these contracts to the Adult Wellbeing Partnership.

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Whilst the City of London agrees to maintain eligibility at Critical and Substantial, we will be evaluating this position with the development of new eligibility criteria in the Care Bill.

We will protect social care services by offering the right level of support according to a person's assessed needs. This will be supported by the development of the integrated Care plans led by the GPs and the multi-disciplinary teams which will include Adult Social Care.

The City already has a strong record of delivering individualised support and supporting people to exercise their choice to remain at home and retain their independence, empowering them to do as much as possible for themselves while they are able.

Enhancing health services to include admissions avoidance and enhanced preventative support will mean that there is potentially an increased number of service users for whom the City will be delivering care and support. Integrating with Health will assist us to deliver a range of options to those requiring support, including more personalised budgets including a health focus.

Please explain how local social care services will be protected within your plans

The City is fully committed to protecting its social care services and although it may appear vulnerable due to its size, the CCG is fully supportive of the BCF Plan and have been actively engaged in the development of it. Our colleagues in the CCGs in Tower Hamlets and Islington have committed to engage with the delivery of the plan and with joint working across areas in order to support our residents who are registered in their areas and for their residents registered in our area.

In the fact that the City has its own BCF plan and a distinct pooled budget, we will ensure that the fund is demonstrably spent for the benefit of our residents. This in itself will protect social care services in that we will be able to identify further preventative work that comes under the auspices of social care or of Housing working jointly with our social care staff.

By enhancing the preventative services we offer, we will be aligning our position with the Care Bill well in advance of it being enacted and therefore increasing the opportunity of making a difference to service users in a timely way. This takes on importance particularly for those residents who might benefit from schemes such as Telecare. As the major provider of accommodation within the City, our Housing services can enhance our use of aids and adaptations of the clients who are most in need, but also installing Telecare for those who might otherwise require a GP visit or even who might be admitted.

During 2014/15 we will be reviewing and monitoring usage of services and monitoring the budget closely so that we can realign and deliver further cost savings as many of our residents do not use particular services, or if they do use them, this will be in minute volume. This will enable us through our Joint Commissioning Group to align funding to

needs and to respond proactively to those needs.

Clear care pathways are being established which identify who the lead providers are for key interventions. Our eligibility criteria of substantial and critical need remains and all who meet the FACS criteria will continue to receive good care management and regular review of needs. This duty of care will continue to be met with the funding allocation of 2014/15 and thereafter.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

The Reablement and Occupational Therapy service sits within Adult Social Care and focuses primarily on offering a service to people who are coming home following a serious illness or injury, and need rehabilitation and confidence building to regain their skills and independence back in their own homes. The team offers daily support for up to 6 weeks. The service has recently been inspected by the Care Quality Commission, and was found to have met all key outcomes for a safe, efficient and professional skilled service.

Adult Social Care runs a responsive daily duty service from 9-5 which is linked to the Reablement service. The City's ability to offer support for people being discharged from hospital is exemplary, with no charges from hospital trusts for any delayed discharges. Adult Social Care have sought to develop sound links with key hospitals including the Royal London and University College Hospital, to ensure good communication leads to safe discharge back home for City residents.

There are very few admissions from the City to the acute sector, even fewer at a weekend. We will be working with Paradoc out of hours (a scheme whereby a GP will attend emergency calls with a paramedic to meet needs of people who might otherwise have been directed to A&E) as part of an admissions avoidance service, emulating a model being developed in Islington. Having our Joint Care Navigator posts will assist us in identifying patients from the City who would potentially be discharged on a weekend to ensure that services were in place to support them leaving hospital. We have a long-standing commissioned arrangement with Hackney Borough Council to provide our out of hours social care service.

Agreement for these posts came through the City of London, the Royal London and UCLH and their CCGs, the City and Hackney CCG and the City of London Health and Wellbeing Board, and a copy of the bid is attached as one of the supporting documents to this plan.

Due to a very low volume of cases going into hospital, there are inevitably very few discharges that could not be managed within Monday to Friday working. However, where we are aware of service users who may be discharged over a weekend, the Joint Care Navigators will work flexibly to support these discharge arrangements and this form part of their contracts.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Currently we do not use the NHS as a primary identifier; however we are currently implementing a new social care IT system which has the capability to use the NHS number; we have therefore begun a process to commence implementing this.

We have commissioned a project to undertake a review of integrated care with the City and also of our IT systems and data sharing. We will use their recommendations to both refine our overall integrated care pathways and also our use of IT systems. Through this project work we will work closely with partner organisations to develop appropriate agreements and use of Open APIs to secure interoperability standards.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Adult Social Care is committed to using the NHS number as a primary identifier. We have undertaken to include the NHS identifier on all social care records to enable us to communicate using this number. This exercise will be completed by July 2014. Communication between health and the local authority using this number will commence by September 2014.

The CCG has commissioned and is sponsoring a project to conduct a detailed review of our IT systems and integrated care processes and procedures which will help us to establish how this may be most effectively achieved.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Through the IT project commissioned and sponsored by the CCG we are committed to working with partner organisations and the use of Open APIs to secure interoperability standards. This work is currently in progress.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We are committed to ensuring the appropriate IG Controls are in place. The Information project will explore and scrutinise information governance more widely. The findings and recommendations will serve as our baseline of best practice to influence cybersecurity, system access, data sharing and related controls. In addition we will use this information to establish future best practice procedures.

This project is sponsored by the CCG Health and will review systems in both health and Social Care, including information sharing arrangements and will recommend the next steps in securely managing shared data. It will review the whole area of information governance and will be used to establish the correct controls and appropriate procedures.

The outcomes of this joint review of information sharing arrangements will be presented

to partners and will conclude in June 2014 with an agreement to the 'One City' information model. Our Caldicott 2 compliant Information Sharing agreement will be signed off by October 2014.

We are committed to ensuring that appropriate IG Controls are in place for the governance and exchange of health related data.

We are committed to ensuring that all information is protected in accordance with its level of confidentiality and sensitivity, and associated risks. Areas of focus include:

a) Confidentiality: assuring that sensitive data is read only by authorised individuals, and is not disclosed to unauthorised individuals or the public.
b) Integrity: safeguarding the accuracy and completeness of information and software, and protecting it from improper modification.
c) Availability: ensuring that information, systems, networks and applications are available when required to departments, groups or users that have a valid reason and authority to access them.

We have commissioned an assessment of the current state of readiness across partners with regard to information sharing and integrated care. The assessment will clarify information governance issues relating to integrated care and risk stratification and inform our development path for 14/15.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

We currently work very closely with the GP practice in the City to ensure that health needs are included in the Social Care Plan, based on the Adult Social Care Assessment. The CCG are working with GPs (including the one practice in the City) using a risk stratification tool to develop care plans for the most vulnerable frail elderly and to develop multi-disciplinary teams. The GP would be the accountable professional for the care plan. Our Joint Care Navigators will be attending the MDT meetings in both Tower Hamlets and Islington surgeries in order to co-ordinate the interface between health and social care and to assist those residents through the system if they are admitted to the acute sector.

A risk stratification tool will be adopted within each general practice with a focus on frail and vulnerable elderly patients and service users within the borough.

Our Practice- based Coordinated Care project described in 2c will have GPs taking the lead in coordinating care as the agreed accountable lead professionals for people who are assessed as high risk of hospital admission. The project will adopt the criteria put forward by the City and Hackney CCG Local Enhanced Service for vulnerable and frail patients which is as follows:-

- Well known to GPs as vulnerable
- A recent fall or 2+ falls in 2 months
- Medically unstable

- Socially isolated
- A high intensity social services package or under RICS
- Death of spouse or close family member within last 6 months
- On 4 or more medicines which have been prescribed for 6 months or more
- Repeatedly fail to attend medication reviews when invited
- Are over 75 and have not visited the surgery in 3 years
- Who are on other disease registers and do not attend checks when invited
- Someone over 65 whose prescribing costs are >£100 per month
- Over 65 who has had more than 2 OPD visits in the last 12 months
- Patients where the hospital has telephoned practices to discuss

Those who meet the criteria will be included in the project and the results of the proactive intervention will be closely monitored over the life of the project to assess the impact. We estimate that there will be 1771 such patients in City and Hackney and GPs will be contracted to lead the care planning and multi-disciplinary case management processes for these patients. There are approximately 30-35 service users in the City who have been identified as potentially meeting the initial criteria for a joint care plan.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk associated with pooling budgets	Low	2014/15 will be used to prioritise the development of a robust section 75 agreement and governance structure to support the BCF in 2015/16. This area of work will be jointly pump primed to ensure that the section 75 has appropriate arrangements to manage financial and performance related risks. The CCG and Council will seek to align budgets and explore opportunities to increase the budgets that are pooled in the future. A full business case and joint risk assessment will be required to before recommendations to pool additional budgets into the BCF are agreed.
Benefits realisation	Medium	Due to our size and the very small numbers of people requiring acute health intervention, there are very few financial savings that could be realised from our plan. We are aware, however that there are improvement there can be made in the patient experience of services and in delivering the changes our residents wish to see. We will use data collection methods already in use through the Adult Service User Feedback Survey and the Carers Survey to demonstrate a change in service user experience of the care and support they have received. This is reflected in the locally defined indicator we have agreed with the CCGs.
BCF performance funding	High	BCF plans are “front loaded” to reduce the risk of performance related national conditions and performance indicators not being met. In addition, the BCF financial model will include some contingencies to manage the risk of performance related payments, and the rate at which benefits are realised for reinvestment into jointly agreed plans. We approached NHS England in January 2014 to highlight the issue that performance in the City is impacted on when 1 additional person requires residential care (as an example). Assurance was given by NHS

		England that: “Our general approach is that targets should be set locally, so we would hope that you, the CCG and your area team could agree an approach that works for your unique situation.” (NHS England email 21st Jan 2014) and “It is not NHS England’s intention to penalise small local authorities.” (NHS England email 28th January 2014) The CCG has agreed our metrics alongside the City and what the required improvements should be and how we will use the Joint Navigator posts to enhance the services we currently provide in order to stabilise our performance.
National Conditions and Performance Measures	**High**	The National Conditions and Performance measures will be kept under review by our Adult Wellbeing Partnership where partners will hold each other to account for the delivery of the outcomes identified in the plan. The Health and Wellbeing Board will hold the Adult Wellbeing Partnership to account for delivery of improvements identified in the plan. Baseline data identified by NHS England from GLA estimates of population are significantly out of alignment with our own estimates of the population of the City. This has a significant impact on the assurance process which uses the GLA baseline. We have agreed realistic and achievable targets alongside City and Hackney CCG, however this could impact on our performance related payment despite assurances from NHS England (see above)
CCG may prioritise the needs of Hackney residents over the needs of City residents	**Low**	A separate plan is being submitted for each local authority. The City will be holding the pooled budget which serves as further leverage with providers to ensure that services are delivered for the benefit of our residents and enables us to tailor bespoke services and packages of care.
Impact on providers	**Low**	There is a perceived risk that because we have spot purchasing arrangements with most of our providers, we would be unable to benefit from large scale commissioning arrangements, particularly with delivering services at short notice as providers may prioritise their bigger contracts.

		In order to mitigate this we are reviewing our contract arrangements with our providers to ensure that we are given the same priority as any other local authority and that there will be financial penalties in place for the providers who are unable to deliver.
Organisational capacity	Low	BCF is something that both the CCG and the City are firmly committed to in order to improve services for our residents. By working jointly together and creating the Joint Care Navigator posts, we will see administrative efficiencies that will result in a better experience of services for our residents who require acute health intervention. We are reviewing our contractual arrangements with our providers and are using the opportunities that the BCF gives us to develop our market position and enhance the services that we provide locally. Our Adult Wellbeing Partnership delivers a programme management function and provides a strategic overview to the operational delivery of the services which will allow senior management to respond promptly to any emerging needs across health and social care.
Statutory requirements	Low	The Care Bill will create additional burdens for Local Authorities from April 2015 onwards. To ensure that Adults Social Care is ready for legislative changes we anticipate additional resources being required during 2014/15 and 2015/16 to deliver the changes that the legislation will require. Within the City, we already have a system that enables us to manage deferred payments. We have pre-empted the Act in evaluating the impact of the cost-cap and have estimated the increase in numbers of people who are likely to be eligible for care and support in future. Both of these issues have been consulted on with our Adult Advisory Group and with Healthwatch. The services we provide in relation to advice and information on care issues are

		commissioned from Toynbee Hall and the contract expires next year. We are already considering what the tendering process should look like and this will include a bigger focus on the Care Bill and advice and support around this. Costs of implementation will need to be met from the BCF and other additional DH funding, for which we are awaiting full guidance. Central Government Guidance regarding funding for the on-going increase in the numbers of eligible customers anticipated to receive social care support as a result of the Bill has yet to be announced. We will ensure that, in line with the guidance, the BCF plans for the City reflect the requirement to support the implementation of Social Care Reform, and that sufficient funding is allocated from the BCF and transferred to the Local Authority. This is currently a risk, as no additional funding is allocated to the BCF over and above the additional NHS transfer and the Care Bill has not yet been enacted, which means that there are potentially additional risks in relation to
Complex care pathways	**Medium**	As a large proportion of our residents are registered with GPs outside of the City and we interact with three CCGs, the care pathways for our residents are often complex. We have commissioned Tricordant to review the care pathways and recommend alternatives that will provide clarity for our service users. The Joint Care Navigators will assist patients with navigating their way through the pathways, ensuring that routes through care are co-ordinated and that delays are minimised.
Lack of support from Central Government for a separate BCF	**High**	Our residents and service users matter to the City. Their small volume makes them particularly vulnerable when decisions are made on a national basis. Rather than decisions relating to them being taken by an entity which is remote and does not appreciate the impact of its decisions, which creates a disadvantage for them, we opt to develop our own bespoke City BCF Plan.

		Baseline data identified by NHS England from GLA estimates of population are significantly out of alignment with our own estimates of the population of the City. This has a significant impact on the assurance process which uses the GLA baseline. We have agreed realistic, achievable and deliverable targets alongside City and Hackney CCG. In preparing a City-specific BCF plan that will be agreed by our Health and Wellbeing Board and our partner CCGs, we will ensure that we follow the national models but apply them in a way that protects our residents and delivers a positive change in experience of health and social care services.
Structural disadvantage makes it challenging to assess the impact of individual interventions on the overall metrics when delivered as an overall package – impacts on our ability to make investment / disinvestment decisions	**High**	This relates predominantly to our size, but also to the fact that our service users interact with 3 different CCGs. NHS England has been unable to deliver meaningful data to assist in the preparation of this plan. Poor evidence base for the scale of savings anticipated nationally to be achieved by reducing emergency activity under BCF – particularly applying to such a small resident population as the City. However, the City and its partners are clear that we can mitigate this risk by enhancing our data analysis capacity locally to ensure that meaningful data can be extracted across the 3 CCGs and the City's Social Care data through its database, Frameworki. All 3 CCGs are committed to meet together regularly to review the care pathways and to ensure that data is shared regularly for performance reporting to the Adult Wellbeing Partnership and Health and Wellbeing Board. This performance data will be scrutinised locally within management team meetings, the Adult Wellbeing Partnership and the Health and Wellbeing Board will hold the Adult Wellbeing Partnership to account for the delivery of relevant data.

Negative impact on the level and quality of mental health services	Low	Current structures will remain for service users with mental health issues and will be reinforced by the addition of integrated systems and early identification of service users with issues. ELFT will remain as the key provider and service users will be able to access RAID and AMHP social workers. Joint care navigators will work closely with both health and social care teams to provide a clear liaison between the two. Early identification of patients with dementia will be assisted through the multi-disciplinary integrated care plans. The quality of these services will be monitored through the Adult social care survey and through the regular feedback undertaken with service users and residents.
Information governance	Low	There is a strong commitment across the partnership to deliver the project within timescales and to include the NHS identifier for all social care records. A project will be undertaken in 2014 for completion by July 2014 for including the NHS identifier. Any delays in this project will not adversely impact the commitment to using the NHS identifier by April 2015 and the absolute latest for including the identifiers will be by October 2014.

This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

The three tabs containing tables have been protected so that the structure can not be modified in a way that will impede the collation of all HWB plans. However, for the finance tables whole rows can still be inserted by right clicking on the row number to the left of the sheet and clicking 'insert'.

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