Public Document Pack

Health and Wellbeing Board

Date: **FRIDAY, 30 MAY 2014**

Time: **11.00am**

Venue: **COMMITTEE ROOMS**

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

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

Lunch will be served in the Guildhall Club at the rising of the Committee.

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. **COURT ORDER**
To receive the order of the Court of Common Council from 1st May 2014

For information
(Pages 1 - 2)

4. **ELECTION OF CHAIRMAN**
To elect a Chairman in accordance in Standing Order 29.

For Decision

5. **ELECTION OF DEPUTY CHAIRMAN**
To elect a Deputy Chairman in accordance in Standing Order 30.

For Decision

6. **MINUTES**
To agree the minutes of the previous Board meeting.

For Decision
(Pages 3 - 10)

7. **BUSINESS HEALTHY - CITY WORKER INITIATIVE**
Report of the Health and Wellbeing Policy Development Manager

For Decision
(Pages 11 - 26)

8. **SERVICE REVIEW OF DRUG AND ALCOHOL SERVICES, UPDATE REPORT**
Report of the Director of Community and Children's Services.

For Information
(Pages 27 - 36)

9. **EXERCISE ON REFERRAL PROGRAMME**
Report of the Director of Community and Children's Services

For Information
(Pages 37 - 64)

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

For Information
(Pages 65 - 68)

11. **HOMELESSNESS STRATEGY 2014-2019**
Report of the Director of Community and Children's Services

For Information
(Pages 69 - 116)

12. **JOINT HEALTH AND WELLBEING STRATEGY UPDATE**
Report of the Health and Wellbeing Policy Development Manager

For Decision
(Pages 117 - 148)

13. **JSNA CITY SUPPLEMENT PUBLIC CONSULTATION**
Report of the Director of Community and Children's Services.

For Decision
(Pages 149 - 276)

14. **INTEGRATED CARE REVIEW AND DEVELOPMENT OF ONE CITY MODEL**
Report of the Assistant Director People, Department of Community and Children's Services

For Decision
(Pages 277 - 316)

15. **INTRODUCTION OF THE LATE NIGHT LEVY IN THE CITY OF LONDON**
Report of the Director of Markets and Consumer Protection

For Information
(Pages 317 - 404)

16. **SMOKEFREE CHILDREN'S PLAYGROUND**
Report of the Director of Community and Children's Services/Director of Open Spaces

For Information
(Pages 405 - 416)

17. **INFORMATION REPORT**
Report of the Executive Support Officer

For Information
(Pages 417 - 430)

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

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

20. **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.

Part 2 - Non Public Reports

21. **HEALTH AND WELLBEING BOARD PERFORMANCE REPORT**
Report of the Commissioning and Performance Manager (Public Health)

For Decision
(Pages 431 - 442)

22. **JOINT COMMISSIONING - ADULT SOCIAL CARE AND PUBLIC HEALTH**
Report of the Director of Community and Children's Services

For Decision
(Pages 443 - 448)

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

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

WOOLF, Mayor	**RESOLVED:** That the Court of Common Council holden in the Guildhall of the City of London on Thursday 1st May 2014, doth hereby appoint the following Committee until the first meeting of the Court in April, 2015.

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 the Members referred to in paragraph 1.

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 named individual who will substitute for them and have the authority to make decisions in the event that they are unable to attend a meeting.

Bradell

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HEALTH AND WELLBEING BOARD

Tuesday, 1 April 2014

Minutes of the meeting of the Health and Wellbeing Board held at on Tuesday, 1 April 2014 at 1.45pm

Present

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
Gareth Moore
Deputy John Tomlinson

In Attendance
Deputy Michael Welbank

Officers:

Natasha Dogra	-	Town Clerk's Office
Alex Orme	-	Town Clerk's Office
Chris Pelham	-	Community and Children's Department
Farrah Hart	-	Community and Children's Department
Simon Cribbens	-	Community and Children's Department
Maria Cheung	-	Community and Children's Department
Derek Read	-	Department of the Built Environment
Greg Williams	-	Public Relations Office
Paul Haigh	-	City & Hackney CCG
Anna Garner	-	City & Hackney CCG

1. **APOLOGIES OF ABSENCE**
   Apologies were received from Angela Starling and Vivienne Littlechild.

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: In response to a query regarding the Health and Wellbeing Board Communications Strategy, Officers said they had met with colleagues across the organisation to promote awareness of the Board's achievements to date and future work to be undertaken. Members agreed that this work would help to ensure that Officers naturally began to think about health and wellbeing in all aspects of their work. Discussions ensued with regards to promoting awareness of the Board, and Members agreed that a report to the May Court of Common Council which set out what the Board had achieved in its first year would usefully ensure a clearer understanding of the Health and Wellbeing Board.

Resolved: Members agreed to delegate authority to the Town Clerk, in consultation with the Chairman and Deputy Chairman, to submit a Health and Wellbeing Board information report to the Court of Common Council.

4. **SIGNAGE REVIEW**

The Board received a presentation from Iain Simmons, Assistant Director or Local Transport, informing Members of the following:

- A lot of work was being done to promote the physical environment in the City and get the public walking.
- A positive way finding system would encourage people to walk instead of driving or taking public transport and would promote the health and wellbeing of residents, city workers and visitors to the City.
- The City's current way finding system consisted of 12 street maps, 200 finger posts and 14 interactive signs.
- The Legible London scheme had been adopted pan London but had not yet been introduced in the City. The scheme was a £60million investment driven by TfL and the key components were printed walking maps, tube station maps, journey planners, bus stop maps, cycle hire spot maps and interactive maps.
- A scheme involving 15 signs would take 6-8 months to complete and would cost approximately £125 – 250k.
- A report would be submitted to the Planning and Transportation Committee in May regarding signage in the City and initiating ways to improve the current signage.

Members agreed that signage in the City needed to be updated as it would encourage more walking and therefore promote the health and wellbeing of people in the Square Mile. Signs with orange tops may be useful as they would attract the attention of those who were navigating their way around the City. Members agreed that they would support any proposals to the Planning and Transportation Committee regarding such improvements.

In response to a query from Members, Officers said the signs around the Golden Lane Estate and the Barbican Estate were in need of updating. Improved signage around the Barbican Estate would have many advantages for those navigating their way around the estate. However, relevant bodies would need to be consulted before any new signage could be implemented. Members agreed that any news signs must accommodate people with physical disabilities and visual impairments.

In response to a query regarding the 'yellow line' on the pathways of the Barbican Estate, Officers agreed to investigate this and report back to Members of the Board.

5. **TERMS OF REFERENCE**

The Board received the report of the Town Clerk which informed Members that at the Board meeting on 6 November 2013, Members approved their current terms of reference. The revised 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 named individual who will substitute for them and have the authority to make decisions in the event that they are unable to attend a meeting.

Resolved: That Members approved the revised terms of reference of the Board

6. **HEALTHWATCH CITY OF LONDON UPDATE**

The Board received the report of the Chair of Healthwatch which informed of the Healthwatch City of London priorities for 2014/15 and points raised at the evidence session with the London Assembly Health Committee. The four priorities agreed for consultation were:

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

Members agreed that the regular bulletin updates from Healthwatch were very useful and encouraged all Members to sign up to receive this update.

7. **CCG 5 YEAR STRATEGIC PLAN**

The Board received the report of the NHS City and Hackney Clinical Commissioning Group which informed Members of their first draft 5 year strategic plan to NHS England. The plan would be iterated and consulted on through March and April 2014, with final submission in June 2014.

Officers informed Members that the current draft of the plan outlined the vision, clinical objectives and interventions and how the CCG would manage and monitor progress. Members noted the 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 the CCG would respond to these needs.

8. **CCG INVESTMENT PLAN**

The Board received the report of the NHS City and Hackney Clinical Commissioning Group which informed Members of a range of new services and initiatives the CCG were commissioning to improve care for our patients, using CCG investment of nearly £18m to tackle important local issues identified by their patients and clinicians.

Members noted that 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 were 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. The Members 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

In response to a query from Members, Officers said they used the word ‘patient’ instead of ‘people’ because from the CCG’s perspective the people they delivered services for were patients. However, from the Health and Wellbeing Board’s perspective they would be called people.

9. **JSNA UPDATE REPORT**

The Board received the report of the Policy Development Manager which informed Members that 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 had been produced in parallel and contained a number of new findings relating to City and Hackney residents; and other City populations. As the Health and Wellbeing Profile was a data refresh document, it did not require consultation; however, the JSNA City supplement was a new document and should undergo a period of public consultation.

Officers informed Members that the key trends arising from shared City and Hackney data were:

• 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 remained high compared to England.
• There were reports of increases in child dental decay and local research highlights high rates of decay and poor mouth hygiene in adults.
• There had 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.

Rough Sleepers
• The City had 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 were British nationals and the remaining come from Eastern Europe.
• Over half of the rough sleepers had 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.

Resolved: Members approved 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.

10. **INFORMATION REPORT**
The Board received the report of the Executive Support Officer which informed Members
of key updates to subjects of interest to the Board, such as:
• 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
• Health Services
• Disease Prevention
• Social Care and Health inequalities
• Substance Misuse
• Environmental Health
• Health and Wellbeing Board Guidance

11. **DEVELOPMENT DAY UPDATE**

The Board received the report of the Policy Development Manager which informed Members that the Development Day would take place on 2nd May 2014 at Walbrook Wharf. The Board would focus on 'changing behaviours' on this day.

12. **BETTER CARE FUND**

The Board received the report of the Assistant Director of People which informed Members that the Better Care Fund (BCF) final plan was 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.

Members noted that the City's BCF plan set out how it would 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 would support the delivery of the City's BCF plan would take
place in 2014/15 to enable full implementation in 2015/16.

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) was 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.

The City's BCF plan would 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.

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).

Members noted that there would be a number of implications arising from this fund and the proposals that would emerge. Principally, 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.

The intention from the Government was that CCGs and local authorities would create pooled budgets in order to facilitate integration. Given that the City's population is so small, having separate pooled budgets for each integration project would likely not be viable. However, there was the possibility of combining the whole fund into one pooled budget to have a City-specific pooled budget with the CCG. If there were any joint-funded posts as a result of the fund, this would also require HR advice on management arrangements.

Resolved: That Members:
• Approved the final BCF plan for submission to NHS England.
• Delegated 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.

13. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
In response to a query from Members, Officers agreed that statistics reported to the Board must be clearly explained. This was due to statistics about the City being misconstrued due to the geographical nature of the Square Mile.

14. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
As this may be his last meeting with the Board, the Chairman thanked Deputy John Tomlinson, Chairman of the Port Health and Environmental Services Committee, for his useful input to the work of the Board over the past year.

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. **NON PUBLIC MINUTES**
Resolved – That the minutes of the previous meeting be agreed as an accurate record.

17. **NON PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
There were none.

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 3.20pm

Chairman

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Committee(s):	Date(s):
Health and Wellbeing Board	30 May 2014
Subject: Business Healthy – City Worker Initiative	**Public**
Report of: Health and Wellbeing Policy Development Manager	**For Decision**

Summary

This paper provides a summary of progress on the Business Healthy initiative and sets out recommendations for its further development.

Business Healthy has sought to establish the extent to which City businesses would welcome support around workplace health and, if so, what form that support should take.

So far, the initiative has established a network, the Business Healthy Circle, as well as an online resource, the Business Healthy Lab.

Initial feedback from businesses has been extremely positive, and there are clear opportunities to carry this work forward.

Recommendation(s)

Members are asked to:

- note this report and its contents
- endorse the proposed approach to the work of the Business Healthy Circle and Business Healthy Lab

Main Report

Background

1. Poor health is estimated to cost the British economy over £100bn annually[1]. In London a business with 250 employees is estimated to make a loss of around £250,000 annually through sickness absence[2]. This makes employee health a significant strategic issue for the individuals themselves and for business.

2. The Health and Well-being Board (HWB) of the City of London Corporation (CoLC) has clear responsibilities under the 2012 Health and Social Care Act to promote the health and well-being of those who live or work in the City. It

[1] Dame Carol Black (2008) Review of the Health of Britain's working Age Population: Working for a Healthier Tomorrow. www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthoer-tomorrow.pdf
[2] GLA Economics (2012) London's Business Case for Employees Health and well-being. www.gov.uk/sites/default/files/health-wellbeing-2012.pdf

has, as an early priority in its work, decided to set up a strategic initiative designed to promote the health of City workers, and to achieve impact on their health, in a co-ordinated and coherent way.

3. This initiative, Business Healthy , has sought to establish the extent to which City businesses would welcome support in this area and, if so, what form that support should take. It is also intended to help the City of London promote itself as an excellent place to work and hence an ideal location for staff to develop, skills to grow and businesses to thrive.

Business Healthy Initiative

4. There are currently two elements to the Business Healthy initiative, the Business Healthy Circle and the Business Healthy Lab. Both were launched at a conference hosted by the Lord Mayor of London at the Mansion House on 11th March attended by leaders from small and large businesses based in the City of London.

5. *The Business Healthy Circle* brings together leaders from City businesses who want to co-create improvements in the health and well-being of the City workforce. The Circle is a virtual group designed to connect business leaders, human resources, health and safety, occupational health, communications and senior staff representatives to cut across normal professional boundaries and deliver solutions. It will
   - promote the business case for worker health and well-being
   - share best practice on what works between disciplines and companies from different sectors sponsor intelligence gathering, learning and sharing
   - turn the case into action
   - track progress and make it visible.
   - **http://www.businesshealthy.org/circle.html**

The Business Healthy Lab

6. The Lab is the engine room for the project, bringing together research, evidence, policies, practice and case studies to focus on what needs to be done and what can be done to improve the health, well-being and performance of people working in the City.
   - http://www.businesshealthy.org/lab.html

Current Position

7. In 2012, 400,000 people were employed in the City of London in over 14,000 businesses. 215 of these would be considered 'large' (employing more than 250 people) but most are much smaller. The UK leads the world in a number of financial services and many of these businesses are located in the City of London. In this respect, maintaining the health of its employees is of paramount importance to the national economy.

8. There is increasing interest in workplace health from leading companies who are finding that they can make a convincing business case for investing in health programmes. They understand that a successful company will tend to have a healthy, productive workforce, and that employers have a vested interest in reducing absenteeism and increasing productivity by improving the health of their employees. However, employers' commitment to health and wellbeing goes further than this, as they recognise that offering positive health programmes to their staff can improve staff recruitment and retention - as well as being a positive contribution to corporate social responsibility.

9. Generally health and wellbeing provision for City workers is good and in some cases excellent – particularly for those working in large companies. Many companies are already implementing interventions that can fast-track people back into work if they have a health problem. Businesses want to move their health and wellbeing strategies forward so that they help to prevent workers from going off sick, and most businesses acknowledge that there needs to be a better alignment between sickness absence rates and health and well-being interventions.

Building the Case

10. Research has shown that programmes would appear to be most effective when they combine aspects from different health issues into an integrated programme. Examples might include physical activity, diet and smoking combined with cognitive approaches to behavioural change. There is evidence of positive effects of wellness programmes on exercise, dietary, smoking, alcohol and mental health outcomes as well as physiological markers (BMI, blood pressure and blood cholesterol) amongst participants[3]. Established public health approaches have been adapted in relation to workplace health. These focus on:-

    - population-based health protection and promotion
    - targeted prevention for groups at risk and
    - support / interventions for those with health problems.

11. In reality, a combination of all three approaches are required to provide an effective approach to workforce health. It is likely that population-based approaches – such as to those working in the City of London – will affect the largest number.

Options

12. The overall business case for tackling health at work may be clear, any serious attempt to engage with the health of workers in the City should from the outset establish what specific businesses in the City (as well as their

[3] City of London (2014) Best Practice in Promoting Employee Health and Well-being in the City of London. www.cityoflondon.gov.uk/business/economicresearch

partners from public agencies and charities) actually want to achieve and their appetite to take action.

13. An assessment has been made through three main channels, which together can inform decisions on next steps.

Business Healthy Conference

14. The Business Healthy Conference held at the Mansion House on 11th March brought together world-class speakers and case studies to articulate and explore the business case for addressing the health of workers in the City and the implications for businesses in terms of commitment and action. The event, at which the Business Healthy Circle was also launched, was attended by around 100 invited leaders from both large and small businesses and organisations.

15. The Conference therefore represented an ideal opportunity to gauge levels of interest and initial ideas for focus to make progress. The immediate feedback was exceptionally positive and supportive for the case and revealed an appetite for collective action behind the idea of making the health of workers a defining characteristic of the City of London (see appendix).

16. The formal evaluation of conference confirmed this, as with attendees saying that they found the conference to be inspiring and thought-provoking, complementing the depth, authority and relevance of the speakers and appreciating the way in which the business case was developed and the practical way in which the issue was discussed. 60% said that would like to be members of the Circle and 30% said that they would welcome being kept informed.

17. As concrete next steps, delegates said that they wished to see

- the Business Healthy Circle providing leadership and advocacy and oversight of the development of Business Healthy as a continuing and coherent initiative
- further development of the Business Healthy Lab as a way of sharing knowledge, tools and promoting connections
- commitment by the Corporation itself to become a visible Business Healthy exemplar in its own right
- early evidence of companies in the City sharing knowledge and good practice about tools and approaches that work
- the Circle operating primarily in a virtual way through on-line information-sharing or chat-rooms
- face-to-face sessions or master-classes on specific issues e.g. alcohol and addiction
- information on “getting started” in a practical way
- a focus on issues of confidentiality and trust which would allow workers to feel confident about Business Healthy and access support without stigma
- active support for managers so that they can look after themselves and as a result look after their staff better

- support on what constitutes proper evidence about “return on investment” for business healthy activities
- assistance with developing metrics and making a stronger case to Boards for inclusion in mainstream strategies

18. There were some other interesting issues raised at table discussion during the Conference which are captured in the following statements as they are important in framing next steps.

- The City could indeed work together as a whole on this issue to give London a global advantage over other competitor cities.
- Many companies are unaware of what services are available from the public sector and the NHS in particular and therefore underuse them.
- Inclusion and promotion of SMEs as an integral part of the Circle and what it stands for would be an important sign of serious commitment by larger organizations.
- The Circle was something which would work as a forum through which organisations could share best-practice even though individually they are often in competition.
- The Circle would only work if there was a clear business model which secured funds and commitments.
- Business Healthy should be sensitive to existing alliances and programmes but it was a good means for overcoming some issues of fragmentation, duplication and even contradiction between existing.
- Embracing different approaches and resisting the temptation to become monolithic would be important for Business Healthy to establish and retain credibility.
- Communication, gaining momentum and securing early wins were necessary to show what Business Healthy was about.
- Making access to professional health and well-being services for workers as easy as possible might require looking at physical location of services in the City

Business Healthy Survey

19. In addition to gain further intelligence to guide next steps, businesses that stated that they wished to be kept informed about the Circle – but who also stated that they did not wish to attend meetings as part of the Circle’s development – were surveyed in March 2014. They were asked:

- what they would like the Business Healthy Circle to prioritise in its first twelve months of operation;
- how they would like the Business Healthy Circle to operate
- how they would like it to be resourced

- would they be interested in a City Workers' Health Centre, offering health and well-being services?

20. 40 businesses were surveyed and 24 businesses replied. The findings from each of the questions are set out below. Overall the survey showed that Businesses would welcome:

- engagement with the Circle through on-line surveys and on-line resources;
- a programme of events on specific issues;
- access to mentoring and knowledge sharing with fellow professionals;
- a range of ways of funding are adopted.

Figure 4: What Do You Think the Business Healthy Circle Should Prioritise in Its First Twelve Months?

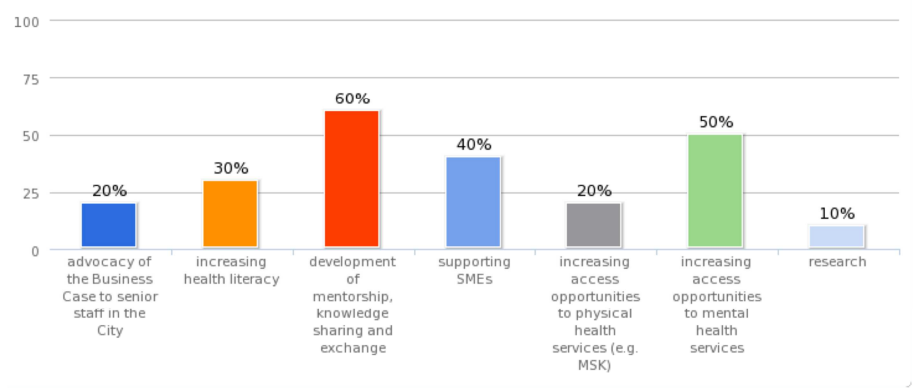


Figure 5: How would you like to see the Business Healthy Circle Operate?

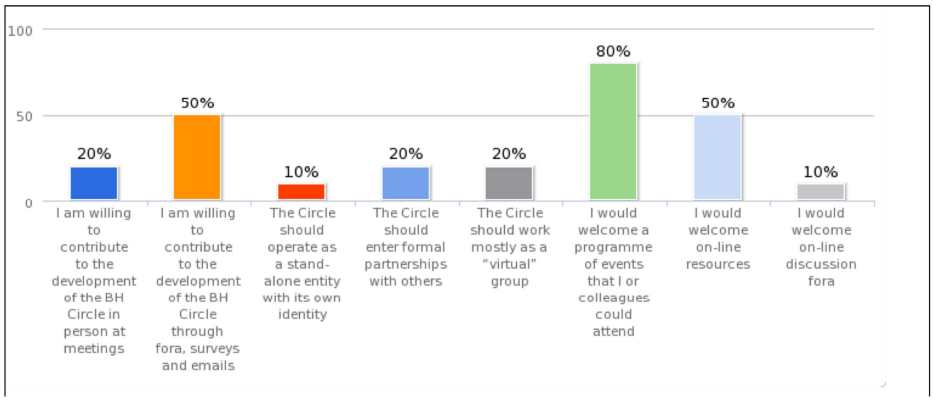
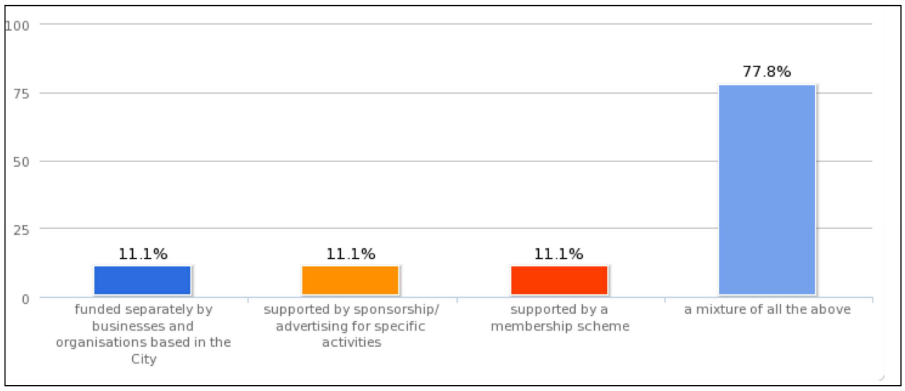


Figure 6: The Circle will be Better Able to succeed if Resources are:



21. There was very little support for a physical health centre for City workers as an early priority (a view also reflected in the Conference and the first Circle meeting). This perhaps reflects a sense that there are other more immediate issues and mapping of services which need to be addressed first. It may be that the idea of having a new base to augment existing health and well-being services and to act as a visible focal point for Business Healthy might emerge from further work in the coming months.

Business Healthy Circle

22. Those businesses who expressed an interest in being part of the development of the Business Healthy Circle were invited to attend a round-table to discuss priorities and next steps.

23. On March 25th this first meeting of the Business Healthy Circle was held at the Guildhall. Attendees were drawn from professional services, construction, financial services and the public sector. The meeting was chaired by Sir Stephen O'Brien, Chair of Barts Health.

24. A number of themes emerged from this meeting which resonated with the Conference and the survey results:

- Businesses would welcome a knowledge hub that provides examples of good practice and an opportunity to share experience and expertise. Smaller businesses would welcome a source of advice and support – especially where there was no in-house HR or access to professional health and well-being capability.
- Many companies struggle with developing the case and pulling together a convincing approach to their Boards. There is a role for the Business Healthy Lab / Business Healthy Circle in developing materials that help with this – and potentially for running or supporting road-shows in-house.
- There are a large number of for-profit and not-for-profit businesses competing for market share in the health and well-being / EAP space. It would be helpful if the Business Healthy Circle could provide some sort

of signposting through the broad range of offers. Business Healthy could also potentially become a more active agent in provision of quality-assured services

- Employers have tended to concentrate their investment on the provision of tertiary services for their direct employees. Business Healthy can bring together employers, charities and public health to work upstream. Business Healthy must also seek ways to support those employed as part of the outsourced workforce.
- There was a strong preference for the Circle to operate virtually. Whilst there might be a need for a physical centre this should only be considered once the Circle had achieved a greater level of maturity. In the meantime consideration should be given to using existing facilities – pharmacies, voluntary and private sector provision.

25. The key role of arriving quickly at a sustainable business model for the Business Healthy initiative emerged as a key priority with some members of the Circle providing a range of different suggestions about possible, even likely, sources of funding and support at international, national and local levels. The need for some enablement funding from the Corporation whilst the business model was developed was also seen as a necessary pre-requisite for getting momentum and focus.

Proposals

26. The Business Healthy Circle has attracted a wide-ranging and potentially powerful membership which could provide the drive needed to make the vision for Business Healthy turn into practice. (The current membership is at Appendix 1)

27. This active support now needs to be built on, and momentum generated behind the priorities identified at the Conference and by the subsequent survey and first meeting of the Business Healthy Circle.

28. Sir Stephen O'Brien has indicated he is willing to continue as Chair of the Business Healthy Circle for the next few months. In addition some enabling support funding will be allocated by the City of London Corporation to cover the period to the end of 2014. This is designed to provide necessary technical and specialist support to the Circle and the Lab as they develop, and also to provide momentum and targets for Business Healthy to establish its longer-term, sustainable business model and the key relationships on which its success depends.

29. The following next steps have been identified for the Business Healthy initiative as a result of work to date:

- to grow the Business Healthy Circle as a virtual group providing leadership for the Business Healthy initiative in line with its remit (Appendix 1) and for a detailed programme of work to be developed over the summer 2014

- to extend and promote the Business Healthy Lab as a knowledge hub for sharing of the business case, best practice, research, information and toolkits
- to develop a business model to support the work of the Circle and the Lab on a sustainable basis into the future
- to map existing health and well-being and EAP services within the City with a view to providing a signposting service
- to set up a programme of events and master classes
- to establish a clear communications, partnership development and engagement process to support the visibility and reach of Business Healthy
- to identify a set of indicators of impact.

Conclusion

30. The Business Healthy initiative has got off to a very good start with significant support for the concept and an appetite for practical action from a notable number of key supporters within the City.

31. Business Healthy has the potential to provide an important and trusted process for addressing critical issues in relation to the health of workers within the City.

Appendices

Appendix 1 - Members of the Business Healthy Circle at 31st March 2014
Appendix 2 - What is the Business Healthy Circle?
Appendix 3 - The Business Healthy Conference - Feedback

Background Papers:

31st January 2014. *Worker Health Update*
4th July 2013. *Workplace Health*

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Appendix 1

Members of the Business Healthy Circle at 31st March 2014

Allott and Associates
Aviva
Barts Health NHS Trust
Bird and Bird
Buck Consultants
BUPA
Capita HW
City and Hackney CCG
City of London Corporation
Classic Tours
Deloitte
Dentons
Department of Health
East London Mental Health NHS Foundation Trust
First Rand Bank
Foundry Studios
Goldman Sachs
Greater London Authority
Homerton University NHS Trust
Jones Lang Lasalle
KPMG International
Land Lease
Lansons Communications,
Linklaters LLP
London Chamber of Commerce and Industry
Marylebone Associates
MHFA England
Mitsubishi UFJ Securities
Natixis
Nomura
Public Health England
Robert McAlpine
Scope
Slaughter and May
Standard Bank
Tower Hamlets CCG

Appendix 2

How leaders are enhancing their competitive edge

What is the Business Healthy Circle?

The **Business Healthy Circle** is a dynamic group of people working in the City of London, who share a commitment to transforming the health and well-being of fellow City workers by collective action.

What it aims to achieve

The goal is to establish positive health and well-being as a defining part of the way the City is seen and works, in a way that delivers genuine competitive advantage – a hallmark that will differentiate the City, as a place to work and do business, from other international business centres.

The Circle is about all workers in the City wherever they work. It embodies a shared belief that securing the scale of change in culture and image needed in the City depends on

- fundamental changes in priorities and working practices
- adoption of innovative thinking and action
- measurable improvement in performance for the City as a whole
- open and transparent public reporting and celebration of success.

How it works

The Circle is about advocacy as well as collective action. It works with others who share its goals and approach, drawing in additional skills and experience to progress its aims. It is not a membership organisation.

There is already a lot of good work underway in individual organisations with a presence in the City, and in a number of professional networks. They are raising the profile of the economic and social importance of health and well-being and what needs to be done. The Business Healthy Website provides details and links to some of the latest and best work.

Why it matters

It is the absolute focus on change within the footprint of the City which makes the Circle such an invaluable agent for the type of behavioural and cultural change that is of critical importance to the future of City, and indeed of the UK.

The City of London can become known internationally as the place where the best thinking on health and well-being turns into reality for the people who work there, improving their motivation and organisational performance.

The Circle has a key role in supporting these vital personal, social and economic benefits.

http://businesshealthy.org/circle.html

Appendix 3

The Business Healthy Conference - Feedback

http://www.businesshealthy.org/index.html

Business Healthy was formally launched at an event hosted by the Rt Hon Lord Mayor of London in the Mansion House on 11 March 2014 to which leaders of large and small businesses were invited. The Chairman of the Health and Wellbeing Board also hosted a special dinner prior to the conference, to further emphasise the City's commitment to workplace health and wellbeing.

The following speakers presented at the conference:

- Fiona Woolf CBE, the Right Honourable the Lord Mayor of the City of London.
- Duncan Selbie, Chief Executive, Public Health (England)
- Dame Carol Black, Expert Advisor, Health and Work, Department of Health, England.
- Sir Stephen O'Brien CBE, Chair, Barts and the London NHS Trust
- Professor Stephen Bevan, Director of the Centre for Workforce Effectiveness, Work Foundation
- The Rev Dr Martin Dudley, Chair, Health and Well-being Board, City of London Corporation.
- John Barradell, Town Clerk and Chief Executive, City of London Corporation.
- Dr Penny Bevan CBE, Director of Public Health, City of London Corporation.

Panel discussion participants included:

- Louise Aston, Workwell Director, Business in the Community
- Dr Steve Boorman CBE, Chief Medical Adviser, Capita and adviser to the Department of Work and Pensions;
- Peter Rodgers, Deputy General Counsel, KPMG and Chair of the City Mental Health Alliance
- Patrick Watt, Corporate Director, Bupa
- Ade Adetosoye OBE, Director of Community and Children's Services, City of London

Feedback from participants

On the Conference as a whole

- Very interesting and useful, will go back with more actions!
- Very worthwhile
- Good idea overall
- Very useful thought provoker which provided tips and guidance that I can take on board and do something with for the benefit of colleagues
- Excellent, incredibly informative – very well organised – succinct
- Very clear direction on how to steer businesses into a healthier workforce
- Very inspiring, focused, quite rightly on action
- Very useful 'first steps' on a lone road!
- Great networking opportunities
- I thought it very good in kicking off a very worthy initiative
- Excellent, good pace, inspiring
- Too much of the early part – too many people "setting the scene" and "making the business care" – wasn't needed
- Excellent, thoroughly enjoyed it and felt empowered to promote health and wellbeing and would like to be part of the circle
- Perhaps a more diverse group of speakers would have appealed
- Important initiative, I was pleased to be invited
- Very interesting – some slides were presented very quickly – please make available
- I am a Physiotherapist and attended with our OHA and H&S Manager. We have a good programme in place but it gave us ideas on how to reach a wider audience in our firm
- Refreshingly engaging, positive approach to the bigger picture of Health & Wellbeing at Work
- Professional and informative

On the Presentations

- Thought-provoking
- Excellent – lots of new data.
- Opinion forming
- Enjoyed the pace and content – kept me engaged and enthused
- Relevant, inspiring
- "Work Life" balance is key
- Balanced, well presented and focused. Great examples of drive within the wellbeing of employees
- Extremely informative
- Succinct
- Good mix, motivational
- I thought all good and relevant – quite inspirational
- Good. Some slides hard to read
- Very helpful
- Stephen Bevan excellent, the "meat on the bones"
- Engaging speakers, well presented
- Very strong content and thought provoking
- Perfect – need some more case studies
- All very well presented

On the Panel

- Enjoyed discussion, would have liked to have asked questions
- Why not involve the delegates?
- Good balance of participants, well chaired!
- Very credible
- Fantastic/informative discussion
- Wide thought leadership but would have been better if we could ask questions
- Good range of expertise, mental healthcare particularly interesting
- Quality Speakers
- Would have been helpful to take questions from audience

- Good mix of business/medical and research
- Quite useful
- Very engaging and practical
- Interesting

About Business Healthy

- Great idea – keep it going – virtually!
- A broader range/cross section of those involved in the industry would be good to widen its influence
- Must include more practicalities 'How do I actually 'do' it?'
- Any initiative that provides access to best practice is a great resource. I need to find the time to make the most of it!
- Exciting times
- Raising awareness, health literacy. Investment in a staff healthy environment leads to an impact on the base line of the business
- "Talk about Mental Health"
- Leading the way for the Public and Third sector too – well done
- Useful Initiative
- A much needed framework to get started
- A super initiative which we would love to support and learn from
- A very good initiative definitely worthy of support
- Interesting discussions? Outcome though
- Good idea. Do make sure it doesn't end up competing with others for employers' time and resources as there are a few similar organisations/initiatives around. Co-ordination will be key and identifying the USP of this initiative
- Great platform to promote health and wellbeing in the City and Community
- It is a valuable potential resources and I would be pleased to engage
- Interesting and innovative idea that I hope turns into a practical reality
- Look for roadmap and benchmarks nationwide. Tap into IOSH/EUS+H [Health and Safety]
- A great initiative
- Interested

Committee(s):		Date(s):
Community and Children's Services	For Information	11 Apr 2014
Health and Wellbeing Board	For Information	30 May 2014
Subject: Service Review of Drug and Alcohol Services, Update Report		**Public**
Report of: Director of Community and Children's Services		**For Information**

Summary

This report updates Members on the status of the City's drug and alcohol services review. The early stages of the review have included an examination of the evidence and policy surrounding substance misuse and analysis of the current spend on different elements of the service.

The key outcomes of the review to date are as follows:

- There is a need to focus on prevention of drug and alcohol misuse as well as on treatment of entrenched users.
- There is potential to link the drug and alcohol misuse service with other addictions services, for example smoking and gambling.
- There is potential to link the drug and alcohol misuse service with other risk-taking behaviours, particularly for City workers.
- There are inherent links between drug and alcohol misuse and mental health services, and these should not be ignored. As such, it is necessary that the service should have a 'no wrong door' policy, and links across to mental health prevention and treatment services.
- The tobacco control programme review has been aligned to run in parallel to the drug and alcohol services review.

Recommendation(s)

Members are asked to:

- Note the report.

Main Report

Background

1. In January and February 2014 it was reported to the Health and Wellbeing Board and Community and Children's Services Committee respectively that an initial review of all public health services had been undertaken. This initial review had highlighted a number of areas requiring a full service review, of which substance misuse (drug and alcohol) services was one.

2. The necessity for the review was highlighted by a recent message from Duncan Selbie, Chief Executive of Public Health England, stating that he will shortly be writing to all local authorities to ask them to share the progress they have made in improving prevention programmes for drugs and alcohol, and in improving outcomes and value for money.

Current Position

3. The current substance misuse service is provided by the City of London Substance Misuse Partnership (SMP). The funding for the service is provided by the public health budget, City of London Police, and the Safer City Partnership. The current spend from the public health budget on this service, including management costs, is £295,000, with an additional £106,000 provided by City of London Police and £29,000 provided by the Safer City Partnership.
4. Almost all of the current work involves drug and alcohol treatment services for residents, with only a very small proportion of resource being spent on prevention work for drugs.
5. The current specialist treatment is jointly commissioned with the London Borough (LB) of Hackney from the Alcohol Recovery Centre (ARC) and Specialist Addiction Unit (SAU), which is an expensive service. Additionally, City clients accessing the service have expressed the opinion that the service is too far away; however, they have acknowledged that it is useful. The ARC also provides a lot of support to the substance misuse team. LB Hackney is currently reviewing its substance misuse service, particularly its commissioned specialist services. Officers from the City of London Corporation (CoLC) are on the programme board for this review, and will be assessing the strategic fit with the City's needs as the LB Hackney review develops.
6. To date, drug and/or alcohol prevention work with workers or businesses in the City has been of limited scope and of unknown efficacy. Despite efforts from the team it has proved to be a difficult area to penetrate, and as such would require additional resources to ensure its effectiveness. There is potential for this to link with the emerging Business Healthy Circle in future.
7. The amounts paid for the different levels of service are currently unbalanced. Best practice and quality standards indicate that the spend should be far higher on prevention work with healthy or low risk users, in order to prevent future misuse, with smaller amounts of money spent on the higher risk users and entrenched addicts. As stated above, this is currently not the case – there is very limited prevention work undertaken as the focus and drive has been towards treatment.

Evidence Review

8. An evidence review was completed in January 2014, looking at best practice reviews that have taken place elsewhere in the UK as well as the National

Institute for Health and Care Excellence (NICE) quality standards for drug and alcohol services. This evidence review has highlighted areas that the drug and alcohol services commissioned by the City should concentrate on. These are detailed under the following headings:

a. Information and awareness
b. Educating children and young people
c. Training for frontline workers
d. Treatment services
e. Tracking clients across services
f. No wrong door
g. Hospital liaison
h. Vulnerable groups
    i. Looked after children
    ii. Rough sleepers
    iii. Tenancy support
    iv. Dual diagnosis and mental health services
    v. Children and families
    vi. Older people
i. Reducing substance-related crime/violence
j. Premises selling alcohol

Information and Awareness

9. There is strong evidence to link risk-taking and addictive behaviours such as smoking, drugs, alcohol and gambling in commissioned services. These behaviours are often exhibited together, and with a linked service can therefore be tackled at the same time. In line with this, the tobacco control review has been aligned to run in parallel with the substance misuse review, and there are references to tobacco control within this report. During the reviews, consideration will be given to the feasibility of a combined or linked service.

10. Within the City worker population, there is a particular risk-taking culture that may contribute to the development of health issues and addictions. This has the potential to impact on both City workers and their employers. In terms of prevention and awareness-raising activities, attitudinal research shows that City workers do not like to admit that they have relinquished control, so this could be a potential communications angle. There is also potential to conduct research on the role of City employers as ‘enablers’.

Educating Children and Young People

11. Public Health England has released figures showing the benefits of drug and alcohol interventions for young people. Across England, young people's drug and alcohol interventions result in £4.3m health savings and £100m crime savings per year. They can also help young people get in to education, employment and training, bringing a total lifetime benefit of up to £159m. This means that every £1 spent on young people's drug and alcohol intervention brings a benefit of £5 to £8.

12. The City of London Police currently commission the Drug Abuse Resistance Education (DARE) programme which is aimed at teenagers and primary school-aged children. Police officers run pupil education sessions on drugs in three of the private schools in the City, and have also conducted some sessions with teachers. There is anecdotal evidence that drugs can be a problem with teenagers around exam time in particular.

13. City Gateway, the City's provider of youth services, has provided two sessions on cannabis usage to young people engaged in the youth service.

Training for Frontline Workers

14. There are plans in place to train all frontline staff including children's social care, rough sleeper outreach teams and housing officers. Social workers within adult social care have already received training.

15. Some training of bar and club staff was carried out by Project Eclipse, which was managed by the London Drug and Alcohol Policy Forum and partially funded by the SMP.

16. There is a gap in training of receptionists, security officers, City of London street cleansing staff and other frontline workers who are in contact with people on a daily basis and may be able to provide either brief interventions or signposting to appropriate prevention services.

Treatment Services

17. The services have not been evaluated to look at the effectiveness of treatment and outcomes. There is a need for this to be completed to ensure that people are not re-entering the system at a later date, and also to ensure that the services are generally fit for purpose.

Tracking Clients Across Services

18. The substance misuse team currently use a web-based care management system. It will need to be investigated as to whether this can be integrated with Frameworki and other City systems, in order to be able to track across social work, families, housing and other teams to improve integration of care across services.

No Wrong Door

19. Substance misuse care managers currently act as the link between social care and substance misuse services.

20. Broadway's homeless outreach service is excellent at making referrals to the substance misuse service, and integration between the homelessness and substance misuse teams is working very well.

21. The City funds a substance misuse nurse to work at the Neaman Practice in the City, and Health E1 in Tower Hamlets. This is working very well, and has increased the number of referrals coming through to the team from these practices.

Hospital Liaison

22. Evidence from Public Health England shows that one alcohol liaison nurse can prevent 97 accident and emergency (A&E) visits and 57 hospital admissions.

23. There is currently no hospital liaison for drug or alcohol services. As most hospitals retain lists of A&E admissions that are alcohol or drugs related, there is potential to link with the Section 256 funded social worker liaisons which will be in place shortly.

Vulnerable Groups

i. Looked after children

24. Looked after young people are particularly vulnerable, and NICE has issued specific guidance about reducing substance misuse in this group. The City does not currently undertake any substance misuse work with looked after children placed in other authorities; however, conversations have now started with the children and families team to look at prevention strategies for looked after children and care leavers. It will be important to ensure that this group is looked after, either as part of a wrap-around service with the host authority or by providing limited one-to-one support.

ii. Rough sleepers

25. Evidence suggests that floating support for rough sleepers is extremely important to ensure that they do not slip between authorities and services. In the City we have a good floating support for rough sleepers – it comes at the start of their journey and the team are allowed to work with rough sleepers who are housed out of the borough.

iii. Tenancy support

26. The Tenancy Support Officers working for CoLC provide brief interventions for drugs and alcohol to tenants living on our estates who are in receipt of support. The key benefits to this are the identification of tenants in need of interventions and support, as well as reduced rates of drug and alcohol misuse on our estates.

iv. Dual diagnosis and mental health services

27. There is strong evidence to show the links between mental health and substance misuse, and many patients have dual diagnoses. Dual diagnosis patients currently access drug and alcohol treatment services first, even if substance misuse is not their primary issue. It then falls to the substance misuse team to convince other services that there are cognitive or mental health issues that need to be dealt with as the underlying problem.

28. Currently, substance misuse is not integrated within mental health prevention services. This will need to be considered alongside other prevention services to be commissioned.

v. Children and families

29. The evidence shows that targeted education for troubled families should be an essential component of the prevention services in place for City residents. Substance misuse services should aim to work directly with other City teams to offer specific support to these families, taking a whole family approach to prevention.

30. The SMP is an active member of the Troubled Families Strategy Group and is working with children and families.

vi. Older people

31. Alcohol dependence in older people is often under-detected. An age-specific outreach approach is required for this group.

Reducing Substance-related Crime/Violence

32. The current Drugs Intervention Programme (DIP) is jointly funded by the City of London Police and Public Health England. As the name of the service shows, this is a drugs programme and involves only a relatively small number of alcohol interventions. Discussions are currently under way with City of London Police as to the vision for this and other substance misuse services, ensuring a joined-up approach under the review.

33. Alcohol, particularly when combined with cocaine, can be a contributing factor to violent crime within the City. This is a key area that needs to be targeted with City workers.

Premises Selling Alcohol

34. Premises selling alcohol should be encouraged to work together in order to share information both with each other and with the City about drug and alcohol misuse. Sharing with the City will take time to build trust and ensure that licensing issues do not come into play; however, information sharing should be facilitated and encouraged. This will link with the ‘Safety Thirst’ campaign co-ordinated by the Safer City Partnership.

Public Health Outcomes Framework

35. The current service contributes to the Public Health Outcomes Framework (PHOF); however, it has been identified that by focusing on prevention, as suggested in the evidence above and by Public Health England, it could make a far greater contribution. This can be seen in the table below. For ease of reference, the tobacco control work has also been included in this table.

PHOF Indicators	Current service	Drugs	Alcohol	Tobacco
1.09 – Sickness absence	x	x	x	x
1.10 – KSI causalities on England's roads		x	x	
1.11 – Domestic abuse	x		x	
1.12 – Violent crime (including sexual violence)	x	x	x	
2.01 – Low birth weight of term babies			x	x
2.03 – Smoking status at time of delivery				x
2.04 – Under 18 conceptions			x	
2.14 – Smoking prevalence				x
2.15 – Successful completion of drug treatment	x	x		
2.18 – Alcohol-related admissions to hospital	x		x	
2.24 – Injuries due to falls in people aged 65 and over			x	
3.02 – Chlamydia diagnoses			x	
4.03 – Mortality rate from causes considered preventable	x	x	x	x
4.04 – Under 75 mortality rate from CVD				x
4.05 – Under 75 mortality rate from cancer	x	x	x	x
4.06 – Under 75 mortality rate from liver disease	x	x	x	
4.07 – Under 75 mortality rate from respiratory disease				x
4.08 – Mortality from communicable diseases	x	x	x	

36. As expressed above, there is strong evidence to show the benefits of looking at addictive behaviours together. The government provide guidelines on unhealthy behaviours that should be avoided to reduce health problems later in life. Some 70% of adults seen by services in the NHS are not adhering to the government guidelines on two or more of these unhealthy behaviours. By clustering behaviours in this manner, every contact can count, and three potentially linked behaviours can be addressed with both residents and workers in the City.

37. In addition to this, the efficiency savings that can be made on management costs by combining the services could be translated into further funding for prevention work with residents and workers in the City.

Tobacco Control

38. As stated above, a review of the tobacco control services commissioned by the City is currently under way. The current management of the tobacco control programme is complex, with some aspects managed directly by CoLC and some led by LB Hackney. The current total spend on the services is £355,000. This includes time spent by the commissioning and management teams in attending meetings. Much of this time is duplicated in meetings and management of substance misuse services.

39. Smoking prevalence within the City is high, particularly among City workers. It is therefore unsurprising that the smoking cessation and prevention programme has a high cost attached to it. That said, it is important that these services are working in a co-ordinated and joined-up manner to achieve the best outcomes with the best value for money.

40. Further information on the tobacco control review will be provided to Members on completion of both reviews.

Timescale

41. It is proposed that during April–June, key partners including the City of London Police, Safer City Partnership and members of the current SMP will be consulted on the review. A proposal will then be brought to the Health and Wellbeing Board in July, and the Community and Children's Services Committee in September.

Conclusion

42. The evidence from the substance misuse review thus far shows a need for a service with a focus on prevention. This is in line with policy shifts from Public Health England.

43. The review is ongoing and will explore all options to assist the focus on prevention while ensuring that treatment is available for those who need it. It will also explore possible links with other public health services.

Appendices

None

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Committee:	**Date:**
Health and Wellbeing Board	30 May 2014
Subject: Exercise on Referral Programme.	**Public**
Report of: Director of Community and Children's Services	**For Information**

Summary

The Exercise on Referral Programmes' core aim is to provide individuals referred by their GP and other health professionals, with an introduction to the benefits of exercise with the aim of including more physical activity in their lifestyle.

Participants with a variety of medical conditions, such as hypertension, diabetes, obesity, high cholesterol and depression, learn how to exercise safely and effectively, as well as how to achieve behavioural change. By re-educating and supervising participants we aim to empower them to continue exercising regularly and thus benefit from a more active lifestyle.

Since the pilot programme began the scheme has been offered to over 100 individuals. In year one of the full scheme, 73 participants were referred on to the exercise on referral programme, of these 62 attended an initial assessment (85%) and 24 completed the programme within the statuary 12 weeks. The remaining participants referred in April 2013 - March 2014 are due to complete the programme by the end of June 2014.

14 participants have been referred back to the doctor due to a variety of reasons; change in their medical circumstance; being too ill to take part at the present time; non-attendance. 1 participant has been referred back to the doctor as a result of being ineligible to participate on the programme. The total number of re-referrals has decreased since the pilot programme.

The scheme has been very well received by partners and has continued to grow and develop new partnerships. The focus for year one has been to raise awareness of the scheme with partners, increase referrals and create new partnerships. The programme is now actively receiving referrals from six different partners, with another three partners engaged and ready to refer.

Recommendation(s)

Members are asked to:

- Consider the proposals in the report for year two.
- Consider whether there are any further aspects that the Health and Wellbeing Board would want to be included in the programme.

Main Report

Background

1. Physical inactivity is an independent risk factor in the development of serious long terms conditions such as coronary heart disease (CHD), type 2 diabetes and strokes. National data suggests 61% of people in England are overweight with 25% of that being classed as obese. It shows that 66% of adults are not achieving the recommended minimum of at least 30 minutes of moderate intensity physical activity on 5 or more days of the week with only 25% of obese people achieving the recommended minimum. Furthermore, national data shows that only 27% of people in England eat the recommended 5-a-day fruit and vegetables. In London, 21% of the population are obese with 45% of these having high blood pressure.

2. In 2007 the Department of Health published Best Practice Guidance for the Commissioning of Exercise on Referral Services. This recommended that exercise on referral services should be available for those people who would gain health benefits from regular physical activity as part of the medical management of a chronic condition, and/or who are at risk of CHD.

3. The City of London Exercise on Referral (EOR) pilot was launched in January 2013 with the full programme officially launching on 1 April 2013 after the success of the pilot. The City of London (Public Health) funded the programme for year one between April 2013 – March 2014.

4. The aims of the Exercise on Referral programme are:

    - To offer effective exercise for participants with medical conditions;
    - To empower and motivate participants to make informed choices to improve their physical, mental and social well-being through physical activity;
    - To advise, support and motivate participants who would benefit from increased physical activity;
    - To empower participants to make positive changes to their lifestyles and create long term change in exercise behaviour;
    - To allow participants to meet the 5 x 30 minutes per week of physical activity for health message;
    - To promote access to facilities;
    - To undertake health assessments and subsequent exercise prescription

Current Position

5. The year one focus has been to increase the referrals and awareness to all partners and create new partnerships. The programme is now actively receiving referrals from six different partners, with another three partners

engaged and ready to refer. At present the Neaman practice refers the majority of participants (92% in year one).

6. 73 individuals engaged in the programme during year one. The programme has seen a significant increase in referrals to the previous City and Hackney commissioned Exercise on Referral scheme. 24 people have completed the whole programme (34%) of those referred since April 2013.

7. The scheme offers 13 hours a week in total, which includes initial assessments, programme setting, end of programme assessments and instructor supervised exercise sessions. The programme is led by 3 instructors employed on the programme.

8. Exit Routes for the programme include Young at Heart, City of Sport and a reduced price Golden Lane Sport & Fitness membership. After year one, out of the 24 completers, 12 have joined the Young at Heart programme and 10 have discounted memberships at Golden Lane. The remaining completers include one moving back to the USA, and one undisclosed.

9. Please refer to Appendix 1 for a full breakdown of the year one programme statistics.

Proposals

10. Following evaluation of year one of the programme the following proposals have been developed:

    a. Increase the number of City residents referred (2013/14 Target: 73 residents) and open up the avenues for City workers to be referred to the programme.

    b. Increase the number of completers. (Target 60% of those who begin the programme). Ensuring participants complete in 12 weeks (16 weeks with a 4 week grace period for holidays and illnesses). This should enable the number of completers to increase as the number of re-referrals will decrease.

    c. Consider working with and accepting referrals from GP surgeries outside of the City of London boarders to ensure all City residents who may live on the boarders have access to the programme.

    d. To enhance the programme to become a Cardiac phase IV, Exercise after Stroke and Cancer rehabilitation accredited programme. This is to ensure the programme can continue to work parallel with the JSNA for the City of London.

11. These proposals are manageable within the current budget for the programme and have been accepted by officers. The year two programme is now underway.

Corporate & Strategic Implications

12. The City of London Exercise on referral programme addresses the following JHWS priorities;

- Mental Health - More people with mental health issues can find effective, joined up help.
- More people in the City are socially connected and know where to go for help. (JSNA priority -Social Isolation)
- More people in the City take advantage of Public Health preventative interventions, with a particular focus on at-risk groups.
- Older people in the City receive regular health checks – with referral exit routes to the City of London Exercise on Referral scheme.
- More people in the City are physically active (JSNA priority – Cardiovascular disease and social isolation).

13. The Exercise on Referral Programme also supports the following aims of the City Together Strategy:

- 'to support our communities', specifically to 'encourage healthy lifestyles and protect and improve City communities' health and wellbeing' In addition 'to enhance services for older people to enable them to enjoy greater independence and better health for as long as possible'.

14. Corporate Plan

- Deliver against the key target to "encourage more local residents, business, workers and children to participate in sporting activities".

The Exercise on Referral Programme recognises the aims and actions within the Health and Wellbeing Board's aims to:

- Improve the Health and Wellbeing of the Community
- Providing and improving access to quality primary care health services

Implications and Risks

15. There is a risk to the current capacity of the exercise on referral scheme if there is significantly increased uptake and attendance due to limited instructor time and equipment availability.

16. The intention to accept City workers on to the programme may have additional implications on the complexity of referral pathways required to ensure medical clearance.

17. The financial implications of the Year two programme can be managed within the City of London Corporation Public Health Budget

Conclusion

18. The extension of the Exercise on Referral programme in Year two will provide a service that is delivered locally to meet the needs of our residents and workers.

Appendices

- Appendix 1: EOR Report April 2013 - March 2014.

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Exercise on Referral Scheme

Year 1: Annual Report
1st April 2013 to 31st March 2014

Contents

1. Executive Summary

Introduction

The Exercise on Referral Programmes' core aim is to provide individuals referred by their GP and other health professionals, with an introduction to the benefits of exercise with the aim of facilitating the process whereby they include physical activity in their lifestyle.

Participants with a variety of medical conditions, such as, hypertension, diabetes, obesity, high cholesterol and depression, learn how to exercise safely and effectively, as well as how to achieve psychological behavioural change. By re-educating and supervising participants we aim to empower them to continue exercising regularly and thus benefit from a more active lifestyle.

The scheme offers 13 hours a week in total, which includes initial assessments, programme setting, end assessments and regular attendance. We have seen a significant increase in referrals to the previous City and Hackney commissioned Exercise on Referral scheme.

73 participants have been referred, of them 62 attended an initial assessment (85% of participants). 21 are still completing their programmes of which all should complete within the statuary 12 weeks. 3 are due to finish by 31 March 2014. (The remaining participants referred in April 2013 - March 2014 are due to have all completed by the end of June 2014.) 25 people have completed the whole programme (34%) of those referred since April 2013, with a further 18 completing of those who were referred between January 2013 and March 2013. 14 have been referred back to the doctor due to a change in their medical circumstance / being too ill to take part at the present time or non attendance which is an 19% decrease since the pilot programme.

The scheme has been very well received with partners. Since the pilot programme, the scheme has continued to grow and embed itself in the City of London. The focus has been to increase the referrals and awareness to all partners and create new partnerships. The completion rate has been gradually improving and now the focus is to minimise the number of re-referrals.

2. Overview

Background

Physical inactivity is an independent risk factor in the development of serious long terms conditions such as coronary heart disease (CHD), type 2 diabetes and strokes.

National data suggests 61% of people in England are overweight in England with 25% of that being classed as obese. It shows that 66% of adults are not achieving the recommended minimum of at least 30 minutes of moderate intensity physical activity on 5 or more days of the week with only 25% of obese people achieving the

recommended minimum. Further to that, National data shows that only 27% of people in England eat the recommended 5 a day.

In London, 21% of the population are obese with 45% of these having high blood pressure.

In 2007 the Department of Health published Best Practice Guidance for the Commissioning of Exercise on Referral Services. This recommended that exercise on referral services should be available for those people who would gain health benefits from regular physical activity as part of the medical management of a chronic condition, and/or who are at risk of CHD.

Strategic Context
The Exercise on Referral Programme will contribute to local plans and strategies including:

The City Together Strategy
The City Together; the Heart of a World Class City which…

Key Themes	Key Goals
… Supports our communities	To protect and improve the health and well being of our communities, by encouraging healthy lifestyles and taking a preventative approach through accessible health promotion and early intervention, while giving our communities greater choice and influence in the use of health and care services
	To enhance services for older people to enable them to enjoy greater independence and better health for as long as possible

Corporate Plan

Deliver against the key target to "encourage more local residents, business, workers and children to participate in sporting activities".

Health and Wellbeing Board

The Exercise on Referral Programme recognises the aims and actions within the Health and Wellbeing Board and aligns with the following Joint Health and Wellbeing Strategy Priorities:

- Improve the Health and Wellbeing of the Community.
- Increase participation in physical activity for all of the city's communities.

JHWS priorities -

- Mental Health - More people with mental health issues can find effective, joined up help.
- More people in the City are socially connected and know where to go for help. (JSNA priority -Social Isolation)
- More people in the City take advantage of Public Health preventative interventions, with a particular focus on at-risk groups.
- Older people in the City receive regular health checks – with referral exit routes to the City of London Exercise on Referral scheme.
- More people in the City are physically active (JSNA priority – Cardiovascular disease and social isolation).

Service Aims

- To offer effective exercise for participants with medical conditions
- To empower and motivate participants to make informed choices to improve their physical, mental and social well-being through physical activity
- To advise, support and motivate participants who would benefit from increased physical activity
- To empower participants to make positive changes to their lifestyles and create long term change in exercise behaviour
- To allow participants to meet the 5x30 physical activity for health message
- To promote access to sport and physical activity facilities
- To undertake health assessments and subsequent exercise prescription

Recruitment of participants and referral pathway

- Participants must be a City of London Resident
- Participants registered with a GP in the City of London (Neaman Practice, City Wellbeing practice) and / or GP's in surrounding boroughs.
- Participants diagnosed with a health condition as per the exercise referral programme inclusion criteria (see below).
- Referral pathway is followed as per the referral pathway below.

Eligibility for the Programme

Inclusion Criteria

The service is intended for people who meet the following criteria:

- Aged 18 years +
- Participant's current physical activity levels must either be sedentary or insufficiently active to be accepted into the programme.

Sedentary: less than 30 minutes of physical activity a week

Insufficiently Active - less than 5x30 minutes moderately intensity physical activity per week.

They want to receive support to become more active, in conjunction with at least one of the following:

- Type 1 or type 2 diabetes
- Hypertension (<180/100mmHg)
- Hyperlipidaemia (> 5mmol/l)
- BMI >30 (BMI>25 if another risk factor present)
- chronic respiratory disease
- Neurological conditions such as Multiple Sclerosis
- Asthma/COPD
- peripheral vascular disease
- stable angina
- diagnosed coronary heart disease
- osteoporosis
- long-standing back pain
- arthritis
- Physical disabilities where independent physical activity is suitable
- People with mental health conditions e.g. depression and anxiety.
- The capacity and motivation to increase their levels of physical activity

assessed by the referrer as either 'low' or 'medium' risk, using the risk stratification tool (See section 14 Medical Risk Stratification Tool). The condition of the participant specified on the referral form, determines the contact time and level of supervision provided. The higher risk participants will have more contact time within the allocated sessions than the lower risk participants. Experience from the pilot has shaped the programme to allow lower risk participants to attend the gym at any time once the initial assessment and individual programme is set. Medium risk participants can only attend in instructor led sessions.

Exclusion Criteria

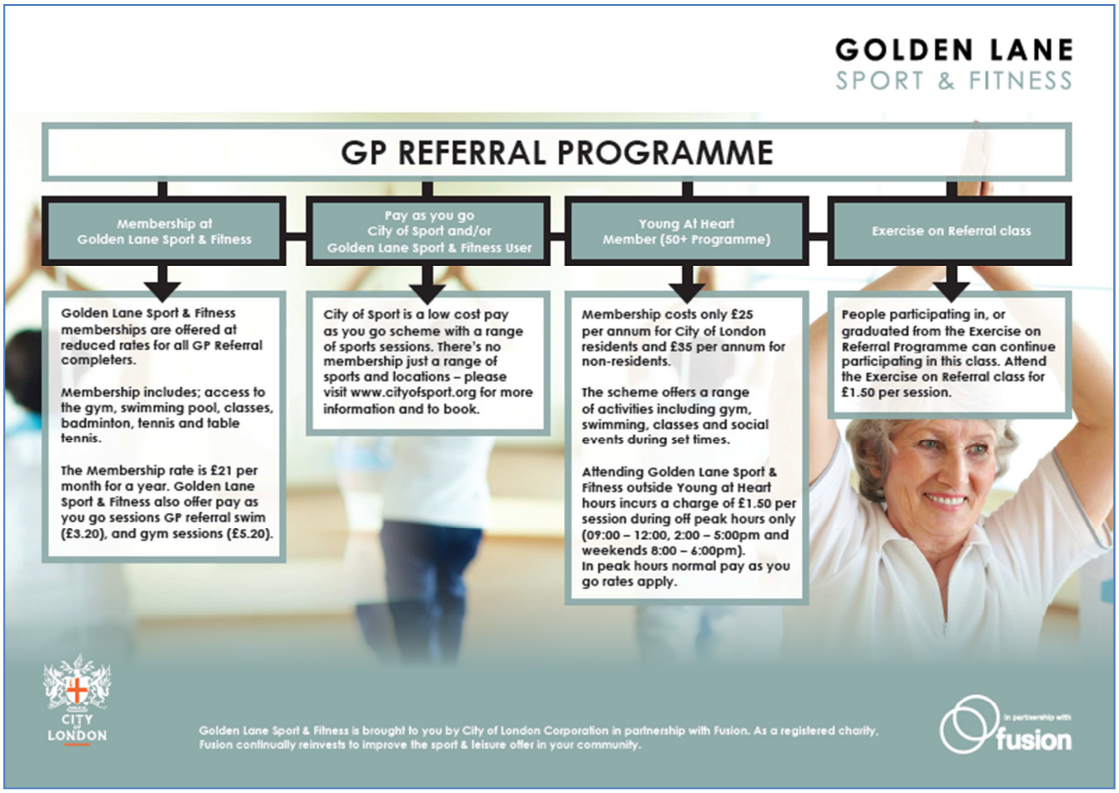
Inappropriate referrals include:

- Over 65 and at risk of falls
- Unstable or uncontrolled cardiac disease or a recent cardiac event
- Heart failure
- Angina
- Uncontrolled BP over 180/100
- Claudication
- Recent Stroke/TIA (unless referred by neuro-rehabilitation)
- Severe osteoarthritis
- Dizziness or syncope
- Orthopnoea or PND
- Severe or brittle asthma COPD
- Poorly controlled Diabetes
- any medical condition not controlled
- any muscoskeletal conditions that do not allow independent exercise individuals

GP Referral participants pathway

GP Referral Exit Routes

There are four exit routes for the Exercise on Referral programme; these are highlighted below in the table.



Instructor Profiles

Rachel Luker

- BSc Sport and Exercise Science (University of Northampton)
- Level 3 personal trainer
- Aqua aerobics instructor
- Exercise with disabled people
- GP Referral qualified
- ETM
- Les Mills qualified

Ahmet Mehmet

- GP referral qualified
- Diploma in person centred therapy
- Advanced certificate in CBT
- Mindfulness for those in the supporting professions
- Level 3 Personal Trainer
- Circuits instructor

Ayo Shodimu

- BSc (HONS) Sports Therapist
- GP Exercise Referral Qualified
- Personal Trainer (REPs Level 3)
- Coaching Assistant Qualified (England Athletics)
- Emergency First Aid Qualified

3. Monitoring and Evaluation of the programme.

The programme from April 2013 to March 2014 has seen 73 people referred so far.

Of them 62 attended an initial assessment (85% of participants), 21 are still completing their programmes (29%) with all of them due to complete within the stated timeframe. 25 people have completed the whole programme (34%) with a further 9 people (12%) due their final assessments. They have missed weeks due to a number of reasons including ill health, holidays and being too busy.

10 of the 24 people have completed the whole programme within the specified 12 weeks (42%) with many on course to finish but have been delayed due to missing

classes and assessments due to a variety of reasons. We continue to monitor the individuals to ensure they finish the programme albeit not within the specified timeframes in these cases.

14 people (19%) have been referred back to their doctor due to lack of contact in both attendance on via telephone/mail, with 2 people (14%) due to a change in their medical circumstance / being too ill to take part at the present time. 1 person unfortunately died before they were able to complete the programme. This is a decrease in 13% since the pilot programme and is a big focus of ours. These 16 (1 deceased) can be re-referred to the programme but they will not complete their programme within the specified 12 weeks.

11(15%) never attended the Initial Assessment after multiple contact so have never started the programme.

Monitoring of KPI's for the Exercise on Referral programme

KPI	Target	Achieved from 1 April 2013
Number of referrals received	60	73 received (121%) 67 (92%) Neaman Practice
Time between receipt of referral and provider making contact with patient	72 hrs (3 working days)	90% within 72hrs (66 people) 88% same day (64 people)
Time between provider making first contact and first assessment	No more than 3 weeks (15 working days)	73% within 3 weeks (53 people) **average 12 days**
Number attending first appointment for assessment	48 (80% of target)	62 attended (85%)*
Number starting first training session	42 (70% of target)	62 attended (85%)*
Number completing the programme	40 (67% of target)	**25 (out of 73) (34%)***** 43 (out of 104) (41%)
Number of completers with an increase in activity from baseline *	40 (67% of target)	**16 (out of 25) (64%)***** 26 (out of 43) (60%)
Number of people that improved at least one physiological health indicator at week 12 of the programme (End Assessment statistics).	70% of completers achieved a reduction in their blood pressure, BMI and/or resting heart rate.	improved BP *** **76% (19 out of 25**) 77% (33 out of 43) improved weight **76% (19 out of 25)** 72% (31 out of 43) improved BMI **52% (13 out of 25)** 56% (24 out of 43)
Number of 6 month follow-ups successfully contacted (from Initial Assessment date).	80% of the number that completed the programme	86% (32 of 37 completers)**
Number of people that took up an identified Exercise on Referral exit route and still active at 6 months after their Initial Assessment.	75% of the number that completed the programme	**88% (22 out of 25)***** 93% (40 out of 43)****
Number of 12 month follow-ups successfully contacted (from Initial Assessment date).	80% of the number that completed the programme	n/a
Number of people that took up an identified Exercise on Referral exit route and still active at 12 months after their Initial Assessment.	70% of the number that completed the programme	n/a

Table 2.

*** 11 (15%) people did not respond to contact therefore did not attend their IA or first training session. They have been referred back to the GP via the SLA procedure. 1 was referred back to his GP due to being a Cardiac Patient.**

****The majority of participants were within the date range, however two participants were out of the country for periods of time so skewed the data.**

***** The first number, those who started and finished in this financial year. The second number is the total number of completers including those who started in the pilot programme but finished in this financial year.**

****** This is actually 38% from all initial referrals , Still active is defined as still participating in their exit route of our Young at Heart program or a membership at Golden Lane Sport & Leisure.**

*******Of the 69 people due their 6 monthly follow ups, 31 (44%) didn't complete the programme and 1 (0.1%) is still in the programme for various reasons, therefore they are not included in the statistics.**

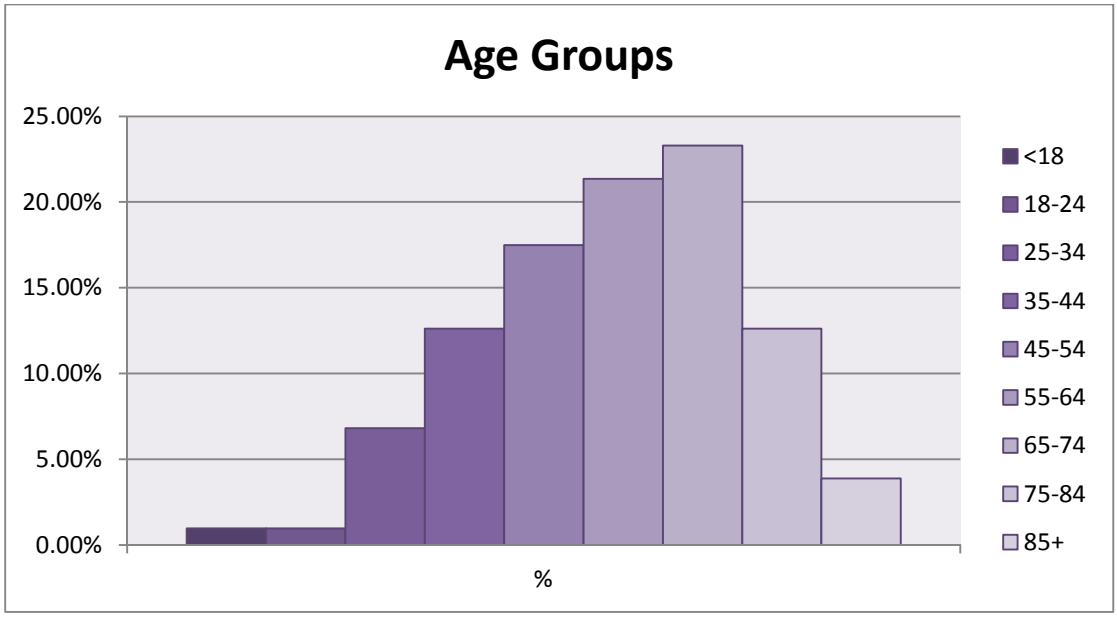
******* *37 completers' includes those from the pilot scheme who 6 month update was due in this financial year**

Demographic data:

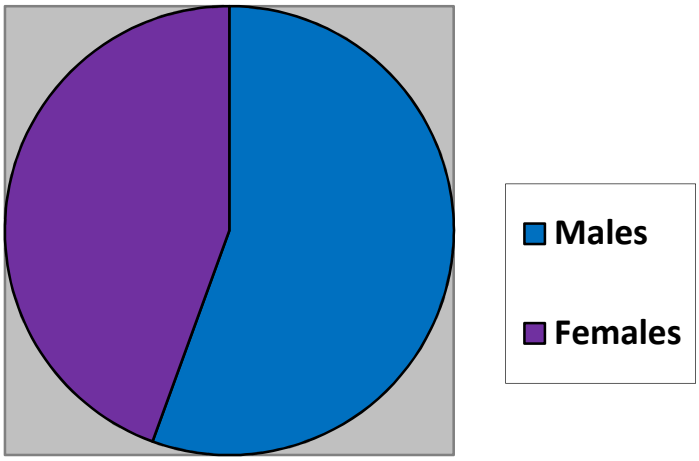
All 73 referrals:

Referrers demographic	
Age	Average 58 (Range: Lowest – 16 Highest: 89)
Gender	Female: 40 Male: 32

Table 3.



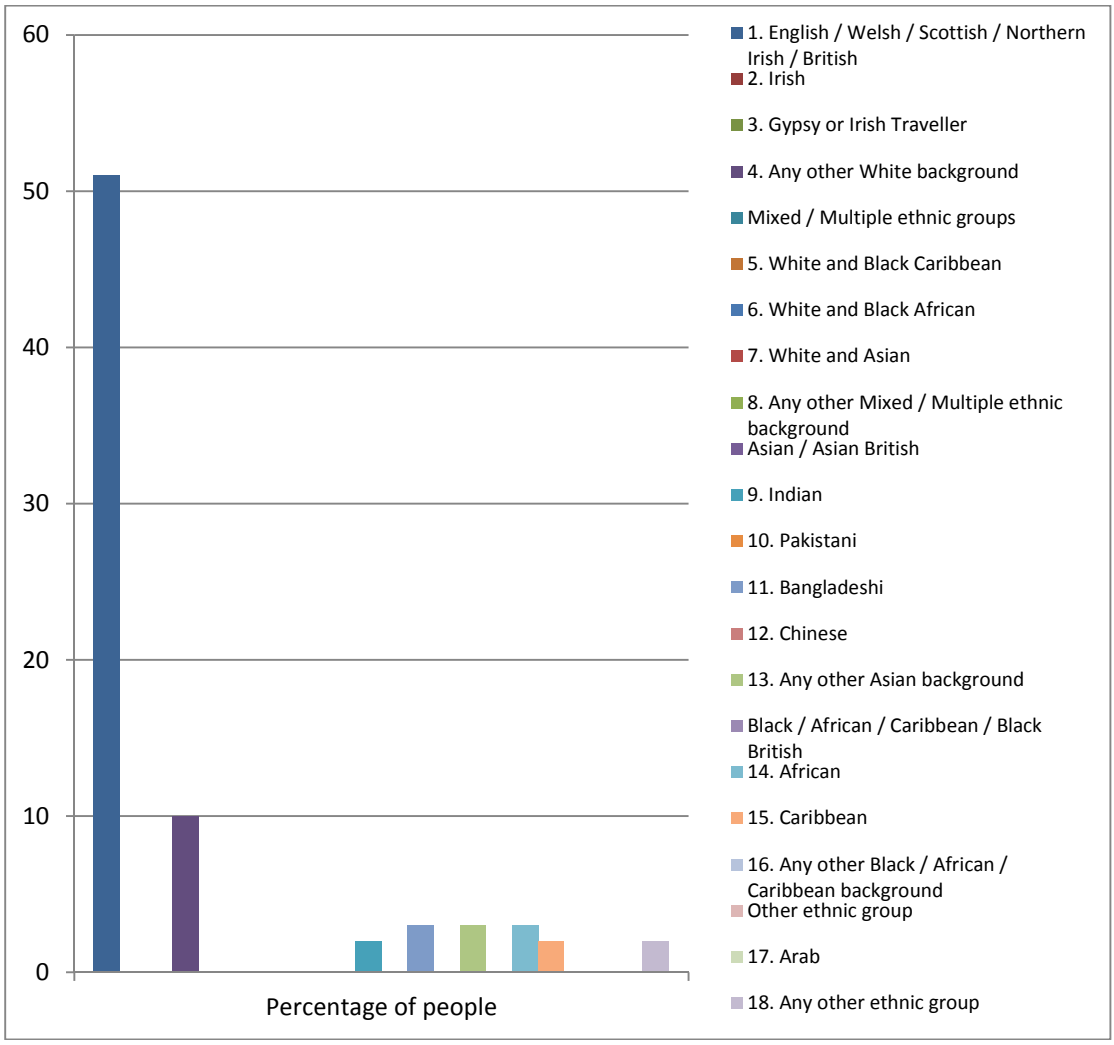
Graph 1: Age of referrals



Graph 2: Gender of Referrals

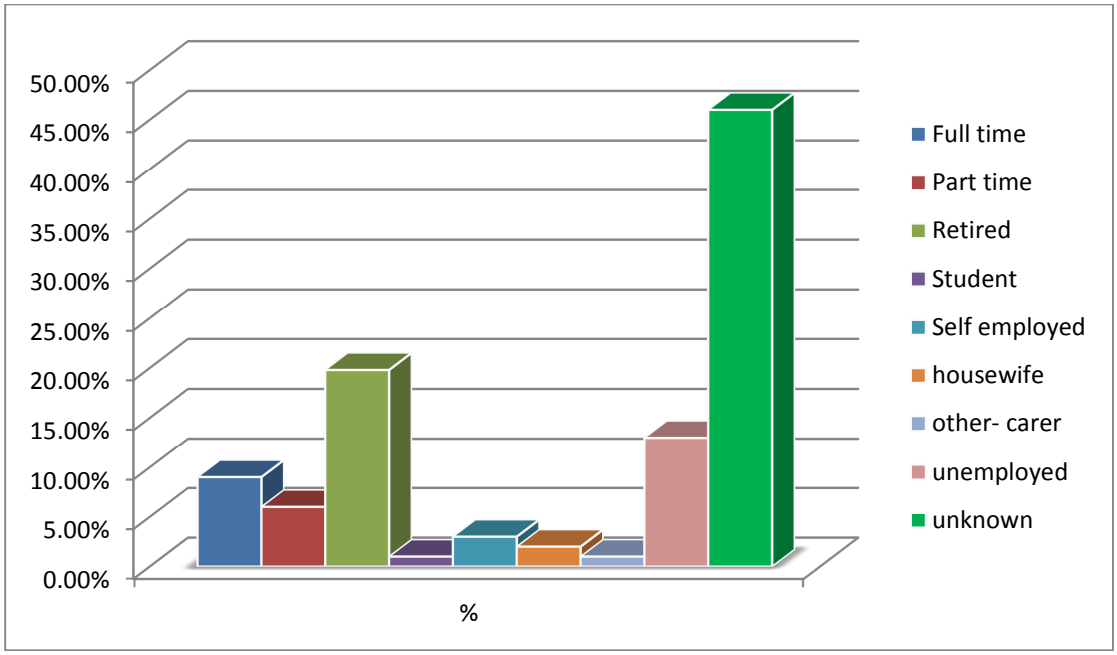
Graph 1 shows that the average age of our participants is 58, but we have a range of 73 years giving us strength in depth. We typically see more females in most of our

programmes targeting older people / health, but Graph 2 shows a strength of the programme in that we have slightly more males in the programme showing the programme caters well for both genders.



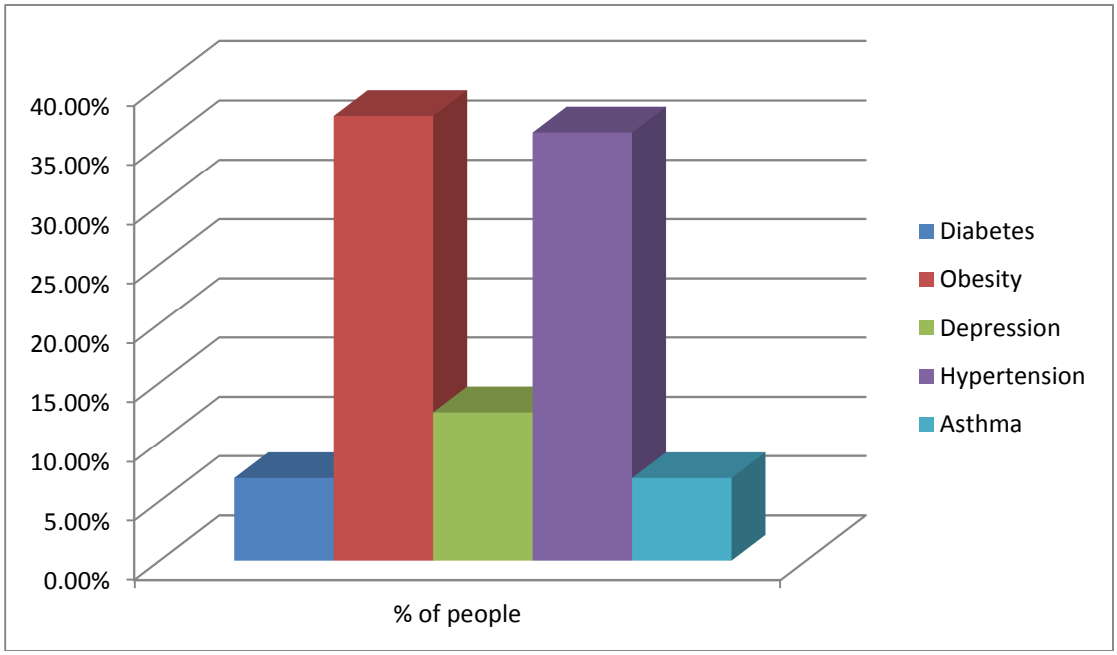
Graph 3: Ethnicity of referrals.

The above graph shows the ethnic breakdown of the pilot participants. English, Welsh, Scottish, Northern Irish and British and other white background are the main referred groups with a large percent unknown or not disclosed.



Graph 4: Employment Status

The above graph shows that most of our referrals that we have information about, are retired or unemployed which gives us a basis of what time of day is best to engage most of our clients.



Graph 5: Types of medical conditions.

The vast majority of users on the scheme have multiple health conditions, individuals are rarely referred due to one condition. The majority of referrals are from those who are obese (37%) followed by hypertension (36%) and Depression (12%).

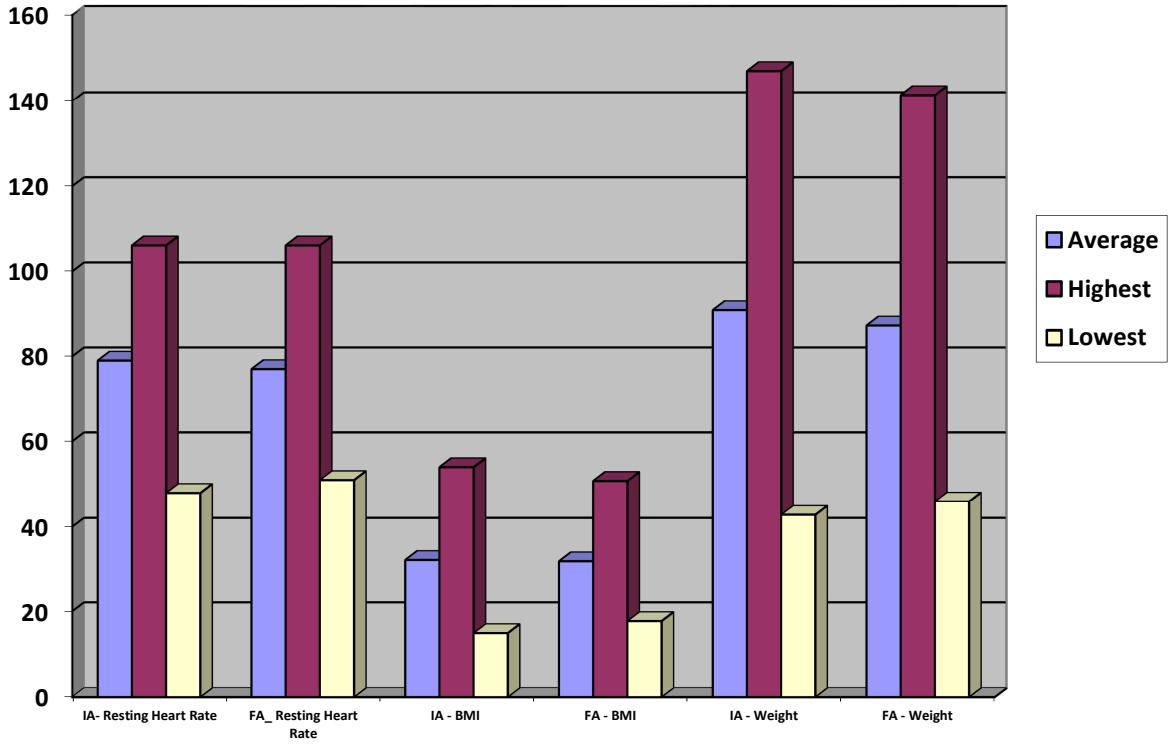
Physiological measurements at Initial Assessment.

62 people attended their Initial Assessment out of 73 referrals.

Physiological measurement	At Initial Assessment	After programme
Resting Heart Rate	Average 79 (Range: Lowest: 48 – Highest: 106)	Average 77 (Range: Lowest 51 – Highest 106)
Blood Pressure	Average 148/86 (Range: Lowest: 98/73 – Highest: 162/116)	Average 134/85 (Range: Lowest: 98/73 – Highest: 145/89)
BMI (height/weight)*	Average 32.2 (Range: Lowest: 14.9 – Highest: 54)	Average 31.9 (Range: Lowest: 17.70 – Highest: 50.8)
Weight	Average 91 (Range: Lowest: 42 – Highest: 147	Average 87 ((Range: Lowest: 46 – Highest: 141)

Table 4: Physiological measurements at Initial Assessment and Final Assessment

Out of the 62 people that attended their Initial Assessment 25 have completed the programme:

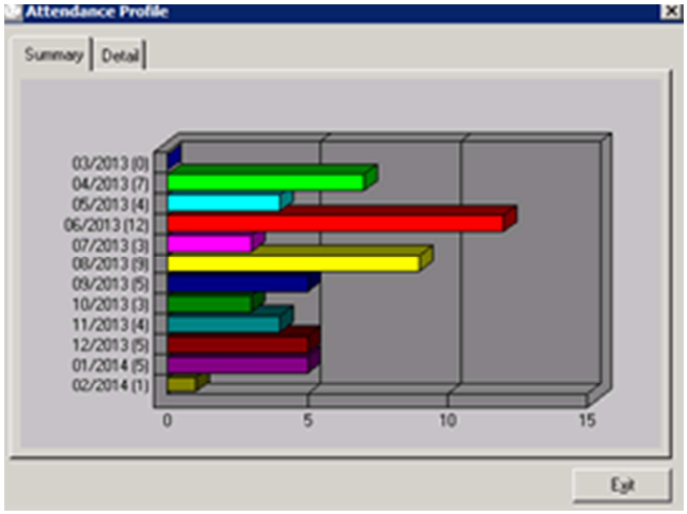


Graph 6: Average physiological measurements at End Assessment of the completers.

Of the 25 people that have currently completed the course, 23 people (92%) improved at least one physiological health indicator at the End Assessment and 16 had an increased activity from baseline with the other 9 maintaining their activity. 18

out of 25 saw a decrease in their resting heart rate (RHR), 19 out of 25 saw a decrease in their blood pressure and 19 of the 25 saw a weight loss.

Exit routes
Of the 25 people that have completed the programme, 12 have gone on to the Young at Heart programme and 10 are now on discounted memberships with one moving back to the USA, one moving away and one was undisclosed.



Graph 7: Membership attendance of former EoR client
The above graph shows the attendance to Golden Lane Sport and Fitness, by month, from a former Exercise on Referral client. This shows that our exit routes are being utilised well.

6 Monthly Follow ups
Since the start of the programme, including the pilot scheme we have 69 people who are due their 6 monthly follow up appointments. Of these 69, 31 people have not completed the programme therefore have not been accounted for. Of the 37 who have completed, 32 have had their 6 month follow up. 29 of the 32 completers (90%) have stated they feel their health has improved since being on the programme and have continued with physical activity.

Evaluating re-referrals and overdue assessments
Of the 73 referrals, 14 have been re-referred back to the GP. Of these, 11 were due to non attendance for the initial assessment and no contact since then, 2 were due to illness which affected their attendance on the programme and 1 was deceased.
There are currently 9 final assessments outstanding with these not completed due to 5 people having no contact after 3 attempts of the follow up and 4 people being due to non attendance in the latter stages of their programme, therefore not having their final assessment. These will be re-referred after 3 months of no contact.

Partnerships and referrals to the programme.
We have undertaken extensive partnership work to ensure the schemes are operating effectively, in line with local needs and the national quality assurance

framework for exercise on referral schemes. Of the 73 referrals, 67 came from the Neaman Practice, 2 from the City Wellbeing practice, 1 from Goswell road pharmacy 1 from the Substance Misuse Team, 1 from St Peter's Street Medical practice and 1 from Donald Winicott Centre.

The two City of London GP practices have been met with and individually and explained the referral procedure, strategic fit and benefits of the programme.

The central referral point is the Neaman Practice in the City of London. Other referral points include;

- City Advice Service, Toynbee Hall
- Substance Misuse Team.
- Homeless services including Broadway
- Adult Social Care
- Physiotherapists
- Pharmacies
- Dentists
- GP's
- Practice Nurse
- Community Nurse
- Mental health professionals
- Occupational therapists
- Specialist nurses

Summary of the programme to date.

Key strengths

- The number of referrals made.
- Easy transition to exit routes including reduced membership, CoL resident pay as you go rates and Young at Heart.
- Excellent staff involved with the programme who are essential to the programme, who are all trained in exercise referral and are registered REPS (register of exercise professionals) level 3, have an enhanced CRB check and have a minimum expected competence level in first aid training.
- Extended staff training, one instructor has completed their aqua course so we can offer this as a class and further training is planned for the coming year.
- Programme has been commissioned to run for an additional full year in 2014/15.
- The procedure for referral has now been ingrained at the Neaman Practice.
- Extensive partnership work has taken place and the scheme has benefitted from this and continues to do so.

Key issues:

- During the April 2013 to March 2014 we experienced a number of issues during the programme with the amount of participants who are on holiday during the summer months and also Christmas holidays; as a result our end assessment dates have been over target.
- Monitoring participants through the BMI scale seemed to be an issue as this is not a reliable form of measuring, due to it not being able to distinguish between muscle mass and body fat. We would look to utilise a body circumference measure or body fat percentage instead going forward.
- We have received numerous referrals for City workers that we have had to decline as they are not City residents. We feel that they are in need of the programme and may not have programmes where they live thus would like to accept City of London providers participants going forward in the scheme.

Proposals for 2014/15

- Increase the number of City residents referred and open up the avenues for City workers to be referred. (Target 73 residents. Target for City workers to be determined.
- Increase the number of completers. (Target 60%)
- Monitor Customer satisfaction.
- Ensure participants complete 12 consecutive weeks. (16 weeks with a 4 week grace period for holidays and illnesses)
- Increase the number of partners contacted.
- Work with and accept referrals from GP surgeries outside of the City of London.
- To develop the programme to enable City workers to access the GP Referral scheme. The service will be targeted at City of London low paid/high risk workers within the square mile, working in the following sectors: Manufacturing, Construction, Retail, Food Service, Transport and Storage.
- To enhance the awareness of the programme becoming Cardiac phase IV accredited programme and increase awareness to referrers.
- To monitor the number of Stroke and Cancer rehabilitation referrals in order determine the need for up skilling instructors in these areas.
- Incorporate monitoring of physiological measurements at 6 months and 12 months to track progress.

SWOT analysis of the City of London Exercise on Referral Scheme

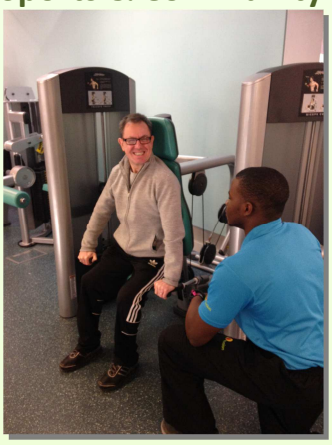
Strengths	**Weaknesses**
1. There is 1 to 1 tuition for 12 weeks not 1 to group sessions like most other GP referral schemes. 2. Partnership work with other services promotions of cross referrals. 3. Fusion Lifestyle Sports Development team have an in depth understanding and knowledge of the local area and variety of exit routes. 4. The scheme is hosted in a newly refurbished leisure centre which has a greater variety and range of activities on offer. It is a sports specific environment compared to the doctor's surgery and has changing rooms that are fully accessible. 5. The geographical location is an advantage for the residents, and is less than a mile from the main GP surgery. 6. Consistency of the instructor from the Exercise on Referral scheme through to the exit routes and weight management course. 7. Offer specific weight management course.	1. Do not have a measure of the total number of residents that would be eligible for the scheme. 2. Gym based sessions only until participant numbers grow. 3. Do not accept cardiac rehab patients. 4. The monitoring and evaluation will not be substantial until the 12 month marker for each individual. *See risk mitigation section.
Opportunities	**Threats**
1. Long term potential to include City Workers. 2.The pilot was a success, there is the potential to increase the programme to include permanent evening and weekend sessions. 3. Measure the requirement for class based exercise when there are more participants, classes and swimming based activities. 4. Long term potential to include cardiac rehabilitation in the scheme. 5. Opportunity to work with Tower Hamlets public health commissioners and surgeries to refer Portsoken Ward residents. 6. On the findings from the pilot we are to introduce a high/moderate/low risk induction / programme card to clearly identify risk categories.	1. Health and Wellbeing boards are newly established, funding may not re-commission Exercise on Referral programmes after 31.3.15. 2. Changeover of staff from the GP practices and partners, loss of knowledge. 3. Need to build new relationships. 4. Saturate the number of City residents needing the scheme.

Risk mitigation

1. Do not have a measure of the total number of City residents that would be eligible for the scheme – Working with Adult Social Care and their database to produce a procedure on cross referrals.
2. Need to establish effective referral pathways for City workers - in discussion with the public health team around this.
3. Gym and Aqua based sessions only until participant numbers grow – We continually review the timetable and look to deliver additional class's dependant on feedback from current participants.
4. Do not accept cancer or stroke rehab patients – The number of stroke and cancer rehabilitation referrals will be measured, with the long term aim of recruiting/up skilling specialised rehabilitation instructors if needed.

This will help us develop and evolve the scheme over the next 12 months.

Sports & Community Case Study



Exercise on Referral – Jan 2014: CS No 2.
City of London

Target Group: Exercise on Referral Participants

Funded Scheme: The City of London GP Referral Scheme is funded by City of London Health and Wellbeing Board

Scheme Summary: Supporting participants and encouraging an active healthier lifestyle.

Participation Impact: From limited/no exercise participants become regular gym users.

Key Outcomes:

On starting the programme this participant was 5 month post-stroke. He had been discharged from the hospital in February 2012 and joined our scheme 3 weeks later. Initially the participant was only able to maneuveor with the assistance of a care worker and his zimmer frame. Due to issues with his balance all exercises were performed in a comfortable seated position and were supplementing the exercise program previously prescribed by his last care worker. Cardiovascular exercises for both the upper and lower body were favoured to begin with as they also allowed the participant to work on his co-ordination. As the participants strength and confidence grew he was gradually progressed onto strengthening exercises using resistance machines, this was a process the participant had been looking forward to as regaining his strength was a top priority he had set himself. Alongside the home-based balance and co-ordination exercises he was performing, the participant eventually progressed to a level of strength and mobility that he was comfortable at as he was able to perform most of his daily tasks: regaining his independence. This participant was highly motivated and the team found him a great pleasure to work with.

	1st Assessment	Exit Assessment
Blood pressure	123/84 hr84	126/74 hr65
Weight	58.8kgs	65.9kgs
Height	160cm	160cm
BMI	22.9	25.7

Sports & Community Case Study

Exercise on Referral – Jan 2014: CS No 1.
City of London

Target Group: Exercise on Referral Participants
Funded Scheme: The City of London GP Referral Scheme is funded by City of London Health and Wellbeing Board
Scheme Summary: Supporting participants and encouraging an active healthier lifestyle.
Participation Impact: From limited/no exercise participants become regular gym users.

Key Outcomes:

At the start of the programme this participant was extremely cautious and nervous about exercise particularly concerning his lower back and knee. The instructor started off by prescribing a cardio-vascular work out which was low impact and focused on improving fitness. As the participants confidence grew we added additional strength and conditioning exercises to his programme. These were mainly focused on his lower back and legs. With some trial and error we managed to work through the technique in these exercises and the participants programme grew. Just over half way through the scheme the participant reported that he no longer had pain in his knee or back and that he wanted to try and increase the intensity of his workout. The instructor then set about gradually increasing the intensity and integrated some interval training. Overall the participant has been a pleasure to work with and a very determined person. The Exercise on referral team has no doubt that with continued support he will go on and achieve more fitness and weight loss gains.

Please find the key performance indicator statistics below highlighting his success on the programme through weight loss.

	1st Assessment	Exit Assessment
Blood pressure	122/86 hr70	123/87 hr55
Weight	97kgs	86.9kgs
Height	180cm	180cm
BMI	29.7	26.8

Committee(s):	Date(s):
Health and Wellbeing Board	30 May 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.
This update covers the following points:

- The forthcoming annual report from Healthwatch City of London
- Involvement in the Dementia Awareness day 20 May 2014
- Our joint event with the Corporation on the JSNA City Supplement
- Work with the Bengali group based in the Portsoken ward

Recommendation(s)

Members are asked to:

- Note this report, which is for information only

Main Report

Background

1. This report is to update Members on key developments and activities undertaken by Healthwatch.

Current Position

Healthwatch Mission statement and Priorities

2. A consultation was held on the Healthwatch City of London mission statement and priorities and has now closed. Feedback will be taken to the next Healthwatch City of London board meeting on 27 May for discussion and approval. The final mission statement and priorities will be agreed and then circulated to stakeholders.

Healthwatch City of London annual report

3. We are currently working on our annual report for the first year of Healthwatch City of London. Through the report we aim not only to meet legal requirements but also to demonstrate our work to stakeholders in the community in terms of impact and how we have worked with local partners and groups in the City. The report will cover the following areas:

- How we have delivered against our statutory activities
- The impact of our work on the commissioning, provision and on the management of health and care services
- How local peoples' needs and experiences of health and care services have been obtained
- Work we have done to get the views of young and older people, disadvantaged or vulnerable people and people who are seldom heard
- How volunteers and lay people are engaged in our work and governance structures

4. The report will be publicly available and sent to the following bodies: Healthwatch England, The Care Quality Commission, NHS England, City and Hackney CCG, the overview and scrutiny committee for the City, the City of London Corporation.

Involvement in the Dementia Awareness Day 20 May

5. Healthwatch City of London has worked in partnership with the City of London Adult Social Care Team in publicising the event on dementia awareness on 20 May. The event links in with our priority on dementia and will include discussion sessions on the following areas:

    - What to do if you are worried about Dementia
    - Dementia Friends
    - Dementia Friendly City of London

6. Healthwatch has also publicised the Memory Club Tea Party and Reminiscence which will include:

    - Dementia information and hand-outs
    - Interactive activities
    - How new technology can help you with your memory

7. There has already been significant interest in the event from members who want to become more connected with joined up services in the Dementia Friendly City of London and who want to find out where to go for help if necessary.

Consultation event on the JSNA City Supplement 1 May

8. On Thursday 1 May Healthwatch City of London ran a join consultation event with the City of London on the Joint Strategic Needs Assessment 2014 for the City of London. The focus was on the City Supplement and how it reflects the needs of the City. The objective of the event was to look at the health needs of people in the City, how they are changing and how services should respond. We wanted to ensure that services are shaped to suit the health needs of local people now and in the future.

9. The attendees were a mixture of residents and workers in the City and providers of health and social care. After a presentation on the JSNA City supplement the attendees discussed the document in small groups depending on whether they were residents or providers. Questions included:

    - Any surprises so far?
    - Do you think the JSNA reflect the City, as you know it?
    - Is there anything missing that you think should be in here?

- Having seen the JSNA data, what issues do you think we need to focus on more?

10. A full report on the feedback from the group sessions will be provided by Farrah Hart, Health and Wellbeing Policy Development Manager and Maria Cheung, Health and Wellbeing Executive Support. Comments received by Healthwatch City of London on our evaluation form highlighted that attendees liked the interactive nature of the meeting and found the chance to share concerns with other residents and providers useful. Topics that were suggested for future meetings included: diabetes checks at City pharmacies, care in the home and care homes, mental health, air quality and related health issues and social isolation.

Work with the Bengali group based in Portsoken

11. The Healthwatch Manager has made connections with the Portsoken group of Asian women. During the meeting it was identified that none of the ladies attended the City GP's. There were difficulties in attending surgeries as the doctors tended to be male and the interpreters were male therefore ladies are not comfortable to speak about their concerns or medical problems.

12. The ladies tended not to attend breast screening as they felt embarrassed. They were worried that men or male interpreters may be there; that talking to strangers was uncomfortable and felt that their English is not good enough to communicate health concerns, especially if a form is to be filled. We will be looking into the possibilities of making a block booking for breast screening and taking all the ladies together with their community worker.

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 details on our published annual report.

Appendices

n/a

Samantha Mauger
Chair of Healthwatch City of London

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Committee(s):			Date(s):
Community and Children's Services	–	For decision	13 June 2014
Health and Wellbeing Board	–	For information	30 May 2014
City of London Police Committee	–	For information	23 May 2014
Port Health and Environmental Services Committee	–	For information	13 May 2014

Subject:	Public
Homelessness Strategy 2014–2019	

Report of:
Director of Community and Children's Services

Summary

This report seeks approval from Members for the Homelessness Strategy 2014–2019.

The Homelessness Act 2002 requires the City of London to review homelessness in its area and develop a local strategy every five years. This report introduces to Members the third City of London Homelessness Strategy developed in response to this legislative requirement.

The strategy identifies five strategic priorities developed through consultation with Members, external and internal stakeholders, and users of homeless services in the City or supported by the City. These are:

- preventing homelessness
- ending rough sleeping
- increasing the supply of and access to accommodation
- delivering outstanding integrated services
- improving the health and wellbeing of homeless people.

For each priority the strategy identifies what will be done to address the key challenges of that priority. The nature and complexity of homelessness is such that delivery of this strategy will require the commitment, response and resources of a number of partner agencies and City of London services – including policing, health providers, environmental services, voluntary sector providers and a range of services within the Department of Community and Children's Services.

A separate action plan will be developed to support the implementation of the approved Homelessness Strategy and monitor its progress. This action plan will be refreshed annually.

Recommendation(s)

Members are asked to:

- approve the Homelessness Strategy.

Main Report

Background

1. The Homelessness Act 2002 requires local authorities to review and renew their homelessness strategy every five years. The purpose of this strategy is to set out the City of London's priorities. These will govern a framework within which the City and its partners can deliver better outcomes for individuals who are homeless or at risk of homelessness.

2. The City of London's Homelessness Strategy 2014–2019 has been developed to replace the previous strategy approved by Grand Committee in 2008. It also replaces and incorporates the previous Rough Sleeping Strategy. The strategy sits alongside the Housing Strategy, Housing Allocations Policy and Health and Wellbeing Strategy in setting out the City of London's comprehensive response to homelessness.

3. The City's Homelessness Strategy will govern our approach for five years. However, in a period of emerging policies and economic change, it is vital that it remains responsive. For that reason it will be underpinned by a separate action plan that will be refreshed annually. This is currently being developed.

Current Position

4. The incidence of homelessness in the City of London is atypical in that there are relatively high levels of rough sleeping, but low levels of statutory homelessness (applications from families and individuals seeking local authority support under the provisions of the Housing Act 1996).

5. Across 2012–2013 284 people were recorded sleeping on the streets of the Square Mile of whom 112 (39 per cent) were seen rough sleeping for the first time. In the same year, the City took 37 applications from households who were homeless or at risk of homelessness and accepted a duty to house 20. A further 70 households were given housing advice to prevent or end homelessness.

6. Rough sleeping and wider homelessness are increasing across London. In 2012–2013 rough sleeping in the capital rose by 13 per cent: in the same period the City of London experienced an increase of 14 per cent.

7. There is a commitment at a national, regional and sub-regional level to tackle homelessness. This commitment is echoed in the City of London and articulated through its achievements, Homelessness Strategy and delivery of services.

8. Since the last Homelessness Strategy the City of London has increased opportunities to find homes in the private rented sector, helped families at risk of homelessness through its Troubled Families Project, supported innovative partnership projects to tackle rough sleeping such as pan-London Personalisation and the Lodge, and recommissioned independent advice for City residents and workers in need of support.

Proposals

9. A draft City of London Homelessness Strategy has been prepared for Members' consideration (see Appendix 1). It was developed through consultation with key stakeholders, including Members, teams across the Department of Community and Children's Services, Built Environment, the Community Safety Partnership, the City of London Police Service, health providers, voluntary sector services, neighbouring boroughs and those who have experienced homelessness and those who remain homeless in the City.

10. The strategy also draws on the successes, learning and changing environment that have been experienced within and beyond the City since the last strategy was produced. It highlights the five priorities:
    - preventing homelessness
    - ending rough sleeping
    - increasing supply of and access to accommodation
    - delivering outstanding integrated services
    - improving the health and wellbeing of homeless people.

11. Under each priority, the strategy states 'we will'. The 'we' does not refer to the City alone. It is instead a reference to the broad range of partners – City services, outreach services, health services, the City of London Police, businesses and others – who have a role in delivering better outcomes for those who are homeless or at risk of homelessness.

12. Where the City is responsible, it will lead on the delivery of actions, and where partners are responsible, the City will work to co-ordinate and support delivery where necessary. The City will lead on monitoring the implementation of this strategy and reporting its progress.

13. The City will develop the action plan that supports this strategy and that delivers the commitments made under each priority. Many of the actions will replicate the commitments set out in the strategy but will provide greater detail of the lead, timescales and measurable outcomes. Further detailed actions will be a product of initial actions to review process and services. Others will respond to emerging trends or changes in resources or legislation.

14. The action plan will be refreshed annually. Its delivery will be monitored by the leadership team of the City's Department of Community and Children's Services, and reported to its Grand Committee.

15. The development of the strategy has been subject to an Equalities Impact Assessment which is attached as Appendix 2. Where target equality groups are over-represented in homelessness it is believed that the implementation of the Homelessness Strategy will benefit these groups positively. The City of London uses a range of specialist support agencies to meet the needs of equalities groups such as those from particular migrant communities or the lesbian, gay, bisexual and transgender community. It is acknowledged that the collection of monitoring information could be improved.

Corporate and Strategic Implications

16. The City's Corporate Strategy seeks a world class City which supports our communities through the appropriate provision of housing, and supports a safer and stronger City through supporting community cohesion. This Homelessness Strategy supports the delivery of that vision, the delivery of the Corporate Plan that underpins it, and the City's drive to deliver high-quality, accessible and responsive services benefiting its communities, neighbours, London and the nation.

17. The City's Homelessness Strategy sits alongside other Community and Children's Services strategies including the Housing Strategy, Housing Allocations Policy and the Health and Wellbeing Strategy.

Other Implications

18. Homelessness is driven by a number of factors. Most of these are beyond the control of the City of London or any local authority. As such the demand and implications for services can be hard to predict.

19. Rough sleeping, in particular, requires the input of a range of partner organisations from within and outside the City. The co-operation of City of London Adult Social Care, the police, health, Built Environment and housing services is necessary for the delivery of the Homelessness Strategy. Therefore the strategy has implications for the resources of these teams and organisations, and calls upon them will need to be negotiated and agreed.

20. The Comptroller and City Solicitor has been consulted and has no additional comment. There are no additional financial or HR implications arising from this report.

Conclusion

21. The City of London Homelessness Strategy 2014–2019 sets out a five-year vision to deliver better outcomes for those who are homeless and those at risk of becoming so. Through broad consultation it has identified the City's strategic priorities for tackling homelessness, the outcomes sought in relation to those priorities and the actions to deliver them. Its approval by Members will give direction to the range of partners necessary for its delivery and to secure its implementation.

Appendices

- Appendix 1 – Draft City of London Homelessness Strategy 2014–2019
- Appendix 2 – Equalities Impact Assessment

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Cover page

The City of London Corporation Homelessness Strategy

2014–2019

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The City of London Corporation Homelessness Strategy

2014–2019

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1. Introduction

Homelessness presents most obviously in the City of London among those seen sleeping rough on the streets or in the doorways of the Square Mile. However, homelessness is wider than rough sleeping, and includes those hidden from view who may sleep on a friend's sofa or in a squat. It can also include those who have a roof over their head, but one under which it is not safe to remain, or those who occupy a home that is unsuitable due to severe overcrowding.

Homelessness is experienced by single people, couples and families with children. It can be a consequence of personal circumstances such as ill health and family breakdown, or wider issues such as unemployment and housing shortage.

Being without a home can have significant negative impacts on employment, education, health and wellbeing. In its worst manifestation – rough sleeping – homelessness can result in lasting damage to physical and mental health, and premature death. Homelessness can also have significant costs to society and the public purse.

The City of London Corporation ('the City') is committed to tackling homelessness. This commitment is articulated below in the five strategic priorities that will drive our response and services over the coming years. These are:

- preventing homelessness
- ending rough sleeping
- increasing supply of and access to accommodation
- delivering outstanding integrated services, and
- improving the health and wellbeing of homeless people.

In pursuing these priorities the City will continue to find innovative and practical ways to help those who are at risk of homelessness or find themselves without a home. Integral to this approach is the strength of the partnerships within the City itself, and with our statutory and voluntary sector partners. This Homelessness Strategy sets out a framework within which those partnerships can continue to thrive in order to deliver better outcomes for individuals, and more efficient and effective services.

The City's Homelessness Strategy will govern our approach for five years. However, in a period of emerging policies and economic change, it is vital that it remains responsive. For that reason it will be underpinned by a separate action plan that will be refreshed annually.

2. Strategic context

National context

The current Government has set out a clear commitment to tackling homelessness. In its housing strategy, *Laying the foundations: A housing strategy for England* (November 2011), the Government states:

> …tackling homelessness is a key priority for the Government. We recognise that this will be a demanding task over the next few years, as the legacy of the recession continues to bite. We know that statutory homelessness

acceptances are rising and there are signs that rough sleeping is increasing in key areas such as London.

The pressure recognised in this strategy underpinned the publication of the first report of the ministerial working group on preventing and tackling homelessness – *Vision to end rough sleeping* – and the follow-up policy paper – *Making every contact count: A joint approach to preventing homelessness.*[1] The latter sets out ten local challenges to local authorities and their partners to:

- adopt a corporate commitment to prevent homelessness which has buy-in across all local authority services
- actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs
- offer a housing options prevention service to all clients, including written advice
- adopt a No Second Night Out model or an effective local alternative
- have housing pathways agreed or in development with each key partner and client group that include appropriate accommodation and support
- develop a suitable private rented sector offer for all client groups, including advice and support to both client and landlord
- actively engage in preventing mortgage repossessions, including through the Mortgage Rescue Scheme
- have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually to be responsive to emerging needs
- not place any young person aged 16 or 17 in bed and breakfast accommodation, and
- not place any families in bed and breakfast accommodation unless in an emergency and for no longer than six weeks.

In meeting these challenges it is the Government's intention that local authorities should deliver 'Gold Standard' services to those who are homeless or at risk of homelessness.

The Government's policy ambitions are set out in a context of legislative change and significant financial pressure in the public sector. The Localism Act 2011 introduced a number of freedoms and flexibilities with the potential to significantly change local approaches to tackling homelessness and meeting housing need. These include the power for local authorities to fully discharge their duty to secure accommodation for homeless households through an offer of suitable accommodation in the private rented sector. It also introduced the freedom for an authority to decide whether to continue operating an open housing register or introduce local eligibility criteria to determine who qualifies for social housing.

Alongside these reforms, the Government is also undertaking a radical reform of the welfare system. The reforms, aimed at creating a fairer system that better incentivises work, have – among other changes – introduced caps on the total amount of benefit payable to households. In London this change may restrict access to the private rented sector for larger households in housing need.

[1] www.gov.uk/government/publications/making-every-contact-count-a-joint-approach-to-preventing-homelessness

Regional context

The Mayor of London's *London Housing Strategy* (February 2010) sets out his regional priorities and policies for housing in the capital.[2] The housing policies and strategies for local authorities in London are required to be in 'general conformity' with the Mayor's strategy. The Mayor has since published a revised draft, *Homes for London: The Draft London Housing Strategy 2013*, for consultation with the public.[3] Both documents set out clearly the Mayor's commitments to tackling homelessness and ending rough sleeping in the capital.

The Mayor has set out his support for the Government's social housing reform agenda. He recognises that the reform will give local authorities far more say over how and to whom their social housing is allocated and will give greater flexibility in how they prevent and deal with homelessness. His strategy also recognises the importance of the private rented sector in providing for households in housing need, including those who are homeless. However, his draft strategy expects a balanced approach, which provides opportunity for homeless households in both the private and the social sector. He is also committed to increasing the number of affordable homes to buy and to rent, in order to tackle growing waiting lists, homelessness and overcrowding.

In his first term, the Mayor committed to end rough sleeping by the end of 2012. Significant progress was made towards this target, including within the City. However, his ambition that no one should live on the streets, and that no one arriving new to the streets should spend more than one night out, has not been fully met. Despite this, the Mayor has made clear that his commitment to end rough sleeping remains. This was supported by the establishment of the Mayor's Rough Sleeping Group in 2013, a strategic grouping of mainly central London authorities, of which the City is a core member.

City context

The City's Corporate Strategy seeks a world class City which supports our communities through the appropriate provision of housing, and supports a safer and stronger City through supporting community cohesion. This strategy supports the delivery of that vision, the delivery of the Corporate Plan that underpins it, and the City's drive to deliver high-quality, accessible and responsive services benefiting its communities, neighbours, London and the nation.

The City's Homelessness Strategy sits alongside the Housing Strategy and Housing Allocations Policy. The Housing Strategy includes within its strategic aims a commitment to:

- increase the supply of homes
- make better use of existing homes
- prevent homelessness
- address the impact of welfare reform
- improve access to support, and
- reduce rough sleeping.

[2] www.london.gov.uk/sites/default/files/archives/uploads-Housing_Strategy_Final_Feb10.pdf
[3] www.london.gov.uk/priorities/housing-land/consultations/draft-london-housing-strategy

As such, the Housing Strategy is critical to the delivery of the priorities set out within this strategy. However, the nature of homelessness and rough sleeping in the City means that this strategy cannot be delivered in isolation of the City's wider role and strategic priorities. Therefore it integrates with, and supports the delivery of, a number of the City's strategies and policies, including:

- ***City Together Strategy: The heart of a world class city 2008–2014***, which identifies the challenge of supporting our communities, including those experiencing homelessness and rough sleeping
- ***Corporate Plan 2013-17***, in which responding to the implications of welfare reform, the Localism Act, and NHS and public health reforms is a key priority
- ***Department of Community and Children's Services Business Plan***, in which protecting and safeguarding vulnerable people through better prevention and early intervention is a priority
- ***Joint Health and Wellbeing Strategy***, in which improving the health and wellbeing of those who are homeless and sleeping rough is identified as a priority, and which sets out plans to reduce health inequalities between local communities, and
- ***Safer City Partnership Plan 2013-16***, which sets out the City's response to domestic abuse, a significant cause of homelessness, and anti-social behaviour.

In addition to ensuring that the cross-cutting approach to preventing and tackling homelessness and rough sleeping is reflected in its key strategic documents, the City has also established a Rough Sleeping Strategy Group to ensure the delivery and responsiveness of these commitments. The group brings together key internal and external partners including Adult Social Care, the City's outreach provider, the City of London Police, local clergy and health partners. The People Division of the Department of Community and Children's Services uses its Senior Management Team meetings to provide a multidisciplinary approach to tackle specific complex cases. Oversight of this work and the wider approach to homelessness is provided by the City's Community and Children's Services Grand Committee.

3. Background, housing need and homelessness in the City

Place and population

The City of London is both the historical and the geographical heart of the capital, bordered by seven central London boroughs. At just one square mile in size it is the world's leading international financial centre, with more than 6,000 businesses, and is also an important visitor destination and transport hub.

The number of people usually resident in the City is around 7,400, with an additional 1,400 people who have a second home in the City but live elsewhere. Over the last decade, population growth has been slow, but it is projected to accelerate and reach 9,190 by 2021.

The City has 4,390 households and large numbers of people of working age. Compared with Greater London there is a greater proportion of people aged between 25 and 69 and fewer young people aged below 18 years. Only 10 per cent of households have children, compared with around 30 per cent for London and the

rest of the country. Average household size is small, and many people (56 per cent) live alone.

The City's population is predominantly white (79 per cent), with the second largest ethnic group being Asian (13 per cent). This group – which includes Indian, Bangladeshi and Chinese populations – has grown over the past decade. The City has a relatively small black population compared with the London-wide population and England and Wales.

This resident population is dwarfed by the City's daytime working population which, at more than 383,000, is some 50 times larger than the resident one. This is projected to grow to 428,000 by 2026.

Housing need

The housing market within the City reflects its unique size and economy and the mobility of some sectors of the population. A large private rented sector provides homes to about 34 per cent of City households; around 19 per cent of households live in social rented housing, and 42 per cent of homes are owner-occupied. As with much of central London and beyond, demand for housing in all tenures outstrips supply. Prices are among the highest in the capital and are increasing faster than wage growth. Private sector rent levels in the City are beyond the reach of any households on benefits.

Demand for the City's social housing is high, with more than 1,000 households on the housing register (waiting list). Overcrowding is a challenge for the City, with around one in three of all households within its boundaries living in accommodation lacking one or more rooms. Of those households on the City's housing register, 326 are overcrowded. In addition to the impacts that overcrowding can have on health and child development, it can also trigger homelessness. It is an issue that also has a disproportionate impact on black and minority ethnic households.

Homelessness

Its location, size, population and boundaries inform the nature of the City's homelessness challenge. Homelessness and housing needs arise among the City's resident population and its working population. Many who are already homeless, particularly those who sleep rough, come to the City's streets drawn by the busy transport hubs or quieter nighttime environment of the non-residential areas.

The most harmful and most obvious manifestation of homelessness is rough sleeping. However, local authorities also assist households who are homeless (but not street homeless) or who are threatened with homelessness. Some may apply for assistance and in certain circumstances a local authority will have a legal duty to secure accommodation for them. Others at risk of homelessness, or dealing with issues that can easily lead to homelessness, will often seek housing advice from independent agencies as well as the City's services.

Homeless households

The City's Housing Needs and Homelessness services provide advice and assistance to those in housing need, and undertake formal assessments of homelessness

applications to determine whether the City must provide assistance under current legislation.

In 2012/13 the City took 37 applications from households who were homeless or at risk of homelessness. The number of applications has increased in the last two years and is set to continue at this level in 2013/14. The majority of those who approach the City for assistance have a local connection based on employment rather than residency. Of those who applied for assistance in 2012/13, 20 were both homeless and in priority need, and the City accepted a duty to secure settled accommodation.

The City also provided temporary accommodation to 25 households who were either homeless applicants pending a decision on their case, or those whom the City had a duty to house and who were awaiting an offer of settled accommodation. The City is rarely able to provide temporary accommodation within its boundaries, but the majority of 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. The most common issue they dealt with was rent arrears in both social and private rented sector housing. In addition, the City's Housing Needs and Homelessness teams provided advice and assistance to prevent or end the homelessness of a further 51 households.

Rough sleeping

The rough sleeping population is often very transient, and therefore levels of rough sleeping in the City cannot be separated from trends and issues experienced in London as a whole.

In the last four years, the number of rough sleepers seen in the capital has increased dramatically, from 3,472 in 2008/09 to 6,473 in 2012/13.[4] During this period both the number and proportion of rough sleepers from Central and Eastern Europe have increased dramatically, and Central and Eastern European nationals now account for more than a quarter of those seen on the streets.

Over the course of 2012/13, outreach teams recorded a total of 284 people sleeping rough in the City – the sixth highest total in the capital.[5] Of these people, 112 (39 per cent) were new to the streets of London, another 112 (39 per cent) were longer-term rough sleepers who had been seen both in the reported year and in the year before, and 60 (21 per cent) were those who had returned to the streets after a period away. Of those who were new to the streets, 50 per cent were seen just once. The vast majority of those met were male (94 per cent), and 85 per cent were aged between 25 and 55 years. In line with the regional trend, the City has experienced a growth in rough sleepers from European countries (other than the UK), with Central and Eastern European nationals accounting for 28 per cent of those seen on the streets.

4. Progress since the last strategy

[4] www.broadwaylondon.org/CHAIN/Reports/S2h2013/Street-to-Home-report-2012_20132.pdf
[5] www.broadwaylondon.org/CHAIN/Reports/S2h2013/Street-to-Home-report-2012_20132.pdf

Much has been achieved since the publication of the City's last homelessness strategy, including:

- enhanced private rented sector opportunities for families and single people through the City Rent Deposit Scheme, Real Lettings[6] and the East London Housing Partnership's Single Homelessness Project[7]
- the development and expansion (in partnership with Broadway) of the Personalised Budget project, which has succeeded in bringing 20 of the City's most entrenched long-term rough sleepers off the streets
- the development (in partnership with St Mungo's) of The Lodge – an innovative accommodation scheme designed to meet the needs of London's most entrenched rough sleepers
- accommodating 657 people who slept rough in the City and reconnecting a further 267 to advice and services in their home area over the last five years
- moving from having London's third highest annual rough sleeping count in 2007/08 to the sixth highest in 2012/13
- supporting Broadway to deliver an innovative programme of week-long 'pop-up hubs' to provide rapid intervention and support for those sleeping rough in the City which have succeeded in accommodating 25 people
- joint work to design out rough sleeping hotspots and areas that are inaccessible to support workers
- delivery of a Troubled Families project to support households in need of support, including those at risk of eviction
- development of processes and guidance to support care leavers establishing a tenancy
- meeting the City's duty to provide temporary accommodation without placing any young people into bed and breakfast accommodation, and ensuring that no family placed in bed and breakfast accommodation spends more than six weeks in this emergency accommodation
- recommissioning independent advice services for City residents and workers, and
- expanding tenancy support provision to vulnerable households in City of London housing.

5. Developing this strategy

This strategy has been developed through consultation with key stakeholders, including those who have experienced homelessness and those who remain homeless in the City. Others consulted include the following.

Internal:

- Members of the Court of Common Council of the City of London Corporation
- Adult Social Care
- Built Environment
- Children's Social Care
- City of London Police
- Community Safety Partnership
- Early Years and Education
- Housing
- Public Health

[6] For information on Real Lettings, see www.reallettings.com/
[7] For information on the Single Homelessness Project, see www.lbbd.gov.uk/elhp/pdf/SHP-Plan.pdf

- Substance Misuse Partnership

External:
- Broadway
- East London NHS Foundation Trust
- London Borough of Tower Hamlets
- London Probation Trust
- Pathway Homeless Team, Royal London Hospital
- Providence Row
- Providence Row Housing Association
- Toynbee Hall
- Westminster City Council

The strategy also draws on the successes, learning and changing environment that have been experienced within and beyond the City since the last strategy was produced.

This process has identified five key priorities, set out in the section below. For each priority, we set out the issues and challenges the City experiences, what the implementation of this strategy will achieve in addressing that priority, and what will be done to secure those achievements.

No homelessness strategy can be delivered by one organisation. Where under each priority the strategy states 'we will', the 'we' does not refer to the City alone. It is instead a reference to the broad range of partners – City services, outreach services, health services, the City of London Police, businesses and others – who have a role in delivering better outcomes for those who are homeless or at risk of homelessness. Where the City is responsible, it will lead on the delivery of actions, and where partners are responsible, the City will work to co-ordinate and support delivery where necessary. The City will lead on monitoring the implementation of this strategy and reporting its progress (see section 7).

6. Priorities

Priority 1: Preventing homelessness

Why this is a priority:

Homelessness has significant social and financial costs. For families and individuals, homelessness impacts on health, wellbeing, education and employment – impacts that can have lasting consequences for individuals and society. The cost of homelessness to the public purse is also considerable. For the City, providing temporary accommodation and support to homeless families dislocated from their community and support networks can be very costly. Where those who have been helped off the City's streets return to rough sleeping, this places further burdens on outreach services and the resources of partners such as mental health services and the police. Therefore preventing homelessness is a key priority.

Homelessness prevention ranges from early identification and intervention to crisis responses. Identifying those at risk can be challenging, as they may not approach specialist services or recognise the potential to lose their home. For that reason it is

imperative that services across the City are able to identify risk and respond or signpost appropriately as early as possible.

Key challenges:

- In 2012/13, 110 people approached the City for housing advice and support.
- The most common reason for loss of last settled address for households making homeless applications to the City is that family or friends are no longer willing or able to accommodate.
- Some 21 per cent of rough sleepers met in the City in 2012/13 had returned to the streets after a period away.
- A total of 65 City tenants were affected by changes that reduced their welfare benefits – changes that may also impact on some low income workers in the Square Mile.

What we will achieve:

The City will maximise the potential to prevent homelessness by:

- delivering accessible services
- providing effective housing advice and information, and
- supporting people to stay in their homes.

What we will do:

Accessible services

We will:

- review access routes and referral mechanisms to the City's Housing Needs and Homelessness services to ensure that they are clear and customer focused
- provide a free, confidential and independent advice and information service for residents, workers and students in the City who need support with issues such as employment, relationships, benefits and housing, and
- offer phone-based, internet-based and face-to-face housing options advice and homelessness prevention services.

Effective housing advice and information

We will:

- review and improve information on the City's website relating to housing need, housing options and homelessness
- offer tailored support and information to tenants affected by changes to welfare benefits in order to mitigate any negative impacts
- improve recording and data monitoring of housing waiting list and homelessness applicants, and housing advice needs, to inform the design and delivery of services, and
- provide signposting and written advice and assistance to homeless people whom the City does not have a duty to house.

Supporting people to stay in their homes

We will:

- identify vulnerable City tenants at risk of homelessness through joint working between Housing and Adult and Children's Social Care services
- use our Tenancy Support Team to co-ordinate the input and support of services to help to sustain tenancies at risk
- expand the scope of the Tenancy Support Team across landlords and tenures
- develop and promote our Good Neighbour Scheme to provide informal support and earlier opportunities for intervention for City tenants who may be vulnerable
- develop and promote the Befriending Scheme for clients of the City's Adult Social Care services in all tenures to provide informal support and earlier opportunities for intervention
- promote skills and employment as a means to prevent homelessness, sustain housing and increase housing options
- review our protocol for housing management services to ensure that we trigger appropriate interventions and support at the earliest stage for those at risk of eviction
- work with the City's Housing and Adult Social Care Group and Adult Wellbeing Partnership Board to drive continuing integration of services to support vulnerable adults to prevent homelessness and sustain tenancies
- prevent family breakdown and tackle other issues that may result in homelessness through the work of our Children and Families service
- develop a financial inclusion approach for tenants to ensure that they minimise the risk of financial difficulties
- develop a domestic abuse policy to improve multi-agency working and strengthen awareness, responses and support across City services encountering those experiencing domestic abuse
- revise the City's approach to managing anti-social behaviour in its housing to ensure effective intervention to prevent eviction, and
- ensure that there is support for former rough sleepers to help sustain their life away from the streets.

Case study - tenancy sustainment

P fled his home country and arrived in Britain without a legal guardian. P was allocated to the City of London as an unaccompanied minor in need of support. The City was unable to arrange a secure family placement for P, but did arrange specialist accommodation including a two year stay at a foyer for young people.

At the end of this period of care, P was given a tenancy in a City of London property, and provided with support to help establish independence. Support was reduced and finally ended when P appeared fully independent.

P was referred to the City's Tenancy Sustainment Team when rent arrears threatened eviction. The worker supporting P discovered that P's benefits had been stopped and this had led to rent arrears and triggered severe self-neglect. The worker suspected P had underlying mental health issues, which were subsequently diagnosed. Adult Social Care services provided advice and emergency funding.

P engages well with the Tenancy Sustainment Team. They helped P claim benefits for those unable to work and have appealed the sanctions that saw Job Seekers Allowance stopped. They have helped reduce other debts and agreed a payment plan to repay rent arrears and end the risk of eviction. P is engaging with mental health services and now wants to find work.

Priority 2: Ending rough sleeping

Why this is a priority:

Rough sleeping is the most acute and visible form of homelessness, and an issue that remains a challenge within the City of London and beyond. Those who 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 a 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 who continue to sleep 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.

In addition to the impact on individuals, rough sleeping can also have negative impacts on the wider community. The presence of rough sleepers can act to draw others – often the vulnerable – to the streets. For those who live, work or learn in the City, the presence of rough sleepers, beggars and street drinkers can be intimidating, and may undermine their confidence in local support services and the police. Rough sleeping can also impact negatively on specific areas, and may damage business and tourism.

For these reasons the City shares the Mayor of London's ambition to end rough sleeping. It is imperative that a night on the streets does not lead to a lifetime of rough sleeping, and no one should call the streets of the City their home. Ending rough sleeping will require continued partnership and effective collaboration with neighbouring boroughs, voluntary sector providers, health services, the City of

London Police, adult social care services and others. Tackling rough sleeping, especially among those who are entrenched, chaotic or stuck in substance misuse requires more than offering support. Active enforcement, coupled with assertive outreach, is a key factor in reducing numbers by encouraging the take-up of services and accommodation. Within the City there are examples of how such an approach has positively transformed the lives of individuals who had previously spent years sleeping rough.

Key challenges:

- The number of new rough sleepers coming to the streets of London increased by 14 per cent in the last year.
- The success of the City's work with entrenched, older rough sleepers has seen the profile of the rough sleeping population change over recent years to one that is younger.
- Transiency, lack of local connection, accommodation pressures and mainstream models of service delivery make tackling complex and multiple health needs challenging and potentially very costly.
- In the last year, ten people sleeping rough in the City required a Mental Health Act assessment due to concerns about their mental ill health.

What we will achieve:

The City will work in partnership to provide a range of services that:

- deliver a rapid response to those who are new to the streets, to prevent them from spending a second night out
- prevent the return to rough sleeping of those who have been helped to leave the streets
- ensure that no one calls the streets of the Square Mile their home, and
- develop approaches that cut across services, policies and partners to support our vision to end rough sleeping.

What we will do:

No second night out for new rough sleepers

We will:

- provide outreach coverage in the City with the capacity to respond every day of the week
- deliver local responses to prevent new rough sleepers spending a second night on the streets and work proactively and co-operatively with the pan-London No Second Night Out service
- monitor and set targets to increase the proportion of new rough sleepers prevented from spending a second night out
- develop a clear service offer and approach focused on voluntary reconnection for those from European countries, and
- promote the No Second Night Out helpline and StreetLink online reporting tool to provide an opportunity for the public and business to report concerns about rough sleepers.

Preventing return to the streets

We will:

- work with the London-wide rough sleeping Social Impact Bond targeted at those who return frequently to the streets, to secure more sustainable outcomes for that group in the City
- examine the scope of the City's outreach team to provide transitional support to those placed in accommodation who are at risk of eviction or abandonment
- provide tenancy support to rough sleepers housed independently in the City's housing stock, and
- work with our partner services, including local day centres, to ensure that those who have slept rough develop the skills, such as those focused on employment, to sustain life away from the streets.

Ensuring that no one lives on the streets

We will:

- deliver specialist accommodation targeted at the most entrenched rough sleepers
- continue to use personalisation as an approach to help the most entrenched engage with services
- ensure that none of those identified within the 'Rough Sleeping 205' for whom the City is responsible are sleeping rough by the end of 2014, and
- partner with the Home Office and City of London Police to work with those who are not UK nationals who may need regularisation or Home Office enforcement action to resolve their rough sleeping.

Cross-cutting actions

We will:

- undertake a review of the accommodation pathway, including move-on options, available to meet the varying and sometimes complex needs of rough sleepers in the City
- maintain an assertive and consistent approach to outreach working
- review the needs of former rough sleepers in supported living accommodation to ensure that their needs are being met most appropriately
- work with the City's clergy to develop the contribution of churches to tackling rough sleeping and strengthen their links with services
- adopt and develop best practice in police liaison and joint working with City mental health services
- review with the Safer City Partnership the role of, approaches to and use of enforcement action to tackle rough sleeping
- review and develop integrated approaches for rough sleepers needing intervention from substance misuse, mental health or other adult social care services to ensure clarity of processes, responsibilities and roles
- foster and support further innovation in service provision
- discourage and disrupt begging and other behaviours that may sustain people on the streets, and those that cause nuisance

- work with the business and resident community to improve their knowledge of services, provide opportunities to support services, and develop shared solutions to rough sleeping issues, and
- work with the City Health and Wellbeing Board to improve the health of rough sleepers (see priority 5).

Case study - rough sleeping

J first slept rough in the City in 2008. Like many who sleep rough, J's life history is complex and troubled – involving periods of care, self-harm and domestic abuse. J was, and remains, a user of heroin and crack cocaine – begging to provide the £200 a day spent on drugs. J's history of drug use has resulted in serious physical illness including lasting liver damage.

J has been accommodated a number of times. The City provided a home, but arrears, refusal to engage with support, and problematic behaviour led to eviction. J was subsequently provided with specialist accommodation, but refused to live there. J later settled into a hostel for two years, but arrears, refusal to engage with support, and finally an assault led to another eviction

A number of specialist agencies are working in the City and Tower Hamlets to provide support. J is once again in temporary accommodation, is claiming benefits and has been prescribed methadone – all of which has resulted in much reduced drug use and begging. J is awaiting a more settled home.

Priority 3: Increasing supply of and access to accommodation

Why this is a priority:

Accessing accommodation is crucial to both preventing and resolving homelessness, whether through providing a long-term home, or through providing interim or specialist accommodation from where a more lasting solution can be achieved. However, accessing accommodation in the capital can be very difficult, as demand is high, and in many parts of London house prices and private rents are beyond the reach of those on low incomes. Within the City the supply of housing of any tenure is scarce and the ability to increase supply is extremely limited.

To meet its legal duty to house certain homeless households, the City makes use of homes that become available in its stock of affordable social housing. However, the number of vacant properties each year is limited, and those that become available cater for a range of housing needs groups. Where the City is required to provide interim temporary accommodation for a prolonged period pending an offer of a long-term home, this can be costly to the authority and detrimental to the household.

For those seeking move-on from hostels to independent living, or households seeking advice on housing options, the private rented sector (PRS) is the primary offer. For

City services, this inevitably means supporting access to the PRS outside its boundaries.

The localisation of revenue funding for hostels and supported housing to local authorities, and the current funding constraints faced, have resulted in a loss of accommodation available to those with little or no local connection. This impacts particularly on rough sleepers, who are often transient and gravitate to central London areas where they have little connection.

Trends across London would suggest that demand from homeless households for accommodation – whether temporary accommodation, specialist provision (such as hostels and supported housing) or longer-term homes – is rising: latest figures show a 13 per cent rise in the number of households accepted as homeless by local authorities in the capital.[8] While the City has not experienced the dramatic increases in homelessness that some London boroughs have faced, demand has not diminished and is likely to increase in the future.

Key challenges:

- In 2012/13 the City had 117 properties become available for allocation (of which five were new build).
- The City's size means that there are very limited opportunities to develop additional affordable housing.
- Increasing private sector rents and limits to the Local Housing Allowance payable have resulted in many areas becoming unaffordable to those on benefits.
- Competition for housing in London is great across all tenures and areas.

What we will achieve:

The City will increase the supply of, and access to, accommodation by:

- developing more affordable homes within and outside its boundaries
- making greater use of the PRS to meet housing needs
- investing in specialist provision for rough sleepers, and
- improving access to and increasing the range of suitable temporary accommodation options.

What we will do:

More affordable homes

We will:

- use the City's Section 106 receipts to build additional affordable housing on land available on estates within the Square Mile, and on the City's estates in neighbouring boroughs
- acquire or seek partnership to access land in other boroughs to develop affordable housing schemes, and
- tackle unlawful occupancy within the City's social housing stock to maximise the number of properties available to let.

[8] www.gov.uk/government/publications/statutory-homelessness-in-england-july-to-september-2013

Greater use of the PRS

We will:

- review the City's Rent Deposit Scheme to explore its potential to support more private sector tenancies
- use the flexibilities granted through the Localism Act 2011 to make greater use of the PRS to meet the City's duty to house some homeless households and develop a protocol to underpin this use, and
- work with partners to increase the PRS opportunities for those in need.

Invest in specialist provision for rough sleepers

We will:

- invest in specialist move-on accommodation targeted at former long-term rough sleepers accommodated in the Lodge project, and
- undertake a review of the accommodation pathway, including move-on options, available to meet the varying needs of rough sleepers in the City.

Access to and range of temporary accommodation

We will:

- undertake a review of temporary accommodation options available and where necessary increase the options available to the City, and
- review procurement processes to ensure timely access to temporary accommodation.

Priority 4: Delivering outstanding integrated services

Why this is a priority:

The risk of or experience of homelessness is traumatic, and can impact on the wellbeing of individuals and families, often dislocating people from support and stability. Many of those whom the City helps have complex needs – whether in terms of their housing, health, lifestyle or personal circumstances. Help for individuals and families may require input from specialist advice agencies, social care teams and outreach workers in addition to the work of the City's homelessness services.

Many of those who approach the City for help will be guided to help themselves, while others will need more intensive support. Given the limited housing supply in the City and the limited local connection of many who are homeless in the Square Mile (particularly those who sleep rough), resolving homelessness will usually require help to access housing outside the City's boundaries or to reconnect to areas where there is entitlement to services.

Preventing homelessness is a priority. To achieve this, it is imperative to identify those at risk of homelessness at the earliest stage in order to provide appropriate support and advice services. This requires professionals across disciplines and organisations to be able to identify the risk of homelessness, and know how best to respond.

Key challenges:

- Those who are homeless or at risk of homelessness may seek help from a range of services and organisations both inside and outside the City.
- Homelessness is not just about accommodation, but frequently takes in a range of complex personal factors and/or wider structural factors such as the economy or service provision.

What we will achieve:

The City will deliver outstanding integrated services by:

- striving for continuous improvement in frontline housing services
- integrating services through improved processes, protocols, communications and information sharing, and
- developing and strengthening effective partnerships within and beyond the City of London.

What we will do:

Continuous improvement

We will:

- review the systems and processes of the Housing Needs and Homelessness team to identify opportunities to improve delivery
- commit to become a Gold Standard[9] authority and use the resources and tools made available through this scheme to ensure that the City continues to offer excellent housing advice and information to those at risk of homelessness in all tenures
- ensure that the views, experience and suggestions of service users help to shape the services commissioned and delivered by the City
- report the progress of this strategy and issues that emerge to the City of London Adult Wellbeing Board
- use new technology and social media to improve the effectiveness and reach of, and to further develop, City services, and
- learn from the achievements and success of other agencies and local authorities, and share the learning from the City's successes.

Integrating services

We will:

- review and agree the processes and protocols providing access to services delivered to homeless people by City of London partners such as Adult Social Care, the Substance Misuse Partnership and the Safer City Partnership
- make better use of information technology to support service integration and efficiency
- provide a link worker within the Housing Needs team to work with our Children and Families Service to support care leavers housed by the City
- ensure that services working with rough sleepers, people suffering domestic abuse, young people and other risk groups signpost people appropriately to

[9] www.goldstandard.practitionersupport.org/display/PUBLIC/Public+space+Home

agencies that can help with housing problems or with other issues that put them at risk of homelessness
- promote closer working with health, prison and probation services to prevent homelessness on discharge or release, and
- improve referral processes and information sharing when working with the City of London Police.

Effective partnerships

We will:
- work in partnership with neighbouring boroughs, sub-regional partnerships and the Mayor of London's Rough Sleeping Group to deliver consistent approaches to rough sleeping across borough boundaries and learn from best practice
- actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs to help prevent homelessness
- work with partners in the criminal justice sector through MARAC and MAPPA arrangements to provide appropriate support, including housing, to victims and offenders
- ensure consistent, transparent policies and protocols to foster improved co-operation with partners, and
- maintain the multi-agency Rough Sleeping Strategy Group.

Case study – homeless family

MV and her child approached the City of London for help after fleeing domestic abuse from her home in the homes counties. Originally from Asia, MV had little knowledge of where to get help, but came to the City as she had worked in the Square Mile as a shop worker.

The City's housing needs team recognised the severity of her situation and took a homelessness application. Having placed her and her child in temporary accommodation, the team helped MV sort out problems with her benefits and referred her for support from Asian Women's Aid – a specialist London based agency.

The City assessed MV's homelessness application and accepted a duty to rehouse her. Through their work with a partner organisation, the housing needs team secured MV a home for herself and her child in a private rented sector flat in west London. She has now secured permanent work in the City.

Priority 5: Improving the health and wellbeing of homeless people

Why this is a priority:

All forms of homelessness can lead to poor physical and mental health. However, those who sleep rough are at greatest risk of ill health and premature death. Physical illnesses such as chronic chest conditions, tuberculosis and hepatitis C are more prevalent among rough sleepers, and commonly combine with mental ill health and substance misuse. The experience of central London hospitals is that rough sleepers are more likely to attend emergency services, are more likely to be admitted and will have more health needs. Beyond the disastrous health implications for the individual, rough sleeping costs health services millions of pounds – much of which is preventable.

Despite this, rough sleepers can face barriers to accessing services due to provider attitudes, service models, inability to register with a GP, a lack of knowledge of services, eligibility issues, a lack of continuity of care, and potential cost implications to local health and care services.

Homelessness can also dislocate individuals and families from support networks and services. Placements into temporary accommodation in other local authority areas also risk recipient services such as education or social services being unaware of new households in their area.

Key challenges:

- Rough sleepers access A&E seven times more than the general population.[10]
- In 2012/13, 46 per cent of rough sleepers in contact with services in the City had alcohol problems, 30 per cent had drug problems and 45 per cent had mental health problems (with many having more than one of these problems).
- Life expectancy of long-term rough sleepers is just over 40 years.[11]
- Given its size and local housing costs, the City can only place households into temporary accommodation in other local authority areas, which are often distant from existing support services.

What we will achieve:

The City will improve the health and wellbeing of homeless people by:

- improving access to and delivery of health services, and
- improving communication with local authorities in which temporary accommodation placements are made.

What we will do:

Access and delivery

We will:

- work with partner services for rough sleepers such as Street Med and the mobile 'Find&Treat' tuberculosis service to provide better access to healthcare for City homeless clients

[10] www.homeless.org.uk/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf
[11] www.londonpathway.org.uk/uploads/BMJ_2012345-e5999.pdf

- include the needs of rough sleepers in the Health and Wellbeing Board's Joint Strategic Needs Assessment and strategy
- improve the integration of services (see priority 4)
- improve the knowledge and practice of frontline services to enable them to identify need and to signpost to specialist health and substance misuse services, and
- use existing services and initiatives to offer public health services such as vaccinations and smoking cessation to rough sleepers.

Communication

We will:

- implement NOTIFY to ensure that people placed out of the City are linked into the appropriate services they require, and
- ensure processes to prevent any hospital discharge to the streets.

Case study - City Bridge Trust

City Bridge Trust is the grant-making arm of Bridge House Estates. It was established to make use of funds surplus to bridge requirements and provides grants totalling around £15m per year towards charitable activity benefitting Greater London. The Trust aims to address disadvantage by supporting charitable activity across Greater London through quality grant-making and related activities.

Through its various programmes the Trust is currently supporting 25 projects working with homeless people with grants totalling over £2.1 million. Projects being supported include:

- *a number of initiatives focussed on supporting those who are homeless and experience mental ill health*
- *support for "Choir with No Name" – which runs choirs for homeless and formerly homeless men and women*
- *structured vocational training and support for young people(16-25) with mental health issues, facing homelessness, to increase their employability*
- *help for homeless families to integrate with each other and the local community through English and advocacy courses and cross-cultural events, and*
- *a horticulture based volunteering programme in the Queen Elizabeth Hall Roof Garden, to promote improved mental health and well-being among homeless people.*

7. Costs and resources

Homelessness can have a lasting negative impact on the wellbeing of individuals and families. There are also a range of financial and societal costs arising from homelessness through:

- failed tenancies
- health and substance misuse problems and increased contact with A&E departments

- involvement with the police and criminal justice system (as both victims and perpetrators of crime)
- prolonged unemployment and costs of welfare benefits and economic inactivity
- disruption to education.

A Government review of evidence of the cost of homelessness estimates of the annual costs to government ranging from £24,000 - £30,000 (gross) per person[12].

Providing services to homeless people carries an economic cost to the City of London. Direct costs incurred from responding to homelessness include staffing to deliver advice and assessments, provision of outreach services, temporary and specialist accommodation, rent deposit payments and police support for targeted operations. For the City of London these amount to £XXX(circa £950k [tbc]). Almost half of this cost is met through Government grants and housing benefit receipts.

Investment in services to prevent homelessness and to support those who are homeless can stem escalating need which could require more costly public services. Research undertaken for the Government on the net financial benefits of the Supporting People programme (housing related support to vulnerable adults) estimated net financial benefits of £3.41bn per annum for the client groups considered (including homeless families and individuals) against an overall investment of £1.61bn.[13]

The City of London will continue to invest in services over the lifetime of this strategy that deliver lasting outcomes for homeless people. In doing so it will seek to minimise the cost burden to the City and the wider public purse.

8. Implementation and delivery

Each of the priorities of this strategy sets out what we will do to achieve its delivery. As set out in section 5, the 'we' in this context are the range of partners, including the City, key to this delivery.

The City will develop the action plan that supports this strategy and that delivers the commitments made under each priority. Many of the actions will replicate the commitments set out above but will provide greater detail of the lead, timescales and measurable outcomes. Further detailed actions will be a product of initial actions to review process and services. Others will respond to emerging trends or changes in resources or legislation.

The action plan will be refreshed annually. Its delivery will be monitored by the leadership team of the City's Department of Community and Children's Services, and reported to its Grand Committee.

[12] www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf
[13] www.gov.uk/government/uploads/system/uploads/attachment_data/file/16136/1274439.pdf

Glossary of terms

Broadway	Voluntary sector organisation providing services to those who are homeless or at risk of homelessness including street outreach, supported housing and hostels.
Central and Eastern European	Estonia, Latvia, Lithuania, Poland, Czech Republic, Slovakia, Hungary, Slovenia, Romania and Bulgaria
Lodge	Specialist accommodation project for long-term rough sleepers that uses the appearance and approach of a hotel operation to overcome resistance to more traditional hostels
MAPPA	Multi-Agency Public Protection Arrangements that require the police, probation and prison services to work together to protect the public from violent and sexual offenders, and with which local authorities are required to co-operate.
MARAC	Multi-Agency Risk Assessment Conferences that enable organisations such as the police, probation, local authorities, prison services, housing and health services to work together to provide a coordinated and effective safety plan for those individuals at the highest risk of domestic abuse.
No Second Night Out	London-wide project aimed at ensuring that those sleeping rough in London for the first time need not spend a second night on the streets.
NOTIFY	Web-based information and notification system, the primary role of which is to notify relevant services of the placement and movement of statutorily homeless households accommodated by London boroughs in temporary accommodation under homelessness legislation
Outreach	Street-based service commissioned by the City to work with those sleeping rough
Rough Sleeping 205	An initiative that originally identified and sought to end the rough sleeping of the 205 most entrenched and prolific rough sleepers in London through the provision of targeted and enhanced services; this cohort has twice been refreshed, but retains the original '205' name
Section 106	Planning obligations placed on new developments which can, in some circumstances, include the provision of financial contributions to invest in affordable housing
Social Impact Bond	A funding model that attracts investment in public services by offering returns to investors linked to the outcomes achieved

	by the service
Statutory homelessness	Homelessness defined within the terms of the homelessness legislation and which determines when local authorities will have a duty to offer accommodation
StreetLink	Internet-based tool to allow the public to alert any local authority in England about a rough sleeper
Street Med	Nurse-led outreach and case management service working to improve access to healthcare for homeless people
Temporary accommodation	Interim accommodation provided by local authorities to homeless households awaiting a decision on their homelessness application, or to those awaiting the allocation of housing

‘You will not get far if you perceive the duty to be over burdensome or take a mechanistic approach….there will be progress if the duty is seen as a way of fundamentally changing the core values and culture of the organisation…..we need and *outcome-oriented approach’* – CRE Chair 2001

Equality Impact Assessment: Stage 1: Initial Screening Form for Policies or Functions (including new & revised)

A: Summary Details

Directorate: Community and Children's Services

Section: People

Person responsible for the assessment: Simon Cribbens

Contact details: simon.cribbens@cityoflondon.gov.uk

Names of other people participating in review: Jonathan Qureshi

Name of Policy to be assessed: Homelessness Strategy

Is this a new or revised policy: Revised

Date policy scheduled for Committee (if relevant): 13 June 2014

B: Preparation

*It is important to consider all available information that could help determine whether the policy could have any actual or **potential** adverse impact. Please attach examples of available monitoring information, research and consultation reports.*

1. Do you have monitoring data available on the number of people (with protected characteristics*) who are using or are potentially impacted upon by your policy? *Please specify what monitoring information you have available (your monitoring information should be compared to the current available census data or more recent population data if available to see whether a proportionate number of people are taking up your service).*

Statutory homelessness statistics for the UK are published by the government[1]. These statistics are drawn from quarterly submissions by each local authority (statutory homelessness returns) which are collated by the Department of Communities and Local Government (DCLG). These returns identify the ethnicity of all those who have made an application to a local authority for help with homelessness or the threat of homelessness. For those applicants who are found to be homeless and for whom an authority accepts a duty to house, the following is reported:

- Age
- Reason for priority
- Reason for loss of home
- Nationality

[1] https://www.gov.uk/government/collections/homelessness-statistics

The last available full-year statutory homelessness figures published for the City of London are for 2012-13. These report detailed data for 18 households accepted as homeless by the City during that period, identifying the characteristics below:

Ethnicity	count	%
White	13	72%
Black	3	17%
Asian	2	11%
Mixed	0	0%
other	0	0%
Total	**18**	**100%**

Ages of those accepted	count	%
18-24	2	11%
25-44	13	72%
45-59	2	11%
60-64	1	6%
65-74	0	0%
75 & over	0	0%
total	**18**	**100%**

Reason for Priority	count	%
Dependent children	3	17%
Physical disability	2	11%
Mental illness or disability	4	22%
Drug dependency	2	11%
other	4	22%
Been in custody	2	11%
fleeing DV	1	6%
total	**18**	100%

A legal duty to house exists for homeless households who have priority need – as shown above. It should be noted that the reason for priority may not reflect an individual's circumstances in full. For example, if someone presents with dependent children, but also has underlying mental health issues, the reason for priority will be recorded as "dependent children" as this is the primary priority need. As such the statistics may mask the prevalence of some characteristics.

Rough sleeping statistics are published by the Combined Homeless and Information Network (CHAIN) on the St Mungo's Broadway website[2]. CHAIN data is based on records of all street contacts with rough sleepers in London. It provides detailed demographic detail for this group including:

- Age

[2] http://www.broadwaylondon.org/CHAIN/Reports.html

- Ethnicity
- Nationality
- Support needs (drugs, mental health, alcohol)
- Gender

CHAIN has published data on rough sleeping in the City of London in 2012-2013. This data shows that 284 people were recorded sleeping rough in the City over the course of that year.

Gender	**count**	**%**
Female	18	6%
Male	266	94%

Age	**count**	**%**
18-25	14	5%
26-35	75	26%
36-45	92	32%
46-55	72	25%
over 55	31	11%
total	**284**	100%

Ethnicity	**%**
White - other	36%
White - Irish	3%
White - British	48%
Refused	0%
Other	1%
Mixed	3%
Black	7%
Asian	2%

Nationality	**count**	**%**
UK	158	56%
Central and East Europe	78	27%
Other Europe	29	10%
Africa	6	2%
America	1	0%
Asia	5	2%
Not known	7	2%
Total	284	100%

2. If monitoring has NOT been undertaken, will it be done in the future or do you have access to relevant monitoring data for this area? If not, specify the arrangement you intend to make; if not please give a reason for your decision.

Monitoring draws on the available published (and therefore verified) data. This data does not capture all target equality group characteristics: faith and sexuality is not reported in this data. Collection of additional data can be difficult at the first point of contact when working with people who are rough sleeping or facing homelessness.

The City is working with its homelessness services to explore how this recording can be improved.

A number of vulnerable and target equality groups are over-represented in the City's homeless population. However it is important to note that given the City's relatively low level of statutory homelessness applications and the changing rough sleeping population mean the level of representation of any group or characteristic can fluctuate considerably from year to year.

Statutory homelessness statistics for 2012-2013 show that 19% of those who made a homeless application to the City and 17% of those accepted to be homeless and owed a duty to house were from the black population. This is high compared to the 2.6% black resident population of the Square Mile, the 5% black City workers population[3] and the 13.3% black resident population of Greater London[4]. Asian households accounted for 16% of applications made, and 11% of those accepted to be homeless and owed a duty, compared to 12.7% resident population and 12% City workers population.

Men are significantly over-represented in the rough sleeping population – consisting of 94% of those contacted on the City's streets. Mental ill health, physical ill health and substance abuse are more prevalent in the rough sleeping population.

Sexuality and faith are not routinely recorded by CHAIN or for the purpose of statutory homeless reporting. These characteristics can be identified through case work. No applicant approached the City as homeless in 2012-2013 as a result of fleeing abuse or threats of violence based on their sexuality or faith.

The City provides signposting to specialist services such as Stonewall Housing (which is also signposted on the website), the Albert Kennedy Trust and Broken Rainbow. It has also referred individuals to support groups and networks reflecting serving specific cultures and faiths.

3. Please list any consultations that you may have had and/or local/national consultations, research or practical guidance that will assist you in completing this EqIA.

We have reviewed the EqIAs of neighbouring boroughs, which although much larger, have similar characteristics to the City in terms of rough sleeping. In developing the strategy we have also consulted with key internal and external stakeholders, including those who have experienced homelessness. The strategy also draws on the successes, learning and changing environment that have been experienced within and beyond the City since the last strategy was produced.

C: Your Policy or Function

[3] JSNA City Supplement-draft (2014)
[4] http://www.cityoflondon.gov.uk/services/environment-and-planning/planning/development-and-population-information/demography-and-housing/Documents/census-information-reports-ethnicity.pdf

1. What is the main purpose of the policy or function?

The Homeless Act 2002 places a duty on local authorities to carry out a review of homelessness in their area and publish a strategy to prevent and respond to homelessness. This is the City of London's third Homelessness Strategy. It sets out the priorities of addressing homelessness, identifies what the City is seeking to achieve, and sets out how it will achieve this. The strategy identifies five key priorities:

1. Preventing homelessness
2. Ending rough sleeping
3. Increasing supply of and access to accommodation
4. Delivering outstanding integrated services
5. Improving the health and wellbeing of homeless people

2 Are there any other objectives of the policy or function, if so what are they?

The strategy sits within the wider objective of the government's commitment to tackling homelessness. The strategy sits alongside the City's broader Housing Strategy and housing allocations scheme.

3 Do any written procedures exist to enable delivery of this policy or function?

The Homelessness Act 2002 and Code of Guidance for Homelessness are the key written procedures governing the statutory homelessness function. The strategy is also supported through guidance from DCLG and Homeless Link in relation to work with rough sleepers. Other supporting documents and procedures include guidance on eligibility, benefits legislation, working with those deemed to have "no recourse to public funds" and housing allocations.

The City Outreach service is delivered in line with the service specification against which it was commissioned.

4 Are there elements of common practice in the service area or function that are ***not*** clearly defined within the written procedures?

No

5 Who are the main stakeholders of the policy?

There are number of stakeholders to this policy. The main stakeholders are the homeless population of the Square Mile. However, other key stakeholders also include partner agencies as discussed in the strategy. The strategy has been developed through consultation with key stakeholders, including those who have experienced homelessness and those who remain homeless in the City. Others consulted include the following.

Internal:

- Members of the Court of Common Council of the City of London Corporation
- Adult Social Care
- Built Environment
- Children's Social Care
- City of London Police
- Community Safety Partnership
- Early Years and Education
- Housing
- Public Health
- Substance Misuse Partnership

External:

- Broadway
- East London NHS Foundation Trust
- London Borough of Tower Hamlets
- London Probation Trust
- Pathway Homeless Team, Royal London Hospital
- Providence Row
- Providence Row Housing Association
- Toynbee Hall
- Westminster City Council

6 Is the policy associated with any other Corporation policy (s)?

The strategy sits alongside the Housing Strategy and Housing Allocations Policy

It also integrates with, and supports the delivery of, a number of the City's strategies and policies, including:

- ***City Together Strategy: The heart of a world class city 2008–2014***, which identifies the challenge of supporting our communities, including those experiencing homelessness and rough sleeping
- ***Corporate Plan 2013-17***, in which responding to the implications of welfare reform, the Localism Act, and NHS and public health reforms is a key priority
- ***Department of Community and Children's Services Business Plan***, in which protecting and safeguarding vulnerable people through better prevention and early intervention is a priority
- ***Joint Health and Wellbeing Strategy***, in which improving the health and wellbeing of those who are homeless and sleeping rough is identified as a priority, and which sets out plans to reduce health inequalities between local communities, and
- ***Safer City Partnership Plan 2013-16***, which sets out the City's response to domestic abuse, a significant cause of homelessness, and anti-social behaviour.

7 Are there any areas of the service/policy that are governed by discretionary powers? If so, is there clear guidance as to how to exercise these?

There is some discretion within the Homelessness Act to provide interim accommodation or assistance to secure housing for those who are homeless but not in priority need. Changes to legislation also give the City the discretion to discharge its duty to house a homeless household into the private rented sector. Guidelines on the City's approach and the use of such discretion will be developed through the implementation of the homelessness strategy.

8 Is the responsibility for the proposed policy or function shared with another department or authority or organisation? If so, what responsibility, and which bodies?

Under each priority, the strategy states 'we will'. The 'we' does not refer to the City alone. It is instead a reference to the broad range of partners – City services, outreach services, health services, the City of London Police, businesses and others – who have a role in delivering better outcomes for those who are homeless or at risk of homelessness. Where the City is responsible, it will lead on the delivery of actions, and where partners are responsible, the City will work to co-ordinate and support delivery where necessary. The City will lead on monitoring the implementation of this strategy and reporting its progress.

The City will develop the action plan that supports this strategy and that delivers the commitments made under each priority. The action plan will be refreshed annually. Its delivery will be monitored by the leadership team of the City's Department of Community and Children's Services, and reported to its Grand Committee

D: The Impact

Assess the potential impact that the policy could have on people who share the protected characteristics. The potential impact could be negative, positive or neutral. If you have assessed negative potential impact for any people who share one or more of the protected characteristics, you will need to also assess whether that negative potential impact is high, medium or low.
(N.B. Impact will not be equally negative or positive or neutral for all groups. There will be differing degrees of impact, the purpose of this section is to highlight whether it is disproportionately different)

a) Identify the potential impact of the policy/service/proposal on men and women:

Gender	Positive	Negative (please specify if High, Medium or Low)	Neutral	Reason
Women	✓			Although under-represented, the needs of this group will be addressed through improved prevention and the development of specific approaches to factors such as Domestic Abuse.
Men	✓			This group is over-represented in the rough sleeping demographic. The strategy makes tackling rough sleeping a priority and therefore is expected to have a beneficial impact for rough sleeping men.
Transgender/ transexual			✓	Services are sensitive to this need and will signpost or refer to specialist agencies as appropriate.

b) identify the potential impact of the policy/service/proposal on the basis of the following:

	Positive	Negative (please	Neutral	Reason

		specify if High, Medium or Low)		
Pregnancy & Maternity	✓			Homelessness legislation provides specific protections for this group.
Marriage & Civil Partnership			✓	

c) Identify the potential impact of the policy/service/proposal on different race groups:

Race	**Positive**	**Negative (please specify if High, Medium or Low)**	**Neutral**	**Reason**
Asian (including Bangladeshi, Pakistani, Indian, Chinese, Vietnamese, Other Asian Background – please specify_____)			✓	This group is highly represented and should benefit from the actions and priorities of the strategy.
Black (including Caribbean, Somali, Other African, Other black background – please specify_____)	✓			This group is over-represented. The improvements driven by the strategy should deliver a positive impact.
White (including English, Scottish, Welsh, Irish, Other white background – please specify_____)			✓	
Mixed/ Dual heritage (White and Black Caribbean, White and Black African, White and Asian, Other mixed background - please specify_____)			✓	
Gypsies/Travellers			✓	Annual monitoring statistics suggest there are no clients in this group in the City.

Other (please specify)				

d) Identify the potential impact of the policy/service/proposal on disabled people:

Disability	Positive	Negative (please specify if High, Medium or Low)	Neutral	Reason
Physical Disability	✓			Legislation provides a statutory responsibility to prioritise homeless people who are vulnerable with these support needs.
Sensory Impairment	✓			Legislation provides a statutory responsibility to prioritise homeless people who are vulnerable with these support needs.
Learning Difficulties	✓			Legislation provides a statutory responsibility to prioritise homeless people who are vulnerable with these support needs.
Mental Health Issues	✓			It is a commitment to this strategy and the City's Health and Wellbeing Board to improve the health of this group.

e) Identify the potential impact of the policy/service/proposal on different age groups:

Age Group (specify, for example younger, older etc)	Positive	Negative (please specify if High, Medium or Low)	Neutral	Reason
Older People	✓			Legislation provides a statutory responsibility to prioritise homeless people who are vulnerable with these support needs.
Young People/children	✓			Legislation provides a statutory responsibility to prioritise homeless people who are vulnerable with these support needs.

f) **i**dentify the potential impact of the policy/service/proposal on lesbians, gay men, bisexual or heterosexual people:

Sexual Orientation	Positive	Negative (please specify if High, Medium or Low)	Neutral	Reason
Lesbian			✓	Support and signposting to specialist services are available for this group.
Gay Men			✓	Support and signposting to specialist services are available for this group.
Bisexual			✓	Support and signposting to specialist services are available for this group.
Heterosexual			✓	Mainstream provision meets the needs of this group. Specialist provision exist for those in circumstances such as domestic abuse.

g) Identify the potential impact of the policy/service/proposal on different religious/faith groups?

Religious/Faith groups (specify)	Positive	Negative (please specify if High, Medium or Low)	Neutral	Reason
Buddhist			✓	This group is not monitored, but it is not anticipated that faith groups will be impacted negatively by the strategy.
Christian			✓	This group is not monitored, but it is not anticipated that faith groups will be impacted negatively by the strategy.
Hindu			✓	This group is not monitored, but it is not anticipated that faith groups will be impacted negatively by the strategy.
Jewish			✓	This group is not monitored, but it is not anticipated that faith groups will be impacted negatively by the strategy.
Muslim			✓	This group is not monitored, but it is not anticipated that faith groups will be impacted negatively by the strategy.
Sikh			✓	This group is not monitored, but it is not anticipated that faith groups will be impacted negatively by the strategy.
Other (please specify)				

h) As a result of completing Question 1 a-f above what is the potential impact of your policy?

High • **Medium** • **Low** ✓

The safety net provision of legislation more broadly supports those with vulnerabilities such as age, mental health etc and are therefore deemed as priority. In addition, the City of London is committed to monitoring the equalities impact of the strategy within the context of the wider monitoring process.

2. Could you minimise or remove any negative potential impact? Explain How.

We have not identified any potential negative impacts but through monitoring will continue to identify any risk and respond accordingly.

3. If there is no evidence that the policy promotes equality of opportunity or prevents unlawful discrimination– could it be adapted so that it does? How?

We believe that the policy promotes equality of opportunity / prevents unlawful discrimination by delivering a targeted response to improve outcomes for clients.

Please ensure that all actions identified are included in the attached action plan and reflected in your service plan.

Please sign and date this form, keep one copy and send one to Equality, Diversity & Human Rights Manager

Signed	Signed	Signed
Simon Cribbens	Service Head	
Date	Date	Date

Action Plan

Recommendation	Key activity	Progress milestones	Officer Responsible	Progress

Committee:	Date:
Health and Wellbeing Board	30 May 2014
Subject: Joint Health and Wellbeing Strategy Update	**Public**
Report of: Health and Wellbeing Policy Development Manager	**For Decision**

Summary

In May 2013, the Health and Wellbeing Board approved the City of London's first Joint Health and Wellbeing Strategy (JHWS), which covers the three year period from 201213 to 2015/16.

The JHWS is now due for its first refresh.

It is proposed that the next Health and Wellbeing Board Development Day be used as an opportunity for Health and Wellbeing Board members to revisit the strategy and its priorities

A full public consultation is not required for a strategy refresh, although local stakeholders should be asked for their views, through Healthwatch

Recommendation

Members are asked to:

- Endorse the approach to refreshing the JHWS set out in this report

Main Report

Background

1. In May 2013, the Health and Wellbeing Board approved the City of London's first Joint Health and Wellbeing Strategy (JHWS), which covers the three year period from 201213 to 2015/16.

2. As the health system was undergoing a time of transition at the time of the strategy's approval, it was agreed that the strategy should be refreshed annually, to reflect changing responsibilities and population health needs.

3. The JHWS is now due for its first refresh.

Proposals

4. It is proposed that the next Health and Wellbeing Board Development Day, scheduled for 18th June 2014 (10.30am – 2.30pm) be used as an opportunity for Health and Wellbeing Board members to revisit the strategy and its priorities, in light of the new responsibilities for health within the health care system; and the new data on health care needs derived from the JSNA Health and Wellbeing Profile and City Supplement.

5. Although a full public consultation is not required for a strategy refresh, it is recommended that local stakeholders be consulted on the refresh, and asked for their views, through Healthwatch.

Corporate & Strategic Implications

6. It is a statutory requirement for Health and Wellbeing Boards to produce a Joint Health and Wellbeing Strategy, and for it to be kept up-to-date.

Appendices

- City of London Joint Health and Wellbeing Strategy

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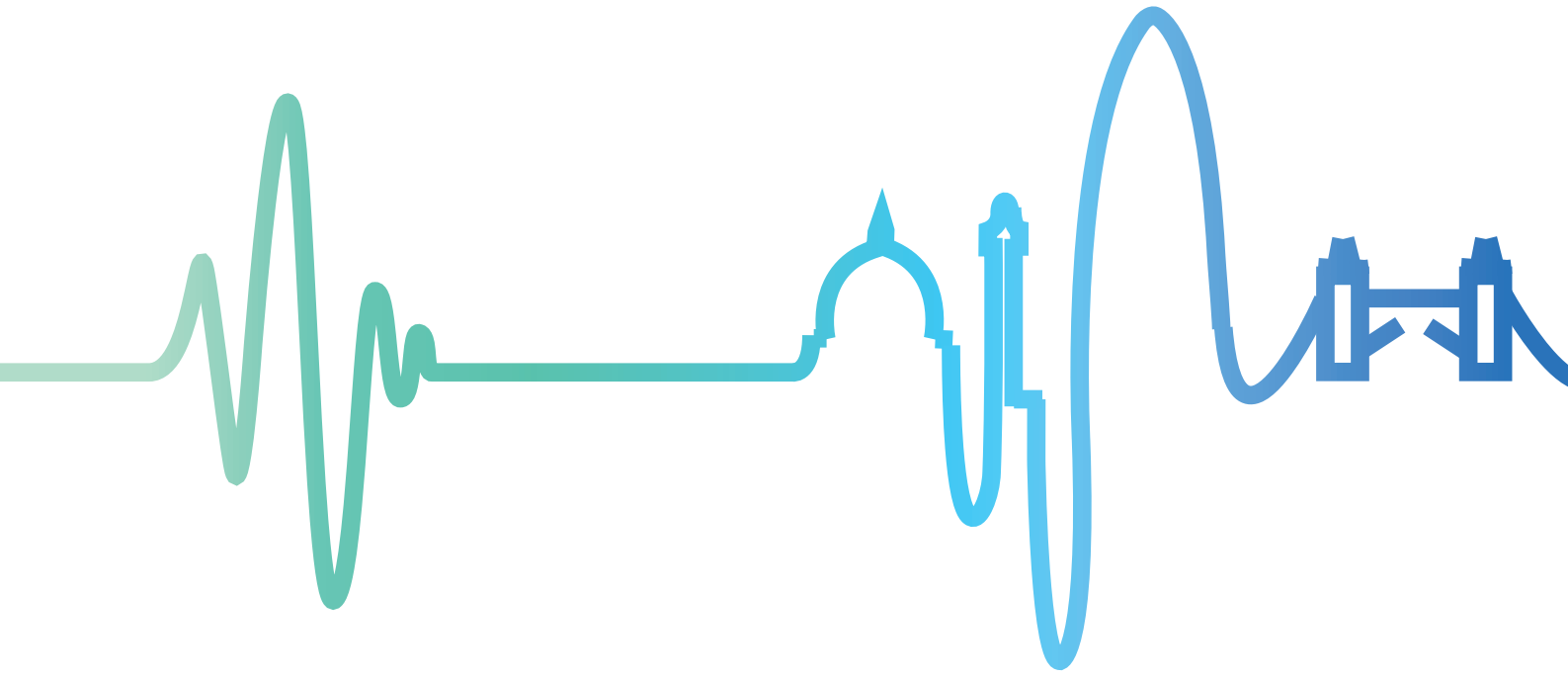
City of London

Joint Health & Wellbeing Strategy



The aim of the joint health and wellbeing strategy is to jointly agree what the greatest issues are for the local community based on evidence in JSNAs, what can be done to address them; and what outcomes are intended to be achieved.

Department of Health, 2012

Introduction

The City of London is a unique area – it contains several populations in one space, with different needs and health issues. According to the Census (2011) there are around 9,000 people who live in the City as residents [1] (1,000 of whom have lived here for fewer than 5 years). The number of dwellings is projected to increase by 110 per annum. 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 space, which is urban and highly developed.

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.

This is the first Health and Wellbeing Strategy produced by the City of London, and it will be refreshed annually, to reflect the changing public health landscape and responsibilities, both during and after the transition.

1 *Including those who occupy a second home outside the City of London*

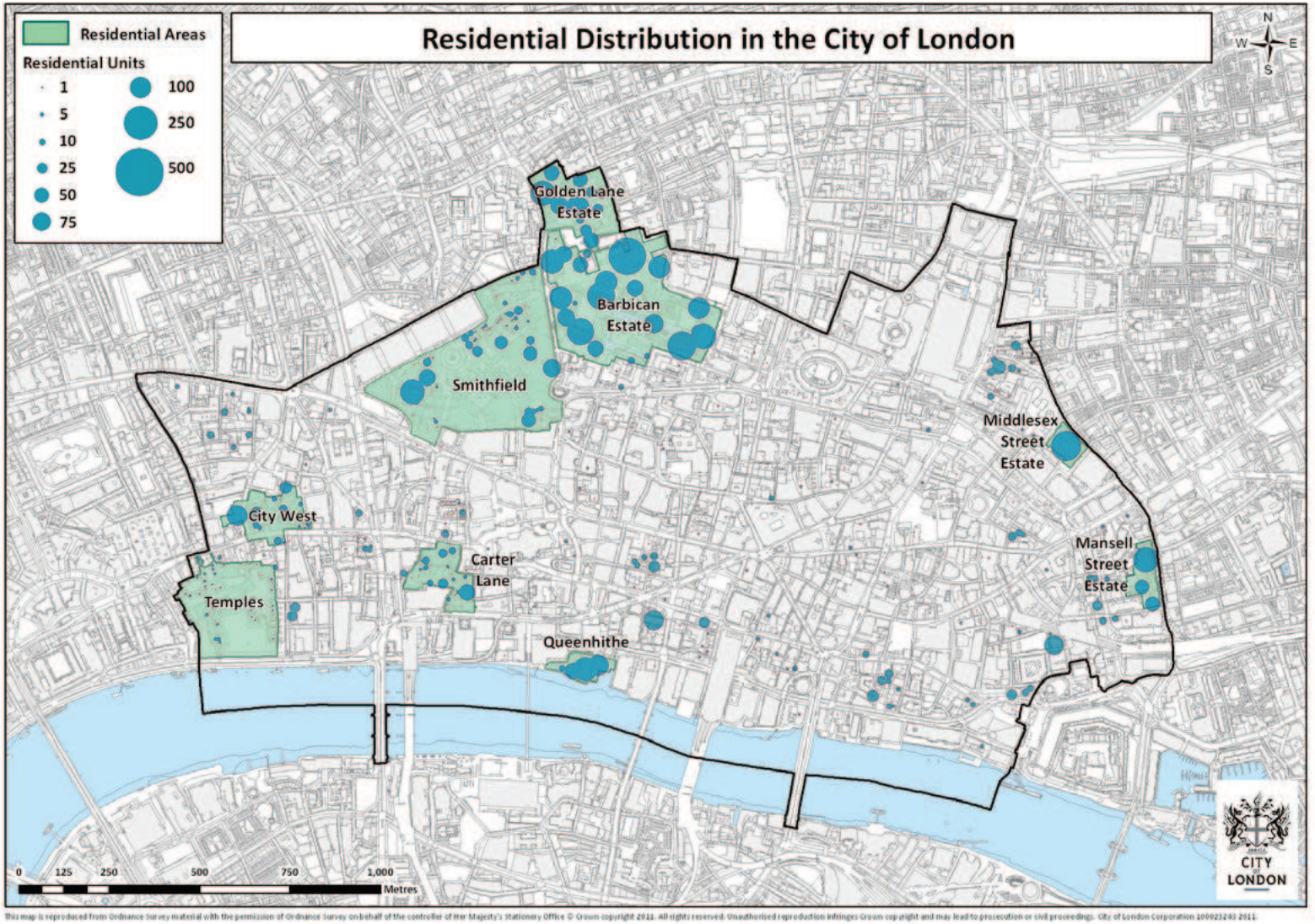


Fig 1. Residential Distribution, based on residential units (COL Planning Department)

Top 5 Boroughs - Daytime Population Density

- City of London (350,000 sq. mi.)
- Westminster (120,000 sq. mi.)
- Kensington and Chelsea (59,000 sq. mi.)
- Camden (55,000 sq. mi.)
- Islington (52,000 sq. mi.)

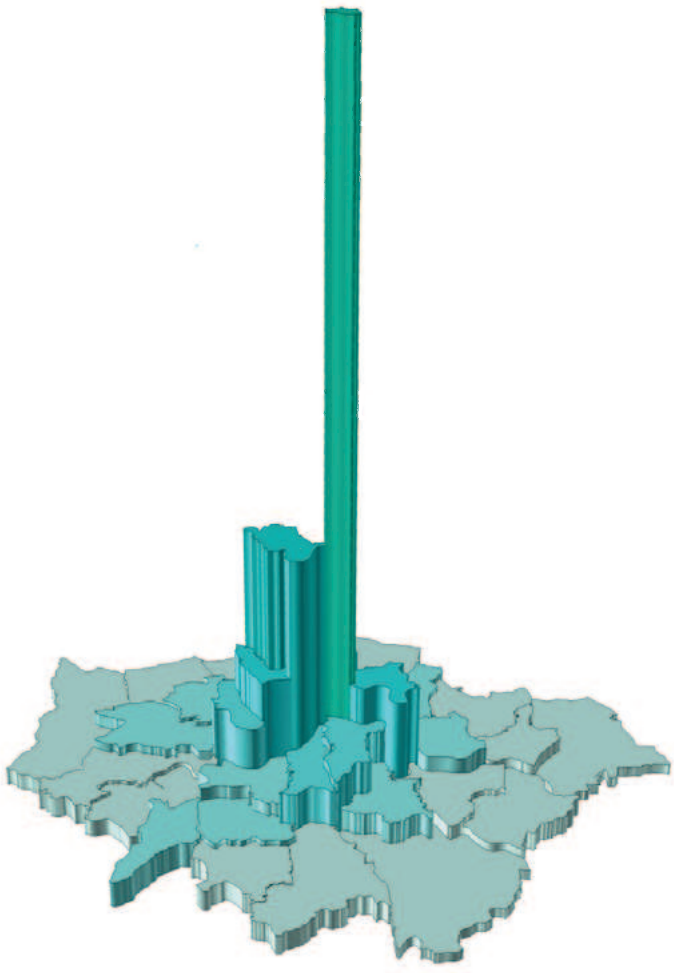


Figure 2: London's daytime population
Data Source: http://data.london.gov.uk/datastore/package/daytime-population-borough

Approach

The Health and Wellbeing Board, through the joint Health and Wellbeing Strategy, aims to align the City's approach to the NHS Outcomes Framework, the Adult Social Care Outcomes Framework and the Public Health Outcomes Framework, through improving the integration of services, particularly between the NHS and local authority. A National Children and Young People's Outcome Framework is currently in development. The Department of Health has identified the Health and Wellbeing Board as the place that brings the three outcomes frameworks together and takes a lead in tackling health inequalities and the wider determinants of health.

Who we are

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, who will be responsible for implementing this strategy.

Timeline

This strategy is intended to cover the three year period from 2012/13 to 2015/16. As we are in a time of transition, we intend to refresh this strategy annually to reflect the changes that have taken place.

December 2013	First draft strategy published for consultation
January - March 2013	Public engagement and Consultation
April 2013	Consultation period finishes
April 2013	The Health & Wellbeing Board takes on statutory role
May 2013	Final strategy published and signed off by Health and Wellbeing Board
Summer 2014	First Strategy Refresh
Summer 2015	Second Strategy Refresh

Wellbeing is a positive physical, social and mental state, and is more than just an absence of illness.

A strategy for health and wellbeing in the City of London

Although we already spend much time protecting people from threats to their health, we want the City to be more than just a safe place. The Health and Social Care Act 2012 presents us with an opportunity to positively influence the health of everyone who lives and works in the City, enabling them to live healthily, preventing ill health developing, and promoting strong and empowered groups of individuals who are motivated to drive positive change within their communities and businesses.

Wellbeing is a positive physical, social and mental state, and is more than just an absence of illness. When a person feels well, they are more likely to value their health and make positive decisions about the way they live. Good mental wellbeing can lead to reduced risk-taking behaviour (such as excessive alcohol intake or smoking), and may improve educational attainment and work productivity.

We know what it takes for people to live healthily. Workers and residents can take their own steps to improve health, and we know that big improvements in health can result from the following: [2]

1. Not smoking or breathing others' smoke
2. Eating a healthy diet
3. Being physically active
4. Achieving and maintaining a healthy weight
5. Moderating alcohol intake
6. Preventing harmful levels of sun exposure
7. Practicing safer sex
8. Attending cancer screening
9. Being safe on the roads
10. Managing stress

2 *Adapted from The Chief Medical Officer's* Ten Tips For Better Health *(Department of Health, 2004)*

However, we also know that health and wellbeing is bigger than just asking individuals to take steps to improve their own health; we also need to ensure that no-one is disproportionately disadvantaged by their circumstances and environment, preventing them from living as healthily as they might like to.

We know that the health of our residents and workers is influenced by social, cultural, economic, psychological and environmental factors, and that these factors can have a cumulative effect throughout a person's life [3]. If we are to improve the health of the whole community, rather than just those who find it easy to adopt healthy behaviours, we need to look at the broader context of people's lives – their income and education; their friends and social networks; the place where they live; the air that they breathe; the beliefs they have about their own health and their ability to make changes; and the individual biological factors that may influence their health. These are "the causes of the causes".

This means that often the best way to help a person's health lies outside what the NHS can do – for example, helping someone to find employment can provide them with a higher income, to buy better quality food for themselves and their families; they will be in a better position to find decent housing and be able to afford to heat it. By meeting new people at work, they can gain new friends and build up social networks, which can help to improve their mental health. Additionally, the routine of working, the sense of identity, and the ability to provide can all have a positive effect on a person's mental wellbeing.

3
Marmot M (2010) Fair Society, Healthy Lives. *University College London.*

As well as employment, we know that there are several other key priority areas that have a huge impact on people's lives and their health. These were identified by Professor Sir Michael Marmot as:-

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

Local authorities are therefore ideally placed to work with health services and other local partners to make a real impact on health and wellbeing. We know there are communities in the City, who find it harder to access services; who are less connected with others; and whose life circumstances make it very difficult for them to make positive changes.

Through the Health and Wellbeing Board, we want this strategy to encourage services, organisations and individuals to work together to prevent where we can; and intervene early when problems do develop; and take steps to reduce the harms arising from behaviours or actions that we cannot prevent.

Within the City, the small size of the resident population presents a number of challenges to strategic planning. It is often difficult for us to get meaningful data about health needs and service provision. Many national statistics are based on taking a "percentage sample" of the population, and using this sample to extrapolate to the whole population, but in the City, this means that they will only have spoken to a handful of people, who may or may not be representative of the City's wider resident population. Additionally, some health conditions only affect a very small number of City residents each year – it is difficult for us to use these numbers to identify trends that are more than just random variation.

For this reason, it is even more vital that we use a combination of quantitative evidence from the JSNA and other health needs assessments, combined with local and community intelligence, to determine our priorities.

Conversely, we also have a huge number of commuters entering the City every day, about whom very little information is collected. The Office of National Statistics collects information about how many people work in the City and in what sectors, but if we want to find out about their health and wellbeing needs, we have to commission this research ourselves.

Strategic Principles

We want our health and wellbeing strategy to influence the Public Health, NHS and Social Care Outcomes, and the Children and Young People's Outcomes, that will make the most difference to the lives of people in the City. We want to acknowledge and support good work we are already undertaking, whilst helping us meet up-coming challenges, including an ageing population, a reduction in household income for many families in the area, and an uncertain economic outlook.

Our priorities are determined through:

- Can we do anything about it – are there cost-effective, evidence based steps we can take to tackle the issue?
- The numbers of people affected
- The severity or impact of the issue
- Does it tie into the objectives of the City's Corporate Plan, which aims to support businesses and communities?
- Will the City be a better place to live and work if we tackle this issue?
- Is there a current gap in provision or service that we have identified?
- Do we have the resources to tackle this (or are there resources that we can get)?
- Was this identified as a priority in the JSNA, or is there strong consensus that this is an issue for local people?

The evidence base for the Joint Health and Wellbeing Strategy

Joint Health and Wellbeing Strategies are strategies for meeting the needs identified in an area's Joint Strategic Needs Assessment (JSNA). JSNAs are assessments of the current and future health and social care needs of the local community. These are needs that could be met by the local authority, CCGs, or NHS England. JSNAs are produced by health and wellbeing boards, and are unique to each local area. [4]

The City's JSNA provides an overview of the local evidence we have about health and social needs in the City.

What we understand from the evidence contained in the JSNA

Although small, the City is by no means homogeneous. Lots of different kinds of people live here, ranging from professionals who work in the City's firms who live alone and in couples, to a growing community of retired people many of whom live alone, as well as whole communities who struggle to make ends meet. The number of rough sleepers in London in growing, and many find their way into the City of London at night, because it is a safe and relatively quiet place to sleep. Although people in the City are diverse, there is also a strong sense of community, and the vast majority who live and work here say they are satisfied with the area. The City has a strong infrastructure of services and agencies, as well as grass-roots organisations and committed individuals who help to make this place thrive.

4 *Department of Health (2012), Draft Statutory Guidance on Joint Strategic Health Assessments and Joint Health and Wellbeing Strategies*

The City's Joint Strategic Needs Assessment (JSNA) 2011/12

The City is mostly a business district, with some areas of high-density housing. As well as the office workers who come into the City in the daytime, the City's bars and restaurants are increasingly popular with visitors in the evenings. The City has an increasingly international worker and resident community, and an ageing resident population. The City borders onto five London boroughs, and residents often have to access services that are delivered outside the Square Mile. The City shares NHS services with Hackney, and the new Clinical Commissioning Group will cover City and Hackney. The catchment area of the City's only GP practice does not cover the whole City, so residents in the east access GP services from Tower Hamlets.

In surveys, the City scores highly as a place to live and work, and it has excellent transport links and cultural services. The City is an urban area, and suffers from poor air quality. Particulate matter and nitrogen dioxide levels are both very high, and there were also 706 noise complaints last year. There are numerous open spaces in the City but they tend to be very small.

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.

The City provides jobs for around 430,000 people, with around 60% of these in the banking, finance and insurance sectors. Around 75% of City workers are professionals, managers or associate professionals, with the remaining quarter in other occupations, including administrative and sales roles. Unemployment benefits claimants rates are low for the City overall, but worklessness is concentrated into particular geographical areas and housing estates.

The housing in the City is different from in other areas: 90% of flats are 2-bed or smaller. Fuel poverty amongst City residents is stable at 6.4%, but the last census showed that many pensioners live alone in the City. There has been

improvement in the City's deprivation ranking in recent years, however huge gaps remain between the areas of Portsoken (40% most deprived) and Barbican (10% least deprived), with 41% of Portsoken children still living in poverty. A local survey showed that 40% of working age lead tenants on the Golden Lane Estate and Middlesex St Estate were not in work, and it is thought that welfare reforms may have a serious impact upon some City residents.

There has been a recent increase in the numbers of bars and restaurants that are staying open late and at weekends, but this is not without its disadvantages. There is a high rate of alcohol related crime, which accounts for 25% of total crime, and is patterned according to "city drinking hours". However, in the past year, there have been drops in reported crime for drug offences, violence, burglary and criminal damage.

There is a high smoking rate amongst workers, which is reported to be linked to stress; however, City smoking cessation services have a quit rate of 39%. There are no reliable figures about smoking rates in City residents, but we know that smoking is the single biggest contributor to health inequalities in the UK. Alcohol-related deaths and hospital admissions are very low for City residents; however, there are no figures that relate to the many non-residents who drink in the City's licensed premises.

We have no data on obesity or healthy eating in the City; however, it is known that there is a low rate of physical activity amongst residents, especially amongst adult women (45% inactive). It can be difficult to exercise in the City, as there is limited green space, and most private gyms in the Square Mile are very expensive. Subsidised membership for residents is available, however, for City residents at the Golden Lane Leisure Centre.

Most babies born to City mothers are born outside the City, with the majority in Camden (at University College Hospital) or Tower Hamlets (in the Royal London Hospital). The numbers relating to NEETS, teenage pregnancies, pregnant smokers, infant deaths and low birth weight babies are so tiny that

they often cannot be disclosed (i.e. there are fewer than five cases of each per year). Data on childhood obesity in the City is unreliable, because we have very few children, but there is 100% participation in PE, and a good range of sports and physical activity projects for young people. Data show that vaccination rates for MMR (measles, mumps and rubella, also known as German measles) are below average compared to both the UK and London, but that the 5-in-1 vaccine, which confers protection against diphtheria, tetanus, whooping cough, polio and bacterial meningitis, has rates that are above average.

Life expectancy in the City is still the highest in the country (82.2 years for men and 89.2 years for women). There is, however, a lack of data around key medical conditions that may affect the City's resident population. One in six older people in the City receive care packages, and there are thought to be a number of carers in the City, who are generally old (average age 64) and have been caring for a long time (average duration 14 years). Local survey data tell us that older people living on the Golden Lane Estate and Middlesex Street Estate have high rates of disability and poor health.

Evidence on City workers

The City of London Corporation and NHS East London and the City commissioned a piece of research to look at the public health and primary healthcare needs of City workers – this research uncovered that a very hard-working and generally healthy group of people work in the City, but that they take risks with alcohol; smoke at a higher than average rate; and many report feeling very stressed. We believe there is potential to tackle some of these issues amongst City workers, which will prevent them storing up health problems for later in life, as well as making them happier and more productive employees right now.

How we intend to tackle the health and wellbeing challenges in the City

We have identified some key areas for the Health and Wellbeing Board to focus upon over the next three years. These are as follows:

1. Bedding-in the new system – maximising opportunities for promoting public health amongst the worker population, and taking on broader responsibilities for health.
    - ↳ Ensuring that the transition does not create gaps or deficiencies
    - ↳ Identifying areas of priority action; watching brief; and business as usual
    - ↳ Creating staffing and commissioning structures that can identify and meet the needs of the population
    - ↳ Maintaining and improving public health intelligence, to build up a clearer picture of our needs and resources in the City.
    - ↳ Finding out more about particular issues – drugs, sexual health, sex workers, primary care access.
2. Improving joint working and integration, to provide better value
    - ↳ Reaching a mutually beneficial agreement, and maintaining a stable relationship between the London Borough of Hackney

and the City of London for the delivery of public health, including some shared services, from April 2013

- ↳ Defining the City's role in relation to other CCGs and local authorities, especially Tower Hamlets – key areas include referrals and discharges; tripartite funding; rehabilitation services; district nursing; and community psychiatric nurses.
- ↳ The membership of the Health and Wellbeing Board and named individuals will ensure harmonisation between plans and strategies within and outside the City (See list of other plans and strategies below)

3. Addressing key health and wellbeing challenges.

- ↳ An extensive consultation exercise was carried out which helped identify priority areas – see table (p20) below. These areas and responses endorsed our approach but also provided us with additional areas for further development.

Particular areas which emerged in the consultation were:

- A lack of information about the needs and attributes of people in the City, particularly workers
- The need for better integration between services to ensure vulnerable people, in particular, have continued provision
- The need to consider obesity and nutrition in the City population
- The need for better collaborative working with businesses to address worker health (including stress)
- The need to improve access to health-promoting facilities. In particular, the affordability of leisure activities.

The most important overall issue that emerged from the consultation was the issue of mental ill-health and how it was addressed, for both residents and 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.

	Priority	Particularly Vulnerable Groups	Evidence Base	Assets	JSNA Priority	Framework [5]		
						PH	SC	NHS
Ensure that more people with mental health issues can find effective, joined up help	1	Rough sleepers Older people with dementia and depression Carers	JSNA Service Mapping Residents' accounts of unsatisfactory experiences	GPs City Advice, Information and Advocacy Services Housing Service LB Hackney	Mental health Homelessness	1.6 1.7 1.8 2.23 4.9 4.16	1F 1H	1.5 2.5 2.6 4.7
Ensure that more people in the City have jobs: more children grow up with economic resources	2	People in deprived areas Children NEETs Young carers	JSNA	Jobcentre Plus Apprenticeships Adult Learning Service City STEP Community Engagement Worker Portsoken Community Centre City Libraries Planning Department: Employment for local residents is promoted by the Local Procurement Charter, supported by planning obligations under the policies of the Core Strategy	Worklessness Child poverty Fuel poverty Mental health Homelessness Welfare reforms	1.1 1.5 1.8	1E 1F	2.2 2.5

5
These refer to the Public Health; Social Care; and NHS outcomes framework indicators that are associated with each priority.

Confirm that City air is healthier to breathe	3	People with particular health conditions (COPD, asthma); Children; Older people	JSNA	Environmental Health, City Air Strategy Police Core Strategy restricts developments that could give rise to air pollution, discourage motor vehicle use and promote active travel and public transport.	Air quality	3.1		
Be assured that more people in the City are physically active	4	Residents who find it difficult to access leisure facilities Older people	JSNA	Golden Lane Leisure Centre City Sports Development team Community Engagement Worker Transport Planning Police Planning: Core Strategy, Open Spaces Strategy, environmental enhancement strategies and various transport strategies seek to protect recreational facilities and open spaces and promote further provision	Cardiovascular disease Social isolation	1.9 2.12 2.13		(1.1)
Enable more people in the City to become socially connected and know where to go for help	6	Older people Carers Rough sleepers	Census Pensions data Evidence of the health impacts of social isolation	Older people's groups Community Engagement Worker Carers' service City Advice, Information and Advocacy Services GPs	Social isolation Fuel poverty Mental Health	1.18 2.23 4.13	1A 1D	2.4
Ensure that more rough sleepers can get health care, including primary care, when they need it	7	Rough sleepers	CHAIN database	Homelessness Outreach Service Homeless Health Provision	Homelessness Mental health			
More people in the City should take advantage of Public Health preventative interventions, with a particular focus on at-risk groups (includes the 3 following areas of focus)								

Ensure that older people in the City receive regular health checks	5	Older people Carers People on care packages	JSNA Evidence on carers' health	GPs Community Groups Community Engagement Worker	Cardiovascular disease	2.22 4.4		1.1
Ensure that children in the City are fully vaccinated	8	Children	JSNA	GPs Community Engagement Worker	Childhood immunisations	3.3		
Ensure that people in the City are screened for cancer at the national minimum rate	10	Portsoken residents; BME residents; People on care packages; Older people	JSNA. Evidence that cancer screening can improve healthy life expectancy.	GPs Community Groups Community Engagement Worker	Cancer prevention	2.19 2.20 4.5		1.4
Ensure that the City is a less noisy place	9	People with mental health issues	JSNA	Environmental Health City of London Police City Noise Strategy Antisocial behaviour protocols Core Strategy resists developments that increase noise.	Mental health			
Confirm that more people in the City are warm in the winter months	11	Priority groups as identified by JSNA	JSNA	Housing Service Community Groups City Libraries Core Strategy requires that new dwellings should meet the standards of the Code for Sustainable Homes, which requires high standards of insulation and energy efficiency.	Fuel poverty	1.17 4.15		
Children and YP priorities		Placeholder, in case we need to include something from the new outcomes framework that is planned						

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.

	Priority	Particularly Vulnerable Groups	Evidence Base	Assets	JSNA Priority	Framework		
						PH	SC	NHS
Ensure that fewer City workers live with stress, anxiety or depression	1	Low-paid workers	City worker health research	City businesses, HSE standards, Livery Companies Environmental Health,	Mental health Smoking Alcohol Cardiovascular disease	1.9 2.23		
Ensure that more City workers have healthy attitudes to alcohol and City drinking	2		City worker health research	Substance Misuse Partnership City of London Police Safety Thirst London Ambulance Service DH alcohol strategy Core Strategy and Statement of Licensing Policy	Alcohol Cardiovascular disease Cancer	1.9 2.18		(1.3)
Ensure that more City workers quit or cut down smoking	2	Low-paid workers	City worker health research	Pharmacists GPs Employers City Street Cleansing Team	Smoking Cardiovascular disease Cancer	1.9 2.14 (2.1) (2.3)		(1.1) (1.2) (1.4) (1.6)

What are the other plans which influence health and wellbeing in the City?

Plan/Strategy	HWB Member(s) Responsible for Harmonisation
Corporate plan, Core Strategy & Local Plan.	Assistant Town Clerk and representative of Policy and Resources Committee
Children and Young People's plan	Director of Community and Children's Services and Chairman/representative of Community and Children's Services Committee
Safer City Partnership	Assistant Town Clerk
Policing Strategy	City of London Police
Substance misuse partnership	Director of Community and Children's Services and Chairman/representative of Community and Children's Services Committee
Planning and transport strategies	Planning and Transportation Committee Member
Environmental health	Director of Environmental Health and Public Protection and Chairman of Port Health and Public Protection Committee
DCCS Business Plan	Director of Community and Children's Services and Chairman/representative of Community and Children's Services Committee
Annual reports of the Adults and the Children's Safeguarding Boards	Director of Community and Children's Services and Chairman/representative of Community and Children's Services Committee
Cultural Strategy	Deputy Chairman of the Culture, Heritage and Libraries Committee
CCG Commissioning Strategy	City and Hackney Clinical Commissioning Group

How the Strategy fits in the City of London Corporation

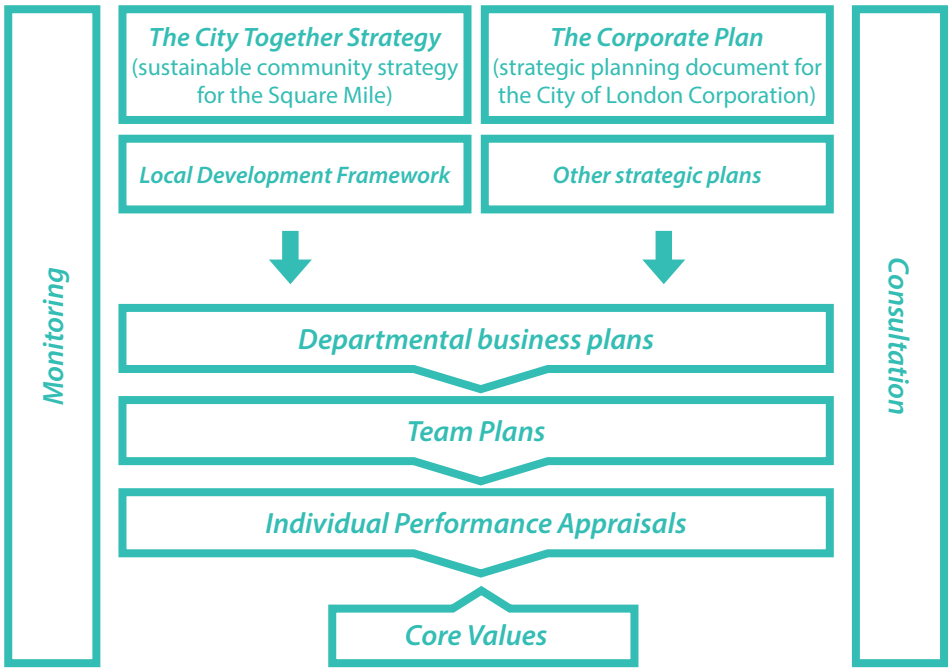


Fig 3. The Planning Cycle at the City of London Corporation

Resources and Assets

The estimated public health allocation for the City of London was given in January 2013 as £1.651m for 2013/14, rising to £1.697m in 2014/15; however, the allocation is expected to fall in the longer term.

As well as financial resources, the Health and Wellbeing Board will need to call on the resources and assets across partners and the wider community if it is to deliver this strategy. The following diagram illustates the organisations, groups and individuals who we will work with.

Appendices

1. Full list of Outcomes Framework indicators
2. What we are already doing around each of our priorities
3. Action plan
4. Engagement and communications plan
5. CCG commissioning intentions

Appendices are not included in this document – please contact healthycity@cityoflondon.gov.uk
or look on www.cityoflondon.gov.uk if you require them.

List of Acronyms

BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
COL	City of London
COPD	Chronic obstructive pulmonary disease
CSR	Corporate Social Responsibility
DCCS	Department of Community and Children's Services
DH	Department of Health
GLA	Greater London Authority
GP	General Practitioner
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
JSNA	Joint Strategic Needs Assessment
NEET	Not in Education, Employment or Training
PCT	Primary Care Trust
PE	Physical Education
PH	Public Health
SC	Social Care
YP	Young People

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Committee(s):		Date(s):
Health and Wellbeing Board	- For Decision	30 May 2014
Subject: JSNA City Supplement Public Consultation		**Public**
Report of: Director of Community and Children's Services		**For Decision**

Summary

In April 2014, members of the Health and Wellbeing Board (HWB) agreed the proposal to initiate a period of public consultation for the new JSNA City Supplement.

This report , sets out the feedback from a community consultation event held with City of London Healthwatch on 1st May 2014. Generally, participants felt that the document was an accurate representation of the City and its needs, but also included a number of suggestions for further areas of investigation that could make it even more complete.

The report also notes new primary care data contained within the City Supplement which shows health inequalities in the City between Portsoken residents and residents registered with the Neaman Practice in smoking, obesity and hypertension.

Recommendation(s)

Members are asked to:

- Approve the content of this report and accept the final draft of the JSNA City Supplement.

Main Report

Background

1. In April 2014, members of the Health and Wellbeing Board (HWB) agreed the proposal to initiate a period of public consultation for the new JSNA City Supplement.
2. This report gives an update on the Healthwatch consultation event that was held on 1st May 2014 and new primary care data received.

Current Position

3. 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.

4. An event was held with City of London Healthwatch at the Artizan Street Library on 1st May 2014. 21 people attended, of whom 11 were City residents.

5. Providers who attended included:

- Toynbee Hall
- City and Hackney Carers
- Hackney & City Alzheimer's Society
- Health Education North Central and East London
- Barbican Tuesday Club
- Crossroads Care Central North London
- East London Foundation Trust
- City 50+ Service at Toynbee Hall
- Green Seniors, City of London group

6. In general, participants were pleased with the JSNA City Supplement, and the fact that it addressed the needs of City of London populations, including workers and rough sleepers, rather than just City and Hackney residents.

7. Participants felt that the document was an accurate representation of the City and its needs, but also included a number of suggestions for further areas of investigation that could make it even more complete.

8. Some participants were surprised by the data contained within the City supplement – for example, the levels of deprivation and worklessness in the east of the City, and the numbers of City residents who were migrants, were noted as surprising.

9. Participants also included a long list of issues that they felt arose from both the data contained within the City supplement as well as the discussions which were held at the event.

10. For example, there was a discussion about the benefits and risks of allowing City workers to register with City of London GPs – it was noted that the huge number of potential new patients could overburden local services, but other participants felt that the additional money being brought into the local health economy would help to create much better facilities for City residents, as well as workers.

11. Other key themes that emerged included:

- The need to consider how the City will cope with an ageing population, including the provision of dementia services
- Preventing social isolation and encouraging good neighbourliness
- Tackling unemployment in City residents
- Encouraging digital participation
- Tackling pollution and promoting green spaces
- Encouraging resident/patient participation and acting on the feedback in a transparent way

- Promoting pharmacies as a mechanism for providing health care for commuters, and revisiting the idea of a walk-in clinic in the City of London
- Improving cycle safety
- Ensuring that NHS/austerity cuts do not impact negatively on local services

12. Written feedback responses from the event are included as Appendix 1.

Other feedback

13. Additional information was received from the public health intelligence team around primary care data. In the first draft of the document, it was stated that the only health data available for the City were from the Neaman Practice's Quality Outcomes Framework data; however, new prevalence data derived from the Clinical Effectiveness Group (CEG) has since become available.

14. The data from CEG is based on extracts from GP practice records. As such, the quality of the data depends upon the quality of the coding used by practices for each condition. Additionally, for some conditions, the numbers of people affected in the City are very small, so the figures must be treated with caution.

15. Despite these caveats, three conditions have been identified for which there are clear differences in numbers between those City residents who are registered with the Neaman Practice, and those who are registered with Tower Hamlets practices (i.e. Portsoken residents).

16. These conditions are:
    - Smoking: 11-15% at Neaman; 21% for Portsoken residents
    - Obesity: 4-9%% for Neaman; 15% in Portsoken
    - Hypertension: 8-10 % in Neaman; 16% in Portsoken

17. These new figures, which are now included in the JSNA City supplement, reveal health inequalities between the different City populations.

Proposals

18. The City of London has a duty to prepare JSNA and to involve the public in this process. The JSNA City Supplement consultation runs until the 31st of May 2014. Any additional comments or corrections received up to this date will be tabled or verbally reported upon at the Health and Wellbeing Board's meeting on this date.

19. If the Health and Wellbeing Board has no further comments or suggestions to make, it is proposed that the Health and Wellbeing Board signs off the final draft of the JSNA City Supplement (Appendix 3)

20. If further amends are required, it is proposed that the Health and Wellbeing Board nominates the Chairman to sign off the final draft once the changes have been made.

21. The final draft of the JSNA City supplement will then be proofread and designed into its final format, ready for publication. The final designed version will be brought to the next meeting of the Health and Wellbeing Board for information.

Appendices

- Appendix 1 – Feedback from consultation event
- Appendix 2 – City and Hackney Health and Wellbeing Profile (JSNA data update, January 2014) (www.hackney.gov.uk/jsna)
- Appendix 3 – JSNA City Supplement.

Background Papers:

1st April 2014, *JSNA Update Report*

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Appendix 1

Feedback from consultation event

What is surprising?	Comment/response from authors
• Didn't realise that 40% of City residents are migrants	
• Air quality figures are worrying	
• Number of tenants not working is a surprise	
• 21% of children in low income families + high number on free school meals	
• High levels of poverty in Portsoken	
• High proportion of BME children	
• High overcrowding	
• City has the 6th highest number of rough sleepers	
• Rough sleepers can register with local GPs – they have serious health problems (does it impact upon the GP's capacity?)	
• Number of City workers with alcohol problems	
• No walk-in centres for people who work, but do not live, in the City – this puts an extra load on A&E	
• Some of the statistics are already out of date (e.g. Census is from 2011)	• Unfortunately, such is the nature of official reporting – stats are often not published until 2-3 years after the time period from which they were taken
• Is end of life care really as good as it looks, or is this down to small numbers?	• This is a good point which we will double-check

Appendix 1

Does the document reflect the City?	Comment/response from authors
• The Joint Health and Wellbeing Profile did not take into consideration the daily influx of commuters [the City supplement does]	
• Cultural /community life reasonably well represented.	
• Information well covered	
• Yes, it covers the competing needs of different groups	
• More young families in the Barbican – didn't feel these were reflected	• There is some discussion of these in the appendices
• Would be good if there could be equivalent information on tenants from the Guinness Trust [as there is for Middlesex Street and Golden Lane]	• Agreed – the Housing Team has spoken to the Guinness Trust about this in the past, but no information has been forthcoming yet

Is there anything missing?	Comment/response from authors
• Really well covered!	
• More information on how to deal with rough sleepers	• This is covered in the joint Health and Wellbeing Profile and we did not want to repeat it here
• Information on the costs of museums and libraries, especially for senior citizens	• Beyond the scope of JSNA
• More information on dental service, optician, physiotherapy and chiropody provision	• Dental and optometry is covered in chapter 8. We will see if we can get information about chiropody and physiotherapy, but these may need to be included in future editions.

Appendix 1

• There are more office developments now	• The nature of development in the City is covered in chapters 2 and 4
• Exploration of distance to medical appointments [and transport networks]	• A map of medical facilities is provided in chapter 8. Transport networks are discussed in chapter 4.
• Data on what working-age residents in work are doing – do they work unsociable hours? [Are they able to access services?]	• There is unlikely to be a single answer to this question
• Need an analysis of commuting stats – which stations do commuters use; how does commuting impact upon health and wellbeing?	• TfL commuting stats for the City are fairly out-of-date; however we have a map of commuters' postcodes which we can include.
• Need more information about elderly care, dementia and ill health in the elderly	• More detailed information is covered in chapters
• Walk-in centres [and why the City doesn't have one]	
• Accessibility and mobility is a very important issue for the City, as there are a lot of stairs – more ramps are needed	
• More of a focus on new technologies – we were told we would be able to get prescriptions and book GP appointments online	
• Mental health services and facilities in the City	• A mental health needs assessment is currently underway
• How fuel poverty is defined	• This is included in chapter 4.
• Definition of overcrowding, and information on how overcrowding impacts upon local services	• Definition and impacts are included in chapter 4
• Tower Hamlets GP information on City residents who are registered with Tower Hamlets GPs	• This data has now been added for smoking, hypertension and obesity
• More clarity on some statistics – e.g. actual size of older population	• These figures are included in chapter 3

Appendix 1

Having seen the data, what issues do you think we need to focus on more?

- Provision for the elderly, especially home care
- Funding for research into dementia
- Need to focus on the ageing population
- Increasing elderly population means an increasing need to look at ease of access to dementia diagnosis – currently people are seen in Hackney Wick memory clinic or assessed in their own homes.
- How will the dementia strategy work with local mental health services?
- Preventing social isolation
- Good neighbourly care ought to be encouraged, perhaps by instigating pupils based in local schools to visit care homes, hospitals, etc.
- Assistance in becoming work-ready
- Address areas of unemployment – needs to be a clear focus, as it is linked to poor health and health outcomes
- Digital communication to engage and involve
- Environmental pollution should be a priority, to take account of the worsening pollution levels
- Green spaces, how well they are used, how they are balanced with buildings, health benefits.
- More attention needed on engaging residents to participate e.g. patient participant group
- Patient/resident feedback should be better coordinated
- Need to know what's going to happen next (transparent course of action)
- City counsellors should be present at meetings of Healthwatch to address and answer questions raised by residents
- How City and Hackney work together
- Promoting pharmacies for minor consultations
- Providing GP services for City workers could support the provision of primary care for the City as a whole
- Re-establishing a walk-in GP practice in the City
- Focus on air quality – is it worse than surrounding boroughs?
- Safer cycling
- Effects of austerity cuts
- Investigate how NHS procurement is conducted locally
- Focus on the closure of GP surgeries that border the City

Appendix 1

- Investigate the closure of services such as the chiropody services and increases in referrals to private consultants
- Lack of training for receptionists
- Getting overseas health tourists to pay for their treatment

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City of London Corporation

Accuracy Matters

[A]Document control

Lead author:	Maria Cheung Health and Wellbeing Executive Support Officer
Document owner:	Director of Community and Children's Services
Approved/agreed by:	Health and Wellbeing Board
Issue date:	May 2014
Version number:	DRAFT 1.2
Review due date:	
Details of development and consultation:	Developed by the Health and Wellbeing Executive Support Officer and the Health and Wellbeing Policy Development Manager
How will the document be disseminated to all relevant staff?	
How will the document be implemented?	
Who will review the document (job title)?	
What other documents should this be read in conjunction with?	• City and Hackney Health and Wellbeing Profile • City of London Joint Health and Wellbeing Strategy

Revisions

Version no.	Page/ paragraph no.	Description of amendment	Date approved
1.0		Original	
1.1			
1.2		Figures and tables	

Contents[CH]

[TYPESETTER: PLEASE DELETE ALL ERROR MESSAGES. PAGE NUMBERS WILL BE ADDED AT PROOFREADING STAGE]

[B]Acknowledgements

We would like to thank the Public Health Team at the London Borough of Croydon for their innovative approach to Joint Strategic Needs Assessment, which has been instrumental in shaping this document.

1. Background[CH]

[A]City and Hackney Joint Strategic Needs Assessment

The City of London has a statutory duty to conduct Joint Strategic Needs Assessment (JSNA) as required. This is a process which examines the health and wellbeing needs of the people in the locality. The City currently conducts JSNA with the London Borough of Hackney, as we share a health budget and much of our data is currently aggregated with Hackney's. This joint document is published as the City and Hackney 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. JSNA is an ongoing, iterative process, led by the Public Health Team and involving the City of London Corporation (Community and Children's Services), NHS City and Hackney Clinical Commissioning Group (CCG), City of London Healthwatch, the voluntary and community sector and other partners.

[A]The City Supplement: a City digest

The City Supplement is the first report to pull together all the data that is available and disaggregated specific to the City's population. This includes evidence from the City and Hackney JSNA process, as well as evidence from 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 requirements, it does not provide all the information needed 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.

[B]What the City Supplement is used for[1]

- To supplement the City and Hackney Health and Wellbeing Profile in providing 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] London Borough of Croydon (2012)

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

[A]The social determinants of health

The 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. These are 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.

[B]The health map

Barton and Grant and the UK Public Health Association strategic interest group (2006)[3] developed a health map which shows how individual determinants – including a person's age and 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, including wealth creation and markets
- community – social capital and networks
- lifestyle

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

[2] Raphael, D (2004) *Social Determinants of Health: Canadian perspectives*. Toronto: Canadian Scholars' Press Inc.

[3] Barton, H and Grant, M (2006) 'A health map for the local human habitat'. *The Journal of the Royal Society for the Promotion of Health*, 126 (6), 252–253. ISSN 1466–424

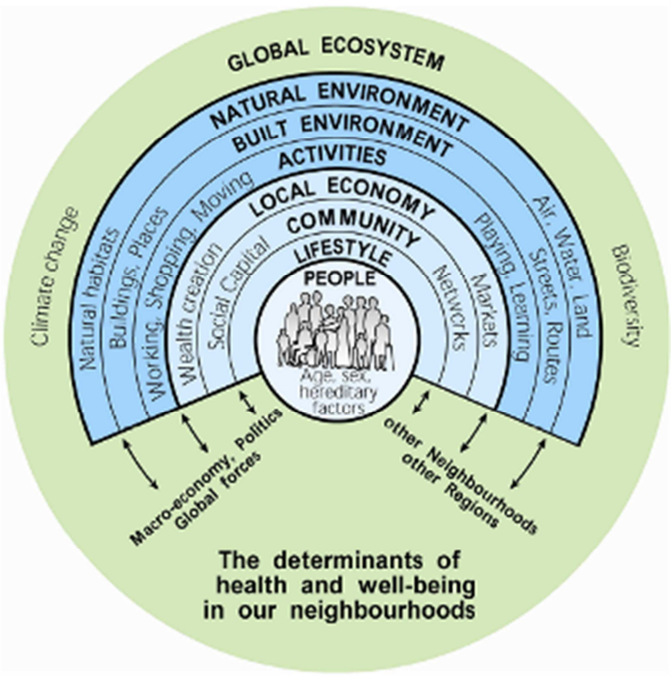


Figure 1.1 Health map

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 on or can influence the conditions in which people live and work and, to a certain extent, the life chances of individuals.

[A]Health in All Policies

Health in All Policies (HiAP) is a collaborative approach that integrates and articulates health considerations into policymaking across all 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 HiAP[4] approach aims to improve the accountability of policymakers for health impacts at all levels of policymaking by: taking into account the health and health system implications of decisions across sectors; seeking synergies; and avoiding harmful health impacts in order to achieve better population health and health equity.

Incorporating health considerations into policies across all sectors is challenging and, even when decisions are made, implementation may only be partial or unsustainable. One public health think tank[5] suggests the following actions to achieve successful collaboration:

- identify shared goals

[4] Ministry of Social Affairs and Health, Finland (May 2013) *Health in All Policies: Seizing opportunities, implementing policies*

[5] Association of State and Territorial Health Officials. See: www.astho.org/HiAP/?terms=health+in+all+policies

- engage partners early and develop relationships
- define a common language
- activate 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.

[A]Life course approach

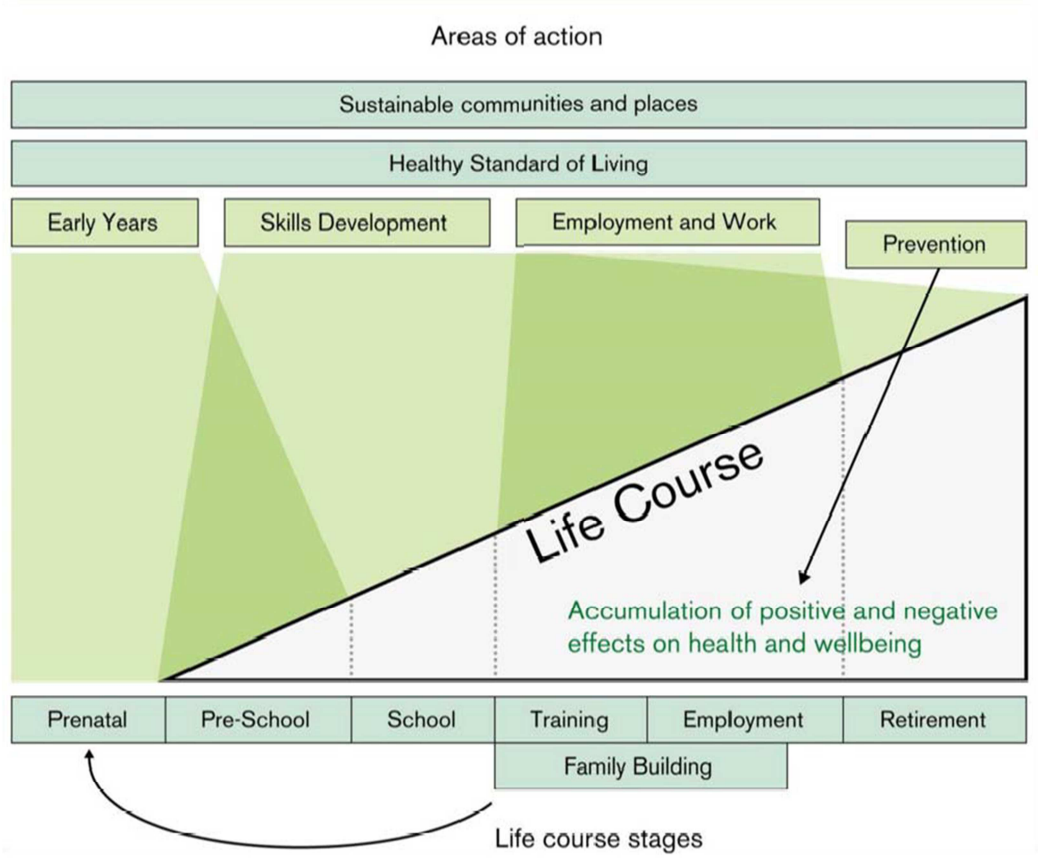
A complementary way to view the effects of social determinants of health is to take a temporal rather than a spatial approach.

This is the approach taken by the Marmot Team in their 2010 report on health inequalities in England, *Fair Society, Healthy Lives*[6].

- The report 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 the story: action to reduce health inequalities must start before birth and be followed through the life of a 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.

[6] Marmot M (2010) Fair Society, Healthy Lives

Figure 1.2. Areas of action and intervention across the life course



[A]Format of the City Supplement

The City Supplement incorporates both a spatial view of health and wellbeing – beginning with the 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.

Together, these two ways of describing health and wellbeing needs 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 ranging from community and early life through to later life.[7] 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 the environment	Community cohesion and neighbourhood attachment, air quality, transport, green spaces, noise pollution, leisure and cultural facilities, climate change, crime and safety

[7] London Borough of Croydon (2012)

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	The 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

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[A]Limitations of the dataset

[B]Resident data

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

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

[B]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 provide

insights into the health needs of City workers: *The Public Health and Primary Healthcare Needs of City Workers* and *Insight into City Drinkers*.[8,9]

[B]Rough sleeper data

The main source of data on rough sleepers in the City comes from the Combined Homelessness and Information Network (CHAIN) database. The CHAIN 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 **Error! Reference source not found.**, 'Data limitations'.

[8] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[9] *Insight into City Drinkers* (2012)

2. The City's geography[CH]

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

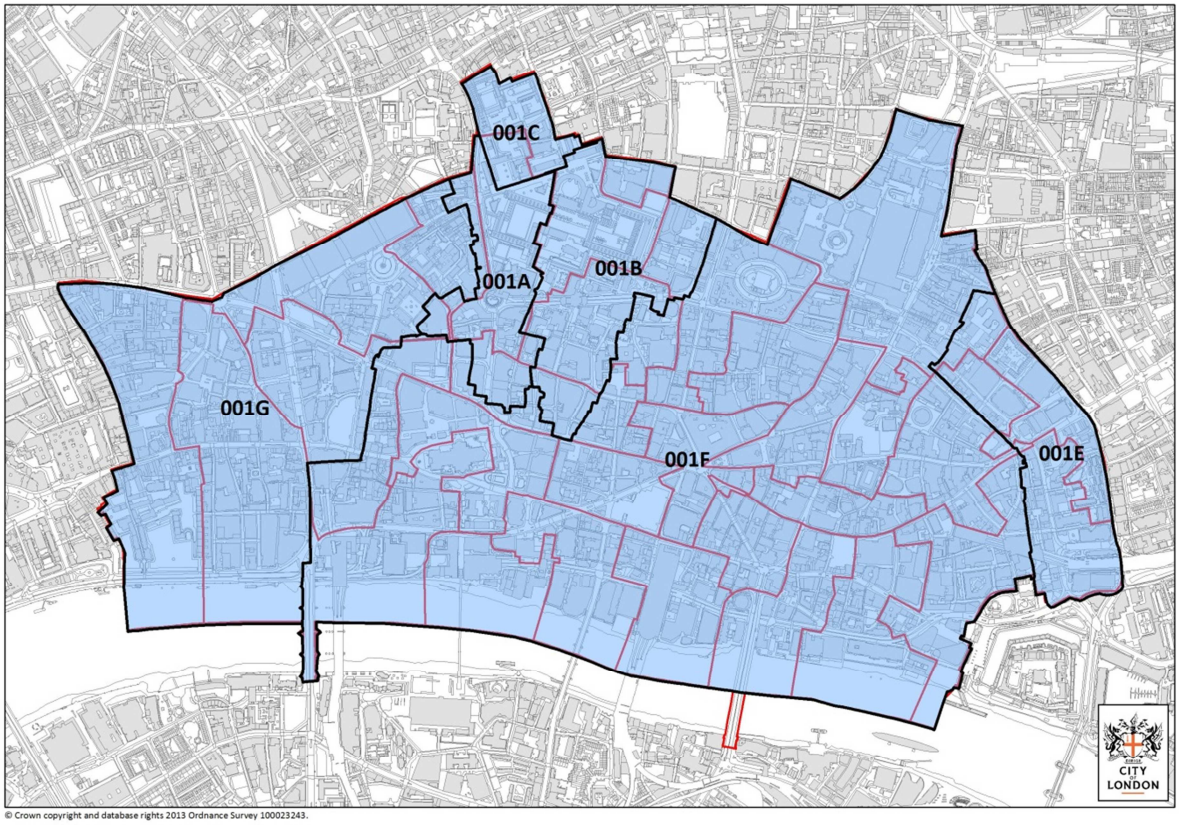


Figure 2.1. Map of the City of London showing LSOAs in black and ward boundaries in red

Four of the City's LSOAs broadly correspond to particular residential populations in the Barbican, Golden Lane and Portsoken Estates, while the other two represent a slightly more dispersed population (see Figure 2.1).

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[CH]

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: 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.

[C]Key findings

[D]Residents

- The City has a small population, which is projected to grow slowly in the coming decades.
- Those aged 65 and over are projected to contribute the most to this growth, with their numbers increasing rapidly in the next decade. (For more information on the health needs of this group, see Chapter 7, '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.

[D]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 to 50 years old).
- City workers are a transient population and about one-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 to care and increased care costs.

[D]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 aged between 20 and 50.
- About half the rough sleepers are British nationals and the remainder come from Eastern Europe.
- Over half the rough sleepers have alcohol problems, around half have mental health problems, and almost one-third have drug problems.

[C]Recommendations

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

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

[C]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 facing City workers?
- How can commissioners tackle the risks of poor health to low-paid migrant workers?
- How can commissioners progress integrated health and housing care for rough sleepers?

[B+]Residents

[A]Population size and age profile

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

Table 3.1 presents the population in five-year age bands, with population pyramids for the area in Figure .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 3.2. School age children are located in the most easterly 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 (Office for National Statistics (ONS) 2012 mid-year estimate)

Age	Population
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 estimate)

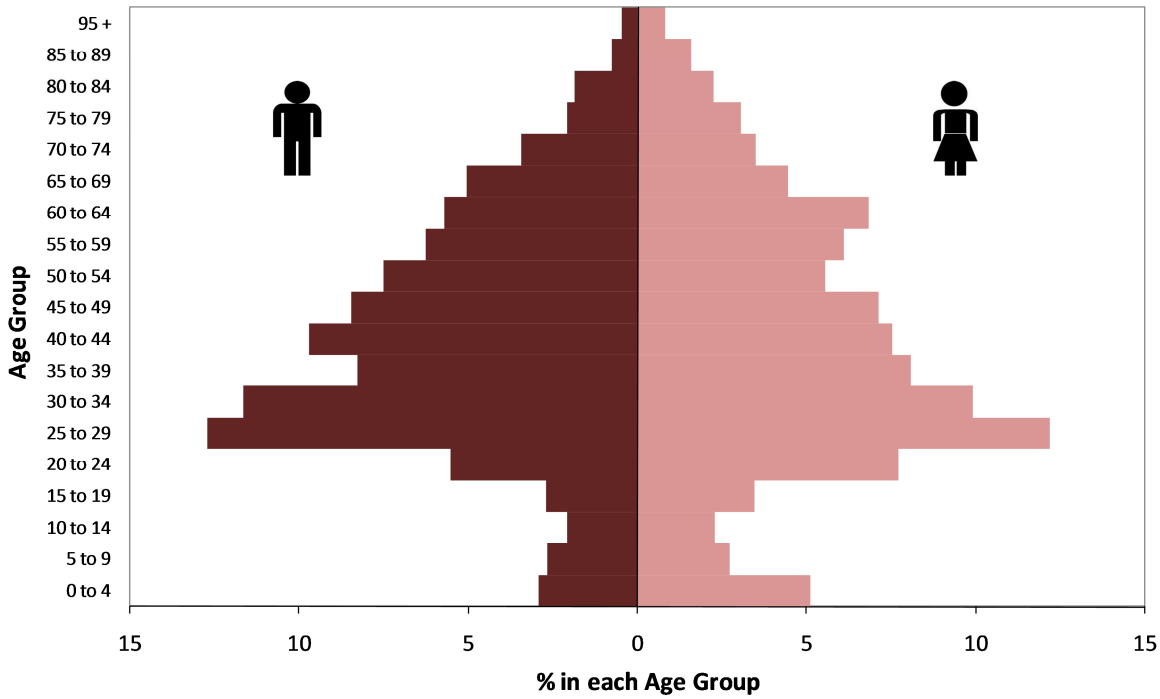
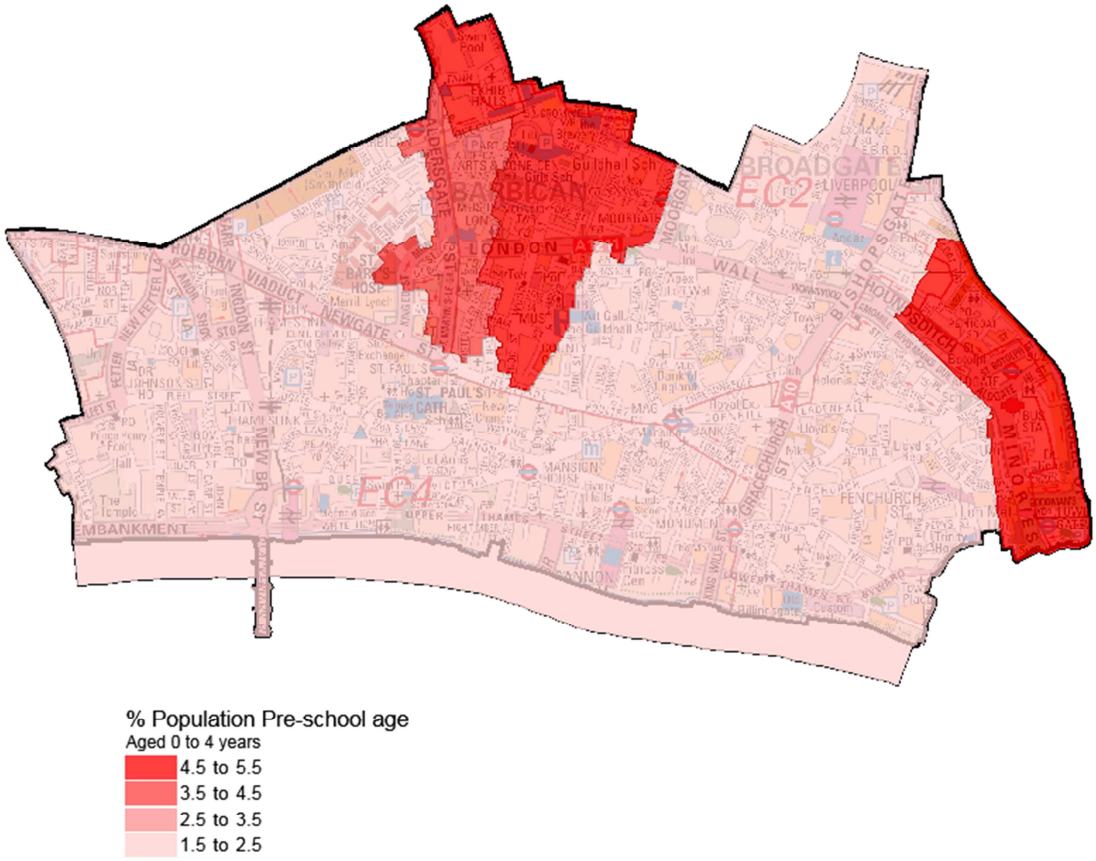
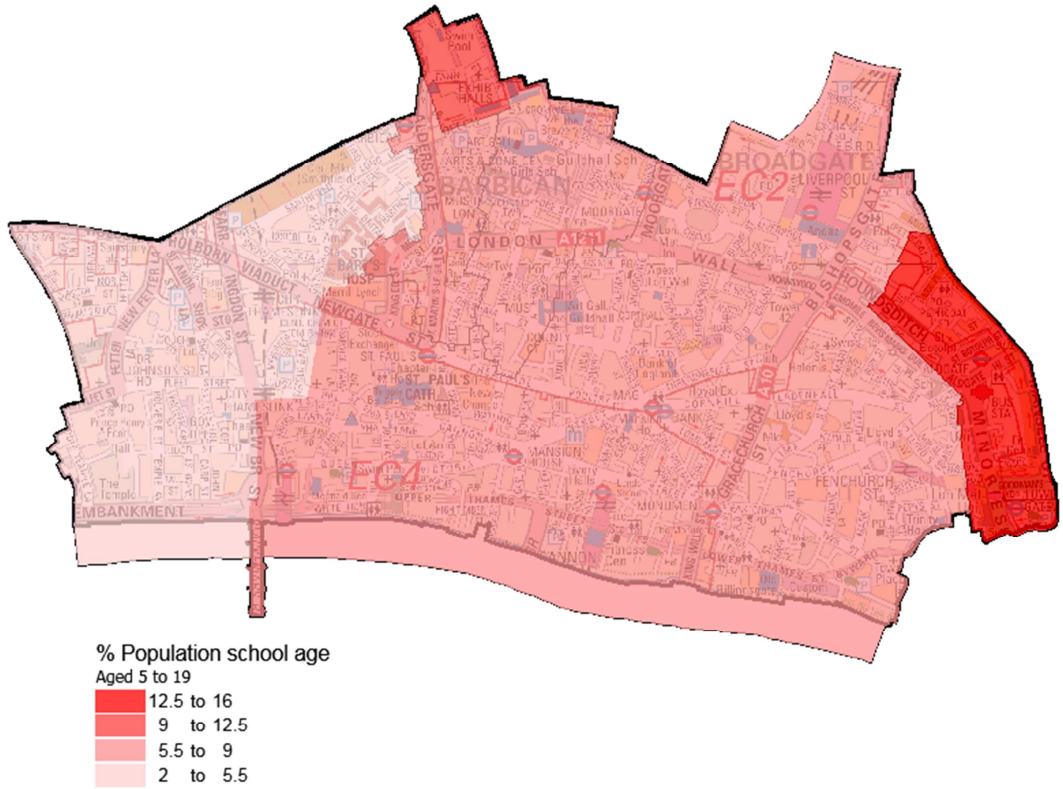


Figure 3.2. Geographical age structure: percentage aged 0-4



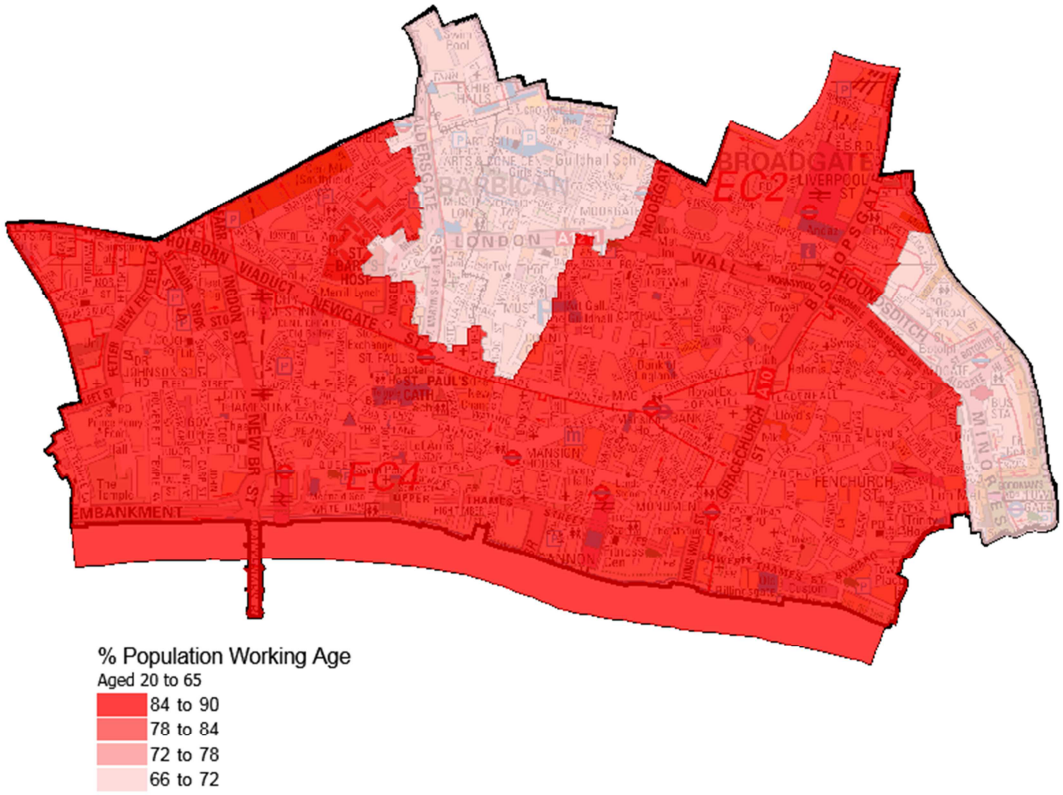
Source: ONS 2012 mid-year estimates

Figure 3.3. Geographical age structure: percentage aged 5-19



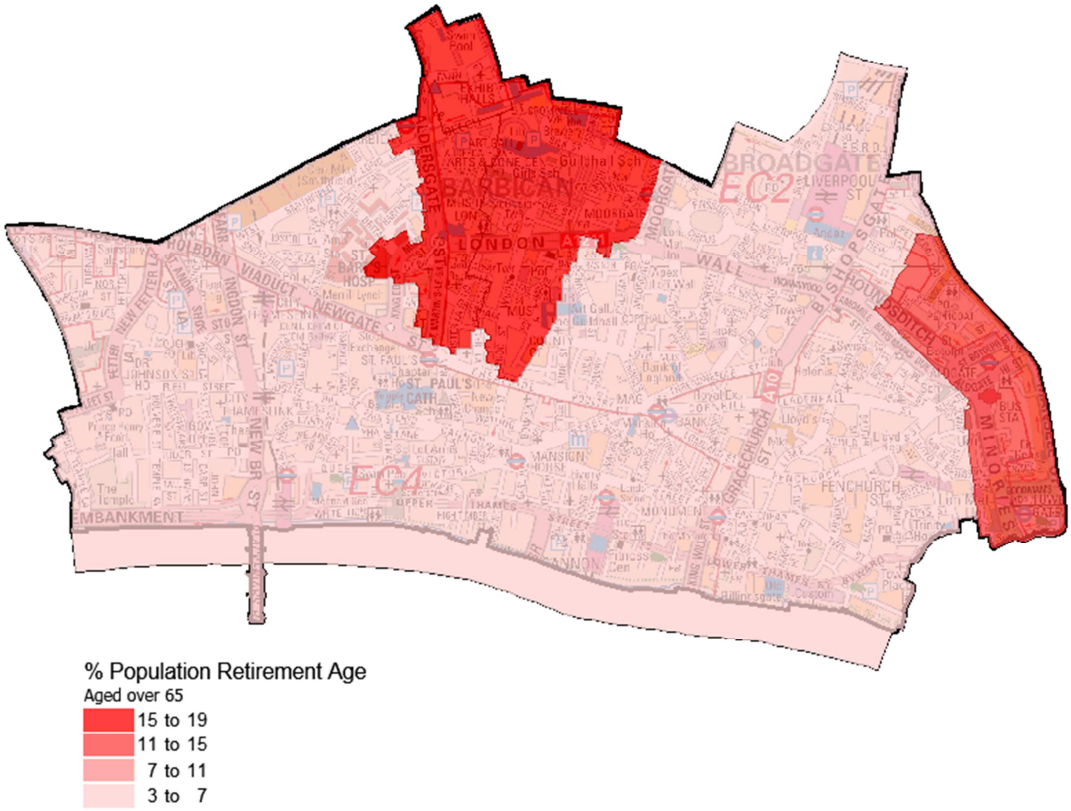
Source: ONS 2012 mid-year estimates

Figure 3.4. Geographical age structure: percentage aged 20-65



Source: ONS 2012 mid-year estimates

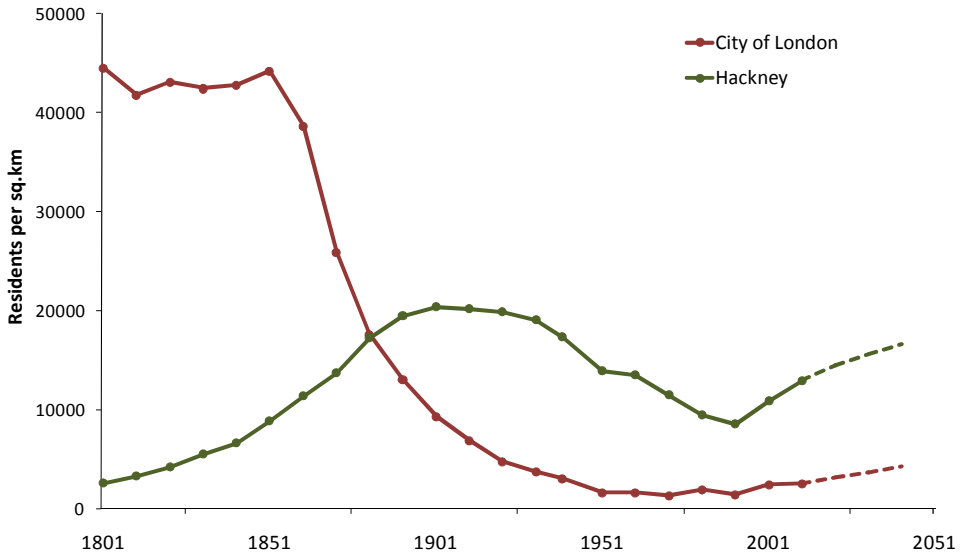
Figure 3.5. Geographical age structure: percentage aged over 65



Source: ONS 2012 mid-year estimates

[B]Population density

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



Source: Greater London Authority (GLA)

The Census 2011 estimates the City of London's population density to be 2,552 residents per km^2. This figure remains historically low, although the current trend is rising (Figure 3.6). However, the population density is greater than this when residents occupying a second home in the City are included. The Census 2011 estimates that there are 1,370 people resident elsewhere in the UK as well as in the City. Including these people 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 only a small proportion of land. Therefore residential densities in the City, as seen in the north (Figure 3.7) are very high, as the majority of housing schemes are multi-storey with little or no outdoor space or car parking.[1] However, density measured by the number of people per household remains low (Figure 3.8).

[1] *City of London Local Development Framework. Core Strategy: Delivering a World Class City* (2010)

Figure 3.7. Population density: number of people per hectare

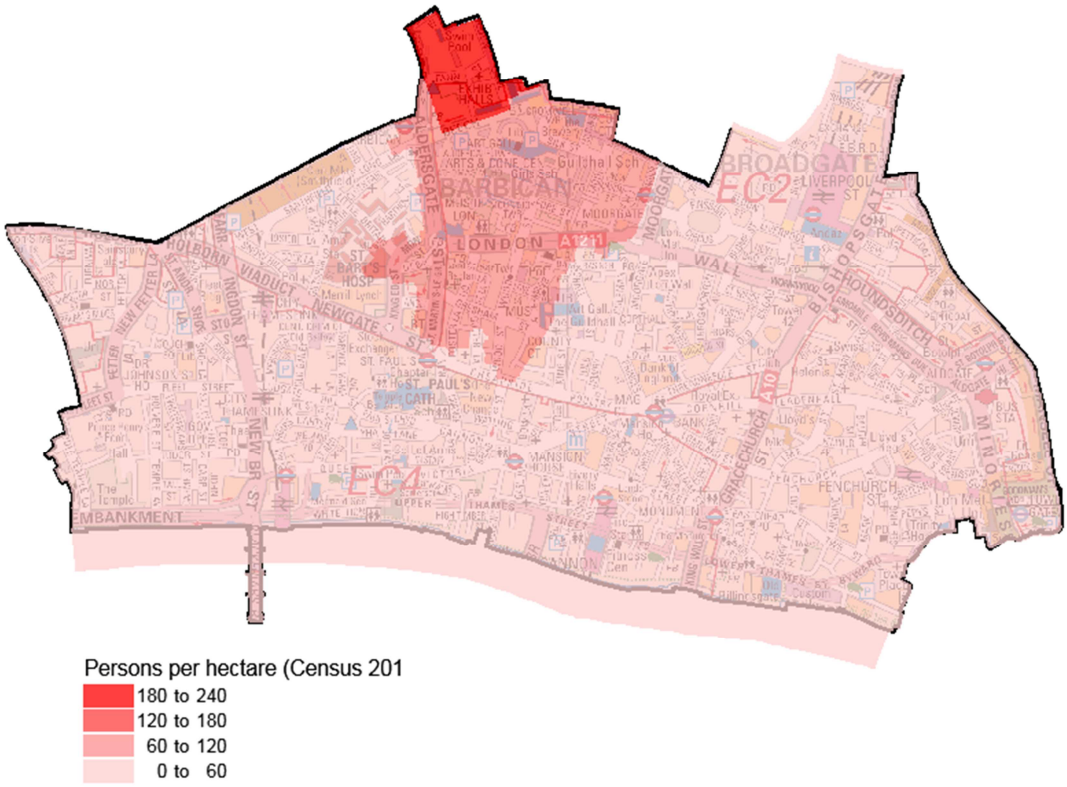
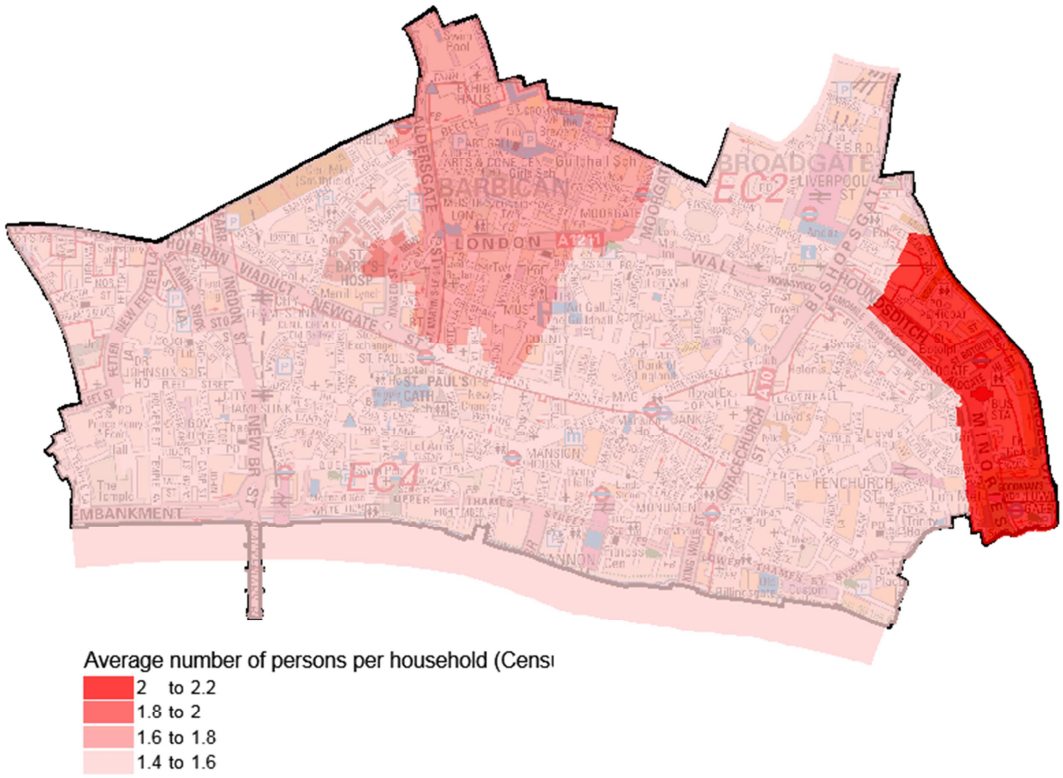


Figure 3.8. Population density: number of people per household



[B]Population change and migration

ONS estimates show that the City's population is growing slowly. It 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 people of working age who come to the City of London for a specific job or employer. ONS estimates are rounded to the nearest 100, which is not entirely helpful in the City context. In future JSNA publications, it is envisaged that more accurate data for births and deaths will be available.

GLA estimates expect the City's population to grow from 7,600 in 2012 to 9,200 in 2037. The majority of growth will be in the working age and ageing populations; however, the number of older people is projected to increase more rapidly in the near future. For more detailed population estimates and projections, see **Error! Reference source not found.**.

Table 3.2. Components of change in population estimates for the City, 2011-12 (numbers rounded to nearest 100)

	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 Census 2011 population, 2,700 (37%) were born abroad, with 44% of these resident in the City for 10 or more years. The main countries of origin are recorded in Table 3.3.3.

Table 3.3. Top 20 countries of birth for residents of the City born outside the UK

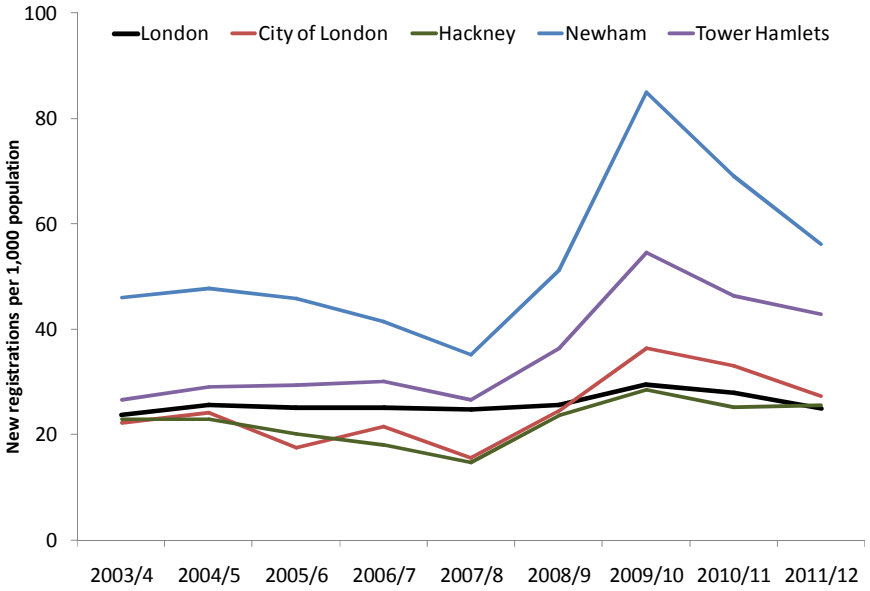
Country of birth	% of population
United States	2.8
France	2.0
Australia	1.9
Germany	1.6
Ireland	1.5
India	1.4
Italy	1.4
Bangladesh	1.3
China	1.3
New Zealand	1.1
Hong Kong	1.0
South Africa	1.0
Spain	1.0
Canada	0.9
Japan	0.7

Greece	0.7
Malaysia	0.7
Russia	0.7
Colombia	0.7
Poland	0.6

Source: Census 2011

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

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



Source: ONS

[A]Ethnicity

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

Table 3.4. Proportions of population of the City in broad ethnic groups

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

Source: Census 2011

Table 3.5. Proportions of population of the City in main (>1%) narrow ethnic groups

Ethnicity	% 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: Census 2011

See **Error! Reference source not found.**', for more information.

[A]Religion

The City is a diverse area, with a wider range of religious identities than England as a whole (Table 3.6).

In the City, 45.3% of residents identify as Christian, with 34.2% having no religion. The next largest religion is Islam, with 5.5% of residents, followed by 2.3% who are Jewish 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 fallen by around 10%, while the proportion identifying as having no religion has increased by roughly the same amount.

See **Error! Reference source not found.**', for more information.

Table 3.6. Proportions of population by religious identification in the City, London and England

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: Census 2011

[A]Languages

In the City, most 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% of residents and East Asian languages by 2.5% (Table 3.7).

Most of those who do not speak English as their main language 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 figure.

The main individual languages spoken in the City are shown in Table 3.8.

Table 3.7. Proportion of respondents' main language groups in the population of the City

Language	% 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: Census 2011

Table 3.8. Proportion of respondents' main languages widely spoken (>1%) in the population of the City

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

Source: Census 2011

See **Error! Reference source not found.**', for more information.

[A]Overall health

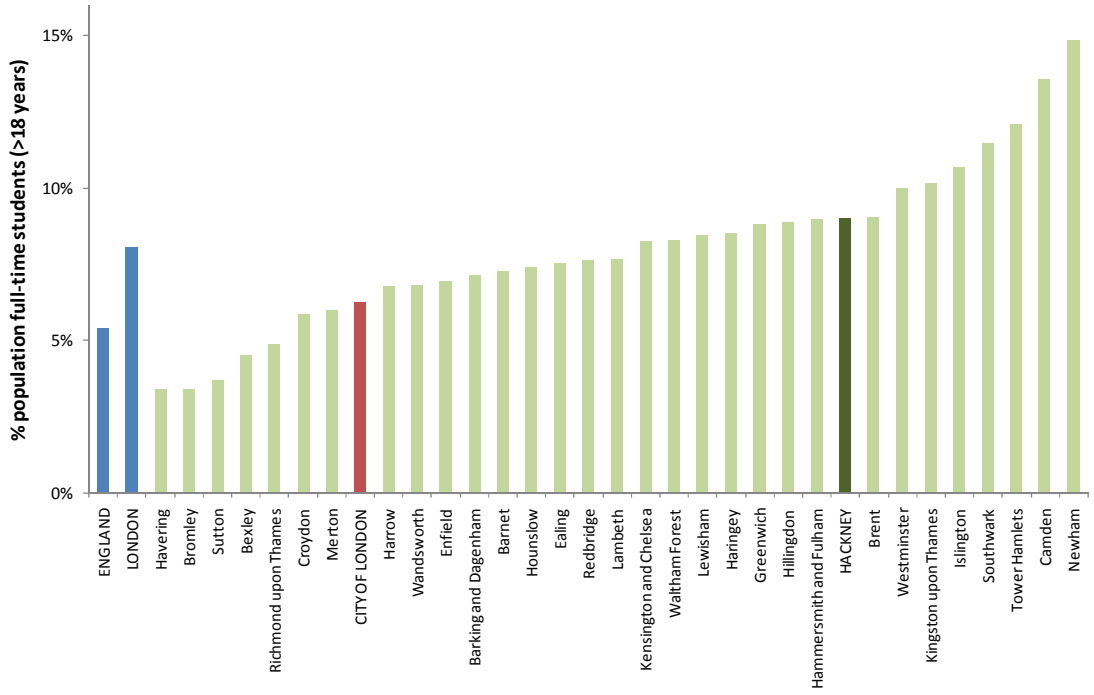
Most City residents consider themselves to be in good or very good health (88% of all residents). However, around one in eight households contains someone with a disability or long-term health

problem. This figure is lower than in London or elsewhere nationally, but there are variations in health between neighbourhoods, reflecting 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 affect around 20% of households. Many of the people affected have a physical disability, are frail or elderly, or suffer with mental health problems. They are most likely to require specialist forms of housing or adaptations and support services to help them remain living independently in their homes.

[B]Students

The Census 2011 was carried out on 27 March 2011. On this date, 400 (6.2%) of those in the City reported that they were full-time students aged over 18. This is lower than the London figure (8.1%) and close to the England figure of 5.4% (see Figure 3.10). It should be noted that students are a particularly mobile population, and this figure will vary widely across the academic year.

Figure 3.10. Proportion of students in the population of London by borough (Census 2011)



[B]Carers

See Chapter 6, 'Working age', for detailed information on carers.

[B]Travellers and Gypsies

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

Overall, the findings from the Census 2011 are consistent with previous independent reports. New insights for City workers not previously available are the age and sex profile by year, religion, housing tenure (see 'Housing' in Chapter 4), education, residency and passport designation.

[A]Population density

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

[A]Age and sex

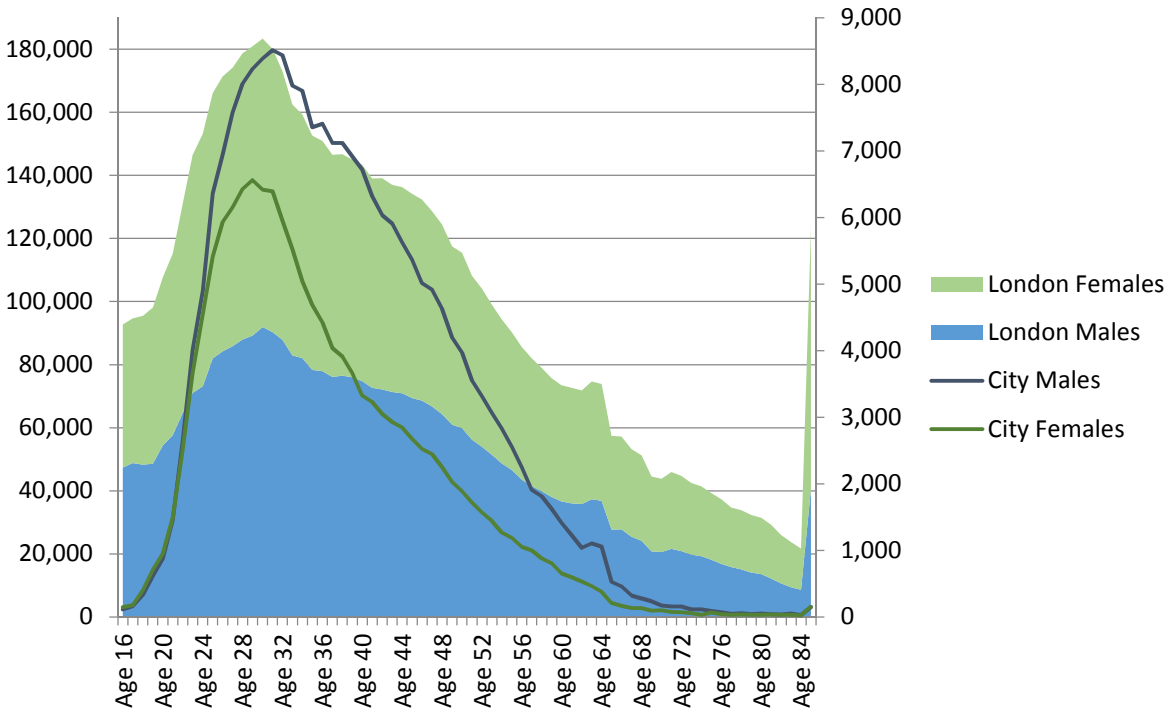
City workers are mainly aged between 20 and 50. Most women working in the City are in their mid-20s to mid-30s, while most men are in their mid-20s to mid-40s. There are over one-third more male (220,265) than female (139,813) daytime City workers, which is the reverse trend to that seen across London as a whole (Figure 3.11).

The younger age and male-dominated profile of City workers is consistent with findings from previous independent reports, and is most likely influenced by the male-dominated finance and insurance industries representing a large portion of the workforce.[2,3] 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.[4]

Although female workers in the City are proportionately fewer in number than male workers, their health needs should not be overlooked and may be unique. For example, *Insights into City Drinkers* found that both female and male City workers drink higher amounts than the national average, suggesting that women in the City may in part drink more because they have been influenced by a wider 'social norm' of heavy drinking.[5] This may also apply to other health needs affecting female City workers surrounded by a predominantly male working population.

Figure 3.11. Profile of City and London workers by sex and age

[2] ibid
[3] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[4] ibid
[5] *Insight into City Drinkers* (2012)

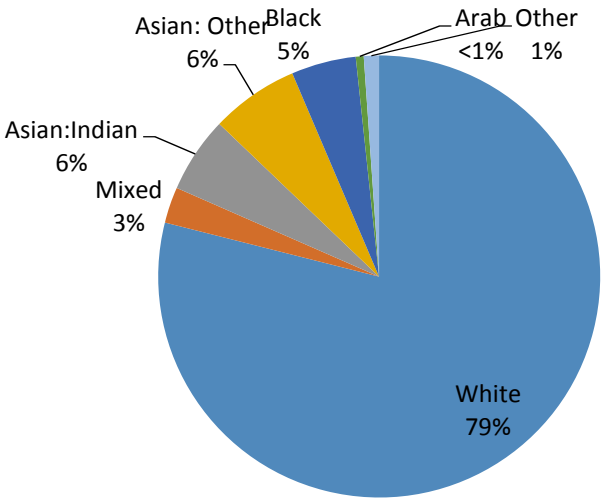


[A]Ethnicity

The ethnic profile of City workers overall reflects the London profile (see Figure 3.12). The majority are white (79%), a relatively large proportion are Asian of Indian origin (6%) and the remaining Asians represent another 6%. A total of 5% are black, 3% are of mixed origin and less than 1% are of Arab origin. These figures are consistent with previous independent reports on City workers.[67]

[6] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[7] *Insight into City Drinkers* (2012)

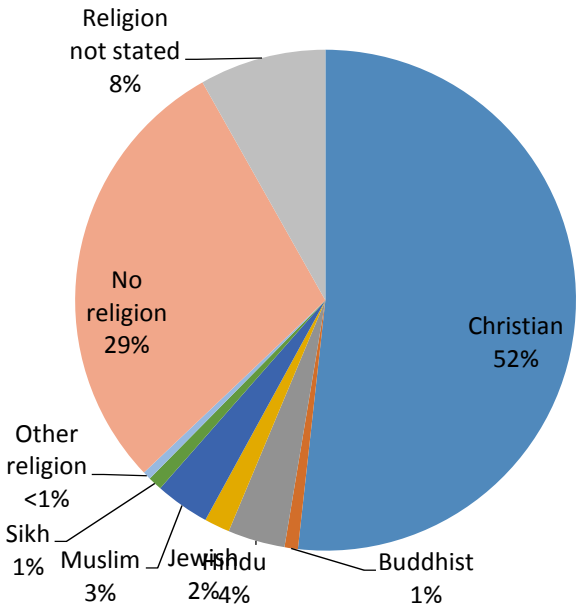
Figure 3.12. Ethnic profile of City workers



[A]Religion

The religious profile of City workers is broadly representative of that across London and England. Half of City workers are Christians, while another third have no religion. A total of 4% are Hindus, 3% are Muslims and 2% are Jewish. Sikhs and Buddhists represent 1% each. Nationally, there is a greater proportion of Christians (59%), and across London there are more Muslims (12%) than among City workers.

Figure 3.13. Religious affiliation of City workers



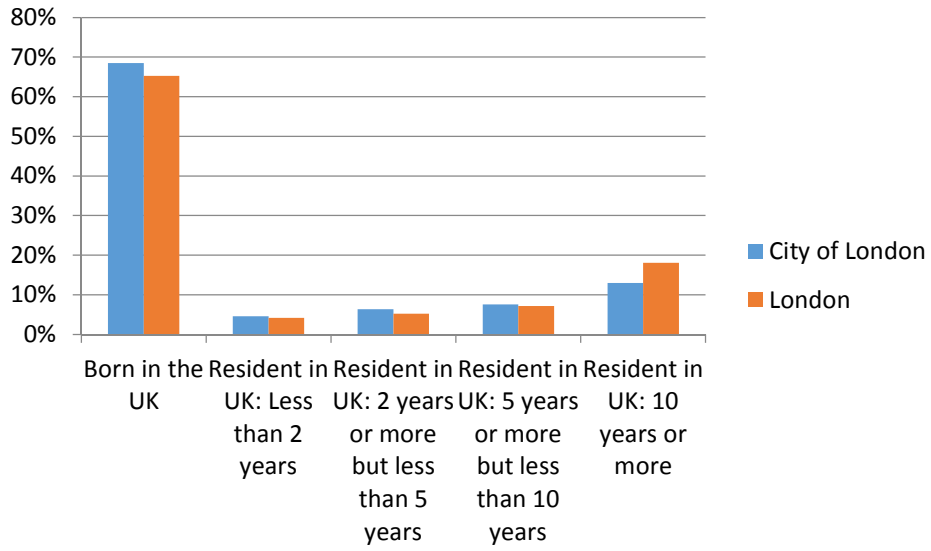
[A]Residency

The majority of City workers were either born in the UK or are short-term residents; both these figures are slightly higher than the London average. 68% of City workers are UK-born and 17% are short-term residents who have been in the UK less than 10 years. Taken together, one-third of all City workers are migrants.

Most migrants are young and healthy. The risk factors most relevant to migrant City workers' health include language and cultural differences, stigma, discrimination, social exclusion, separation from family and sociocultural norms, administrative hurdles and legal status.

Migrants tend to travel with health profiles, values and beliefs that reflect their community of origin. Such profiles and beliefs may have an impact on the health of, and usage of health services by, migrants.[8]

Figure 3.14. Residency profile of City workers



Passport designation and access to healthcare

In total, 78% of City workers have UK passports (see Figure 3.15). Of those with non-UK passports, one-third are from countries that were EU members in March 2001 (Germany, France, Italy, Portugal, Spain and others) and 10% are from countries that joined the EU between April 2001 and March 2011 (Lithuania, Poland and Romania). Another 9% come from each of South Asia, Ireland and Australasia, and 7% are from North America.

Access and entitlement to free NHS treatment are dependent on the length and purpose of residence in the UK, not on nationality. In addition to the common health risks for migrants described above, non-UK nationals encounter some reduced social security and health protection, even as UK residents. For both UK and non-UK citizens, NHS hospital treatment is free and accessible at the point of need, for example in Accident and Emergency (A&E) departments. However, charges

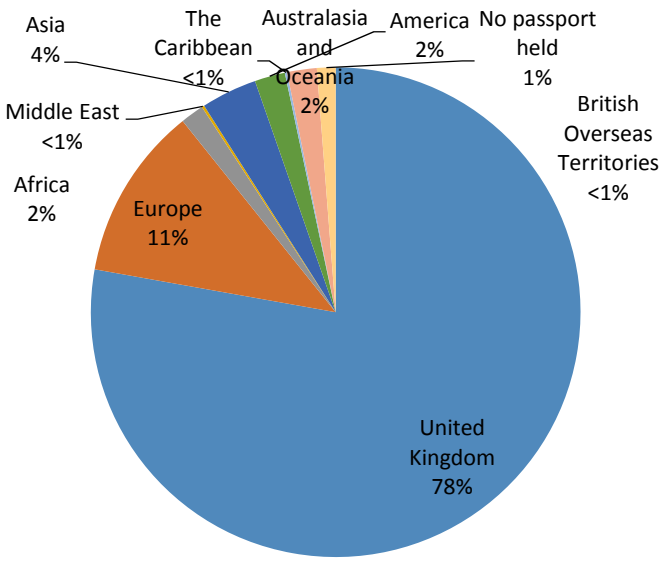
[8] World Health Organization (2010) *Health of Migrants - The Way Forward*

apply to non-UK citizens where subsequent treatments are necessary and the patient is admitted to hospital.

There is some discrepancy among non-UK citizens regarding access to a GP, as GP practices are not legally bound to accept non-UK citizens.[9] 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 for dental treatments and prescription drugs.[10] Therefore non-UK citizens face some extra administrative barriers and fees compared with UK nationals.

It is worth noting that a considerable number of City employers offer private healthcare, which may fill some of these gaps in protection. However, those most at risk 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.[11] (For more information see Chapter 8, 'Healthy Life'.)

Figure 3.15. Passport designation of City workers



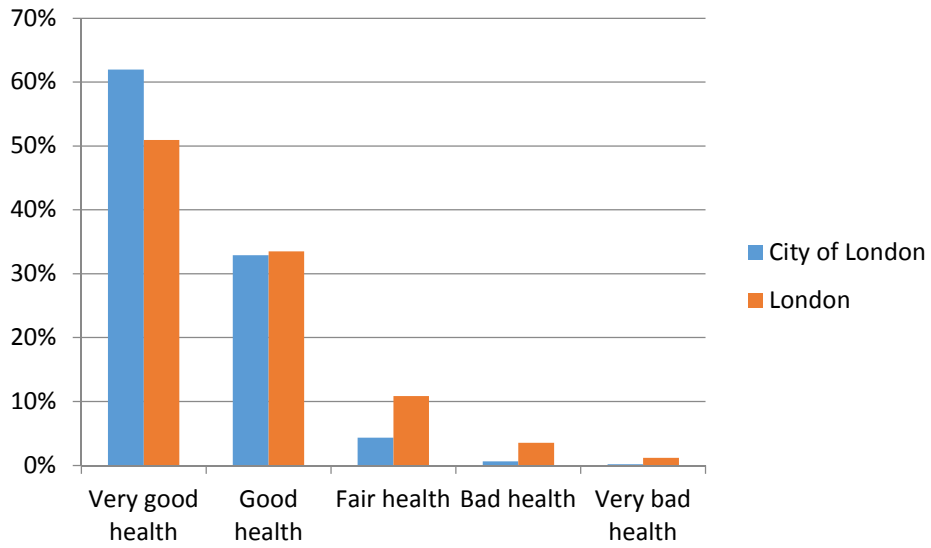
[A]Overall health

Most City workers (62%) perceive themselves as having 'very good health' (Figure 3.16), which is a higher figure than the London average of 51%. This perception is consistent with the findings from the 2012 independent survey *The public health and primary healthcare needs of City workers*.[12] It is most likely related to City workers' age and particular migrant profile, coupled with selection effects (i.e. the City offers demanding jobs that tend to attract healthy people).[13] In addition, the combination of being highly educated and earning a higher income is associated with better health outcomes.

[9] Citizens Advice Bureau (2013) *NHS charges for people from abroad*
[10] ibid
[11] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[12] ibid
[13] ibid

Despite this, there is strong evidence of a culture of long working hours and regularly feeling stressed among City workers, which – coupled with heavy alcohol consumption and smoking – may lead to future health problems.[14] For more information, see the sections 'Lifestyle and behaviours' and 'Mental health' in Chapter 6, 'Working age'.

Figure 3.16. Self-perceived overall health of City workers



Source: Census 2011

[14] ibid

[B+]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 come to the streets with complex personal issues, some have limited entitlement to services – often because their connections are to an area 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.

[A]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.[15]

In 2012/13, a total of 284 people were seen sleeping rough in the City by outreach teams.[16] Of these, 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, and 60 (21%) had returned to the streets after a period away.

[A]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, with a further 11% aged over 55. The majority of those seen (57%) were British nationals, with the bulk of the remainder coming from Europe (predominantly Eastern European countries; see Figure 3.17).

[A]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. Many had more than one of these problems. For more information, see the sections on rough sleepers in Chapter 8, 'Healthy life'.

Rough sleepers are generally in much worse health than other homeless people.[17] National estimates show that the homeless population uses acute hospital services about four times more than the general population, costing at least £85m per year.[18] Rough sleepers access A&E seven times more than the general population, and are more likely to be admitted to hospital in an emergency, which costs four times more than treating an elective in-patient.[19]

[15] Broadway (2013) *CHAIN Street to Home Annual Report 2012/13*
[16] Broadway (2013) *CHAIN Annual Report for City of London 2012/13*
[17] 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 (2010) *Health and Housing in Hackney and the City*
[18] Brodie et al (2013). *Rough sleepers: Health and healthcare*. London: NHS North West London
[19] 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, lack of knowledge of services, lack of continuity of care, transiency, lack of local connection and cost.

Figure 3.17. Nationality of rough sleepers in the City of London, 2012/13 (Broadway)

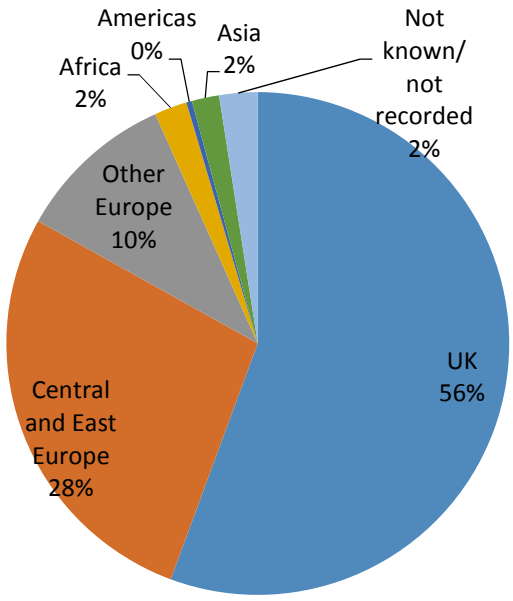
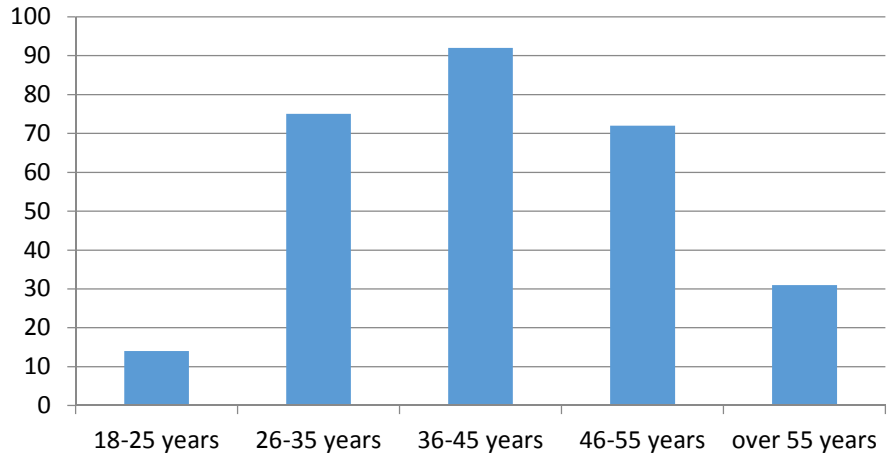


Figure 3.18. People seen sleeping rough by age, 2012/13



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4. Community life[CH]

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 Organization, 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 (i.e. our housing, transport, access to green spaces and air and water quality) and the people and networks within our 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.

[C]Key findings

- More than nine in 10 residents, workers, executives and businesses are satisfied with the City as a place to live, work and 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 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.
- 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 with the local housing strategy.
- 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.
- Overall crime rates in the City are falling; however, some categories of crime are increasing.
- The majority of City workers and residents are either homeowners or rent privately, with both groups containing 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.

[C]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 other London boroughs 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 that health impacts have been considered and incorporated.

[C]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?

[A]Quality of local area

[B]Community cohesion and neighbourhood attachment

Results from a local survey published in May 2013[1] reported that satisfaction with the City as a place to live, work and 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 among businesses has increased by nine percentage points since 2009. The survey reported the perceptions 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 there as its good points. Areas for improvement for both City workers and businesses were traffic congestion, parking, building work/roadworks and expense.

The City scores well on all the indicators of satisfaction and participation in civil society (Table 4.1). City residents see traffic congestion and pollution as needing improvement, followed by road and pavement repairs, affordable decent housing, parks and open spaces and shopping facilities.

Table 4.1. 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%

[B]Transport

The City of London is situated at the heart of London's extensive public transport system. Seven of the 11 London Underground lines and the Docklands Light Railway serve the City via 13 underground stations. There are seven mainline rail stations, four of which are major rail termini. Fifty-two bus routes serve the City's streets. There are also various commuter coach services and riverboat services that operate from piers at Blackfriars, London Bridge and Tower Hill.

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,

[1] City of London Corporation polling, 2013

workers and residents travel to and from the City by public transport, these services can be overcrowded and congested.

Residents of the City make 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 4.2), although there has been a significant overall increase in cycling in the City in recent years due to the popularity of commuter cycling and the Mayor's bike hire scheme. The City of London currently provides public cycle parking facilities for 6,761 bikes. In addition, there are an estimated 4,663 cycle parking 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 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 from 2010, when 41 people were killed or seriously injured and 339 were slightly injured. In 2011 vulnerable road users accounted for the vast majority of the 49 people 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 (involving 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 improving safety 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 focused education, training and enforcement which, taken together, are intended to reduce casualties. A 20 mile per hour 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 4.2. Residents' trips by mode of transport, 2007/08 to 2009/10 (Transport for London (TfL))

	Trips per person	Walk	Cycle	Bus	Under-ground	Rail	Car/motor-cycle	Taxi/ other

	per day							
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%

[B]Road casualties

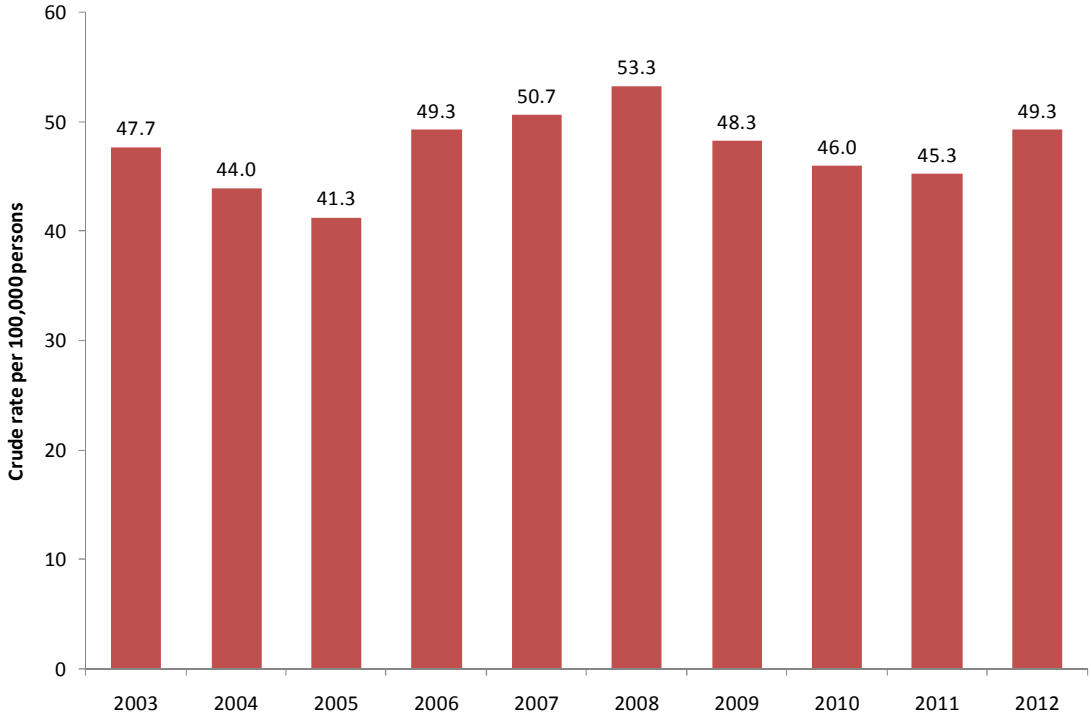
In the City, 58 people were killed or seriously injured on the roads in 2012, an increase of 18% on the previous year. With smaller numbers in the City, there is even more year-on-year variability in this data. However, since 2003 the long-term trend on a three-year rolling average shows a generally consistent number of casualties (Figure 4.1).

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

Table 4.3. Road casualties by road user type, 2012 (Department for Transport (DfT))

	City of London (N=58)	London (N=3,022)	England (N=21,630)
Pedestrian	33%	44%	31%
Pedal cycle	45%	23%	16%
Motorcycle	16%	21%	22%
Car	3%	16%	35%
Bus or coach	3%	3%	1%
Van/light goods vehicle	0%	1%	1%
HGV	0%	0%	1%

Figure 4.1. Three-year rolling average of people killed or seriously injured 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

[B]Green spaces

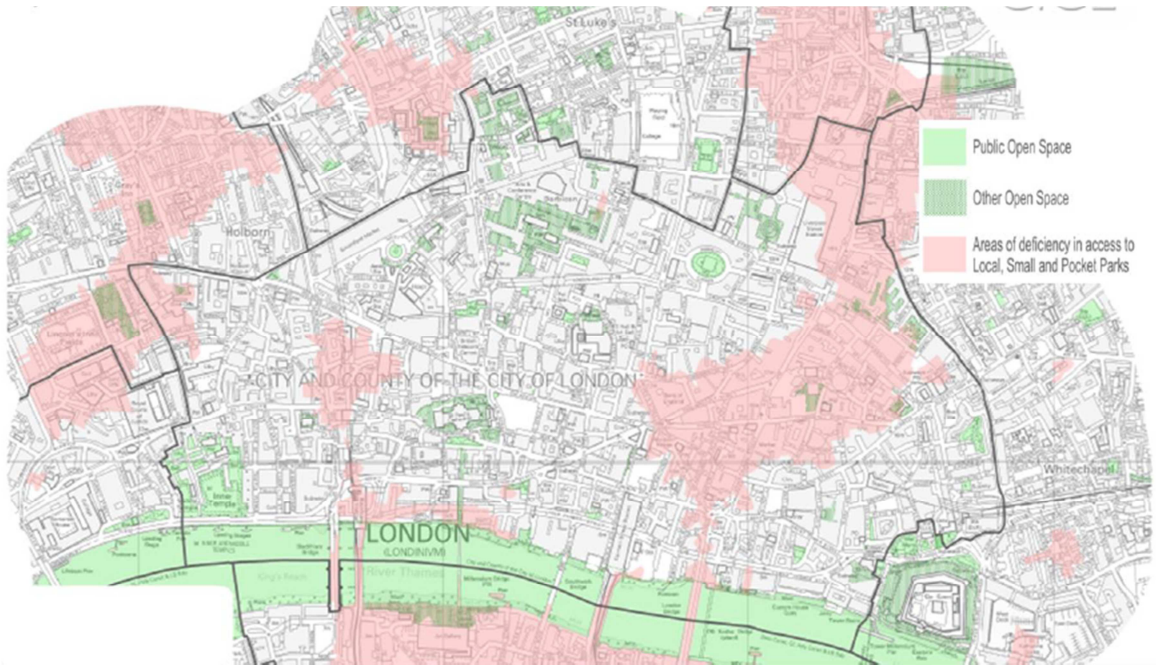
Open spaces in the City of London are an important resource for residents, workers and visitors. A survey of the large daytime population in 2012 found that 86% use the City's public gardens regularly, with 36% visiting at least once per week. Almost all users (79.4%) rate these spaces as good or very good.[2]

As at 31 March 2012, the City of London was found to have 32.09 hectares (320,900m^2) of open space (this does not include land closed due to construction work).[3] 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.[4] 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, 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 4.2 shows the green spaces in the City of London, where the pink areas are defined as areas of deficiency in access to local, small and pocket parks.[5]

In the City, there are 5.2 hectares (51,800m^2) 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 4.2. Green spaces in the City



Source: *Better Environment, Better Health: a GLA guide for London's Boroughs*

[2] City Gardens Visitor Survey, 2012
[3] *Open Spaces Audit Report* (2013)
[4] ibid
[5] *Better Environment, Better Health: a GLA guide to London Boroughs*

Eleven of the open spaces within the Square Mile are Sites of Metropolitan, Borough or Local Importance for Nature Conservation, due to their importance to 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 were named category winner in the London in Bloom competition. They also won 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. Having adopted 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 TfL in developing these proposals. The Mayor of London's Cycling Vision and TfL's Better Junctions programme have contributed to the proposals to provide cyclists with a less intimidating and higher-quality experience as they move through the area.

The health and wellbeing benefits of this new space include reductions in noise and air pollution, as well as increased pedestrian and cycling space.

[B]Noise pollution

Excessive noise seriously harms human health and interferes with people's daily activities at school, work, home and during leisure time. It can disturb sleep, cause cardiovascular and psychophysiological changes, reduce performance and provoke annoyance and alterations in social behaviour.[6]

[6] WHO (2011) *Burden of disease from environmental noise: Quantification of healthy life years lost in Europe*

The City of London received 1,075 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.

The City's Noise Strategy was adopted in 2012 and an action plan is currently being implemented. This brings together 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 that the plan will contribute to the health and wellbeing of the City's communities and support businesses by minimising or reducing noise and noise impacts.

The Public Health Outcomes Framework reports that 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.

[B]Leisure facilities

Golden Lane Sport & Fitness (formerly known as Golden Lane Leisure Centre) has been open since January 2012. The centre offers programmes and memberships aimed at engaging the wider community, including City workers, residents and children. There are currently over 1,100 prepaid members who regularly use the centre, and approximately 2,000 casual pay-and-play visits per month. This is in addition to school and after-school swimming lessons; various clubs and courses ranging from taekwondo and gymnastics to netball and tennis; and the sports activity programmes being continually developed by the Sports Development Team.

The high land values and density of existing buildings in the City mean that space for developing new sports facilities is limited, and often comes at a significant premium. Therefore the Sports Development Team makes use of the City's landscape, which provides an environment 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. These aim to engage with City workers and residents who cannot afford to access the large number of private gyms in the area.

Table 4.4 shows the accessibility of facilities for sport and physical activity in the City of London. It shows which facilities are accessible by private members, which are bookable by the public and which offer full public access.

Table 4.4. Facilities in the City by accessibility

Facility type	Private	Bookable	Public	Total
Artificial/turf pitches	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

[C]Targeted services

A range of targeted programmes has been designed specifically for those who are most inactive and/or people with specific health conditions that could be improved through physical exercise. These include activities and health advice to help workers, residents and families 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 eighth year, the scheme has engaged over 700 individuals in activities including gentle exercise, line dancing, short mat bowls, swimming, gym workouts, chair-based exercise, Pilates, ballroom dancing, table tennis and guided walks. The programme also has social aspects and runs 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, in order to break down access barriers. The programme was awarded the Inspire Mark by the London Organising Committee of the Olympic Games.

[B]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 these budgets. Such mainstream services are likely to play an important role in helping people socialise, meet others, go out and engage in specific activities like art and music.[7]

[C]Libraries

The City of London has five major libraries: Barbican Library, Guildhall Library, Shoe Lane Library, City Business Library and the new Artizan Street Library and Community Centre (replacing the former Camomile Street Library). Some 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

[7] Wood, C (2010) *Personal Best*. London: DEMOS

financial and business data, and runs a full programme of events to support business start-ups and sole traders. Guildhall Library specialises in the history of London and the City, and holds significant collections, including those of many livery companies, the Stock Exchange and Lloyd's of London. And Barbican Library houses a specialist music library which is a centre of regional importance and holds an international award for excellence.

The libraries in the City also provide local communities with a wide variety of services and learning resources. These include community language collections, help and advice sessions, English for Speakers of Other Languages and self-help classes, a toy library and an extensive programme of work with local schools, nurseries and children. There are Rhymetime and Stay and Play sessions for under-fives with their carers at all lending libraries, and 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 and the most valued.[8] The great majority of City residents (85%) use the City's public libraries and are members of at least one City library (75%). In total, 33% of City workers and 11% of people living and working outside the City are members of a City library. The Barbican and Barbican Children's Libraries attract 35% and 20% of visitors from all categories respectively.

All libraries take health and wellbeing information provision very seriously and offer a wide variety of self-help books for loan. 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.

[C]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 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 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 the street scene to arts institutions, festivals, museums, galleries, music 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 per year.[9]

Satisfaction is very high for libraries (93%), museums/galleries (87%) and theatres/concert halls (85%) in the City.[10] In 2011, 94% of service users agreed that the City's libraries and archives and Guildhall Art Gallery offered appropriate and accessible learning opportunities for citizens and community groups, while 99% of parents, carers and teachers agreed that the services and activities offered by the City's libraries and archives and Guildhall Art Gallery contributed to the enjoyment and achievement of children and young people through increased participation in a broad range of high-quality activities.

[8] City Family Festival Life Survey, 2011

[9] City of London Cultural Strategy 2010-14

[10] Public Library Users Survey, 2010

[B]Air quality

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

At the levels found across London and the City, air pollution is a significant cause of disease and death – heart disease and lung cancer in particular, but also respiratory disease and asthma. Department of Health figures suggest that it may even be the fifth highest cause of death in London, ahead of communicable disease, passive smoking, alcohol abuse, road accidents and suicide.[11] As pollution particles pass into the blood and travel throughout our bodies they inflame many organs, and there are now associations with Alzheimer's disease, Parkinson's disease, Type 2 diabetes, cognitive impairment and learning problems in children.[12] 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.

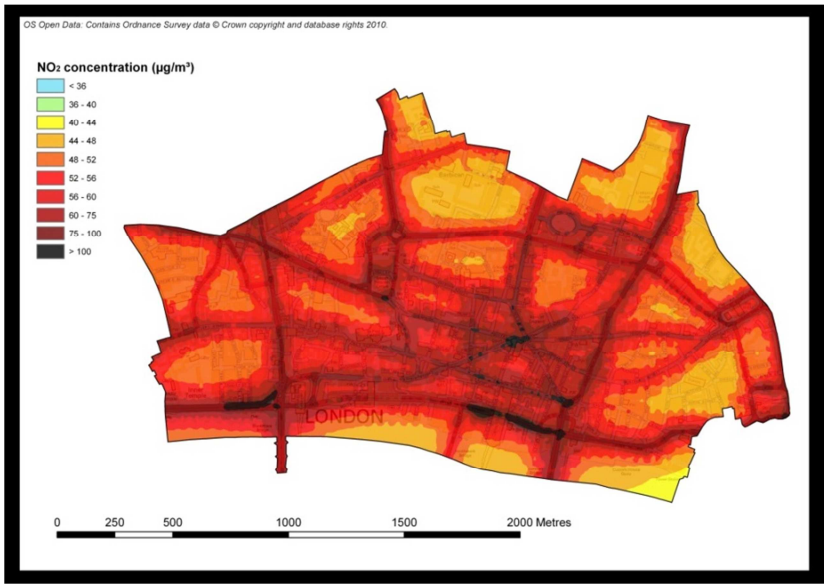
The Public Health Outcomes Framework identifies the City as having the highest fraction of mortality attributable to particulate air pollution. This is based on modelled estimates using the air quality readings in the local area.

[C]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 is compared with 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 4.3 shows the annual average levels of nitrogen dioxide across the City.

Figure 4.3. Annual average concentrations of nitrogen dioxide across the City



[11] Kilbane-Dawe, I and Clement, L (2014) *Report to the City of London Health & Wellbeing Board on Air Pollution*. London: Par Hill Research Ltd
[12] City of London Air Quality Strategy 2011

[C]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.

[C]Reducing exposure to air pollution

Despite the 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 who are vulnerable to poor air quality, as well as improving air quality around Barts Hospital sites across London
- working with Sir John Cass's Foundation Primary School to help the children understand urban air quality and improve air quality around the school
- producing and promoting a smartphone 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

[B]Climate change

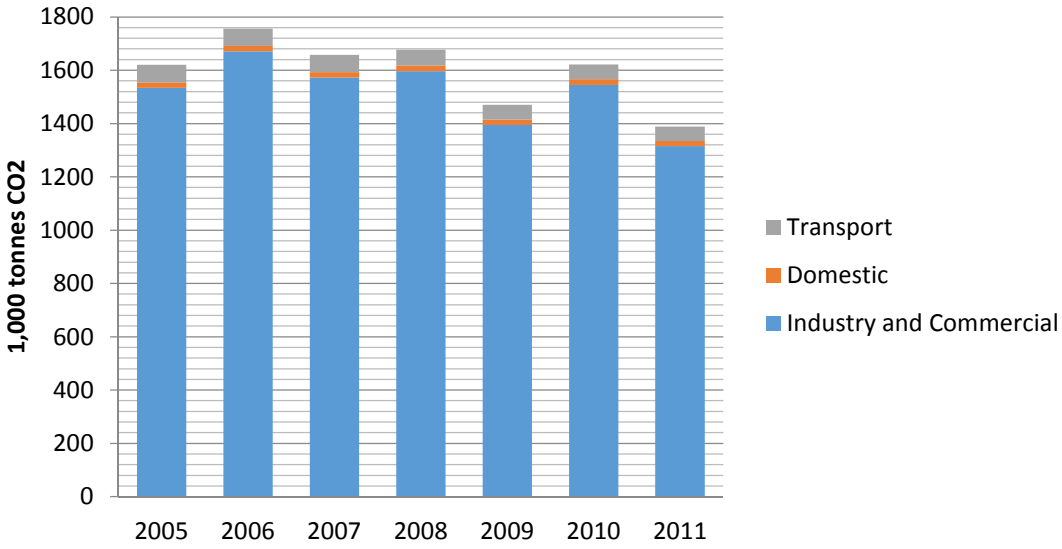
[C]Climate change in the City

In the City, carbon emissions overwhelmingly come from commercial buildings (Figure 4.4). The overall level of carbon emissions fell by 13.7% between 2010 and 2011, from 1,621,700 tonnes of CO_2 to 1,388.800 tonnes of CO_2.[13]

[13] Department of Energy and Climate Change (2011) Local and regional CO2 emissions estimates for 2005-2011 (plus subset data for CO2)

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

Figure 4.4. Sources of carbon dioxide emissions in the City, 2005-11



[B]Crime and safety

Crime affects the health of individual victims and the communities in which they live and has an impact on local health services. Perceptions of the incidence of crime and feelings about 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 that they felt safe when outside in the local area during the day, and more than four out of 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 the streets, and rubbish and litter.[14]

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

- anti-social behaviour
- domestic abuse
- reducing reoffending
- 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.

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

[14] Ipsos Mori/City of London Corporation (2009) *Assessing the City of London's Performance: Results of the Place Survey 2008/09 for the City of London Corporation and partners*

injury, rape, personal robbery, non-dwelling burglary and public disorder). However, even in these categories crime levels remain comparatively low.

The City's night-time economy has grown over recent years, with a large number of people now visiting the City in the evening specifically to socialise. There have been significant changes around the opening hours and licensing of venues, particularly with regard to alcohol licensing and smoking legislation. While 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 or City Advice).

[A]Deprivation

In 2010, the City of London was ranked 262 out of 326 English boroughs, with 326 being the least deprived.[15] 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 north-west of the City.

[A]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 wellbeing. 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 local area, with the aim of building more resilient communities. Prevention, promoting independence and earlier intervention are central to this approach, which focuses on the following:

- preventing homelessness
- tackling rough sleeping
- supporting people with disabilities
- supporting older people
- intervening early to reduce inequalities and tackle deprivation

[B]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 City's vision for planning, divides

[15] City of London Department of Planning and Transportation (2010) *City of London Resident Population Deprivation Index 2010*

the major planning areas into five Key City Places (Figure 4.5). Study Areas indicate the spatial concentration of housing units. The majority of the City's units – 3,718 units, or 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 and 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 on business activity and have the lowest number of units. A total of 50% of dwellings in the City have two or fewer 'habitable rooms', with 20% having only one habitable room.[16]

[C]Housing tenure

There were 6,064 dwellings in the City of London as of 31 March 2011. The most common type of housing tenure in the City is private rented accommodation, which makes up 36% of all households. This is greater than the figure for both Greater London and England and Wales.

Housing tenure with a mortgage in the City (17%) is significantly less common than in Greater London (27%) and England and Wales (33%). There are a relatively high percentage of households in the City that are 'rent free' – 5%, compared with 1% in both Greater London and England and Wales. This could be explained by residents living in company-owned flats. Figure 4.7 compares housing tenure in the City with 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. Most of the rest of the City's residential accommodation is 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 one person, which is significantly higher than the profile for Greater London and England and Wales, where the figure is approximately 30%. Within the City, 12% of single-person households are of pensionable age, according to the Census 2011.[17]

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: just 10% of all households.[18]

Figure 4.5. Dwellings in the City of London, March 2012

[16] City of London Corporation (2011) *Housing info*, 31 March 2011. The term 'habitable room' refers to any room within a housing unit, apart from a bathroom, kitchen or hallway

[17] For these purposes, 'pensionable age' refers to anyone aged 65 or over, although pensionable age can be anything from 61 to 68 years of age

[18] Census 2011: City of London, Residential Population, Households

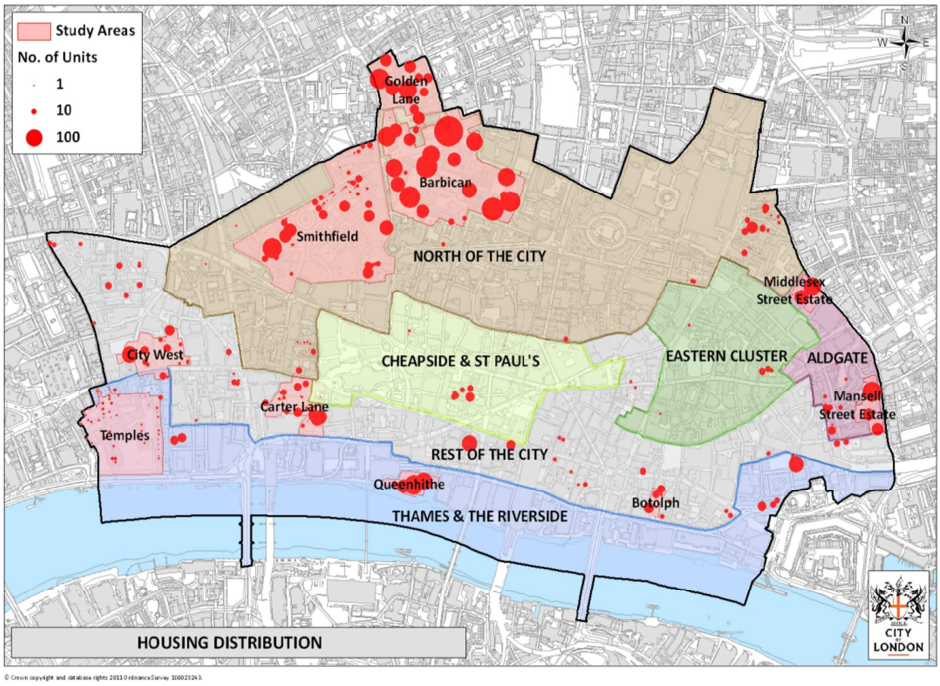
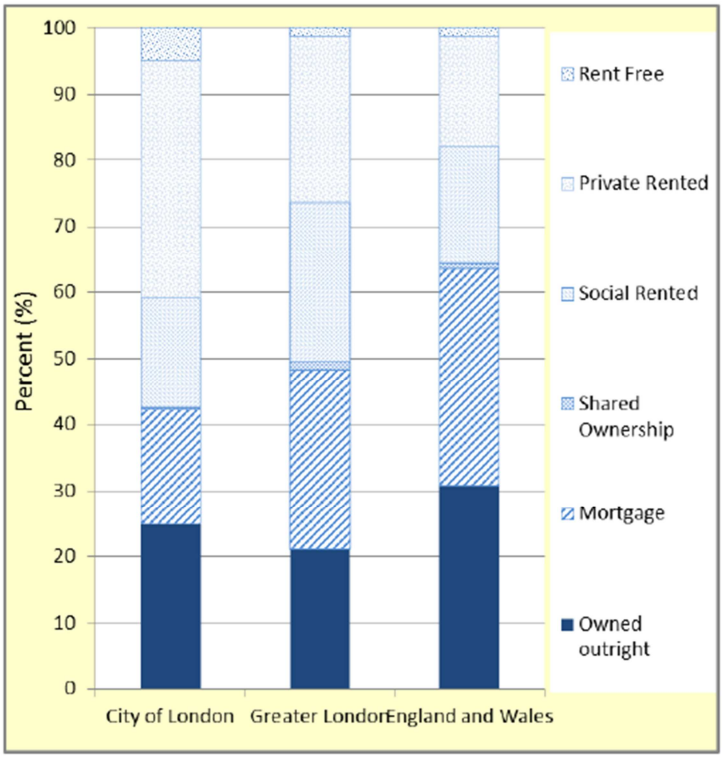


Figure 4.6. Household tenure (Census 2011)



[D]City workers

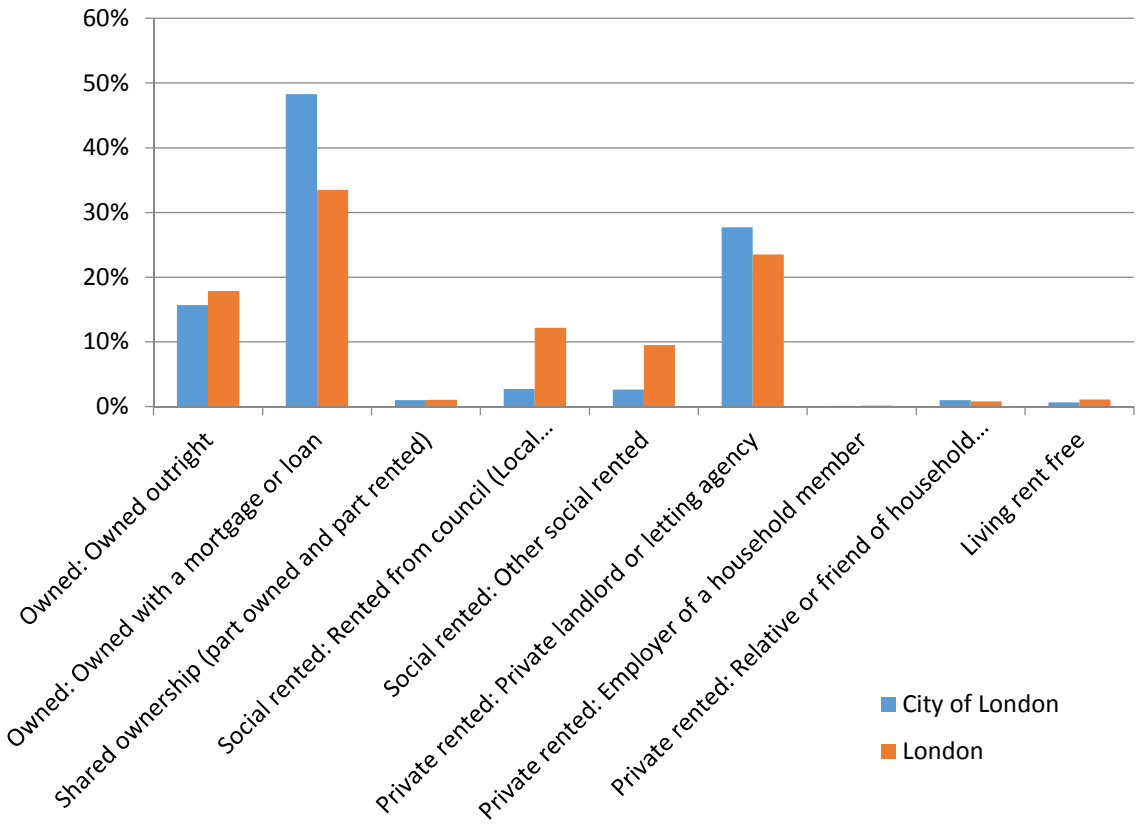
The new Census data has provided an opportunity to examine the housing tenure of daytime City workers. In total, 48% of City workers own property with a 'mortgage or loan', which is notably

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 the council and another 3% rented from other social housing bodies).

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 median weekly wage of all local authorities in the UK.[19] Therefore the low percentage of workers in social housing is to be expected. Although private renting can offer some of the poorest housing quality and worst overcrowding, in the City the proportion of renters affected by this may be diminished, since those with above average earnings can afford better standards of rented accommodation.[20] Despite this, there are some City workers who are not in the higher income bracket – for example, those working in retail – and they are also likely to fall into the 'private rented' category.

The relatively large proportion of private renters may reflect the transient nature of the City's population. This may affect health by increasing the chance of gaps occurring in health records when people move GPs. Finally, the large proportion of home owners with a 'mortgage or loan' is also predictable in this population, who tend to earn higher than average incomes early in their career.

Figure 4.7. Housing tenure of City workers



[19] ONS (2012) *Annual Survey of Hours and Earnings, 2012 Provisional Results*

[20] Scottish Government (2010) *A select review of literature on the relationship between housing and health*

[B]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 Organization identified the main 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. 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, to have reasonably modern facilities and services, and to 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 Greater London Authority 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.

[B]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) and
- 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 rate of fuel poverty. However, all areas in the City are below the national average of 11% fuel poverty.

[B]Overcrowding

Around one in three of all households in the City lives 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.

[A]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 who 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 awaiting a decision on their case, or people whom the City had a duty to house who 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.

[A]Rough sleeping

The City funds Broadway (a London-based homelessness charity) to provide outreach to rough sleepers in the area and arrange accommodation through links with hostels. It also refers rough sleepers to No Second Night Out and No-one Living on the Streets, which are rapid assessment and response services for rough sleepers who are new to the streets and intermediate-term rough sleepers who wish to stop living on the streets. The City also supports the Middle Street Hostel financially, and funds a part-time support post there.

The City has developed innovative accommodation and service models to help its most entrenched rough sleepers leave the streets. Working with St Mungo's, it has developed a new model of hostel accommodation for long-term rough sleepers, whose needs are distinct from those of more transient or chaotic rough sleepers. 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 otherwise have been helped.

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, focusing 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. To date it has succeeded in engaging 27 City rough sleepers and accommodating 26. It was rolled out across London in 2011, and the City of London, in partnership with Broadway, received the Andy Ludlow Award for this work.

The City of London has recently introduced new 'pop-up hubs' in association with Broadway and 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 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.

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5. Early life and family life[CH]

This section covers key aspects of the health and wellbeing of children and young people aged from birth to school leaving age (i.e. 0 to 18). 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 we get older, the influences of our education, socialisation, peer pressure and support, and the difficult transition from adolescence to adulthood become more important.

[C]Key findings

- There are relatively few families and few births in the City. The majority of households in the City are single people.
- Of the 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 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.

[C]Recommendations

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

[C]Questions for commissioners

- How are commissioners preparing for the transfer of public health responsibility for 0 to five-year-olds to the local authority in October 2015?
- A total of 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?
- Are commissioners and commissioned services fully utilising the City's resources to support families out of poverty?

[A]Young people

[B]Local policy context

The Children and Young People Plan (CYPP) 2013 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 this strategy define the City of London 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
- a commitment to improving the governance and accountability frameworks of the education offer
- recognising the role the City of London Corporation can play in its outreach provision across London and seeking to strengthen this offer
- confirming the City of London 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

[A]Population

[B]Demographics

The population data from the Census 2011 shows that there are 269 primary age (four to 10) and 147 secondary age (11 to 16) children living in the City of London, out of an estimated total of 843 0 to 19-year-olds.[1] Of these 843 young people, 361 (43%) are from BME backgrounds.[2]

The City's Resident Insight Project recorded that in November 2012 there were 898 young people aged 0 to 19 resident in the City, of whom 604 were aged 0 to nine and 294 were aged 10 to 19. 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.[3]

[1] ONS mid-year estimates for 2013
[2] City of London Corporation (2013) *Primary Education in the City of London: Annual Report 2013*
[3] ibid

At the age of 11, when children leave the local 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 resident in another borough with more suitable housing for teenagers.

[C]Disabilities

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

[C]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 to 16) looked after by the City of London in 2012/13.[4] All the children in the City 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.[5]

Table 5.1. Number of children looked after by the local authority, 2009-13

Year	Number
2009	15
2010	15
2011	10
2012	5
2013	5

[C]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 four hours per week) and after-school clubs (up to four hours per week).

[4] City of London Corporation (2013) *Safeguarding Children Annual Report*, 2012/13
[5] ibid

[A]Education and training

[B]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, which includes the Cass Child & Family Centre, the City's sole children's centre. Of the pupils attending the school, many of whom do not live in the City, 68% (971) are from BME backgrounds. 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, including Islington secondaries and schools in other neighbouring local authorities such as Tower Hamlets and Hackney.

The City currently funds fewer than five children to be educated outside mainstream local authority provision.

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

[C]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, with all provision for early years education judged to be 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.

[C]Attainment in higher education

The number of young residents (aged 18 to 24) entering the first year of their first undergraduate degree at a UK higher education institution (either full-time or part-time) decreased over the five-year period from 2007/08 to 2011/12 (Figure 5.1). In the 2010/11 academic year, within six months of completing their higher education 33% were in full-time employment, 16.7% were in part-time employment and 11.1% were self-employed. A total of 22.2% were not employed and were not looking for work, while only 5.6% were unemployed and looking to be employed.[6]

Figure 5.1. Young residents progressing to higher education, 2007/08 to 2011/12 (Higher Education Statistics Agency)

[6] City of London Corporation (2013) *The higher education journey of young residents*

[B]Apprenticeships

Apprenticeships are about helping young people fulfil their potential through personal and social development. Apprenticeship programmes can help tackle youth unemployment by matching the skills demanded by employers with those available among the population, especially young workers.

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

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

[A]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, which is defined as the proportion of children living in families in receipt of out-of-work benefits or tax credits whose reported income is less than 60% of the median income.

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

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

[PLEASE RUN PARAS TOGETHER WHEN

In July 2013, the Resident Insight Project revealed that 960 children were living in the City of London, of whom 21% (197) were in low-income households (defined as households in receipt of low-income-based benefits). These locally derived figures are slightly higher than the official estimates; this may be due to undercounting in the national figures. Because these two figures use different definitions of poverty, they are not directly comparable. Of the 197

children living in low-income households, 76 (39%) were in workless households, with the remaining 61% in working households. This reflects the national figures, where the majority of 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 51% of poor children nationally (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 the areas of social housing around Portsoken and Golden Lane.

[B]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 inner London and London as a whole, 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 this school, 22% are entitled to free school meals.[7] A total of 73 out of 1,428 children at the school are City residents aged three to 11.

Table 5.2. 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

[B]Early years support

Local estimates from the Resident Insight Project show that there are 364 children aged 0 to four currently residing in the City of London, of whom 79% are registered with the early years system Synergy Connect.

In total, 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 Cass Child & Family Centre.

Twenty-seven 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 Cass Child & Family Centre.

There were 2,635 visits to the Cass Child & Family Centre in the period April to August 2013. Of these, 42 were related to targeted family support.

[7] School Census 2013

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.[8]

[B]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 to 19=year-olds (and to those with special needs up to the age of 25) by commissioned providers. There are five strands of youth services in the City, run by three service providers who took over contracts in April 2013. The services contracted are: provision of information, advice and guidance; universal youth services; targeted youth services; youth participation; and provision of a client caseload management information system. These changes are expected to improve outcomes-based results and offer better value for money.

[B]Child and adolescent mental health services

Mental health services for children and adolescents in the City are provided jointly with Hackney. As of 2013/14 the services encompassed the following:

- community child psychology services
- specialist child and mental health services
- integrated clinicians in other services for young people

S came into care five years ago. Before coming into care, she 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 child and adolescent mental health services (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 S's behaviour effectively. An improvement in S's behaviour was observed; for example, she previously displayed outbursts of anger, but 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 doing this effectively by her foster carer and social worker. In discussions with her therapist and with her foster carer and social worker, it was decided that S could stop attending sessions with CAHMS; her progress was then reviewed at a meeting with her foster carers, CAMHS worker, social worker and S herself. All were in agreement that she had made significant progress and that she should be discharged by CAMHS. Should it be necessary, it was made clear that she could be referred again in the future.

The CAMHS Framework 2013–15 outlines the vision for the development of CAHMS and for improving emotional health and wellbeing, including an action plan with measurable outcomes aligned with wider national policy.

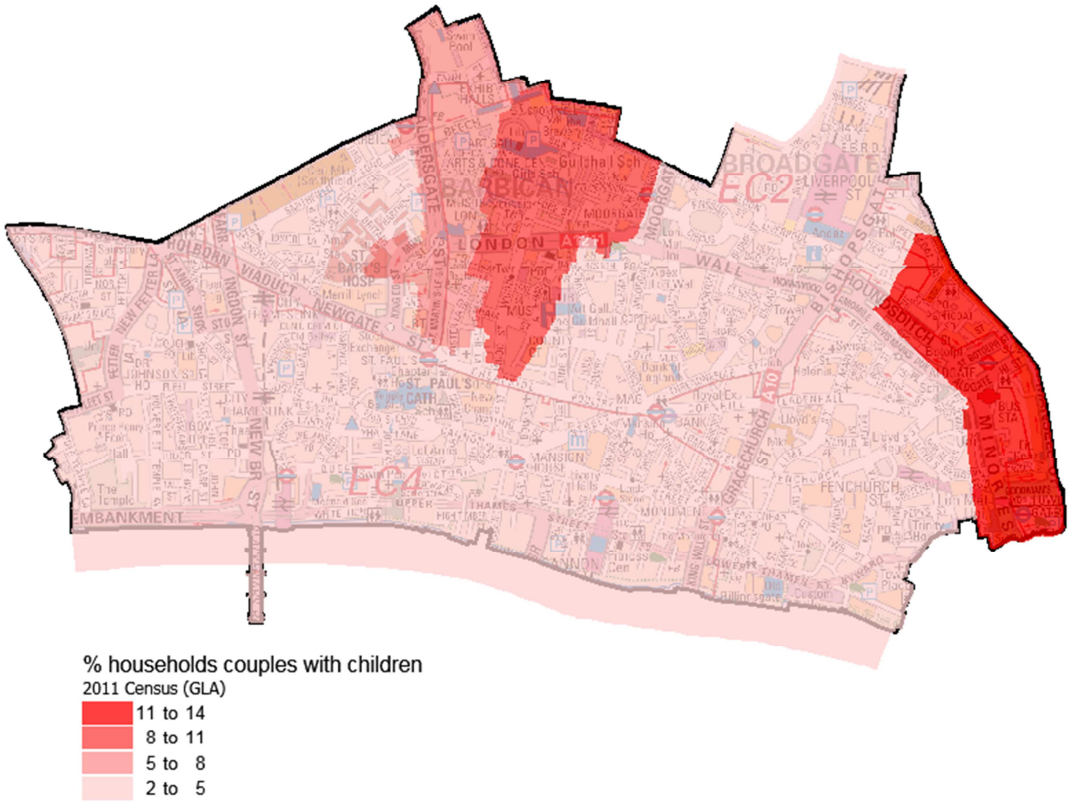
[8] City of London Corporation (2013) *Safeguarding Children Annual Report*, 2012/13

[A]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 has two bedrooms or fewer. Additionally, there is just one state school in the City, which is for primary aged children only. Despite this, there are some families in the City, with particular concentrations in the areas around Barbican, Golden Lane, Mansell Street and Middlesex Street.

The Census 2011 includes detailed information about household structure within the City. Single people are the predominant group (60%) seen throughout the City (see Appendix 7). Almost 30% of households in the north of the City are couples without children. 'Others', which mainly includes those in shared housing, are concentrated in the east on the Mansell Street and Middlesex Street Estates. Couples with children are mainly concentrated in the east, with some in the north.

Figure 5.2. Household structure in the City: percentage of couples with children



[A]Maternity

[B]Smoking and pregnancy

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

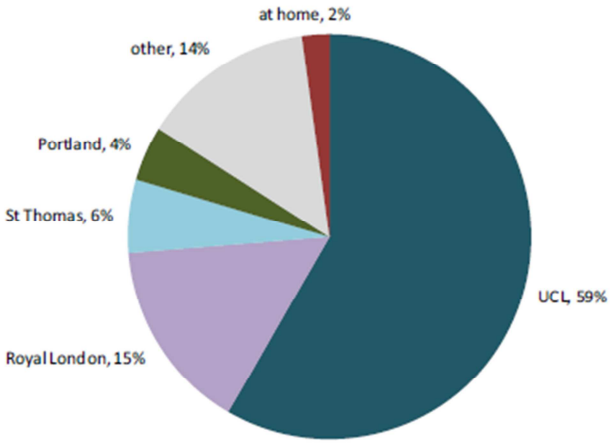
[B]Antenatal care

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

[B]Place of birth and delivery method

Between January 2010 and October 2011, 98% of births to City residents took place in hospital, mainly at University College London Hospitals and the Royal London Hospital.

Figure 5.3. Place of birth of babies with mothers living in the City, Jan 2010 to Oct 2011 (hospital data)



[B]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.

[B]Breastfeeding

In 2010/11 all babies born to City mothers were recorded as being breastfed at the age of six to eight weeks.

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6. Working age

People 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 by an individual and the culture of the employing organisation can have both positive and negative effects on their health. For example, most jobs offer opportunities to network with others, give structure and meaning to life, and offer an income. Many jobs, however, are now largely sedentary, while 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 World Health Organization (WHO) Life Course Approach, functional capacity peaks in early adulthood.[1] Therefore early adulthood is a critical period for interventions that can have a springboard effect to alter subsequent life course trajectories, with implications for health in older life.[2] Healthcare needs in this group tend to relate to specific short-term issues such as flu symptoms, as well as to services aimed at slowing the rate of decline by reducing unhealthy lifestyle behaviours. Maintaining functional capacity – for example through supportive working conditions and options for starting a family or achieving work–life balance – are equally important to this age group.[3]

[C]Key findings

- The City has a new responsibility for co-ordinating 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.
- In total, 23.7% of incidents reported to the City of London Police were alcohol related or connected with licensed premises.
- More women than average (both residents and non-residents) do not participate in the recommended levels of physical activity.

[D]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.
- Smoking and obesity rates are much higher in Portsoken than in the rest of the City.
- Depression rates in residents vary from 2% to 5%, depending on the data source.
- The City recognises the important contribution that carers make to population wellbeing and has developed support for carers.
- Unpaid carers provide vital support to vulnerable people in the City, and it is important that they receive appropriate support.

[1] WHO (2000) *A Life Course Approach to Health*
[2] ibid
[3] *The Public Health and Primary Healthcare Needs of City Workers* (2012)

- The profile of residents using treatment services has changed from unemployed homeless drug users to those in stable housing and employment who have an alcohol problem.

[D]City workers

- Between 2001 and 2012, the City of London saw the biggest increase in employees across all 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 the London average.
- City workers smoke more than the London average. Quit rates among City workers are relatively high (50%).
- Alcohol misuse among both male and female City workers is considerably higher than the national average. Young white males are the predominant misusers of alcohol.
- Over one-fifth of City workers report suffering from depression, anxiety or other mental health conditions, with one-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 drug misuse.
- The City has been working to promote workplace health within the Square Mile and to develop support for businesses in achieving this. The City has commissioned research and initiated a business network.
- It is likely that many City workers have caring responsibilities.

[D]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.

[C]Recommendations

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

[C]Questions for commissioners

- What are commissioners doing to tackle unemployment in the City?
- How are commissioners adapting the substance misuse treatment and prevention services available to residents in line with the change in profile of those needing these services?
- What are commissioners doing to reduce obesity rates in Portsoken?
- How can commissioners prevent the alcohol misuse and mental health issues associated with City workers?
- What are commissioners doing to increase smoking quit rates for City workers and residents in Portsoken?
- How are commissioners ensuring that services are integrated to ensure holistic health support for rough sleepers?
- In conjunction with information in Chapter 4, ‘Community life’, how can commissioners support organisations in building the resilience of City residents, including encouraging a greater take-up of physical exercise?

[A]Economic participation among residents

In the City, 77% of the resident population is of working age.[4] The population is too small for reliable estimates of economic activity to be made.

The Public Health Outcomes Framework identifies sickness absence among City residents as very high. However, this is based on survey data that drew upon an extremely small sample from the City, and is therefore unreliable. The Framework 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.

[A]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 (100 people) were claiming Jobseeker's Allowance. 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 on 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 the 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 on 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, City STEP, aims to place residents from these wards into sustained employment during 2014.

Table 6.1. Key benefits claimed by residents of the City of London, May 2013. Percentages are of the working age population (NOMIS/Department for Work and Pensions)

	The City		London
	Number	%	%
Jobseeker's Allowance	100	1.7%	3.9%
Incapacity Benefit/Employment and Support Allowance	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%

[4] NOMIS, 2011

Disabled	30	0.5%	0.8%
Bereaved	10	0.1%	0.1%
Key out-of-work benefits	240	3.2%	10.9%

[B]Adult learning

There is growing evidence of an association 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[5] 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.[6]

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 50 subjects taught at different locations across the Square Mile. These include community centres, libraries, primary schools, children's centres, the Bishopsgate Institute, the Museum of London and Guildhall Art Gallery. In 2012, there were over 2,000 learners participating in 223 courses.

[A]Jobs within the City

The Office for National Statistics reported that there were 353,800 employees in the City of London in 2012.[7] Between 2001 and 2012, the City of London saw the biggest increase in employees across all 983 areas in London. In 2001 there were 259,500 people working in the City, and by 2012 this figure had risen to 353,800. This is the highest number of employees for any year in the dataset, and between 2011 and 2012 alone it rose by 26,300. This represents an increase of 36% in just over a decade (Figure 6.1).[8]

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 become a considerable industry in the City, comprising 27% of employment. Other sectors combined make up almost one-third (32%) of employment in the City, the most significant of which is administrative and education, which accounts for 15% of City employment (Figure 6.2).

Figure 6.1. Change in number of employees working in London, 2001-12

[5] Marmot M (2010) *Fair Society, Healthy Lives*

[6] British Academy (2014) *If you could do one thing…": Nine local actions to reduce health inequalities*
[7] Office for National Statistics (2013) *Small and Large Firms in London, 2001 to 2012*
[8] Alasdair Rae (2013) 'under the raedar' blog: Employee Growth in London, 2001 to 2012

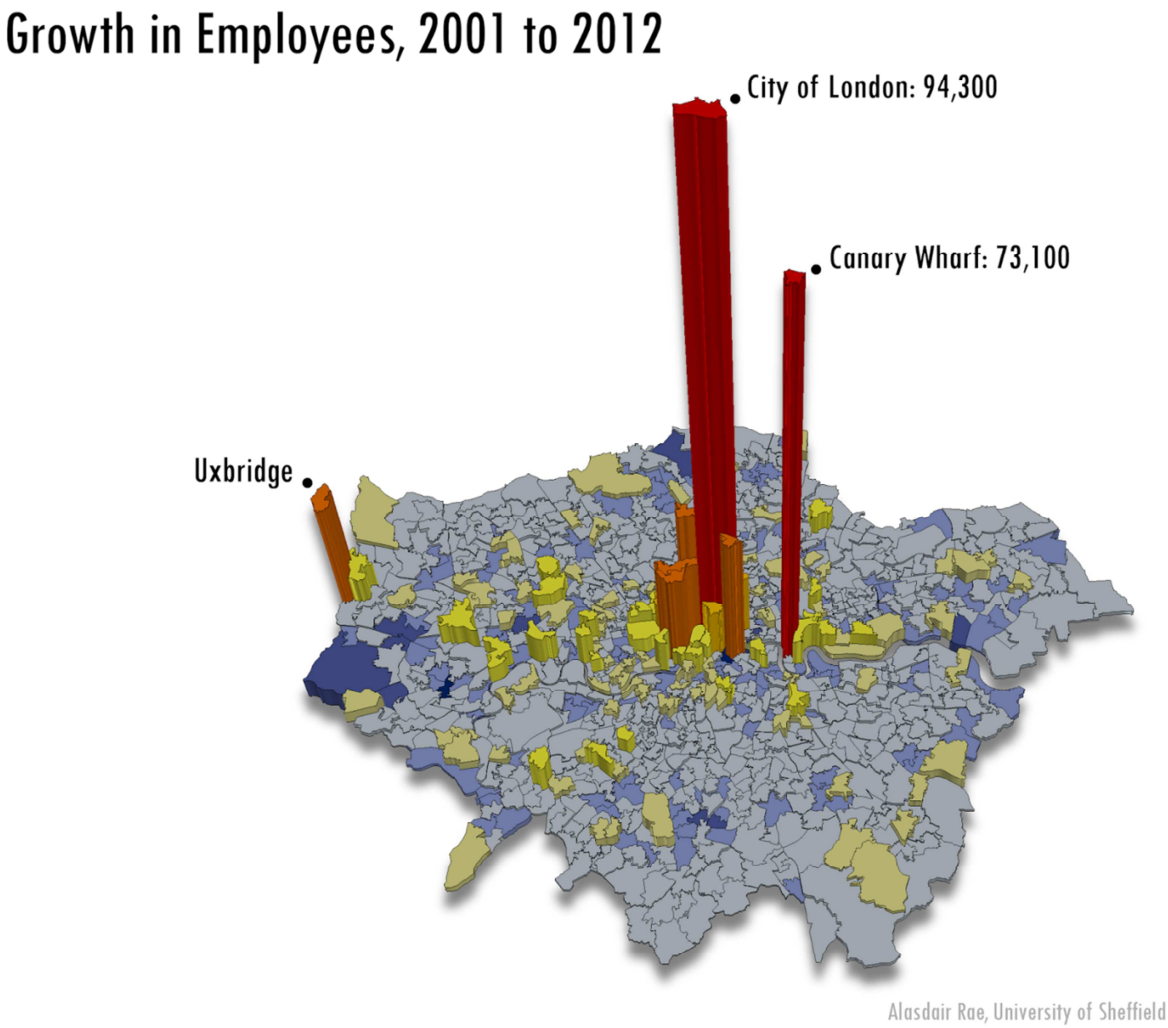
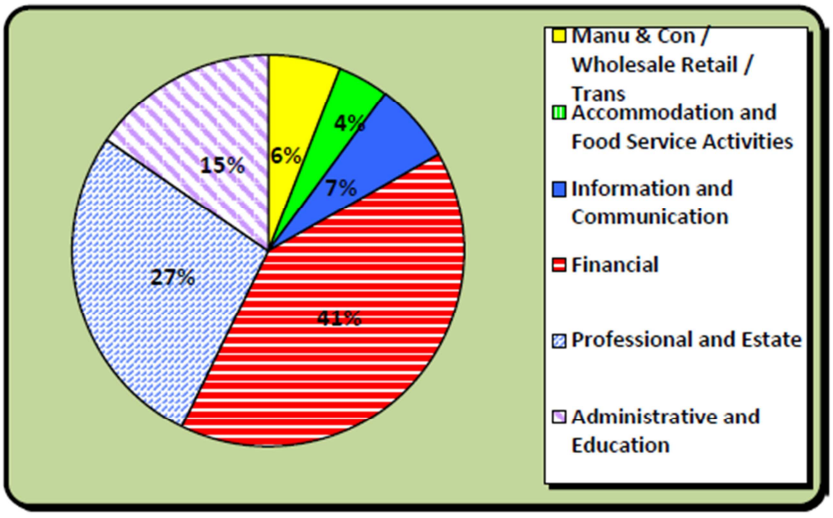


Figure 6.2. Employment by industry in the City, 2011 (Business Register Employment Survey)



There are distinct gender differences within the occupation profiles 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[9] (Figure 6.3).

Figure 6.3. Employment within the City: occupations by sex, 2010/11 (Labour Force Survey)

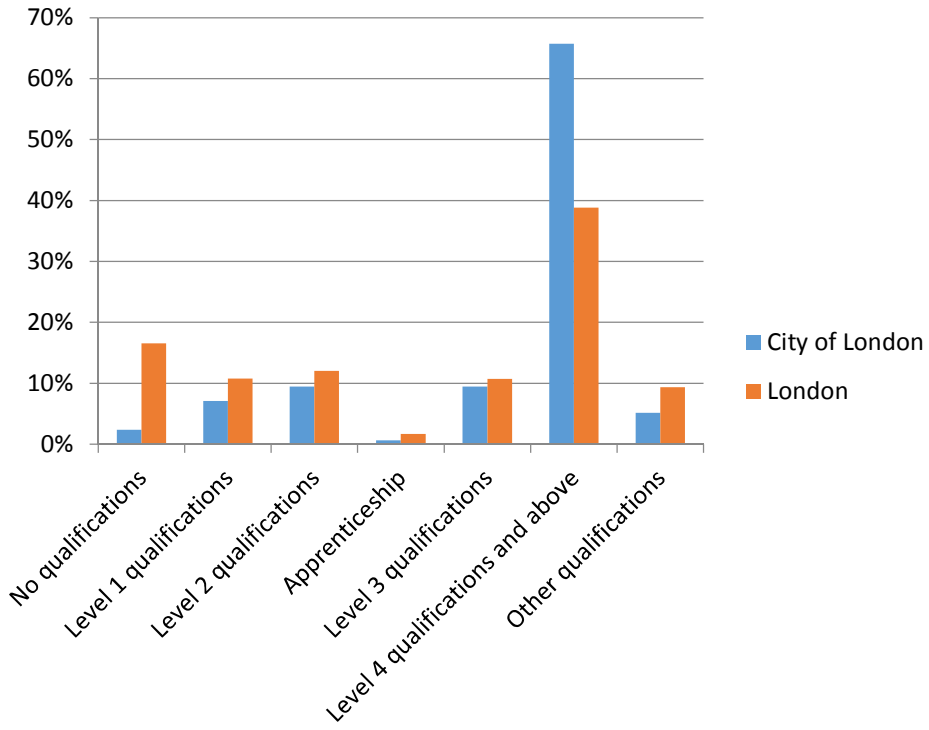
[A]Education and qualifications

[D]City workers

Two-thirds of City workers have at least a level 4 qualification, which exceeds the London average by 27%. Qualification levels are based on the Qualifications and Credit Framework, where levels 4 to 8 are obtained at university and include everything from certificates of higher education through to doctorates.[10] This greater proportion of level 4 qualifications is consistent with the work sectors traditionally seen in the City – that is, the financial and insurance sector (37%) and the associated professional services (18%), which require a higher level of education.[11] Education, income and housing tenure all have enduring associations with health, over time and across different diseases.[12] A highly educated working population is consistent with greater incomes and increased home ownership.

Figure 6.4. Highest levels of qualifications in London

[9] Labour Force Survey 2010/11
[10] OFQUAL (2012) UK Qualifications and Credit Framework. Available at: http://ofqual.gov.uk/help-and-advice/comparing-qualifications
[11] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[12] Health Development Agency (2004) *Health inequalities: concepts, frameworks and policy*



[A]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.[13] Working age ill health is estimated to cost the UK economy over £100bn a year. In 2011, a total of 131 million working days in the UK were lost because of sickness absence.[14]

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

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 (DH) and currently run by the Greater London Authority. The Healthy Workplace Charter is an accredited scheme for employers to demonstrate their commitment to workplace health. The scheme is being used within the City of London Corporation to demonstrate the Corporation's commitment to addressing these issues for our own staff. The Corporation has set the ambitious target of reaching the Charter's 'Excellence' standard.

[13]. DH (2011) *Healthy Lives Healthy People: A Public Health Workforce Strategy*. Available at: www.phe.co.uk

[14]. Office for National Statistics (2012) *Sickness Absence in the Labour Market, April 2012*. Available at: http://www.ons.gov.uk/ons/dcp171776_265016.pdf

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 the focus of workplace health from 'health and safety' to holistic wellbeing, including tackling stress and mental health in modern workplaces.

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 these with 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 provide a business-led response to workplace health issues.

[A]Lifestyle and behaviours

[B]Smoking

[C]Prevalence

[D]Residents

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

Primary care data extracts for the whole City population show that 11% of residents are current smokers, but this figure rises to 21% for patients who are not registered with the Neaman practice (i.e. those who live in Portsoken).

[D]City workers

A survey of City workers in 2010[15] 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%). Of the respondents who reported smoking, about 15.1% smoked regularly and 9.7% were occasional smokers.

[D]Rough sleepers

Research suggests that rough sleepers have very high smoking rates, with surveys showing that around 80 to 90% of people sleeping rough are smokers.[16] It is likely that smoking is a contributing

[15] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[16] Health Development Agency (2004) *Homelessness, smoking and health*

factor to the poor health of rough sleepers, but that rough sleepers find it much harder to access the smoking cessation services that more advantaged people take for granted.

[C]Quitting

In the City, 1,145 people set a quit date in 2012/13, of whom 606 (53%) went on to be successful four-week quitters. Table 6.2 shows the quit rates across different population subgroups. The majority of those accessing stop smoking services were City workers rather than residents, and 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 1.2. People in the City not smoking four weeks after quitting: absolute number and percentage quit rate by population subgroup, 2012/13 (Source: DH)

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%

[C]Smoking cessation support services

A total of 16 pharmacies in the City have signed up to deliver Level II smoking cessation support services. These pharmacies display 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 DH recommended minimum quit rate of 35%. Its carbon monoxide validation was exceptionally high at 97% (the DH minimum standard is 80%).

In total, 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. This mirrors the national trend of a decrease in the number of smokers using stop smoking services, which is thought to be linked to the introduction of e-cigarettes (that is, more smokers are choosing to quit without help from services). 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. In total, 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 made more than three serious failed quit attempts; smoke within an hour of waking; have chronic diseases (such as chronic obstructive pulmonary disease, 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 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 (65%) than women. 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 percentage accessing the pharmacy service, where routine and manual workers make up only 4% of the total.

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.

[B]Physical activity

[C]Sport and physical activity among adults

Sport England's Active People Survey for 2012/13 (published in June 2013) states that 38.2% of adults resident in the City take part in at least one 30-minute session of moderate intensity activity per week. This compares with 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 among females is above the national average at 29%, compared with 19% for males. There is also a high non-participation rate (34%) among people with a disability (the national average is 25%).

Encouragingly, 58% of survey participants did all their sport inside the Square Mile, and 69% of City workers said that they would like to do more sport (32% of those were specifically interested in swimming). Respondents said that if the location was convenient – for example, accessible during lunchtimes – then their levels of activity would increase.

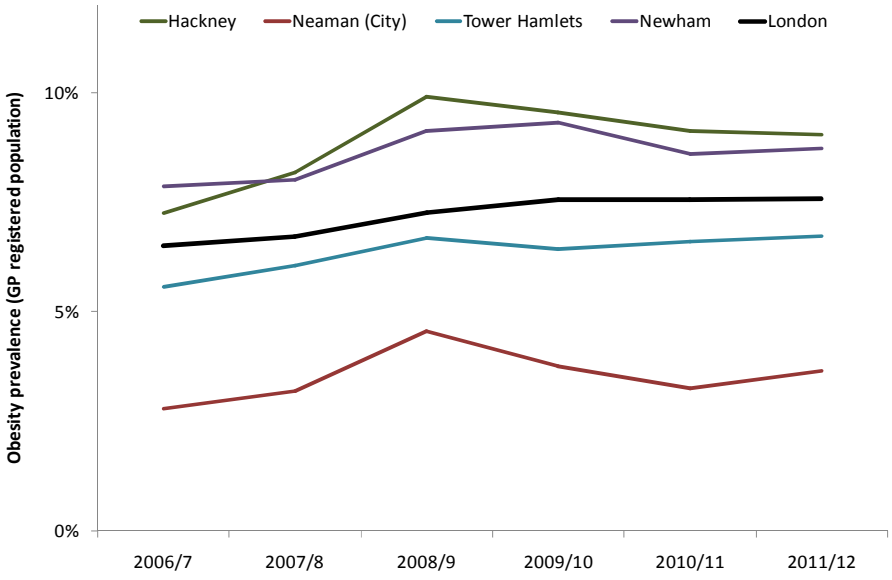
[B]Obesity

Obesity data comes from two sources: Quality and Outcomes Framework (QOF) data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

Around 4% of adults registered with the Neaman practice are obese, which is lower than the rates for surrounding areas and London as a whole (Figure 6.5).

Primary care data extracts for the whole City population estimate that 9% of residents are obese, but that obesity might be as high as 15% in patients who are not registered with the Neaman practice (i.e. those who live in Portsoken).

Figure 6.5. Obese adults as recorded in general practice (QOF)



[B]Alcohol

[C]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 6.3). Compared with the previous year, there seems to be a variable trend in risk. The number of individuals who abstain from alcohol has decreased, but those deemed to be at increasing risk has also reduced compared with the previous year. This may be linked to the ethnic profile of City residents.

[D]City workers

A report on drinking among City workers published in January 2012 found the prevalence of alcohol misuse in 2011 to be a significant issue, as summarised in Table 6.3. A total of 33.4% of City drinkers are at increased risk of alcohol-related harms, compared with 20.1% nationally.[17] These drinkers are not yet necessarily experiencing alcohol-related harms, but are increasing their risk of health and social problems. In total, 12.4% of City drinkers were drinking at a higher risk level, compared with 3.8% in the national population and 8% in London as a whole.[18] 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 Organization. The full 10-question AUDIT places respondents in one of four main categories, ranging from 'lower risk' to 'possible dependence'.

Alcohol misuse in the City may in part be attributed to a complex range of factors such as higher average wealth, high-pressure or risk-based work environments, a culture of entertaining clients and high use of public transport.

Alcohol misuse among both male (56.2%) and female (34.1%) City drinkers is considerably higher than the national averages (33.2% for men and 15.7% for women).[19] Young white males are the predominant misusers of alcohol.

Table 6.3. Estimates of alcohol consumption by City residents and City drinkers by DH risk category, 2011 and 2012[20,21,22]

	Abstain (%)		Lower (%)		Increasing (%)		Higher (%)		Source
	2011	2012	2011	2012	2011	2012	2011	2012	
City residents	19%	14%	50%	70%	22%	22%	8%	9%	*NWPHO*
City workers	–	–	–	–	33%	–	12%	–	*Insight into City Drinkers*
London	24%	22%	52%	73%	16%	20%	8%	7%	*NWPHO*
National	–	–	–	–	20%	–	4%	–	*APMS 2007*

Table 6.4. AUDIT categories by score range

[17] *Insight into City Drinkers* (2012)
[18] ibid
[19] ibid
[20] North West Public Health Observatory (2012) *Local Alcohol Profiles for England (2012 Refresh)*
[21] *Insight into City Drinkers* (2012)
[22] Adult Psychiatric Misuse Survey 2007

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)

[C]Health impacts of alcohol

The annual alcohol-attributable death rate in the City's resident population is 49.6 per 100,000 men and 2.3 per 100,000 women (age-standardised rate). This gives 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 6.5). There were 17 individuals in contact with structured alcohol treatment in 2012/13, 40% of whom completed treatment successfully.

Table 6.5. 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)[23]

	The City		London
	Rate per 100,000 standardised	National rank (out of 354)	Rate per 100,000 standardised
Men	969.7	7	1,535.9
Women	289.0	1	810.9

[D]City workers

Compared with national averages, alcohol-related problems in City workers may be disproportionately social rather than health harms. Health-related problems were less reported than social or behavioural problems (e.g. injury or remorse).[24]

[23] North West Public Health Observatory (2011) *Local Alcohol Profiles 2011*
[24] *Insight into City Drinkers* (2012)

[C]Crime and anti-social behaviour

In 2012/13 the London Ambulance Service dealt with 26 calls regarding alcohol overdoses or alcohol-related accidents in the City, 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 were notified of 5,454 incidents. Of these, 1,292 (23.7%) were alcohol related or connected with licensed premises (public houses, nightclubs and wine bars). A total of 178 (32.1%) were deemed violent offences and 1,013 (26.7%) acquisitive offences.

In general, alcohol-related offences happen after 7pm from Monday to Friday and fall off by midnight. On Thursday, Friday and Saturday, offences are likely to happen through the night until 4am. A total of 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).

[B]Substance misuse

[C]Prevalence of drug use

Local research carried out 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. It also showed that over half of the patrons in these venues were working in the City. National data reveals that the 'prosperous urban' demographic tends to use more drugs than other groups, including cocaine.

[C]Health impacts of drug use

Between April 2007 and March 2013, there were 36,356 incidents leading to ambulance callouts in the City of London, with 304 (0.8%) flagged as being drug related. A total of 48% of the callouts were for individuals under the age of 35, 56% were for males and 41% were for females (3% were not recorded).

[C]Emerging trends in drug use

[D]Residents

The City's treatment services have always been used by more males than females, and this is consistent with services across England. Clients are predominantly 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 problems. This change goes hand in hand with the increase in the numbers of people who are employed and the increase in those with a primary alcohol problem.

[C]Treatment and engagement

[D]Residents
A total of 24 individuals entered the treatment system in 2012/13, adding to the 17 who were already in treatment on 1 April 2012. It is encouraging that the highest number of referrals were self-referrals; the second highest number came from GPs. These were predominantly for people with a primary alcohol problem.

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

[C]Harm reduction

[D]Residents
The prevalence of hepatitis C in injecting drug users is around 50% nationally. The prevalence of hepatitis B in injecting drug users is around 17% nationally. The estimated prevalence of current injecting drug users in the City is 17. Public Health England estimates that 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 local 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 who have a history of injecting. In 2012/13 the uptake of testing was 88%, compared with 73% nationally.

[A]Sexual health

[B]Sexually transmitted infections (STIs)

In total, 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.

[C]Chlamydia screening

Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may have 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 the 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. A total of 17% of 15 to 24-year-olds were tested for chlamydia, with eight cases diagnosed (a positivity rate of 6%).

[C]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 to 59, compared with 2.0 per 1,000 in England. A total of 62 adult residents received HIV-related care, fewer than five of whom were female. Of these, 90% were white. As regards 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 or older) were newly diagnosed in 2011. All 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.

[D]City workers

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

[D]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.

[A]Mental health

[B]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.[25] At any one time, an estimated 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.

[C]Depression

Data on depression in City residents comes from three sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); primary care data extracts, which are of unknown accuracy; and modelled estimates, based on the 'types' of people who live in the City.

In 2012/13, the crude prevalence of depression recorded by the Neaman practice was 3.4% (267 individuals).

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

Primary care data extracts for the whole City population show that 2% of residents have depression, although some modelled estimates put the prevalence of depression as high as 5%.

[C]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 area. In 2012/13, the crude prevalence of severe mental health conditions recorded by the Neaman practice was 0.8% (69 individuals).

[C]Suicide

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

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

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

The suicide prevention strategy identifies some effective local interventions as:

- prevention – putting up 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 of suicides

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 offers information, advice and guidance to City residents and workers, as well as signposting to relevant health services.

[D]City workers

A total of 21% of City workers report suffering from depression, anxiety or other mental health conditions, with 33% stating that their job causes them to be very stressed on a regular basis. Those who report being very stressed several months per year are 2.6 times more likely to identify themselves as being in ‘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 when they are ill.

[D]Rough sleepers

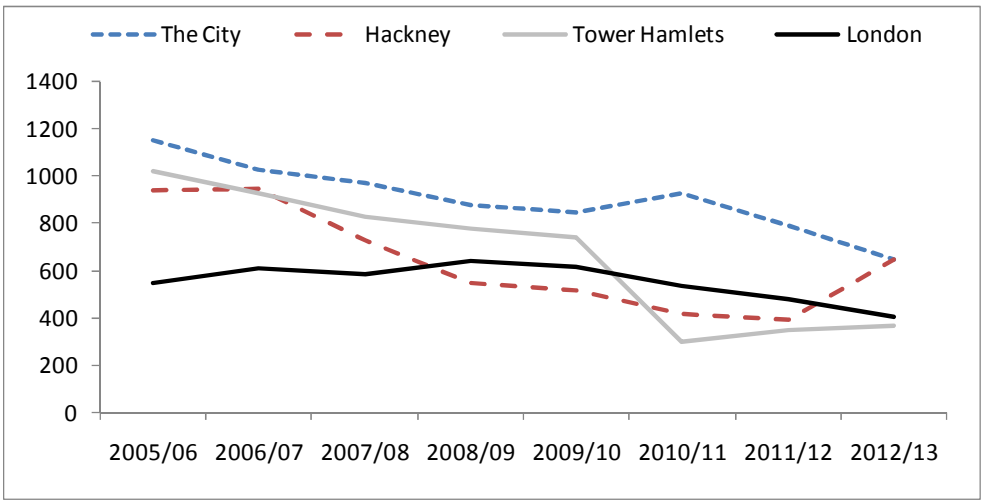
A national audit of the health and wellbeing of homeless people found that seven out of 10 had one or more mental health needs, a rate over twice that of the general population.[26] Within the City, the Combined Homeless and Information Network (CHAIN) database has identified 45% of rough sleepers as having a mental health issue.

[B]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 the Mental Health Minimum Data Set for 2011/12, 89.6% of adults receiving secondary mental health services in the City lived in settled accommodation.

Figure 6.6. Number of adults (aged 18 to 64) with mental health problems receiving care packages per 100,000 population, 2005-13



Source: National Adult Social Care Intelligence Service

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

[A]Carers

[B]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 can 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.

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 T, who suffers from a neurodegenerative condition and is dependent on G in all areas of daily life. T is in a wheelchair and has some speech limitations, which means that G occasionally has to articulate his wishes for him.

Carer needs and support

G feels that being T's informal carer can be challenging at times, as she has to live a very structured life. 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 carer's assessment from adult social care and was awarded a non-means-tested carer's individual budget to aid her in her caring role. This is in addition to her Carer's Allowance, which is a benefit entitlement from the government. She has also been provided with support from the City Carers' Service and advice from City Advice.

Despite the challenges she faces, 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 difficult at times, but feels that being T's carer has been very good for her and has enriched her life in other ways.

[B]Carers in the City

The City Carers' Register lists 58 known carers of clients aged over 18. According to the Census 2011,[27] 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.

[27] 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,[28] 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.

[D]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.

[A]Disability

[B]Learning disabilities

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

For more information about learning disabilities, see **Error! Reference source not found.**'.

[B]Physical disabilities

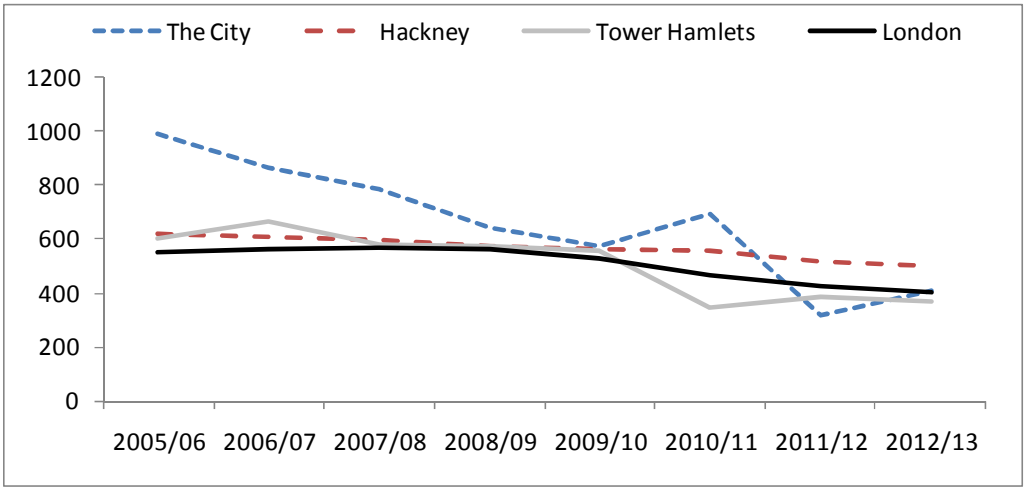
In 2012/13 the City of London provided services to 113 clients with physical disabilities, of whom 80% were aged over 65. A total of 56% of these clients received community-based support (not

[28] City of London Carers' Strategy, 2011

including home care). 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 ongoing support from the City of London Corporation has decreased since 2005/06, with a 46% drop in the rate per 100,000 population (Figure 6.7).

Figure 6.7. Adults with physical disabilities receiving care packages per 100,000 population, 2005-13



[C]Visual impairment

In 2010/11 there were nine people on the City's Visual Impairment Register, with fewer than five registered in each category as partially sighted, blind or deaf/blind.

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7. Later life[CH]

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

[C]Key findings

- Life expectancy is expected to remain high among 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.
- The incidence of age-related health problems such as reduced mobility, dementia and social isolation, as well as the need for additional support and care, is likely to increase.
- The City has been adapting to the increasing demands of the ageing population through increased provision of telehealth, measures to prevent social isolation and creation of a dementia-friendly City.

[C]Recommendations

- Provision for the ageing population should continue to meet the increasing demand projected over the coming decade.
- The provision of health, social care and housing will need to become increasingly interdependent if we are to maintain independence and good quality of life for our ageing City residents.

[C]Questions for commissioners

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

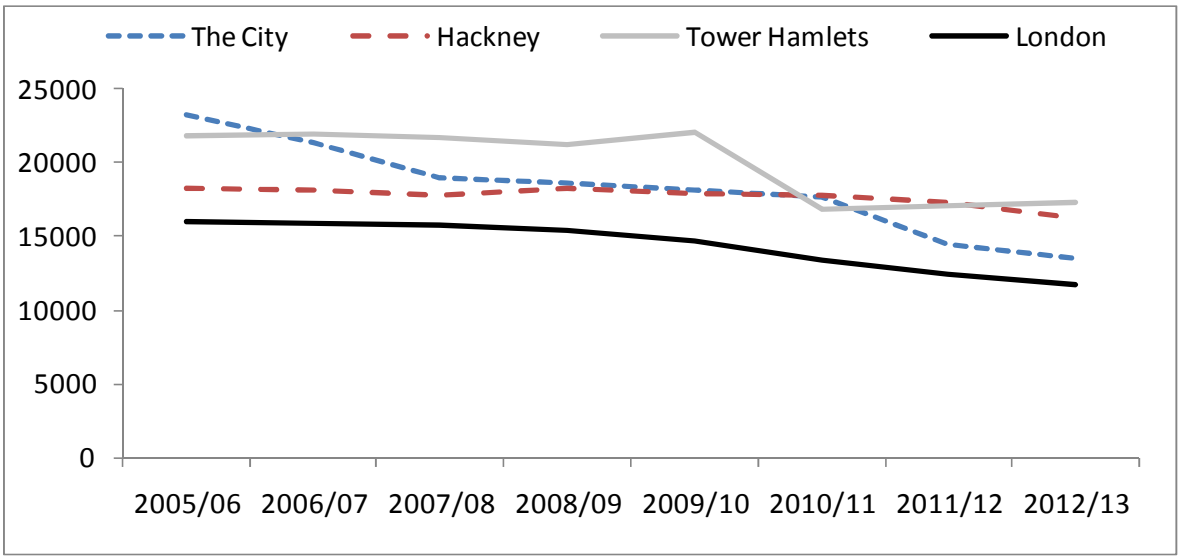
[A]Older people

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 has declined (Figure 7.1).

A survey of residents living on the Golden Lane and Middlesex Street Estates found that people on these estates had 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[1] (Figure 7.2).

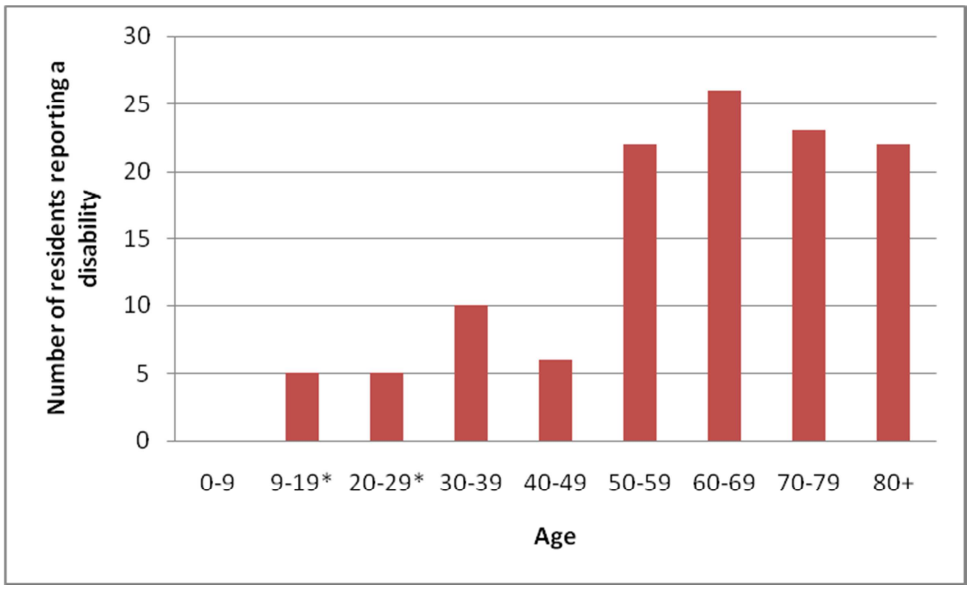
Figure 7.1. Older people (aged 65 and over) receiving care packages per 100,000 population, 2005-13



Source: National Adult Social Care Intelligence Service

Figure 7.2. Age and disability of tenants of Golden Lane and Middlesex Street Estates

[1] City of London housing tenants profiling, 2011



* Fewer than five individuals were reported

Source: City of London

[B]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 7.3. Life expectancy for males in Hackney and the City 2006-10 (London Health Observatory (LHO))

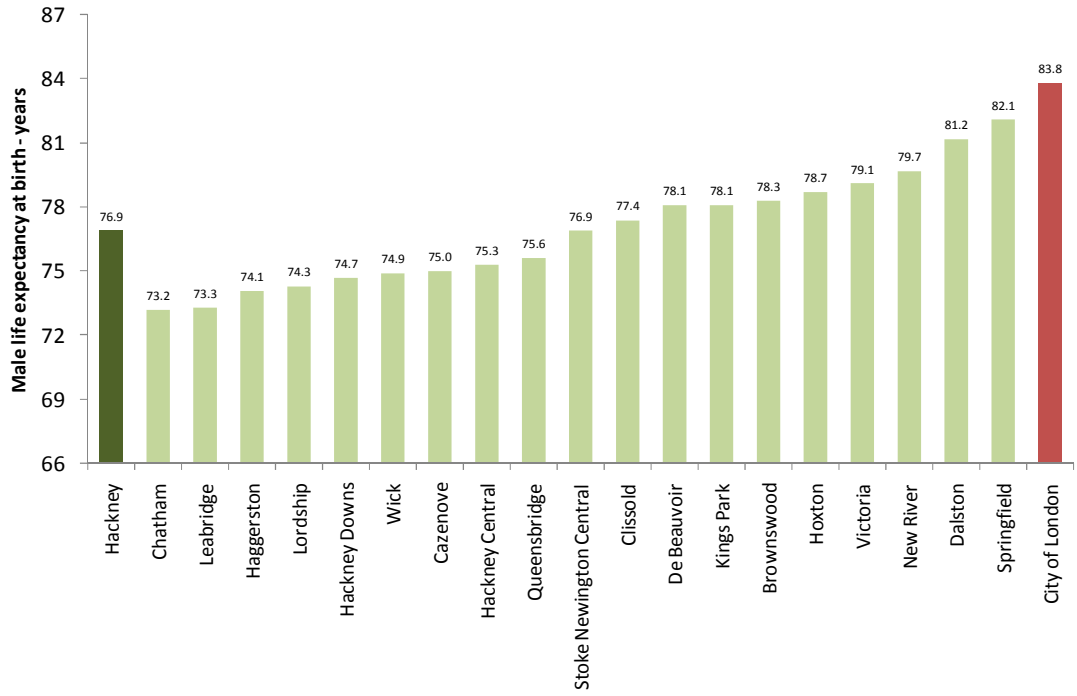
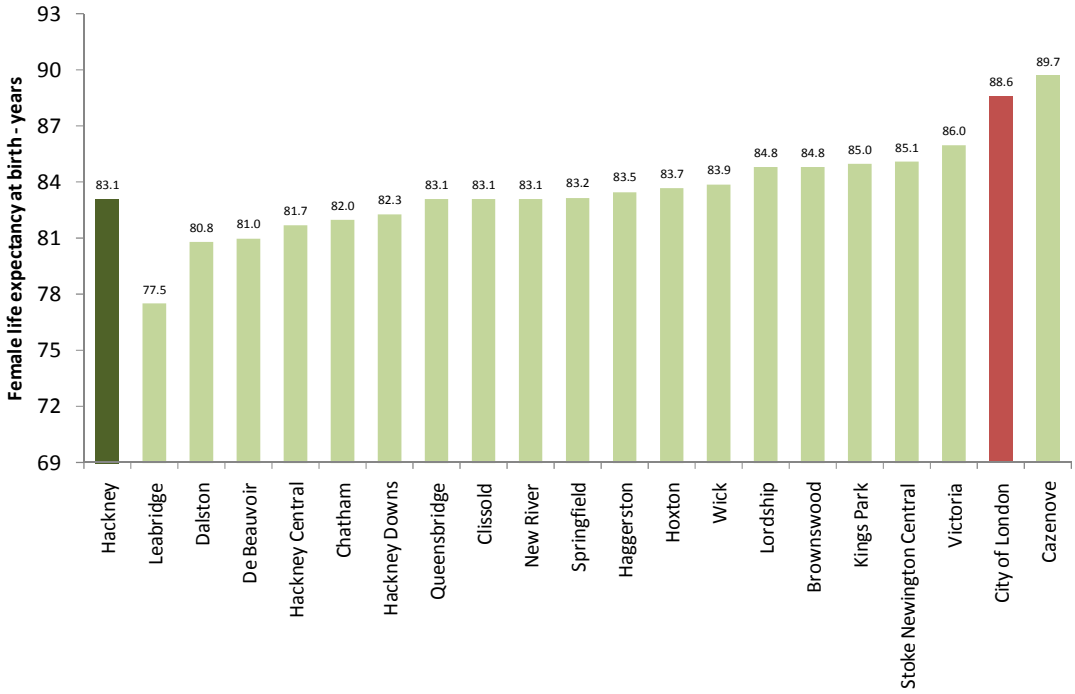


Figure 7.4. Life expectancy for females in Hackney and the City, 2006-10 (LHO)



[B]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, although this figure is very variable year-on-year due to the small numbers 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 died. The trend is erratic due to the small number of deaths but nonetheless demonstrates a long-term decline. For more information see **Error! Reference source not found.**'.

[A]Telecare and telehealth

Telecare and telehealth services use technology to help people 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 help an individual live independently in their own home for longer, avoid a hospital stay or put off moving into a residential care home.[2]

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 Clinical Commissioning Group, the City and Hackney Health and Social Care Forum is working with the London Borough of Hackney, the City of London Corporation and the voluntary and community sector 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, art 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 sector. 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.

[A]Loneliness and social isolation

A report from Age UK on loneliness and isolation states that 7% of people aged 65 or over in England say they always or often feel lonely. Including those who say they are sometimes lonely, the figure rises to 33%. 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.[3]

Within the City, 2,472 households are made up of one person, with 526 of these aged 65 or over. About 58% of these older residents are women and 42% are men. In the City, the growing ageing population (see Appendix 2) suggests that loneliness and social isolation may be increasingly prevalent. In addition, anecdotal evidence from housing officers and City residents suggests that the socially isolated ageing population tends to be concentrated in the north of the City, and may be 'asset rich and income poor'.

[2] For more information see: http://www.nhs.uk/Planners/Yourhealth/Pages/Telecare.aspx
[3] Age UK (2010) *Loneliness and Isolation Evidence Review*

K is an 85-year-old man of white British origin. K is single and lives 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. K is otherwise independent in daily living tasks with access to a care alarm and bathing aids. He tends to find change difficult and has declined referral to the local luncheon club, although 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. He 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 local police community support officers and ward beat officer visit him, which enhances his feeling of security. K's dementia is reported to be manageable in his 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 the Hackney and City Alzheimer's Society.

[A]Dementia

There are estimated to be more than 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.[4.] Adult social care and the local GP practice have confirmed that they currently know of 15 people living in the community and five people in nursing care, but acknowledge that there may be many more people who are not formally diagnosed or who have not accessed statutory social care.

This is recognised as quite a large discrepancy. As a result, the Neaman practice is reviewing its diagnoses of patients who may have signs and symptoms of dementia as a co-morbid factor with their primary diagnosis, and are referring them to the local memory clinic for a further assessment where necessary.

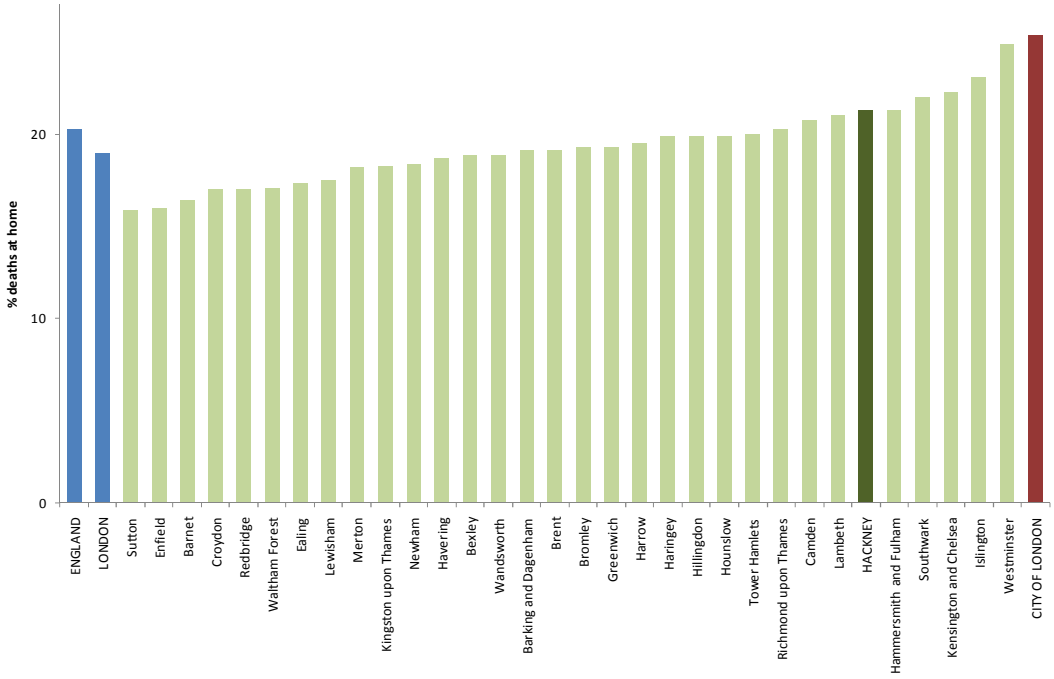
In 2014 the City committed to providing the best possible services to this particularly vulnerable group through its Dementia Strategy. The strategy commits the City of London Corporation to creating a 'dementia-friendly City', where residents and local retail outlets and services will develop a keen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

[A]End-of-life care

In 2010/11, over 25% of deaths among residents of the City took place at home – this was the highest average across all London boroughs and higher than the averages for London and England (Figure 7.5). Generally, more men die at home than women.

Figure 7.5. Percentage of deaths taking place at home, 2008-10 (Health and Social Care Information Centre)

[4] 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

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8. Healthy life[CH]

This final section concentrates on those aspects of wellbeing that 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.

[C]Key findings

- There is potential to expand pharmacy services to meet local health needs. Many residents use community pharmacists located outside the City. 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 together help to strengthen and build communities.

[D]Residents

- A total of 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 from cancer have fallen markedly over the last six years.
- Other disease prevalence estimates for residents show that there are some health inequalities between those living in Portsoken and the rest of the City.
- 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.

[D]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 work rather than one near home, if they were allowed.
- Musculoskeletal, respiratory and mental health problems are the main health conditions reported by City workers.

[D]Rough sleepers

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

[C]Recommendations

- Expanding pharmacy services 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 sector has the potential to relieve pressures on care services, while building a more resilient community for the City's resident population.

[D]City workers

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

[D]Rough sleepers

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

[C]Questions for commissioners

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

[A]Chronic disease

[B]Cancer

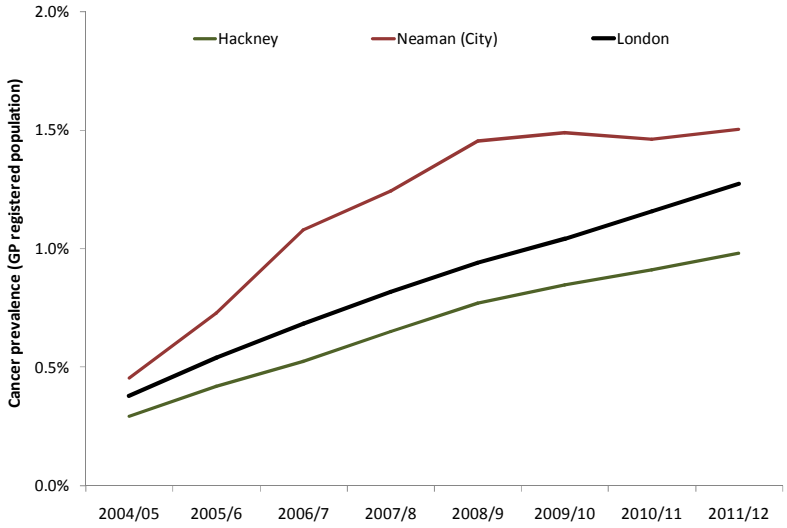
[C]Prevalence

Data on cancer prevalence comes from two sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

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).

Primary care data extracts for the whole of the City suggest that the prevalence of cancer might be as high as 3%.

Figure 8.1. Crude prevalence of cancer in the GP-registered population, 2006-12 (QOF)



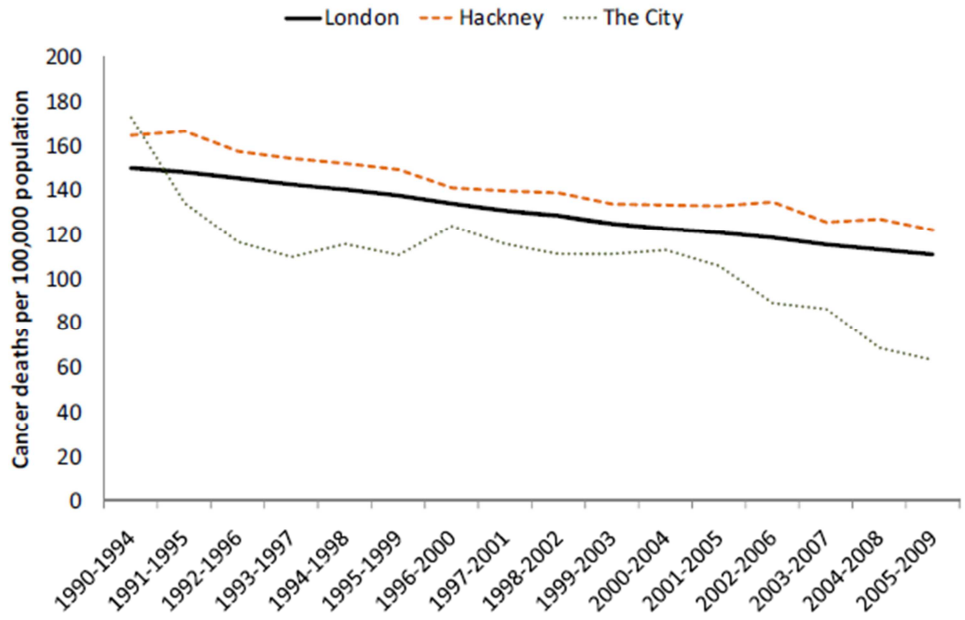
[C]Death and survival rates

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 and 57% men). This is an age-standardised rate of 128 deaths per 100,000 population per year.

Figures 8.2 and 8.3 illustrate the long-term trends in deaths from all cancers and from premature cancer (cancer affecting the under-75s). Both rates in the City are well below the average for London, and premature deaths from cancer have fallen markedly over the last six years.

Figure 8.2. Long-term trend in deaths from all cancers, at all ages (Thames Cancer Registry)

Figure 8.3. Long-term trend in deaths from premature (<75) cancer (Thames Cancer Registry)



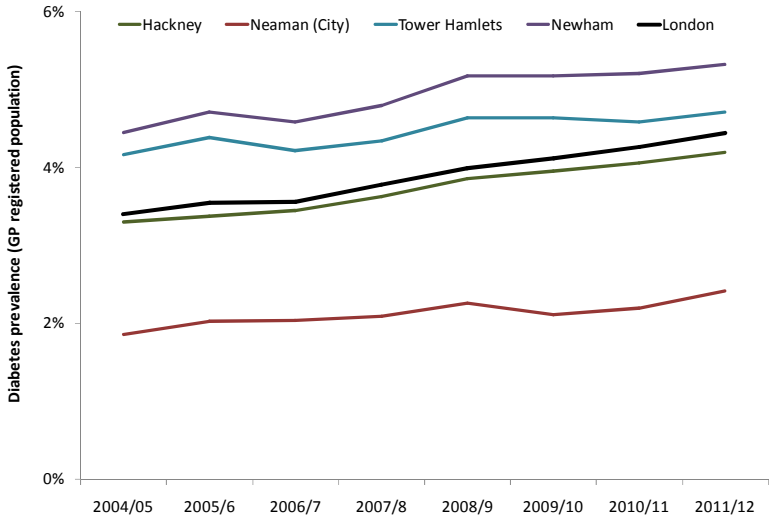
[B]Diabetes

Data on diabetes prevalence comes from two sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

In 2011/12, the crude prevalence of diabetes recorded by the Neaman practice was 2.4% (215 individuals).

Primary care data extracts for the whole City population are similar, suggesting that diabetes affects about 3% of the City's population.

Figure 8.4. Prevalence of diabetes, 2004-12 (QOF)



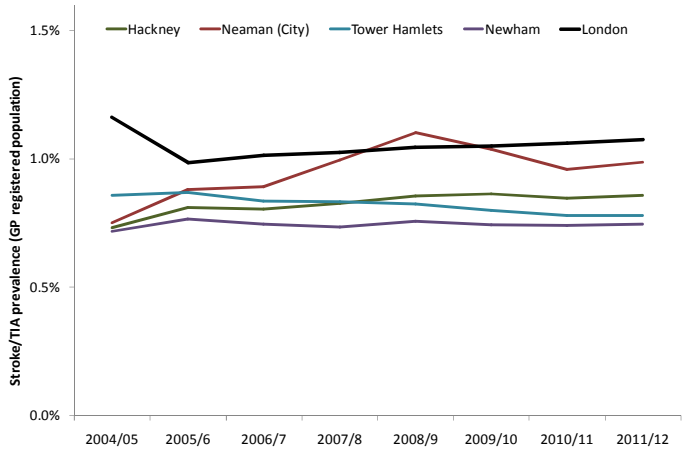
[B]Stroke and transient ischemic attack (TIA)

Data on stroke and TIA prevalence comes from two sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

In 2011/12, the crude prevalence of stroke recorded by the Neaman practice was 1.0% (88 individuals) (Figure 8.5).

Primary care data extracts for the whole City population are similar, showing that 1% of City residents are affected by stroke.

Figure 8.5. Crude prevalence of stroke/TIA in the GP-registered population, 2004-12 (QOF)



[B]Hypertension

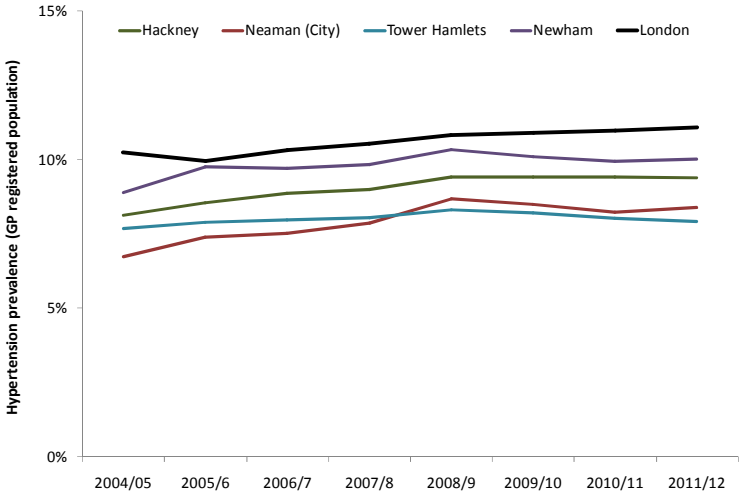
Data on hypertension prevalence comes from two sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

In 2011/12, the crude prevalence of hypertension recorded by the Neaman practice was 8.4% (746 individuals).[1] This rate has been stable for the last four years (Figure 8.6).

Primary care data extracts for the whole City population estimate that 10% of residents have hypertension, but that this figure might be as high as 16% in patients who are not registered with the Neaman practice (i.e. those who live in Portsoken).

Figure 8.6. Crude prevalence of hypertension in the GP-registered population, 2004-12 (QOF)

[1] QOF data



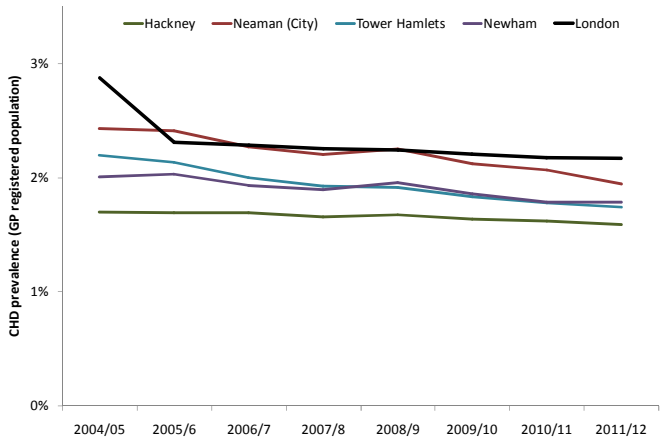
[B]Coronary heart disease (CHD)

Data on CHD prevalence comes from two sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

In 2010/11, the crude prevalence of CHD recorded by the Neaman practice was 1.9% (173 individuals).[2] This is comparable with the average for London. Prevalence has fallen slightly in the past eight years (Figure 8.7).

Primary care data extracts for the whole City population are similar, showing that about 2% of residents have CHD.

Figure 8.7. Prevalence of CHD in the GP-registered population, 2004-12 (QOF)



[B]Sickle cell disease

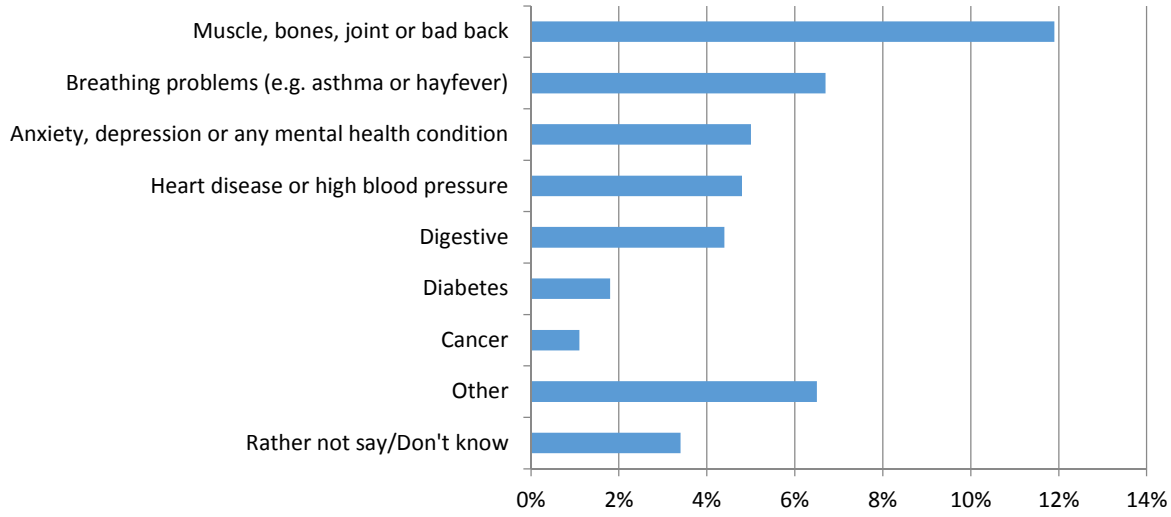
There were no hospital admissions for sickle cell disease in the City in 2010/11.

[2] QOF data

[D]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 listed a range of conditions (multiple answers per respondent were allowed). Musculoskeletal, respiratory and mental health problems were the most common health conditions identified (Figure 8.8).

Figure 8.8. City worker responses to the question, 'Do you have a health problem which has lasted, or is expected to last, at least 12 months?'



[A]Infectious diseases

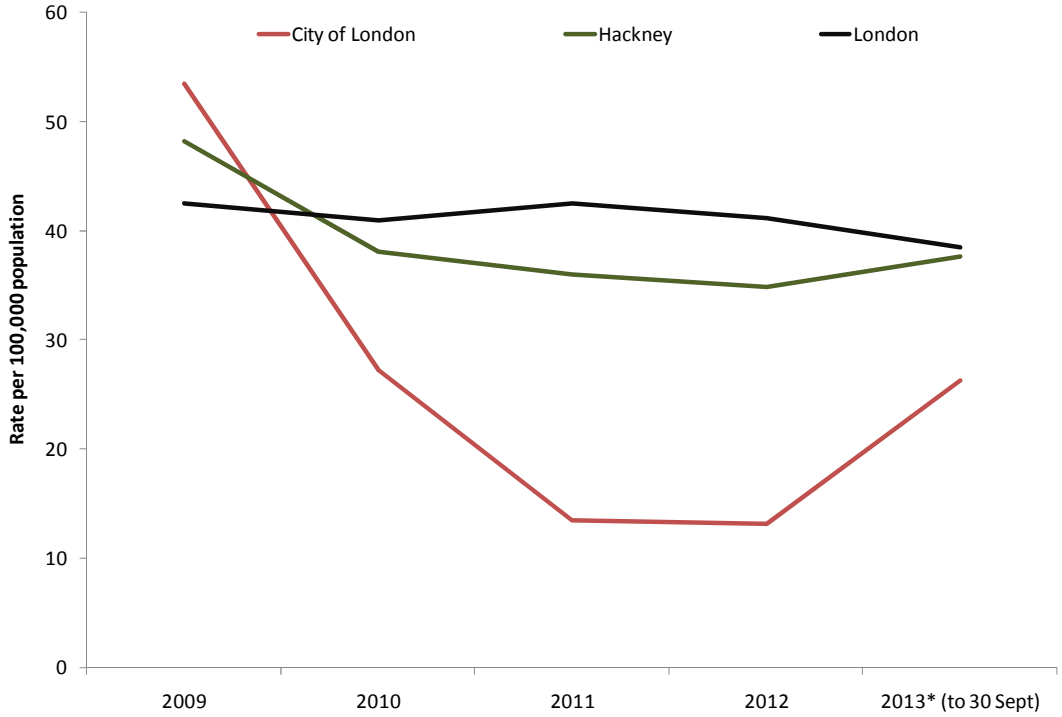
[B]Hepatitis C

Public Health England estimates 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.

[B]Tuberculosis (TB)

The rate of TB incidence among City residents has been steadily declining over the last few years, with a small upturn between 2012 and 2013. However, these rates are based on very small numbers.

Figure 8.9. TB incidence among residents of the City, Hackney and London, 2009-13 (Public Health England)



[D]City workers

As already discussed, 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 found to have TB are usually treated by health services local to where they live.

[D]Rough sleepers

Rough sleepers are vulnerable to TB, with some studies showing that up to 15% of rough sleepers have past or active TB.[3] 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.

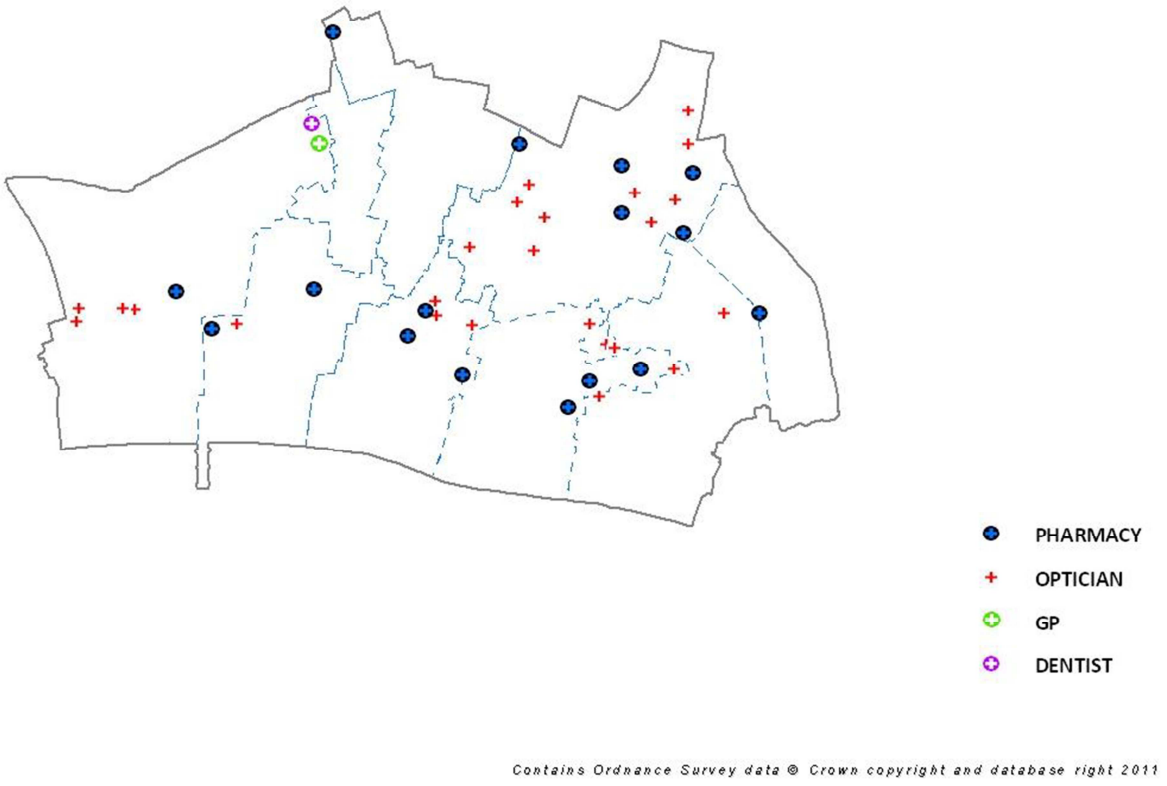
[A]Health services

[B]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 shown in Figure 8.10. In addition, optometry is delivered in residents' homes where necessary, and GPs also offer home visits to residents.

Figure 8.10. Primary care services in the City

[3] NHS North West London (2013) *Rough sleepers: health and healthcare*. Available at: http://homeless.org.uk/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf



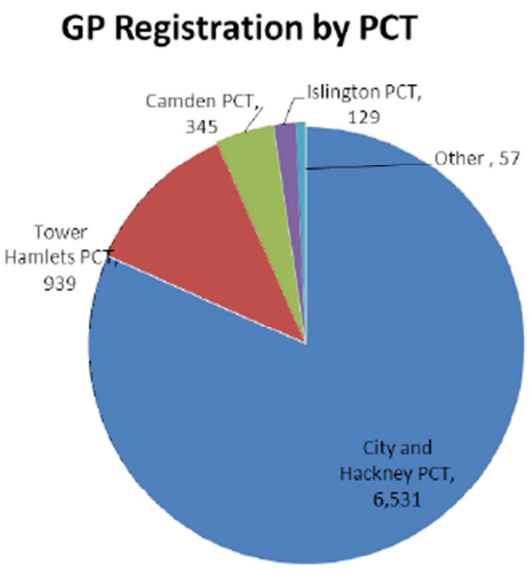
[B]GP registrations

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 8.11).[4] Overall, 18% of residents are registered outside City and Hackney Clinical Commissioning Group (CCG); the majority of these (12%) are registered with GPs in Tower Hamlets. 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.[5]

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 8.11. GP registration of City residents

[4] City and Hackney CCG (2012) 'Mapping of health services in the City of London' (paper presented to City of London Health and Wellbeing Board)
[5] City and Hackney CCG (2012) 'Mapping of health services in the City of London' (paper presented to City of London Health and Wellbeing Board)



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

[D]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 attend the appointment.

Research conducted with City workers showed that one-third of City workers would choose to register with a GP near work rather than one near 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.

[D]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.

[B]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 to 18.

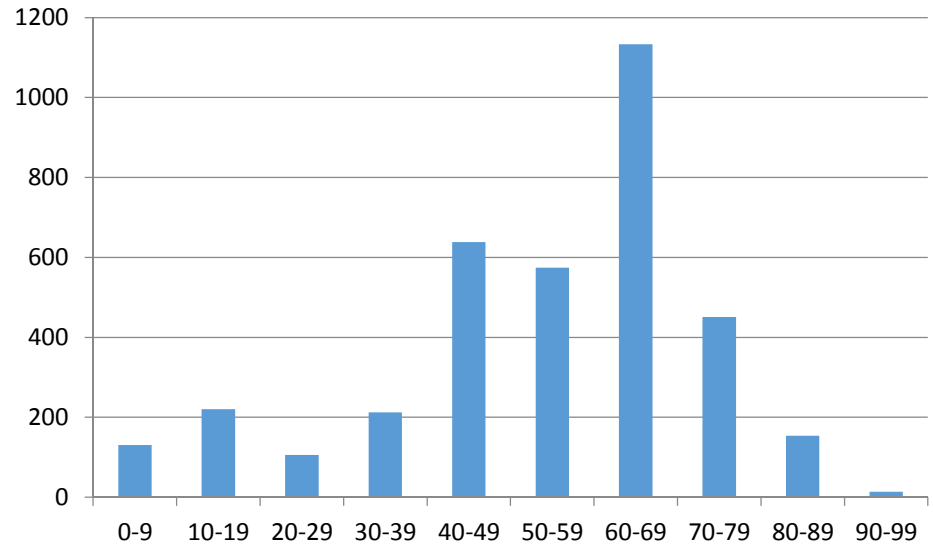
During the period April 2010 to March 2011, residents of the City accessed NHS dental services in the neighbouring boroughs of Hackney, Tower Hamlets, Camden and Islington. The number of

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

[B]Optometry

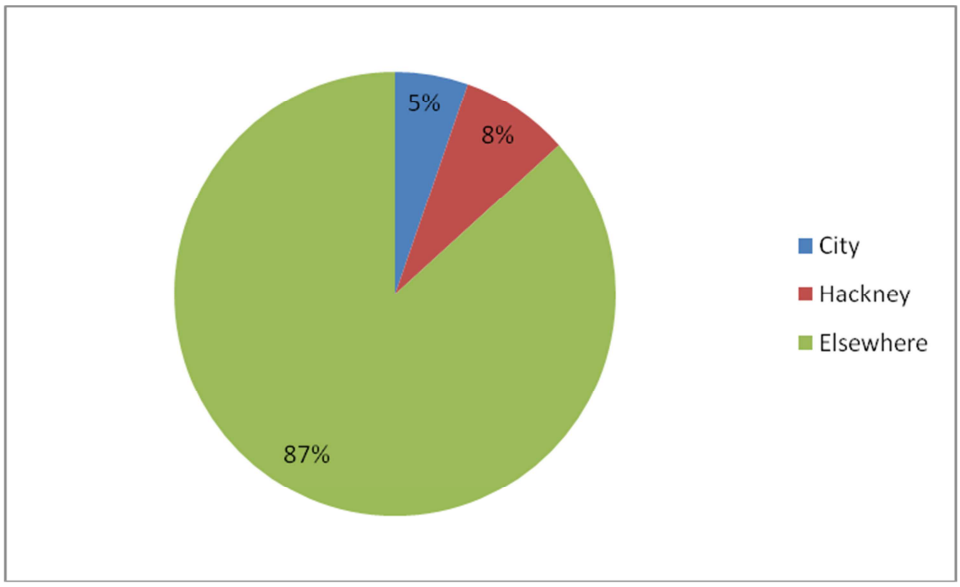
In 2009/10, NHS sight tests in the City were predominantly performed on people aged 40 or over.

Figure 8.12. Age profile of those receiving NHS sight tests from 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 8.13).

Figure 8.13. Residency of those undergoing NHS sight tests with optometrists located in the City



[B]Pharmacies and prescribing

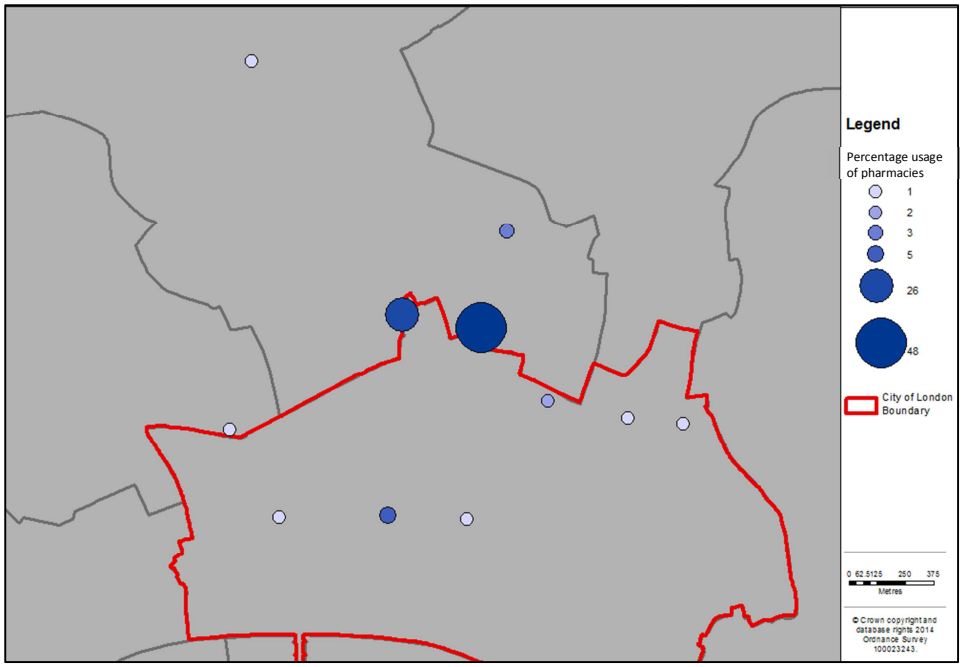
Community pharmacies have had an important role to play in reducing health inequalities, through increasing access to health information, prevention and screening services, signposting patients to other services and supporting them to take medication. There is potential to expand pharmacy services in order to meet local health needs.

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

- chlamydia screening and treatment services, targeting young people in particular
- minor ailments service
- weight management service, designed to help people manage their diet and exercise and maintain a healthy weight
- emergency hormonal contraception service
- Freedom 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 issued by the Neaman practice between June and December 2011[6] 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 8.14. Percentage usage of pharmacies by Neaman practice patients, 2011



[6] ePACT.net, 2011

[D]Rough sleepers

Although there is no City-specific data, the healthcare utilisation and costs of rough sleepers in the City are likely to reflect patterns seen among rough sleepers assessed in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster.[7] The following healthcare needs and utilisation patterns were observed:

- Secondary healthcare costs are at least five times higher for rough sleepers than for the general population.
- Rough sleepers access A&E seven times more than the general population.
- They are more likely to be admitted to hospital as emergency cases, costing four times more than elective in-patients.
- They are four times more likely to attend out-patient health appointments (discounting 'did not attends') than the 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 a hospital had three or more diseases.
- Their healthcare usage increases over time.
- Hospital usage is highest among 30 to 49-year-old men and costs are significantly higher than for the general population.
- Most rough sleepers had clinical conditions related to mental health, trauma and orthopaedics, the digestive system and ophthalmology.

K is a 27-year-old man currently sleeping rough in an underpass. He was born in London and was taken into care at a young age. He was placed with five 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 rent arrears, non-engagement and hoarding, despite numerous case conferences to prevent this. He was then accommodated in a hostel, but was evicted for assault the following year.

Health issues

K's drug use in one year was estimated at £100 worth of heroin and crack per day 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 K's 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, the 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 hospital used all three hospital services (out-patient, in-patient and A&E).

[7] NHS North West London (2013) *Rough sleepers: health and healthcare*. Available at: http://homeless.org.uk/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf

[A]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 these consultations, the following changes were made:

- **Supported Assessment Questionnaire (SAQ)**
  The SAQ is 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 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.

Better Care Fund

The Better Care Fund (BCF) was announced as part of the government's 2013 Spending Review. It brings together separate strands of funding, providing an opportunity to transform local services in order 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*
- *seven-day services in health and social care*
- *early intervention and prevention*
- *better data and information sharing to support care*
- *joined up and co-ordinated 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.

- **Adherence to the Fair Access to Care Services (FACS) eligibility criteria**

  Under FACS there are four bands of eligibility:

  - Substantial/Critical: eligible for an individual budget
  - Low/Moderate: eligible for advice and information **[TYPESETTER: PLEASE USE EN DASHES FOR SUB-BULLETS]**

- **Carers' Strategy and carer's individual budgets**
  Carers are assessed through the 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; those with Substantial eligibility receive £750; and those with Critical eligibility receive £3,000.

- **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.

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

[B]Performance data

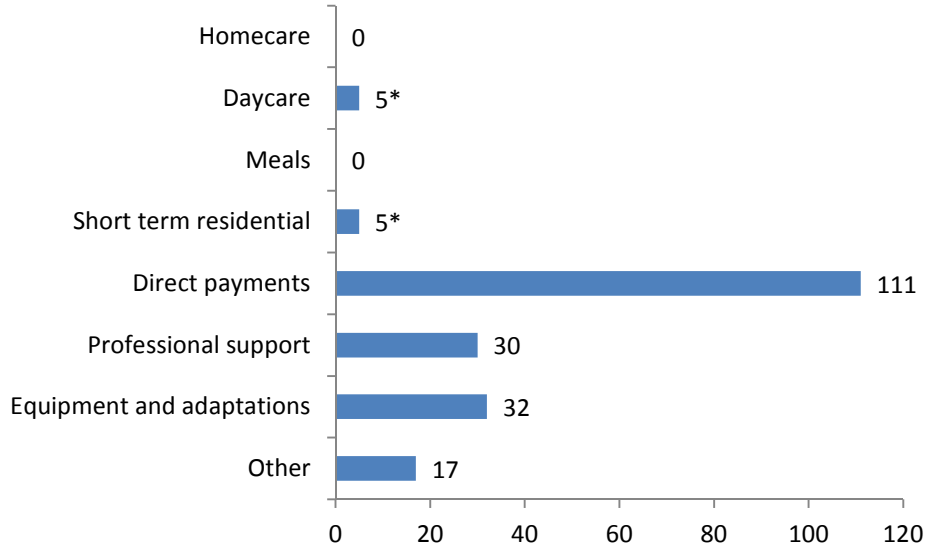
In 2011/12 the City of London carried out its first Adult Social Care User Survey. The survey had an excellent response rate of 63%. Of those who responded, 83% felt that the services they received made them feel safe and secure. In total, 74% of users felt that they had control over their daily life, and 70% of users found it easy to access 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 or over. In this older age group, there were more women than men (58% vs 42%). In the younger (under-65) age group, there were fewer women than men (33% vs 67%).

These social care clients were 88% white, 5% Asian, 3% black and 4% of mixed or other ethnicities. Compared with the Greater London Authority ethnic profile for the City, white clients are over-represented and Asian clients are under-represented. However, the numbers are relatively small so variations do not necessarily reflect inequalities in access.

The graph below shows 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 8.15. Community social care services received from the City of London Corporation, 2012/13 (some clients receive more than one service)



* Fewer than five individuals were reported

[B]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% had mental health needs, 8% had learning disabilities and 4% had substance misuse needs or were vulnerable.

[B]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 is at risk 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, but for whom the City still has a duty of care. Of the 20 alerts, six were for residents placed outside the City.

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.

A was admitted to hospital after he was found by district nurses (who visit three times a week) to be suffering from dehydration and confusion. He had been so confused that he had not used his pendant alarm. He was discharged back home with help from the reablement service, with care to be provided by an agency during evenings and weekends.

A reablement worker visited A one morning to discover him semi-naked, having struggled with dressing and personal care. Further investigation by 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 A's GP about 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 home care 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 recurrence.

The agency worker who failed to attend was suspended pending further investigation and was dealt with by the agency's disciplinary procedures. The cause was identified during the investigation as the carer taking annual leave without appropriate approval, after which the agency responded with adjustments to their policies.

All care staff continue 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. A has continued to have support from his new agency without incident.

[A]The voluntary and community sector

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 voluntary and community sector (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.

[B]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. The charity 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. In total, 62% feel that the scheme is helping to improve their quality of life.

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Committee(s):	Date(s):
Health and Wellbeing Board	30th May 2014
Subject: Integrated Care Review and Development of One City Model	**Public**
Report of: Assistant Director People, Department of Community and Children's Services	**For Decision**

Summary

As part of the development work required to support improved integration between Adult Social Care, local health commissioners and providers, City Of London Community and Children Services commissioned Tricordant Ltd to carry out a review of current arrangements and invite them to make recommendations regarding the implementation of a proposed model.

The review was carried out in 2 stages;

1. A stocktake of current activity, data, pathways and provision of care.
2. The development of a 'One City Model' involving the engagement of key partners and agencies in the development of this model.

The work undertaken was built on the evidence already available to Tricordant via their previous stocktake carried out for City and Hackney CCG and London Borough of Hackney.

The process involved consultation with all the key agencies involved in the CoL Health and Social Care landscape including the City and Hackney CCG, Tower Hamlets CCG, Neaman Practice, CoL Adult Social Care and Public Health, Barts Health, Homerton University Hospital , University College London Hospital and Healthwatch.

Tricordant have completed their review and the attached report at Appendix 1 sets out in detail their findings and recommendations. The steering group endorsed the findings and recommendations in the report at its meeting on the 16th May.

Members are invited to review the full report however there is an Executive Summary in the report which captures the key findings and all the recommendations.

The headline recommendations are focused on the implementation of 3 specific work programmes;

- To conduct an options appraisal on the options for community health

services and Integrated Care support to the Neaman Practice.

- Work with the neighbouring CCGs of Tower Hamlets and Islington on the commissioning of appropriate services and resolve cross-boundary issues creating risk of service or pathway interruption.
- Review and align arrangements within the Adult Social Care team to interface with all relevant provider partners

Recommendation(s)

Members are asked to:

- Note the contents of the Tricordant report at Appendix 1 and agree that Officers should progress the implementation of the recommendations.

Main Report

Background

1. The review has built on the body of knowledge around integrated care already established within the Corporation, particularly in relation to the Better Care Fund plan. The report from Tricordant was commissioned to develop a City model that builds on the strengths and foundations being laid in neighbouring Integrated Care systems.
2. The City has no acute hospital dedicated to its geography with The Royal London and University College Hospital being the closest major providers. The Homerton Hospital, which is commissioned by City and Hackney CCG is an infrequent provider for City residents. The Homerton, however, is technically the provider of community health services to the City but in reality those residents registered with GP's other than those in the Neaman practice will receive community services from the provider aligned to their nearest acute hospital.
3. The Tricordant report highlights that this is an example of the complexity and complication of services within the City and the review has sought to understand the feasibility of developing a City specific model of health and care available to all residents.

Options

4. The Tricordant report notes that a One City model is feasible as a relationship and management model. It proposes to reduce complications and potential service interruptions caused by organisational handovers and also builds on the integrated care work being developed by commissioning and provider

organisations in neighbouring areas through which City residents are already being served. The new model would formalise arrangements and in particularly ensure smooth handovers and clearly navigated pathways for residents.

5. It is anticipated that the proposed course of action can be implemented through re-direction of existing or planned resources. Potential benefits and financial consequences will be investigated in the implementation workstreams.

Proposals

6. The recommendations proposed by the report are:

6.1 To conduct an options appraisal with the Neaman practice and the City and Hackney CCG, working with providers, on the options for community health services and Integrated Care support to the Practice, in order to inform CHS commissioning for the Neaman practice in 2015/16.

6.2 In partnership with neighbouring CCGs in Tower Hamlets and Islington:

6.2.1 To develop the commissioning case for realignment of Community and Adult/OPMH Mental Health Services in support of the Neaman practice

6.2.2 To address the "grey areas" of cross- LA boundary commissioning and clinical governance risk caused inadvertently by PCT legacy contracts for Community Health Services.

6.2.3 To explore with the City and Hackney CCG the designation of a City of London Health commissioning resource to align specifically with arrangements for CoL residents.

6.3 To review and align arrangements in the CoL ASC team to:

6.3.1 Explore and design the ASC team role to coordinate health and social care pathways on behalf of all City residents.

6.3.2 Enable a whole-City view of residents through a Population Care Coordination team/mechanism ("air traffic control") for exchange of regular and up-dated information on City residents who are active recipients of health and/or social, including support commissioned from the Community and Voluntary Sector, and from local intelligence.

6.3.3 To work with GP and provider partners to design and commission Care Navigation roles (x2) to provide 7 day support to the GP practices covering City of London residents.

6.3.4 To ensure active ASC team engagement and participation in the Multi- Disciplinary Teams forming around relevant GP Practice clusters – preferably through named relationships.

6.3.5 To ensure there are clear referral mechanisms in place for Royal London and UCL Hospitals Rapid Response and Discharge Management teams to enable admission avoidance and discharges from hospitals.

Corporate & Strategic Implications

7. The implementation of the recommendations aligns with the requirements set out in the Better Care Fund and the Care Bill. The need to reduce the frequency of admissions into hospitals, improve the discharge processes so that they are timely and responsive and, the need to have community health and social care services that are person centred are all fundamental strategic requirements which, if not in place, could compromise the health and wellbeing of residents and impact on the reputation of the City of London.

Conclusion

8. The review carried out by Tricordant has identified that the implementation phase will need to be developed across 3 work streams;

    a. To conduct an options appraisal on the options for community health services and Integrated Care support to the Neaman Practice.

    b. Work with the neighbouring CCGs of Tower Hamlets and Islington on the commissioning of appropriate services and resolve cross-boundary issues creating risk of service or pathway interruption.

    c. Review and align arrangements within the Adult Social Care team to interface with all relevant provider partners

9. Officers will progress the implementation of these recommendations in order to realise the ambitions set out in the Better Care Fund plan, thereby enabling an improved and more effective integrated health and social care system for the residents of the City of London.

Appendices

- Appendix 1 – Tricordant Final Report on Integrated Care in the City of London – A One City Model

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Integrated Care in the City of London

A One City model

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May 2014

Version Control

Version Number	Date Approved	Author	Brief Description
0.1	9 May	Tricordant	Initial draft for Project Sponsor review
0.2	14 May	Tricordant	Updated content for issue to Project Steering Group
0.3	16 May	Tricordant	Minor amend to Exec Summary text and insert system model diagram.
1.0	19 May	Tricordant	Final report released for publication to Health and Wellbeing Board

CONTENTS

Executive Summary

Introduction

- The brief for the Integrated Care project is to develop a City of London approach to Integrated Care – a One City model for City of London residents.
- The project scope is vulnerable adults and older people with long term conditions or frailty. This includes mental health, end of life care and public health, and also covers the support provided by the voluntary and community services sector.
- The key question posed by the review, in developing a One City model for Integrated Care is:
    - Can the Health and Social Care system in the City of London be organised to improve the equity of opportunity and experience for wellbeing across all residents?
- In answering the question, the proposed model will be rooted in the current reality, and will build on the foundations of the current and emergent patterns of service and relationships so that there is a clear and actionable route to implementation in the short and medium terms.

Current pattern of Services

- The City of London Health and Social Care system is both complex and complicated. While the complexity is shaped by the fact that lots of different organisations contribute to services in the City, the pattern of services is more complicated than necessary. The challenge in the project is to find a set of solutions that both help manage the complexity and also reduce the complications.

What service users say

- Despite the generally positive health status and outcome profiles for City of London residents as a whole, the experience of the service user remains fragmented and confounded by organisational complexity, suggesting there is more to be done to improve outcomes and experience.
- It is notable that the priorities for service users and professionals in the City of London consultation on the Better Care Fund reflect the desire of service users to **experience** joined up care.
- This focus on the service user experience, combined with Patient Choice in Health, drives the need to find some system and organisational solutions to best enable the experience of joined-up care.

Integrated Care service planning

- Integrated Care programmes are critical to the aim of delivering joined up health and social care and are a central component of the One City model.

- There are major Integrated Care programmes in City and Hackney, Tower Hamlets, in Islington and in Camden.
- All the major programmes for Integrated Care are based on virtually the same set of principles and evidence-base. In that respect the programmes in each of the CCG patches are mainly distinguishable by the pace of implementation and the stage of development they have reached.
- Each of these Integrated Care programmes contains service components such as risk profiling for vulnerable adults, rapid response services, discharge management, Multi-Disciplinary Teams wrapped around clusters of GP Practices in primary care, and Case Management for residents with long term conditions.
- All of these have an impact to a greater or lesser extent on City of London residents for whom the City of London Corporation provides Adult Social Care support.

Aims of the City of London Better Care Fund

- The success of the City of London Better Care Fund will be measured in part by the reduction of avoidable admissions to hospital and also of delayed transfers of Care from hospital.
- A key question therefore for this review is "into which hospitals are we trying to avoid admission, and out of which hospitals we are trying to expedite discharge?"

Alignment of Community Health Services (CHS) with acute hospital pathways

- The configuration of hospitals in London, together with patient choice, are just 2 factors that make it unrealistic to consider developing a model where all City residents will align to a single acute hospital and community health services provider for all services.
- While it will not be feasible to construct a model without boundaries and hand-offs/transitions between organisations, it is possible to reduce the number of provider organisations involved for City residents in healthcare, and therefore reduce the number of complications created by multiple hand-offs, pathways and relationships.
- City residents registered with Tower Hamlets GPs receive their CHS and Integrated Care support from Barts Health, and this appears to be the least complicated of the current arrangements in place.
- The least complicated CHS arrangement to serve the Neaman practice, with reduced organisational hand-offs (and therefore patient data transfer or information transparency between organisations) would be to align the Neaman practice with the CHS support to either the Royal London or UCL Hospitals.
- Pathways could arguably be simplified for City residents of the Neaman practice by aligning Primary care with the Rapid Response and Discharge management services around either the Royal London, UCLH or a combination of both.

- Options for optimum CHS support to the Neaman practice need closer analysis and it is recommended they be explored in the next stage of work in conjunction with the Practice, the City and Hackney CCG and the relevant CHS providers to examine the presenting options in conjunction with the opportunity of CHS re-commissioning by CCGs in 2015.
- The flows of patients to specialty centres for trauma, stroke and heart disease, in addition to the general acute flows, will be significant considerations in the appraisal of options.

Alignment of City of London ASC services with system partners

- To interface with the multiple health and CVS partners in the City of London, the Adult Social Care team needs to adjust its alignment with the partners in a systematic way to reflect the reality of patient choice and workflows. This will include:
- Development of the role of the ASC team to "hold the ring" for City residents and become the coordinator/navigator for joined-up health and care at the population level.
- Case management and Care Coordination are key component features of all the integrated care programmes, and will relate initially to the top 1-5% of Very High Intensity users of health care services. In addition to these most vulnerable adults, the remaining 95%, some of whom may otherwise become future high-intensity users, will benefit from Care Navigation support as part of the CoL ASC team and this role should be developed in partnership with GPs and NHS providers.
- With this extended role and scope of the team, the ASC team should establish an internal Residents' Care Coordination mechanism for exchange of regular and up-dated information on City residents who are active recipients of health and/or social care derived from the multiple relationships and information sources in the wider system, including support commissioned from the Community and Voluntary Sector.
- Participation of the City ASC team with the main Integrated Care Multi-Disciplinary Teams wrapped around the main GP practices serving City residents (both currently and in the potential future configurations).
- The CoL ASC team should align to the Rapid Response and Discharge management arrangements that are consistent with majority of acute hospital patient flows both into and out of the Royal London and UCL Hospitals.
- Public Health commissioning should be included in the Residents' Care Coordination team to ensure vulnerable residents have full opportunities to engage with preventive public health interventions and community support.

Summary and recommendations

A One City Model to deliver best quality of experience for every City resident will recognise the choices residents make about where to receive their care, and will focus on the organisation arrangements best suited in the short and longer terms to deliver the experience of integrated care.

The proposed model is rooted in the current reality, and will build on the foundations of the current and emergent patterns of service.

It will be important to satisfy competition rules and organisational legal powers in terms of any proposed changes to current arrangements and therefore much of the emphasis on next steps is around process to reach the right solutions.

The whole system model illustrated and outlined in section 7 of this report is feasible and deliverable through a work programme comprising 3 workstreams as follows:

1. To conduct an options appraisal with the Neaman practice and the City and Hackney CCG, working with providers, on the options for community health services and Integrated Care support to the Practice, in order to inform CHS commissioning for the Neaman practice in 2015/16.
2. In partnership with neighbouring CCGs in Tower Hamlets and Islington:
    a. To develop the commissioning case for realignment of Community and Adult/OPMH Mental Health Services in support of the Neaman practice.
    b. To address the "grey areas" of cross- LA boundary commissioning and clinical governance risk caused inadvertently by PCT legacy contracts for Community Health Services.
    c. To explore with the City and Hackney CCG the designation of a City of London Health commissioning resource to align specifically with arrangements for CoL residents.
3. To review and align arrangements in the CoL ASC team to:
    a. Explore and design the ASC team role to coordinate health and social care pathways on behalf of all City residents.
    b. Enable a whole-City view of residents through a Residents' Care Coordination team/mechanism ("air traffic control") for exchange of regular and up-dated information on City residents who are active recipients of health and/or social, including support commissioned from the Community and Voluntary Sector, and from local intelligence.
    c. To work with GP and provider partners to design and commission Care Navigation roles (x2) to provide 7 day support to the GP practices covering City of London residents.
    d. To ensure active ASC team engagement and participation in the Multi- Disciplinary Teams forming around relevant GP Practice clusters – preferably through named relationships.
    e. To ensure there are clear referral mechanisms in place for Royal London and UCL Hospitals Rapid Response and Discharge Management teams to enable admission avoidance and discharges from hospitals.

A proposed programme of work to take the recommendations forward to the implementation stage will now be developed for agreement among the partners.

1. Introduction

The City of London Corporation commissioned Tricordant to conduct a review of current health and social care provision for older residents within the City and to make recommendations on how this could become a more integrated service.

On the face of it the geography and population size of the City presents a significant opportunity to implement effective and efficient coordination of person-centred health and social care. It is recognised by all parties that care and support services are currently fragmented and that they should be organised around the service user regardless of organisational or professional boundaries.

The Corporation is required to work with a complex and wide range of commissioners and providers, for all of whom the City of London is a small proportion of their total business. The challenge of aligning these various partners to deliver integrated person-centred care is therefore equivalent to many large English Councils in terms of complexity if not of scale.

There is, however, agreement across partner organisations, in line with the pan-London work, that Integrated Care is the intended way of future working for partners within the City of London health and social care economy.

1.1. Project brief and aims

The project brief is to develop a City of London approach to Integrated Care.

The scope of the project is integrated care for vulnerable adults and older people with long term conditions or frailty. This would include mental health, end of life care and public health, and would also cover the support provided by the voluntary and community services sector. Learning disabilities are not included in the scope.

The scope does not include implementation of the final proposals, although it does include developing plans for partnership agreement at Chief Officer level to the final proposals.

Also included within the scope is to make recommendations on the job descriptions of the “in-reach” roles funded through the S256 monies.

The work of the project was carried out over 2 stages, as follows:

1. Stocktake to understand the current position.
2. Development of the “One City” model.

1.1.1 Stock take

The purpose of the stock-take was to inform development by identifying the current activity, patterns and pathways of care, gaps in service and the key initiatives and projects having (or having potential for) systemic impact across services or care pathways for adults with long-term conditions and frailty.

The stocktake takes account of work in the neighbouring Borough Councils and CCGs, particularly in relation to their Integrated Care Pioneer programmes, as well as the pre-existing stock take work done by Tricordant with City of London, the City and Hackney CCG and the Hackney partners.

1.1.2 Developing the One City model of Integrated Care

Following the stock take, the project has developed a bottom-up approach to delivery of Integrated Care for City of London residents, building on the existing infrastructure of the Corporation, Social Care and NHS Primary Care.

The continuing engagement of all key agencies will be critical in co-designing the finalised new model.

1.2. Project methodology

Stage 1 of the project was set up to obtain input from organisational stakeholders through both structured individual interviews and in system-wide workshops or focus groups. In the actual working out of the project, however, it proved difficult to achieve the necessary attendance at workshops, and therefore the majority of the diagnostic work was done through structured interviews. Focus groups were held with the Neaman Practice and the Adult Social Care team.

Stage 2 was initially designed to use a system-wide workshop to co-design the new model. This was not possible for the reasons outlined in the previous paragraph and therefore the majority of work has been done through the Tricordant team working in consultation with the project sponsor and Steering Group members.

1.3. Thank you

Tricordant recognise the support and contribution from the stakeholder organisations and their representatives involved in the project and on the project steering group. In particular we thank

Chris Pelham and Marion Willicome-Lang from the City of London who have acted as Project Sponsor and Project Manager on behalf of the Corporation

2. Context

2.1. About the City of London

The authors recognise much of the material in this report will be known to some readers through other key documents such as the Better Care Fund plan and Public Health profile reports, but the material is included here for completeness of understanding for those readers less familiar with the context and demography of the City of London.

The City of London Corporation has both the largest working and transient population and the smallest resident population in England and Wales which combine to create unique challenges and opportunities. As a local authority it has exactly the same statutory obligations as any other authority in England and Wales, most of which it does through its own organisation and some in partnership with near neighbours. The resident population is dwarfed by the estimated 360,000 workers and tourists who arrive and leave in the City on a daily basis.

An overview of the key facts of the City and its resident population is shown below with a more detailed review attached at Appendix 8.1.

- The City has a resident population of 7,380 people living in 4390 households giving an average household occupancy of 1.7 (Greater London is 2.5 with England/Wales at 2.4).
- Of the total population 1500 people (20%) are over the age of 60.
- The "White" population is 78.6% compared to GL at 59.8% and E/W and 86%.
- Private rented housing accounts for 36% of housing in the City.
- 56% of City residents claim to live in very good health with only 2% saying bad and 1% claiming to be very bad.
- In the Index of Multiple Deprivation the City of London is ranged 259 out of 326 local authorities making it in the 40% less deprived category (similar to the likes of Kingston, Bath, Warwick and Tonbridge) and is the second least deprived in London just behind Richmond.
- There are two distinct population areas to the City; the first being Barbican/Golden Lane and the second the Portsoken Ward around Mansell St/Middlesex St; both areas having their own distinctive situations and differing deprivation and health levels.
- The population of the City is expected to grow to around 10,000 by the year 2026 with the majority, numerically, of that growth being in the 20-64 age group.

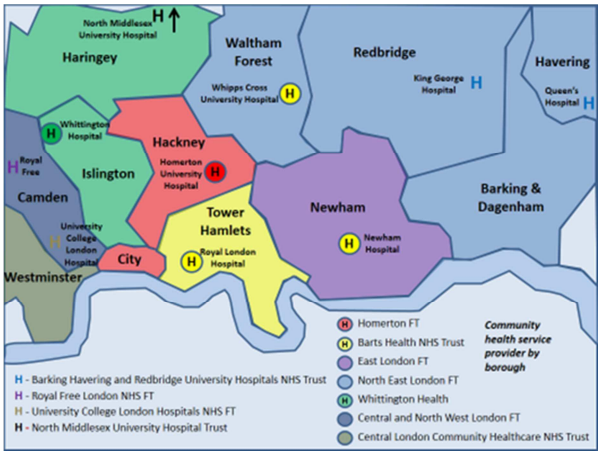
- Significant, however, is the growth in the 65+ age group which will see an over 40% growth in that segment from 1500 to 2170.

The data can be summarised as showing:

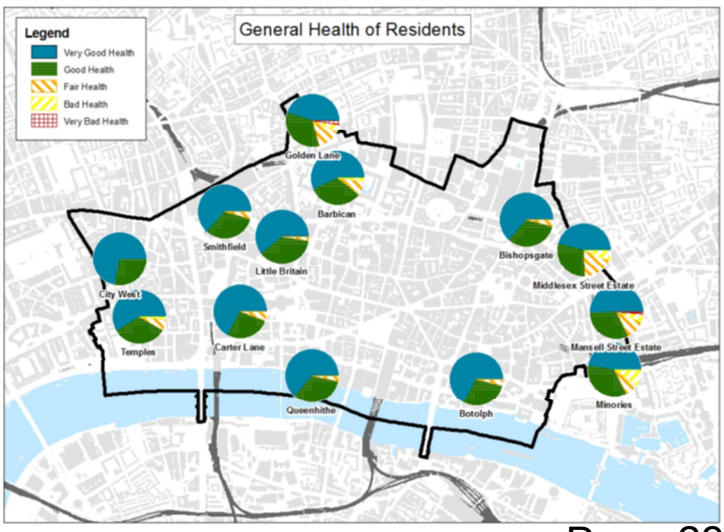
- Compared to the residents of neighbouring authorities, and nationally, those living in the City of London are less deprived, generally in better health and live longer.
- There are pockets of greater deprivation within the City, however this is relatively small and less severe than neighbours; nonetheless significant for those affected.
- Whilst the overall numbers are low, the elderly population of the City are a large proportion and a group that will grow significantly over the next decade.

2.2. Geography, health profile etc.

The City is bounded by the River Thames, the London Boroughs of Camden, Islington, Hackney and Tower Hamlets plus the City of Westminster; all of whom are significantly larger geographically and in terms of resident population and local authority financial budget. The City is however, home to the major financial institutions of the UK and is a world financial and trade centre. It has an incredible historical heritage, is a major tourist area and home of many national treasures. Nationally and internationally, the City of London has major importance.



The map below highlights the main areas of population within the City and shows the general state of health within each of these. Further detail is contained in the data report attached at Appendix 8.1.



Whilst the general picture of the City is one where the health, general wellbeing and life expectancy are much better than neighbouring authorities and, in most instances, the national picture there are small pockets of some concern. These areas around Golden Lane, Mansell St and Middlesex St are well known to the Corporation. However, the latter two

are served by GPs registered in Tower Hamlets CCG and there is some ambiguity contractually in terms of responsibility for CHS provision because of the PCT legacy contracts in place. This is a key area for resolution.

2.3. The Better Care Fund (BCF) and national drive for Integrated Care

The development and delivery of integrated health and social care is central to government plans and the requirements of the BCF have injected genuine financial incentives to move the debate beyond "good intentions". The levers for integration have been strengthened by the introduction of the BCF as a pooled budget overseen by the Health and Wellbeing Board to help drive integration. The pooled budget for the City of London is £819k for the year 2015/16; which compares to the budget of £20m for neighbours Hackney.

2.4. Complex system with lots of partners

The City of London is the only local authority in London who do not have a dedicated and co-terminous Clinical Commissioning Group (CCG) for healthcare services. Across the spectrum of healthcare services the City is dwarfed organisationally by large providers serving significantly larger residential populations, which makes relationship management difficult.

More positively the City team has very good working relationships with various agencies established to work in partnership with social services. There is also excellent and close working with a range of voluntary services both specific to the City and cross-boundary.

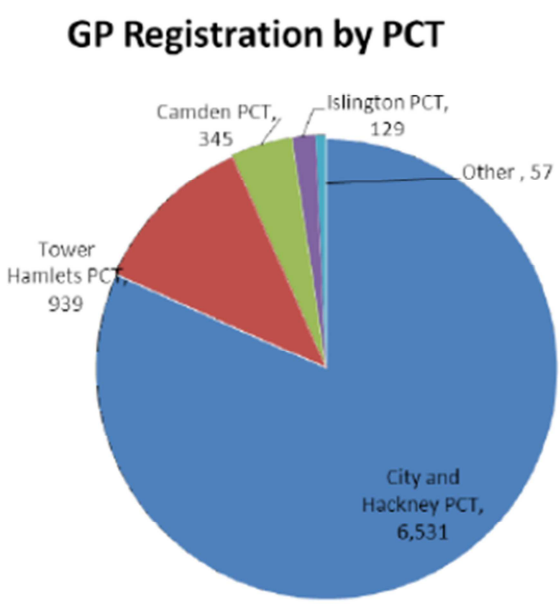
2.5. The partners providing services

Within the stocktake 22 major stakeholder partner organisations were identified and these are listed in Appendix 8.2 along with details of those people who were interviewed from each organisation. The Royal London in Whitechapel and UCLH in Euston are the two principal acute hospitals used by City residents, the former being commissioned by Tower Hamlets CCG and the latter by Camden CCG. The acute hospital commissioned by City and Hackney CCG is the Homerton which is quite some distance from most City residents and therefore rarely used by them.

2.6. GP practice distribution

The Neaman Practice, situated by the Barbican, is the only NHS GP practice based within the boundaries of the City of London and which is a member of City and Hackney CCG. There is one other

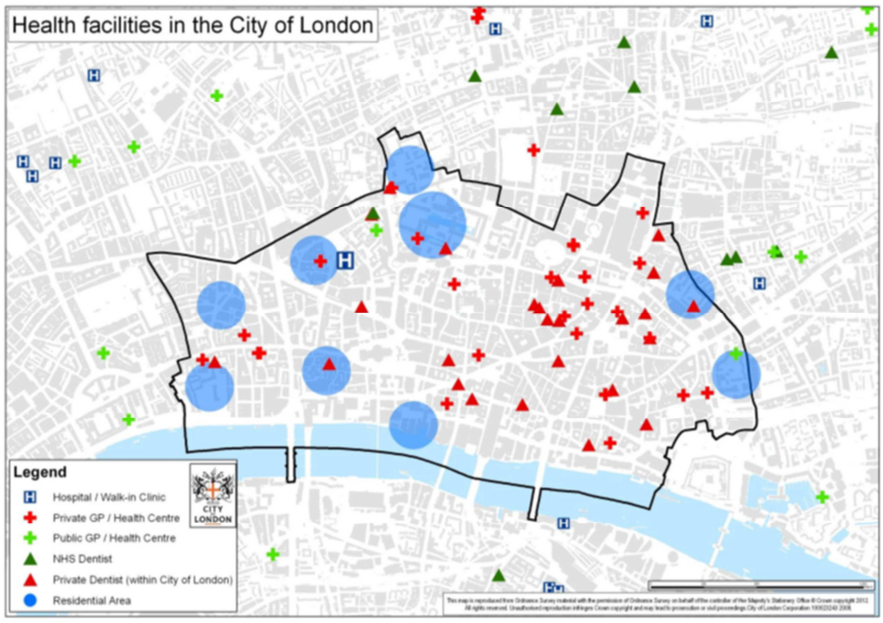
satellite surgery, named the "Green Box" due to being based in a green portable building. This surgery is a satellite of the City Wellbeing practice which is a member of Tower Hamlets CCG.



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

The table above shows the GP practices with the largest number of City Residents and the split by PCT (forerunner of the current CCGs). From this it can be seen that the Neaman Practice cares for the significant majority of City residents with 3 others having a reasonable minority with the remainder spread across a high number of practices across a range of neighbouring CCGs.



Within the City there are also 12 private GPs and this map shows the location of a range of health services across the City. Currently there is little or no relationship with private GPs or hospitals and this is a potential area of development within the new management model.

3. Diagnostic review

3.1. Data headlines

Appendix 8.1 contains a data report which highlights key data with regard to the population, housing, health, health and social care activity plus some data is used throughout the body of this report and in particular section 2. Some key headlines with regard to health and social care activity, however are:

- The number of emergency admissions to hospital is extremely low, estimated at 370 per annum (all ages) which is equivalent to 5% of total population. Hackney, by comparison has some 20,000 per annum equivalent to 8% of their population.
- The number of admissions classed as potentially avoidable is 39 per annum and the target is to reduce this to 10.
- Placements into residential care are down to 4 per annum with a target to further reduce to 3.
- Reablement is proving relatively successful with 86% of those discharged from hospital still at home after 91 days.
- There are approximately 80 open social care cases.

3.2. Data availability

We have been unable to obtain City of London activity data from provider stakeholders during the course of the project. This is not necessarily a sign of unwillingness but more of the "needle in a haystack" element where the level of activity for City residents is inversely proportionate to the effort for large providers to extract it. UCLH found some data that suggested they may have had 10 emergency admissions in one month which has to be taken against their 2,500 emergency admissions on average per month.

The numbers are such that it is a major task for the providers to find the data; however with planning and management agreement this could be managed in future through forward planning rather than retrospectively.

While it will be necessary to obtain accurate data to satisfy the BCF requirements in the future, the authors believe there are low-tech mechanisms that can have an early impact on the reality and experience of residents, such as care navigation and a live "air traffic control" operations board in the CoL ASC team to coordinate and pool local intelligence and knowledge about residents actively in the health and care system at any one time.

3.3. Quality of partnership engagement.

Amongst stakeholder organisations there is an understanding of the "dilemma" faced by the City; however the practical realities of busy large organisations and the day-to-day pressures of the senior managers within them has made quality engagement, with some honourable exceptions, difficult for this project. The difficult reality is that the City has not been seriously understood by the major provider organisations and has not been on their "strategic radar" for integrated health and social care prior to this project.

3.4. City of London team, agencies and voluntary services

The engagement issues generally faced with the large organisations (with the honourable exceptions) were diametrically opposite to the engagement with the Corporations own team and with those from commissioned agencies and the voluntary sector. These stakeholders were very willing to engage and very positive about working with the City both as an organisation and the individuals within where good relationship appear to have been developed.

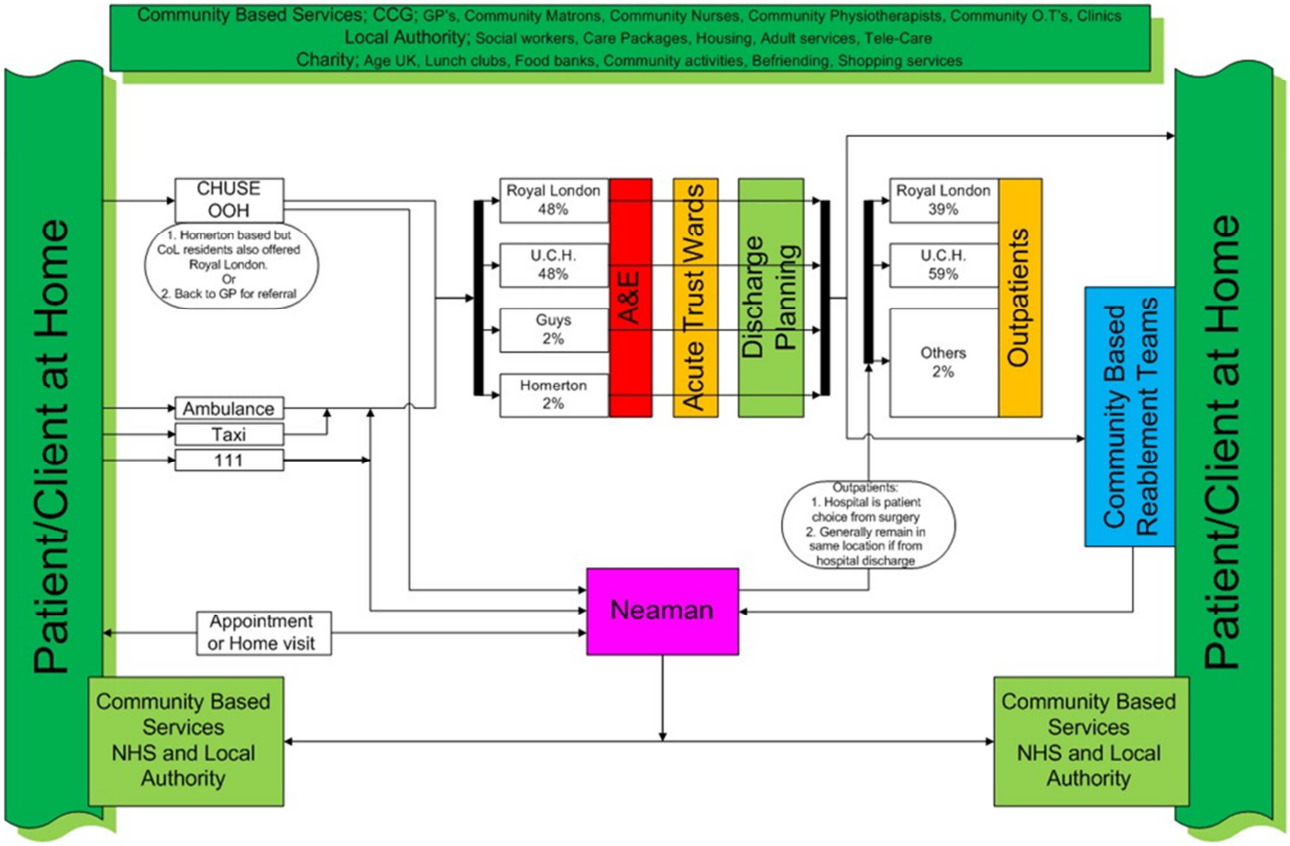
3.5. Complexity of pathways

The project team have been unable to meet with Tower Hamlets GPs despite requests, and therefore it was only possible to review patient pathways from a primary care perspective for those patients who are registered with the Neaman practice.

Technically we understand that HUHFT is commissioned to provide CHS to the whole of the City resident population through its legacy PCT contract. In practice we understand the community health services for residents registered with a Tower Hamlets GP are provided through the Tower Hamlets CCG commissioned contract provided by Barts Health.

The pathway map, below, highlights the key elements of the Neaman practice pathway and the organisations involved. Key factors to note are that UCH and Royal London are the two main acute hospitals for emergency admissions, both with roughly the same level of activity from the practice. The Homerton which is the acute hospital directly relating to and commissioned by City and Hackney CCG treat a very small proportion of patients; which will be single figures (around 5) per annum.

The new City and Hackney out of hours service (CHUSHE) is based from the Homerton hospital, however it is possible to have appointments booked through CHUSHE at the Royal London hospital.



The matrix diagram below captures the complicated nature of the current arrangements for typical patients with long term conditions as we understand them. The matrix illustrates both:

- The numbers of organisational hand-off points (which are the points where continuity of care and transfer of information are at highest risk).
- The uncertainty about responsibility for CHS provision particularly for Islington residents of the Neaman practice.

Provider Pathways: initial stocktake view for City of London

Profile – OVER 65	Residence	GP practice	ASC	CCG	CHS provider	Specialist community provider	Community geriatrician	Acute provider	MH provider
COPD	City	Neaman	City	City and Hackney	HUHFT	HUHFT	HUHFT	Barts or UCLH	ELFT
	Islington	Neaman	Islington	City and Hackney	HUHFT or North Central London FT?	HUHFT or North Central London FT?	HUHFT? HUHFT or North Central London FT?	Barts or UCLH	Camden and Islington MH FT
	City	Spitalfields	City	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts or UCLH	ELFT
	Tower Hamlets	Spitalfields	Tower Hamlets	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts Health	ELFT
Dementia	City	Neaman	City	City & Hackney	HUHFT	HUHFT	HUHFT	Barts or UCLH	ELFT
	Islington	Neaman	Islington	City and Hackney	HUHFT or North Central London FT?	HUHFT or North Central London FT?	HUHFT or North Central London FT?	Barts or UCLH	Camden and Islington MH FT
	City	Spitalfields	City	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts Health	ELFT
	Tower Hamlets	Spitalfields	Tower Hamlets	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts Health	ELFT
LTC regular admission	City	Neaman	City	City and Hackney	HUHFT	HUHFT	HUHFT	Barts or UCLH	ELFT
	Islington	Neaman	Islington	City and Hackney	HUHFT or North Central London FT?	HUHFT or North Central London FT?	HUHFT or North Central London FT?	Barts or UCLH	Camden and Islington FT
	City	Spitalfields	City	Tower Hamlets	Barts Health	Barts Health	Barts Health	Barts or UCLH	ELFT
	Tower Hamlets	Spitalfields	Tower Hamlets	Tower Hamlets	Barts Health CHS	Barts Health	Barts Health	Barts or UCLH	ELFT

3.6. What does and doesn't work well for the Neaman Practice

The Neaman practice focus group highlighted areas that worked well and some that didn't which are relevant to this project, the summary being:

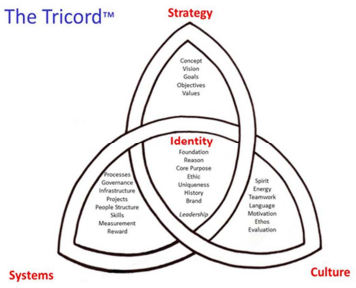
Works well:

- District nurse referrals to the practice and acknowledgements
- Very good relationships with St. Josephs hospice and palliative care team

Not so good:

- IT links to Royal London and UCH
- Communications from hospital to practice including discharge reports
- Patchy communications on A&E attendance and admissions
- Access and provision of Mental Health services to Islington residents
- Only see reports from community reablement teams at end of intervention period – different teams in different locations adds to the void of information
- Poor relationships with social services, no sense of team

3.7. Tricord analysis



Within the Tricordant methodology is the principle of viewing organisations or a work system/service in the context of a "Whole System" and to do this we take a TRICORD view based on the diagram opposite. The Tricord describes all aspects of an organisation that need to be aligned for the whole to be healthy. It is the alignment of the three outer domains of the Tricord acting in balance around the central core that is the source of organisational wholeness.

A Tricord analysis relating to this project was carried out by the Tricordant team and the results of this are detailed in Appendix 8.3. A high level summary of the analysis would conclude that whilst the City, and the Corporation, has a strong identity and culture, the lack of dedicated providers causes both strategic and system issues. Indeed, the most significant areas of "weakness" are in the systems domain where there would appear to be a need for the Corporation to apply their own "identity stamp" through a revised management model.

3.8. High level messages

Some clear high level messages come out of the diagnostic and data review, summarised as follows:

- Multiple organisations, multiple pathways, significant complexity and complication for the population.
- The provision of Community Health Services don't match acute hospital flows for patients.
- City residents are only ever a minority consideration for other organisations.
- 4 CCGs commission services for City of London residents – but principally City and Hackney and Tower Hamlets CCGs.
- There are 3 major sub-systems for City residents in terms of community –based health services:
    - Mental Health – established and seems to be functioning well.
    - Tower Hamlets Integrated Care programme (WELC) – established
    - City and Hackney Integrated Care programme – developing
- Issues for the Corporation are not completely the same as for the Neaman practice – there is a significant complication for the Neaman practice of Islington residents and yet another sub-system – impacts such as MH Crisis Response and provision of Community Health Services.
- However, the sub-systems are all being built on similar principles for Integrated Care.
- There is no single "owner" or coordinator for current health and social care delivery, provision (or commissioning) for all City residents.

- Absence of comprehensive City-resident based information makes analysis difficult – but available data shows small numbers of social care cases, hospital admissions and delayed discharges.
- There is potential for ASC team integration into established and emerging GP practice/cluster MDT arrangements.
- Confusion around provision of Community Health Services for resident or registered populations (this is a legacy of NHS changes to commissioning arrangements and is a Clinical Governance risk).
- Some real assets in voluntary sector.
- Compared to the residents of neighbouring authorities, and nationally, those living in the City of London are less deprived, generally in better health and live longer.
- The projected growth of 65+ age group in next decade when taken with the number of older people living alone poses a significant challenge for the Corporation.
- Need to balance desire to have distinct City identity with established and emerging macro-systems from CCGs and NHS Providers.

4. What the service users and stakeholders say

During the development of the BCF submission the City undertook a consultation event with Healthwatch which produced some clear resident comments and desires in terms of improvements to health and social care. A copy of the report is attached at Appendix 8.4. In general feedback from the event was very positive, however requests for improvement were highlighted as:

- Seamless services without gaps in provision or in the knowledge of people's issues, or delays in providing support or equipment.
- A single named professional to help co-ordinate care at home or on discharge from hospital, and to help navigate through services.
- Information and records to be readily available to, and shared between, health and social care professionals.
- Better communication between services such as GPs and hospitals – especially when being discharged home.
- More individualised support, advice and information for carers - such as helplines, support groups, respite breaks and practical help.
- Services available around the clock.
- A "well-being MOT" to assess needs and the support needed to stay well.
- Support to avoid and tackle social isolation.

- Hospital discharge that is timely, has care in place whatever the day or time leaving hospital, and is not delayed by waits for medication or transport.

5. Current and planned services

This section describes in outline the current organisation and responsibilities for health and care services in the City of London. At Appendix 8.5 the provider matrix diagram was an early stocktake view of some of the system complexities. Whilst this is not, necessarily, totally accurate or up to date it does to a great extent reflect the realities and serves to act as an illustration.

5.1. GP practices

GP practices are now commissioned by NHS England and not by CCGs. The new Chief Executive of NHS England has recently invited CCGS to express an interest in co-commissioning primary care, and therefore there is scope for commissioning arrangements to change in the near future.

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, where residents 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. The out-posted service is commissioned by NHS England.

5.2. Emergency and elective hospital care

City residents are served primarily by the Royal London and University College Hospitals for their emergency and non-emergency hospital services. There are relatively few admissions to the Homerton Hospital for either emergency or elective are.

Hospital services are commissioned by lead CCGs within London. Barts Health by a consortium including Tower Hamlets, Newham and Waltham Forest, UCLH by Camden CCG and the Homerton by City and Hackney CCG.

The London Ambulance Service will despatch the closest ambulance to an incident rather than from a specific Ambulance station. Ambulances will take patients to the nearest available A&E, which could be either Royal London or UCLH.

The designation of Barts Health as a centre for trauma, stroke and heart conditions means that City residents with these conditions will increasingly flow to Barts Health and consolidate the acute hospital flow pattern.

5.3. Community services

Community Health Services (CHS) are commissioned by CCGs, technically for their resident populations, but provision in the City is currently complicated by the recent organisational changes in NHS Commissioning. The current contracts for providers with both HUHFT and Barts Health are legacy contracts from the Primary Care Trusts and are due for re-contracting with the CCGs in both City and Hackney and Tower Hamlets.

The HUHFT contract technically covers all City of London residents, but in reality covers the City residents of the Neaman practice and not the City residents registered with other GP practices outside the City boundaries. We understand the Barts Health CHS provider follows 2 specifications – one covering the Tower Hamlets Borough boundaries and the second covering the cross-boundary and historic "knock-for-knock" arrangements between the PCTs. Under the cross-boundary agreement the Trust provides CHS for the City residents registered with Tower Hamlets GPs.

A complication with CHS for City residents is that the in-reach admission avoidance and rapid response team from Barts Health will assess City residents in the Royal London A&E registered with Tower Hamlets GPs, but not City residents registered with GP practices in other CCGs.

In interviews representatives of Barts Health have confirmed that their Integrated Care programme, which commenced roll-out in October 2013, covers the GP registered population and therefore includes City residents with Tower Hamlets GP practices. The opportunity of CHS re-commissioning in 2015 alongside Integrated Care programme development potentially allows the re-alignment of CHS support to GP practices serving the City.

5.4. Adult and Older Peoples Mental Health

Adult and Older Peoples Mental Health Services are provided to City residents by the East London Foundation Trust and are commissioned by City and Hackney CCG. The arrangements are well established and are reported to work well from the standpoint of both the Corporation ASC team and

the Neaman practice. The ELFT footprint covering multiple CCGs helps avoid the complications created by the differing NHS and Local Authority commissioning responsibilities for registered and resident populations respectively.

The complication for the Neaman practice is that Mental Health Services for the adults and older people who live in Islington are provided by the Islington and Camden NHS Foundation Trust, which operates a different model of care to their counterparts in ELFT.

5.5. Adult Social Care

The City of London operate an in-house adult social care team to fulfil their statutory obligations. Comments via Healthwatch and commissioned agencies say that the service is generally high quality.

Reablement is a key feature of the ASC offering to residents and is used as a preventative measure as well as post hospital discharge. It is a small but effective, if expensive, service costing just under £200k including OT, for the City as a result of being delivered through a mix of in-house staff and commissioned agencies who handle "out of hours" care in evenings and weekends.

An understandable decision was made by the City not to use the City and Hackney intermediate care service, including reablement as part of the City and Hackney RICS review; however it is proposed that this be reviewed as the new model develops because reablement is a critical element of intermediate care and is increasingly integrating with rapid response services around the country.

Within the new model it may be more appropriate and resilient for the ASC team within the City to commission, manage and coordinate intermediate care rather than being the provider.

5.6. Voluntary services

The City work with a good range of voluntary services with whom they have extremely good relationships. Voluntary services are a key part of the overall social care system within the City, providing services to those with "moderate" needs. There is a significant foundation in place to further develop these services and there is a willingness within the sector to work on this with the City.

In addition to service provision, the voluntary sector also provide excellent communication pathways to advise residents of appropriate services and in particular the links in through residents group and local housing management teams. The work of the Penderel Trust in helping residents maximise personal budgets is another notable service provided by the City to their residents which provides a range of further development opportunities within a new model of care.

6. Key opportunities in developing the One City model

Here we describe the current and planned health and care services that will have a systemic impact on the development and delivery of Integrated Care in the City of London.

The purpose here is to identify the opportunities that help create the architecture of the One City model and align the key aims of the BCF submission with the emerging plans to help shape the next stage of planning and implementation of the model

CHS re-commissioning in 2015 in both C&H and TH presents a major opportunity to re-align CHS support to GP practices serving City residents.

6.1. Better Care Fund key aims

The ambition of the City of London BCF application is to create a locality working model for the City "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'"

The key components of the system are described as:

- Preventative support through reablement and through services within the community.
- Case management for the frail elderly
- Practice-based coordinated care.
- Joint Care Navigation.
- Risk stratification of vulnerable older people.
- Supporting Carers.
- Integrated data sharing.
- A "One City Team" to provide rapid response and assessment and clinical support to prevent admission to hospital for up to 72 hours.
- The rapid response team will link in closely with the PARADOC service that is being piloted by City & Hackney CCG and covers the City of London boundaries.

6.2. Community Health Services re-commissioning

In section 5.3 we described how the current configuration of community health services is shaped by the legacy contracts currently in place from the previous PCTs.

There are 2 relevant re-procurements due in 2015:

- City and Hackney CCG.
- Tower Hamlets CCG.

The CHS re-procurements offer 2 opportunities:

- To address the current clinical governance and quality risks in the legacy CHS contracts so that grey areas across local government boundaries are resolved. In terms of provider responsibilities.
- To consider the optimum alignment of CHS with the Neaman practice, taking account of acute hospital flows and the developing Integrated Care programmes.

6.3. Integrated Care Programmes

There are 2 major Integrated Care programmes impacting City of London residents, 2 of which are among the 14 national Pioneer programmes:

- City and Hackney. The programme is in development, with pilots being planned.
- Waltham Forest, East London and City (WELC), which includes Tower Hamlets. The programme is managed by Barts Health, it is one the national Pioneers and is in the second year of implementation.

Effectively these services are being set up by the larger neighbouring systems, of which different parts of the City are sub-systems, and therefore the challenge to the Corporation is how to join in these sub0systems most effectively.

6.3.1 What does good looks like in Integrated Care?

The 2 key Integrated Care programmes of interest to City residents, while different in timing and stages of development, fundamentally share the same characteristics and components to address the ambitions of the City Better Care Fund application. There is an increasingly strong evidence-base to support the interventions

These include:

- Self-care
- Risk profiling to identify the most vulnerable older people in the population.
- Care planning with GPs as nominated clinicians.
- GP Practice-based coordinated care.

- Case management and Single Points of Access for the vulnerable elderly
- Rapid response and discharge management teams.
- Reablement and Intermediate care aligned with rapid response services.
- Specialist support in the community (e.g. Community Geriatrics)
- Specific interventions such as the RAID model in Adult and Older People.

It is also notable that populations in the order of 30,000 to 50,000[1] appear to be the common size for a locality team in the new approach to Integrated Care, significantly larger than the City of London. To be economically viable therefore the One City approach will need to be part of a larger Integrated Care system.

One of the conclusions of this review is that, if the One City model is to be an effective sub-system of a larger Integrated Care model, serious consideration must be given to the options available to simplify pathways and organisational relationships for patients.

6.3.2 City and Hackney

A final draft specification for the Practice Based Integrated Care Pilot in City and Hackney has been sent to the provider community in City and Hackney to invite participation. The pilot has £2m funding from the CCG each year for 2 years 2014-6.

The CCG has committed to involving the City and Hackney Local Authority Commissioners to review the proposals and expect to make a decision no later than the end of May.

Practice based integrated care is a core element of City and Hackney's Better Care Fund Strategy to 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 to co-ordinate care for these patients. This non recurrent CCG funding is to pump prime services which may then be commissioned further as part of the Better Care Fund

The Integrated Care Pilot will focus on frail elderly patients, estimated to represent 20% of local people aged over 75 years.

This integrated care pilot spans three key elements:

- **Patient identification** - comprises risk stratification and enrolling patients
- **Patient management** - comprises creating care plans, running multi-disciplinary case conferences, care co-ordination and care plan implementation

[1] Nigel Edwards, Community Care and the Cost Conundrum, Health Service Journal, 2 May 2014.

- **Supportive measures** - comprise facilitation and training the multi-disciplinary team.

Within the cohort of patients, each patient will have

- An individualised care plan updated fully every year, and reviewed regularly, particularly after any Unscheduled contact with health or social care
- Regular scheduled home visits quarterly which are funded by the CCG contract for vulnerable patients and home visiting
- A responsible named doctor and named nurse who will ensure continuity of care is maintained.
- Via the Cquin Homerton is commissioned to ensure care plans are amended and reviewed as part of any hospital stay and changes communicated to the patient and the registered GP

The City and Hackney Integrated Care Pilot will use individual patient focussed case conferences and Quadrant-based case co-ordination; these are summarised below.

Practice-Based Case Conferences

- Practices will use these case conferences for in-depth case discussions and facilitating the care co-ordination and case management of patients in the scheme.
- They will occur monthly.
- The team will comprise: General Practitioners, Community Matrons and District Nurses, with attendance from other integrated care providers when necessary.
- Funding for GP time to participate in practice based case conferences is funded via the CCG Vulnerable Persons contract.
- GP Practices will be grouped into 4 separate geographical quadrants of c 10 practices per quadrant
- The providers to deliver a multi-agency integrated care team for each quadrant who will provide care to patients on the registered lists of the practices in each quadrant.
- The integrated care team should consist of General Practitioners, Community matron, District Nurse, Mental Health workers, Social Worker, Specialist Nurses, Intermediate Care Therapists, Geriatrician
- Under the model we expect there to be at least one quadrant coordination meeting per quarter
- The specification states that a specific response to meet the needs of the Neaman Practice/City of London is expected from providers in the pilot.

Crisis Response

A key component of this pilot will be to ensure that these patients receive an appropriate out of hospital clinical response at times of crisis rather than an automatic conveyance to A&E. It is essential that the RICS staff are members of the multi-disciplinary team and that the crisis plans developed in the practice meetings are conveyed and communicated to the rapid response team as well as other urgent care services (e.g. LAS and GP OOH).

See Appendix 8.8 for proposed pathway for frail elderly.

6.3.3 WELC programme (commissioned from Barts Health)

The IC Programme in 2 stages, the first of which went live in October 2013.

In Tower Hamlets there are 8 GP Networks, each having a locality MDT, which are planned to be co-located over the next 3 months. The locality teams included specialist input, concluding Community Geriatrics.

City residents registered with Tower Hamlets GP practices are covered by these arrangements. The Spitalfields practice is in Zone 2 with City Wellbeing (which runs the Portsoken Greenbox) in Zone 3.

Stage 1 (year 1)

- Risk profiling (Q Admissions tool) is live and creates flags in the GP and CHS systems (both EMIS), the GP out of hours (Adastra) and ASC Framework I systems. There are plans to join connect in the Mental Health and acute hospital systems via the Orion portal.
- GPs are remunerated and incentivised by the Network Incentivisation Scheme (NIS). This includes mandatory NIS coverage of Palliative Care, Dementia and Heart Failure.
- Network Community Health Teams have
    - District Nurses
    - Community Matrons
    - Physios
    - OT
    - SLT
    - linked MH workers and Palliative care from St Josephs
    - Case coordinators Band 5 and Band 4 attached to each MDT (job descriptions in appendix 8.6)
- There is a Single Assessment Process in the Community Health Teams.

Stage 2 (year 2)

- Alignment with reablement, Mental Health and 3rd sector.
- Rolling out case finding through predictive risk profiling to the next tranche of population.

6.4. Care Navigation

Funding has been secured by the City of London for 18 months for the creation of 2 posts which will have responsibility for coordinating services for 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. The two posts will be pivotal in supporting the multidisciplinary teams and in supporting Care Planning meetings led by the GPs. They will also have responsibility for facilitating discharge for residents from hospitals outside the CCG area. The posts can be central to establishing the Residents Coordinated Care function within CoL. These posts will be recruited to in 2014/15 in order to effect a smooth transition to integrated service delivery in 2015/16.

Research undertaken by Age UK in Kensington and Chelsea demonstrates 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 this context.

While care coordination roles in the Integrated Care teams will focus on the 1-5% most vulnerable older people, Care Navigation roles have potential to cover all patients and take a much broader view. They are well established and evaluated roles in several parts of the country. Sample documentation, evaluation and sample job descriptions are attached at Appendix 8.7

A meeting with Age UK has been arranged to discuss the potential role, and it is recommended that the Integrated Care providers then be engaged to help refine the role in order that it can complement and best fit with the work of Care coordinators as they develop.

6.5. Care planning and named GP responsibility

Through the Vulnerable People's LES contract the City and Hackney CCG 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.

The goal is for each vulnerable patient to have: (a) an individual care plan; (b) regular scheduled home visits, which typically will occur quarterly and (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.

6.6. Paradoc in City and Hackney

This GP and Paramedic fast response service pilot started on 28 March and is based out of the Homerton Ambulance Station, operating 7 days a week from 12pm to midnight.

This service is available to all City of London residents.

6.7. Public Health

Public Health services play a vital role in the maintenance of good health and the prevention of disease. The full range of Public Health commissioned contracts are under review.

Potentially relevant contracts include

Most contracts joint with Hackney, but several are City only contracts:

- Smoking Cessation – level 2 service through 15 Boots pharmacies. There are 16 pharmacies in City in total. 180k pa
- Smoking cessation [level 3] Queen Mary Hospital. 52k pa.
- Exercise referral programme with Fusion Lifestyles – 37k. Accessed via Social Prescribing via GP.
    - Neaman practice over target on referrals.
    - Working with TH re access for TH GP registered City-resident patients.

- Community Health Engagement Coordinator in Portsoken Ward. Operates out of Portsoken Health and Community Centre. Employed by Toynbee Hall. Supports Bengali women accessing exercise and diet advice. Police run boxing classes for youth.
- NHS Health Checks.
    - Neaman practice contracted through Hackney.
    - City contracts with 2 Pharmacies – 1 Boots, 1 independent.
    - TLC target vulnerable and hard to reach adults. Trained in brief interventions for alcohol and obesity.

- Jointly commissioned with Hackney
    - Obesity management [Boots plus independent pharmacy]
    - Time Credit system, provided by Spice. Want to extend into Portsoken.

- Carers service – mainly respite care through Age UK Camden
- City 50+ - Toynbee Hall.
- Dementia programme- dementia friendly café
- Supported living – residential placements, with wide range of values.
- City Wellbeing Practice operates 2 half days out of Portsoken Health and Community Centre – TH GPs.
- Dentistry – Dental Health Promotion about to be reviewed and will include older people – has been mainly focussed on children to date.

6.8. Telecare, to include telehealth

Telecare and telehealth are proven interventions to support vulnerable people to live independently and we understand tenders are being invited by the Corporation for these services.

There is opportunity to develop a clear strategy for aligned telecare and telehealth with partners.

6.9. Adult and Older Peoples Mental Health

The City and Hackney CCG plans 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.

The City has a Dementia strategy with a City-specific approach to caring for residents and tapping into the strengths of the community.

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.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 use.

6.10. Livery companies

The livery companies are a unique feature of the City of London and support local charitable activities and they also provide alms housing. We are aware of Livery Company contributions to primary care developments in Tower Hamlets and note the opportunity for their continuing engagement in the development of the health and support system.

7. Developing the "One City" model

7.1. Whole System model map

In order to represent the complexity of the current system visually and illustrate how it can be made less complicated we have developed the model in figure 1.

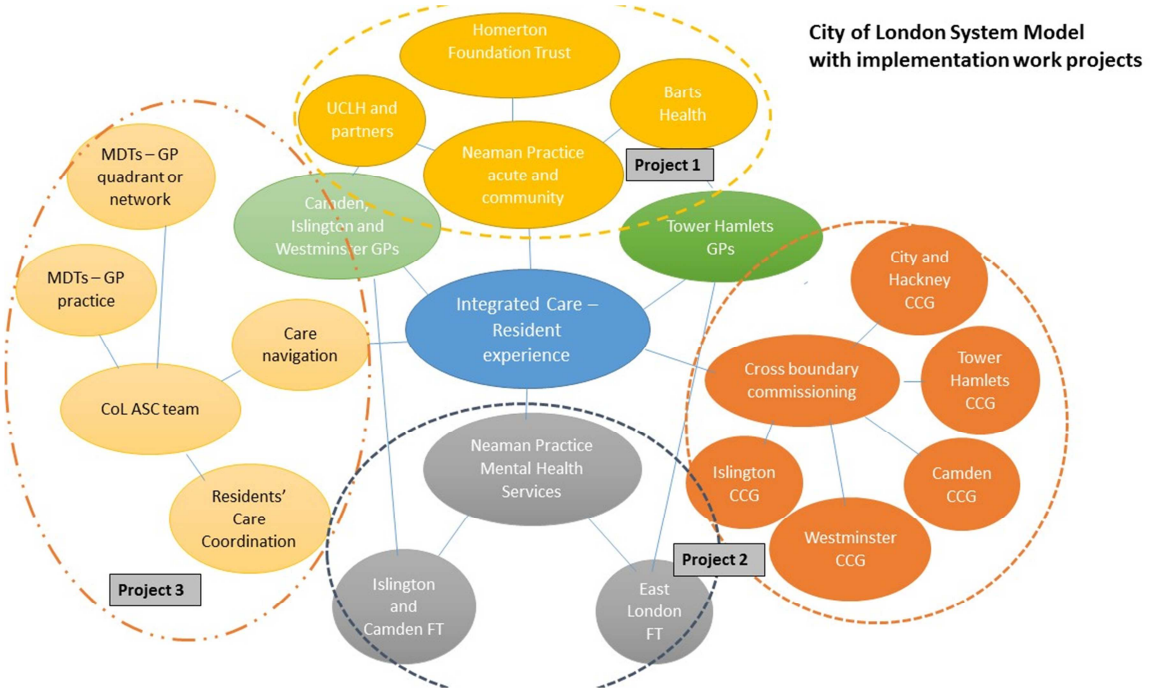


Figure 1

The model highlights four areas where component improvements in the system can combine to deliver improved experience in health and social care for the residents of the City of London. Depending on place of residence and registered GP practice certain components of the system will be delivered differently. The proposed model can operate as a managed system which:

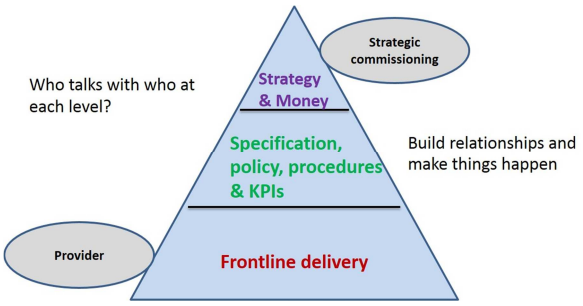
- Reduces the potential for organisational "fault lines", where the system risk is highest for patients and residents.
- Creates an explicit role for the City of London ASC team to coordinate the experience of residents through "air traffic control".

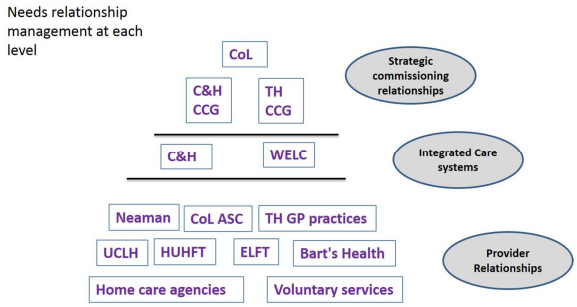
  Clarifies accountabilities across boundaries for the commissioning and delivery of health care.

7.2. Developing and managing relationships

A key to successful development of the "One City" model will be in the development and ongoing management of relationships with other organisations. These relationships will need to happen at levels of the organisations with the appropriate people held responsible for these key relationships. The management model of care depends on high quality personal relationships.

The two following diagrams illustrate the need to be clear on the named individuals who will work with their peers at each level and also the major organisations within each of the levels. The resourcing issue will need to be assessed through the proposed workstream 3 focussing on the role and shape of the ASC team.





In effect these diagrams illustrate how the "One City" model needs building on the foundation of relationships in commissioning, service specification and provision through clear multi-level peer to peer relationships. The knowledge of who is responsible for what and the holding to account for the delivery of the agreements is critical to making the model work.

7.3. The single point of knowledge

Within most integrated care systems there has been created a "Single Point of Access" or a "Single Point of Referral" which, depending on the specific model, is the one place all professionals can contact to seek guidance or effect a smooth patient handover to the next service.

Single Points of Access are being established in the wider Integrated Care systems which will impact on City of London residents. Therefore aiming to create a Single Point of Access in the City risks duplicating or not joining with the emerging systems.

There is however a clear gap in the system where currently no-one holds the ring or coordinates the "on the ground" intelligence and information about City residents who are actively engaged in the health and/or care system. The review has identified the gaps already in information availability between organisations, and these information transfer issues are clear fault lines in the system where handovers and speedy movement to the next stage of a pathway is essential for residents' experience of joined-up care.

We call this a "single point of knowledge" which is likened to air traffic control or ward rounds. It is a single point of coordination (or operation room) where the team will know, based on local intelligence gathered from multiple sources, who is in the system, where they are, what they are waiting for and what is planned for the next steps. It can operate as a low-tech system (such as a whiteboard in a confidential and secure area) where the next steps are not dependent on electronic data transfer between organisations.

Care Navigators are envisaged as the coordinators of the "air traffic control" and will ensure the smooth transitions and handovers with the appropriate teams in the sub-systems. Whilst this may benefit from integrated IT systems in the long run, it will need little more than good staff with pen and paper/white board to become very effective in the immediate term.

7.4. Delivering the points raised through Healthwatch

In section 4 we mention the issues raised at the Healthwatch event in December. We believe the recommendations and emerging services identified in this report will allow the City of London health and care system to respond to these points in the short and medium terms.

The key priorities were:

- Clear pathway and system, including hospital discharge, for each patient managed by a care navigator.
- Both C&H and TH CCG integrated care plans involve 7 day working, named professionals and 3 monthly home visits and MDT for all over 75s.
- Single point of knowledge combined with improved IT systems will allow better appropriate transfer of client data.
- Further development of voluntary services to deliver even better communication, resident/carer support and mechanisms to combat social isolation.
- Health MOTs starting to be delivered through Public Health commissioned Health Checks.

7.5. Summary and recommendations

A One City Model to deliver best quality of experience for every City resident will recognise the choices residents make about where to receive their care, and will focus on the organisation arrangements best suited in the short and longer terms to deliver the experience of integrated care.

The proposed model is rooted in the current reality, and will build on the foundations of the current and emergent patterns of service.

It will be important to satisfy competition rules and organisational legal powers in terms of any proposed changes to current arrangements and therefore much of the emphasis on next steps is around process to reach the right solutions.

The whole system model illustrated and outlined in section 7 of this report is feasible and deliverable through a work programme comprising 3 workstreams as follows:

1. To conduct an options appraisal with the Neaman practice and the City and Hackney CCG, working with providers, on the options for community health services and Integrated Care support to the Practice, in order to inform CHS commissioning for the Neaman practice in 2015/16.
2. In partnership with neighbouring CCGs in Tower Hamlets and Islington:
    a. To develop the commissioning case for realignment of Community and Adult/OPMH Mental Health Services in support of the Neaman practice.
    b. To address the "grey areas" of cross- LA boundary commissioning and clinical governance risk caused inadvertently by PCT legacy contracts for Community Health Services.
    c. To explore with the City and Hackney CCG the designation of a City of London Health commissioning resource to align specifically with arrangements for CoL residents.
3. To review and align arrangements in the CoL ASC team to:
    a. Explore and design the ASC team role to coordinate health and social care pathways on behalf of all City residents.
    b. Enable a whole-City view of residents through a Residents' Care Coordination team/mechanism ("air traffic control") for exchange of regular and up-dated information on City residents who are active recipients of health and/or social, including support commissioned from the Community and Voluntary Sector, and from local intelligence.
    c. To work with GP and provider partners to design and commission Care Navigation roles (x2) to provide 7 day support to the GP practices covering City of London residents.
    d. To ensure active ASC team engagement and participation in the Multi- Disciplinary Teams forming around relevant GP Practice clusters – preferably through named relationships.
    e. To ensure there are clear referral mechanisms in place for Royal London and UCL Hospitals Rapid Response and Discharge Management teams to enable admission avoidance and discharges from hospitals.

A proposed programme of work to take the recommendations forward to the implementation stage will now be developed for agreement among the partners.

8. Appendices

8.1. Data Report

CoL final report - data section v2.pdf

8.2. Stakeholder list and interviews

CoL Stakeholder and Interview List fo

8.3. Tricord analysis

CoL Tricord Summary for Report

8.4. Healthwatch consultation event

2013.12.12 BCF consultation event s

8.5. Provider matrix diagram

Matrix diagram for report.pptx

8.6. Care coordinators – Barts Health

Care Coordinator Band 4.docx

8.7. Care Navigators

K&C Primary Care Navigators 2012 201

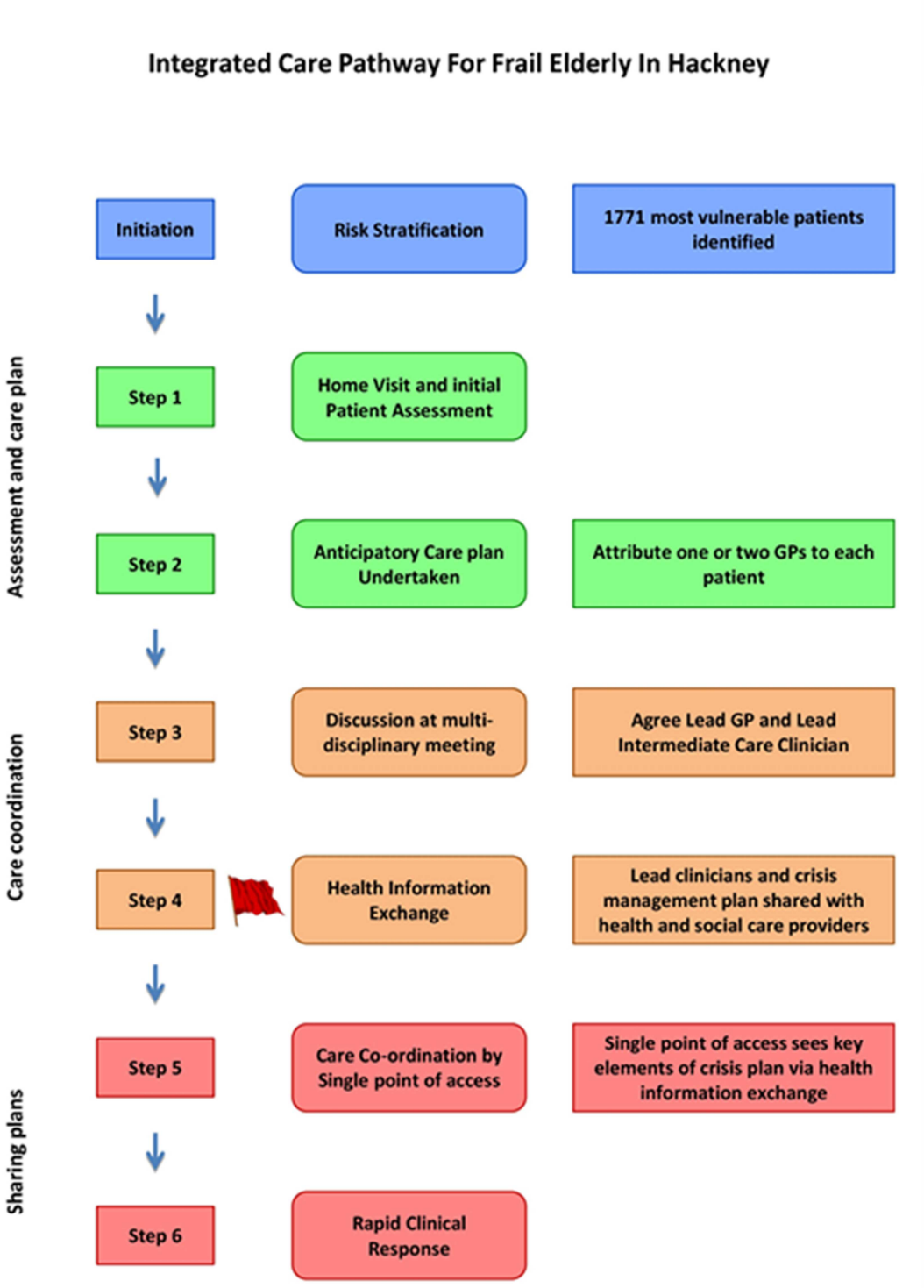
care navigator - Age UK IoW.docx

Care-Navigator-Job -description-.doc

care_navigator Yorkshire and Humb

care navigator - job description pack.do

8.8. Proposed City and Hackney IC pathway



Committee(s):	Date(s):
Licensing Committee Health and Wellbeing Board - For information Court of Common Council - For decision	28 April 2014 30 May 2014 12 June 2014
Subject: Introduction of the Late Night Levy in the City of London	Public
Report of: Director Markets and Consumer Protection	

Summary

The Police Reform and Social Responsibility Act 2011 introduced the power for licensing authorities to impose a Late Night Levy. Within the legislation there is a requirement to consult on various matters relating to a proposed levy prior to its introduction. Members were informed of the proposed consultation process in a report to the Licensing Committee on 14 January 2013.

The City Corporation has now consulted on introducing such a levy with, amongst others, those persons licensed to sell alcohol after mid-night, licensing solicitors/barristers, Members, all other premises licensed to sell alcohol and relevant trade associations. This report details the results of the consultation and the option to adopt the Late Night Levy.

Recommendations

It is recommended that:

1. Your Committee decides whether or not it would be desirable to apply the Late Night Levy in the City of London
2. In the event that your Committee is of the view that the Late Night Levy should be applied to the City of London, to recommend to the Court of Common Council the adoption of the Late Night Levy to be applied across the City of London to commence on the 1 October 2014 with the late night supply period set from 00:01 to 06:00 to all premises licensed to supply alcohol

and, subject to agreement of the above recommendation, Committee recommends the Court of Common Council to agree that:

a. A reduction in the Levy of 30% be granted to premises operating between 00:01 and 06:00 where the premises have shown that they operate at the standard required to achieve the City of London

Safety Thirst award;

b. The proportion of the net amount of the levy revenue to be paid to the City of London Police is 70%;

c. The final allocation of that portion of the levy to be used by the City Corporation to be decided by the Chairman and Deputy Chairman of the Licensing Committee in consultation with the Director of Markets and Consumer Protection;

d. An annual review of the operation and effect of the levy be carried out and reported to the Licensing Committee.

Main Report

Background

1. The City of London is the world's leading international financial and related business services centre. Whilst primarily a business district, the City of London has an expanding night life which is enjoyed by many thousands of residents and visitors.

2. The number of late night premises is high with around 290 premises licensed to sell alcohol after midnight. The costs of policing the late night economy are substantial.

3. The City Corporation is engaged in active partnership working with its licensed premises to ensure high standards of management that will prevent public nuisance. This includes active participation in 'Pubwatch', 'Hotel Forum' and its own Safety Thirst awards scheme and Code of Good Practice. These successful activities have continued to produce positive results.

4. There is a strong working partnership with the City of London Police with the police licensing team co-located on the same floor as the City Corporation's licensing team.

5. Despite this engagement and the standards that are being achieved, the City of London still continues to have levels of alcohol related crime which remain a key priority for the City of London Police to address going forward into 2014/15. Details of the crime statistics can be seen in Appendix 1. Although these figures may seem low compared to the rest of London, they still result in considerable time and expense ensuring that the vast majority of people wishing to enjoy the City of London late at night without causing trouble can do so safely.

6. The crime statistics reported in Appendix 1, with the exception of dealing with persons who are drunk and disorderly, are recordable crimes and do not include all incidents. The Police respond over a typical weekend to approximately ten calls requesting officer assistance that do not ordinarily end as recordable crimes.

7. The levels of anti-social behaviour and public nuisance associated with alcohol, and the difficulties in addressing it with limited policing, has led the City Corporation to pilot the use of a shared service with Westminster City Council Noise Team for dealing with noise including public nuisance issues. The pilot has been reviewed and a faster response time and presence within the City has meant this has been substantially brought back in house from April 2014.

8. The Police Reform and Social Responsibility Act 2011 (PRSRA) introduced the power for licensing authorities to impose a Late Night Levy (the levy) on the whole of their area. The levy enables licensing authorities to raise a contribution from late-opening alcohol suppliers towards policing the night-time economy.

9. The licensing authority can choose the period during which the levy applies every night, between midnight and 6am, and decide what statutory exemptions and reductions should apply.

10. The aim of the levy is to empower local areas to charge businesses that supply alcohol late into the night for the extra enforcement costs that the night-time economy generates for police and licensing authorities. The rationale behind this is that the Government in The Coalition Agreement included the commitment to permit local councils to charge more for late night licences to pay for additional policing. The Government consider it right that businesses which profit by selling alcohol in the night-time economy should contribute towards these costs, rather than relying on other taxpayers in the community to bear the full costs.

11. The licensing authority must consult prior to the introduction of a late night levy and any decision relating to the permitted exemption or reduction categories, the size of the specified proportion, and the period which is to apply to the levy. The consultation commenced on 26 February 2014 and finished on 8 April 2014. A copy of the consultation document can be seen as Appendix 1. The consultation was advertised in the local press and was available either to download from our website or to complete online. All licensed premises were informed of the consultation. A previous consultation exercise was held in 2013 but, having taken legal advice, the decision was taken to run a fresh consultation exercise.

Adopting the levy

12. The amount of the levy is prescribed nationally and is based on the premises rateable value. The annual charges for the levy, and weekly equivalent, will be:

Rateable Value (£)	Rateable Band	Amount of Levy (£)	
		Annual Levy	Weekly Equivalent
0 – 4,300	A	299	5.75
4,301 – 33,000	B	768	14.77
33,301 – 87,000	C	1,259	24.21
87,001 – 125,000	D	1,365 (2,730*)	26.25 (52.50*)
125,001 +	E	1,493 (4,440*)	28.71 (85.39*)

* Where a multiplier applies for premises used exclusively or primarily for the supply of alcohol for consumption on the premises (bands D & E only)

13. Premises would pay their levy when their annual licence fee becomes due and therefore the levy payments may not be collected until up to a year after the implementation date. By law, any non-payment of the levy by the due date must result in the suspension of a premises licence or club premises certificate until payment has been made.

14. Of the revenue collected, the City Corporation is able to deduct the costs of administering the levy and then a minimum of 70% of the balance has to be passed to the City of London Police. Administration costs are estimated to be no more than £15,000 per annum.

15. The City of London Police are not bound by any restrictions as to how their portion of the money is to be spent. However, they have given assurances that it will be used towards the following objectives:

- To cover the costs associated with licensing hearings, advice and objections to Temporary Event Notices (TEN`s etc.), estimated as being between £20,000 and £30,000 per annum. It is clear that the police (as a responsible authority) are the key contributor when it comes to identifying a need for a realistic objection to a grant, variation or submission of a TEN.

- Funding three additional officers to run an effective 'action team' within the police licensing team. The action team would actively target the licensed premises that have been identified via the Force Intelligence Bureau (FIB) as premises that are responsible for the majority of crime and or disorder occurring at their premises. They would work with those premises so that they can achieve better results in promoting the licensing objectives. Furthermore it would fall to them to identify persistence in failures and contraventions of licensing conditions.

- The night time economy has grown considerably in the City of London since the evolution of the police licensing team to its current form; however the team has not been expanded accordingly. Over time several 'problem' premises have been identified but, owing to a lack of tangible high-grade evidence, it has taken a considerable amount of time to deal effectively and efficiently with them. The extra three staff would facilitate preventative measures in order that further, more formal action is not necessary.

- Covert operations to detect offences, and as a consequence supply high-grade evidence of licensing offences allowing early intervention, would also be funded. This role needs to be carried out by trained officers (sometimes from other forces), as the City's own licensing officers are known. Past experience would suggest this activity would occur approximately five or six times a year.

- In addition, it would allow the police licensing action team to further its partnership working with the London Fire Brigade, Security Industry Authority, and Trading Standards to be available to engage/detect/advise and enforce where the evidence is overwhelming; to learn lessons and to continue to promote good practice.

16. The City Corporation is however required to spend its allocation in specific areas namely:
    - The reduction or prevention of crime and disorder
    - The promotion of public safety
    - The reduction or prevention of public nuisance
    - The cleaning of any highway maintainable at the public expense within the City of London (other than a trunk road) or any land to which the public are entitled or permitted to have access with or without payment and which is open to the air

17. The proposals for spending the City Corporation's allocations are:
    - Towards funding a post to operate the Code of Practice and Risk Assessment Scheme. The postholder would work closely with all licensed premises in an advisory capacity in order that they have the best possible chance of promoting the licensing objectives.
    - To fund a team of officers to work during the period midnight to 06:00 a.m. Officers would be able to respond speedily to complaints from members of the public where they are being disturbed by excessive noise. This will allow officers to see the problems as they are occurring and take the appropriate action. In the majority of cases this would

involve working in partnership with the licensed premises in question to alleviate problem areas.

18. The income estimates can be seen in the table below:

	A	B	C	D	Local Authority Portion	Police Portion
Amount raised if Levy introduced from 00:01 to 06:00	474,949	332,464	317,464	222,225	£66,668	£155,558
Amount raised if Levy introduced from 01:01 to 06:00	301,917	211,342	196,342	137,439	£27,488	£109,951
Amount raised if Levy introduced from 02:01 to 06:00	144,435	101,105	86,105	60,273	£12,055	£48,219
Amount raised if Levy introduced from 03:01 to 06:00	57,171	40,020	25,020	17,514	£3,503	£14,011
Amount raised if Levy introduced from 04:01 to 06:00	16,044	11,231	N/A	N/A	N/A	N/A
Amount raised if Levy introduced from 05:01 to 06:00	8,106	5,674	N/A	N/A	N/A	N/A

The columns in the table refer to the following:

- A – Total amount raised if all 290 premises were to pay the levy without any deductions.
- B – Total amount raised if 30% of all premises varied their hours to bring them outside the levy period. (figure based on the experience of other local authorities).
- C – Total amount raised from 70% of the premises less £15k to administer the scheme.
- D – Total amount raised from 70% of the premises less the administration costs and less a discount of 30% to account for premises participating in the Safety Thirst Award Scheme (the actual income likely if all recommendations in this report are approved).
- The final two columns show the amount in column D split between the City of London Police and the City Corporation, with 70% going to the Police and 30% to the City Corporation.

Criteria to be considered in making the decision

19. In deciding whether to adopt the levy, the City Corporation has to discuss the need with the relevant Chief Officer of Police, in this case the Commissioner of the City of London Police. The City of London Police have expressed their support for the levy and the Commissioner has been involved in the design of the proposed system.

20. The City Corporation has to have regard to the costs of policing and other arrangements for the reduction of crime and disorder in connection with the supply of alcohol between midnight and 6 a.m. and, having regard to these

costs, the desirability of raising the revenue to be applied in the prescribed manner.

21. The annual policing costs for these hours are difficult to accurately assess given that they cover various actions in various parts of the service and can include call handling, emergency response, investigation, detection and court time. It is estimated that the costs incurred by the Police are in excess of £2.1m. It is not possible to demonstrate that 100% of this expenditure relates to crime committed as a result of alcohol purchased during the late night supply period in the City of London. However, such precision could never be attained and does not need to be. The information provides a broad indication of the costs of policing and other arrangements for the reduction or prevention of crime and disorder in connection with the supply of alcohol between midnight and 6 a.m.

22. The City Corporation has to have regard to the results of the consultation which are given below. The statistical analysis of the consultation can be seen as Appendix 2.

23. General comments relating to each of the eight main questions have been collated and presented as Appendix 3. A few of the responses make significant comments and have been reproduced in full as Appendices 4a to 4e.

24. The City Corporation also has to have to have regard to the financial risk in adopting the levy. With administration costs, and the impact of reductions and exemptions being taken into consideration, it would not be a viable proposition if the gross levy amount was to fall below £100k.

Response to the Consultation

25. There were 70 responses to the consultation. 34 of these were written responses and 36 responded online. 18 of these were from premises that currently have a license to sell alcohol after mid-night, 16 from premises that currently have a licence to sell alcohol up to mid-night, 5 from residents, 12 from Members (of whom 4 are also residents), and 19 others. Included in the 'other' category were responses from trade representatives, solicitors and companies representing a number of licensed premises in the City of London.

Question 1 - Do you agree that a late night levy be introduced in the City of London?

26. 67% of responses that answered Question 1 were in favour of the levy. Overall 27 of the premises selling alcohol after mid-night were represented in the responses, either directly or from being represented and included in the 'other' category ('affected premises'). Of these 70% were against the levy.

27. The City of London has 747 premises selling alcohol of which approximately 290 would be liable to pay the levy if there were no exemptions. The response rate from these premises was 9%.

Question 2 - Do you agree that if a levy was to be introduced it should operate between midnight and 6 a.m.?

28. The suggested hours of 00:00 to 06:00 were supported by 59% of respondents. The consultation sought views on alternative levy hours with 20% preferring 01:00 to 06:00, 12% preferring 02:00 to 06:00 and 9% preferring some other time period.

29. To avoid complications with premises unsure as to whether they fall within the levy period or not, all periods are recommended to run from one minute past the hour. The suggested hours within the consultation would thus be 00:01 to 06:00.

Question 3 – Do you agree that there should be no exemptions from paying the levy?

30. 43% of respondents agreed that there should be no exemptions. There was some support for other exemptions as follows:

- Premises offering overnight accommodation that sell alcohol only to guests – 26%
- Theatres and cinemas selling to ticket holders, participants and invited guests to a private event – 19%
- Bingo Halls – 10%
- Community Amateur Sports Clubs – 10%
- Community premises (successfully applying for the replacement of the mandatory 'designated premises supervisor' condition) – 14%
- Premises only selling alcohol in the supply period by virtue of the fact they are permitted to supply alcohol during this period on 1st January each year – 26%
- Business Improvement Districts – 11%

Question 4 – Do you agree that businesses meeting the 'small business rate relief' criteria should not receive a reduction?

31. 67% of respondents agreed that there should be no reduction for businesses meeting the 'small business rate relief' criteria.

Question 5 – Do you agree that premise meeting the requirements of the Safety Thirst Award Scheme should be entitled to a 30% discount?

32. 77% of respondents agreed that premises should receive a 30% reduction. The majority of respondents see the Safety Thirst award scheme as an additional means to reduce crime and disorder.

Question 6 – Do you agree that the minimum 70% of the net revenue raised from the levy should go to the Police?

33. 74% of respondents agreed with the split with the remaining 30% being retained by the City Corporation.

Question 7 – Do you agree with the way in which the City Corporation will spend their portion of the levy?

34. 77% of respondents agreed with the way in which the City Corporation were to spend their percentage of the levy.

Question 8 – Do you agree with the way in which the City of London Police will spend their portion of the levy?

35. 80% of respondents agreed with the way in which the City of London Police were to spend their percentage of the levy.

Implications

Financial

36. The first £15,000 per annum in a full year (£7,500 in 2014/15) will be retained by the City Corporation to meet the costs of administering the levy.

37. In addition, based upon the assumptions made in this report, the levy could generate up to £67,000 in a full year for the City Corporation to be applied in the prescribed manner. This figure makes allowances for exemptions and a number of businesses reducing their hours of operation to bring them outside the levy period. At the end of each financial year, a statement of the total levy payments for the year, including details of exemptions and discounts, will be prepared.

38. This additional revenue has to be spent on specified purposes within the parameters set out in paragraph 16, and the final allocation of these funds is still being determined. Most, or all, of the likely costs to be met from the allocation are new costs to the City Corporation, so there will be no overall net financial benefit.

Legal

39. The Local Authorities (Functions and Responsibilities)(England) Regulations 2000 as amended specify that the functions relating to the introduction of the late night levy has to be a decision of the full Common Council.

40. In making the decision whether to adopt the levy the City Corporation must consider the matters set out in section 125(3) of the Police Reform and Social Responsibility Act 2011 namely:

    - The costs of policing and other arrangements for the reduction or prevention of crime and disorder, in connection with the supply of alcohol between midnight and 6am and,
    - Having regard to these costs, the desirability of raising revenue to be applied in the prescribed manner.

41. The City Corporation must take full and proper account of the consultation responses in deciding whether to introduce the levy and if so, the design of that levy.

42. The City Corporation may decide that there are some types of premises which should be exempt from the levy. The categories of exempt premises are specified in the Late Night Levy (Expenses, Exemptions and Reductions) Regulations 2012 and are set out in the City Corporation's consultation document (see Appendix 1). The City Corporation is unable to choose a category of premises for exemption from the levy if it is not prescribed in the regulations.

43. The City Corporation can decide to offer a reduction from the levy to best practice schemes that meet the criteria specified in the Late Night Levy (Expenses, Exemptions and Reductions) Regulations 2012 as follows:

    - A clear rationale as to why the scheme's objectives and activities will, or are likely to, result in a reduction of alcohol-related crime and disorder;
    - A requirement for active participation in the scheme by members; and
    - A mechanism to identify and remove in a timely manner those members who do not participate appropriately

    Eligible premises will receive a 30 percent reduction from the levy.

44. The net revenue must be split between the City Corporation and the City of London Police. The City Corporation must pay the Police at least 70% of the net levy. Costs incurred in the introduction, administration and collection of the levy may be deducted from the gross revenue prior to the levy being apportioned.

45. If the City Corporation decide to adopt the levy it must notify the Chief Officer of Police and all holders of licences which permit the supply of alcohol within the late night supply period. The Home Office Amended Guidance on the Late Night Levy recommends that the start date of the levy is set no less than three months after the notifications are sent. This will allow sufficient time for holders with a relevant late night authorisation to make a free variation to their licence to reduce their licensed hours to avoid operating within the late night supply period and thus avoid paying the levy.

Background Papers:

Report to Licensing Committee 22 October 2012: 'Late Night Levy and Early Morning Restriction Orders'.

Report to Licensing Committee 14 January2013: 'Late Night Levy'

Appendices:

Appendix 1 Consultation Document

Appendix 2 Consultation statistical Analysis

Appendix 3 Consultation general comments

Appendix 4a-e Full responses to consultation

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CITY OF LONDON CORPORATION

LATE NIGHT LEVY - CONSULTATION

1. Background

1.1. The City of London is the world's leading international financial and related business services centre. The City of London Corporation provides local government services for this financial and commercial heart of Britain, the 'Square Mile'.

1.2. Whilst primarily a business district, the City of London has a significant residential population and an expanding night life which is enjoyed by many thousands of residents and visitors. In order to maintain the City of London's reputation as a safe City, an active night time economy brings with it additional costs for the Corporation, the City Police, and other services dealing with public nuisance and crime & disorder.

1.3. The Police Reform and Social Responsibility Act 2011 (PRSR) amends and supplements the Licensing Act 2003 allowing local authorities to charge a levy to persons who are licensed to sell alcohol late at night in the authority's area as a means of raising a contribution towards the cost of dealing with the late-night economy.

2. What is a Late Night Levy?

2.1. If implemented the levy would be an additional fee to be charged to those premises licensed to sell alcohol during the supply period. The supply period must begin at or after midnight and end at or before 6 am. For example, if the supply period was set between 1am and 6am then every premises licensed to sell alcohol within the City of London, at any time during that period, would be subject to the levy.

2.2. The amount of the levy has been set by regulation and is calculated according to the rateable value of the premises. If implemented, the levy would be collected alongside the annual licence fee.

Rateable Value (£)	Rateable Band	Amount of Levy (£)	
		Annual Levy	Weekly Equivalent
0 – 4,300	A	299	5.75
4,301 – 33,000	B	768	14.77
33,301 – 87,000	C	1,259	24.21
87,001 – 125,000	D	1,365 (2,730*)	26.25 (52.50*)
125,001 +	E	1,493 (4,440*)	28.71 (85.39*)

*Premises that exclusively or primarily sell alcohol for consumption on the premises

2.3. Only premises licensed to sell alcohol are affected by a levy. A premises only providing regulated entertainment or late night refreshment would not be included.

3. Why a Late Night Levy in the City of London?

3.1. The desirability and need of introducing a late night levy within the City of London has been discussed with the City of London Police. Although the number of alcohol related crimes have decreased in the last two years, there remains a significant number occurring between midnight and six in the morning.

3.2. Alcohol related crimes include any of the following where alcohol has been an aggravating factor:

- Violence against the person (common assault, actual bodily harm, grievous bodily harm)
- Public order offences (relative to the Public Order Act 1986)
- Drunk and Disorderly

Although not a 'recordable' offence, drunk and disorderly is included due to the inordinate amount of police time taken in dealing with it.

3.3. The number of alcohol related crimes that have taken place within the City of London during the past two years between midnight and 06.00 a.m. can be seen in the tables below. This accounts for over 50% of the total number of alcohol related crimes that take place within the City of London.

Offence Category	Drunk & Disorderly	Violence With Injury	Violence Without Injury	Public Order Offences
Statistics For The Year				
1st November 2012 – 31st October 2013				
0000 - 0100	13	16	5	9
0100 - 0200	8	35	14	8
0200 - 0300	8	28	6	5
0300 - 0400	15	22	6	2
0400 -0500	2	11	5	3
0500 - 0600	2	2	2	2
Total	48	114	38	29
			Grand Total	**229**

Offence Category	Drunk & Disorderly	Violence With Injury	Violence Without Injury	Public Order Offences
Statistics For The Year 1st November 2011 – 31st October 2012				
0000 - 0100	29	20	14	9
0100 - 0200	13	15	7	2
0200 - 0300	11	26	9	6
0300 - 0400	14	20	6	10
0400 -0500	14	9	6	3
0500 - 0600	6	7	1	1
Total	87	97	43	31
			Grand Total	258

3.4. The costs involved in policing the night time economy relate primarily to staffing costs. Operational requirements arise from intelligence, statistics and specific taskings. To ensure appropriate levels of staff are on duty at any given time a format known as 'minimum numbers' is used and relates to the minimum number of all ranks that would be on duty at any given time.

3.5. Night duties are deemed to be any time between 20:00 and 06:30. Enforcing the night time economy between these hours costs the Police just over £2m. (The period relevant to the late night levy is almost 60% of the total hours expenditure for night duties). The £2m is made up approximately as follows:

- Uniform Policing 1,543,882
- Intelligence and Information 335,070
- Criminal Investigations Department 252,570

Total: £2,131,522

3.6. In addition to the above costs, around 150 of the alcohol related crimes involve further investigation at a cost of approximately £645,000.

3.7. The above figures are minimum costs. They do not take into account sudden specific needs involving extra resources and overtime. Additionally, where crimes above involve violent disorder, grievous bodily harm, and attempted murder etc., further investigative costs can amount to hundreds of thousands of pounds for them alone.

3.8. Compared to other areas, crime numbers in the City of London are low. However, the City of London Police have the same need to respond to Home Office requirements to reduce crime as well as the ongoing need to respond to the fear of crime regularly identified in the British Crime Survey. If there are any improvements in crime

reduction to be had, it is the duty of the City Police to identify appropriate areas to respond and fund those in any way it can.

City of London Code of Practice and Risk Scheme

3.9. In April 2013 the City of London introduced a Code of Practice with the aim of providing premises licence holders guidance on good practice in the promotion of the four licensing objectives.

3.10. In addition to the Code, a 'Traffic Light' risk scheme was introduced as a tool to assist the Corporation in identifying, at an early stage, those premises that may be having difficulty in promoting the licensing objectives.

3.11. The intention is that the risk scheme assists greater partnership working with licensed permises, helping to identify areas that are not working quite right, putting an action plan in place to rectify the problems thus avoiding unnecessary formal action at a later date.

3.12. The operation of the scheme is currently being funded on a temporary basis which is unsustainable in the long term. Funds raised through the late night levy would help to fund the scheme on a permanent basis and permit the Corporation to work even closer with licensed premises with the joint aim of providing a safe place for people to go and enjoy the night time economy (see also 5.10 to 5.12).

4. How much would a Late Night Levy raise?

4.1. The City of London currently has 747 premises licensed to sell alcohol of which 290 premises are licensed to sell alcohol after midnight. The total number of premises licensed to sell alcohol between midnight and 6 a.m. can be seen in the table below.

Premises Rateable Band	Fee Per Premises In Each Band	Number of premises that sell alcohol in each of the hour bands between midnight and 06:00 a.m.					
		00:01 - 01:00	01:01 - 02:00	02:01 - 03:00	03:01 - 04:00	04:01 - 05:00	05:01 - 06:00
A	£299	1	1	5	0	0	0
B	£768	6	2	3	4	1	0
C	£1,259	56	43	16	1	0	2
D	£1,365	13	11	11	0	0	3
D (multiplier)	£2,730	2	5	3	1	1	0
E	£1,493	32	25	12	2	0	1
E (multiplier)	£4,440	6	8	5	7	1	0
Total		**116**	**95**	**55**	**15**	**3**	**6**

4.2. If every one of the above 290 premises paid a Levy it would raise approximately £475,000 each year. At least 70% of this sum has to be paid to the City of London Police with the remainder being kept by the City Corporation in order to help fund activities aimed at decreasing crime and disorder associated with the night time economy (see also 5.10 to 5.12).

4.3. However, it is likely that some of the premises that do not open beyond midnight on a regular basis, but have a licence to do so if they so wished, would vary their licence to bring forward the terminal hour for alcohol sales to midnight. This service would be free of charge for a three month period following an announcement that a levy would be introduced and would take a premises outside of the levy period. Based on the experience of other local authorities, this figure can be as high as 30% of the total number of premises selling alcohol after midnight which, in the case of the City of London, equates to 87 premises.

4.4. There are various costs associated with operating a Late Night Levy which would be incurred by the City Corporation. These costs have been calculated to be approximately £15,000 to cover the first year period up to the 31 March 2015. These costs may increase or decrease in future years. This administration cost can be taken from the money raised through a Levy before it is allocated to the City Corporation and the Police.

4.5. The City Corporation can use the levy to support participation by premises in best practice schemes by applying a 30% discount to those premises who so participate. It is recommended that any premises meeting the criteria enabling them to gain a City of London's Safety Thirst Award would receive a reduction on their levy payment.

4.6. By offering such a discount, it is hoped that premises would be encouraged to participate in the Safety Thirst scheme with the aim of reducing alcohol related crime and disorder.

4.7. The table below shows how much money is likely to be produced from the introduction of a levy for different levy periods. Each row shows the amounts for a ley period which is gradually reducing in time by taking back the start time of the levy period. Row one for example, showing money raised if the levy period was for the full six hours and ran from midnight to 06:00 a.m. The last row shows money raised if the levy period was only for one hour between 05:00 and 06:00 a.m.

The columns in the table refer to the following:

- A – Total amount raised if all 290 premise were to pay the levy without any deductions.
- B – Total amount raised if 30% of all premises varied their hours to bring them outside the levy period.
- C – Total amount raised from 70% of the premises less £15k to administer the scheme.
- D – Total amount raised from 70% of the premises less the administration costs and less a discount 0f 30% to account for premises participating in the Safety Thirst Award Scheme.
- The final two columns is the amount in column D split between the City Corporation and the City of London Police, with 70% going to the Police and 30% to the City Corporation.

	A	B	C	D	Local Authority Portion	Police Portion
Amount raised if Levy introduced from midnight to 06:00	474,949	332,464	317,464	222,225	£ 66,668	£ 155,558
Amount raised if Levy introduced from 01:00 to 06:00	301,917	211,342	196,342	137,439	£ 27,488	£ 109,951
Amount raised if Levy introduced from 02:00 to 06:00	144,435	101,105	86,105	60,273	£ 12,055	£ 48,219
Amount raised if Levy introduced from 03:00 to 06:00	57,171	40,020	25,020	17,514	£ 3,503	£ 14,011
Amount raised if Levy introduced from 04:00 to 06:00	16,044	11,231	N/A	N/A	N/A	N/A
Amount raised if Levy introduced from 05:00 to 06:00	8,106	5,674	N/A	N/A	N/A	N/A

5. What will Levy funds be spent on?

5.1. At least 70% of net revenue raised by the levy must be paid to the City of London Police. In order to meet the requirements of both the Police and the City Corporation it is suggested that the minimum 70% be given to the Police with the remaining 30% going to the City Corporation.

5.2. There are no restrictions placed by legislation on how the Police are to spend their portion of the levy. Fears have been expressed in other areas, particularly other London Boroughs, that money raised through a levy and given to the Police could be spent in areas that are totally unrelated to the local authority collecting the money. However, the City of London Police work exclusively within the City of London and any such fears would not therefore be realised. The Police have indicated that any money raised will be spent in areas outlined in sections 5.5 to 5.9 below.

5.3. There are restrictions placed on the types of activities that licensing authorities can fund with the levy revenue to ensure that money is spent on tackling alcohol related crime and disorder namely:

- The reduction or prevention of crime and disorder
- The promotion of public safety
- The reduction or prevention of public nuisance
- The cleaning of any highway maintainable at the public expense within the City of London (other than a trunk road) or any land to which the public are entitled or permitted to have access with or without payment and which is open to the air

5.4. If a levy was introduced, the City of London licensing authority would spend any money raised on the areas outlined in sections 5.10 to 5.12 below.

Portion allocated to City of London Police

5.5. To cover the costs associated with licensing hearings, advice and objections to Temporary Event Notices (TEN`s etc.), is estimated as being between £20,000 and £30,000 per annum. It is clear that the police (as a responsible authority) are the key contributor when it comes to identifying a need for a realistic objection to a grant, variation or submission of a TEN.

5.6. Funding three additional officers to run an effective 'action team' within the licensing department. The team would actively target the licensed premises that have been identified via the Force Intelligence Bureau (FIB) as premises that are responsible for the majority of crime and or disorder occurring at their premises. They would work with those premises so that they can achieve better results in promoting the licensing objectives. Furthermore it would fall to them to identify persistence in failures and contraventions of licensing conditions.

5.7. The night time economy has grown considerably in the City of London since the evolvement of the police Licensing Team to its current form; however the team has not been expanded accordingly. Over time several "problem" premises have been identified but, owing to a lack of tangible high-grade evidence, it has taken a considerable amount of time to deal effectively and efficiently with them. The extra three staff would facilitate preventative measures in order that further, more formal action is not necessary.

5.8. Covert operations to detect offences and as a consequence supply high-grade evidence of licensing offences allowing early intervention would also be funded. This role needs to be carried out by trained officers (sometimes from other forces), as the City's own licensing officers are known. Past experience would suggest this activity would occur approximately five or six times a year.

5.9. In addition, it would allow the Licensing Action Team to further its partnership working with the London Fire Brigade, Security Industry Association, and Trading Standards to be available to engage/detect/advise and enforce where the evidence is overwhelming; to learn lessons and to continue to promote good practice.

Portion allocated to City of London Corporation

5.10. The City Corporation would use the money raised from a Levy in two areas. Firstly, it would go towards funding a post to operate the Code of Practice and Risk Assessment scheme. The postholder would work closely with all licensed premises in an advisory capacity in order that they have the best possible chance of promoting the licensing objectives.

5.11. Secondly, the City Corporation would fund a team of officers to work during the period midnight to 06:00 a.m. Officers would be able to respond speedily to complaints from members of the public where they are being disturbed by excessive noise. This will allow officers to see the problems as they are occurring and take the appropriate action. In the majority of cases this would involve working in partnership with the licensed premises in question to alleviate problem areas.

5.12. The cost to the City Corporation would be approximately:

- Additional Post - £57k. (This amount includes other charges associated with the post and is not solely salary).
- Night time response - £23k

6. What should be the Late Night Supply Period?

6.1. Data provided by the City of London Police show that the period midnight to 06:00 a.m. accounts for the majority of alcohol related crimes committed in the City of London.

6.2. Just over 50% of violent crimes committed in the City are alcohol related whereas between mid-night and 6 a.m. 80% of violent crimes committed are alcohol related.

6.3. The Government has indicated[1] that the Late Night Levy charges are designed to reflect an estimate of the number of police hours that may be required as a result of premises opening beyond midnight. It was estimated that, very broadly, one hour of a police officer's time may reasonably be expected to be incurred for every two hours that a large premises opens late (This was not intended to provide an accurate assessment of how much the late night economy costs police forces, but provided a means for setting an appropriate Levy charge based on the principle that police resources are employed as a result of premises opening late). To ensure that the charge was fair and proportionate on business, proportionately smaller charges were set for premises with a lower rateable value.

6.4. Police data above show that alcohol related crimes are being committed on a regular basis from midnight. Therefore, in order to use the money raised through a Levy in the most efficient and cost effective manner, it is proposed that any Levy period should be between the hours of midnight and 6 a.m.

7. What exemptions should be allowed?

7.1. Certain types of premises may be granted an exemption as prescribed in regulations. These are as follows:

- **Premises with overnight accommodation:** This exemption is not applicable to any premises which serve alcohol to members of the public who are not staying overnight at the premises, such as a hotel bar which can be accessed by the general public.
- **Theatres and Cinemas:** Premises in this category must ensure that, during the late night supply period, the sale of alcohol is only made for consumption on the premises to ticket holders, participants in the production or invited guests to a private event at the premises.
- **Bingo Halls:** Premises must be licensed and regulated under the Gambling Act 2005 and the playing of bingo is the primary activity carried on at the premises.
- **Community Amateur Sports Clubs (CASC):** This exemption only applies to those premises registered as a CASC under section 658 of the Corporation Tax Act 2012.

[1] 'Dealing with the problems of late night drinking - secondary legislation consultation' (Home Office Impact Assessment)

- **Community premises:** Premises in this category must have successfully applied for the replacement of the mandatory 'designated premises supervisor' condition.
- **Country village pubs:** Not applicable in the City of London.
- **New Year's Eve:** This applies to premises which are authorised to sell alcohol in the supply period only by virtue of the fact they are permitted to supply alcohol during this period on 1st January each year.
- **Business Improvement Districts (BIDs):** Licensing authorities can offer an exemption from the levy for premises which participate in BIDs that operate in the night time economy. There are currently no BIDs within the City of London.

7.2. It is envisaged that no exemptions will be given in the City. All premises falling in one or more of the above categories and authorised to sell alcohol between midnight and 06:00 a.m. do contribute, to some extent, to the cost of policing the late night economy. Further rationale for not applying any exemptions is that this approach creates a level playing field for all affected premises and keeps administrative burdens and costs to a minimum.

8. What reductions should be allowed?

8.1. In addition to the above a licensing authority can also offer a reduction to:

- Premises that are in receipt of Small Business Rate Relief and have a rateable value of £12,000 or less. The reduction is only available to premises that supply alcohol for consumption on the premises.
- Membership to a suitable best practice scheme designed to reduce alcohol crime and disorder.

8.2. The City of London currently operates a Code of Practice and Risk Assessment Scheme whereby premises accumulate points for activities which are detrimental to one or more of the licensing objectives. When a certain number of points are reached, actions will be agreed between the licensing authority and the premises with the aim of reducing, and finally eliminating, the detrimental activities. From 2014 this scheme is to be linked with the Corporation's award scheme 'Safety Thirst' for well-run licensed premises where patrons can drink safely.

For more information on the Code of Practice and Risk Assessment Scheme please go to Code and Risk Scheme.

8.3. The Council is eager to encourage premises to participate in their Safety Thirst scheme that actively works to reduce crime and disorder in the late night economy. Therefore it is proposed that if a Levy were to be introduced, compliance with the scheme would attract a 30% reduction which is the maximum permitted under legislation.

8.4. It is not proposed that the reduction be applied to those premises in receipt of a Small Business Rate Relief. The fact that premises are in receipt of rate relief does not diminish their contribution to the cost of policing the night time economy. However, those premises do have the opportunity of meeting the Safety Thirst criteria and obtaining a reduction of 30% on their Levy payments through that means.

9. General Considerations

9.1. The night time economy does provide significant economic benefits for the City of London and the City Corporation must examine any potential detriments that might be caused by the introduction of the Late Night Levy.

9.2. The Late Night Levy will range from £299 to £4,440 per year. This is the equivalent of between 82p and £12.19 per day. It is considered unlikely that this would have a detrimental effect on affected businesses or cause them to change their operations. The Government has said[2] that premises are expected to make higher profits than the cost of the Levy and thus not be dissuaded from operating (as distinct from possessing authorisation allowing them to operate). They consider that 25% is a reasonable estimate of the proportion of premises that may seek to avoid the Levy, by changing their authorisation where they do not actually operate during those hours. But they also say that they expect that only a very small proportion of premises will reduce their actual operating hours to avoid the Levy.

9.3. The UK Government sets the amount of the Late Night Levy and has not indicated that it intends to increase the amount of the Levy regularly. It has indicated that it proposes to review the whole policy in 2017. On this basis, the introduction of the Levy is not expected to significantly affect the Night Time Economy in the City.

9.4. Some may argue that the costs of addressing crime and disorder should be financed through general taxation rather than be a burden on operators. Parliament has however created the power to introduce the Late Night Levy and require a low but significant contribution to the costs by operators. The principal has been decided by Parliament and the Corporation does not see any need to question that.

10. What next?

10.1. A copy of this consultation document will be sent to the following persons allowing for as wide a consultation as possible:

- Premises licence holders in the City of London
- Responsible authorities
- Members of the Court of Common Council
- Other interested City Corporation services
- Representatives of local residents

In addition to the above the consultation documents will be available on the City of London's website.

10.2. The consultation will commence on Wednesday 26 February 2014 and finish on Tuesday 08 April 2014.

[2] 'Dealing with the problems of late night drinking - secondary legislation consultation' (Home Office Impact Assessment)

10.3. If a levy is introduced it will commence from October 1 2014. An announcement will be made in June 2014 allowing three months for licence holders to make a free application to vary their licence if they wish to avoid paying the levy.

10.4. The approximate timetable if a levy was to be introduced is as follows:

26 February 2014	Consultation commences
08 April 2014	Consultation finishes
April 2014	Consideration and analysis of survey results
April 2014	Report to Licensing Committee
May 2014	Report to Court of Common Council
June 2014	Announcement of decision
Jul-Sep 2014	Determination of applications to vary a premises licence to take licence outside the levy period (if required)
October 2014	Start of Levy Year

11. How can I express my views?

11.1. Complete the questionnaire attached to this consultation document (pages13-17) and send it to:

Licensing Service
Levy Consultation
Walbrook Wharf
Upper Thames Street
EC4R 3TD

11.2. Alternatively email a copy of the completed questionnaire to licensing@cityoflondon.gov.uk.

11.3. Further documentation can be downloaded from our web site or we can send you a copy on request. For further information please call the licensing team on 020 7332 3406.

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CITY OF LONDON CORPORATION

LATE NIGHT LEVY

CONSULTATION QUESTIONNAIRE

Question 1

It is proposed that a Late Night Levy be introduced in the City of London in order to assist in the funding of the reduction and prevention of crime and disorder in connection with the late night supply of alcohol.

a) Do you agree that a late night levy should be introduced in the City of London? Yes/No

b) If not please give your reasons below?

(n.b. If you answer 'No' to this question, any further answers will only be taken into consideration if a Levy is introduced. Your opposition to the introduction of a Levy will still be noted and be of prime consideration in any decision made).

Question 2

It is proposed that the Levy should be introduced for those premises who supply alcohol between the hours of midnight and 6 a.m.

a) Do you agree that if a levy was to be introduced it should operate between these times? Yes/No

b) If not, during what time period do you think the levy should operate and why?

1am – 6am ☐

2am – 6am ☐

Any other time span ☐ (please state which time span)

Reasons for your choice of time period:

Question 3

It is proposed that no premises should be exempted from paying the Levy.

a) Do you agree that there should be no exemptions? Yes/No

b) If not, which of the following types of premises do you think should be exempted from paying the levy? (mark each one you think should be exempted).

- Overnight Accommodation ☐
- Theatres & Cinemas ☐
- Bingo Halls ☐
- Community Amateur Sports Clubs ☐
- Community Premises ☐
- New Year's Eve ☐
- Business Improvement Districts ☐
- No Exemptions ☐

c) If you have ticked one or more of the boxes above please give your reasons below.

Question 4

It is proposed that premises meeting the necessary 'small business rate relief' criteria should not be entitled to a reduction in Levy.

a) Do you agree that such premises should not receive a reduction? Yes/No

b) If not, please give your reasons below?

Question 5

It is proposed that those premises meeting the requirements of the Safety Thirst Award Scheme should be entitled to a 30% reduction in their Levy payment.

a) Do you agree that such premises should receive a 30% reduction? Yes/No

b) Please give your reasons below.

Question 6

It is proposed that the income raised from the Levy should be divided between the City Corporation and the City of London Police with 30% going to the City Corporation and 70% to the Police.

a) Do you agree that the net revenue from the levy should be split in this way? Yes/No

b) If not, please give your reasons for this and the split you feel would be more appropriate (Please remember that the City of London Police cannot receive less than 70%).

Question 7

It is proposed that that income from the Levy received by the City Corporation will be spent in accordance with paragraphs 5.10 and 5.11 of this document.

a) Do you agree with the way in which the City Corporation will spend their portion of the levy. Yes/No

b) If not, please give your reasons below and any suggestions you have for ways in which the money can be spent (please remember that the money can only be spent on those areas described in paragraph 5.3 of this document.

Question 8

a) Do you agree with the way in which the City of London Police will spend their portion of the Levy? Yes/ No

b) If not, please give your reasons below giving examples where possible of how you think the money would be better spent.

Question 9

Have you any other comments to make regarding the introduction of a Late Night Levy?

Thank you for completing this questionnaire. Could you please indicate below the capacity in which you are making your comments?

Licensed Premises (with licence to sell alcohol after Mid-night)	☐
Licensed Premises (with licence to sell alcohol no later than Mid-night)	☐
Non-Licensed Business (no licence to sell alcohol)	☐
Resident	☐
Alderman or Common Councilman	☐
Other (please state)	☐

We are happy to accept the consultation questionnaire anonymously but if you would like to tell us who you are then please complete your details below:

Name: _____

Organisation you represent (if relevant): _____

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Appendix 2

Analysis of Consultation

Questions 1-2

Question 1 - Do you agree that a late night levy be introduced in the City of London?

Question 2 - Do you agree that if a levy was to be introduced it should operate between midnight and 6 a.m.? *(Those responding in the first column '12-6' agree with this statement).*

Category of Respondent	Total Respondents		Q.1 Yes	Q.1 No		Q.2 12-6	Q.2 1-6	Q.2 2-6	Q.2 Other
Selling alcohol after midnight	18		9	8		3	6	4	3
Selling alcohol before midnight	16		13	3		10	3	0	0
Other Businesses	0		0	0		0	0	0	0
Residents	5		5	0		5	0	0	0
Members	12		12	0		10	2	0	0
Other	19		7	11		7	1	3	2
TOTAL	70		46	22		35	12	7	5

Question 3

Question 3 – Do you agree that there should be no exemptions from paying the levy? *(Those responding in the 'none' column agree that there should be no exemptions. Other columns represent the number of respondents that feel a particular category should be exempted).*

Category of Respondent	Q.3 None	Hotels	Theatre	Bingo	Sports	Comm-unity	New Year	B.I.D.'s
Selling alcohol after midnight	4	5	3	2	3	3	5	1
Selling alcohol before midnight	6	5	4	3	2	3	5	2
Other Businesses	0	0	0	0	0	0	0	0
Residents	5	0	0	0	0	0	0	0
Members	6	4	4	0	2	3	2	1
Other	9	4	2	2	0	1	6	4
TOTAL	30	18	13	7	7	10	18	8

Questions 4-8

Question 4 – Do you agree that businesses meeting the 'small business rate relief' criteria should not receive a reduction?

Question 5 – Do you agree that premise meeting the requirements of the Safety Thirst Award Scheme should be entitled to a 30% discount?

Question 6 – Do you agree that the minimum 70% of the net revenue raised from the levy should go to the Police?

Question 7 – Do you agree with the way in which the City Corporation will spend their portion of the levy?

Question 8 – Do you agree with the way in which the City of London Police will spend their portion of the levy?

Category of Respondent	Q.4		Q.5		Q.6		Q.7		Q.8	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Selling alcohol after midnight	8	7	12	2	10	5	10	4	10	3
Selling alcohol before midnight	12	2	10	4	11	3	10	3	12	1
Other Businesses	1	0	1	0	1	0	1	0	1	0
Residents	4	0	3	1	3	1	3	0	2	0
Members	9	3	9	3	11	1	12	0	12	0
Other	8	9	12	4	9	6	8	6	7	7
TOTAL	42	21	47	14	45	16	44	13	44	11

General Consultation Comments

Question One - Do you agree that a late night levy be introduced in the City of London?

Placing additional financial pressure on social and leisure businesses may discourage such businesses to the detriment of City Corporation objectives (6).

Well run establishments should not be penalised, only those that have and do pose a risk (3).

The levy should not become a general tax.

Crime is low in the City. Levy is unwarranted (2).

The crime figures do not support the introduction of a LNL. There is no indication what % of alcohol related crime is attributed directly to licensed premises. The evidence does not relate the crime figures to the supply of alcohol between midnight and 6am. Alcohol related crime is a small proportion of overall crime in the City. City Corporation is already adequately funded. City of London crime figures are low compared to other areas.

It is unfair to seek funds from a class of premises because they trade during a specific period. The fee structure of licensing is currently under review and may lead to double taxation when considered with the LNL

Businesses in City of London already pay high rates. Crime in City of London is low therefore a LNL is not justified. Good practice schemes should be incentivised - they have positive impact in dealing with problems. There is no certainty that monies raised by LNL will be used to address crime and disorder.

There is no basis for introducing a LNL. Crime is low in the City. Late night licences are being granted by City of London despite the perceived problems with the NTE.

LNL will impose significant cost burden on hospitality industry, affecting viability of businesses. Business rates are high and should cover some of the costs the levy seeks to meet. Operators likely to cut back hours so as not to pay levy resulting in uniform terminal hour in the City. LNL makes no distinction between good and bad operators. Voluntary good practice schemes are more cost effective and promote a better buy in from operators

Question Two - Do you agree that if a levy was to be introduced it should operate between midnight and 6 a.m.?

Little happens before mid-night. If period set at a later time it would lessen the burden on many premises

Late as possible to minimise impact on pubs and restaurants. (5)

Problems start after 11p.m. therefore period should start earlier

Allowing drinking until 1am discourages binge drinking before closing time.(2)

There is more risk of drunken disorder due to hardcore drinkers after 2am

Any problems associated with alcohol related crimes in the City can be addressed through BIDS and Safety Thirst.

If a LNL is adopted it should not commence before 3am as this is the time there appears to be a problem with alcohol related offences linked to the NTE

More detailed examination of crime figures is required to justify the introduction of a LNL

Question Three - Do you agree that there should be no exemptions from paying the levy?

All should be treated the same except for New Year's Eve (NYE)

All premises should contribute (2)

If LNL is adopted it would be unfair to have any exemptions

Responsible suppliers of alcohol should not be penalised

Livery halls should be exempt as they do not add to the problems associated with Night Time Economy.(5)

Bingo halls should not be exempt. Everyplace where the public attends should pay the Levy

Must be a level playing field except for BIDS and NYE

Overnight accommodation, theatres, cinemas and community premises operate in a manner where it is normal to have customers consuming alcohol after midnight. Not the sort of place where trouble would be anticipated and should be exempt. NYE should also be exempt.(2)

Restaurants should be exempt. Only clubs operating after 3am should pay.

Restaurants should be exempt. Diners generally do not cause disturbance. Sports people tend not to get drunk, neither do people who go to the cinema, theatre or community premises. People traditionally get drunk on New Year's Eve into the early hours. A levy for this would be profiteering.

Drunk people in a hotel do not cause disturbance on the streets. NYE celebrations should be free of obstacles

Overnight accommodation premises do not contribute significantly to the detrimental effects of the NTE. Hotels should be exempted where they only serve alcohol to people staying overnight at the premises as they ae not likely to leave the hotel and be a burden to policing the NTE. NYE should be treated as a special occasion. It is reasonable to exempt premises contributing to a BID.

Overnight accommodation premises should not have to pay if they only provide alcohol to those staying there. Theatre, cinema and Bingo Halls should not pay as they are unlikely to contribute to alcohol related crime and disorder. NYE is a national event that in the past has been deregulated and should be exempted.

Overnight accommodation shuould be exempt where supply is only to those staying there. NYE is a one off occasion and should be exempted. Knock on effect would be for premises to vary hours to remove NYE and then apply for TENs - an increased workload for the licensing authority. Premises in BIDs should be exempt as they contribute to the improvement of city centres.

NYE should be exempted as it is a significant public celebration. Premises in BIDs should be exempt as they contribute to the improvement of city centres.

Additional costs on community premises would impact on the inclusiveness of people in the area

Question Four - Do you agree that businesses meeting the 'small business rate relief' criteria should not receive a reduction?

Levy should be reduced in proportion to the rate reduction

Opportunity to discount an SBBR should be taken up to limit damage to the economy of small businesses

It will be detrimental to small businesses (if they didn't get the discount) (5)

Small premises attract as much police attention - why should they get a reduce rate (3)

Businesses should be incentivised (by getting a discount)

If LNL is adopted it would be unfair to penalise large businesses. Small businesses can add to NTE problems

Small businesses qualifying for small business rate relief are not likely to sell much alcohol and should be exempted

No evidence to suggest that alcohol supplied on such premises is any less likely to contribute to crime and disorder

Question Five - Do you agree that premise meeting the requirements of the Safety Thirst Award Scheme should be entitled to a 30% discount?

Everyone trading after 1a.m. should pay the Levy, there should be no financial merit for meeting the requirements of reasonable schemes

Everyone should be treated the same

Too complicated (3)

If businesses invest in best practice schemes they should have their Levy reduced.

If a levy is introduced we will consider withdrawing from all good practice schemes. These were designed, and in our opinion ensure, our premises are run in an orderly fashion. The introduction of a levy across the piece ignores this and therefore membership becomes irrelevant.

Puts in danger voluntary partnership working

As important as Safety Thirst is premises should be meeting these standards anyway. Too high a discount.

Should be more support for street cleaning

Root cause of alcohol related disorders and violence is only alcohol. Reducing alcohol supply in this supply period is the only solution

Persons applying for awards are not those employed after 1am. Awards do not translate to real change on the ground.

There should be a reward/incentive for encouraging safe drinking practices (12)

It should be incremental. 15% in the first year and 30% in following years

A scheme must be rigorous, audited and followed up with compliance visits. A 20% reduction is more reasonable

Pubwatch should also be considered for a reduction

Question Six - Do you agree that the minimum 70% of the net revenue raised from the levy should go to the Police?

Not proportionate as Local Authority incur large cleaning bills

Greater percentage to the Local Authority

Should be sufficient amounts for street cleaning (2)

Local Authority should only cover administration - the rest should go to the Police

100% income to police (2)

90% to police as they bear the burden of late night drinking. 10% to City of London

There should be no levy. It will end up funding areas of LA & Police work not associated with NTE

The levy should be used to provide 'added value' to well run businesses, not just to fund existing activities and commitments

Why should the local authority get any more money. They collect business rates

Neither organisation needs more money to police a problem that has not been proven on the face of the consultation document

As there is no binding requirement for Police to spend its share in policing the NTE, the licensing authority should get is maximum possible share. Consideration should be given to the development of a joint programme which would pool the levy proceeds to maximise impact

Question Seven - Do you agree with the way in which the City Corporation will spend their portion of the levy?

Not to be used simply for administration.

Money should be set aside for damage/repair and street cleansing

Money should not fund new positions in Local Authority - should support business led good practice schemes

Spending on administration and enforcement is not likely to sufficient impact or engage operators. A liaison group of operators and authorities should be set up to decide on spending priorities. This will develop collaborative approach to improving the NTE.

Money should go to police (2)

There should be no levy

It is not fair for a small portion of licensed premises to pay for a service that will benefit all licensed premises. The LNL should not be used to create a general enforcement post. Money should go towards street cleansing

Income should be used to fund enforcement of licensing and planning objectives and to increase night time street cleansing

Why should the local authority get any more money. They collect business rates

If a LNL is adopted, money would be better focused on dealing with crime and disorder associated with NTE.

Increased inspections may not have a material impact on alcohol related crimes. There is a concern that LNL proceeds will be used to fund work not linked to the NTE

The amount raised in revenue for the licensing authority may not be as much as anticipated and question whether City of London will be able to deliver its programme

Question Eight - Do you agree with the way in which the City of London Police will spend their portion of the levy?

Too much emphasis on administration (2)

There should be no levy

The proposed new action team should work with licensing & planning to enforce licensing and planning objectives of NTE

The evidence indicates no link between licensed premises and alcohol related crime

The Police action team does not appear to be focussed on the NTE. Money should be used to fund extra officers on the street during the levy period

LNL proceeds should be used to provide front line policing of the NTE, not on administration

Police resources should be directed at dealing with irresponsible and criminal individuals and businesses that do not comply. Police must engage businesses.

LNL proceeds should be spent in a manner which benefits all operators who contribute eg, funding of participation in partnership schemes to benefit whole NTE. Good operators should not see their money spent on enforcement action against poor ones

Question Nine – General Comments

Only charge Levy to those causing the problems (4)

Target only problem premises and not every one, particularly not Livery companies (2)

Banks should be exempt

No restriction on spending by the Local Authority - leave it flexible

If premises do not make sufficient profit to the pay the Levy they can reduce their hours to bring themselves outside of the Levy period.

Companies benefitting from the late night economy should pay for enhanced policing and protection for residents

Income from LNL could be used to fund additional costs of night time parking enforcement.

Businesses still struggling with effects of recession. Rising costs have put businesses out of business; additional costs will be a burden. Closed businesses will raise no revenue for the authority. A blanket levy charge is unfair and does not take into account the real areas of risk

Livery Halls are not known for creating disturbance. They should be exempt (2)

Licensed premises have additional costs associated with provision of security staff & CCTV. No more costs (2)

Premises that have been prosecuted should pay 5x the levy for the first offence and 20x the levy for second offence

All organisations should support improvement to the social environment. The initiative needs to be carefully controlled and must not creep forward before midnight as a means of enhancing revenue

Asking businesses that only operate occasionally beyond midnight to pay the levy would be unfair

There is no requirement for a LNL in City of London. The evidence does not support it. It would be unnecessary, unfair, unprofitable and disproportionate. Results can be achieved by more effective and economic means. Problematic premises can be dealt with by way of review.

There is a concern that monies raised by the LNL will not be used by the Police or Licensing Authority for additional policing related to the NTE. A LNL will force premises into reducing hours to avoid paying the fee. Losing this amenity in City of London will be detrimental. Business rates in City of London are already high. The amount of revenue raised by a LNL could be less than expected. There is a review process under the Licensing Act 2003 to deal with problem premises. Should the introduction of a LNL be postponed until the Licensing Act 2003 fees review is complete?

The LNL is a significant tax to be imposed on premises already struggling financially. Crime is low in City of London. Many premises will vary hours to fall outside of LNL period.

**n.b. Figures in brackets represent the number of similar comments made*

ALMR

LATE NIGHT LEVY CONSULTATION
A SUBMISSION BY THE ASSOCIATION OF LICENSED MULTIPLE RETAILERS

The Association of Licensed Multiple Retailers (*ALMR*) welcomes the opportunity to submit additional written evidence to the City of London's consultation on the introduction of a late night levy. As the only national trade body dedicated to representing licensed hospitality, including late night businesses, we are well placed to do so. A significant number of our members operate within the City of London and will be directly affected by the proposed levy. Whilst some of these will be larger, modern bars with a significant food or entertainment offer, many will be traditional wet led outlets; all are substantive and sizeable employers and all are opposed to the proposals. This response builds on our earlier submission to the original levy consultation.

Background & Overview

The night time economy is one of the UK's primary economic sectors and makes a positive contribution:

- Generates £66 billion in revenue - 6% of UK turnover
- Employs 6% of the UK workforce – 550,000 directly and 450,000 indirectly
- Accounts for 8% of UK firms – two thirds of them small businesses
- Paying 46% of turnover in taxes - funding vital public services
- Generating £209k GVA per outlet for the wider local economy
- Serving 20 million meals a week, 3.6 million cups of coffee and 15 million customers
- Investing on average 8% of turnover directly in crime reduction, rising to 11% for late night businesses
- Participating in industry schemes like Best Bar None, Purple Flag, Pub/ClubWatch and BIDs

In the City of London, the **importance of the sector in terms of employment and job creation** should not be under-estimated. Leisure is the second largest employer, generating 21% of all jobs in the City compared to 30% in business services. ALMR research suggests the 747 licensed hospitality businesses in the City employ over 17,000 people and generate a GVA of more than £142 million a year; premises licensed after midnight contribute more per site to this measure than comparable venues which close earlier. This positive job creation record could be jeopardised as a result of the additional costs of a levy or the reduction in profits some businesses will face by closing earlier to avoid the costs; bringing closing hours forward to before midnight may have the effect of removing a full shift.

The City Prospectus identifies **hospitality as playing an important role in the City's economy and society** and in particular in maintaining the City's status as a pre-eminent business centre. In recent years, the industry has invested heavily in retail redevelopment and regeneration initiatives across the City which have transformed it from a district which closed down in the early evening, on bank holidays and at weekends to one which fulfils the Prospective objective to "meet the high expectations of the business, resident, student and visitor community". A recent economic paper produced by the Greater London Authority estimated that on average, for all London Boroughs, despite crime and disorder costs local authorities are net beneficiaries from the NTE, with a cost-benefit ratio of between 1:5.5 and 1:8.8; this rises to 1:26.5 in the City, underlining the importance of the sector to the local economy.

The night time economy is not just an important economic business sector in its own right, it also **underpins the success and contribution of other businesses** within the city. A vibrant, eclectic and attractive licensed hospitality offer attracts leisure spend throughout the day as well as the evening and is vital to supporting and sustaining the city's events, retail and tourism communities. Visitors, residents and businesses, depend on a

diverse range of eating and drinking out outlets. The businesses that thrive and provide a vibrant late night offer are often the same businesses which provide those services throughout the day – and vice versa.
The health of the sector and the economy are interlinked and measures such as the levy which undermine late night businesses will have a knock on effect on the viability of trade during the day and evening. A late night levy will therefore result in businesses either closing earlier or focusing on quick, volume sales, particularly high-margin alcohol sales, resulting in a less diverse NTE going forward. The proposals risk damaging the City's reputation and image as a "7 days a week, late night economy" as identified in the City Prospectus.

It is worth noting in this context that City's night time economy is in direct competition with neighbouring Boroughs. The levy could adversely impact the council's strategic objective of capturing more and different leisure visitors. The proposals would therefore place City at a further **competitive disadvantage.**

Clearly, the City attracts a large proportion of workers and other visitors who, together with residents, have an eating and drinking spend which increases the area's GDP. It is important that this is not only recognised but taken into account in any analysis of crime and disorder figures – the true metric is crime per head not resident or visitor for example– and in any final assessment of the socio-economic risk of imposing a levy.

While the consultation briefly acknowledges the vibrancy and dynamism of the NTE, we are disappointed that it does not recognise that the **majority of users enjoy the late night economy safely and responsibly**. HMIC data reveals significantly lower levels of violent crime in the City per capita than in the next-best force; this will be significantly reduced if plotted against the large number of visitors. HMIC also reports crime being "broadly stable between the years ending March 2011 and March 2012 and fell between the years ending March 2012 and March 2013". Indeed, the City of London has, in other circumstances, promoted itself as a low crime area.

The consultation also fails to take due account of the fact that the majority of licensed hospitality **businesses in the City work hard and invest heavily in minimising any nuisance or problems which may arise.** Historically, the City has always recognised the need to maintain a careful balance and recognised that an effective solution to potential problems arising from the late night economy can only be delivered through a partnership approach with relevant organisation, including licensed premises. Indeed, a report published by the police in July 2013 shows that this type of multi-agency working has achieved a 1.9% reduction in violent crime – something they had thought to be "out of reach".

It is also unclear from the Corporation's proposals that the money raised by the proposed levy will be spent within the City's night time economy; rather, it appears that the revenue would be used to fund enforcement and inspection activity against already-compliant, responsible businesses. While the Corporation cannot control how the City of London Police spends its portion of the money, the Corporation should commit to using any revenue from this proposed new tax exclusively to fund activities intended to ameliorate environmental problems that may arise in a night time economy, such as litter, noise and crime, as intended by the legislation.

The current **Best Practice**, risk assessed and targeted approach **is delivering meaningful results in an already low risk environment.** It balances the conflicting demands of business, residents and visitors; ensures that action is directed at those premises causing a problem or failing to manage their businesses effectively; and avoids unduly penalising the responsible majority. The imposition of a levy risks disrupting that balance and undermining positive partnership working and, more importantly, trade support for existing initiatives such as Safety Thirst and the Good Practice Guide.

Finally, we are concerned that the proposals may undermine existing licensing policy by effectively reintroducing a terminal hour. Section 57 of the policy states that the Council will encourage longer hours and Section 73 and

74 encourage varied closing times in different areas so that "patrons leave for natural reasons over longer periods, thus minimising disturbance". These policies were explicitly introduced to prevent a replication of previous large scale departures, whatever the hour, which the City acknowledges in its licensing policy was to the detriment of the licensing objectives. The levy will cut across this policy intent as many businesses will amend their hours as a result of its imposition.

We therefore believe that a levy would be **undesirable and inappropriate.** It would damage the economic competitiveness of the night time economy as a whole, reduce diversity and mix of outlet and would not tackle problems arising from off-sales of alcohol or consumption outside the City.

Response to Consultation Questions

1. **Do you agree that a Late Night Levy be introduced in the City of London?**
   No, we do not agree that a Levy should be introduced.

   The *ALMR* continues to oppose the imposition of an additional tax on late night businesses at a national and local level, particularly when it will be not be levied on all the businesses engaged in late night activity and contributing towards the anti-social behaviour and disorder problems arising from it. Businesses already face paying a series of additional local taxes in the form of supplementary business rates as well as contributing to a range of voluntary social responsibility initiatives and investing in their own internal management standards and security.

   The consultation document acknowledges that crime numbers in the City of London are low and, despite almost a doubling of visitor numbers, have remained largely unchanged. Indeed, in the year ending October 2013, total alcohol related crime fell by 11% and is clearly trending downwards. A police report published in July 2013 showed that violent crime was down by almost a third in December 2012 as compared to previous years and HMIC reports also show that violent crime has fallen over the previous two years. Levels of anti-social behaviour are also declining. It is difficult, therefore, to identify the significant and serious problems which justify the imposition of a levy or require the investment of additional resources.

   These falls in violent crime and anti-social behaviour took place ahead of the introduction of the City's Good Practice Guide and Traffic Light scheme and the more proactive enforcement which accompanies them. While these schemes are by no means perfect – there is more scope to incentivise good practice through positive points and penalty points may be being over-applied where one incident involves multiple participants - both measures have the potential to reduce crime levels even further. It is, however, too early to assess the impact of either and therefore consideration of a levy is premature; its imposition may also undermine trade support for these existing measures.

   What is clear, however, is that current voluntary best practice initiatives such as Safety Thirst and Best Bar None – neither of which depend on intrusive enforcement and inspections - are having a positive impact in dealing with the root cause of potential problems (rather than delaying with their after-effects) and promoting responsible retailing. By tackling problems at source and preventing them arising in the first place, we believe that this approach will be more effective at tackling alcohol related crime and disorder and thereby reducing the costs associated with policing the late night economy.

   More importantly, businesses remain concerned that there is no certainty that the monies raised will be used to address specific problems in their area. We remain unclear as to how the inspection and

enforcement activity against existing premises will reduce and prevent general problems of crime and disorder on the City streets.

2. **Do you agree that if a levy was to be introduced it should operated between midnight and 6am?**
Given that we do not believe a LNL is an appropriate and proportionate intervention in the market, we do not believe that any Late Night Supply Period should be imposed. We therefore disagree with the proposal for midnight to 6am.

b. **If not, during what time period do you think the levy should operate and why?**
The decision as to the supply period should be evidence-based and justifiable. Based on the tables on pages 2 and 3, it would appear that there may be evidence of a particular problem at 3am connected with alcohol related offences and arguably most likely in relation to consumption within the NTE. An earlier start time may mean that incidents are included in the levy period which are caused by consumption in a domestic or street setting, or outside the City, earlier in the evening.

3. **Do you agree that there should be no exemptions from paying the levy?**
While we do not support the imposition of a levy on any business we agree that, if the problems post-midnight are sufficiently serious to warrant its imposition, then all businesses selling alcohol at that time should be liable.

The only exception to this should be businesses which are licensed to sell alcohol after midnight on New Year's Eve. Prior to the introduction of the Licensing Act 2003, the Government legislated to deregulate at a national licensing hours for all premises for New Year's Eve. This was a grandfather right protected under the transition to the new licensing regime and it would be wrong for it to be removed by anything other than due legal process. The levy should not apply to premises which have a relevant late night authorisation in respect of New Year's Eve.

4. **It is proposed that premises meeting the necessary 'small business rate relief' criteria should not be entitled to a reduction in the Levy?**
No.
Given the significant additional costs a levy will impose, and the fact that this may undermine the viability of smaller businesses in particular, we believe that the Council should employ all discretionary reductions or discounts which are available to them.

5. **Do you feel that premises meeting the Safety Thirst Award Scheme should be entitled to a 30% reduction in the levy?**
Yes.
It is accepted at a national level and indeed in the Council's Licensing Policy that voluntary best practice and partnership schemes which are focused on raising management standards are far more effective than other, more blunt measures, in tackling alcohol related harms. We believe that a partnership approach which deals with the root cause of any problems and is targeted and proportionate is a better means than a flat rate levy on all business. The imposition of a levy may raise revenue to clean up any problems, but it will do nothing to deliver better management standards and encourage responsible retail practice which may prevent such problems occurring in the first place or at least make them much easier to deal with.

Our preference remains for these schemes to be used in preference to a levy, but if a levy is to be imposed then a 30% reduction is vital to ensure that operators are not deterred from participating and the schemes are not undermined.

6. **Do you agree that the net revenue from the levy should be split with 30% going to the Local Authority and 70% to the Police? If not, how would you rather see the money spent?**
How the levy proceeds are to be split is arguably of less importance than whether a new tax should be imposed in the first place. We do not agree that it is desirable to raise the revenue through a levy; as noted above, a more collaborative partnership approach may well have delivered more effective results without the need for a levy. We urge the Council and police to continue to work in partnership with the licensed retail trade to deliver effective solutions to clearly defined problems.

7. **Do you agree with the way in which the Licensing Authority are intending to spend their portion of the levy. If you do not agree with the way in which the Licensing Authority are to spend their proportion of the levy, how would you rather see the money spent?**
We are concerned that you can only answer this question by accepting that a levy will be introduced. We do not agree with the way in which either the police or the local authority are intending to spend their portion of the levy but that does not mean that we believe the money should be otherwise spent; we do not believe that the money should be raised in the first place.

   We question whether increased inspections will have a material impact on the number of alcohol related crimes on the street or general disorder and believe that this is the wrong focus of activity when existing best practice and traffic light schemes are already directed in this area. This will only further penalise and burden responsible operators but do nothing to reduce crime more generally or contribute to the costs of policing the late night economy.

   The Government consultation on locally set licensing fees makes clear that the these fees are to be used to fund the establishment of an appropriate licensing department. We are concerned that the Corporation is proposing to use levy proceeds to fund administrative work that is not clearly linked to eliminating or tackling problems in the NTE.

   If a levy is to be introduced then the proceeds must be focused on front line policing of the NTE, not on administration.

8. **Do you agree with the way in which the Police will spend their portion of the levy?**
We are concerned that you can only answer this question by accepting that a levy will be introduced. We do not agree with the way in which either the police or the local authority are intending to spend their portion of the levy but that does not mean that we believe the money should be otherwise spent; we do not believe that the money should be raised in the first place.

   We are, however, extremely concerned that the police are proposing using levy proceeds to cover their legal costs associated with taking cases against individual premises or objecting to TENs and applications. We believe that this is wholly inappropriate and could have a distortative effect on enforcement priorities and activity. As originally envisaged, the levy was designed to tackle general problems or costs associated with policing the late night economy, not individual cases which were specifically attributable to individual premises. In this way it was to provide additional resources over and above those already directed at tackling problem premises.

If a levy is to be introduced then the proceeds must be focused on front line policing of the NTE, not on administration.

9. **Have you any other comments to make regarding the introduction of a Late Night Levy?**
In deciding whether to introduce a late night levy, the licensing authority must bear in mind that this will be seen as a significant and substantive extra tax imposed by the Council on operators who are already struggling in the current financial climate. It will have direct consequences for business profitability and viability as well as GVA to the local economy and employment patterns.

The City of London's current low levels of crime and disorder and strong reputation for being a safe night out are dependent on attracting a wide and diverse range of customers, venues and activities after dark. Imposing a significant additional operating cost on those businesses will inevitably mean that will narrow going forward to those drink led late night businesses which can generate sufficient income to cover the levy costs and this may jeopardise the city's status, income and investment by the sector – this would not just be restricted to night time businesses but would have a knock on effect across the day-time economy. Many of our members have said that they will voluntarily vary their hours to exempt themselves from the levy – this will not only reduce the mix of businesses trading, but also reduce levy revenues.

Sections 57, 73 and 74 of the Corporation's highlight the importance of flexible licensing hours and staggered closing times in managing gradual dispersal and minimising anti-social behaviour and disturbances. If a number of premises reduce their hours as a result of the levy, this could potentially create anti-social behaviour issues with a large number of premises closing at the same time and a return to the spike of crime, disorder and nuisance at midnight observed across the country prior to the introduction of the Licensing Act 2003.

The National Alcohol Strategy states that targeted action taken voluntarily by pubs and clubs themselves is most effective in curbing irresponsible drinking and associated drunken violence. The Home Secretary, Theresa May, in publishing the strategy, suggested that a legislative approach, either national or local, was a 'sledgehammer' which all too often misses its target and that a partnership approach was more effective. This is demonstrably the case in the City of London and our concern is that the imposition of a flat rate tax may undermine this and the businesses the Corporation needs to realise its strategic ambitions for the City.

RESPONSE OF JD WETHERSPOON PLC TO THE CITY OF LONDON CORPORATION'S LATE NIGHT LEVY CONSULTATION FEBRUARY TO APRIL 2014

Question 1

It is proposed that a Late Night levy be introduced in the City of London in order to assist in the funding of the reduction and prevention of crime and disorder in connection with the late night supply of alcohol.

a) Do you agree that a late night levy should be introduced in the City of London?

No.

b) If not please give your reasons below.

JD Wetherspoon PLC is one of the United Kingdom's largest and most well-known operators of managed pubs, employing over 33,000 people. Founded in 1979 by our current chairman Tim Martin, the company has 909 premises spread throughout England, Wales, Scotland and Northern Ireland.

During that period, the company has been at the forefront of the evolution of the pub with such initiatives as breakfast opening, increased access for families, the promotion of real ale and the wider availability of food.

The company has long established policies and procedures to ensure its premises promote the licensing objectives. We are committed to partnership working at every level to ensure that our pubs, and the late night economy in which they operate, are safe environments for our staff and customers.

As well as being a significant source of employment, especially for workers in the 18 to 25 age range, our premises are valuable social and community assets where people of all ages can eat, meat and drink in safe and comfortable surroundings.

JD Wetherspoon currently operates 4 premises in the City of London Corporation Licensing Authority area, 3 of which would be liable to contribute to the Levy on the assumption it applied to premises authorised to sell alcohol after Midnight.

Historically, we have had a constructive working relationship with the City of London Police. We oppose the imposition of the Levy but wish to reiterate that this should in no way be taken as a lessening of our commitment to continue working with the authorities in the City going forward.

We are opposed to the implementation of a Levy for several reasons. Firstly, it will impose a significant further cost burden on the hospitality industry within the City, when the overall costs the industry must pay whether for food, drink, labour and taxes continue to rise and customers' real incomes shrink impacting on profitability, and in some instances, the very viabilty of the businesses effected.

The Levy also follows on from a decade of significant and costly legislative change for the licensed industry starting with the Licensing Act 2003, the ban on smoking in public places and myriad other ancilliary legislation during the same period all of which has increased the red tape burden, both in money and time, required for compliance.

We have calculated a total annual Levy payment for the 3 premises likely to be effected by the levy of £10,373.00

In addition to the above, we pay business rates with a reasonable expectation that some of the costs the Levy seeks to meet would be met from those.The industry is also one of the most highly taxed in the country; last financial year alone we paid almost £551,000,000 in VAT, Corporation Tax, NI, excise duty and other ancilliary taxes.

We are a large national operator better placed to absorb such costs, but smaller independent operators may not, leading to a loss of individuality in the City's late night economy if those operators choose not to trade in it because of the increased financial burden.Nonetheless should the Levy be introuduced we will be forced to consider the economic viabilty of trading our premises in the late night supply period.If there is not an economic case for remaining open, then we will not do so with a conseqential impact on jobs and amenity.

It is not so much the financial impact of the Levy in isolation that should be considered, but its cumulative impact alongside the other increasing costs referred to above.

The late night economy of the City is not composed solely of businesses which may lead to crime and disorder. Many businesses impacted by the levy serve a diverse customer base visiting the numerous restaurants, cultural and business events that are a crucial part of the City's national and international appeal. It is these businesses that will be most affected by the Levy in that their trade in the Levy period may not be great in comparison to alcohol led, high volume premises and therefore have the least means to pay it. They are most likely to opt not to trade beyond the period the Levy applies leaving a likely mono-culture of larger premises and cutting down customer diversity; a diversity which has been long acknowledged as making for a more peaceable atmosphere in town and city centres.

The City of London Corporation should also consider the risk of a de facto uniform terminal hour for premises arising as operators cut back their premises licences to cease at the time the Levy applies from. This will mean more customers on the street at the same time with resultant pressure on resources such as taxis, fast food outlets and policing.

If operators do choose to pay the Levy then they will have to look to ways to generate the additional income to pay it. In a late night economy which is already very competitive this may lead to further discounted drinks promotions.

Given the economic and cultural contribution the late night economy makes to the City, the justification for imposing a greater financial burden on it needs to be a compelling one.

The fairness of the Levy should also be taken into account. We operate our premises in the City in close cooperation with the Police and other authorities. We adhere to responsible drinks retailing and steer away from those promotions which undoubtedly encourage intoxication and anti-social behaviour. The Levy however, makes no distinction between good and bad operators. The justification for a Levy in general terms has been expressed as making the polluter pay, but of course whilst the polluter does pay, so do others who contribute little to the crime and disorder the cost of reducing the levy seeks to meet

We would instead place a greater emphasis on partnership working with operators.There are many examples of succesful voluntary schemes between venues and authorities which have a direct impact on reducing crime and disorder and therefore the costs of policing it.These include Best Bar None, Pubwatch, Purple Flag and Business Improvement Districts. These schemes allow venues to use their own inherent expertise and knowledge of the business

environment to effect change rather than simply being asked to fund work by others who do not have such expertise and knowledge. The schemes are therefore much more cost effective and promote a greater buy in from operators than that which will be created by a Levy which many will, with justification, view as simply an additonal tax.

Question 2

It is proposed that the Levy should be introduced for those premises who supply alcohol between the hours of Midnight and 6 a.m.

a) Do you agree that if a levy was to be introduced it should operate between these times?

No.

b) If not, during what time period do you think the levy should operate and why?

1am – 6am
2am – 6am
Any other time span (please state which time span)

We do not support the Levy in principle therefore do not advocate any time period for its operation.

If a Levy was to be introduced, we would argue that it should apply to true late night operators as opposed to those venues, largely pubs and restaurants, whose licences only allow them to trade a limited time after midnight, perhaps on one or two nights a week, and whose main business focus is therefore before midnight. It is not these types of venues whose customers traditionally contribute to late night disorder. It is noteworthy that from the crime figures for alcohol related violent crimes provided by the City of London Police, the highest number of crimes take place in the period from 0100 to 0300. Can it be reasonable, fair or proportionate that premises that may cease selling alcohol at Midnight, 0030 or 0100 be required to pay for dealing with crimes occurring hours after they are shut?

Question 3

It is proposed that no premises should be exempted from paying the Levy.

a) Do you agree there should be no exemptions?

No

b) If not, which of the following types of premises do you think should be exempted from paying the levy? (mark each one you think should be exempted).

Overnight Accommodation
Theatres & Cinemas
Bingo Halls
Community Amateur Sports Clubs
Community Premises
New Year's Eve

Business Improvement Districts
No Exemptions

As a general principle, we do not support any proposed exemption to the Levy based on individual types of premises with the exception of New Year's Eve and premises within a Business Improvement District. The basis of the introduction of the Levy is to meet the costs of policing and other arrangements for the reduction or prevention of crime and disorder, in connection with the supply of alcohol. There is nothing inherent in any of the possible exemption categories which suggests that the alcohol supplied on such premises is any less likely to contribute to such crime and disorder.

c) If you have ticked one or more boxes above please give your reasons below?

Many premises which are not normally licensed to sell alcohol beyond 0000 or later will have permission for extended hours on New Year's Eve. All licensed premises which converted their old justice's on-licence will have grandfathered over a right to open until the commencement time for the sale of alcohol on New Year's Day. If a Levy exemption was not applied, such premises would face the choice of either paying the Levy for the benefit of one night's extended trading or varying their premises licence creating a significant administrative burden on them and the City of London's licensing team.

Quite apart from this consideration, New Year's Eve is one of the most significant public celebrations in the calendar and venues should be able to trade beyond midnight without paying a levy so that they can contribute to that celebration.

We refer to the benefits of partnership schemes in our response to question 1b. We note that that there is no qualifying BID currently in the City of London but the availability of an exemption will be a strong encouragement to one being established. The effectiveness of BIDs in improving standards and reducing crime and disorder in the late night economy has been clearly shown in Birmingham's Broad Street and Nottingham.

Question 4

It is proposed that premises meeting the necessary "small business rate relief" criteria should not be entitled to a reduction in Levy.

a) Do you agree that such premises should not receive a reduction?

No

b) If not, please give your reasons below?

Please see our response to question 3b above.

Question 5

It is proposed that those premises meeting the requirements of the Safety Thirst Award Scheme should be entitled to a 30% reduction in their Levy payment.

a) Do you agree that such premises should receive a 30% reduction?

Yes

b) Please give your reasons below

Anything which encourages participation in best practice schemes should be encouraged. These schemes are proven to deliver real improvements in the late night economy in a cost effective way. We support a full 30% reduction for premises which meet the requirements of the Safety Thirst Award Scheme.

We would recommend however that there is not too much prescription in the type of best practice scheme which would potentially attract a reduction. Certain types of scheme are more suited to certain types of premises and the wider the range of schemes which could attract a reduction then the greater the likelihood of those schemes gaining membership and momentum.

Question 6

It is proposed that the income raised from the Levy should be divided between the Local Authority and the City of London Police with 30% going to the local Authority and 70% to the Police.

a) Do you agree that the net revenue from the Levy should be split in this way?

Yes. Given that there is no binding requirement for the Police to spend its share in policing the late night economy in the proposed Levy area, we would prefer to see the licensing authority being given its maximum possible share.

Consideration should be given to the development of a joint programme which would pool the levy proceeds to maximise impact.

b) If not, please give your reasons for this and the split you feel would be more appropriate (Please remember that the Police cannot receive less than 70%)

N/A

Question 7

It is proposed that the income from the Levy received by the Local Authority will be spent in accordance with paragraphs 5.10 and 5.11 of this document.

a) Do you agree with the way in which the Licensing Authority will spend their portion of the levy?

No.

b) If not, please give your reasons below and any suggestions you have for ways in which the money can be spent (please remember that he money can only be spent on those areas described in paragraph 5.3 of this document)

We are concerned that the focus of the spending is either on administration or enforcement neither of which we consider likely to have sufficient practical impact nor to engage sufficiently the operators who will be paying the Levy. A much more creative means of applying the Levy proceeds should be developed and we advocate that a liaison group comprising of operators and authorities is set up to decide on spending priorities. This will develop a collaborative approach and allow the monies to be spent in ways most likely to see an improvement in the late night economy. This approach has been followed in Newcastle upon Tyne where a decision to introduce the Levy has already been taken and the first liaison meeting is to take place later this month. This might include street or taxi marshals or other measures to improve the public space and actually encourage peaceable visitors to the late night economy to everyone's benefit.

Question 8

a) Do you agree with the way in which the Police will spendtheir portion of the levy?

No.

b) If not, please give your reasons below giving examples where possible of how you think the money would be better spent.

Whilst we fully support a focus on operators who are not promoting the licensing objectives, the Police proposals for their share of the Levy proceeds seem unduly narrow. The levy proceeds, or at the very least a significant proportion, should be spent in a manner which benefits all operators who contribute to it in a much more imaginative fashion. This could involve the funding of participation in partnership schemes/initiatives which benefit the whole late night economy and drive standards up across the whole range of operators. Good operators should not see their money solely spent on enforcement action against poor ones.

Question 9

Have you any other comments to make regarding the introduction of a Late Night Levy?

We note that some of the criticims of the previous consultation have, at least in part, been addressed in this consultation.

We note the attempt to outline the costs incurred in policing the period between 0000 and 0600 in the City of London area but the costs provided cover the period 2000 to 0630 and whilst there is an approximation of how much of those costs are incurred in the proposed supply period itself, there is no further breakdown to show when exactly those costs are incurred. Without this information it is difficult to asses when an appropriate supply period is.

We are also concerned that the evdience provided in the consultation as to exisitng crime figures merely presents two years' figures. This is an improvement on the original consultation but we consider it still impossible to assess any statistical trend. How can it be established if the figures are rising or falling especially in light of various initiatives such as the City of London Police's recently introduced traffic light scheme? The national figures for alcohol related violent crime are falling and it is essential in any consideration of whether an economically damaging Levy is required in the City to see the trends for similar crime in the area.

We strongly urge that further detailed cosnideration is given to the impact of the Levy on operators of licensed premises in the City and why, if the evdience establishes that there is a trend of rising alcohol related crime and disorder, a partnership based approach cannot be used to tackle it.

JD Wetherspoon PLC

8th April 2014

APPENDIX 4c.

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2 April 2014

Our Ref: GBH/MXS/09856

Dear Sirs

Response to Consultation Questions as set out in the Consultation Document on the introduction of a Late Levy in the City of London

This firm acts on the behalf of the Grange Hotels Group and specifically within the City of London for the Grange St Pauls on Carter Lane and the Grange City in Coopers Row, the first of which lays adjacent to St Pauls Cathedral and the second laying adjacent to the Tower of London.

The Grange City Hotel is a five star hotel which incorporates the last remaining section of the London's roman wall as a main feature and houses 307 guest bedrooms and suites and includes several bars and restaurants within. It also includes very large ballrooms and meeting rooms with conference facilities and attracts many thousands of discerning guests each year. The Grange St Pauls is another luxury five star hotel adjacent to St Pauls Cathedral and contains 433 guest bedrooms with a similar array of bars and restaurants and a nightclub. It also includes very large meetings spaces and events areas and attracts thousands of discerning guests each year. The two hotels employ hundreds of people on their staff and obviously contributes substantially to the local economy both in supporting local businessman and also the payment of non-domestic rate. It's also significant elector in City Council Elections.

This letter is submitted as the Hotel's comments on the draft late night levy proposals set out in the City Council's consultation document. We will deal with each question in turn as follows:-

Question 1a – Do you agree that a Late Night Levy should be introduced in the City of London?

We would make all the same points which were made in our previous submission to the previous consultation in our letter dated the 5th September 2013.

We do not agree with the implementation of any late night levy or tax in this regard.

Firstly, the Licensing Act 2003 provides that in making a decision as to the levy the licensing authority must consider:

(a) The costs of policing and other arrangements for the reduction or prevention of crime and disorder in connection with the supply of alcohol between midnight and 6am and

(b) Having regard to these costs, the desirability of raising revenue to be applied in accordance with the late night levy provisions.

Since the last consultation document it is clear that the City of London were concerned about the porosity of evidence to support the police submissions in relation to the costs of policing the late night economy. The previous, rather spurious graph has now been omitted to be replaced with two tables which purport to set out the number of alcohol related crime that has taken place within the City of London during the last two years between midnight and 0600. It goes on to say that the figures in the two charts represent about 50% of the total number of alcohol related crimes that take place within the City of London.

In other words just under 50% is attributable to other hours of the day and it is submitted that given the almost 50/50 split between the so called "alcohol related crimes" between midnight and 0600 and those in the rest of day there is little justification for the imposition of a late levy on the basis of these figures alone. It is unclear why the City of London would seek to tax businesses in a difficult economic climate in relation to "alcohol related crime" occurring during the hours set out in the tables in the document when there is also equivalent number of "alcohol related crimes" occurring in the rest of the day. There is, therefore, no apparent dramatic leap in "alcohol related crimes" during the early hours of the morning compared with the rest of day.

Again, as in the previous document there is no attempt to discriminate between alcohol related crimes caused generally and those which are directly related to licenced premises. No figures are provided for the number of alcohol related crimes that occur inside domestic residences and which include violence within those residences. No figures are supplied as to the alcohol related crimes occurring in public places which are not attributable to licenced premises. Furthermore, it is not established that insofar as any crimes are related to licenced premises those premises were not outside the City of London rather than within its boundaries.

It is therefore submitted that of the 258 matters occurring in 2011/12 and 229 matters occurring in 2012/13 a significant number must be removed on the basis that not all of these figures are attributable to licenced premises. The City Council is again reminded that the licensing authority is required to consider the costs of policing and other arrangements for the reduction or prevention of crime and disorder in connection with the supply of alcohol between midnight and 0600 in its area. There is no evidence whatsoever which relates these

figures to the supply of alcohol within licenced premises during the hours in question within the City of London. It is submitted, therefore, that the figures are meaningless and cannot act as the basis for the imposition of a levy or tax across nearly 300 businesses.

The figures contained within the two tables also represent a tiny proportion of the overall figures of crime reported within the City of London. For example, total recorded crime for just the month of February 2014 and January 2014 amounted to over 600 matters in each month. Over 1200 reports of crime in just two months. The figures set out in the tables refer to 487 matters in two years. Accordingly, there is more recorded crime in total in one month in the City of London than there is in all alcohol related crimes in the last two years from the police figures. This therefore represents a tiny fraction of the overall recorded levels of crime in the City. On average of about 600 reported crimes per month in the last two years there has been a total of 14,500 reported crimes compared to 480 alcohol related matters. This represents 0.03% of the total. The figures which are quoted are from the Police.UK Crime Mapping Analyses.

In terms of the income afforded to the police by the tax, it is submitted that the City of London police already benefits from a substantial budget as set out in its recent Annual Report for 2012/2013. This report states that the City of London police recedes at £109,400,000.00 in 2012/13 compared to £103,504,000.00 in 2011/12. Its expenditure of £109,400,000.00 is exactly matched by its income in the form of grants from the Home Office and the Police Authority as well as a combination of other grants and reimbursements.

In a time of financial restraints it appears that the City of London police income has risen from £103,000,000.00 to £109,000,000.00 and there is therefore no justification for suggesting that they now require an extra £155,000.00 or 0.0014% of the overall total.

The same principles relate to the income of the Corporation of London with over a £100,000,000.00 income.

Finally, the consultation document at paragraph 3.8 admits that crime numbers in the City of London are low compared to other areas.

Accordingly, the incomplete figures provided in the consultation document cannot act as the basis for the imposition of a tax on 300 businesses within the City of London.

Question 1(b) If not, please give your reasons below:

For all the reasons given above the late night levy is opposed. There is simply no reliable evidence upon which a reasonable council properly directing itself could come to a conclusion that there is a requirement for a tax on 300 businesses within its area when there is no link provided between the numbers of "alcohol related crimes" and those premises. No evidence is provided by the police for the numbers of alcohol related crimes occurring within domestic residences or on the streets which are not related to licenced premises within its

area. It is submitted that many alcohol related matters are connected to domestic incidents or alternatively to the sale of alcohol and off licences including supermarkets and possibly to licenced premises outside of the City of London. In any event there is a figure which would reduce those figures set out in the tables produced in the consultation document. Those figures as we have said above also represent a tiny proportion of the overall crime levels within the City of London.

It is also submitted that if there is indeed a problem associated with "alcohol related crimes" connected to licenced premises within the City of London then these can be addressed through business improvement districts where businesses work together to raise their own money to tackle issues and through the City of London's own "safety thirst" scheme which is successful.

As we have indicated before it is for the police service within the City of London with a substantial budget running into hundreds of millions of pounds to organise its priorities and allocate resources sensibly.

Question 2(a) Do you agree that if a levy was to be introduced it should not be between these times midnight to 0600?

It follows that if we suggest that there should be no late night levy within the City then we can agree with the proposed time periods set out in the question.

Furthermore as we have suggested above the figures presented are unreliable and uninformative and do not give an accurate portrayal of alcohol related crimes which relate directly to licenced premises within this City of London.

Furthermore, the paper does not seek to define what is it meant by "alcohol related crime". Does this mean that those crimes related to individuals who had consumed alcohol or can it also mean reported crimes which occurred within the vicinity of licenced premises and those licenced premises were used as a marker in order to identify the location of the crime. None of this is clear from the statistics produced by the police.

Accordingly no comment can be made upon the various hours in which it is said that there is a majority of alcohol related crime because of the aforesaid reasons.

Question 3(a) Do you agree that there should be no exemptions?

As our client is not in support of the late night levy then it follows that it would not wish to make any comments upon any exemptions. If a policy is adopted it would seem unfair to have exemptions particularly in the case of our client's hotel group where a hotel without a nightclub would not face the tax but one with a nightclub would be subject to the tax. Again, if there is to be a policy of exemptions then there would have to be clear evidence to suggest that those falling within the exempt category have no connection with the "alcohol related

crimes" those that fall outside the categories do have that link. As we have said above there is figure work or evidence to connect any of the alcohol related crime to any licenced premises.

Question 4

As our client is not in agreement with the levy then it would not seek to comment in detail on the small business rate relief scheme.

Again, it would seem unfair to penalise a large premises which has no alcohol related crime whatsoever whilst exempting from the tax, a small business which might be the source of significant alcohol related crime incidents.

Again, there is no evidence to support either contention.

Question 5

Our client does not agree with the imposition of the late night levy in the City of London and therefore cannot comment on whether there should be a 30% reduction in the levy payment for those meeting the requirements of the safety thirst award scheme.

If the City insists on imposing such a tax and it is clear to our client that those premises who are taking part in best bar none schemes or pub watch or business improvement districts should indeed be entitled to a reduction in a levy up to the maximum 30%.

Question 6

For the reasons given above, our client does not agree with the imposition of a levy and by implication is not agreeing with the allocation of resources to the police and to the local authority. The reasons for this are set out in the answer to question 1 above. Both organisations benefit from substantial income in excess of £100,000,000.00 per annum and it is not accepted that either organisation needs more money to police a problem that has not been proven on the face of the consultation document.

Question 7

For the reasons given above the levy is opposed and the allocation of monies for such a levy are also opposed.

In making a decision as to the levy the licensing authority must consider the costs of policing and other arrangements for the reduction or prevention of crime and disorder in connection with the supply of alcohol and not public nuisance. The council's proposals seem to indicate that the allocation of money would be directed toward the employment of an officer to deal with noise nuisance in the evenings. Whilst the allocation of its share of the resources to a licensing authority maybe spent on matters involving public nuisance under the Late Night Levy (application administration) Regulations 2012 it is submitted that a more proper use

would be focused on crime and disorder which is the very reason why the levy would have been raised in the first place. Hence the reason for all the police crime figures contained within the consultation document.

To the extent that the licensing authority seeks to allocate its share of the proceeds to issues around public nuisance it is suggested that there is already schemes within the City Council area which contribute to this objective namely – "safety thirst". The council should already have allocated reasonable resources to this project from its great levy in any event. As pointed out above the council receives an income of over £100,000,000.00 a year.

Question 8

It follows that if we do not agree with the imposition of a levy then we do not agree with the way in which the police will spend their portion of the levy.

In our respectful submission the evidence produced in the consultation document indicates no link between licenced premises within the Corporation of London and the perceived problem of "alcohol related crime". Given that there is no evidence to establish that licenced premises are in the main the cause of alcohol related crime, it is submitted that there is no necessity for the funding of three additional police officers to this task. Officer time could be better spent and in reducing the on average 600 reported crimes per month within the corporation's area related to anti-social behaviour, bicycle theft, burglary, crime damage and arson, drugs, thefts, possession of weapons, public order, robbery, shoplifting, theft from a person, vehicle crime and violence and sexual offences. For this the police budget is £104,000,000.00 per annum.

Question 9

We would invite the corporation to consider all the answers given above to the various questions and would suggest in conclusion that there is no requirement for a late night tax in this area imposed on 300 local businesses during a period of economic hardship and difficulty. It is out of all proportion to the rather questionable figures produced by the police in this respect. Those figures show about 500 so called "alcohol related crimes" in 24 months when there are on average 600 crime types reported every month in the City of London. Furthermore, the City of London police are in receipt of a substantial budgetary income of £104,000,000.00 per annum.

Finally, we sight the words used by Philip Colvin QC in his recent book "Licenced Premises: Law Practice and Policy" where he concludes unequivocally the follow:

"In most cases, the introduction of the levy will be an unnecessary, unfair, unprofitable and disproportionate bureaucratic intervention. There is little that the levy can achieve which is not obtainable by more effective and economic means."

We would agree with those sentiments and concentrate particularly on the disproportionate element of Mr Colvin's conclusion. If there are a few problem premises in the City of

London, which undoubtedly there are, then these may be dealt with through the existing licensing regime by way of intervention and review. It is, however, unfair to penalise the vast majority of the 300 businesses which act fully in accordance with the law and are not responsible for the alcohol related crimes reported.

Our client does not believe that a further tax on hard pressed businesses during an economic downturn such as the one we are experiencing is an inappropriate way forward. The extra taxation imposed on the 300 businesses all with licences after midnight will have a considerable impact upon all of those trading concerns. It should be remembered that the vast majority of those operating are very small businesses. This is not, therefore, a minor cost to business. It is many times the cost of premises licence to many of the businesses and it should always be remembered that all of these businesses particularly as large as our own clients contribute significantly through business rates to central government which eventually reverts back to the Corporation of London. The hotel also pays large sums in terms of security and other measures designed to ensure that the running the licenced premises does not conflict with the four licensing objectives.

Yours faithfully

Jeffrey Green Russell Limited

JEFFREY GREEN RUSSELL LIMITED

RESPONSE TO CITY OF LONDON CORPORATION LATE NIGHT LEVY CONSULTATION QUESTIONNAIRE (April 2014)

NAME : JOHN GAUNT & PARTNERS ON BEHALF OF MARSTON'S PLC

ADDRESS : OMEGA COURT 372 – 374 CEMETERY ROAD SHEFFIELD S11 8FT

Introduction to the Revised Consultation on the Introduction of a Late Night Levy

The City of London has re-issued its consultation on the introduction of a late night levy but has chosen not to disclose the reason for the decision to consult again and makes no reference to the responses received. The Licensing Committee were due to receive the "analysed result of the recent consultation to the next Committee Meeting in February". The agenda for that meeting did not contain reference to any such analysis, nor was there any reference in the minutes of the meeting.[1]

The revised consultation appears to be an attempt in some instances at least to re-butt the evidence and arguments put forward by the respondents to the consultation "a majority of which were from licensed premises"[1] (76 responses were received). This is not an opportunity afforded to those respondents.

We note the qualification given to any answer of 'No' in Question 1. It cannot be right that any further comment on the levy is to be disregarded if the respondent maintains his opposition to the levy. The levy is a complicated instrument and the response will vary in accordance to the decisions that might be made to various aspects of the levy. For instance a hotel operator may be opposed to the levy because as currently proposed the hotel operator has to pay the levy. If that were to change to exclude hotels the hotel operator may well revise his opinion.

Similarly being opposed to the levy should not preclude perfectly valid comments as to the time limits for such a levy were it to be introduced and other similar questions.

The police now acknowledge that "compared to other areas, crime numbers are low" but go on to say that "it is the duty of the City Police to identify appropriate areas to respond and fund those in any way that it can." This is surely a spurious argument which ignores the efforts of the late night businesses to operate good businesses and co-operate in reducing

[1] 21 October 2013 Minutes of the meeting of the Licensing Committee held at the Guildhall EC2 at 1.45pm

crime. It ignores the rights of those businesses whose only reward is to be asked to pay more.

The consultation makes the statement that "Although the number of alcohol related crimes have decreased in the last two years, there remains a significant number occurring between midnight and six in the morning." The figures quoted for the year ended 31st October records a total of 48 offences between midnight and 6am, less than one a week and there is no evidence presented that these are all related to late night premises. Local community consultation undertaken by the police identify rough sleeping as the chief priority for the police, three out of four priorities being identified as such.[2]

We believe that the consultation is flawed and undemocratic in the way that it has been re-presented in this way and that no reference has been made to the prior consultation. Respondents have not even received an apology for the time and effort that has now to be put into making what is in effect a new response, since the form and nature of some of the questions have changed.

[2] http://www.police.uk/city-of-london/cp/priorities/ (January 2014)

RESPONSE TO CITY OF LONDON CORPORATION LATE NIGHT LEVY CONSULTATION QUESTIONNAIRE (April 2014)

Question 1

It is proposed that a Late Night Levy be introduced in the City of London in order to assist in the funding of the reduction and prevention of crime and disorder in connection with the late night supply of alcohol.

a) Do you agree that a late night levy should be introduced in the City of London? ~~Yes~~/No

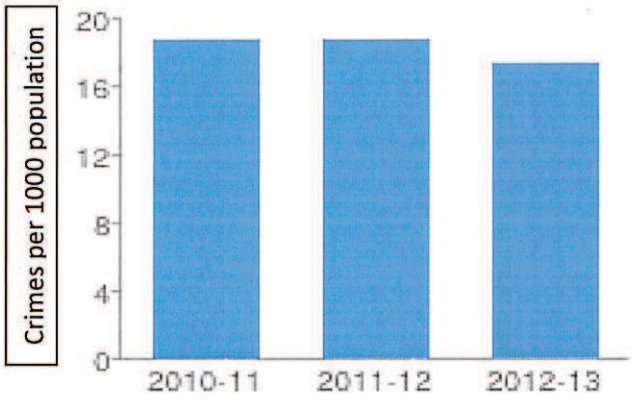
b) If not please give your reasons below?

(n.b. If you answer 'No' to this question, any further answers will only be taken into consideration if a Levy is introduced. Your opposition to the introduction of a Levy will still be noted and be of prime consideration in any decision made)

We do not agree and can see no basis on which we and others operating late at night should pay additionally for police services which are already provided.

As a responsible operator with premises in the City of London and throughout the UK we are fundamentally opposed to paying a levy to be able to continue trading with the hours that have been granted to our venues and to which no blame has been attached.

Marston's PLC operates The Rack and Tenter, the Pitcher & Piano, both of which have been granted late night hours with permission to sell alcohol until 2am. In addition Marston's also operates, The Cockpit and The Pavilion End, public houses that do not serve alcohol beyond 11pm and midnight respectively but which would nevertheless be influenced if the late night economy of the City of London was to be adversely affected by the introduction of a levy. The consultation now acknowledges that the incidence of crime has fallen in the City of London as can be seen from the crime figures published both by the police themselves[3] and by the independent evaluation website CrimeStatsUK[4]



Independent information on force-level crime and anti-social behaviour provided by Her Majesty's Inspectorate of Constabulary shows that crime in the City of London "remained broadly stable between

[3] http://www.police.uk/city-of-london/cp/performance
[4] http://www.ukcrimestats.com/

the years ending March 2011 and March 2012, and fell between the years ending March 2012 and March 2013. In the last year, crime was below the national average."[5]

This is borne out in the monthly figures published by CrimeStatsUK[6] shown below. ASB and Violent Crime which most closely reflect crimes that might be expected to arise in the Night Time Economy both show significant reductions over the last two and half years.

Crime in City of London Corporation

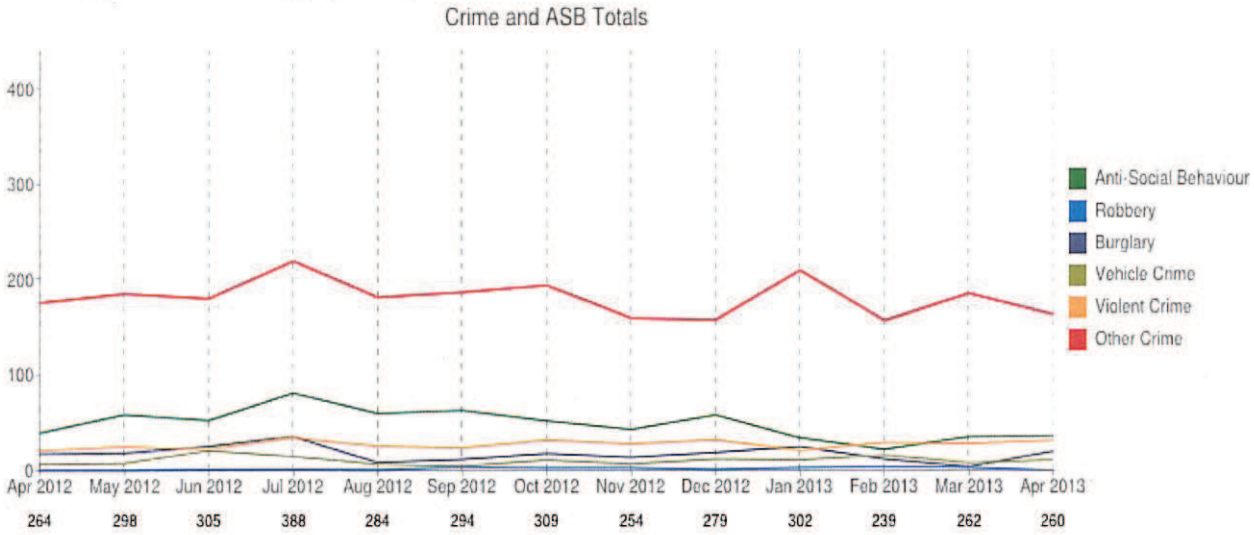
	ASB	Burglary	Robbery	Vehicle	Violent	Other Total	Total
Apr 2013	36	20	0	11	31	162	260
Mar 2013	35	4	3	8	28	184	262
Feb 2013	22	12	4	16	29	156	239
Jan 2013	34	25	3	11	21	208	302
Dec 2012	58	19	1	12	32	157	279
Nov 2012	43	14	3	7	28	159	254
Oct 2012	52	18	3	11	32	193	309
Sep 2012	63	12	4	5	24	186	294
Aug 2012	60	9	1	7	26	181	284
Jul 2012	81	36	2	15	35	219	388
Jun 2012	53	26	2	21	23	180	305
May 2012	59	19	1	8	26	185	298
Apr 2012	40	18	1	7	22	176	264
Mar 2012	55	8	1	16	25	201	306
Feb 2012	43	10	3	8	30	186	280
Jan 2012	51	17	2	5	25	137	237
Dec 2011	32	5	0	3	18	93	151
Nov 2011	141	17	3	11	55	343	570
Oct 2011	126	18	4	7	29	290	474
Sep 2011	129	25	2	13	46	396	611
Aug 2011	109	31	2	13	62	357	574
Jul 2011	169	27	5	10	62	380	653

[5] http://www.police.uk/overview/?q=City+of+London%2C+Greater+London%2C+UK
[6] http://www.ukcrimestats.com/Subdivisions/LBO/2512/

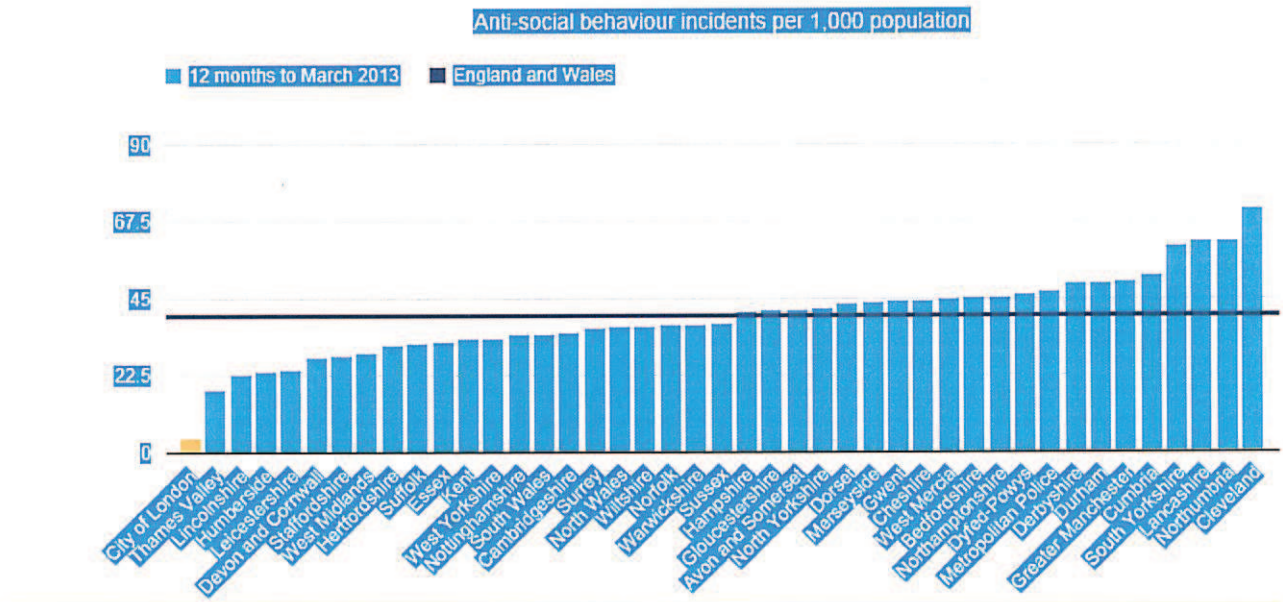
	ASB	Burglary	Robbery	Vehicle	Violent	Other Total	Total
Jun 2011	131	31	3	23	46	435	669
May 2011	160	26	5	16	53	384	644
Apr 2011	139	28	4	15	41	353	580
Mar 2011	130	14	3	19	60	436	662
Feb 2011	125	15	4	19	55	324	542
Jan 2011	121	14	1	20	64	342	562
Dec 2010	137	8	4	14	52	315	530

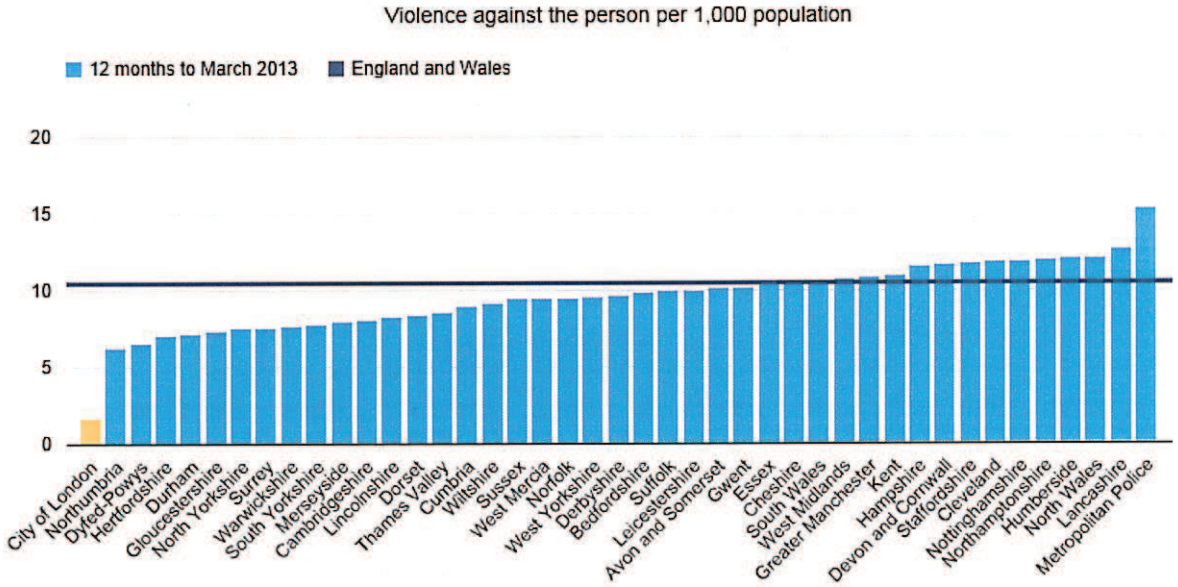
More recently published figures show that total crime had fallen from 260 in April 2013 to 236 in January 2014 with ASB falling from 36 to 23 in the same period.

These figures are shown graphically below:



Police figures also indicate that both in anti-social behaviour and violent crime the City of London has the lowest levels per head of population this despite having a low resident population of only 8,400 people, albeit supplemented by over 300,000 commuters and visitors each day, who are surely responsible for some of the crime committed.





None of these figures indicate a serious or growing problem, quite the opposite making the case for increased funding much more unsustainable.

More recent figures from the City of London Community Policing website[7] report that the number of crimes in the City during January 2014 was 619 down from 696 in the previous January 2013, a reduction of some 11%.

The Licensing Authority itself does not seem to have any difficulty in granting later licences. If policing and general levels of disorder were a serious concern we would question why the Council has granted later hours to a number of venues over the last twelve months or so. These include the following:

REVOLUTION extended from 3am to 4am on Saturday nights; AMBER, CITY POINT from 2am to 4am; and COS BAR from 1am to 3am and a new application from Punch Taverns for BIRD OF SMITHFIELD which was granted 3am on Friday & Saturday nights and 2am the rest of the week.

This does not sound like an area that is having a problem with the policing of the evening economy. No serious objections appear to have been raised against any of these applications including the police.

This view is supported by the City of London Corporation Safer City Partnership who maintain that

"the City remains a safe place in which to live, visit and do business, is a source of great pride to those of us charged with its safety and wellbeing.[8]

Question 2

It is proposed that the Levy should be introduced for those premises who supply alcohol between the hours of midnight and 6 a.m.

a) Do you agree that if a levy was to be introduced it should operate between these times? Yes/No

b) If not, during what time period do you think the levy should operate and why?

☐ **1am – 6am**
☐ **2am – 6am**

Any other time span (please state which time span) _____

Reasons for your choice of time period:

[7] http://www.police.uk/city-of-london/cp/
[8] http://www.cityoflondon.police.uk/CityPolice/CommunityPolicing/About/SaferCityPartnership/#sthash.uanGYys6.dpuf

Since Marstons are opposed to the introduction of a levy it is placed in a difficult position in respect of the question of the charging period. The police evidence on the crime statistics does not provide the absolute number of offences but presents the data in terms of the percentage of alcohol related crimes throughout the day.

Data from CrimeStatsUK quoted under Question 1 on violent crime shows that in the 12 months to April 2013 there were 335 violent crimes in the City of London Corporation area and 634 in the area covered by the City of London Police Force. The police evidence presented in the consultation states that just over 50% of these are alcohol related which halves these figures to around 160 and 320 per year or less than one a day over the whole police force area. There is clearly a need for a more detailed examination of the figures used to justify the intervention of a levy.

Question 3
It is proposed that no premises should be exempted from paying the Levy.

a) Do you agree that there should be no exemptions? ~~Yes~~/No

b) If not, which of the following types of premises do you think should be exempted from paying the levy? (mark each one you think should be exempted).

Overnight Accommodation	☒
Theatres & Cinemas	☐
Bingo Halls	☐
Community Amateur Sports Clubs	☐
Community Premises	☐
New Year's Eve	☒
Business Improvement Districts	☒
No Exemptions	☐

c) If you have ticked one or more of the boxes above please give your reasons below.

Overnight Accommodation

The Government enabled Licensing Authorities to apply the exemption to hotels on the grounds that only bona fide residents would be exempt and that hotel bars would have to exclude members of the public at the times the levy applies to qualify for the exemption. We agree with this and would like to stress the importance of the hotel sector to the financial health of the City which provides facilities to both employers for business visitors and tourists which are vital to the economy as a whole. We can see no good reason to apply the levy to hotels.

New Year's Eve

The introduction of a general relaxation of opening hours over New Year's Eve has generally been recognised as a success and is a one off occasion that may be used by result in many businesses that are not open beyond midnight at any other time of the year. Those premises which retained the ability to open through new Year's Eve on the granting of 'grandfather rights' during transition to the new licensing Act would become caught up in a levy if the exemption were not granted. The Government recognised this through its concession to a non-fee paying application to remove the permission. They could then instead apply for a Temporary Event Notice (TEN) to restore the late opening for New Year's Eve, which rather defeats the extension of the late night n]levy to such premises.

Those premises that more generally trade later may also chose to reduce their hours, particularly if they don't actually trade that often into the early hours. Apart from reducing the amount the levy would raise this would almost certainly increase the reliance on TENs by those businesses.

A refusal to allow this exemption would result in the generation of a large number of Temporary Event Notices, resulting in extra work for the Council and police.

Business Improvement Districts

BIDs are an excellent way of improving city centres and other areas and should be encouraged. The Government permitted the exclusion of premises within a BID for the very good reason that they are worthy of support. There is every reason to believe that businesses within a BID area that are not exempted will not repeat their support of a BID in a subsequent ballot.

While the City of London does not yet have a BID in place it should not exclude the possibility of providing an exemption for any future BID. We would also urge the Council to look at the benefits of the introduction of a BID and to consider the introduction of one before it introduces a levy. Experience in places such as Nottingham and Birmingham has demonstrated the beneficial effects of BIDS particularly in reducing crime in the Night Time Economy.

The Council's rationale for not applying any exemptions simply does not bear examination. There is clearly a difference in the size, scope and nature of the businesses liable to be included in a level. A late night club is quite obviously a different attraction from a hotel guest seeking a nightcap. Further it is far from the truth to assert that the council's "approach creates a level playing field for all affected premises". Those premises would strongly against and the contention that it "keeps administrative burdens and costs to a minimum" may be true for the Council it should not for businesses to pay higher charges simply for the convenience of the Council.

Question 4

It is proposed that premises meeting the necessary 'small business rate relief' criteria should not be entitles to a reduction in Levy.

a) Do you agree that such premises should not receive a reduction? ~~Yes~~/No

b) If not, please give your reasons below?

We rather doubt that there are any businesses that qualify within the City of London but if there are the Council should apply the exemption. A business with a rateable value of £12,000 in the City of London or less will be selling little very alcohol. The council figures show that there are only 7 premises in Band A that would fall under the exemption. There are only a further 16 premises that come under Band B having a rateable value up to £33,000. Assuming that half of these have a rateable value below under the £12,000, that would still only leave 15 exempted premises out of the 747 identified by the Council. The regulations allow for exemption for premise up to a rateable value of £12,000 for a good reason and the Council should re-consider its position on this.

Question 5

It is proposed that those premises meeting the requirements of the Safety Thirst Award Scheme should be entitled to a 30% reduction in their Levy payment.

a) Do you agree that such premises should receive a 30% reduction? Yes/~~No~~

b) Please give your reasons below

While we agree that the inclusion of Thirst Award Scheme in the entitlement to a 30% reduction we also urge the council to look at schemes more in the terms expressed by its own Licensing Committee who said when considering both EMROs and the Late Night Levy in October 2012:

"There are other wider considerations which may also be taken into account such as: the economic effects of the levy on operators, City Police's own capacity to fund crime prevention, the effect of the levy on voluntary schemes for reducing crime and disorder (Safety Thirst), whether there are any alternative means to reduce crime and disorder such as a Business Crime Reduction Partnership, and the equitability of changing the burden to operators rather than the community. These options would be addressed in any further detailed report on this issue."

That the Council now considers Safety Thirst as qualifying for an exemption, a provision not made in the earlier consultation, is to be welcomed but we are bound to observe that the introduction of a levy will attack the very heart of the voluntary scheme and that despite attracting the reduction, businesses will be reluctant to participate. If they do continue to participate they may do so for the wrong reason.

The consultation makes no mention of Pubwatch. There are number of Pubwatch schemes within the City and we firmly believe that these best practice schemes are worthy of a discount and to deny them this facility may well prove counter-productive. The police and the Corporation both benefit from good partnership working and to refuse the discount would demonstrate bad faith to those schemes that are keen to work in partnership.

Pubwatch qualifies as a good practice schemes under the regulations.[9] We urge the council to consider their inclusion in the 30% allowable reduction category, if the levy is adopted.

In its publication "Calling Last Orders"[10] the City of London Police pledge to "Work with partners, community, stakeholders and businesses to reduce precursory issues that lead to violence and related offences. We will listen to their concerns and respond appropriately." The introduction of a levy will

[9]

[10] http://www.cityoflondon.police.uk/NR/rdonlyres/CEF41A93-19FA-41BA-A90B-1258B48B75E5/0/LastOrdersV2.pdf

make this task more difficult and a refusal to allow the discount can only exacerbate that and lead to a deterioration in the willingness to collaborate.

The Council should also ensure that it has the ability to provide any future BID with the same discount if exemption is not granted to that BID, thereby removing the need for a separate consultation.

Question 6

It is proposed that the income raised from the Levy should be divided between the Local Authority and the City of London Police with 30% going to the Local Authority and 70% to the Police.

a) Do you agree that the net revenue from the levy should be split in this way? Yes/~~No~~

b) If not, please give your reasons for this and the split you feel would be more appropriate (Please remember that the Police cannot receive less than 70%).

Question 7

It is proposed that that income from the Levy received by the Local Authority will be spent in accordance with paragraphs 5.10 and 5.11 of this document.

a) Do you agree with the way in which the Local Authority will spend their portion of the levy. Yes/~~No~~

b) If not, please give your reasons below and any suggestions you have for ways in which the money can be spent (please remember that the money can only be spent on those areas described in paragraph 5.3 of this document.)

Again the proper answer to the question is not a simple yes or no. We are disappointed that the Council has not been more imaginative in use of the potential income raised by a levy. The emphasis again is on enforcement against premises, the vast majority of whom take great pains to comply with the law, since their livelihood and continues existence depends upon it. With crime figures falling there has been no recognition that responsible operators have played in contributing to that fall. The industry has engaged in and promoted many good practice schemes from pubwatches, through Best Bar None, Challenge 21 and so forth.

We seriously question whether the council will be able to deliver its programme when the council's estimate of the amount of its share is £66,668 when the two identified costs of £57,000 (additional post) and £23,000 (night time response) amount to £70,000. The estimate appears to exclude the cost of the

'team of officers to work during the midnight and 6am' the additional post being =created to operate the Code of Practice and Risk Assessment scheme.

The Council assumes that the levy will not affect businesses or the decisions they make. This is not true and is demonstrated by the Council's own assessment that 30% will most likely reduce their permissions to trade to avoid the levy. At the same time the amount raised for the council is assessed at only £66,668, not a particulary significant sum and one that is likely to be diminished further if the £15,000 allocated for administration proves an under-estimate.

Question 8

a) Do you agree with the way in which the Police will spend their portion of the Levy? ~~Yes~~/ No

b) If not, please give your reasons below giving examples where possible of how you think the money would be better spent.

The consultation reports that the police have now identified the funding of three additional officers but do not attribute a cost to that, leaving the question as to whether they are funding full-time posts. The only specific cost identified is that of that to cover the police costs associated with the discharge of their responsibilities under the Act, including dealing with Temporary Event Notices. This is an entirely inappropriate use of the funds provided under the terms of the levy. The Licensing Act, 2003 did not provide funding to the police for discharging its duties under the Act and little of this identified cost would be incurred by the businesses covered by the levy, since they would have little need of TENs.

The police bid for funding appears to rely primarily on the fact they have not discharged their duty in the past if "problem" premises have been identified but have not been dealt with.

We are extremely disappointed and concerned that the police cannot see any better way to allocate additional funds to activity that is already covered and are not looking to tackle one of the root causes of any crime and that is the individuals themselves. The arguments put by Government for the introduction of the levy and Early Morning Restrictions under the Police Reform & Social Responsibility Act 2011 was that there were needed where there were problems despite the presence of well-run businesses. The action proposed by the police should already have been taken against businesses that do not comply. There would be more sympathy for levy if the resources were directed at irresponsible and criminal individuals. There is no suggestion that any additional policing is being placed in this direction.

Paragraph 5.9 of the consultation states that the police would "allow the Licensing Team to further its partnership working" identifying those partners which do NOT include the trade. This is a fundamental oversight indicative of the failure of the police to properly engage businesses in the partnership. On this

basis alone we object to the imposition of a levy. The police must learn to work in partnership with business. The Code of Practice or any other initiative has little chance of success without that understanding.

Question 9

Have you any other comments to make regarding the introduction of a Late Night Levy?

We are disappointed that the Council has not seen to enter into any prior discussion with the businesses directly affected by the proposal. We note that the Council has withdrawn its statement from the revised consultation that "it is the view of the licensing authority that a levy should be introduced in order to contribute to the costs of policing the late night economy", we are worried by the thought that this remains the view of the Council and that the outcome of the consultation has been pre-determined.

We remain disappointed that the undertaking that "Officers would bring the analysed result of the recent consultation to the next Committee Meeting in February"[11] has not been honoured and that the Licensing Committee did not get the opportunity to see those responses. Nor does the Committee appear to have any influence as to the need for or form of the revised consultation.

The Council has not sought to make any assessment of the economic effect on the businesses concerned nor the activity within the night time economy that might be reduced. The City is a big draw for businesses and tourists alike and withdrawal of some of the venues from the market late at night might affect the attraction of the City as a place of entertainment.

The police have not made a case for the levy either in terms of the crime rate, or of their funding needs and the levy looks like what it, is a way of raising additional money. At best the money raised will go towards more enforcement activity on venues rather than on individuals where we believe any such additional funding would have the most beneficial effect.

In its report of the Licensing Committee's meeting on the 22nd October of last year (2012) the committee determined (Paragraph 15) that

"There are other wider considerations which may also be taken into account such as: the economic effects of the levy on operators, City Police's own capacity to fund crime prevention, the effect of the levy on voluntary schemes for reducing crime and disorder (Safety Thirst), whether there are any alternative means to reduce crime and disorder such as a Business Crime Reduction Partnership, and the equitability of changing the burden to operators rather than the community. These options would be addressed in any further detailed report on this issue."

[11] 21 October 2013 - Minutes of the meeting of the Licensing Committee held at the Guildhall EC2.

We can find no evidence that any such investigations have been carried out and that contrary to the Committee's wish that these other concerns be addressed the City of London have proceeded on the basis of the Corporation's officials which is reported in Paragraph 22 of the same meeting which states that:

We believe that the consultation is seriously flawed in both the evidence it presents and the reasoning, such as it is, neither of which justify the introduction of a levy. The Council should rather be encouraging a productive dialogue between businesses, police and itself taking a partnership approach to improving the social amenities for the residents and visitors to the City. Without such an approach we are firmly of the opinion that the levy will not only do little or nothing to address anti-social; behaviour and other alcohol-related crime but runs the real risk of producing counter-intuitive results leading to a worsening of the situation and alienation of those businesses operating in the area who are best placed to help.

We urge the Council to re-consider its proposal.

Thank you for completing this questionnaire. Could you please indicate below the capacity in which you are making your comments?

☒ Licensed Premises (with licence to sell alcohol after Mid-night)

☒ Licensed Premises (with licence to sell alcohol no later than Mid-night)

☐ Non-Licensed Business (no licence to sell alcohol)

☐ Resident

☐ Alderman or Common Councilman

☐ Other (please state)

We are happy to accept the consultation questionnaire anonymously but if you would like to tell us who you are then please complete your details below:

Name: **John Gaunt & Partners:** Omega Court, 372-374 Cemetery Road ,Sheffield S11 8FT
Email: info@john-gaunt.co.uk

Organisation you represent (if relevant): **Marstons PLC**

Appendix 4E

City of London

Consultation on the Proposal to Introduce a Late Night Levy

Response from Punch Taverns plc.

Punch Taverns is one of the UK's largest leased pub companies with a portfolio of around 4,000 leased pubs nationwide, ranging from pub restaurants to traditional drink led locals. Our aim is to become the UK's highest quality, most trusted and best value leased Pub Company. Our premises are operated by thousands of enterprising individuals – who we call our Partners - who are running their own pub businesses in our premises.

In 2005 we took the decision to hold the premises licence for our estate. Although we do not undertake licensable activities in our leased pubs, the holding of the premises licence imposes upon our business a significant obligation in terms of licensing regulation and compliance.

Corporate Social Responsibility (CSR) is embedded across many elements of our business, from corporate fundraising to responsible retailing. We have dedicated teams in place to assist in ensuring that our premises operate to the highest standards.

As Portman Group signatories and supporters of Drinkaware we do not condone irresponsible promotions and pricing of alcohol, and we have actively supported the 'Why let good times go bad?' campaign to tackle excessive drinking amongst 18 to 25 year olds.

Responsible retailing forms a key part of our partner training, and in the last eighteen months many of our Partners have completed our responsible retailing training. We also provide Risk Management manuals to our partners, which give clear guidance on current legislation and best practice, backed up by the support of our Risk and Compliance Teams, who provide specialist advice and guidance. We also support the BBPA's Customer Unit Awareness Campaign, part of the Association's contribution to the Government's Alcohol Responsibility Deal by making information and publicity available to our partners.

To further support our partners, we launched "The Punch Buying Club" offering our partners an online 24/7 service allowing partners to access all possible assistance to help run their business, this includes online training, regional workshops, legislative updates and best practice messages, Risk Management material such as mandatory signage and many other such materials.

All of our Partner Development Managers (PDM's) are trained to a minimum of BII level 4 in Multiple Retail Management, which consists of eight modules including communication, negotiating, business knowledge and marketing. We believe a well-trained, talented and high performing team will help our partners reach their potential and ensure their premises are well run.

We also have a number of other specialist employees to ensure that our partners are provided with the best knowledge throughout their relationship with Punch Taverns; our recently appointed New Business Development Managers (NBDM) are in place to provide our partners with up-weighted assistance and support for all newly launched businesses during their first six months of trading. This provides a platform for success and ensures they understand everything for running a safe, legal and compliant business

We believe that Punch Taverns is in a uniquely qualified position to make a valuable submission as, not only do our circa 4,000 premises cover every local authority area in England and Wales, but we also have significant experience and knowledge of the Licensing Act 2003, the Police Reform and Social Responsibility Act 2011 and associated relevant legislation.

We fully support the view that premises should be well run and promote the four licensing objectives. We do not however, support the view that those premises or indeed any premises should be obliged to pay a levy in addition to licensing fees, business rates and general taxation. The Licensing Act 2003 and associated relevant legislation contain sufficient safeguards and means of dealing with premises that cause or contribute to crime and disorder.

Furthermore, with the publication of the Home Office consultation on fees under the Licensing Act 2003, the proposal could potential see general licensing costs increase in the lowest band pubs. This could see licensed premises annual fees increase by 957% if the maximum is applied. It has been stated by Government that small businesses are at the heart of the economic recovery and are key in creating jobs in the community, and as such are committed to supporting them as far as possible such as cutting taxes, removing red tape and improving the small business infrastructure. We are strongly of the view that Local Authorities trying to implement a levy are penalising small and medium sized responsible premises who have the permission to trade into the levy supply period at a time of economic difficultly. Placing further financial burdens on already struggling businesses will only inhibit economic growth in the community.

It should not be forgotten that many premises that are permitted to supply alcohol beyond 00:01 will have conditions on their premises licences requiring the employment of door staff, the installation and use of a CCTV system and other such conditions, which result in a one off or on-going cost to the premises in terms of compliance. These premises, if the late night levy is adopted, will have to, in addition to bearing the expense of the foregoing, pay the levy (if they do not want to reduce the hours for which they are currently legally entitled to supply alcohol).

Whilst it is no doubt the case that the budgets of both the Police and the Authority are under pressure, licensed premises pay their annual licensing renewal fee, their business rates and other taxes. Licensed premises being required to pay another tax would be most unwelcome. For some businesses the late night levy will simply be unaffordable. It is quite likely the case that very many licensed premises that trade during the proposed late night levy supply period, will be required by conditions on their premises licences to incur expense regarding the installation and operation of CCTV systems, the employment of SIA registered door staff, the use of polycarbonate containers, etc. These conditions would have been imposed to promote the licensing objective of the prevention of crime and disorder. To be required to incur the expense of compliance with conditions and in addition to pay the late night levy when the likelihood of there being additional policing or other arrangements is most unwelcome to say the least.

CITY OF LONDON CORPORATION

LATE NIGHT LEVY

CONSULTATION QUESTIONNAIRE

Question 1

It is proposed that a Late Night Levy be introduced in the City of London in order to assist in the funding of the reduction and prevention of crime and disorder in connection with the late night supply of alcohol.

a) Do you agree that a late night levy should be introduced in the City of London?

No

b) If not please give your reasons below?

Fees are already raised through ordinary taxation, business rates, licence fee etc. It is inherently unfair to seek to raise funds from a 'class' of premises based simply on their legal right to trade during a specified period. It is also premature to consult on a late night levy when the entire fee structure for licensing is under review and may be changed substantially and in ways that conflict or have an element of 'double taxation' when considered next to the Late Night Levy.

Tel: 01283 501600 Fax: 01283 501803 Web: www.punchtaverns.com
Punch Taverns I Jubilee House I Second Avenue I Burton upon Trent I Staffordshire I DE14 2WF

Question 2
It is proposed that the Levy should be introduced for those premises who supply alcohol between the hours of midnight and 6 a.m.

a) Do you agree that if a levy was to be introduced it should operate between these times?

No

b) If not, during what time period do you think the levy should operate and why?

1am – 6am	☐	
2am – 6am	x	
Any other time span	☐	(please state which time span)

Reasons for your choice of time period:

There can only really be a true distinction between premises that operate solely as late night venues and premises that trade into a late night period. For fairness, the levy period should be set in such a way as to ensure that it catches only those premises that trade solely late at night. 2am is a reasonable time to make this distinction.

Question 3
It is proposed that no premises should be exempted from paying the Levy.

a) Do you agree that there should be no exemptions?

No

b) If not, which of the following types of premises do you think should be exempted from paying the levy? (Mark each one you think should be exempted).

Overnight Accommodation	x
Theatres & Cinemas	x
Bingo Halls	x
Community Amateur Sports Clubs	☐
Community Premises	☐
New Year's Eve	x
Business Improvement Districts	☐
No Exemptions	☐

c) If you have ticked one or more of the boxes above please give your reasons below.

Overnight accommodation:
On the basis that the exemption should only apply to permit the supply of alcohol to those who are staying at the premises, for consumption on the premises.

Theatre and Cinema:
We hold the view that these premises should be exempt on the basis that the supply of alcohol is ancillary to their business and they are unlikely to contribute to any crime and disorder issues that affect the NTE during the proposed supply period. The exempt supply should end at the conclusion of the film or theatre production.

Bingo Halls:
We hold the view that these premises should be exempt on the basis that the supply of alcohol is ancillary to their business and they are unlikely to contribute to any crime and disorder issues that affect the NTE during the proposed supply period. The exempt supply should end at the conclusion of the playing of bingo.

New Year's Eve:
New Year's Eve is a national event that in the past has been de-regulated to enable premises to operate later hours for the sale and supply of alcohol. It is often an extension to hours that has been 'grandfathered' onto licences without any other extended hours applied for and as such to require the fee to be paid would be an unreasonable burden for many operators and would result in significant additional burden to the authority in terms of administration of 'free' minor variations to remove.

Question 4
It is proposed that premises meeting the necessary 'small business rate relief' criteria should not be entitled to a reduction in Levy.

a) Do you agree that such premises should not receive a reduction?

No

b) If not, please give your reasons below?

We submit that such premises should be entitled to a reduction in respect of any levy adopted. Of all the premises that may be affected by a levy that may be adopted, these are some of the premises that can least afford to pay it.

Question 5
It is proposed that those premises meeting the requirements of the Safety Thirst Award Scheme should be entitled to a 30% reduction in their Levy payment.

a) Do you agree that such premises should receive a 30% reduction?

Yes

b) Please give your reasons below.

This answer is given notwithstanding we feel that other award schemes should be considered for eligibility, such as Best Nar None and Purple Flag. To fail to recognise such schemes reduces their viability and given that the levy is being introduced to deal with late night crime and disorder, all such schemes that have a positive effect need to be recognised.

It is suggested that any best practise scheme that involves an element of expense to premises in order to qualify- be that by way of paying a fee to join or because of costs associated in achieving the accreditation standard- this should be taken into account and a reduction to the levy applied.

Given that many premises are already required to invest as a matter of course in CCTV, door staff and other provisions mainly related to trading later into the night, as well as costs in achieving 'best practise', the reduction should be set at 30%

Question 6
It is proposed that the income raised from the Levy should be divided between the City Corporation and the City of London Police with 30% going to the City Corporation and 70% to the Police.

a) Do you agree that the net revenue from the levy should be split in this way?

Yes

b) If not, please give your reasons for this and the split you feel would be more appropriate (Please remember that the City of London Police cannot receive less than 70%).

Question 7
It is proposed that that income from the Levy received by the City Corporation will be spent in accordance with paragraphs 5.10 and 5.11 of this document.

a) Do you agree with the way in which the City Corporation will spend their portion of the levy?

No

b) If not, please give your reasons below and any suggestions you have for ways in which the money can be spent (please remember that the money can only be spent on those areas described in paragraph 5.3 of this document.

Point 5.10 of the consultation relates to a post created for the benefit of all licence holders and as such it is harmful and wrong to expect only a section to pay for it.

Point 5.11 of the consultation would purport to create night time posts only. This, we suggest is wholly unrealistic and will in truth become an enforcement body paid for by late night operators but used as a means of enforcing against all premises holders. This is not the purpose of the Levy.

Regulation 8 of The Late night levy (Application and Administration) Regulations 2012 is prescriptive regarding how the Licensing Authority must apply its proportion of any monies raised by the adoption of the Late Night Levy.

We believe that the council's portion of the levy should be used for cleaning of any highway maintainable at the public expense within the City of London and for other schemes that would benefit all parties paying the Levy.

Question 8

a) Do you agree with the way in which the City of London Police will spend their portion of the Levy?

No

b) If not, please give your reasons below giving examples where possible of how you think the money would be better spent.

Using funding to pay for objections to TENs is simply robbing Peter to pay Paul. TENs are excluded from the Late Nigh Levy. To get applicants to pay a levy to allow the police to object to it is unfair. Presumably most applications come from premises who do not have later hours (including those who reduce their hours to avoid paying the levy)

The 'action team' does not appear to be focussed on the night time economy. Again, this is a misallocation of the funds raised.

Covert operations are not used necessarily for 'early intervention'. Indeed it is certainly not solely used for the night time economy. For instance, test purchase operations should not be paid for by the Late Night Levy given that such operations need to focus on a much wider time period.

Should the Late Night Levy be introduced, the police portion of the levy should be used to fund extra officers on the street during the levy period and nothing more.

Question 9

Have you any other comments to make regarding the introduction of a Late Night Levy?

It is accepted that in these challenging times, all (new) sources of possible revenue need to be considered. That said, the concern is that the monies generated by the late night levy will be used to limit the savings that the Police and the Authority need to secure to their budgets and that the monies raised will not be used to pay for additional policing or other arrangements related to the late night economy.

The City of London is almost unique in that it is predominantly a 'working' borough that operates working hours much later than those in other business districts - particularly with its significant number of international corporations. Therefore, the City has a service industry that supports the Cities unique hours. As such, we have concerns that the Levy, if introduced, will have detrimental consequences in forcing restaurants and pubs to vary their hours in order to avoid paying the Levy. This is because often trade after midnight is not sufficient to warrant payment of an additional Levy. We also feel that there has not been enough consideration given to the fact that business rates in the City of London are generally very high and therefore the Levy charged will also be higher than in other areas. Losing this amenity could have a detrimental effect on the image and perception of the City of London as one of the world's leading commercial centres.

In addition, implementation of a levy is likely to cost more than envisaged to administer and the amount of revenue raised could be significantly less than expected. It would appear that there has been no consideration of 'hidden' costs, such as the inevitable increase in TEN's applications that will require processing and will in all probability lead to more hearings before the Licensing Committee.

Whilst the Police and Council incur costs in relation to the reduction or prevention of crime and disorder in connection with the supply of alcohol between 00.00am and 6.00am, the night time economy provides economic benefits to the City which may be lost, at least in part, on implementation of a levy.

It is far from clear what funds will be raised by the late night levy, if it is introduced (despite the figures quoted above). We have concerns that any monies raised will not be sufficient to ensure the Authority can properly comply with its obligations under regulation 8 of The Late Night Levy (Application and Administration) Regulations 2012.

Further, we disagree with the figures stated in the consultation as being the sums that will be raised. Many premises who either do not use their later hours or who simply have permissions for the odd Bank Holiday that take them into the Late Night Levy period will simply remove those permissions, which will reduce the amount raised.

Certainly we would have serious concerns about the use of the Levy to fund enforcement action against all premises irrespective of whether they operate later hours or indeed have any effect on the night time economy.

It is also important to take into account the fact that when premises secured permission to undertake the supply of alcohol during the proposed late night levy period they will have, in many cases, been required to comply with conditions to assist in ensuring they were able to continue to promote the licensing objectives. Complying with these conditions will, in many cases, have resulted in the premises incurring not inconsiderable expense.

Additionally, if there are particular premises that are not promoting the licensing objectives, they can be subjected to, amongst other measures, a review under section 51 of the 2003 Act, a summary review under section 53A of the Act, a prosecution under section 136 of the Act, a closure order under section 161 of the Act or a closure notice under section 19 of the Criminal justice and Police Act 2001.

As such, and for all the reasons stated above it is felt that the Late Night Levy will not benefit the City of London in any meaningful way.

Of greatest significance, however, is the Fees consultation currently under way. It would be a significant error in judgement to seek to implement a levy of premises who are currently being asked to contemplate significant fee increases in any event. In addition, there are elements of the fee consultation that overlap with the purpose of the LNL. Whilst the police would not directly see any monetary gain from a change in the fee structures it is likely that there will be a significant effect on the Night Time Economy that would not be fully understood before a levy is introduced.

Thank you for completing this questionnaire. Could you please indicate below the capacity in which you are making your comments?

Licensed Premises (with licence to sell alcohol after Mid-night)	☐
Licensed Premises (with licence to sell alcohol no later than Mid-night)	☐
Non-Licensed Business (no licence to sell alcohol)	☐
Resident	☐
Alderman or Common Councilman	☐
Other (please state)	

National Pub Company with premises in the City of London both entitled to sell alcohol after midnight and with no such entitlement.

We are happy to accept the consultation questionnaire anonymously but if you would like to tell us who you are then please complete your details below:

Name: Steven Buckley

Organisation you represent (if relevant): Punch Taverns plc.

This response is made for and on behalf of Punch Taverns plc.

Committee(s):			Date(s):
Health and Wellbeing Board	-	For information	30 May 2014
Open Spaces City Gardens Committee	-	For decision For information	2 June 2014
Community and Children's Services Committee	-	For decision	13 June 2014
Housing Sub Committee	-		10 July 2014
Subject: Smokefree Children's Playgrounds			**Public**
Report of: Director of Community and Children's Services/Director of Open Spaces			**For Decision**

Summary

This report presents the proposal of implementing voluntary no smoking codes within children's playgrounds, for a trial period of six months, in four identified areas in the City:

- Middlesex Street estate
- Tower Hill Gardens
- Portsoken Street
- West Smithfield Rotunda Garden

The key aim of smokefree children's playgrounds is to deter children and young people from smoking. The objectives include:

- To reduce child exposure to smoking and help to decrease the number of young people starting to smoke
- To decrease cigarette litter such as cigarette ends, empty packets and wrappers to playgrounds more pleasant and to protect wildlife.
- To reduce the risk of children putting toxic cigarettes ends into their mouths

A consultation exercise has been carried out with the public and Friends of City Gardens, which evidenced support for this initiative.

Recommendation(s)

Members are asked to:

- Agree the smokefree children's playgrounds' proposal in principle
- Agree the four playgrounds where the proposal should be implemented for a trial period

Main Report

Background

1. The Healthy Lives, Healthy People: A Tobacco Control Plan for England, published in 2011 described what the Government would do to reduce tobacco use over the next five years.[1] In the plan, support is given to local communities and organisations who want to go further than the requirements of smokefree laws in creating environments free from second hand smoke, for example, in children's playgrounds, outdoor parts of shopping centres and venues associated with sports and leisure activities.

2. An increasing number of Councils in the UK are creating smokefree playgrounds. The usual mechanism is by using voluntary codes; although some Councils are considering whether seeking local regulatory powers would be practicable.

3. The benefits of stopping smoking in playgrounds have been identified as follows[2]:

   - To support the denormalisation of smoking
   - The reduce the risk of exposure to second hand smoke
   - To reduce smoking-related litter and the threat of cigarette ends, which are non-biodegradable and toxic to children, wildlife and the environment
   - To reduce fire risk
   - To offer the potential for increased use of parks and recreation areas

4. Children become aware of cigarettes at an early age. Three out of four children are aware of cigarettes before they reach the age of five, irrespective of whether or not their parents' smoke. However, if young people see smoking as a normal part of everyday life, they are more likely to become smokers themselves.[3]

5. Denormalisation of smoking is a phrase used in tobacco control to refer to the breaking down of community acceptance and tolerance for smoking.[4] Children, it is argued, are greatly influenced by their sense of what is normal and attractive, which is in turn influenced by the imagery and social meaning attached to different behaviours portrayed in media and youth culture.[4]

6. Measures which discourage the use of tobacco in premises covered by smokefree legislation and prevent smoking activity in outdoor settings, such as play areas, by means of codes or norms also have a denormalising affect by reducing the exposure that children have to smoking.

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[1] HM Government (2011) The Healthy Lives, Healthy People: A Tobacco Control Plan for England.
[2] UK Healthy Cities Network (2012) The case for smokefree children's play areas. Available at: www.healthycities.org.uk/uploads/files/network_briefing_smokefree_childrens_play_areas_v2.pdf
[3] Office for National Statistics (1997), Teenage smoking attitudes in 1996.
[4] Hastings G and Angus K (2008), Forever cool: the influence of smoking imagery on young people. Available at: www.management.stir.ac.uk/about-us/?a=19777

Current Position

7. The City Tobacco Control Alliance meets quarterly and is responsible for overseeing a range of work streams delivering the Corporation's tobacco control priorities.
8. There are different work streams of the Alliance, two of which are to denormalise smoking and to prevent young people from starting to smoke.
9. Currently all playgrounds in the City permit smoking as they are not included within the national smokefree legislation.
10. The Alliance has identified four possible playgrounds where a voluntary code could be implemented. These playgrounds are located in:
    a. Middlesex Street Estate
    b. Tower Hill Gardens
    c. Portsoken Street
    d. West Smithfield Rotunda Garden
11. The public, residents of Middlesex Street Estate and Friends of City Gardens have been consulted on the proposals, full details in Appendix 1 and 2.
12. Implementation and communication of the proposal was discussed with the Area Manager of Middlesex Street Estate. A briefing note was posted to all residents of Middlesex Street estate detailing the proposal and asking for comments. Details were also posted on their Facebook page. No feedback has been received.
13. The Friends of City Gardens are in general favour of the proposal, however they do have some concerns; enforcement, appropriate signage and removal of litter bins. They also suggest that gardens heavily used by City workers or visitors would be better placed to implement this proposal.
14. The City Gardens Support Services Officers assisted completion of questionnaires to users in the three identified gardens. 27 questionnaires were completed. The majority of respondents are in favour of voluntary smokefree children's playgrounds, but did note issues with enforcement.
15. 89% of respondents stated it is very important/moderately important for the City of London Corporation to prevent children being exposed to second hand smoke.
16. 85% of respondents strongly agreed/agreed on a voluntary code of not smoking within the children's playgrounds. 55% strongly agreed/agreed on a voluntary code of not smoking within the entire garden.
17. 74% of respondents strongly agreed/agreed that appropriate signage would strengthen the message.
18. Half of respondents believe a voluntary code of not smoking will reduce levels of smoking in the area, however, 37% believe it will be difficult to enforce.

Proposals

19. It is proposed that smokefree playgrounds will be implemented for a trial period of 6 months and evaluated to inform future delivery.

20. It is proposed that implementation of the smokefree playgrounds will involve:

    a. Initial observation of smokers in the identified areas to determine a baseline for evaluation.

    b. Development of public information resources and appropriate signage. See Appendix 3 for examples of signage.

    c. Provision of smokefree training for gardeners and housing officers to enable them to respond to questions from the public and to signpost them to local Stop Smoking Services.

    d. A launch of smokefree playgrounds by preparing press releases.

21. The effectiveness of the initiative is proposed to be measured by an initial observation of smokers in the identified areas before the launch of the project. This observation will be repeated after the trial period and compared.

22. The Public Health Team will work in partnership with the Area Manager for Middlesex Street Estate to ensure the initiative is communicated to all residents. Letters will be sent to all residents, as well as posters displayed in communal areas. Training of the housing officers will ensure that they are equipped to answer residents' questions.

23. Please note this initiative will not be policed by Corporation officers. We expect it to be self policing, supported by the appropriate signage. Examples of smokefree outdoor areas around the world show that signage acts as a simple yet powerful deterrent and is largely self regulating.

Conclusion

24. Smokefree children's playgrounds are becoming increasingly common in the UK and have strong public support. The evidence from the local consultation mirrors this support. However, enforcement is deemed as an issue.

25. Smokefree children's playgrounds are an important component of tobacco control policy in helping to reduce the health and economic burden of smoking in our communities.

26. The Board are asked to agree the proposal of smokefree playgrounds, and agree which playgrounds should be identified.

Appendices

- Appendix 1 – Comments from Friends of City Gardens
- Appendix 2 – Results from public consultation
- Appendix 3 – Example of signage

Gillian Robinson
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City and Hackney Public Health Service

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Appendix 1

Feedback from the Friends of City Gardens

1. The three gardens selected for the trial are in socially deprived areas (Portsoken, Smithfield (close to hospital and used by rough sleepers) and Tower Hill gardens and although all 3 had children's play areas it was felt the trial would be more meaningful if it included gardens heavily used by City workers or visitors - such as Cleary or St Paul's.

2. Although banning smoking in gardens and in particular those with children's' play areas might be desirable enforcing it would be impossible.

3. More positive steps to stop smoking were generally felt to be more effective than a ban. Perhaps engagement with smokers in these gardens as part of the consultation and providing positive encouragement to stop would be more effective.

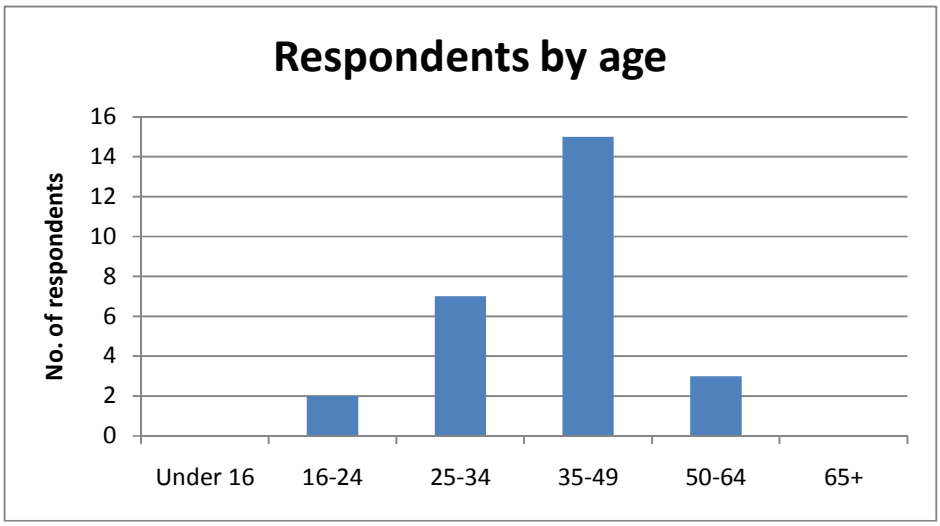
4. Using signs such as **thank you for not smoking in the children's play area** might be more effective - such as those in Fortune Park.

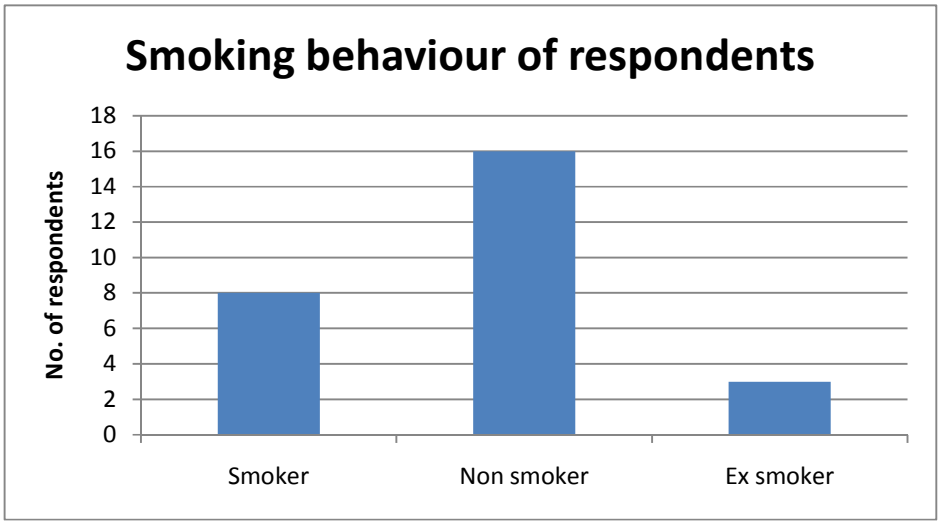
5. We would be concerned that if smoking was banned that smoking litter bins would be removed which would be likely to create a litter problem as people would still smoke and throw their butts on the ground and in flower beds where they are difficult to remove.

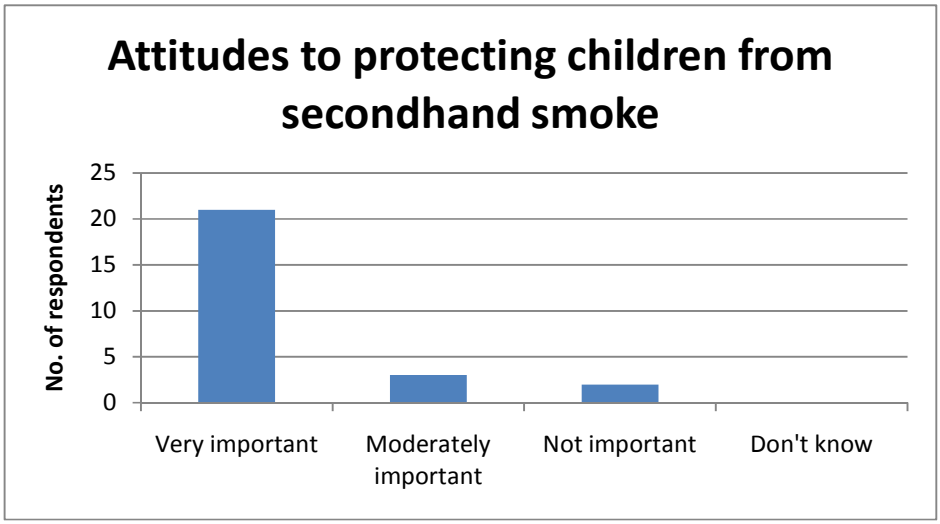
6. We would also be concerned that Smoking Ban signage could be intrusive and spoil the relaxed atmosphere of the gardens.

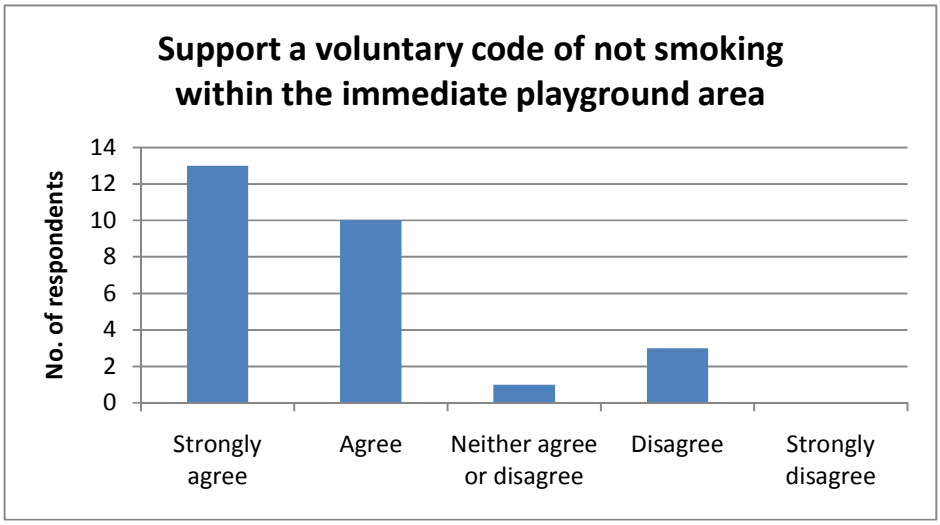
Appendix 2

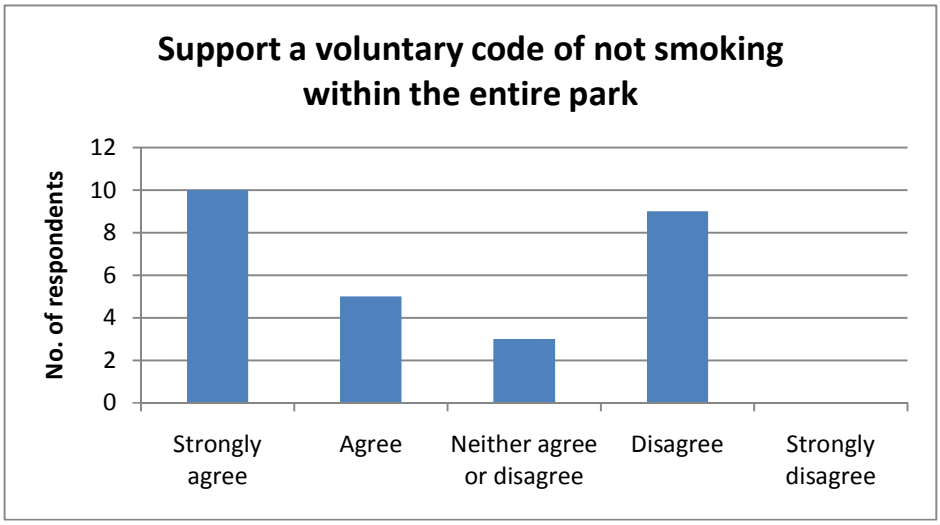
Results from public consultation

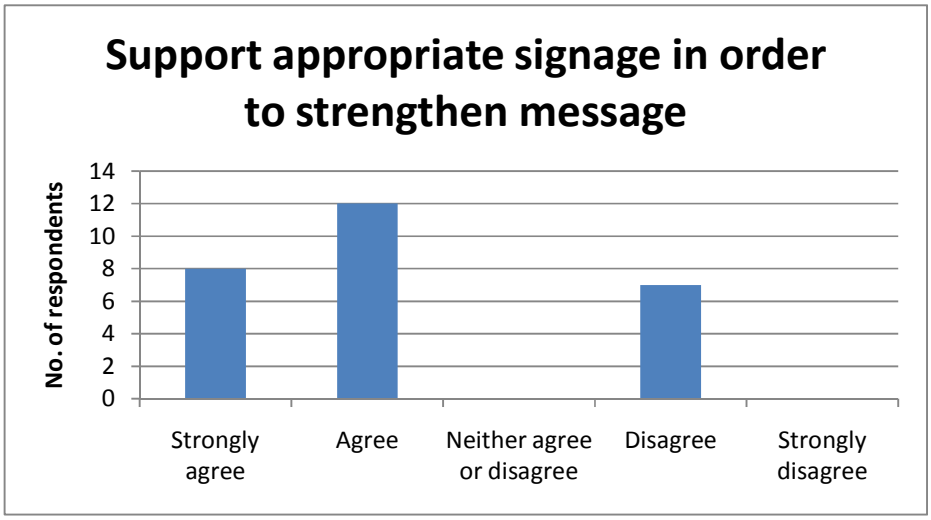


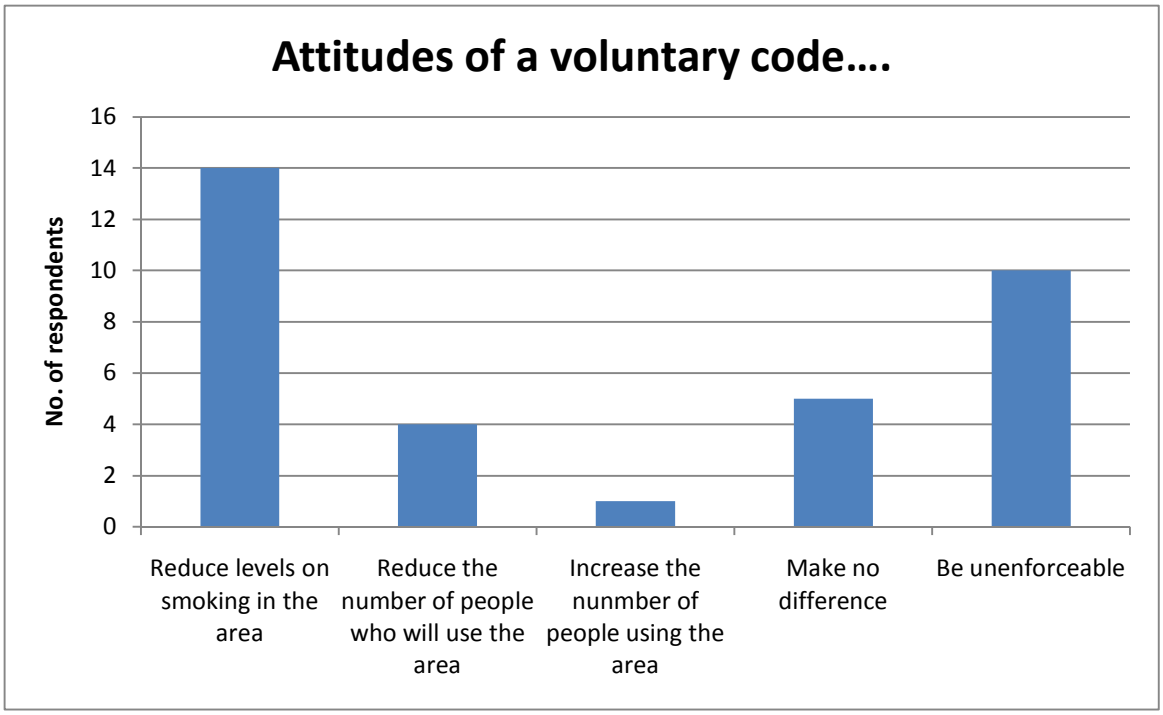



Attitudes to protecting children from secondhand smoke
No. of respondents
25
20
15
10
5
0
Very important
Moderately important
Not important
Don't know


Support a voluntary code of not smoking within the immediate playground area
No. of respondents
14
12
10
8
6
4
2
0
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree


Support a voluntary code of not smoking within the entire park
No. of respondents
12
10
8
6
4
2
0
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree





What is your view on the CoLC creating smokefree outdoor spaces where children (under 18) are present?

Good idea
Good idea
Good idea
Good idea
Good idea as long as there are places where people can smoke
Agree, where there is a heavy presence of children
Yes, good idea
Has a duty to provide spaces that children are not subject to smoke
There should be smokefree spaces
Playgrounds - yes
This park should be a no go area for smokers
Are you addressing the core issue - air pollution

Agree but should also have places for smokers
A good thing depending upon size of space and no. of people presently smoking there
Important for children to be in a smokefree area
Support scheme
A very good project
Very sensible, a good idea. The less children are exposed to smoking and observing those smoking the better
Agree. I wouldn't smoke next to people who are eating or children.
Not supportive
Of course, good idea

Other potential smokefree areas suggested
Smoking should be banned in all outdoor parks/gardens
Building entrances
Rule should be introduced on a site by site basis
Parks only
Don't like smoking outside stations
Focus on areas where children are present
All public parks
Outside tube stations

Comments
Good idea, but right location? Bigger issue - air quality
Lots of restrictions on smokers already. Fence off play area?
How many children really use the space ratio to smoker and other users?
Smoking banned so much that it is difficult to say where it is a problem. Doorway smoking is unpleasant
Smoking ban doesn't work outside Smithfield Market
Smoking in gardens is ok if they are courteous and not sit close to others when smoking
What would stressy bankers do?
Depends on location. Usage can vary - nursery across the road use the site
Second-hand smoke has less impact in outdoor areas
No children use the park. Enough limitations on smokers already
If it's voluntary, people may not comply
A brilliant idea
Should be compulsory
What is the proposal for e-smoking? There is no secondary smoke, should it be treated differently? No, in my opinion but there is no public statement on this.

Appendix 3

Examples of signage

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Committee(s):	Date(s):
Health and Wellbeing Board	30 May 2014
Subject: Information report	**Public**
Report of: Executive Support Officer	**For Information**

Summary

This report is intended to give Health and Wellbeing Board Members an overview of key updates on subjects of interest to the Board where a full report is not necessary. Details of where Members can find further information, or contact details for the relevant officer are set out within each section as appropriate.

Local updates

- Barts Health NHS Trust Cleaner Air Project
- Transforming Services, Changing Lives in East London
- Safer City Partnership Review
- Better Care Fund update

Policy updates

- Events
- Health Inequalities
- Older People
- Children and Young People
- Smoking
- Alcohol
- Mental Health
- Carers
- Environmental Health
- Diet and Nutrition
- Communicable Diseases
- Health and Wellbeing Board Guidance
- Public Health Guidance/Tools

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 are set out within each section as appropriate.

LOCAL UPDATES

Barts Health NHS Trust Cleaner Air Project

2. Barts Health NHS Trust is taking action to improve air quality across East London. Between 2014 and 2016, the Barts Health Cleaner Air Project aims to boost the health and wellbeing of at risk communities, enabling them to better protect themselves from the negative effects of air pollution. The City of London Corporation is supporting this ambitious programme, to build on the work already done to improve air quality in the Square Mile

3. The Cleaner Air project is a partnership between Barts Health NHS Trust, the GLA, the four local authorities in which Barts Health is based, and environmental charity Global Action Plan.

4. It takes a multi-faceted approach to the issue of improving local air quality, tackling both preventative measures to improve air quality and helping to enable at-risk communities to protect themselves from the negative effects of pollution, which are already evident.

5. Benefits of the project to the Board include:

   - Supports Health & Wellbeing Boards to achieve their goals of improving the health and wellbeing of their local population, whilst reducing health inequalities.
   - Helps to create better informed and more effective public health strategies and community engagement through cutting edge behaviour change theory, generating original, validated local data and collating project learnings and recommendations.

6. This evidence based approach will enable:
   - Baseline current pollutant levels across the four local authority areas
   - Accurately track and measure the success of interventions
   - Engage with a wide range of individuals and groups including patients, staff, and community members/groups
   - Track short and longer term health improvements
   - Link at risk community members/groups to available NHS services

7. The contact officer is Ruth Calderwood: 020 7332 1162

Transforming Services, Changing Lives in East London

8. Transforming Services, Changing Lives (TSCL) is a clinical review programme established by local clinical commissioning groups (CCGs) Waltham Forest, Tower Hamlets, Barking and Dagenham, Newham, and Redbridge; NHS England; Barts Health NHS Trust and other local providers, including Homerton University Hospital NHS Foundation Trust.

9. The aim of the programme is to understand the current demands on the NHS and analyse the local health economy. Local clinicians have been asked to use their own knowledge of national and international best practice to review the quality and performance of East London health and social care services, highlight areas of good practice that should be maintained and developed, and set out if, why, and in what specialties they think there may be a case for change to ensure the very best care for local residents. It will not, at this stage, set out any recommendations for change.

10. A public and patient reference group has been established to provide ideas and feedback to clinicians leading the TSCL programme. The group is made up of representatives from three broad groups:

    - local branches of Healthwatch, including City Healthwatch
    - patient representatives from the CCGs involved in the programme
    - patient representatives from the providers involved in the programme, including Homerton University Hospital

11. During the summer the initial thoughts and ideas being developed by clinicians will be tested out with a wider group of stakeholders before publishing a Case for Change in autumn 2014.

12. Following the publication of the Case for Change, if partner organisations conclude change may be necessary a longer term transformation programme incorporating wide public and patient engagement will be considered.

13. The contact officer is Zoe Hooper, TSCL Communications Manager: TSCL@nelcsu.nhs.uk / 0203 688 1678

Safer City Partnership Review

14. Over the last four months, the Safer City Partnership (SCP) Review took place. The review process engaged the statutory partners, City of London Police, London Fire Brigade, Health and Probation. The process also included a number of key officers within the City of London Corporation and Members with links to the SCP.

15. From the review a number of recommendations have been produced with resources within the SCP team being highlighted as essential. The current lack of resources has resulted in limiting the ability of the SCP's scope to operate effectively. 'Partnership' priority planning has been limited and would benefit from greater partner involvement.

16. The review also looked at the number of groups which meet to tackle a wide range of issues such as antisocial behaviour, night time economy, vehicle crime reduction, drug and alcohol abuse and domestic violence, all working well in their own rights but some lacking coordination and a framework linking them to the strategic governance of the SCP Strategy Group and other Committees etc. such as the Health and Wellbeing Board.

17. The recommendations will re-establish resources within the SCP team and look to develop a clear framework of governance and performance. Plans will be developed together with partners to explore opportunities to co-locate and work together more intelligently and share resources.

18. Work has now started to re-establish the SCP team and an interim Community Safety Manager has been appointed, further work will take place to recruit to the two vacant Community Safety Officer posts, this will then create capacity to deliver the SCP Annual Priority Plan and strengthen links with partners. Engagement with Partners has begun and there have been positive discussions on how to move the Partnership forward and improve joined up working".

19. The contact officer is Alex Orme: 020 7332 1397

Better Care Fund update

20. The City of London Better Care Fund Plan and performance metrics were submitted to NHS England on 4 April 2014. On 6 May 2014 NHS England wrote to all local authorities to provide an overview of the quality assurance process, confirming the regional process was complete and a national process was "now underway to determine any further requirements or areas for clarification." The regional process identified some gaps in data in the City of London submission that have now been provided.

21. The contact officer is Simon Cribbens: 0207 332 1210

POLICY UPDATES

Events

22. **Health and Wellbeing Boards one year on**
This one day event will provide an opportunity to discuss the progress and next steps for Health and Wellbeing Boards and the impact so far of the return of public health to local authorities**.**

- When: Thursday June 26th 2014, 9:30am-4:00pm
- Where: Aston University Birmingham
- Booking: www.coventus.net

Health Inequalities

23. Race equality and health inequalities: towards more integrated policy and practice
This paper argues that within the English health system the equality and diversity (E&D) and health inequalities (HI) agendas remain poorly integrated at both national and local level. In particular, the HI agenda has largely failed to pay explicit attention to axes of inequality other than the socioeconomic gradient.
    - Link: http://www.better-health.org.uk/sites/default/files/briefings/downloads/Health%20Briefing%2032_0.pdf
    - *There is a population of BME families and individuals in the Portsoken ward who may have particular health issues*

24. **The maternal mental health of migrant women**
This briefing examines why there is low take-up of maternal mental related services by migrant women in the UK. It considers how maternal mental health care providers can develop services which meet the needs of migrant women.

    - Link: http://www.better-health.org.uk/sites/default/files/briefings/downloads/Health_Briefing_31_0.pdf
    - *The City has a high migrant population.*

25. **Living well for longer: national support for local action to reduce premature avoidable mortality**
This document sets out how the health and care system aims to become amongst the best in Europe at reducing levels of avoidable mortality. Focusing on cancer, stroke, heart, liver and lung diseases, it sets out examples of good practice and help for local commissioning and service delivery.

    - Link to guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf

26. **The equity action spectrum: taking a comprehensive approach. Guidance for addressing inequities in health.**
This is one of a series of policy briefs that describe practical actions to address health inequities, especially in relation to tobacco, alcohol, obesity and injury, the priority public health challenges facing Europe. It provides a framework that policy-makers at national, regional and local levels can apply to their own unique context, to help them consider the processes by which inequities occur and suggest policy interventions to address them.

- Link: http://www.euro.who.int/en/publications/abstracts/equity-action-spectrum-taking-a-comprehensive-approach-the.-guidance-for-addressing-inequities-in-health

27. **Good practice in improving care for vulnerable groups**
This report includes examples of good primary care that improves registration and access to care. It outlines what makes good practice and explains why the chosen approaches are successful in improving access to primary care.

- Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307376/Promising_Practice.pdf

28. **Inclusive practice**
This report reviews the impact of efforts to provide good access to primary care services. It reviews levels of hospitalisation for the four vulnerable groups identified in the Inclusion Health programme: vulnerable migrants; gypsies and travellers; people who are homeless; and sex workers.

- Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305912/Inclusive_Practice.pdf

Older people

29. Focus on: social care for older people - reductions in adult social services for older people in England
This report examines the scale and scope of cuts to social services for older people in England from 2009/10 to 2012/13. It reveals that most local authorities are tightly rationing social care for the over-65s in response to cuts, resulting in significant drops in the number of people receiving services.

- Link: http://www.nuffieldtrust.org.uk/publications/focus-social-care-older-people

30. **Transforming primary care: safe, proactive, personalised care for those who need it most**
This guidance sets out plans for more proactive, personalised and joined up care, including the Proactive Care Programme, providing the 800,000 patients with the most complex health and care needs with a personal care and support plan; a named accountable GP; a professional to coordinate their care; and same-day telephone consultations.

- Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf

31. **The generation strain: collective solutions to care in an ageing society**

The number of older people in need of care is expected to outstrip the number of family members able to provide informal care for the first time in 2017, according to a report by IPPR. The report says that the number of people aged 65 and over without children to care for them will almost double before the end of the next decade and that by 2030, there will be more than 2 million people in England without a child to care for them if needed.

- Link: http://www.ippr.org/assets/media/publications/pdf/generation-strain_Apr2014.pdf

32. **Learning for care homes from alternative residential care settings.**
This review explores the learning from delivery of care in residential services for children and young people, residential services and supported housing for people with learning disabilities and hospice care, and considers how this can be applied in care homes for older people.

- Link: http://www.jrf.org.uk/sites/files/jrf/residential-care-learning-full.pdf
- *There is an aging population in the City who may eventually require home care and end-of-life services at home.*

33. **Flu plan: winter 2014 to 2015**
This plan sets out a coordinated and evidence-based approach to planning for and responding to the demands of flu across England. It will aid the development of robust and flexible operational plans by local organisations and emergency planners within the NHS and local government.

- Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/306638/FluPlan2014_accessible.pdf

34. **Comobidities: a framework of principles for system-wide action**
This document sets out the current challenges faced in the health and social care system in treating people with 2 or more long term health conditions. It proposes changes to the system to improve care.

- Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307143/Comorbidities_framework.pdf

35. **Ageing alone: loneliness and the oldest old**
This report argues that loneliness should be a public health priority and explores practical steps that can be taken to reduce levels of loneliness among the oldest old. Addressed to politicians and policy makers in both central and local government, leaders and innovators in the voluntary and community sector, and wider society as a whole, the report urges them to give more priority to the services and support that we know can help older people avoid ageing in loneliness and isolation.

- Link: https://cminteractive.net/ci/centreforum/tomfrostick/ageingalone.pdf

36. **Crime, fear of crime and mental health**
This study is a synthesis of theory and systematic reviews of interventions and qualitative evidence. It examined how interventions to reduce crime and fear of crime could help to improve population-level wellbeing and mental health

- Link: http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0005/115349/FullReport-phr02020.pdf
- *The City has low crime however older people may have fear of crime, especially with the increasing late night economy and recent marketing campaigns.*

Children and young people

37. School nursing: public health services guidance
This guidance supports effective commissioning of school nursing services to provide public health for school aged children. It also explains how local school nursing services can be used and improved to meet local needs.

- Link to report on maximising school nursing team contribution: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf
- Link to report on promoting emotional wellbeing and positive mental health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299268/Emotional_Health_and_Wellbeing_pathway_Interactive_FINAL.pdf
- Link to report on supporting young carers: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299270/Young_Carers_pathway_Interactive_FINAL.pdf

Smoking

38. Smoking, plain packaging and public health
This briefing aims to analyse policies towards tobacco harm reduction and looks at the effectiveness of plain packaging policies.

- Link: http://www.adamsmith.org/sites/default/files/research/files/ASIsmokingplainpackagingWEB.pdf
- *Smoking is an issue for all populations in the City*

39. **Standardised packaging of tobacco - report of the independent review undertaken by Sir Cyril Chantler**

This report concludes that standardised packaging of tobacco is likely to contribute to a reduction in smoking, including reducing the rate of children taking up smoking.

- Link: http://www.kcl.ac.uk/health/10035-TSO-2901853-Chantler-Review-ACCESSIBLE.PDF

Alcohol

40. **Liver disease: today's complacency, tomorrow's catastrophe**
This report reveals a consensus across the medical community on the urgent need for action on liver disease, as well as on the actions that are required. It finds that deaths from liver disease in England have risen 40% between 2001-2012.

- Link: http://www.hcvaction.org.uk/resource/liver-disease-todays-complacency-tomorrows-catastrophe-all-party-parliamentary-hepatology
- *Liver disease has strong links to alcohol misuse*

41. **Responsibility deal alcohol network: pledge to remove 1 billion units of alcohol from the market by the end of 2015: first interim monitoring report**
This report explains the progress that has been made towards the Public Health Responsibility Deal Alcohol Network pledge to remove 1 billion units of alcohol from the market by the end of 2015. It shows that so far the number of units of alcohol sold has been reduced by a quarter of a billion.

- Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/306529/RDAN_-_Unit_Reduction_Pledge_-_1st_interim_monitoring_report.pdf

42. **Global status report on alcohol and health 2014**
This report provides country profiles for alcohol consumption in the 194 WHO Member States, as well as the impact on public health and policy responses. It found that worldwide, 3.3 million deaths in 2012 were due to harmful use of alcohol.

- Link: http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_1.pdf?ua=1

Mental Health

43. **#MHN2014: the future of mental health**
This paper discusses what challenges mental health services face and what these challenges might mean for the future of the nation's mental health.

- Link: http://www.nhsconfed.org/Publications/Documents/The_future_of_mental_health_03_2014.pdf

44. **Mental Healthwatch handbook: improving mental health with your community**
This handbook provides information on how Healthwatch can help improve mental health with a range of partners including central government, service users, commissioners, providers, the voluntary sector and councils.

- Link: www.nsun.org.uk/.../mentalhealthwatchhandbookv1april20142.pdf

45. **Managing patients with complex needs: evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service**
This report reviews a service that helps GPs in the City of London and Hackney to support people who fall through the gaps in existing service provision. It finds that it improves health at the same time as reducing costs in both primary and secondary care services

- Link: www.centreformentalhealth.org.uk/.../Managing_patients_complex_needs. pdf

Carers

46. Supporting employees who are caring for someone with dementia
Carers UK and Employers for Carers carried out an employer and employee survey between October 2013 and January 2014 to find out the impact of working while also caring for someone with dementia. This report sets out the key findings and emerging issues from these surveys. It concludes by making 10 recommendations for employers, health and social care services and government to take to facilitate better support for employees who are caring for loved ones with dementia.

- Link: http://www.carersuk.org/for-professionals/policy/policy-library/supporting-employees-who-are-caring-for-someone-with-dementia
- *It is likely that many City workers also have caring responsibilities.*

47. **NHS England's commitment to carers**
This document sets out a series of commitments that NHS England will do to support carers, reflecting what NHS England has heard from carers during a number of engagement events.

- Link: http://www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf

Environmental Health

48. Active by design: designing places for healthier lives
This guide looks at how the design of buildings and public spaces in cities and towns can lead to positive changes in our lifestyle and ultimately to greater levels of physical activity. It outlines the key facts which detail the problems of inactivity; examples of action which could be taken; and suggestions for different sectors and professions.

- Link: https://www.designcouncil.org.uk/sites/default/files/asset/document/Active_By_Design_Brochure_web_LATEST.pdf

49. **Reports from the Committee on the medical Effects of Air Pollutants** (COMEAP) COMEAP advises on all matters concerning the health effects of air pollutants. These reports include reviews of: the UK air quality index; mortality effects of long-term exposure to particulate air pollution in the UK; long-term exposure to air pollution: effect on mortality; and cardiovascular disease and air pollution.

- Link: https://www.gov.uk/government/collections/comeap-reports

Diet and Nutrition

50. **Good Food For London**
This report provides an accessible view of progress made by London boroughs towards a healthy sustainable and ethical food system. The report celebrates achievements made by boroughs that are showing leadership and challenges other boroughs to follow their good example. *Note registration is required to download the full report, however the maps are free to access.*

- Link: http://www.sustainweb.org/londonfoodlink/good_food_for_london_2013/
- *This report particularly covers boroughs engaging in healthier catering overall and in schools.*

51. Blood sugar rush: diabetes time bomb in London
This report finds that almost half a million Londoners are living with Type 2 diabetes and that the figure is set to increase exponentially over the coming

years. It aims to find out what is driving the increase in Type 2 diabetes across London, and how the delivery of diabetes care is managed and where improvements can be made in providing that care.

- Link: http://www.london.gov.uk/sites/default/files/Diabetes%20report.pdf

Communicable disease

52. **Surveillance of infectious disease**
This briefing describes current surveillance efforts and examines new technological developments and their likely impacts on UK and international public health.

- Link: www.parliament.uk/briefing-papers/post-pn-462.pdf
- *The high density of City workers may increase the risk of infectious disease in the Square Mile.*

53. **HIV prevention in the UK**
This note describes patterns of infection and policies to increase HIV testing. It also summarises evidence for using antiretrovirals as a preventive measure.

- Link: www.parliament.uk/briefing-papers/POST-PN-**463**.pdf

54. **Sexual and reproductive health evidence summaries**
This package of new resources provides the latest evidence on the impact and economics of opportunistic chlamydia screening, and HIV screening and testing. PHE have produced evidence summaries and leaders' briefings which aim to inform the planning and commissioning of these services.

- Link for HIV testing: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVTesting/
- Link for Chlamydia testing: http://www.chlamydiascreening.nhs.uk/ps/evidence.asp
- *Local authorities are mandated to provide open access sexual health services.*

Public Health Framework/Tools

55. **Health research 2014**
These briefings detail the results of research which explored local charities and voluntary organisations' attitudes and experiences of local health organisations. The research looked at the extent to which these local charities and voluntary organisations felt that they were able to influence JSNAs and the nature of their relationship with local CCGs and local Healthwatch.

- Link to JSNA briefing: www.**navca**.org.uk/downloads/generate/3719
- Link to Healthwatch briefing: www.navca.org.uk/downloads/generate/3718
- Link to CCG briefing: www.navca.org.uk/downloads/generate/3717

56. **Local government briefings**
NICE has developed local government briefings for a range of different public health topics. These briefings are meant for local authorities and their partner organisations in the health and voluntary sectors, in particular those involved with health and wellbeing boards. These new briefings discuss community engagement to improve health and contraceptive services.

- Community engagement: http://publications.nice.org.uk/community-engagement-to-improve-health-lgb16
- Contraceptive services: http://publications.nice.org.uk/contraceptive-services-lgb17
- Encouraging people to have NHS Health Checks: http://publications.nice.org.uk/encouraging-people-to-have-nhs-health-checks-and-supporting-them-to-reduce-risk-factors-lgb15
- Improving access to health and social care services for those who do not routinely use them: http://publications.nice.org.uk/improving-access-to-health-and-social-care-services-for-people-who-do-not-routinely-use-them-lgb14
- Body Mass index for Black, Asian and minority ethnic groups: http://publications.nice.org.uk/body-mass-index-thresholds-for-intervening-to-prevent-ill-health-among-black-asian-and-other-lgb13
- Social and emotional wellbeing for children and young people: http://publications.nice.org.uk/social-and-emotional-wellbeing-for-children-and-young-people-lgb12
- Tuberculosis for vulnerable groups: http://publications.nice.org.uk/tuberculosis-in-vulnerable-groups-lgb11

Health and Wellbeing Board Guidance

57. 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: www.parliament.uk/briefing-papers/SN06844.pdf

58. **Break on through: overcoming barriers to integration**
This report focuses on what local areas can do themselves to transform, and how central government can support service integration. It highlights the key

barriers to service integration and what actions need to be taken locally and by central government in order to facilitate change.

- Link: http://www.nlgn.org.uk/public/wp-content/uploads/BREAK-ON-THROUGH1.pdf

59. **Leadership – easier said than done**
This report explores general leadership issues and looks at the capacity of individuals at all levels of an organisation to buy into and lead on the organisational agenda, highlighting how misaligned organisational structures and processes can get in the way of leadership.

- Link: http://www.cipd.co.uk/binaries/leadership(web).pdf

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