City of London Corporation

City Supplement

Health and Wellbeing Profile

Joint Strategic Needs Assessment

Document Control

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

1. Background

City and Hackney Joint Strategic Needs Assessment (JSNA)

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

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

The City Supplement - A City Digest

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

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

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

What the City Supplement is used for[1]:

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

[1] *LB Croydon* (2012)

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

The social determinants of health

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

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

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

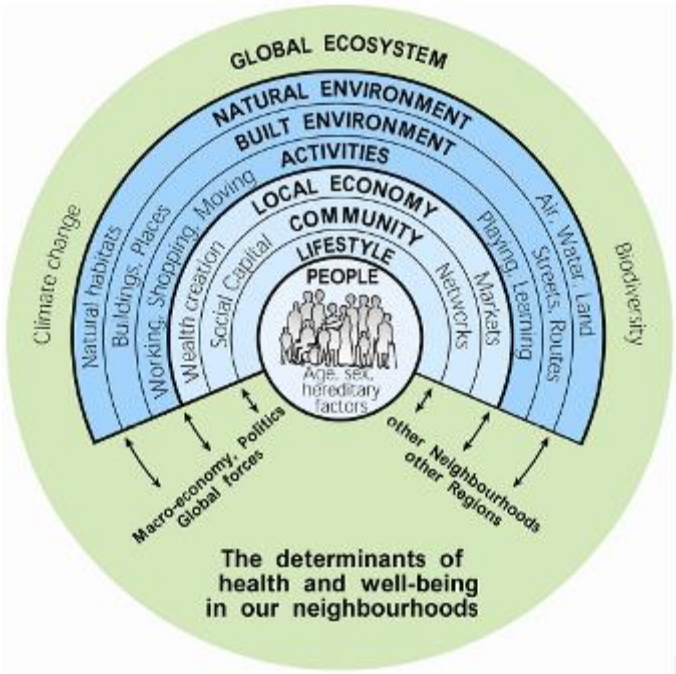
The Health map

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

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

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

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



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

Health in All Policies

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

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

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

- Identify shared goals
- Engage partners early and develop relationships

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

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

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

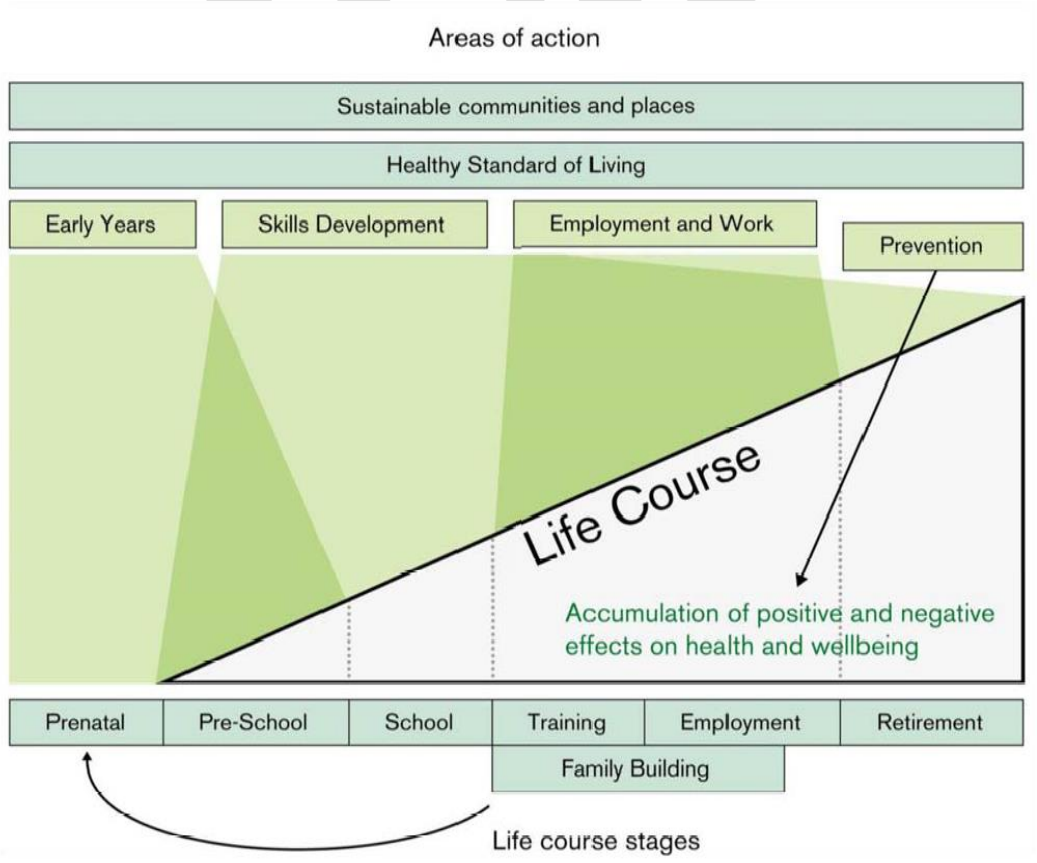
Life Course Approach

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

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

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

Figure 1.1 Areas of action and intervention across the life course



Format of the City Supplement

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

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

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

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

[5] *LB Croydon* (2012)

Limitations of the dataset

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

Resident data

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

City worker data

In October 2013, a new release of Census 2011 data estimated the population and characteristics of the workday population across England and Wales. This Census intelligence is the first of its kind, and is of particular importance to the City of London, since the workday population is 56 times higher than the resident population. Two independent reports have also been commissioned to gain insights into the health needs of City Workers – *The Public Health and Primary Healthcare Needs of City Workers*, and *Insight into City Drinkers*.[6][7]

Rough sleeper data

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

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

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

2. The City's Geography

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

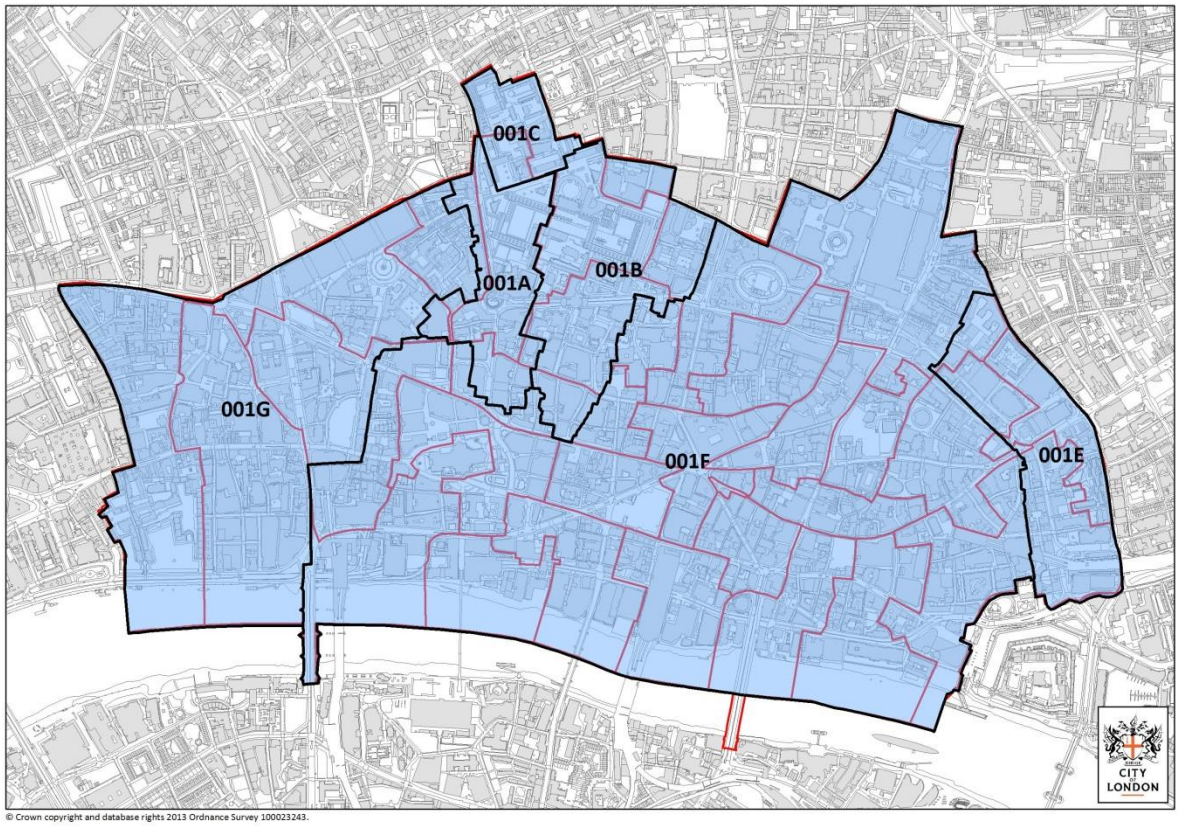


Figure 3.2 Map of the City of London showing Lower Super Output Areas in black and ward boundaries in red

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

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

3. The City's Population

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

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

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

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

Key Findings

Residents

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

City workers

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

Rough Sleepers

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

Recommendations

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

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

Questions for Commissioners

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

RESIDENTS

Population size and age profile

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

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

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

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

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

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

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

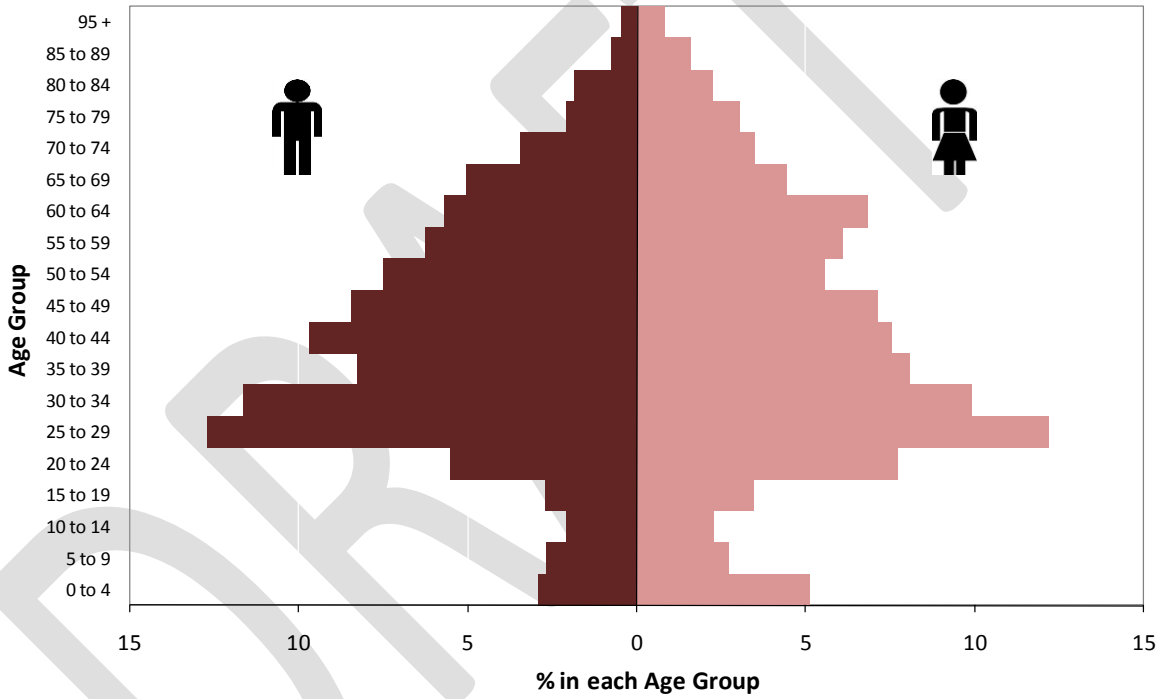
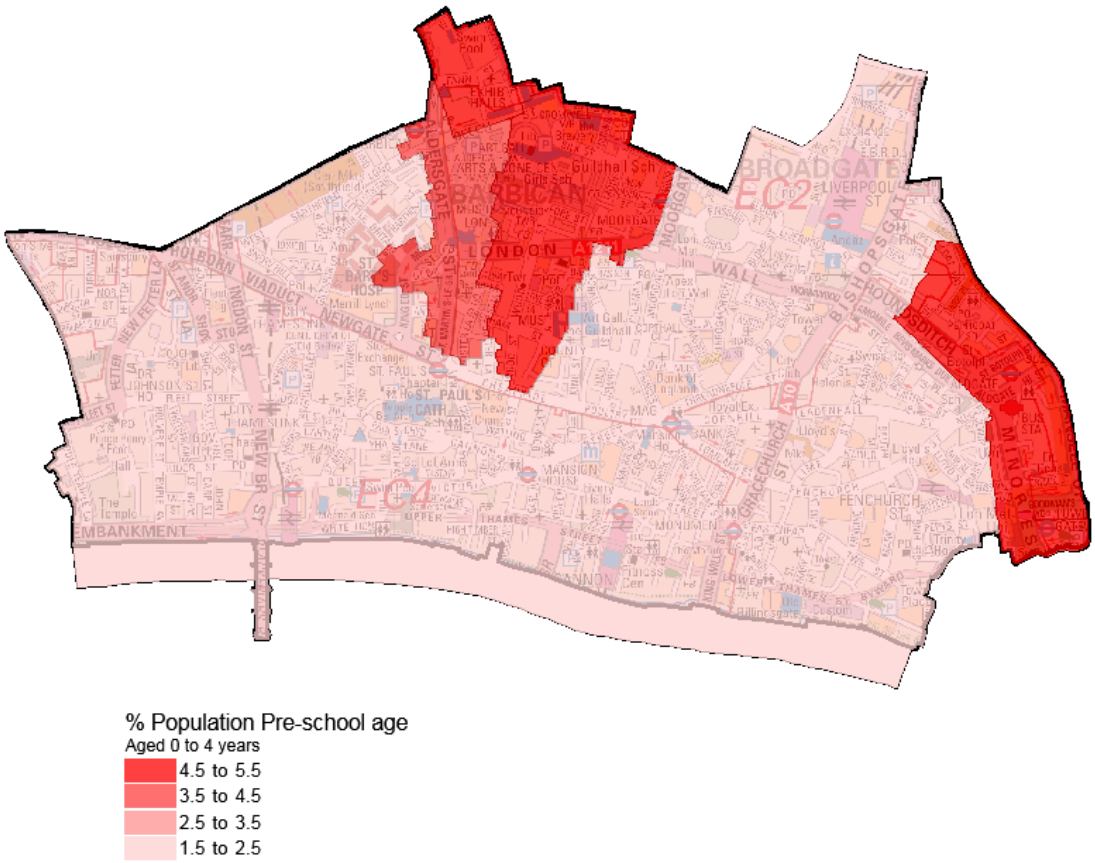
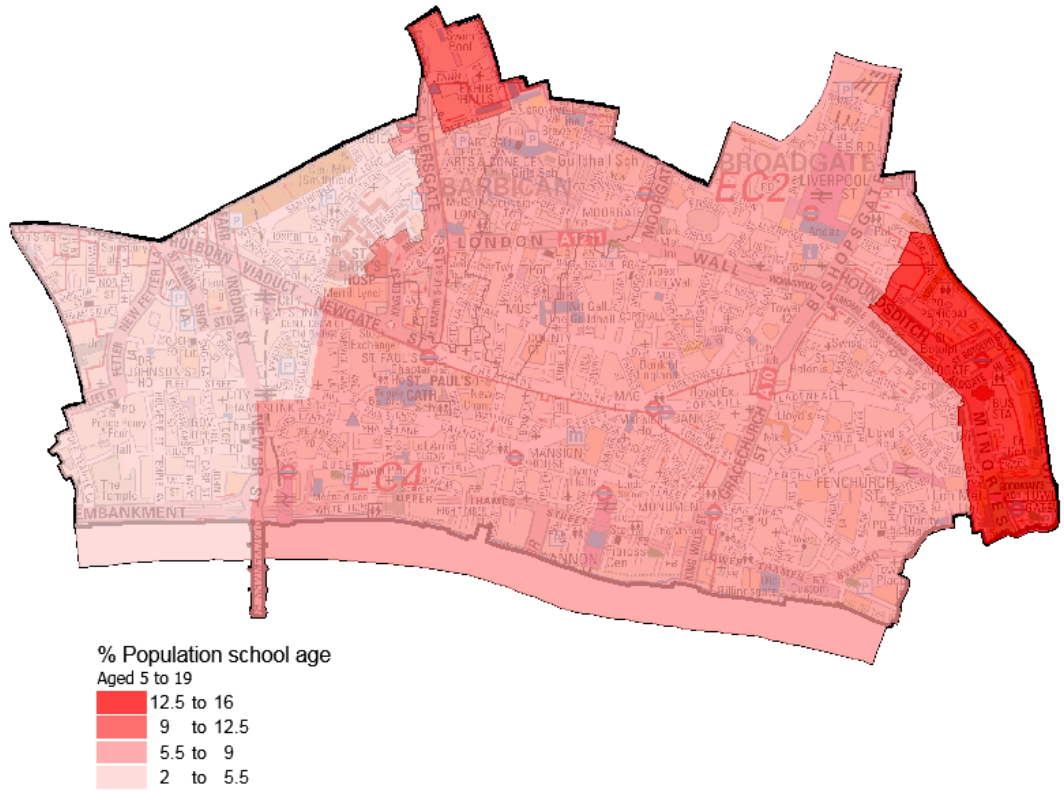


Figure 3.2 Geographical age structure: percentage aged 0-4



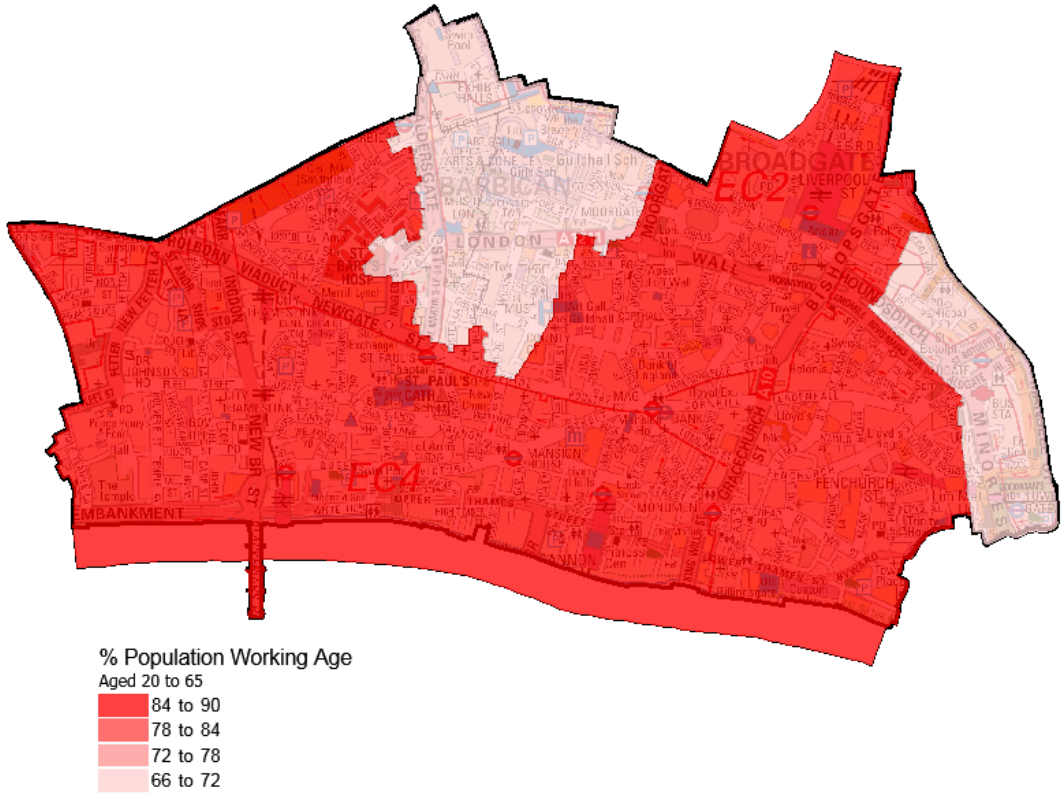
Source: ONS 2012 mid-year estimates

Figure 3.3 Geographical age structure: percentage aged 5-19



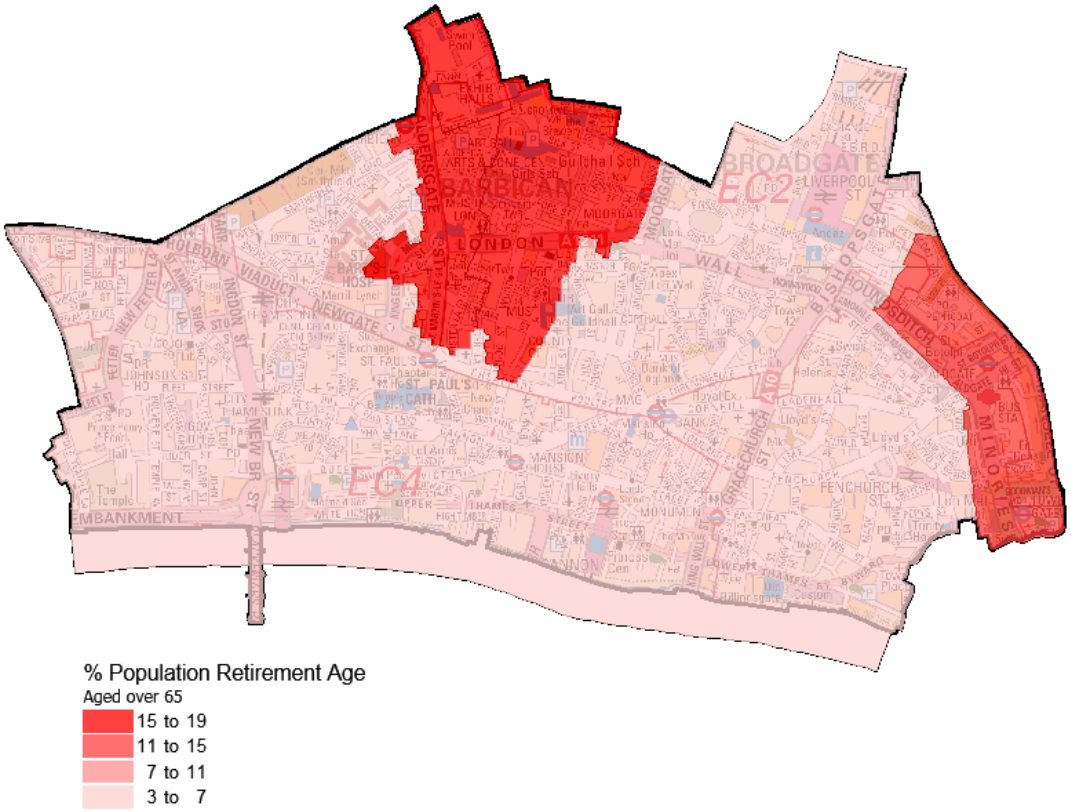
Source: ONS 2012 mid-year estimates

Figure 3.4 Geographical age structure: percentage aged 20-65



Source: ONS 2012 mid-year estimates

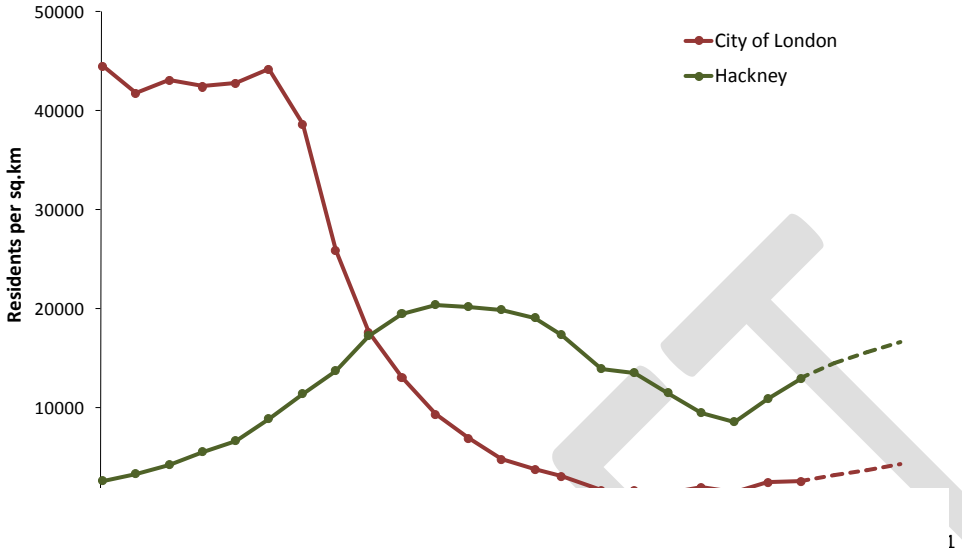
Figure 3.5 Geographical age structure: percentage aged over 65



Source: ONS 2012 mid-year estimates

Population density

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



Source: Greater London Authority (GLA)

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

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

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

Figure 3.7 Population density: number of persons per hectare

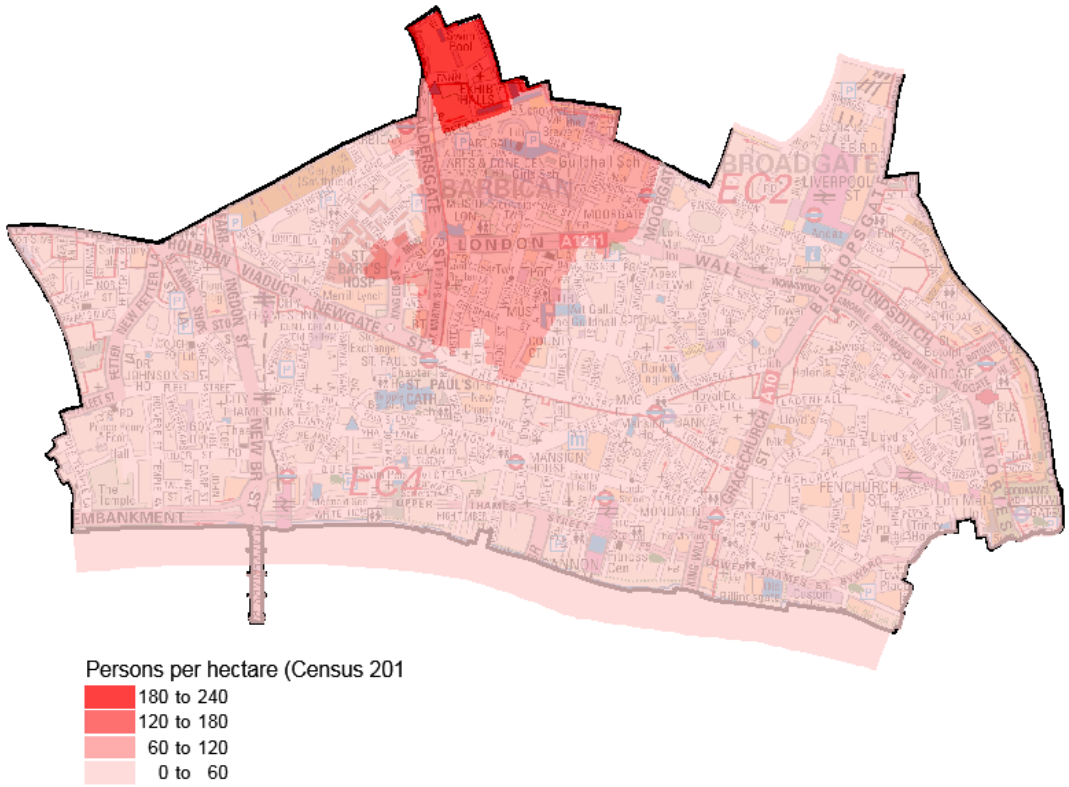
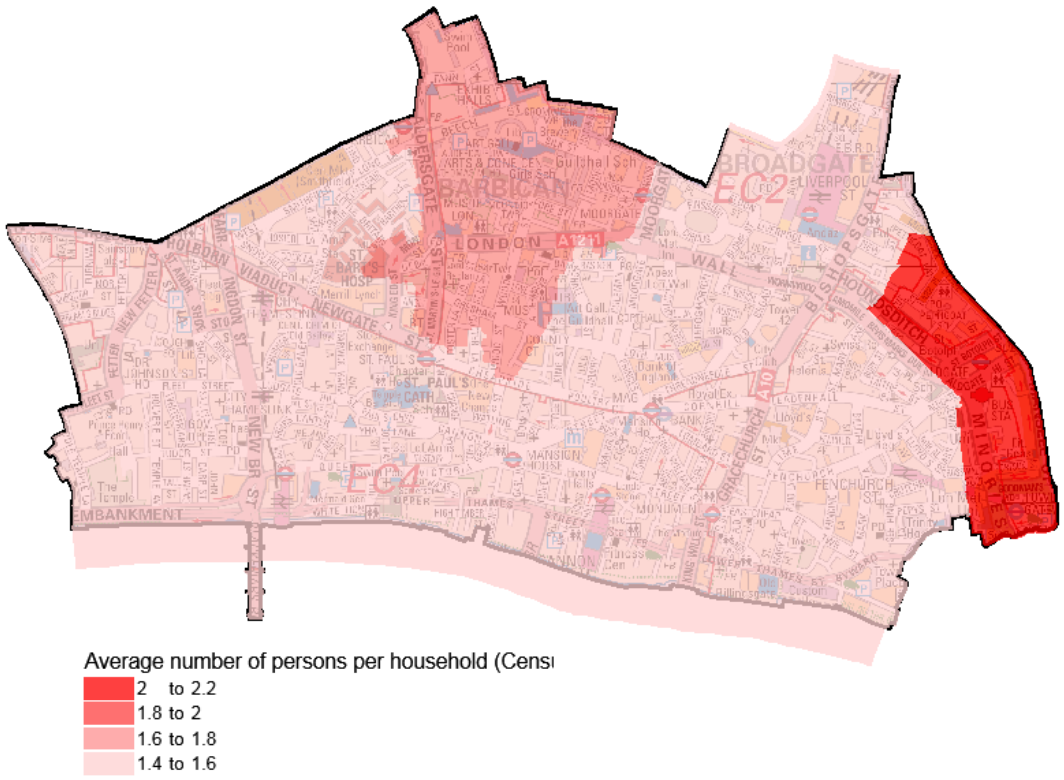


Figure 3.8 Population density: number of persons per household



Population change and migration

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

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

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

	The City	
	Number	**%**

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

Source: ONS

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

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

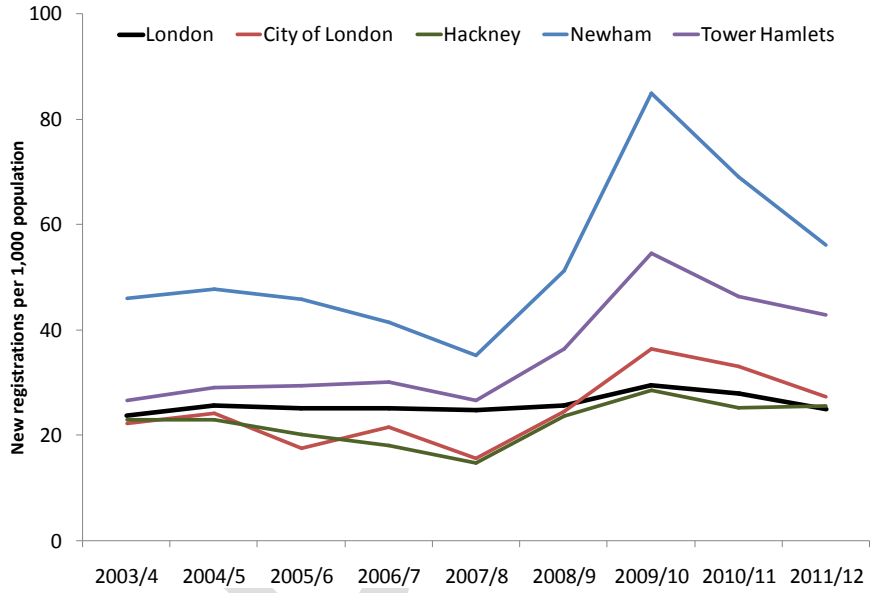
City	
Country of birth	**% of population**
United States	2.8
France	2.0
Australia	1.9
Germany	1.6
Ireland	1.5
India	1.4
Italy	1.4
Bangladesh	1.3
China	1.3
New Zealand	1.1
Hong Kong	1.0
South Africa	1.0

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

Source: 2011 Census

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

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



Source: ONS

Ethnicity

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

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

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

Source: 2011 Census

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

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

Source: 2011 Census

See Appendix 3 – Ethnicity for more information.

Religion

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

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

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

See Appendix 4 - Religion for more information.

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

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

Source: 2011 Census

Languages

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

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

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

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

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

Source: 2011 Census

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

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

Source: 2011 Census

See Appendix 5 – Languages for more information

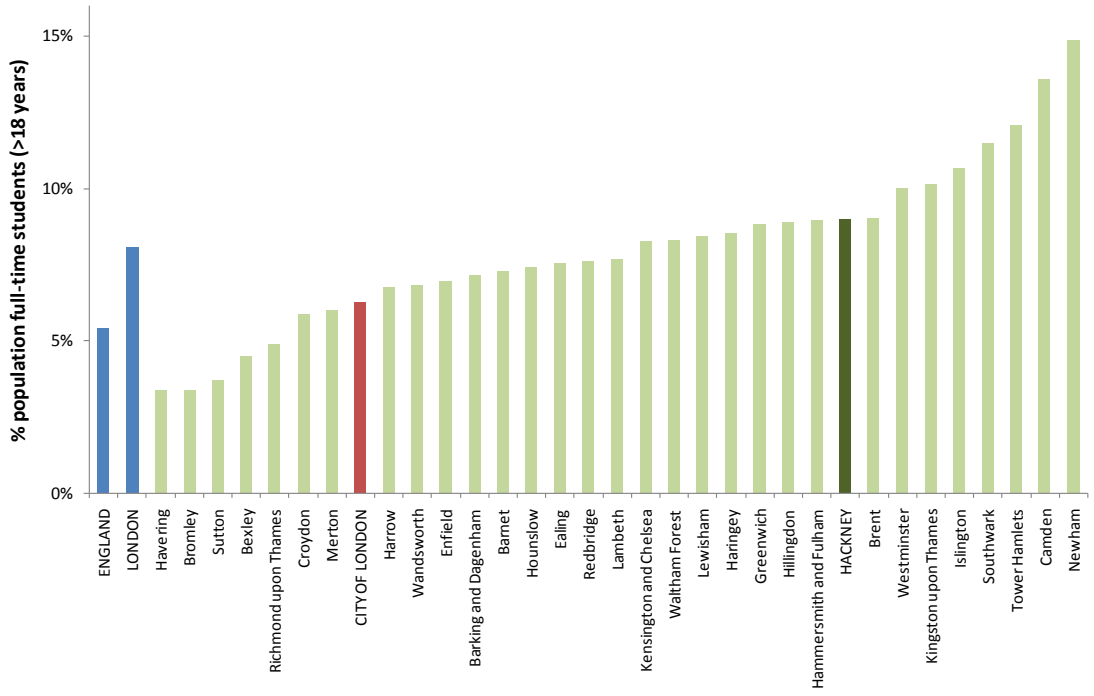
Overall Health

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

Students

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

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



Carers

See Working Age section for detailed information on carers.

Travellers and Gypsies

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

CITY WORKERS

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

Population Density

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

Age and Sex

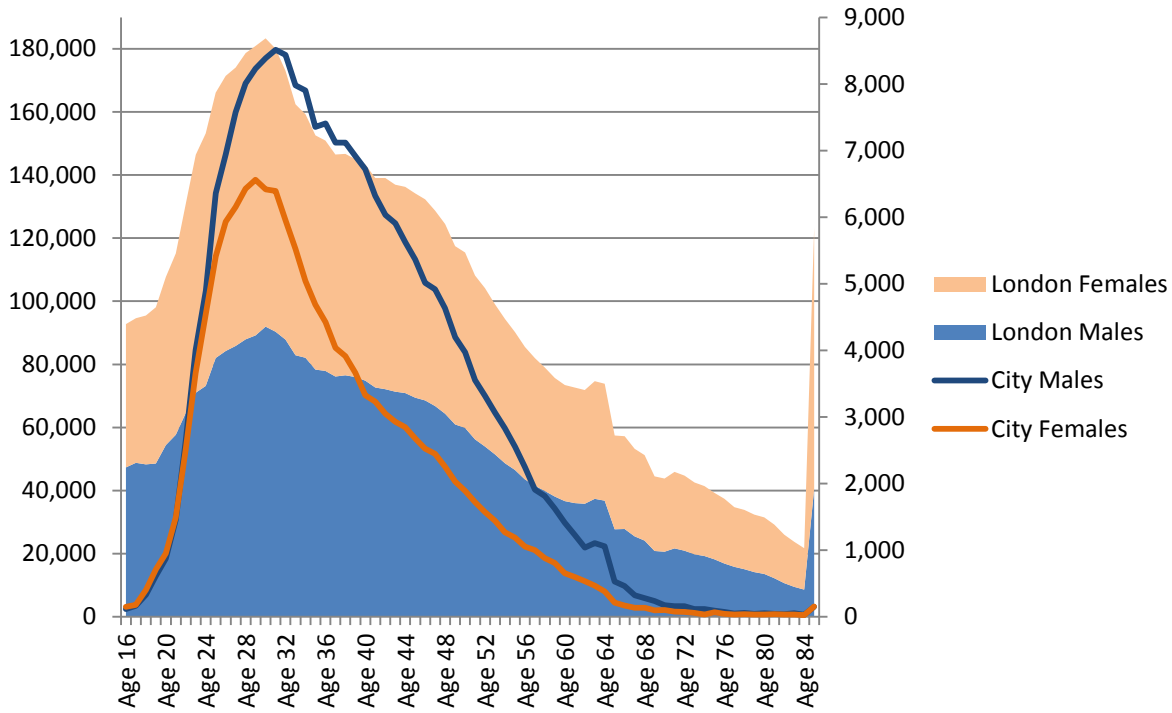
City workers are mainly aged between 20 and 50 years of age. Most women working in the City are aged between the mid-20s to mid-30s; whereas men are aged between the mid-20s to mid-40s. There are over a third more male (220,265) than female (139,813) daytime City workers, which is the reverse trend of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

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

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

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

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

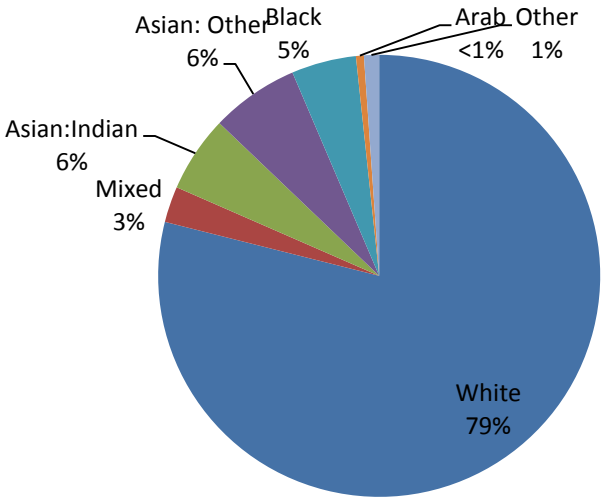


Ethnic Group

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

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

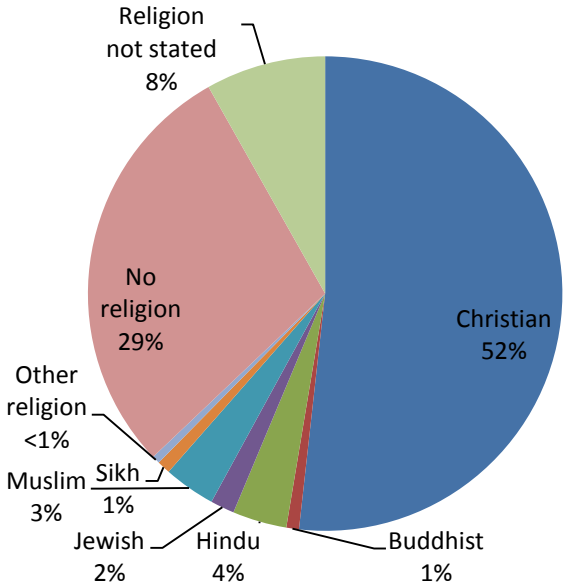
Figure 3.10: Ethnic Profile of City workers



Religion

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

Figure 3.11: Religious Affiliation of City workers



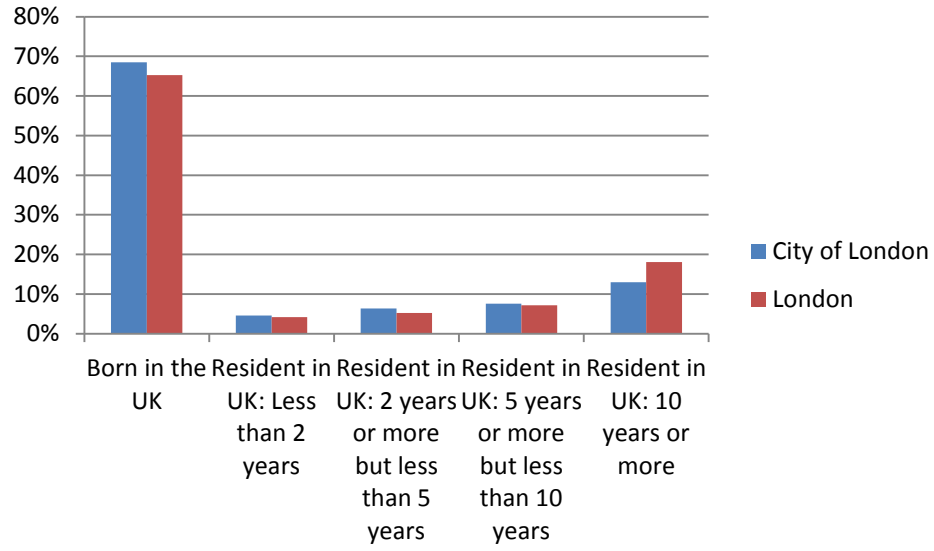
Residency

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

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

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

Figure 3.12: Residency of City workers



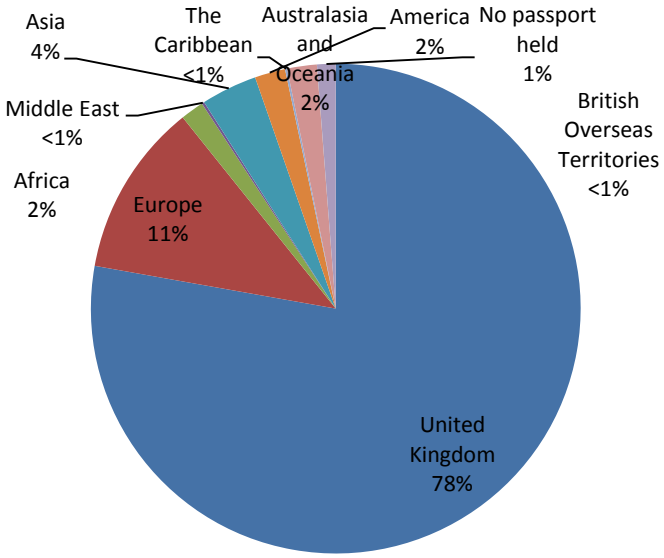
Passport Designation

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

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

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

Figure 3.13: Passport designation of City workers



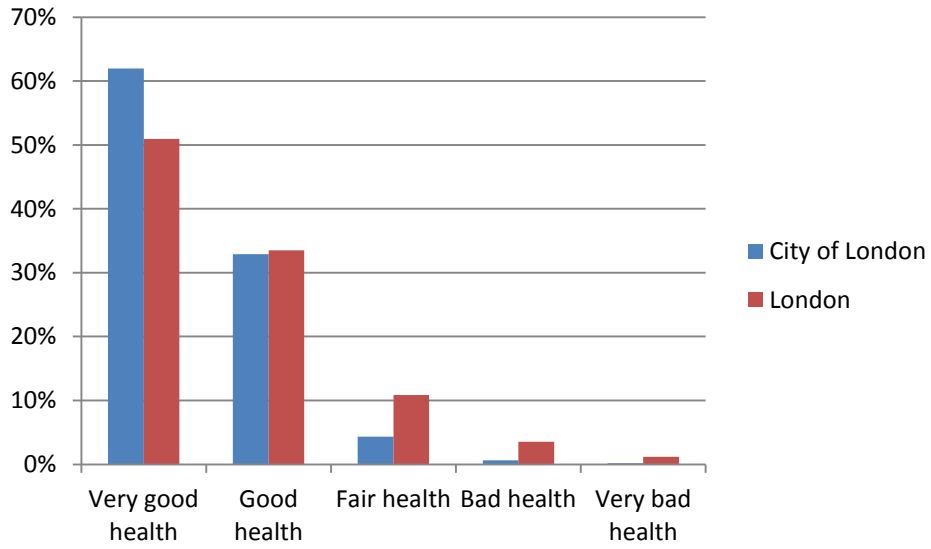
Overall Health

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

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

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

Figure 3.14: Self perceived overall health of City workers



Source: Census 2011

[21] ibid

ROUGH SLEEPERS

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

Population size

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

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

Sex, Age and Ethnic Origin

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

Overall Health

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

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

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

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

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

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

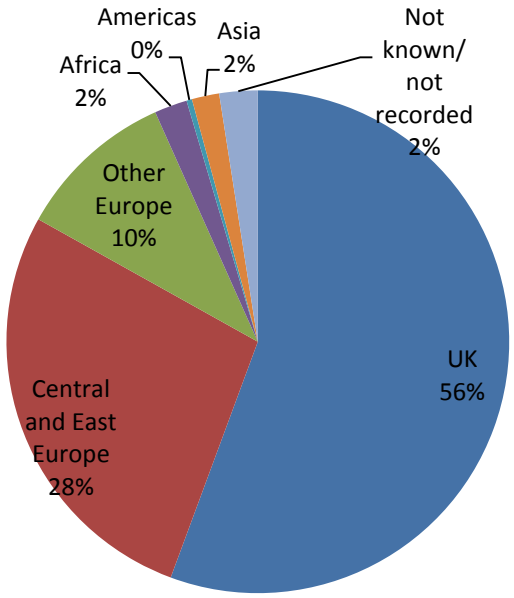
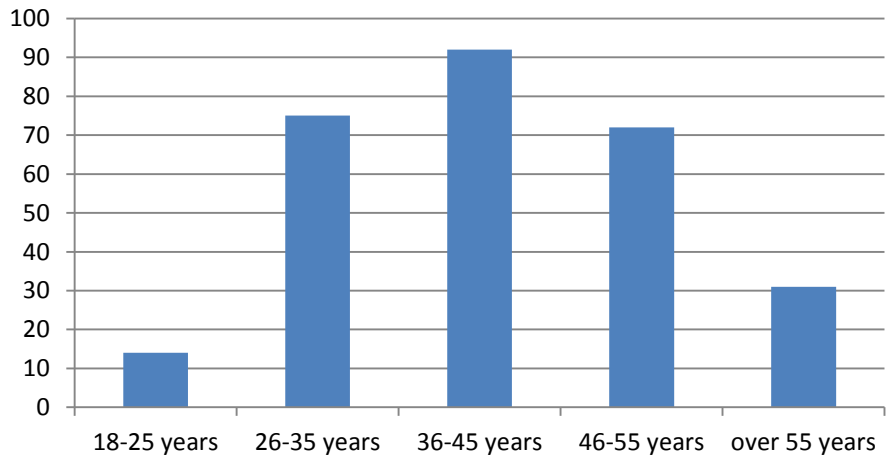


Figure 2.14. People seen sleeping in the year, by age 2012/13



4. Community Life

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

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

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

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

Key Findings

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

Recommendations

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

Questions for Commissioners

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

Quality of Local Area

Community cohesion and neighbourhood attachment

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

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

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

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

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

Transport

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

[27] City of London Corporation Polling 2013

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

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

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

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

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

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

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

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

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

	Trips per	Walk	Cycle	Bus	Under-	Rail	Motor	Taxi/

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

Road casualties

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

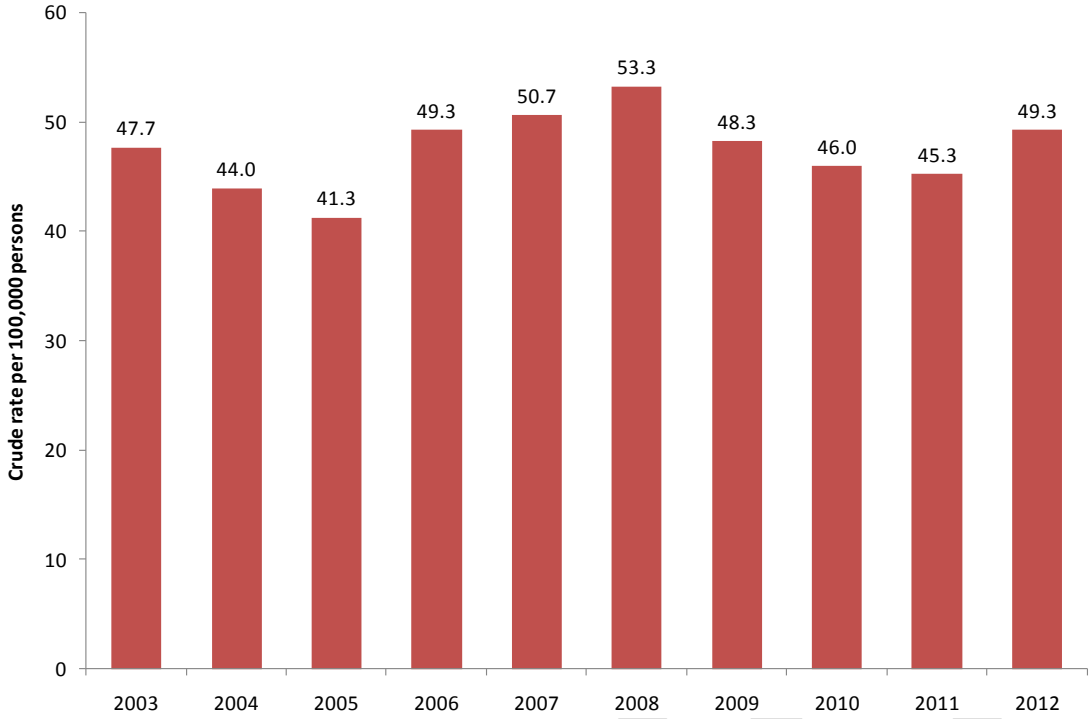
Given the smaller numbers involved, there is even more year-on-year variability in this data in the City. Since 2003, the long-term trend on a three-year rolling average shows a generally consistent number of casualties (Figure 6.6).

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

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

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

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


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

Green Spaces

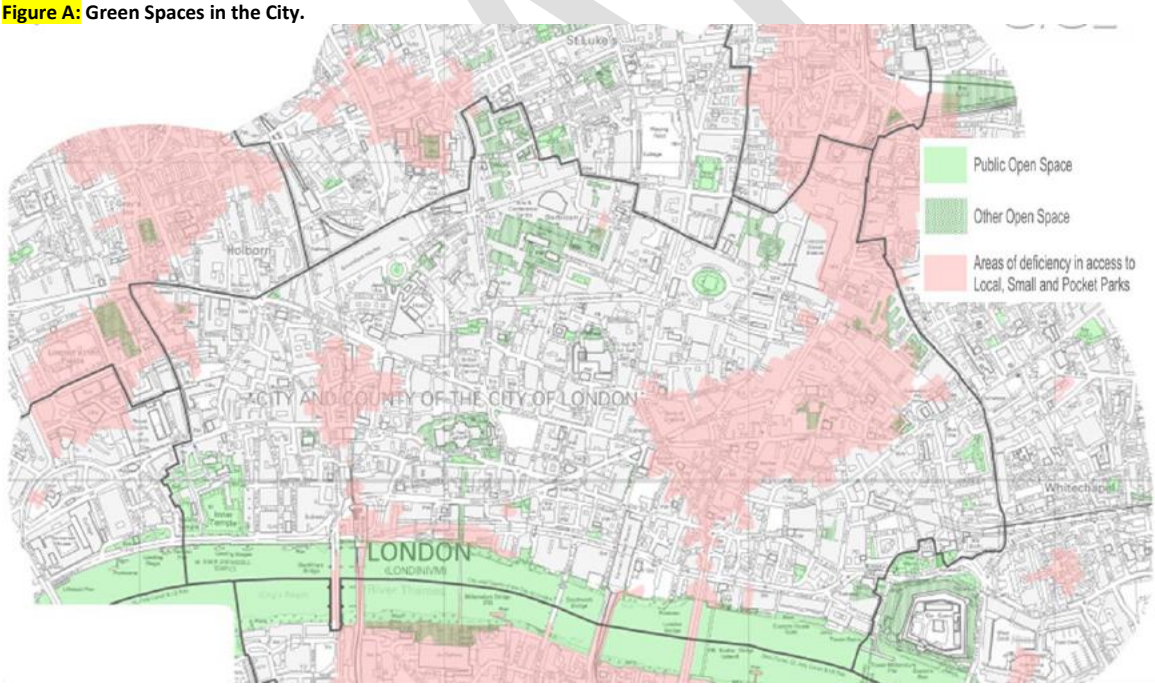
Open spaces in the City of London are an important resource for residents, workers and visitors. A survey of the large daytime population in 2012 found that 86% use the City's public gardens regularly, with 36% visiting at least once per week. Almost all users (79.4%) rate these spaces as good or very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

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

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

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

Figure A: Green Spaces in the City.



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

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

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

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

The Aldgate Project

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

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

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

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

Noise Pollution

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

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

[32] WHO Regional Office for Europe, Noise.

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

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

Leisure facilities

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

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

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

TableXX: Facilities in the City by membership accessibility.

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

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

Targeted services

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

Young at Heart

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

City of Sport

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

Cultural facilities

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

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

Libraries

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

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

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

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

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

Museums and Theatres

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

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

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

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

Air Quality

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

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

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

Source and levels of air pollution in the City

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

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

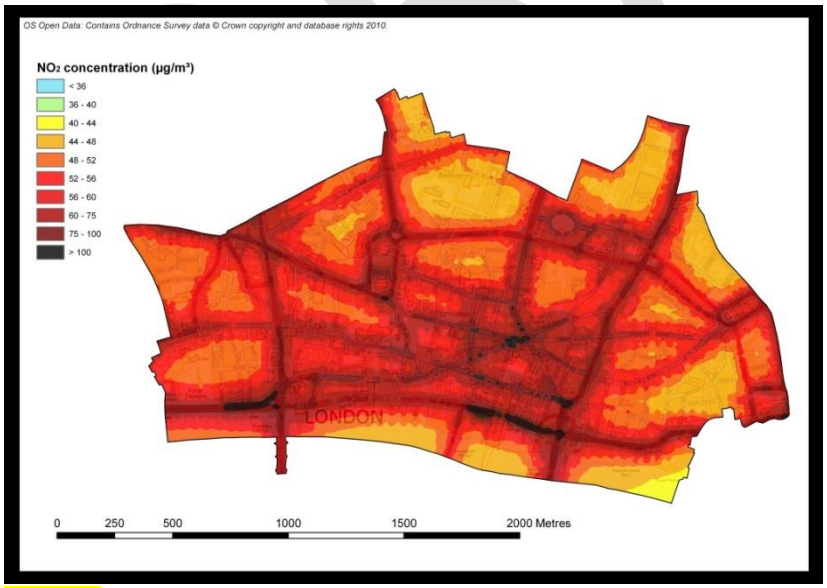


Figure x Annual Average Concentrations of nitrogen dioxide across the City.

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

[38] The City of London Air Quality Strategy 2011

Improving air quality

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

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

Reducing exposure to air pollution

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

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

Climate Change

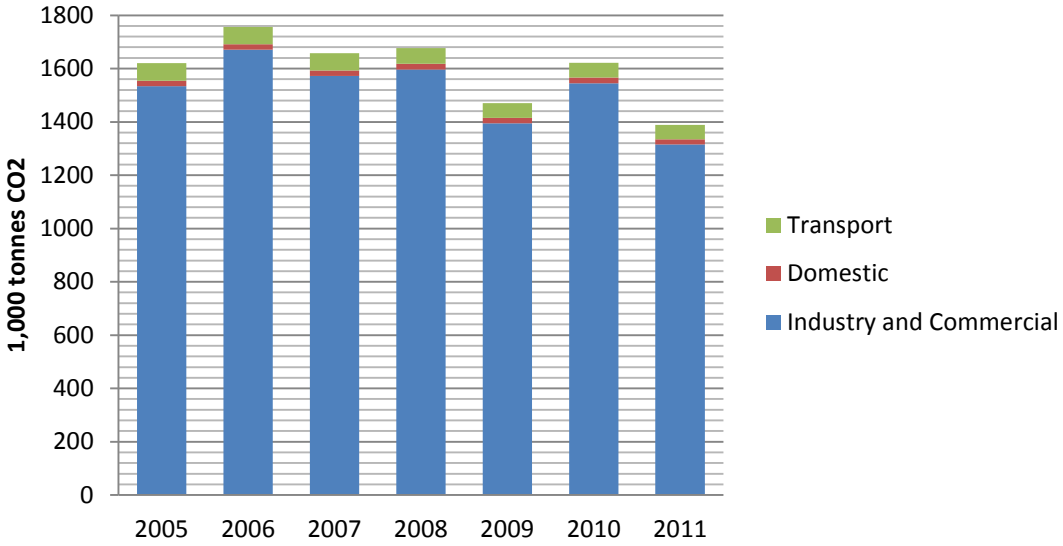
Climate change in the City

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

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

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

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



Crime and Safety

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

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

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

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

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

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

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

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

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

Deprivation

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

Housing

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

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

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

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

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

Housing stock and households

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

Housing tenure

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

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

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

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

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

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

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

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

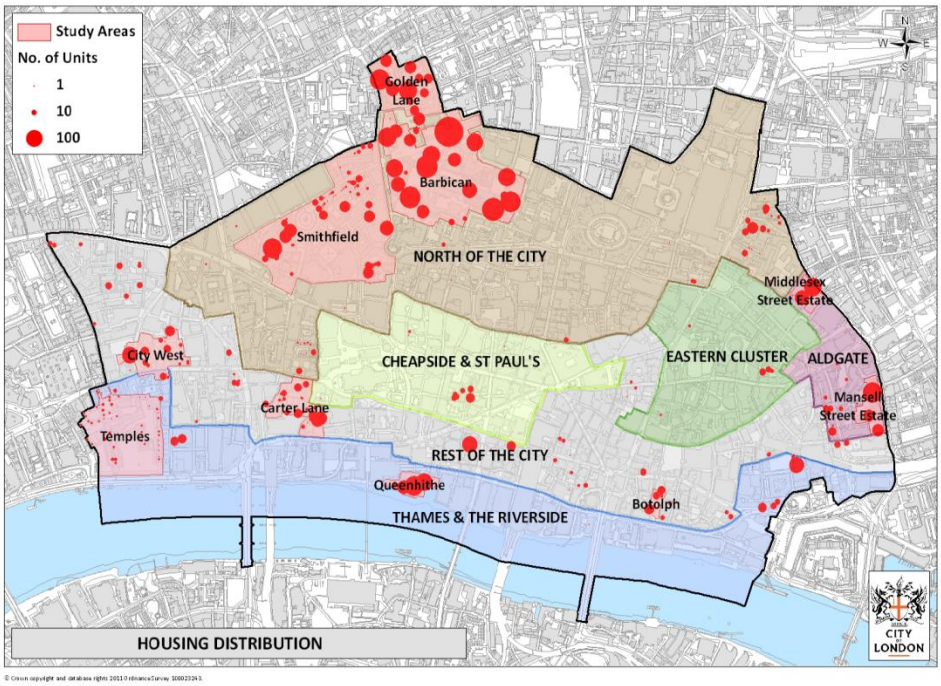
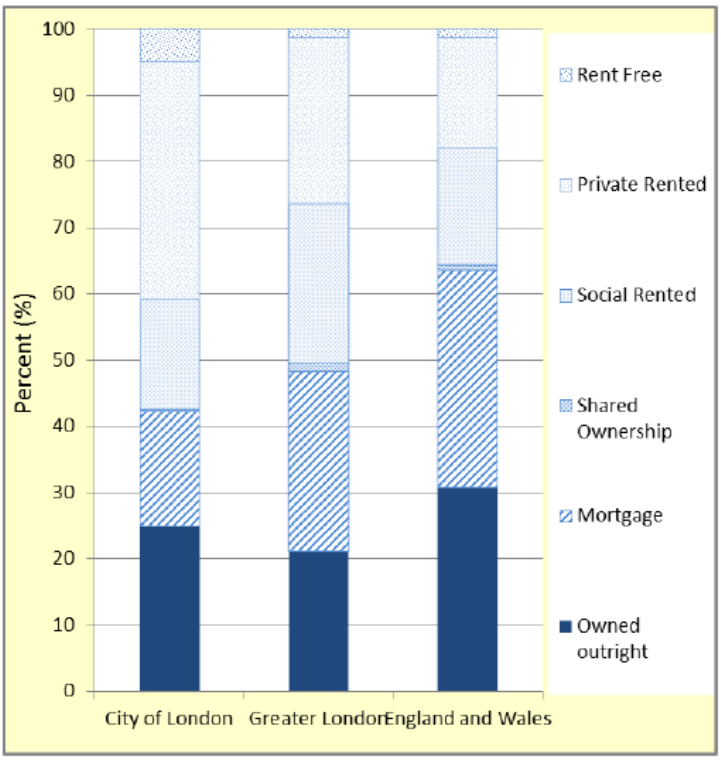


Figure 2.4 – Household Tenure, Census 2011



City Workers

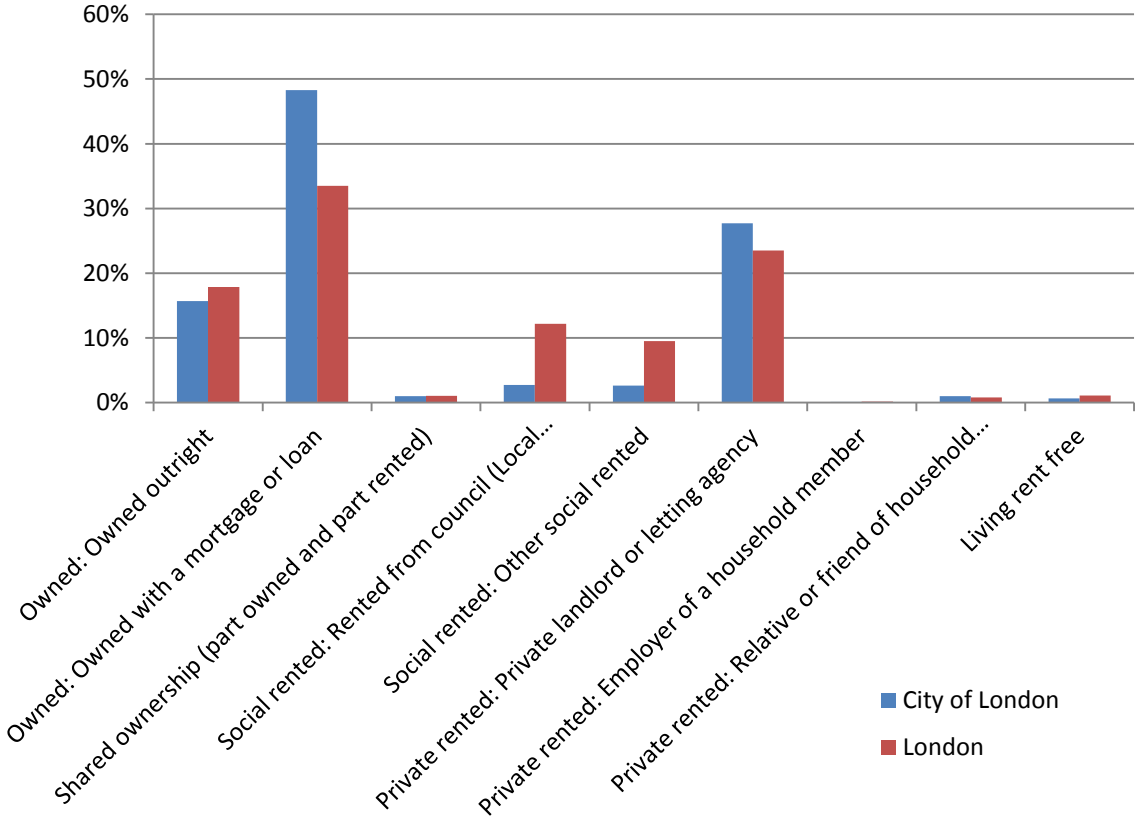
The new Census data has provided an opportunity to present the housing tenure amongst daytime City workers. 48% of City workers own property with a 'mortgage or loan' which is notably higher than the London average of 33%. Another 28% live in privately rented property, which is slightly

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

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

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

Figure 4.2: Housing Tenure of City workers



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

Housing standards

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

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

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

Fuel poverty

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

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

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

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

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

Overcrowding

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

Homelessness

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

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

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

Rough Sleeping

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

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

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

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

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

5. Early Life and Family Life

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

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

Key Findings

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

Recommendations

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

Questions for commissioners

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

Young People

Local policy context

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

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

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

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

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

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

Population

Demographics

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

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

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

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

Disabilities

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

Looked-after children

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

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

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

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

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

Physical activity

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

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

Education and training

Schools

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

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

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

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

Primary School performance

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

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

Attainment to Higher Education

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

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

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

Apprenticeships

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

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

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

Child poverty and deprivation

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

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

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

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

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

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

Free school meals

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

Table 5.1 Free school meals in state-funded primary schools

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

Early years support

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

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

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

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

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

Youth Services

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

Children and Adolescent Mental Health Services

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

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

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

Accessing the service

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

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

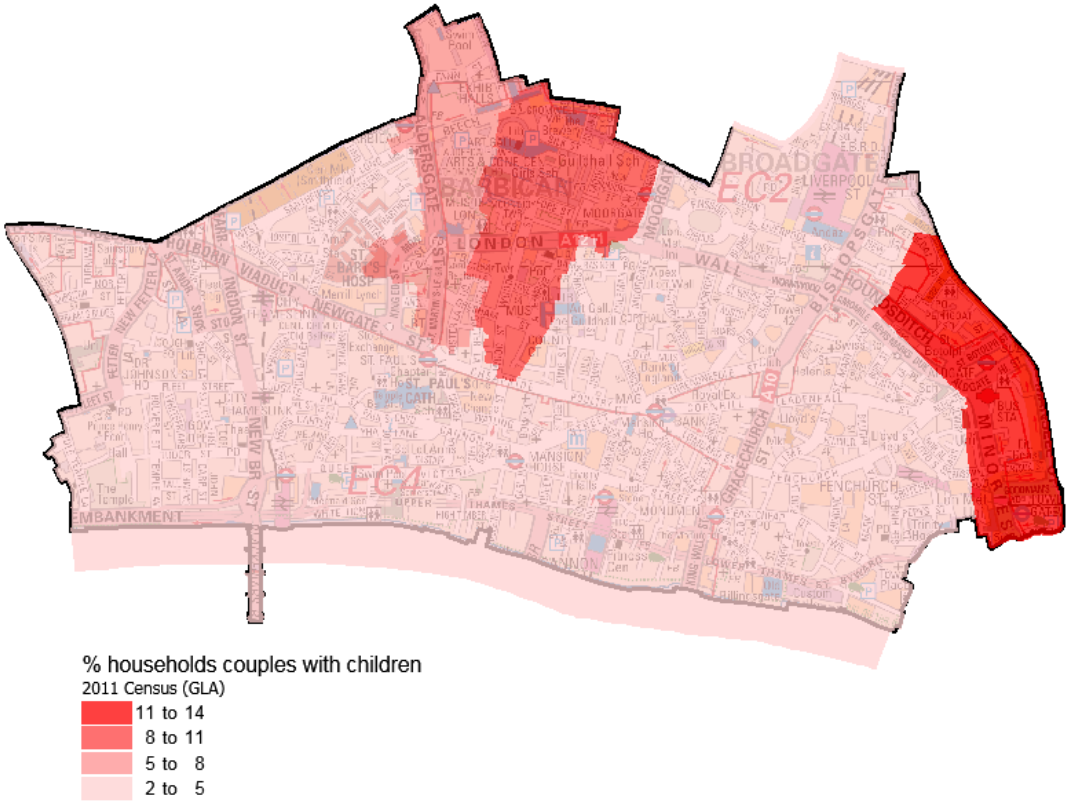
The Child and Adolescent Mental Health Service Framework 2013-15 outlines the vision for the development of emotional health and wellbeing, and Child and Adolescent Mental Health Services including an action plan with measurable outcomes aligned with wider national policy.

Families and households

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

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

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



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

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

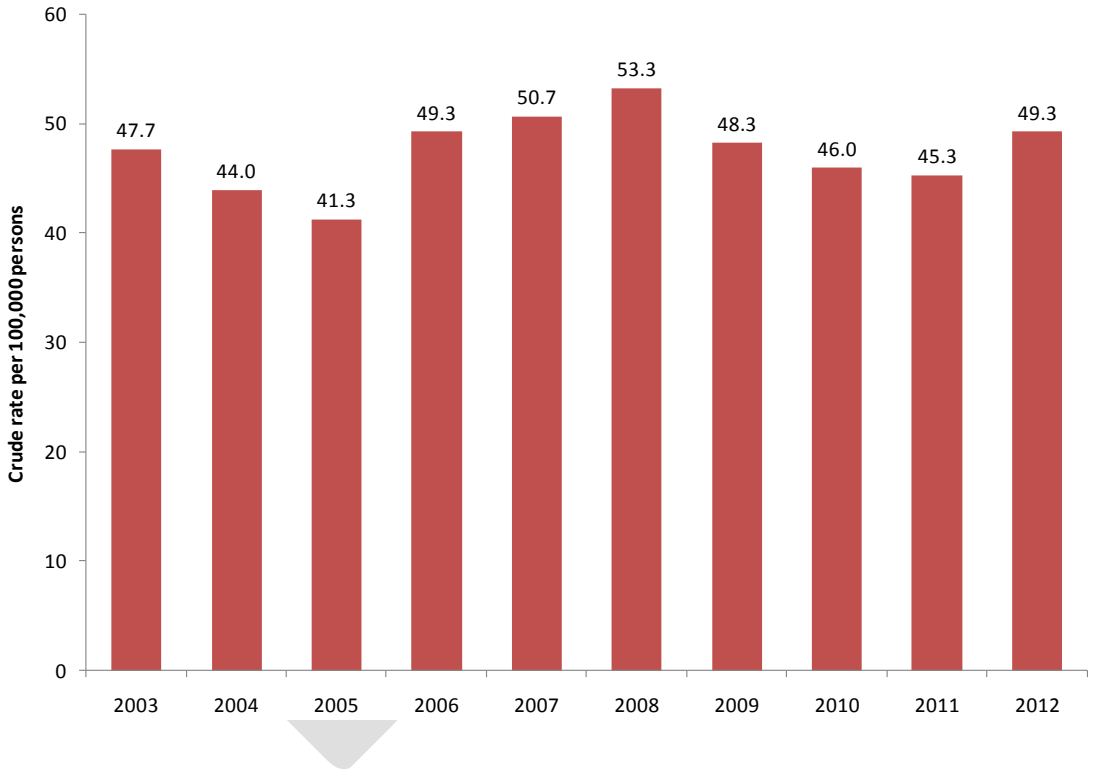
Given the smaller numbers involved, there is even more year-on-year variability in this data in the City. Since 2003, the long-term trend on a three-year rolling average shows a generally consistent number of casualties (Figure 6.6).

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

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

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

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



Maternity

Smoking and pregnancy

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

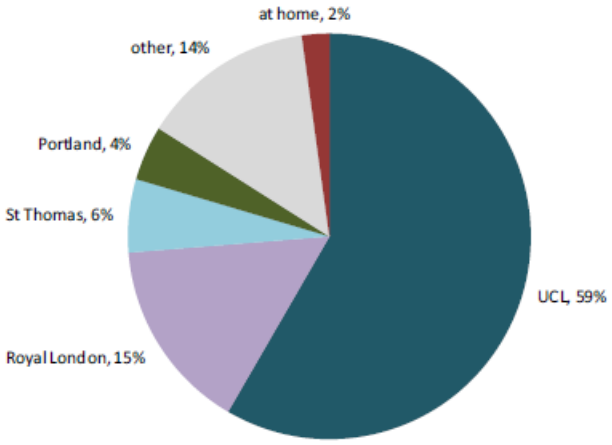
Antenatal care

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

Place of birth and delivery method

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

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



Terminations

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

Breastfeeding

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

6. Working Age

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

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

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

Key Findings

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

Residents

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

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

City workers

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

Rough sleepers

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

Recommendations

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

Questions for commissioners

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

Economic participation amongst residents

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

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

Unemployment and out-of work benefits

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

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

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

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

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

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

[58] NOMIS 2011

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

Adult Learning

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

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

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

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

Jobs within the City

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

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

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

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

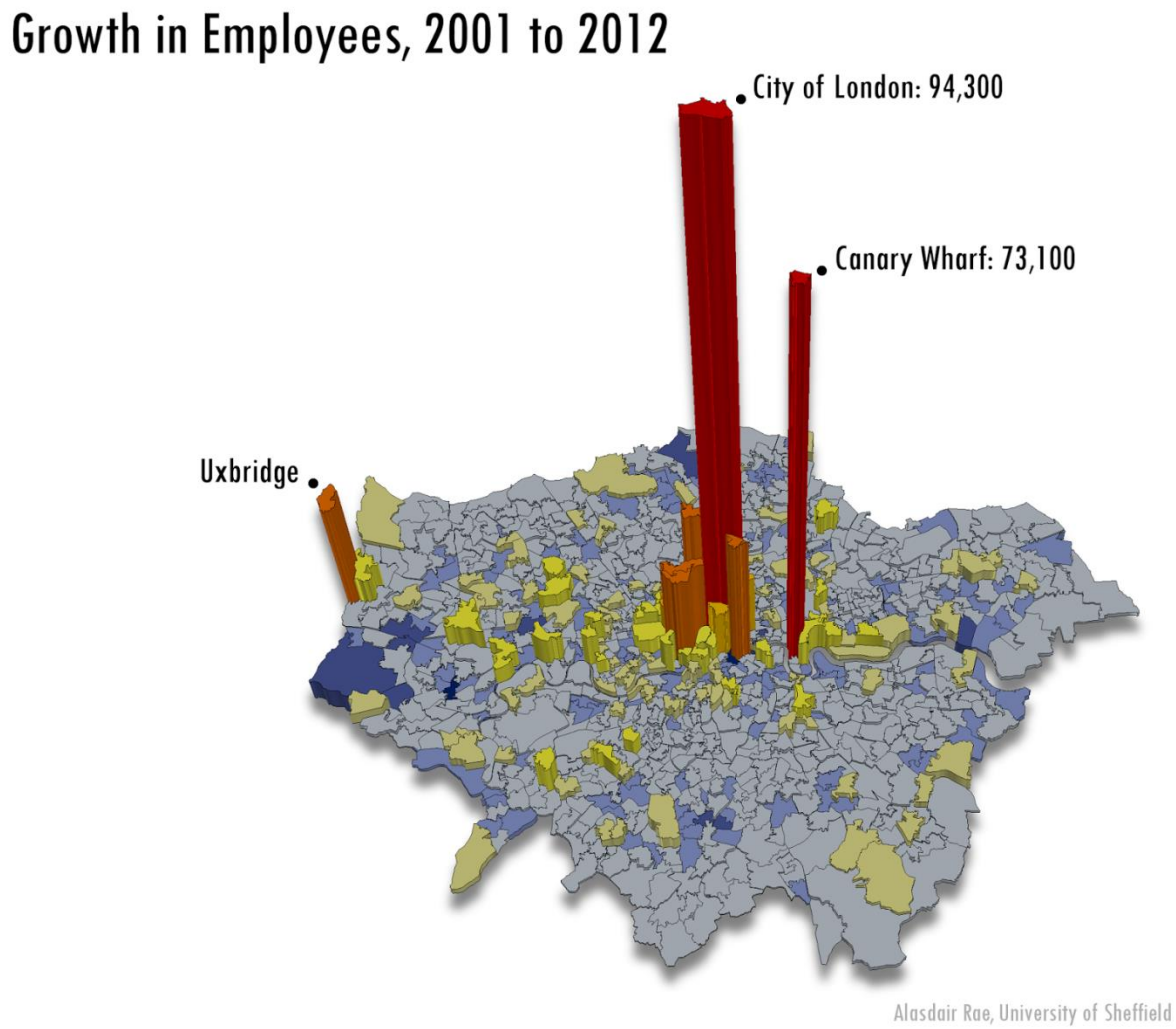
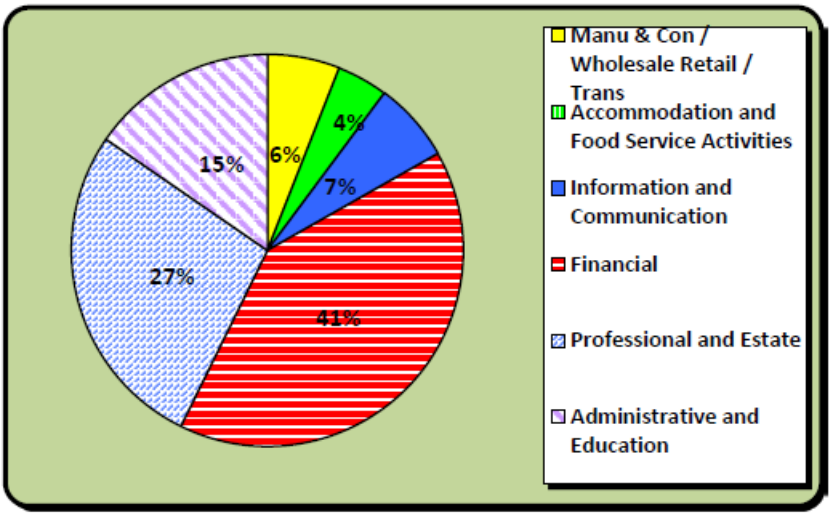
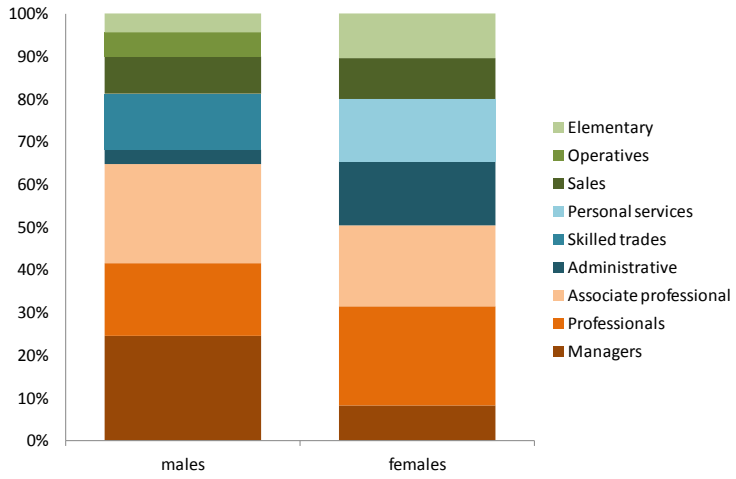


Figure X: Employment by industry in the City, 2011 (BRE)



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

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



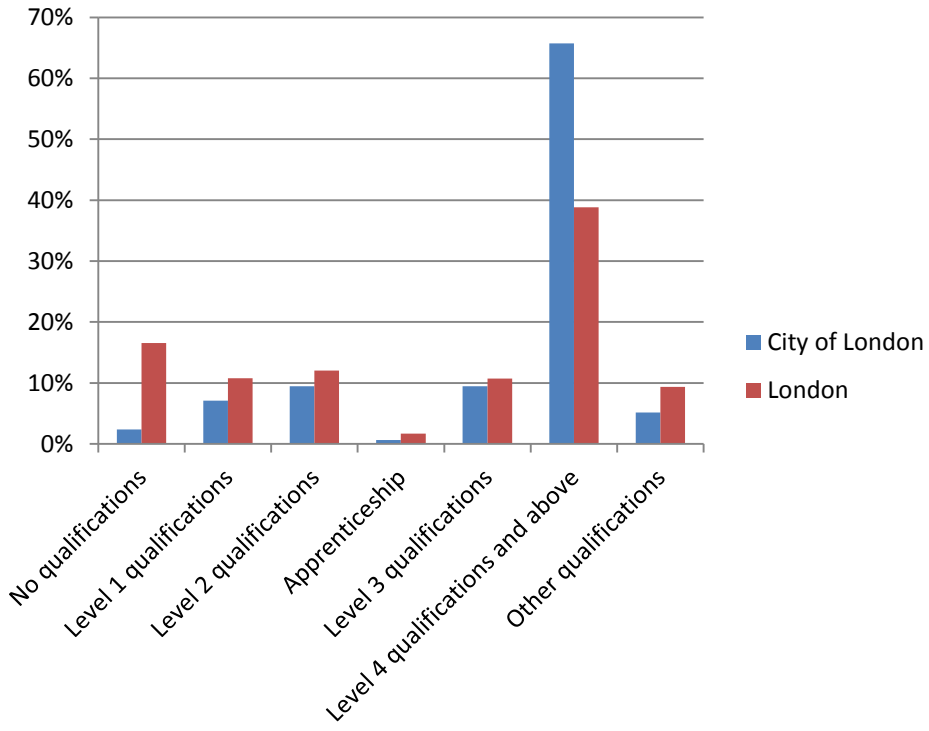
Education and qualifications

City Workers

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

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

Figure 6.2: Highest Level of Qualification



Workplace Health

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

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

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

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

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

the Corporation's commitment to addressing these issues for our own staff. The City Corporation has set the ambitious target of reaching the Excellence standard of the Charter.

Business Healthy Conference

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

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

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

Lifestyle and Behaviours

Smoking

Prevalence

Residents

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

City workers

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

Rough Sleepers

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

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

Quitting

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

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

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

Smoking cessation support services

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

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

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

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

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

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

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

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

Physical activity

Sport and physical activity among adults

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

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

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

Alcohol

Levels of alcohol consumption

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

City Workers

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

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

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

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

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

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

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

Table XXB AUDIT categories by score range

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

(Source: Insight into City Drinkers, 2012)

Health impacts of alcohol

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

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

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

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

Men	969.7	7	1535.9
Women	289.0	1	810.9

City Workers

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

Crime and anti-social behaviour

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

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

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

Substance misuse

Prevalence of drug use

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

Health impacts of drug use

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

Emerging trends in drug use

Residents

[77] Insight into City Drinkers, 2012

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

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

Treatment and engagement

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

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

Harm reduction

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

Sexual Health

Sexually Transmitted Infections (STIs)

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

Chlamydia screening

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

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

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

Human Immunodeficiency Virus (HIV)

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

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

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

Workers

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

Rough sleepers

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

Mental health

Prevalence of mental illness

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

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

Depression

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

Severe mental illness

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

Suicide

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

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

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

The suicide prevention strategy identifies some effective local interventions as:

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

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

City workers

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

Rough sleepers

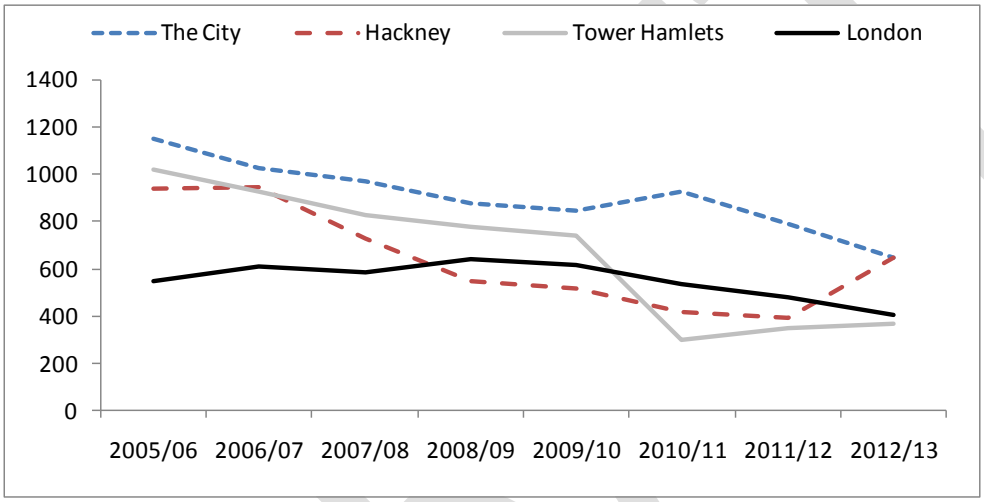
A national audit of the health and wellbeing of homeless people found seven out of 10 clients had one or more mental health need, a rate over twice as great as the general population[79]. Within the City, the CHAIN database identifies 45% of rough sleepers with a mental health issue.

Social care for people with mental health difficulties

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

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

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



Source: National Adult Social Care Intelligence Service (NASCIS)

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

Carers

Support for carers

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

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

Case Study

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

Caring Role

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

Carer Needs and Support

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

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

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

Carers in the City

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

[80] Office for National Statistics, Census 2011

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

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

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

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

City workers

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

Disability

Learning disabilities

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

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

Physical disabilities

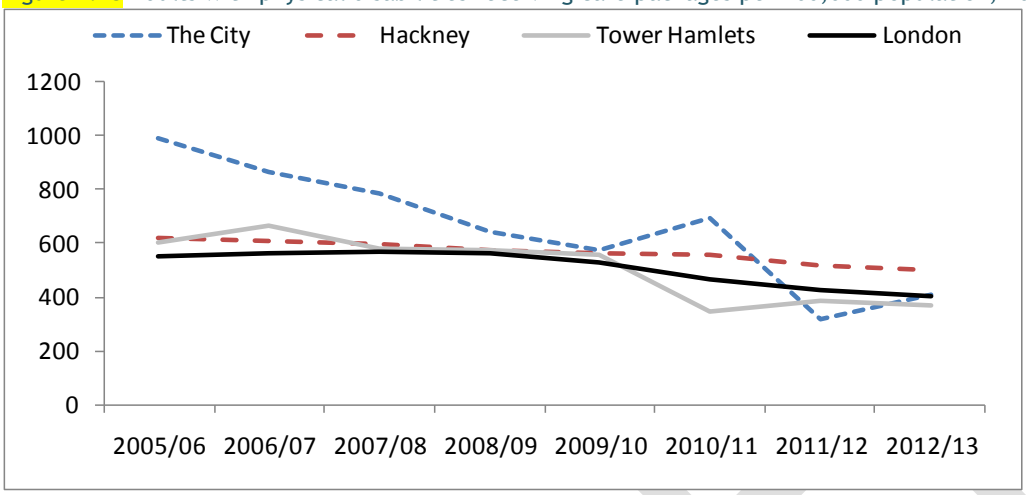
In 2012/13 City of London provided services to 113 clients with physical disabilities, of whom 80% were over 65. 56% of these clients received community-based support (home care not included).

[81] City of London Carers' Strategy, 2011

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

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

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



Visual impairment

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

7. Later Life

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

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

Key Findings

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

Recommendations

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

Questions for commissioners

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

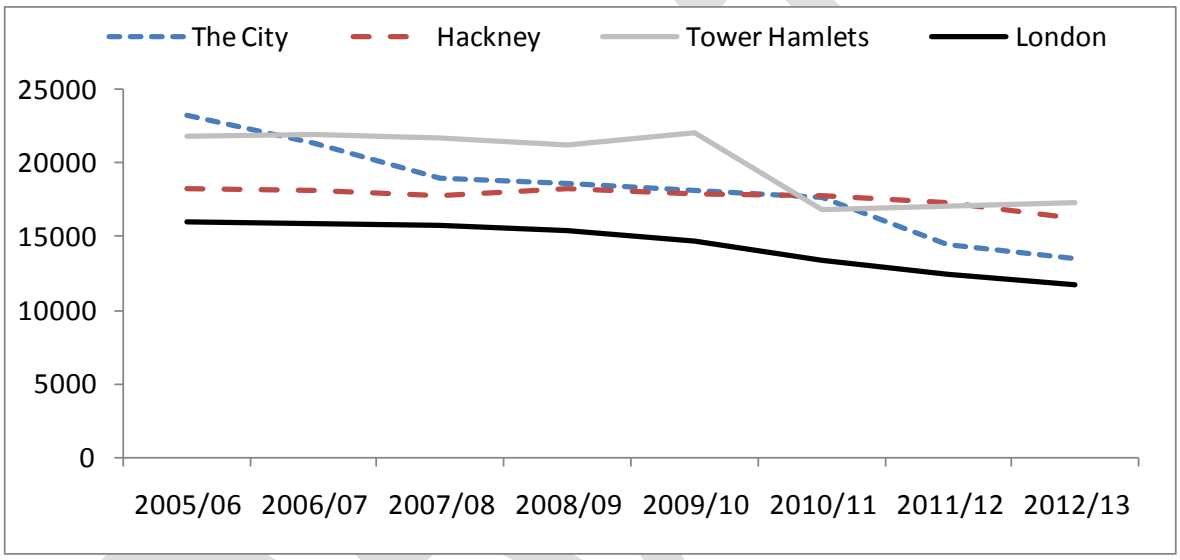
Older people

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

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

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

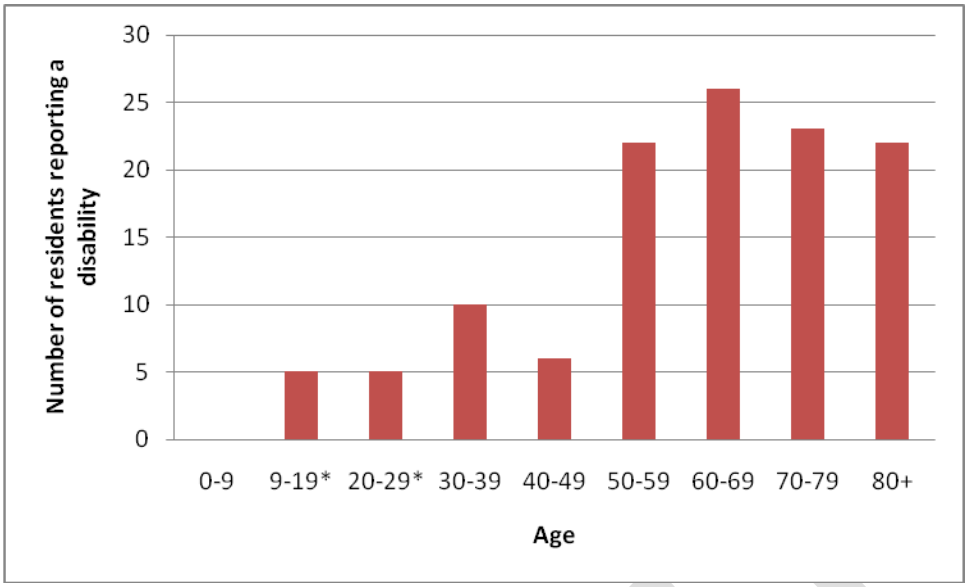
Figure 7.1 Older people (aged 65 and over) receiving care packages per 100,000 population, 2005-13



Source: NASCIS

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

[82] City of London housing tenants profiling, 2011



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

Life expectancy

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

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

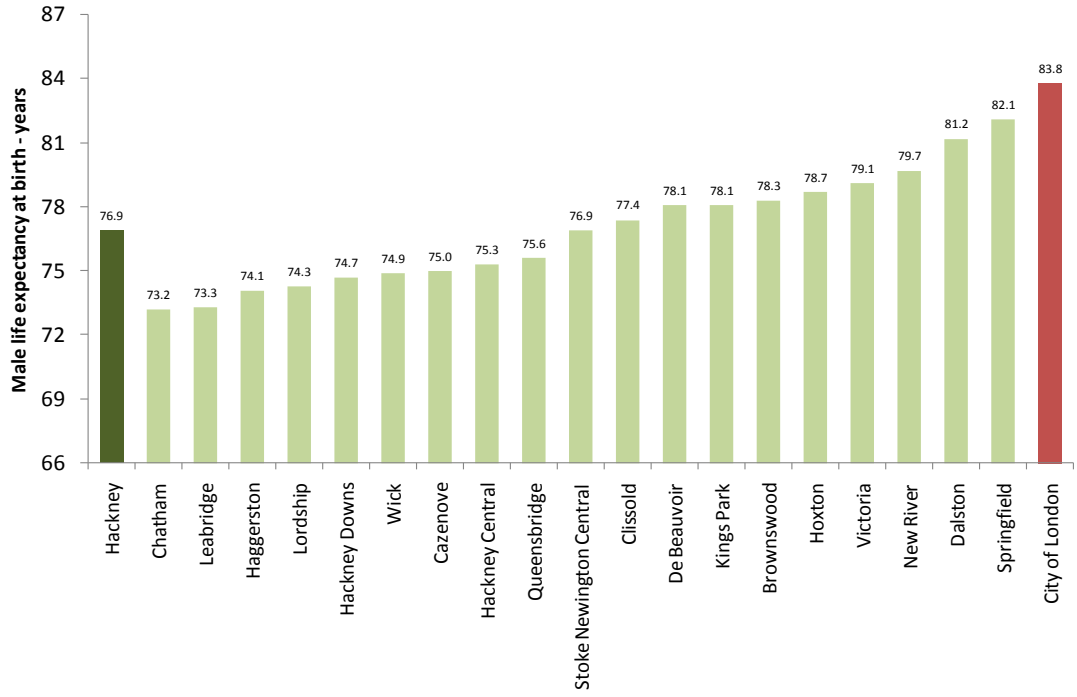
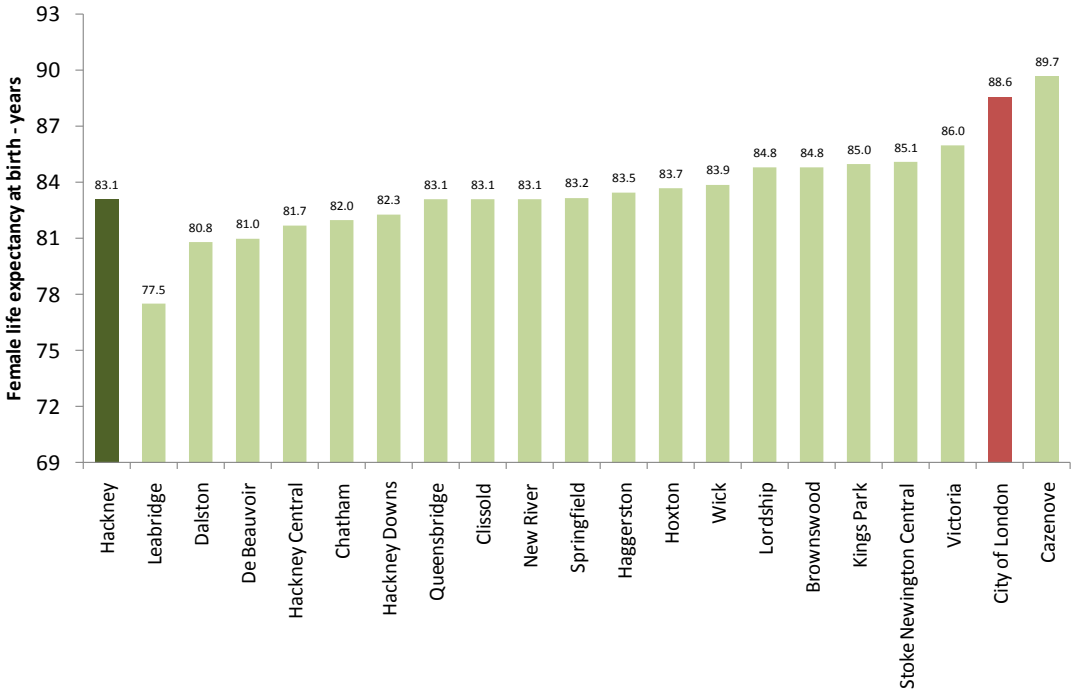


Figure 6.4 Life expectancy for females, Hackney and the City, 2006-10 (LHO)



Deaths

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

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

Telecare and telehealth

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

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

The social prescribing pilot project

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

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

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

Loneliness and social isolation

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

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

Case Study

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

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

Independence and health issues

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

Dementia condition and support

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

Dementia

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

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

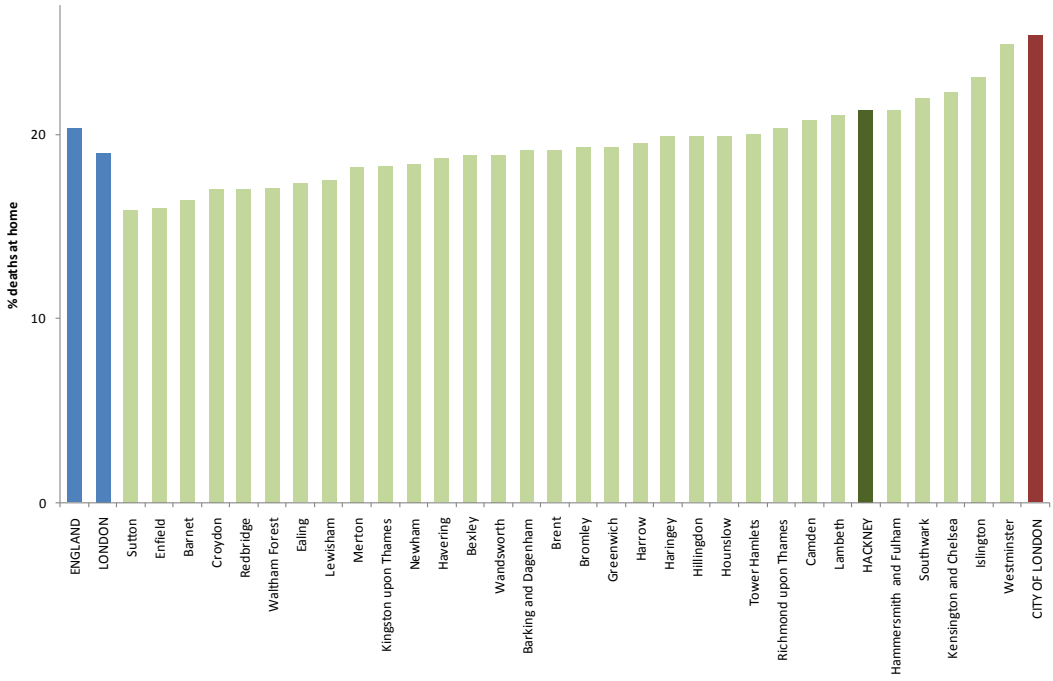
In 2014 the City committed to providing the best possible services to this particularly vulnerable group through the City's Dementia Strategy. The strategy commits the City of London Corporation to creating a "Dementia Friendly City", where residents and local retail outlets and services will develop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

End-of-life care

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

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

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


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

8. Healthy Life

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

Key Findings

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

Residents

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

City workers

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

Rough sleepers

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

Recommendations

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

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

City workers

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

Rough sleepers

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

Questions for commissioners

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

Chronic Disease

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

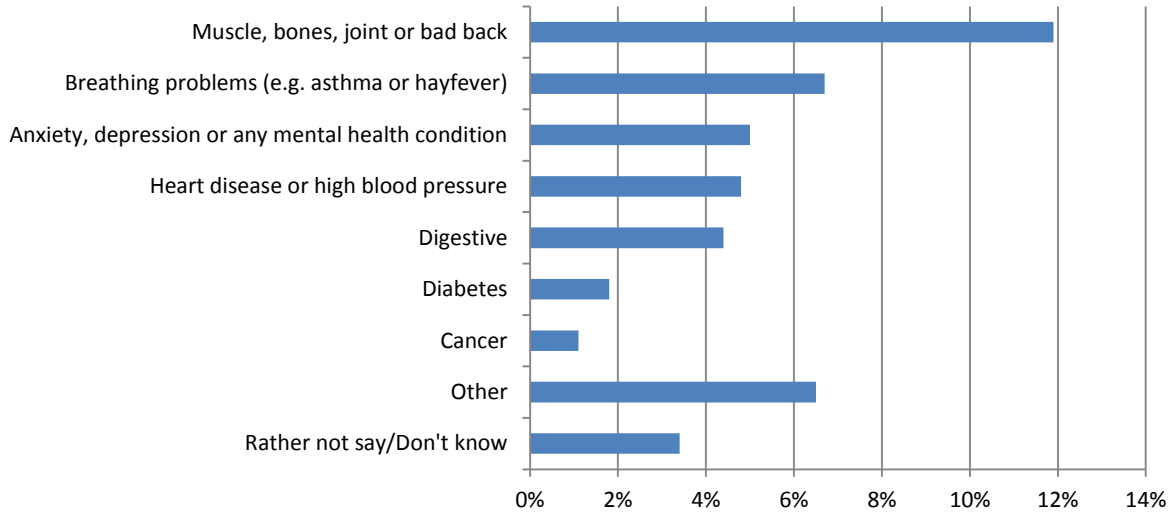
Data are available on cancer, which show that deaths from all cancers and from premature cancer are well below the average for London, and premature deaths have fallen markedly over the last 6 years.

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

City Workers

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

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



Infectious diseases

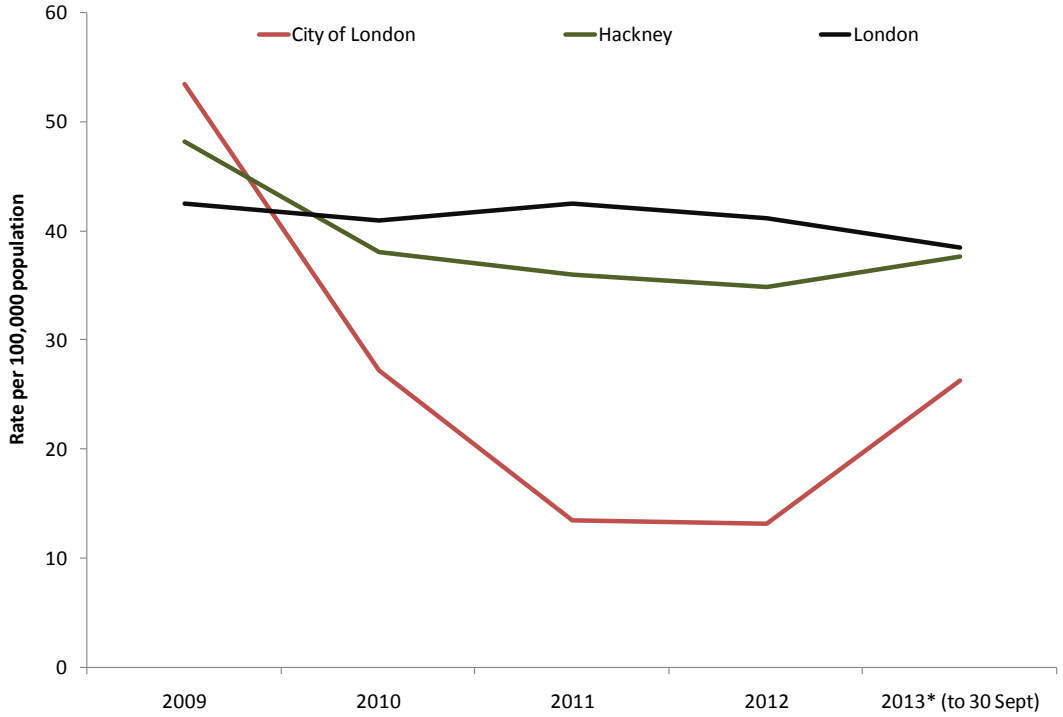
Hepatitis C

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

Tuberculosis (TB)

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

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



City Workers

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

Rough Sleepers

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

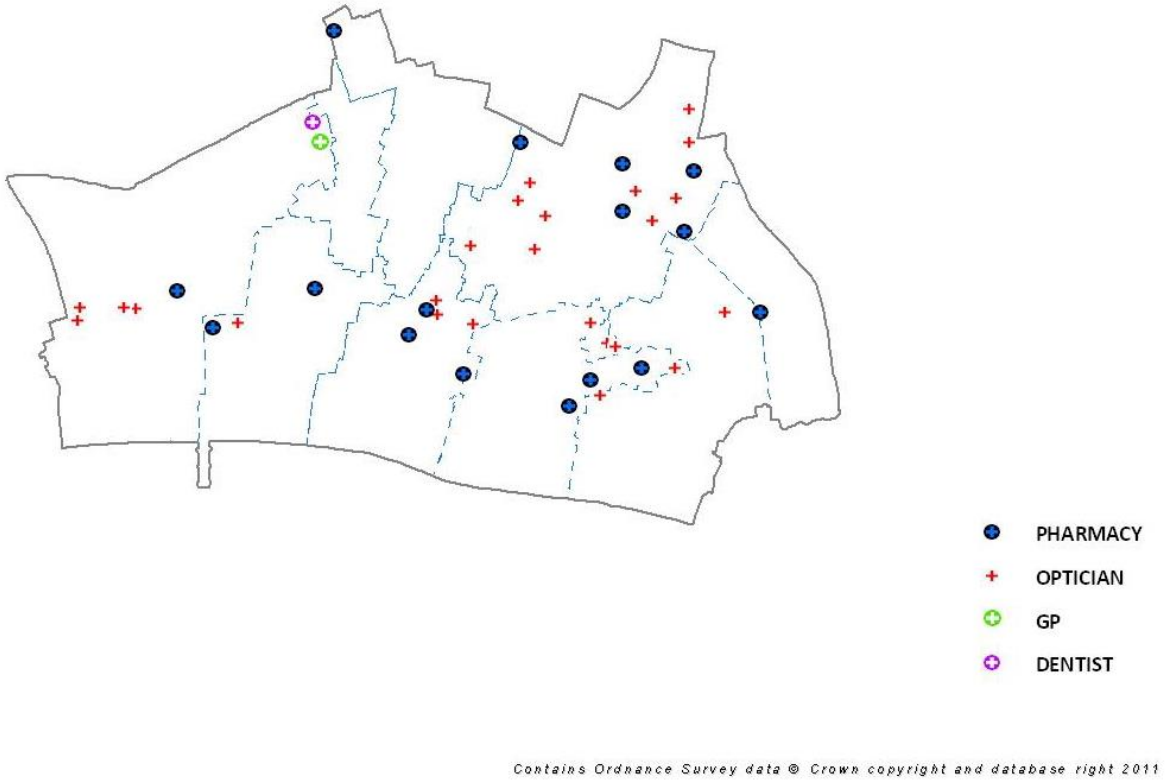
Health Services

Primary care

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

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

Figure 8.1 Primary care services in the City



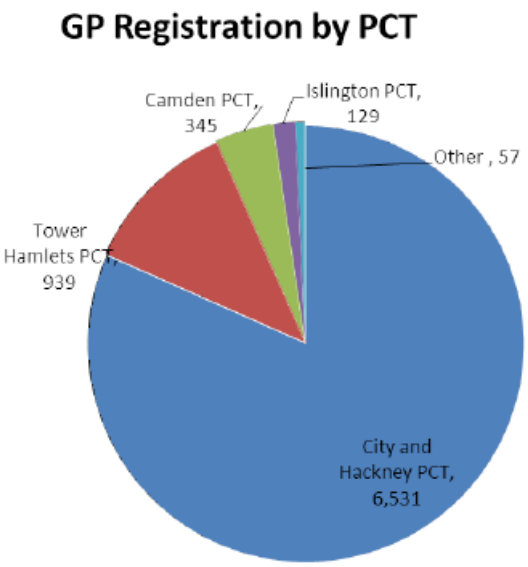
GP registrations

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

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

Figure 8.1 GP registration of City residents

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



Practices with largest number of City Residents

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

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

City Workers

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

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

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

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

Rough Sleepers

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

Dental services

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

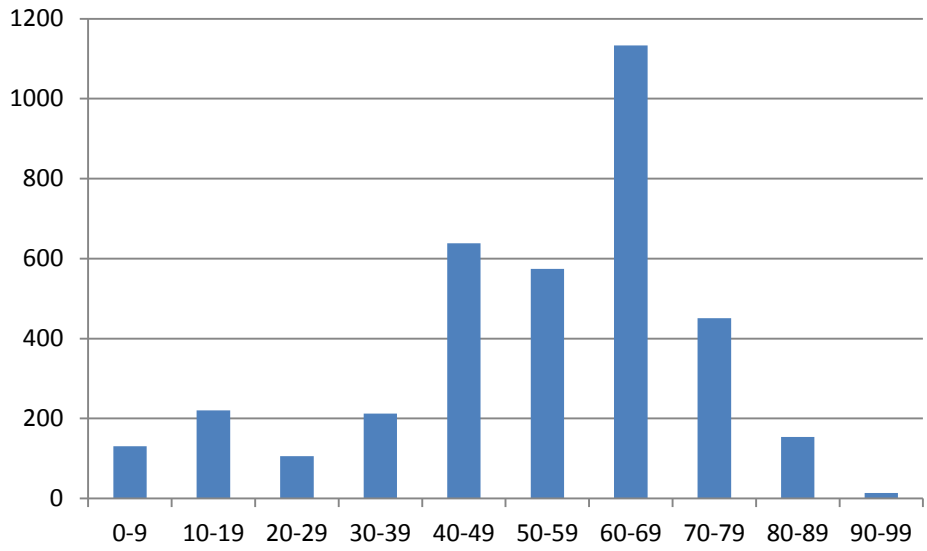
During the period April 2010 to March 2011, residents of the City of London accessed NHS dental services in the neighbouring boroughs of Hackney, Tower Hamlets, Camden and Islington. The

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

Optometry

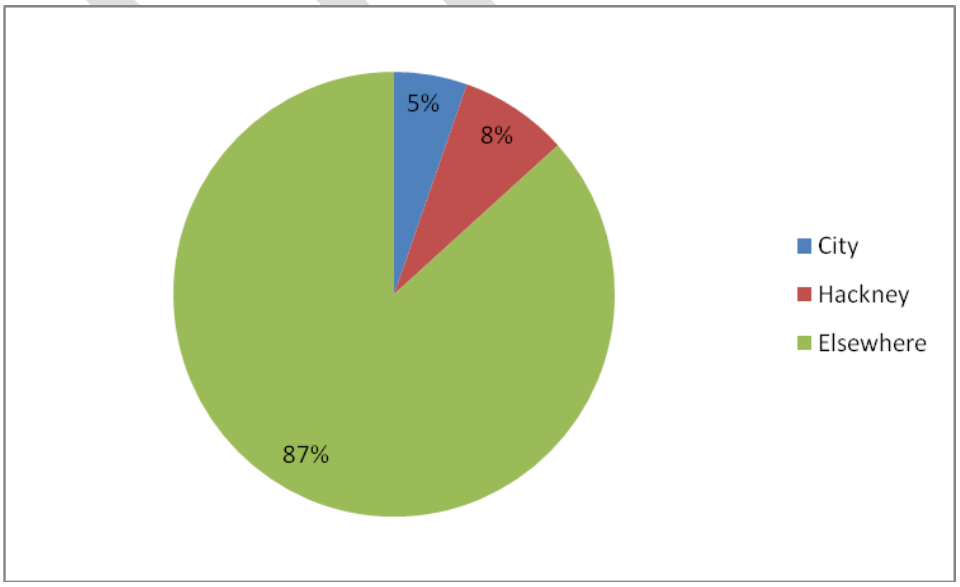
In 2009/10, NHS sights in the City were predominantly performed in the over 40's population.

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



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

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



Pharmacies and prescribing

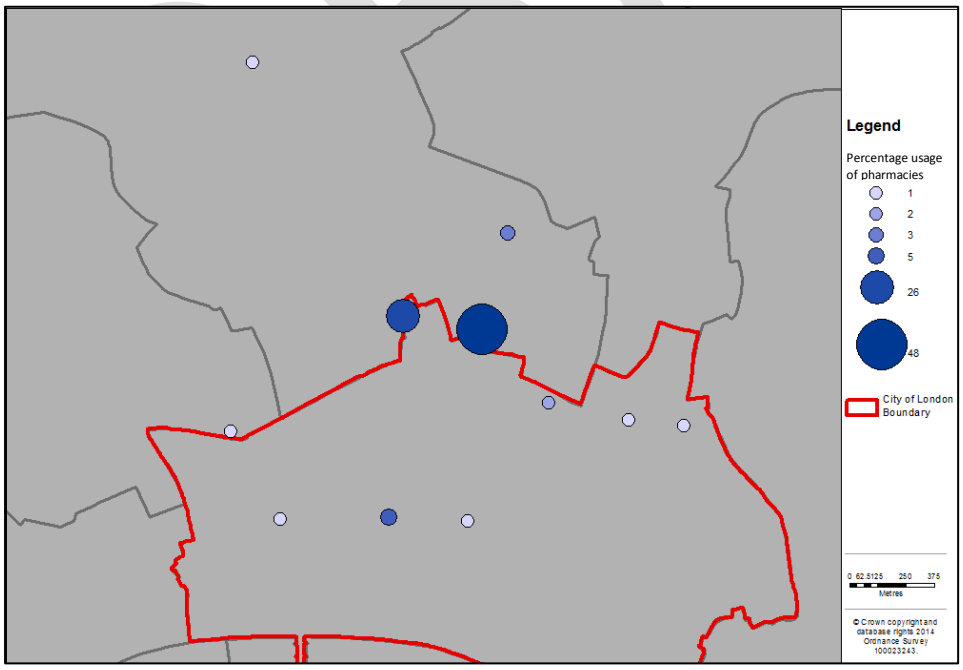
Community pharmacy has had an important role to play in reducing health inequalities through increasing access to health information, prevention and screening services as well as signposting patients to other services and supporting them to take medications. There is a potential to expand services in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

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

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

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

Figure 8.2 Percentage usage of pharmacies by Neaman practice patients 2011



[89] ePACT 2011

Rough sleepers

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

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

Case Study

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

Housing history

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

Health issues

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

Other issues

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

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

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

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

Social Care Services

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

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

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

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

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

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

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

The Better Care Fund (BCF)

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

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

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

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

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

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

Performance Data

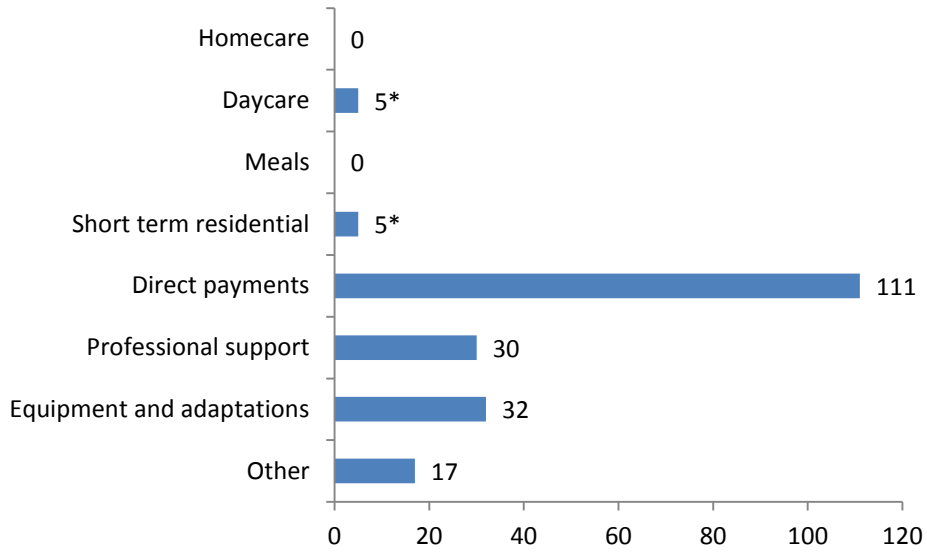
In 2011-2012 the City of London carried out the Adult Social Care User Survey for the first time. The City had an excellent response rate of 63%. Of those who responded, 83% felt that the services they received made them feel safe and secure. 74% of users felt that they have control over their daily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

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

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

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

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



**Fewer than 5 individuals were reported*

Direct payments

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

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

Safeguarding

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

Case Study

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

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

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

Safeguarding process

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

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

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

The Voluntary and Community Services

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

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

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

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

Time Credits

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

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

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

Appendix 1 – Data limitations

Resident data

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

Census 2011:

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

Healthcare Service performance data:

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

Social Care Service performance data:

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

Early life and childhood data

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

Housing data

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

City worker data

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

insights into the health needs of City Workers – *The Public Health and Primary Healthcare Needs of City Workers*, and *Insights into City Drinkers*.[9192]

The 2011 Census release:

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

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

Public health and Primary Healthcare Needs of City Workers:

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

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

Insights into City Drinkers:

This report was commissioned by the City of London Substance Misuse Partnership to gain an insight into the prevalence and nature of alcohol consumption among city workers and identify segments within the community of City workers who could be targeted with public health information about risks associated with consuming alcohol.

The report defined alcohol misuse as those identified as drinking at 'increasing' or 'higher risk' levels as identified by a validated screening tool. Alcohol misuse in itself does not infer 'problematic' drinking, though those drinking at higher risk levels are likely to be experiencing harms including possible dependency.

Rough sleeper data

CHAIN database:

The main source of data for rough sleepers in the City comes from the CHAIN database. The CHAIN (Combined Homelessness and Information Network) database is commissioned and funded by the Greater London Authority and managed by Broadway. It records information about contacts and work done with rough sleepers and members of the wider street population in London. Outreach teams, hostels, day centres and a range of other homelessness services across London access and update the system.

[91] The Public Health and Primary Healthcare Needs of City Workers, May 2012
[92] Insights into City Drinkers, 2012
[93] Office for National Statistics 2013, The Workday Population of England and Wales: An Alternative 2011 Census Output Base

There exists City level data for basic demographics details of rough sleepers, such as age, sex and ethnicity.

Rough sleepers: health and healthcare:

This report entitled Rough sleepers: health and heathcare by NHS North West London provides the health needs evidence where detailed City specific rough sleeper needs do not exist.

Appendix 2 – Demographics

Table 1.7 Projected population age groups in the City to 2037, with percentage rise over previous five years (numbers rounded to nearest 100)

Year		The City				
		0–4	5–19	20–65	>65	All
2007	N (% rise)	300 (22.2)	600 (–0.7)	5,900 (3.6)	900 (4.4)	7,600 (3.9)
2012	N (% rise)	300 (–7.2)	600 (4.9)	5,700 (–2.1)	1,000 (10.9)	7,600 (–0.2)
2017	N (% rise)	300 (8.2)	600 (8.1)	6,000 (4.4)	1,200 (17.3)	8,100 (6.5)
2022	N (% rise)	300 (–0.8)	700 (7.7)	6,200 (2.7)	1,300 (11.3)	8,400 (4.3)
2027	N (% rise)	300 (–0.8)	700 (4.4)	6,300 (2.0)	1,500 (10.1)	8,700 (3.4)
2032	N (% rise)	300 (–0.4)	700 (0.3)	6,300 (1.0)	1,600 (13.2)	9,000 (2.9)
2037	N (% rise)	300 (0.4)	700 (–0.4)	6,400 (1.2)	1,800 (9.6)	9,200 (2.6)

Source: GLA

Figure 1.8 Intercensal population growth (NB: 2001 populations may be underestimated in some areas).

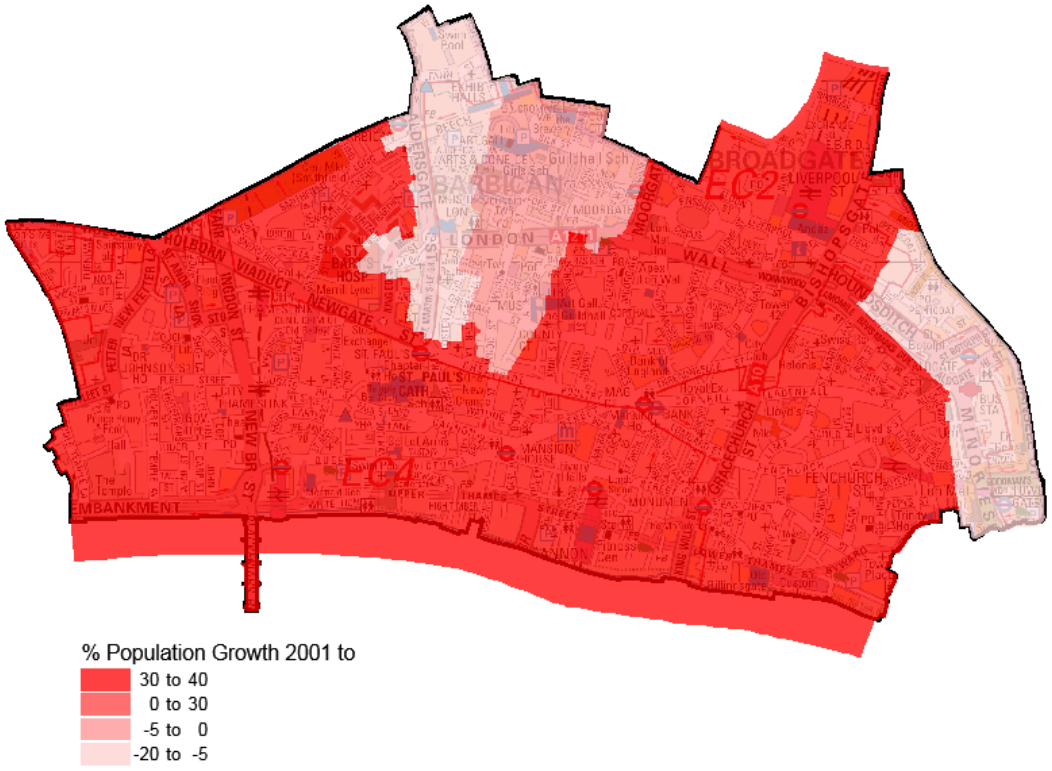
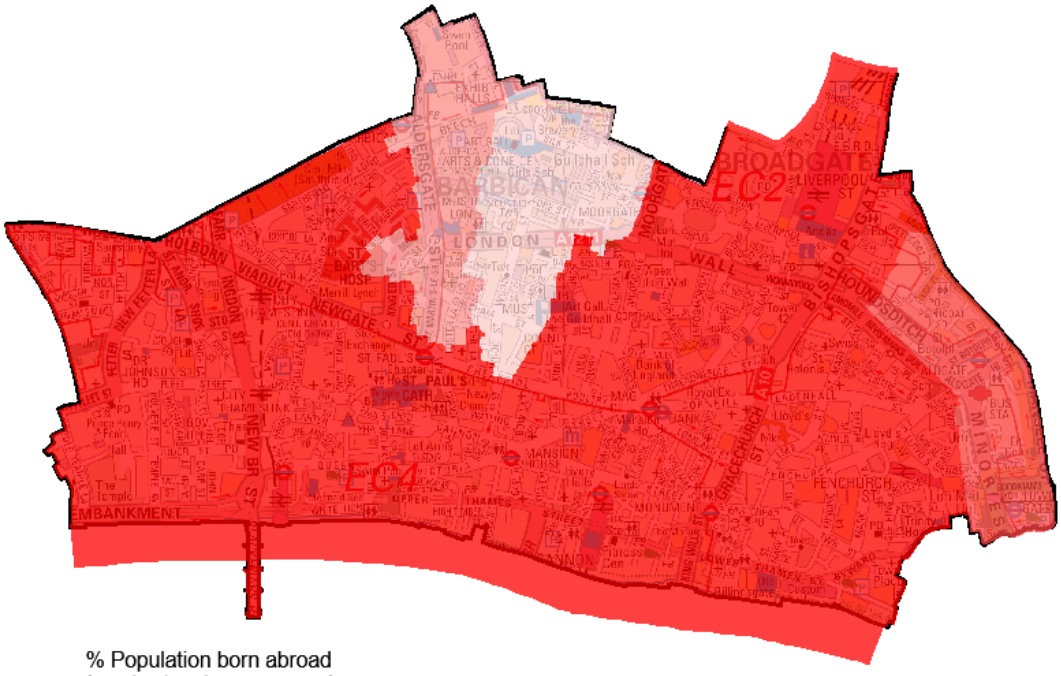


Figure 1.9 Percentage of population who were not born in the UK



% Population born abroad
(GLA data based on 2011 census)

- 44 to 50
- 38 to 44
- 32 to 38
- 26 to 32

Appendix 3 – Ethnicity

Figure 1.10A Ethnicity in the City: percentage of residents who are white

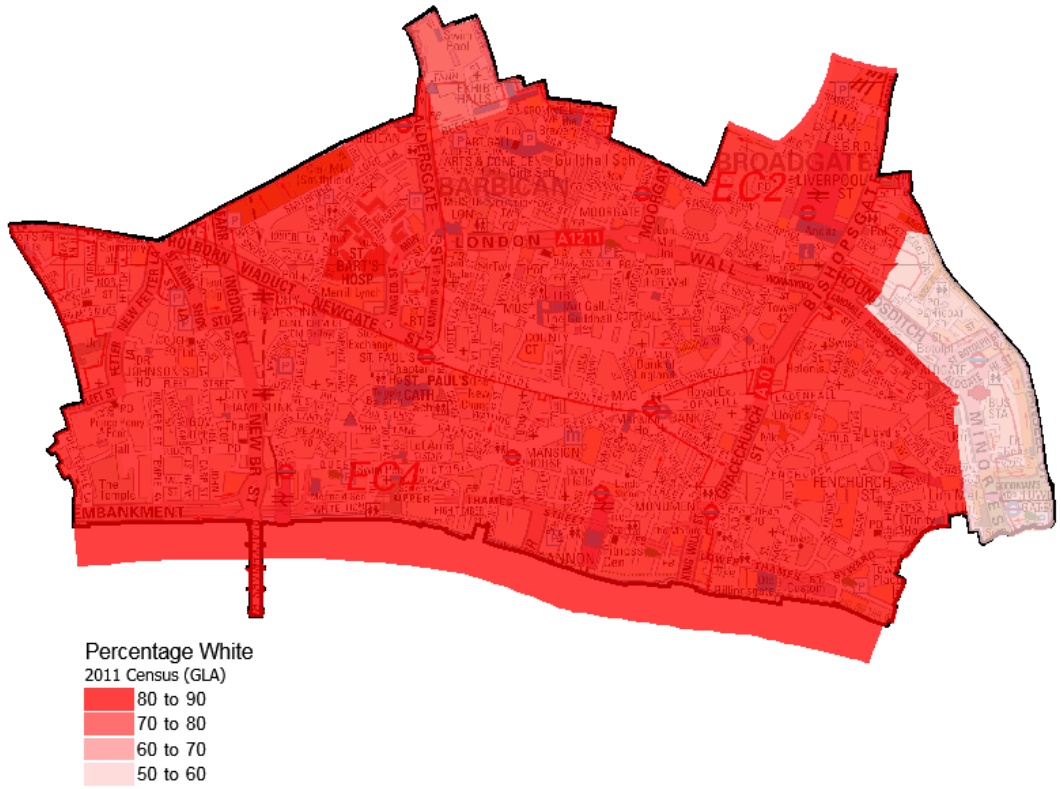


Figure 1.10B Ethnicity in the City: percentage of residents who are black

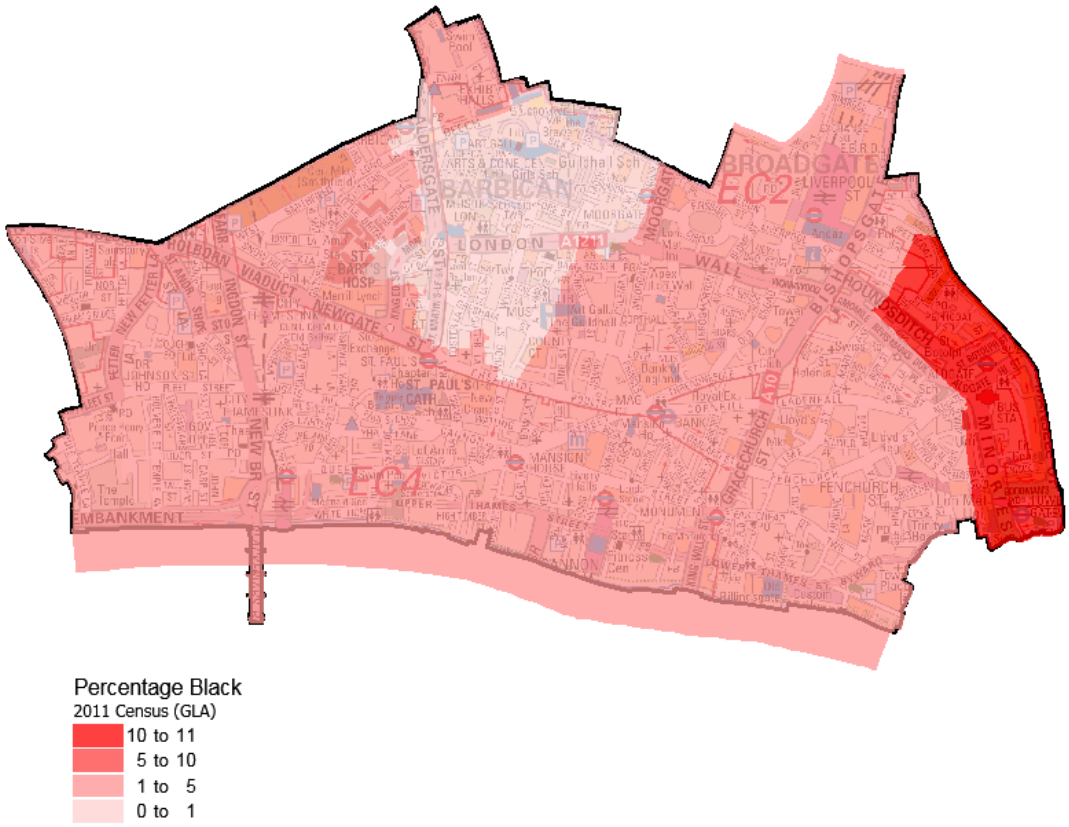


Figure 1.10C Ethnicity in the City: percentage of residents who are Asian

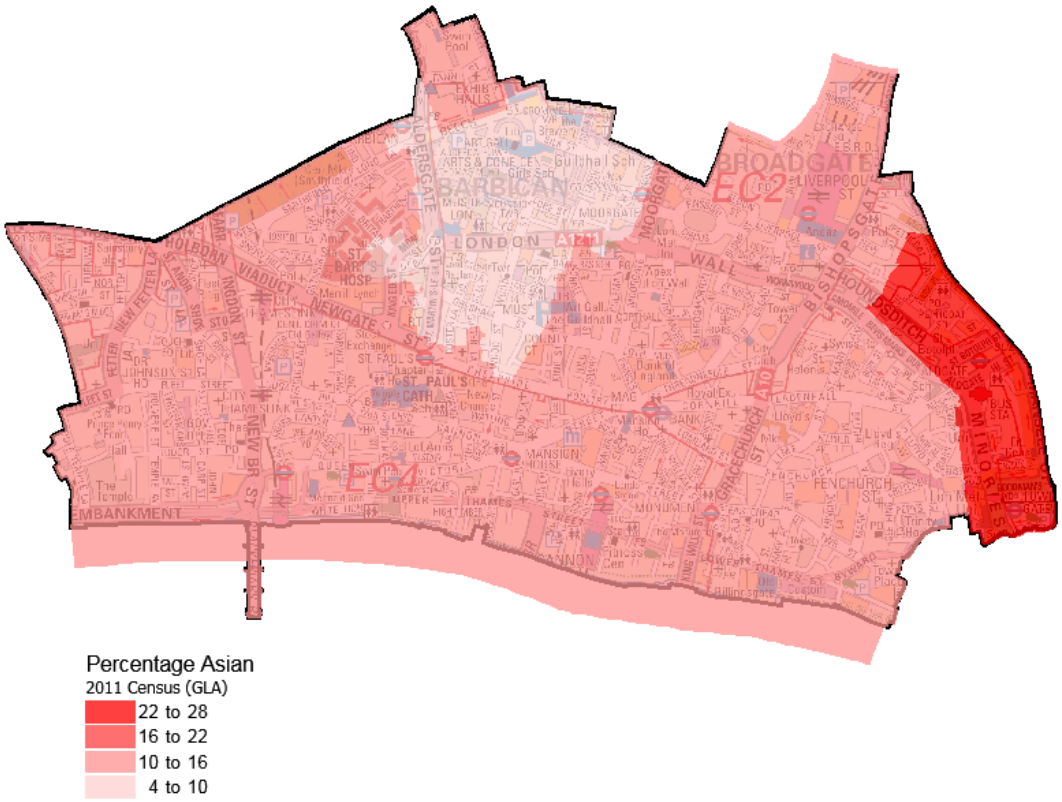
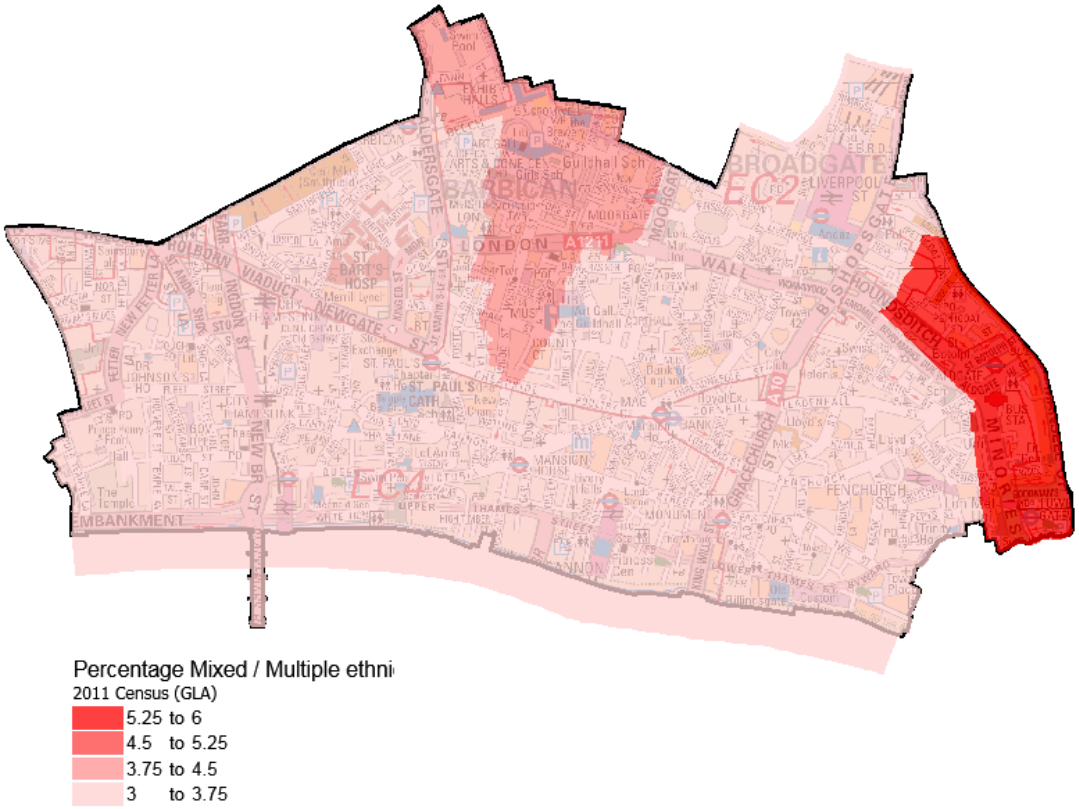


Figure 1.10D Ethnicity in the City: percentage of residents who are of mixed / multiple ethnicity



Appendix 4 - Religion

Figure 1.11A Main religions in the City: percentage of residents who are Christian

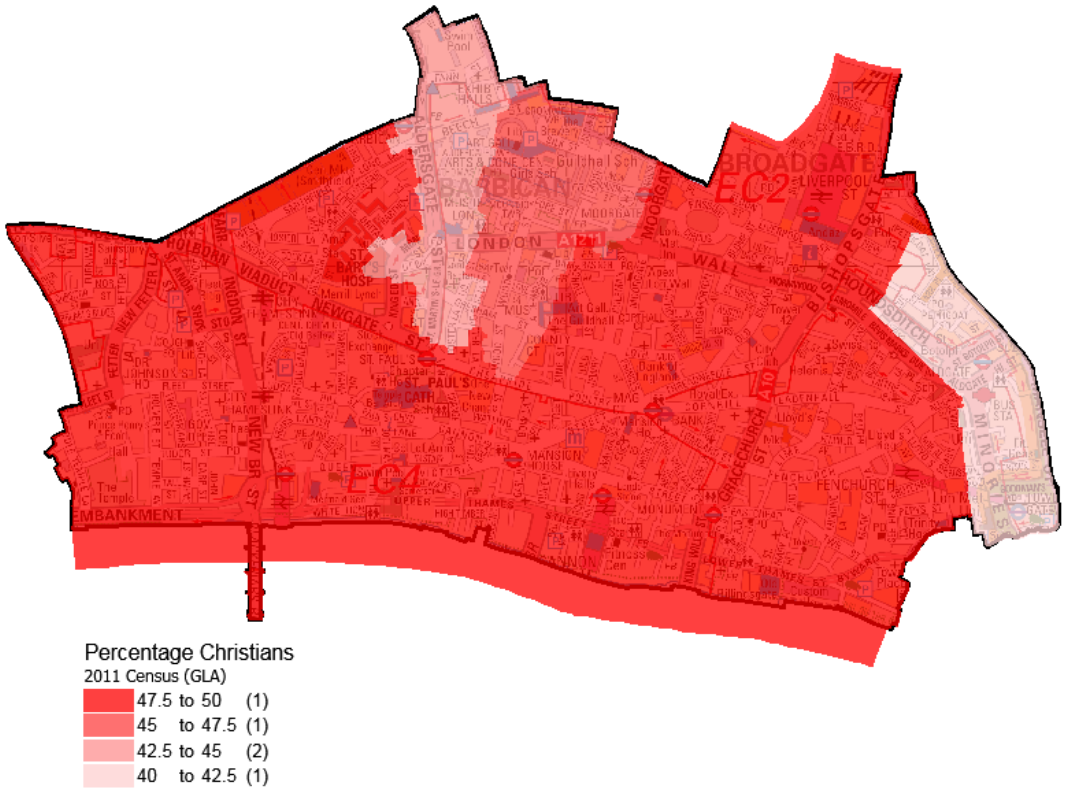


Figure 1.11B Main religions in the City: percentage of residents who are Jewish

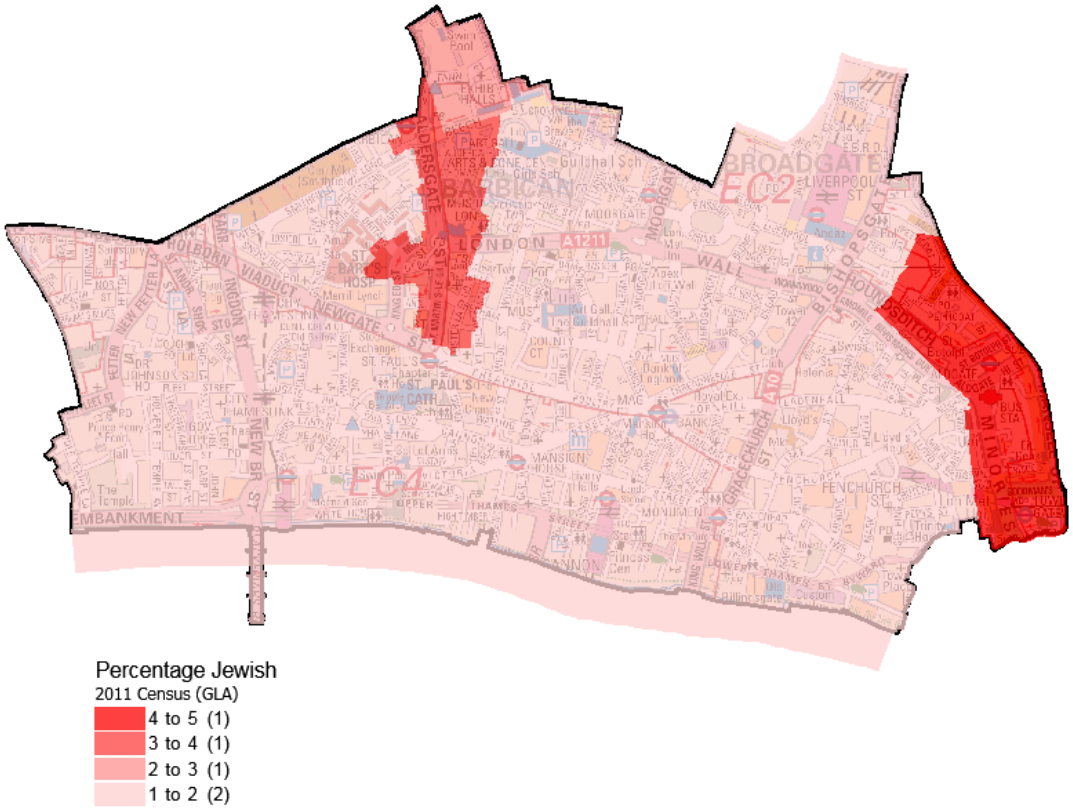


Figure 1.11C Main religions in the City: percentage of residents who are Muslim

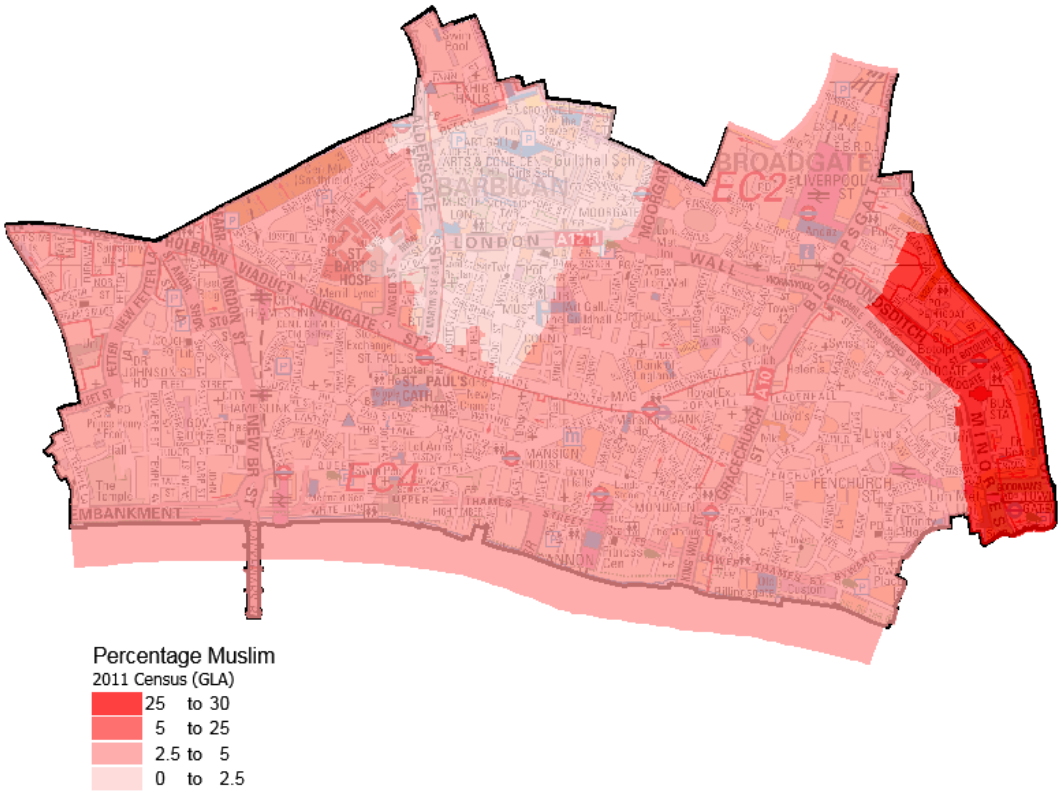
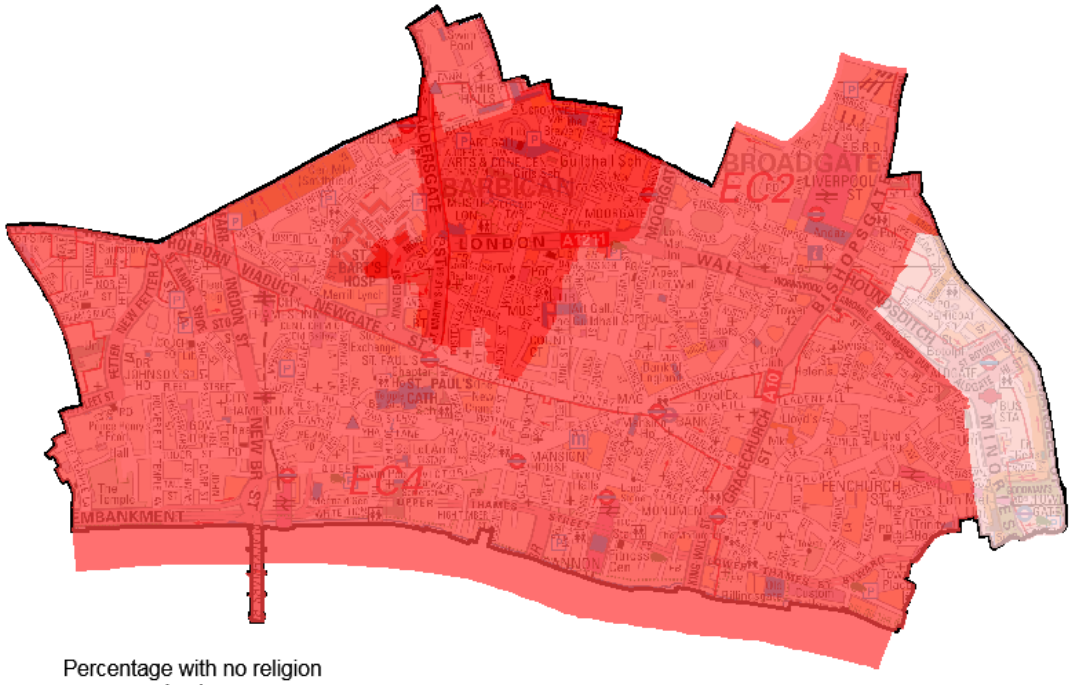
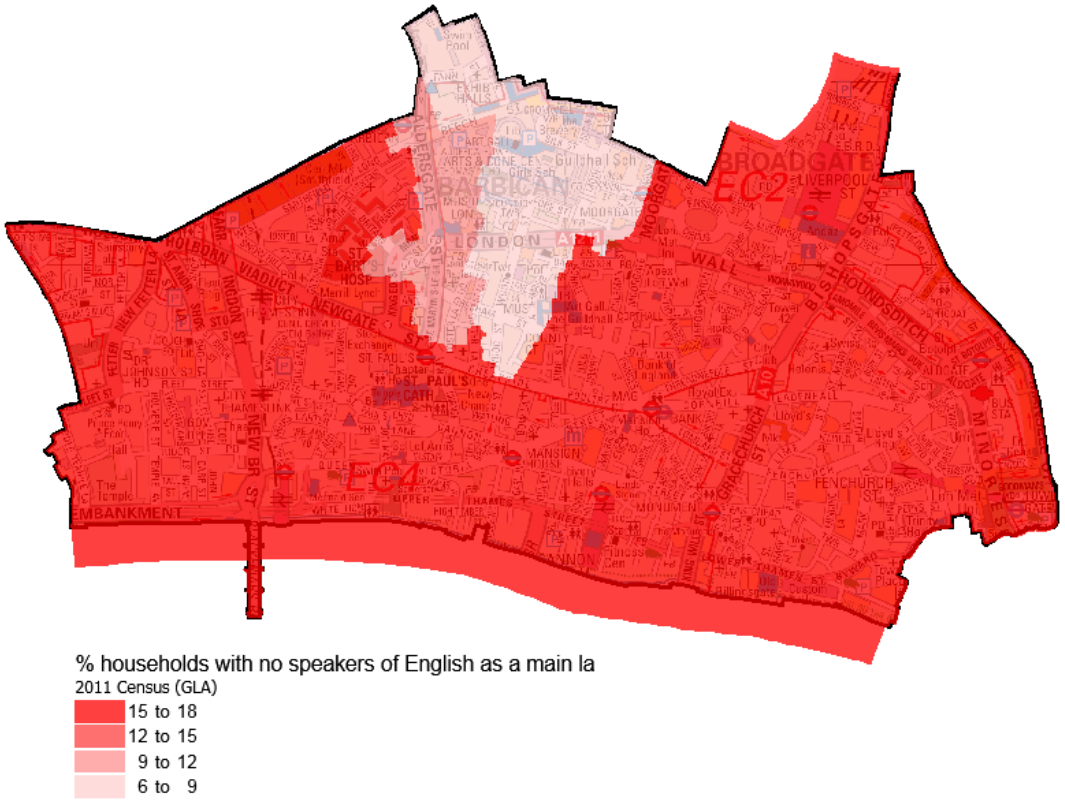


Figure 1.11D Main religions in the City: percentage of residents who state no religion



Appendix 5 – Languages

Figure 1.12 Percentage of households in the City with no speakers of English as a main language.



Appendix 6 - Road casualties

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

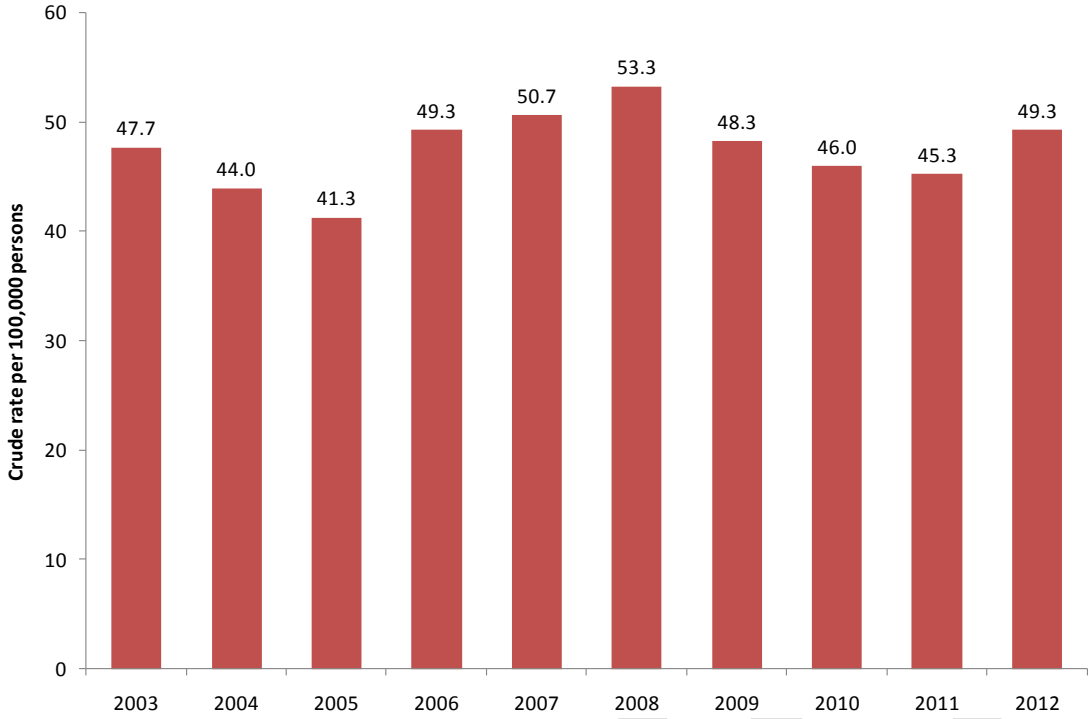
Given the smaller numbers involved, there is even more year-on-year variability in this data in the City. Since 2003, the long-term trend on a three-year rolling average shows a generally consistent number of casualties (Figure 6.6).

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

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

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

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


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

Appendix 7 – Families and Households

Figure 1.13B Household structure in the City: percentage of couples without children

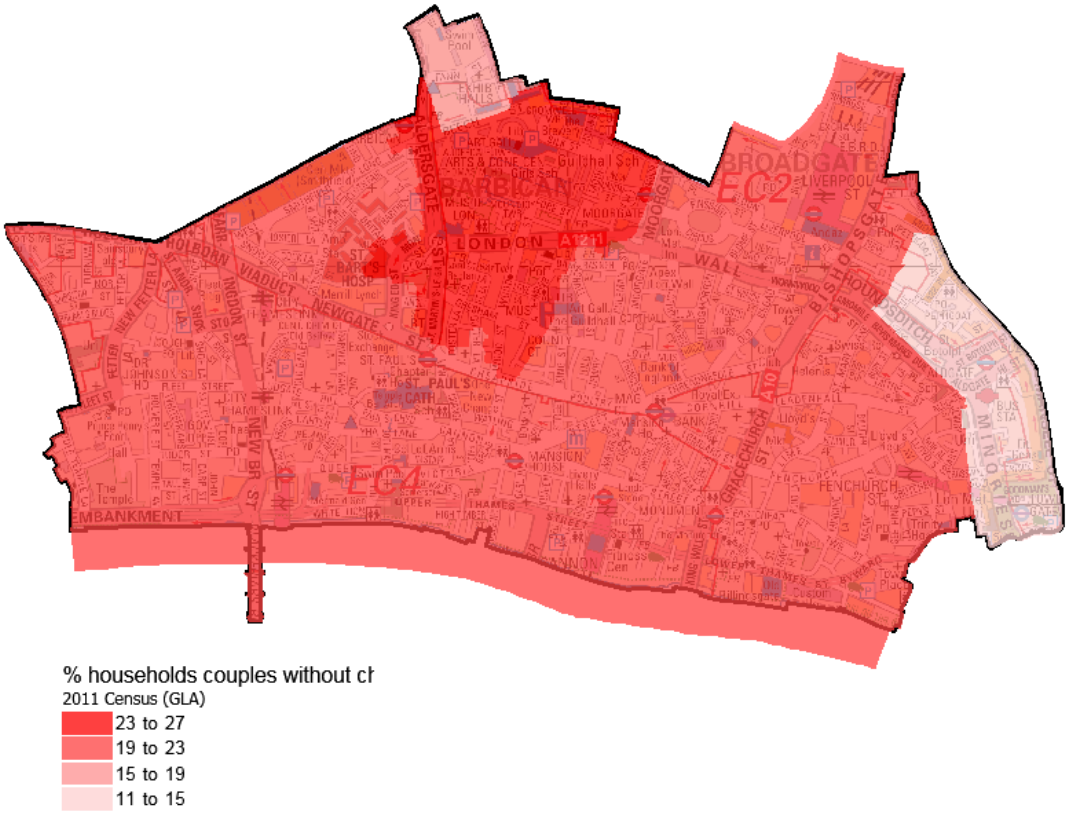


Figure 1.13C Household structure in the City: percentage of lone parent households

Figure 1.13D Household structure in the City: percentage of one person households

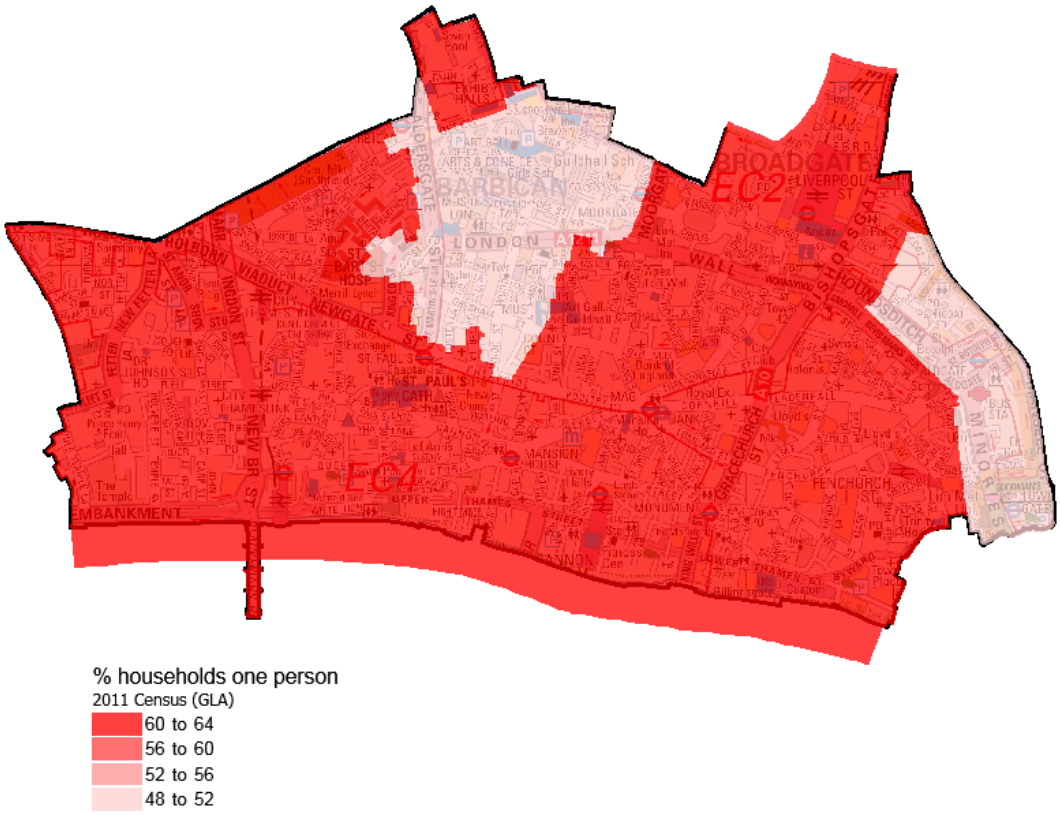
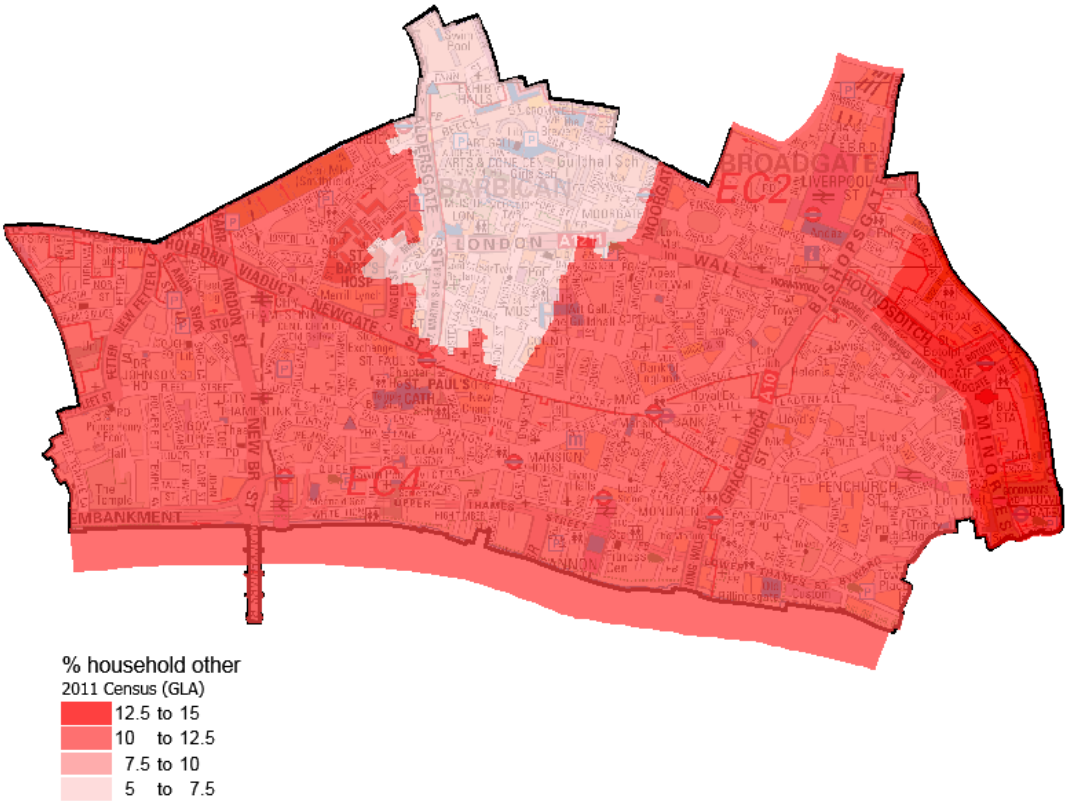


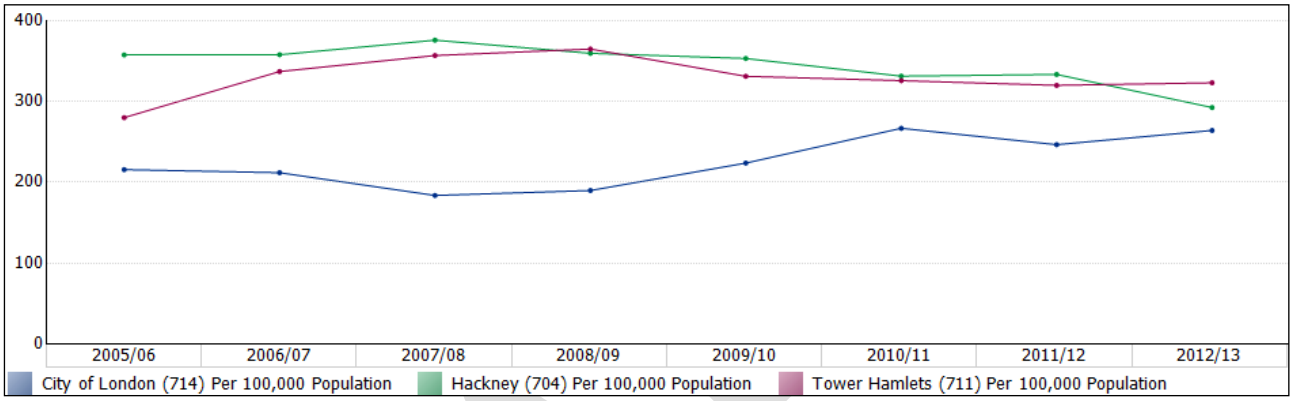
Figure 1.13E Household structure in the City: percentage of other households



Appendix 8 – Learning Disabilities

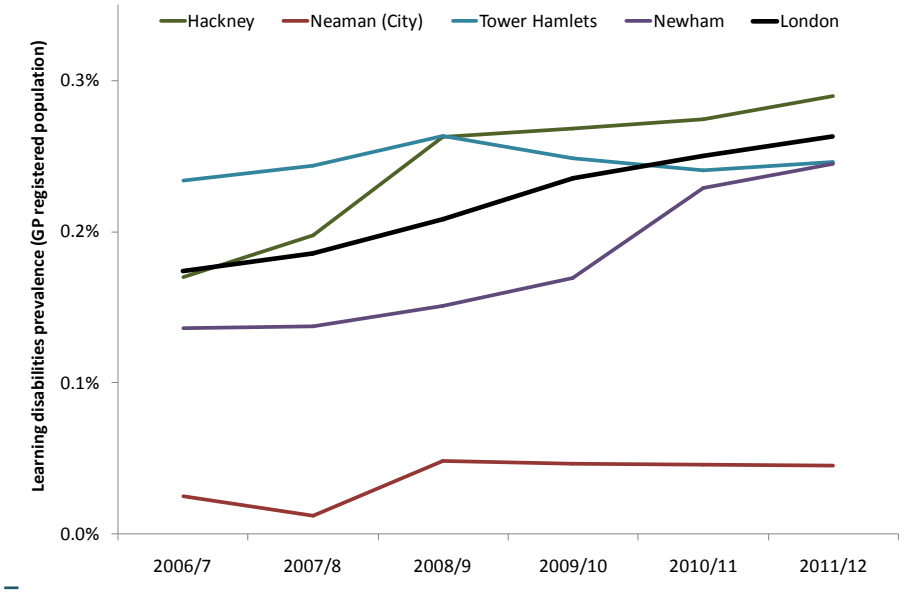
The only general practice data in the City is of those residents registered at the Neaman practice in the northwest of the City. In 2011/12, the prevalence of learning disability recorded by the Neaman practice was 0.1% (fewer than 5 individuals) (Figure 7.12).

Figure 7.8 Adults with a learning disability receiving care packages per 100,000 population, 2005-13



Source: NASCIS

Figure 7.12 Prevalence of recorded learning disabilities in GP-registered populations over time (QOF)



Appendix 9 – Death rates

Figure 0.1Age-adjusted death rates (males) per 100,000 population 2000-2009 (NCHOD)

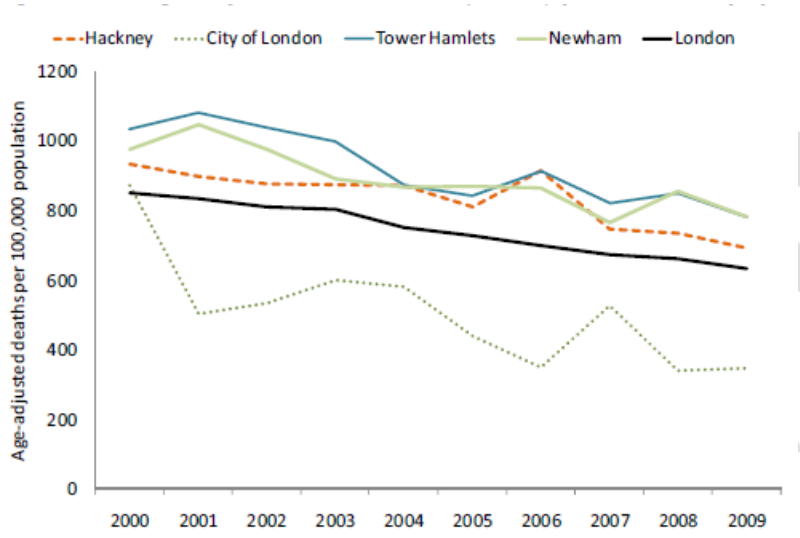


Figure 0.2 Age-adjusted death rates (females) per 100,000 population 2000-20009 (NCHOD)

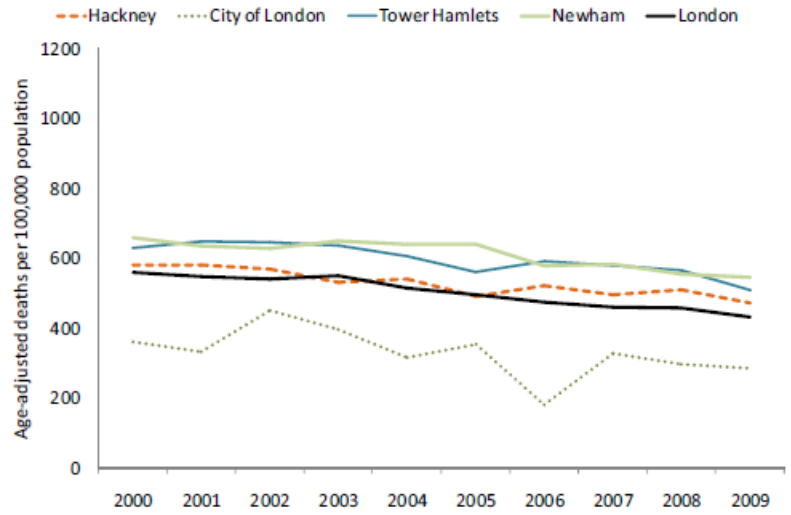


Figure 0.3Age-adjusted pre-mature (<75) death rate (males) per 100,000 people 2000-2009

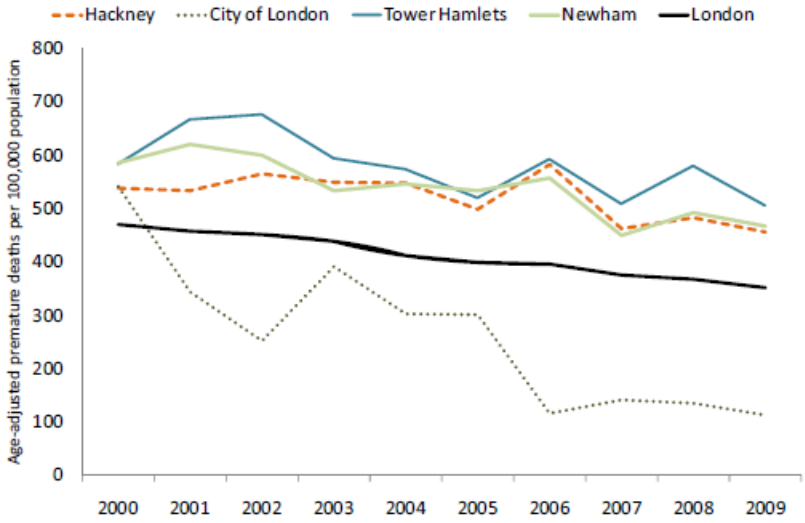
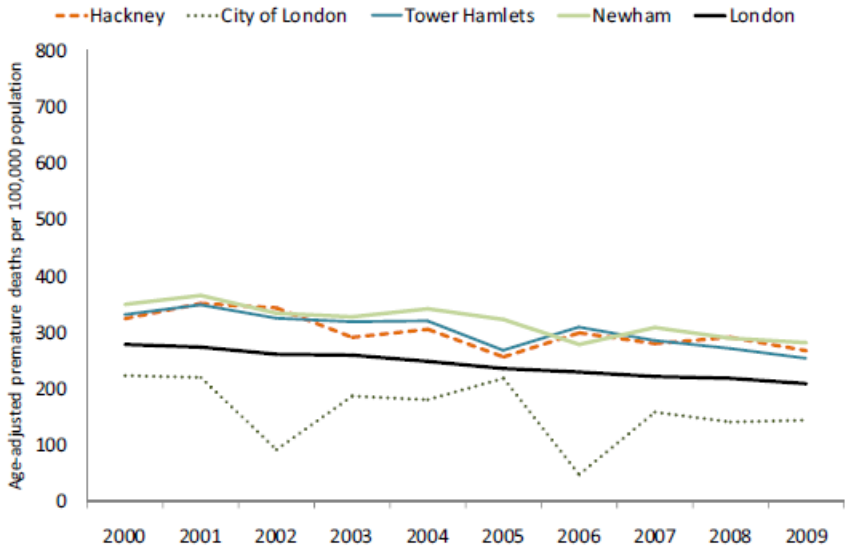


Figure 0.4Aged-adjusted pre-mature (<75) death rate (females) per 100,000 people 2000-2009



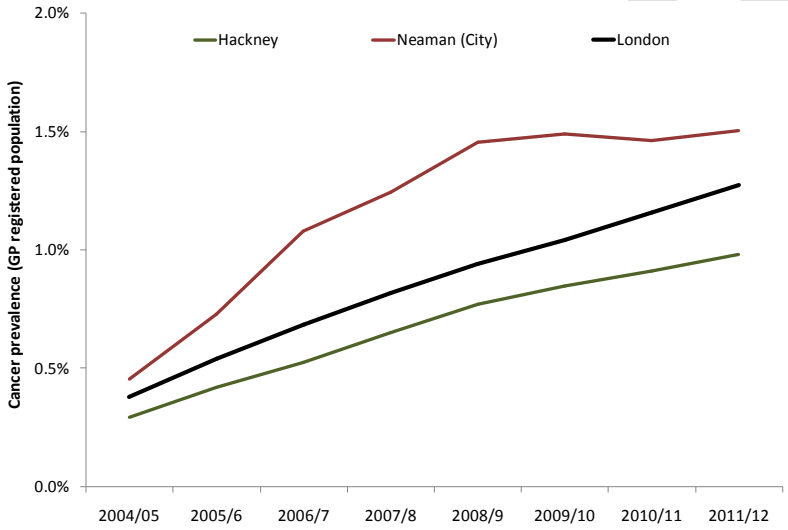
Appendix 10 – Chronic disease

Cancer

Prevalence

There is no data on cancer prevalence among residents of the City, except for those registered at the Neaman practice in the north-west of the area. In 2011/12 the crude prevalence of cancer recorded by the Neaman practice was 1.5% (134 individuals). This rate is relatively high due to the older population (rates are not age-standardised) (Figure 6.8).

Figure 6.8 Crude prevalence of cancer in the GP-registered population, 2006-12 (QOF)



Death and survival

In the City, the annual death rate from cancer over the three years from 2007 to 2009 was an average of 15 people (43% women, 57% men). This is an age standardised rate of 128 deaths per 100,000 population per year.

Figure 6.14 and 6.15 illustrate the long-term trends in deaths from all cancers and from premature cancer (under 75 years). Both rates in the City are well below the average for London and premature deaths have fallen markedly over the last 6 years.

Figure 0.1 Long-term trend in deaths from all cancers, at all ages (Thames Cancer Registry)

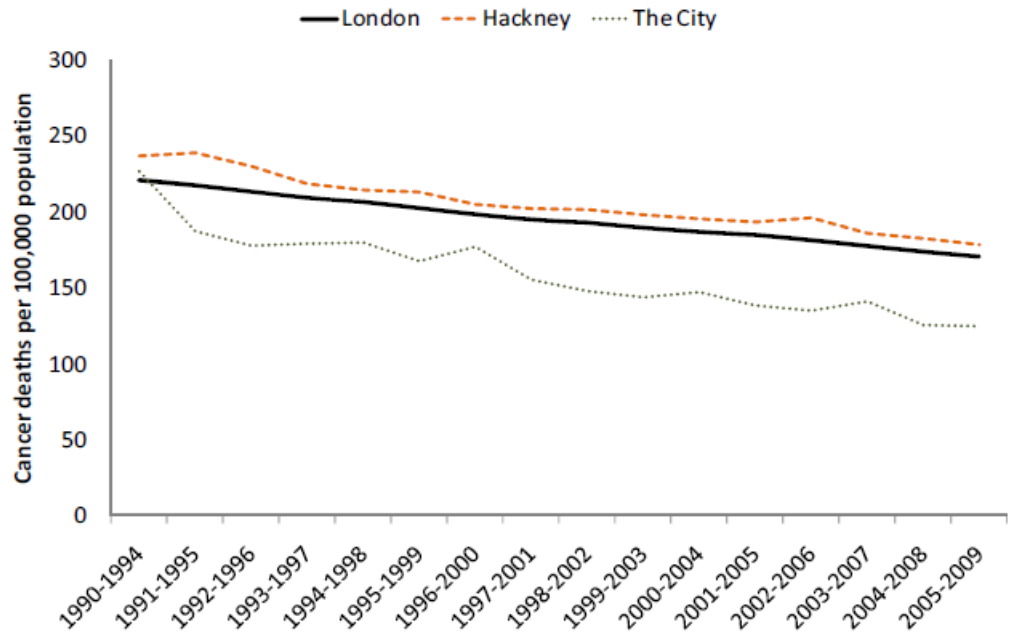
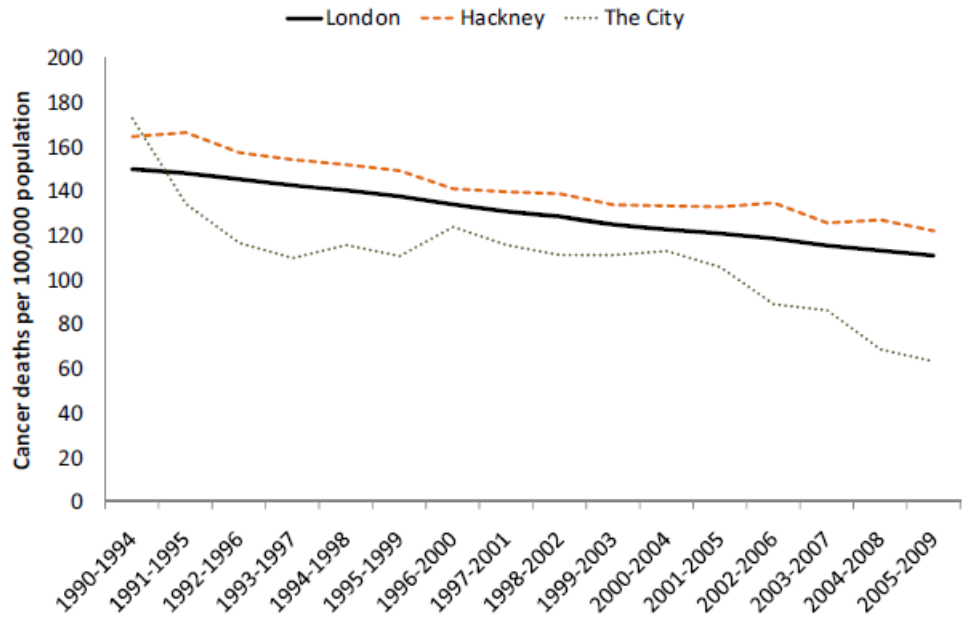


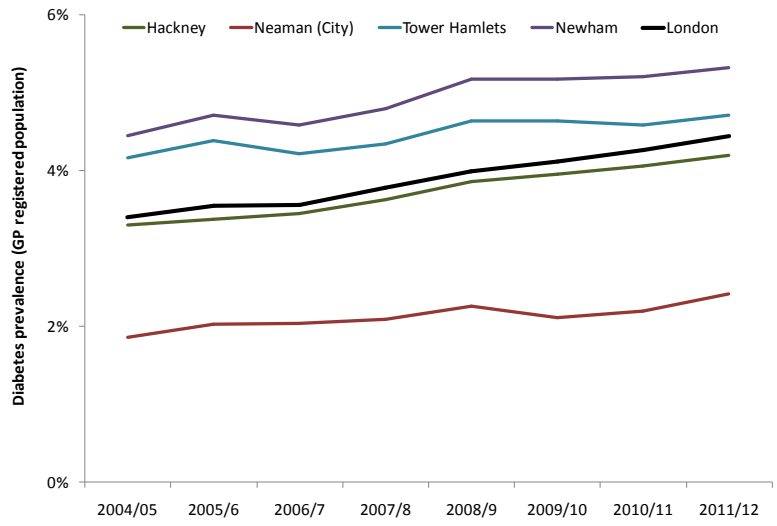
Figure 0.2 Long-term trend in deaths from premature (<75) cancer (Thames Cancer Register)



Diabetes

There is no data on diabetes prevalence among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2011/12, the crude prevalence of diabetes recorded by the Neaman practice was 2.4% (215 individuals) (Figure 6.17).

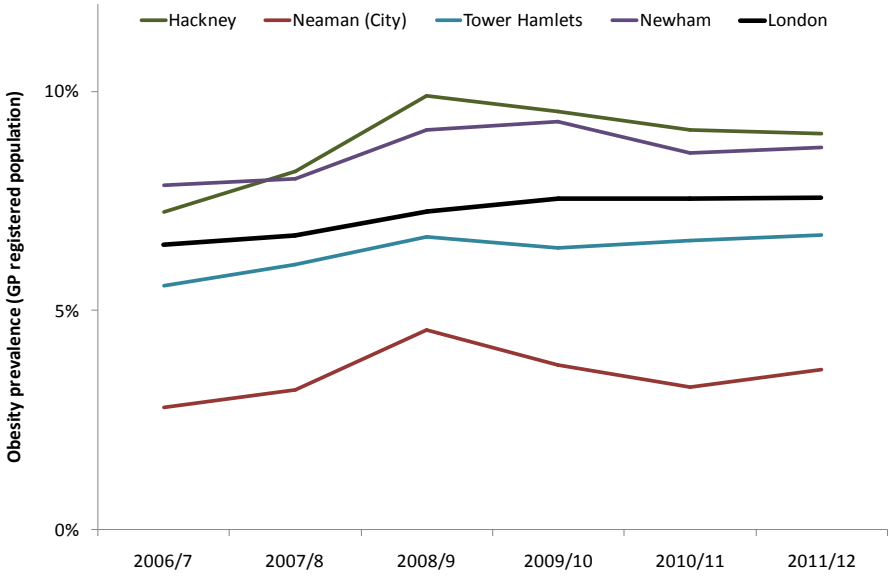
Figure 6.17 Prevalence of diabetes, 2004-12 (QOF)



Obesity

Obesity data is not available for the residents of the City, except for those registered at the Neaman practice in the north-west of the City. Around 4% of these adults are obese, which is lower than the rates for surrounding areas and London as a whole (Figure 3.9).

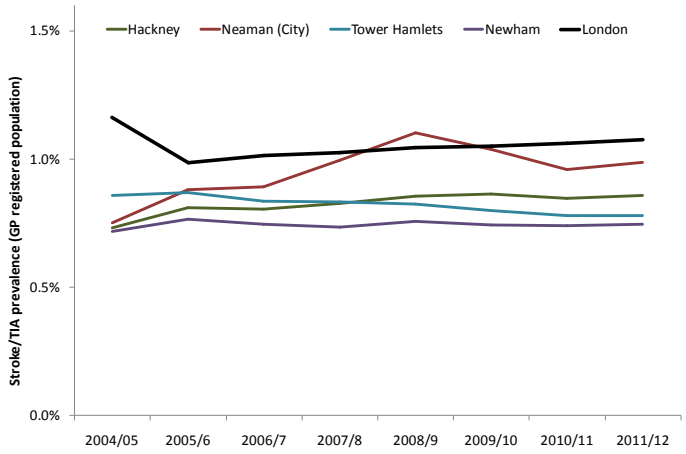
Figure 3.9 Obese adults as recorded in general practice in Hackney (QOF)



Stroke and Transient Ischemic Attack (TIA)

There is no data on stroke prevalence among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2011/12, the crude prevalence of stroke recorded by the Neaman practice was 1.0% (88 individuals) (Figure 6.22).

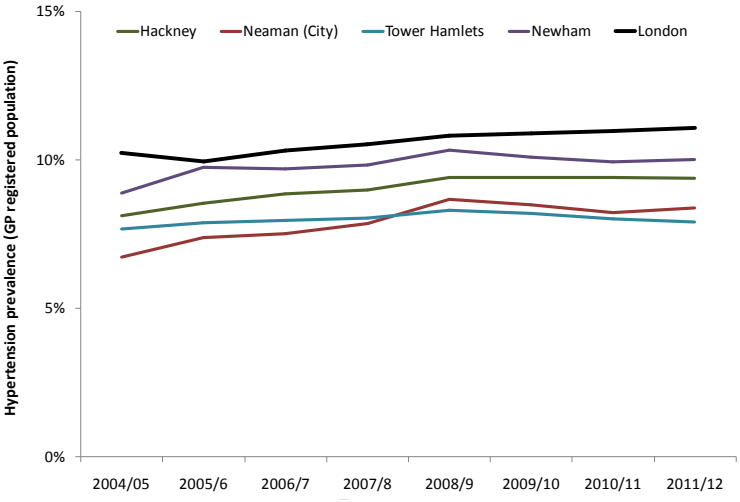
Figure 6.22 Crude prevalence of stroke/TIA in the GP-registered population, 2004-12 (QOF)



Hypertension

There is no data on hypertension among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2011/12, the crude prevalence of hypertension recorded by the Neaman practice was 8.4% (746 individuals).[94] This rate has been stable for the last four years (Figure 6.28).

Figure 6.28 Crude prevalence of hypertension in the GP-registered population, 2004-12 (QOF)



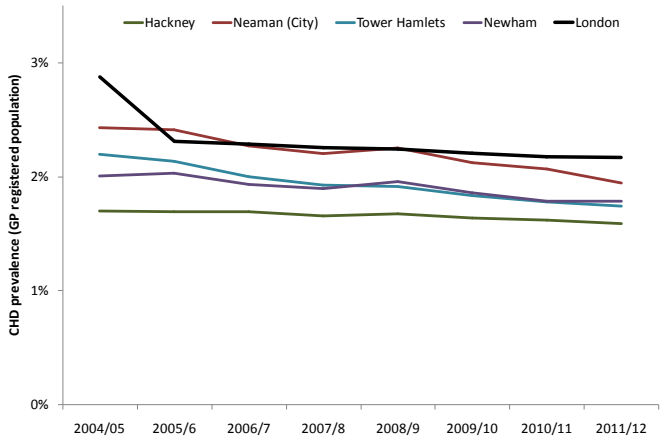
Coronary heart disease

There is no data on coronary heart disease among residents of the City, except for those residents registered at the Neaman practice in the north-west of the City. In 2010/11, the crude prevalence of

[94] QOF data

CHD recorded by the Neaman practice was 1.9% (173 individuals).[95] This crude rate is comparable with the average for London. Prevalence has fallen slightly in the past eight years (Figure 6.34).

Figure 6.34 Prevalence of CHD in the GP-registered population, 2004-12 (QOF)



Sickle Cell Disease

There were no admissions for sickle cells disease in the City in 2010/11.

[95] QOF data