6. Working age

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

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

According to the World Health Organization (WHO) Life Course Approach, functional capacity peaks in early adulthood.[1] Therefore early adulthood is a critical period for interventions that can have a springboard effect to alter subsequent life course trajectories, with implications for health in older life.[2] Healthcare needs in this group tend to relate to specific short-term issues such as flu symptoms, as well as to services aimed at slowing the rate of decline by reducing unhealthy lifestyle behaviours. Maintaining functional capacity – for example through supportive working conditions and options for starting a family or achieving work–life balance – are equally important to this age group.[3]

[C]Key findings

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

[D]Residents

- Unemployment is a significant contributor to poor health and wellbeing. There are discrepancies in unemployment in working age residents between the different housing estates in the City.
- Smoking and obesity rates are much higher in Portsoken than in the rest of the City.
- Depression rates in residents vary from 2% to 5%, depending on the data source.
- The City recognises the important contribution that carers make to population wellbeing and has developed support for carers.
- Unpaid carers provide vital support to vulnerable people in the City, and it is important that they receive appropriate support.

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[1] WHO (2000) *A Life Course Approach to Health*
[2] ibid
[3] *The Public Health and Primary Healthcare Needs of City Workers* (2012)

- The profile of residents using treatment services has changed from unemployed homeless drug users to those in stable housing and employment who have an alcohol problem.

[D]City workers

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

[D]Rough sleepers

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

[C]Recommendations

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

[C]Questions for commissioners

- What are commissioners doing to tackle unemployment in the City?
- How are commissioners adapting the substance misuse treatment and prevention services available to residents in line with the change in profile of those needing these services?
- What are commissioners doing to reduce obesity rates in Portsoken?
- How can commissioners prevent the alcohol misuse and mental health issues associated with City workers?
- What are commissioners doing to increase smoking quit rates for City workers and residents in Portsoken?
- How are commissioners ensuring that services are integrated to ensure holistic health support for rough sleepers?
- In conjunction with information in Chapter 4, ‘Community life’, how can commissioners support organisations in building the resilience of City residents, including encouraging a greater take-up of physical exercise?

[A]Economic participation among residents

In the City, 77% of the resident population is of working age.[4] The population is too small for reliable estimates of economic activity to be made.

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

[A]Unemployment and out-of-work benefits

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

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

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

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

Table 6.1. Key benefits claimed by residents of the City of London, May 2013. Percentages are of the working age population (NOMIS/Department for Work and Pensions)

		The City	London
	Number	%	%
Jobseeker's Allowance	100	1.7%	3.9%
Incapacity Benefit/Employment and Support Allowance	130	2.3%	5.5%
Lone parents	–	–	1.5%
Carers	20	0.3%	1.0%
Others on income-related benefits	10	0.1%	0.4%

[4] NOMIS, 2011

Disabled	30	0.5%	0.8%
Bereaved	10	0.1%	0.1%
Key out-of-work benefits	240	3.2%	10.9%

[B]Adult learning

There is growing evidence of an association between participation in various types of adult learning and improvements in wellbeing, health and health-related behaviours. These benefits can be particularly strong for those people who left school without any qualifications, as well as older people. The Marmot Review[5] identified lifelong learning as one of the key interventions to reduce health inequalities.

Participation in adult learning may reduce the risk of developing depression, and may also encourage other healthy behaviours such as participation in exercise. There is a strong relationship between participation and self-reported life satisfaction and/or psychological wellbeing, and some studies also show that participation in adult learning can help older people to retain verbal ability, verbal memory and verbal fluency.[6]

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

Many varied people participate in lifelong learning courses in the City of London each year, with more than 50 subjects taught at different locations across the Square Mile. These include community centres, libraries, primary schools, children's centres, the Bishopsgate Institute, the Museum of London and Guildhall Art Gallery. In 2012, there were over 2,000 learners participating in 223 courses.

[A]Jobs within the City

The Office for National Statistics reported that there were 353,800 employees in the City of London in 2012.[7] Between 2001 and 2012, the City of London saw the biggest increase in employees across all 983 areas in London. In 2001 there were 259,500 people working in the City, and by 2012 this figure had risen to 353,800. This is the highest number of employees for any year in the dataset, and between 2011 and 2012 alone it rose by 26,300. This represents an increase of 36% in just over a decade (Figure 6.1).[8]

Employment trends show that the financial sector remains the dominant sector in the City (41%). A steady increase in employment levels since 2008 has seen professional and estate become a considerable industry in the City, comprising 27% of employment. Other sectors combined make up almost one-third (32%) of employment in the City, the most significant of which is administrative and education, which accounts for 15% of City employment (Figure 6.2).

Figure 6.1. Change in number of employees working in London, 2001-12

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

[6] British Academy (2014) *If you could do one thing…": Nine local actions to reduce health inequalities*
[7] Office for National Statistics (2013) *Small and Large Firms in London, 2001 to 2012*
[8] Alasdair Rae (2013) 'under the raedar' blog: Employee Growth in London, 2001 to 2012

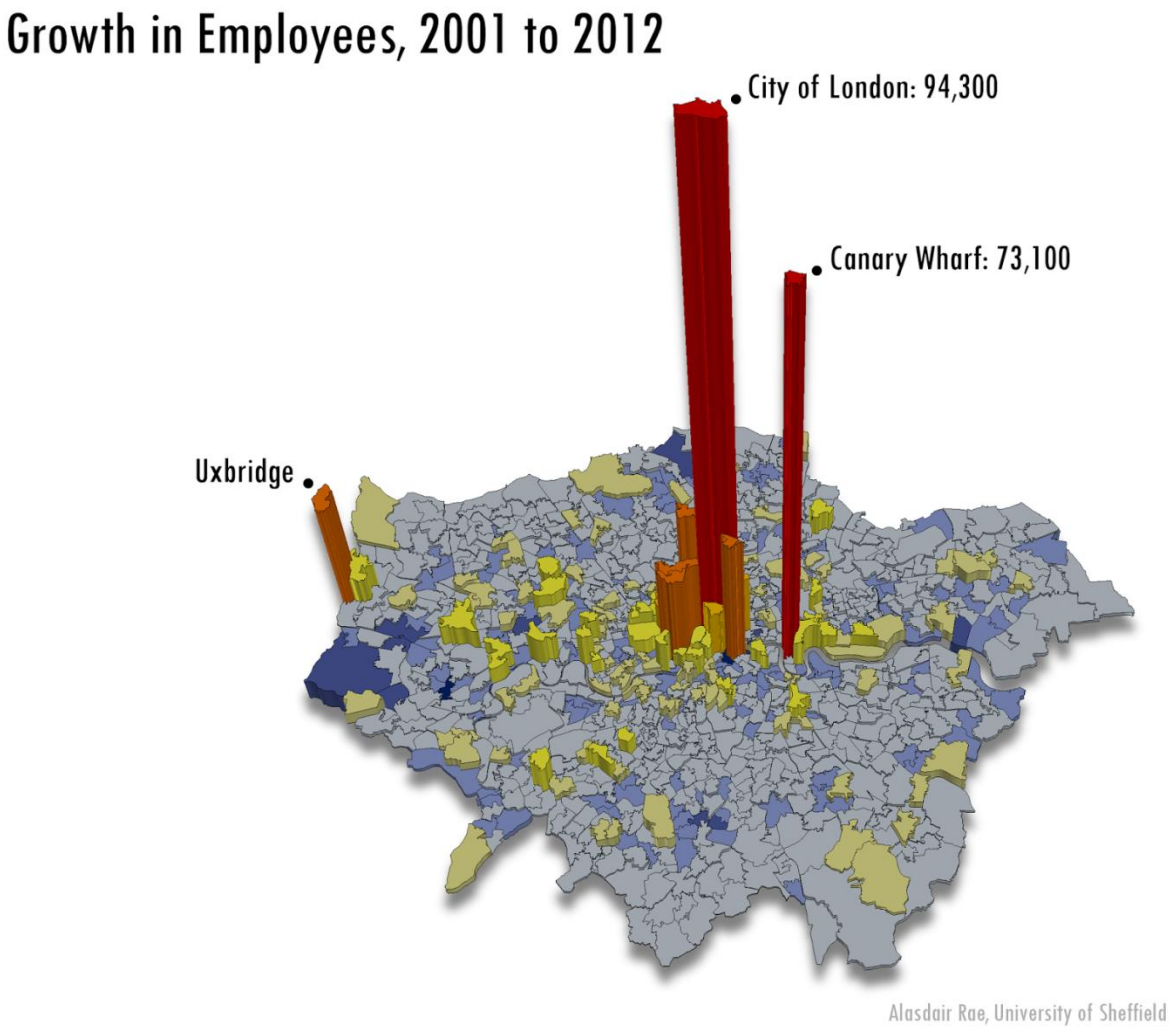
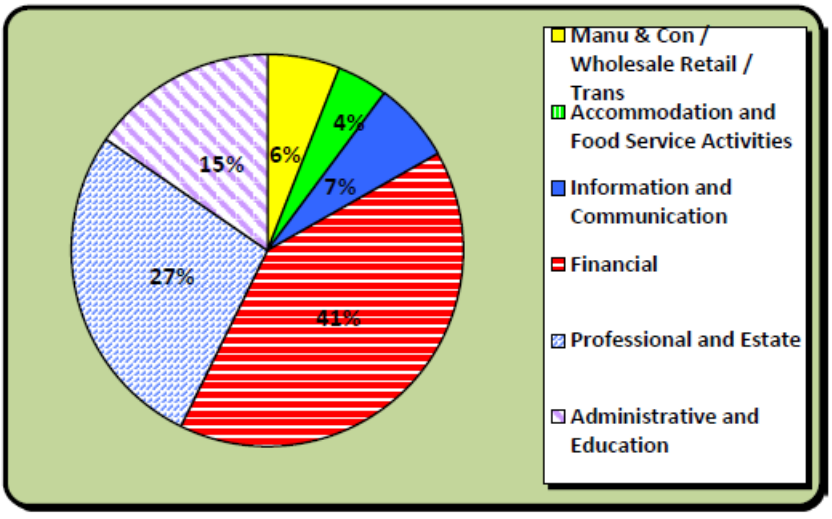


Figure 6.2. Employment by industry in the City, 2011 (Business Register Employment Survey)



There are distinct gender differences within the occupation profiles of jobs within the City. Management and senior official positions are more likely to be occupied by men. Administrative and personal services jobs are more likely to be occupied by women[9] (Figure 6.3).

Figure 6.3. Employment within the City: occupations by sex, 2010/11 (Labour Force Survey)

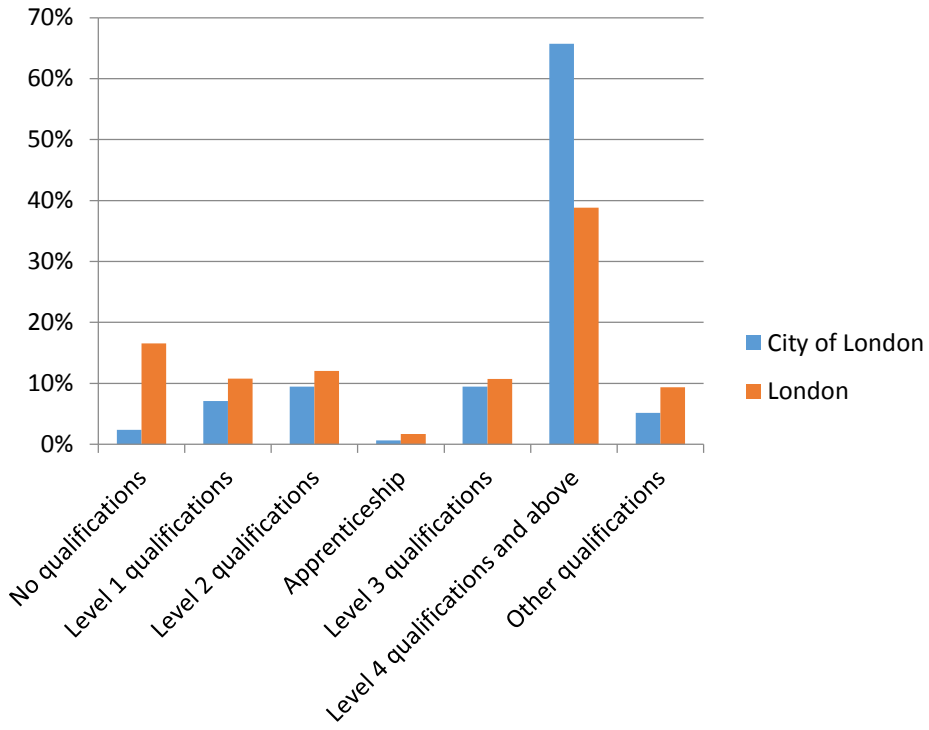
[A]Education and qualifications

[D]City workers

Two-thirds of City workers have at least a level 4 qualification, which exceeds the London average by 27%. Qualification levels are based on the Qualifications and Credit Framework, where levels 4 to 8 are obtained at university and include everything from certificates of higher education through to doctorates.[10] This greater proportion of level 4 qualifications is consistent with the work sectors traditionally seen in the City – that is, the financial and insurance sector (37%) and the associated professional services (18%), which require a higher level of education.[11] Education, income and housing tenure all have enduring associations with health, over time and across different diseases.[12] A highly educated working population is consistent with greater incomes and increased home ownership.

Figure 6.4. Highest levels of qualifications in London

[9] Labour Force Survey 2010/11
[10] OFQUAL (2012) UK Qualifications and Credit Framework. Available at: http://ofqual.gov.uk/help-and-advice/comparing-qualifications
[11] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[12] Health Development Agency (2004) *Health inequalities: concepts, frameworks and policy*



[A]Workplace health

Improving the health of adults of working age is a national public health priority. Workplace health is an essential component of the UK government strategy to tackle health inequalities and increase healthy life expectancy.[13] Working age ill health is estimated to cost the UK economy over £100bn a year. In 2011, a total of 131 million working days in the UK were lost because of sickness absence.[14]

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

The City of London was chosen as a pilot area for the London Healthy Workplace Charter, which is an initiative developed by the Department of Health (DH) and currently run by the Greater London Authority. The Healthy Workplace Charter is an accredited scheme for employers to demonstrate their commitment to workplace health. The scheme is being used within the City of London Corporation to demonstrate the Corporation's commitment to addressing these issues for our own staff. The Corporation has set the ambitious target of reaching the Charter's 'Excellence' standard.

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[13]. DH (2011) *Healthy Lives Healthy People: A Public Health Workforce Strategy*. Available at: www.phe.co.uk

[14]. Office for National Statistics (2012) *Sickness Absence in the Labour Market, April 2012*. Available at: http://www.ons.gov.uk/ons/dcp171776_265016.pdf

Business Healthy Conference

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

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

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

[A]Lifestyle and behaviours

[B]Smoking

[C]Prevalence

[D]Residents

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

Primary care data extracts for the whole City population show that 11% of residents are current smokers, but this figure rises to 21% for patients who are not registered with the Neaman practice (i.e. those who live in Portsoken).

[D]City workers

A survey of City workers in 2010[15] reported that 24.7% of respondents were smokers, representing approximately 91,000 people. This was above the average for both London (17%) and England (20%). Of the respondents who reported smoking, about 15.1% smoked regularly and 9.7% were occasional smokers.

[D]Rough sleepers

Research suggests that rough sleepers have very high smoking rates, with surveys showing that around 80 to 90% of people sleeping rough are smokers.[16] It is likely that smoking is a contributing

[15] *The Public Health and Primary Healthcare Needs of City Workers* (2012)
[16] Health Development Agency (2004) *Homelessness, smoking and health*

factor to the poor health of rough sleepers, but that rough sleepers find it much harder to access the smoking cessation services that more advantaged people take for granted.

[C]Quitting

In the City, 1,145 people set a quit date in 2012/13, of whom 606 (53%) went on to be successful four-week quitters. Table 6.2 shows the quit rates across different population subgroups. The majority of those accessing stop smoking services were City workers rather than residents, and most were in managerial or professional roles. However, quit rates were slightly higher among the smaller numbers of people in intermediate professions, those not employed and those aged 60 or over. Quit rates were lower among 18 to 34-year-olds and the white British/Irish population.

Table 1.2. People in the City not smoking four weeks after quitting: absolute number and percentage quit rate by population subgroup, 2012/13 (Source: DH)

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

[C]Smoking cessation support services

A total of 16 pharmacies in the City have signed up to deliver Level II smoking cessation support services. These pharmacies display the local 'Quit Here' branding in order to raise the profile of the service. In 2012/13, 64% of smokers accessing support to give up smoking in the City did so through their local pharmacy.

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

In total, 87% of the pharmacies achieved or exceeded the minimum recommended quit rate, although overall there was a slight decrease in the number of four-week quitters compared with the previous year. This mirrors the national trend of a decrease in the number of smokers using stop smoking services, which is thought to be linked to the introduction of e-cigarettes (that is, more smokers are choosing to quit without help from services). The quit rate increased from 44% to 51%, which suggests that the quality of stop smoking services in pharmacies is increasing.

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

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

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

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

[B]Physical activity

[C]Sport and physical activity among adults

Sport England's Active People Survey for 2012/13 (published in June 2013) states that 38.2% of adults resident in the City take part in at least one 30-minute session of moderate intensity activity per week. This compares with a London average of 36% and a national average of 35%.

A local survey conducted with both residents and non-residents in the City revealed that the non-participation rate among females is above the national average at 29%, compared with 19% for males. There is also a high non-participation rate (34%) among people with a disability (the national average is 25%).

Encouragingly, 58% of survey participants did all their sport inside the Square Mile, and 69% of City workers said that they would like to do more sport (32% of those were specifically interested in swimming). Respondents said that if the location was convenient – for example, accessible during lunchtimes – then their levels of activity would increase.

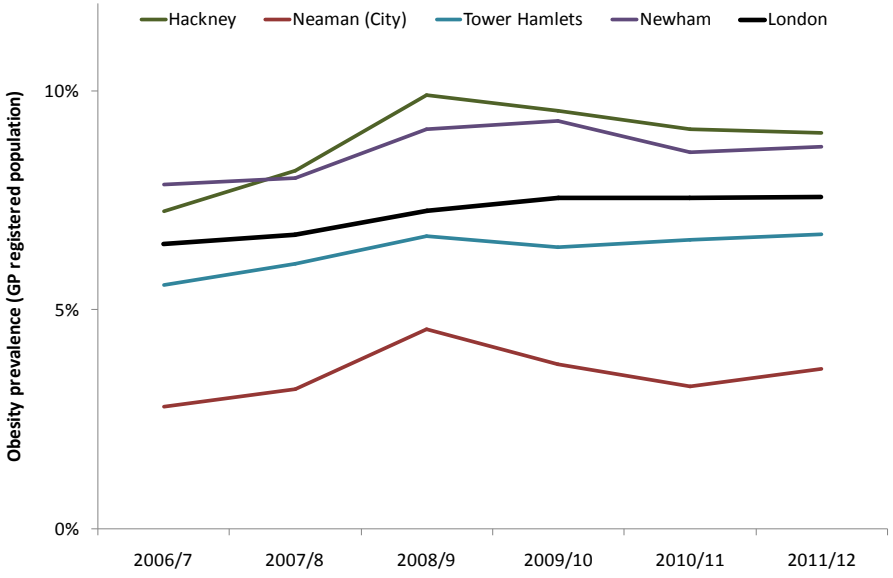
[B]Obesity

Obesity data comes from two sources: Quality and Outcomes Framework (QOF) data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

Around 4% of adults registered with the Neaman practice are obese, which is lower than the rates for surrounding areas and London as a whole (Figure 6.5).

Primary care data extracts for the whole City population estimate that 9% of residents are obese, but that obesity might be as high as 15% in patients who are not registered with the Neaman practice (i.e. those who live in Portsoken).

Figure 6.5. Obese adults as recorded in general practice (QOF)



[B]Alcohol

[C]Levels of alcohol consumption

Synthetic estimates of alcohol consumption in 2012 by City residents suggest a slightly higher level of risk than the average for London (Table 6.3). Compared with the previous year, there seems to be a variable trend in risk. The number of individuals who abstain from alcohol has decreased, but those deemed to be at increasing risk has also reduced compared with the previous year. This may be linked to the ethnic profile of City residents.

[D]City workers

A report on drinking among City workers published in January 2012 found the prevalence of alcohol misuse in 2011 to be a significant issue, as summarised in Table 6.3. A total of 33.4% of City drinkers are at increased risk of alcohol-related harms, compared with 20.1% nationally.[17] These drinkers are not yet necessarily experiencing alcohol-related harms, but are increasing their risk of health and social problems. In total, 12.4% of City drinkers were drinking at a higher risk level, compared with 3.8% in the national population and 8% in London as a whole.[18] Higher risk drinkers are already experiencing alcohol-related harms and many have some level of alcohol dependency.

The scores are derived from the Alcohol Use Disorders Identification Test (AUDIT), a validated health screening tool developed by the World Health Organization. The full 10-question AUDIT places respondents in one of four main categories, ranging from 'lower risk' to 'possible dependence'.

Alcohol misuse in the City may in part be attributed to a complex range of factors such as higher average wealth, high-pressure or risk-based work environments, a culture of entertaining clients and high use of public transport.

Alcohol misuse among both male (56.2%) and female (34.1%) City drinkers is considerably higher than the national averages (33.2% for men and 15.7% for women).[19] Young white males are the predominant misusers of alcohol.

Table 6.3. Estimates of alcohol consumption by City residents and City drinkers by DH risk category, 2011 and 2012[20,21,22]

	Abstain (%)		Lower (%)		Increasing (%)		Higher (%)		Source
	2011	2012	2011	2012	2011	2012	2011	2012	
City residents	19%	14%	50%	70%	22%	22%	8%	9%	*NWPHO*
City workers	–	–	–	–	33%	–	12%	–	*Insight into City Drinkers*
London	24%	22%	52%	73%	16%	20%	8%	7%	*NWPHO*
National	–	–	–	–	20%	–	4%	–	*APMS 2007*

Table 6.4. AUDIT categories by score range

[17] *Insight into City Drinkers* (2012)
[18] ibid
[19] ibid
[20] North West Public Health Observatory (2012) *Local Alcohol Profiles for England (2012 Refresh)*
[21] *Insight into City Drinkers* (2012)
[22] Adult Psychiatric Misuse Survey 2007

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

Source: *Insight into City Drinkers* (2012)

[C]Health impacts of alcohol

The annual alcohol-attributable death rate in the City's resident population is 49.6 per 100,000 men and 2.3 per 100,000 women (age-standardised rate). This gives the City the second lowest rate in the country for women. However, it should be noted that rates in the City can jump dramatically due to the low resident numbers. Alcohol-attributable hospital admissions are also very low in the City's resident population (Table 6.5). There were 17 individuals in contact with structured alcohol treatment in 2012/13, 40% of whom completed treatment successfully.

Table 6.5. Alcohol-attributable hospital admissions for men and women in the City in 2012/13, compared with London average, and national rank (where rank 1 is best)[23]

The City			London
	Rate per 100,000 standardised	National rank (out of 354)	Rate per 100,000 standardised
Men	969.7	7	1,535.9
Women	289.0	1	810.9

[D]City workers

Compared with national averages, alcohol-related problems in City workers may be disproportionately social rather than health harms. Health-related problems were less reported than social or behavioural problems (e.g. injury or remorse).[24]

[23] North West Public Health Observatory (2011) *Local Alcohol Profiles 2011*
[24] *Insight into City Drinkers* (2012)

[C]Crime and anti-social behaviour

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

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

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

[B]Substance misuse

[C]Prevalence of drug use

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

[C]Health impacts of drug use

Between April 2007 and March 2013, there were 36,356 incidents leading to ambulance callouts in the City of London, with 304 (0.8%) flagged as being drug related. A total of 48% of the callouts were for individuals under the age of 35, 56% were for males and 41% were for females (3% were not recorded).

[C]Emerging trends in drug use

[D]Residents

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

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

[C]Treatment and engagement

[D]Residents
A total of 24 individuals entered the treatment system in 2012/13, adding to the 17 who were already in treatment on 1 April 2012. It is encouraging that the highest number of referrals were self-referrals; the second highest number came from GPs. These were predominantly for people with a primary alcohol problem.

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

[C]Harm reduction

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

[A]Sexual health

[B]Sexually transmitted infections (STIs)

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

[C]Chlamydia screening

Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may have serious reproductive health consequences. Public Health England recommends that local areas achieve a testing rate of at least 2,300 per 100,000 resident 15 to 24-year-olds, a level which is expected to produce a decrease in the prevalence of chlamydia. Nationally between January and December 2012, 26% of 15 to 24-year-olds were tested for chlamydia, with an 8% positivity rate.

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

[C]Human Immunodeficiency Virus (HIV)

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

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

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

[D]City workers

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

[D]Rough sleepers

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

[A]Mental health

[B]Prevalence of mental illness

It is estimated that one in four people in the UK will suffer a mental health problem over the course of a year.[25] At any one time, an estimated one in six adults of working age experiences symptoms of mental illness that impair their ability to function. A further sixth of the population have symptoms (such as anxiety or depression) that are severe enough to require healthcare treatment. Between 1% and 2% of the population are likely to have more severe mental illnesses such as schizophrenia or bipolar affective disorder, which require intensive and often continuing treatment and care.

[C]Depression

Data on depression in City residents comes from three sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); primary care data extracts, which are of unknown accuracy; and modelled estimates, based on the 'types' of people who live in the City.

In 2012/13, the crude prevalence of depression recorded by the Neaman practice was 3.4% (267 individuals).

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

Primary care data extracts for the whole City population show that 2% of residents have depression, although some modelled estimates put the prevalence of depression as high as 5%.

[C]Severe mental illness

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

[C]Suicide

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

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

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

The suicide prevention strategy identifies some effective local interventions as:

- prevention – putting up barriers, nets, etc and providing emergency telephone numbers
- working with planning departments and developers to include suicide risk in health and safety considerations when designing tall buildings
- working with the media to encourage responsible reporting of suicides

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

[D]City workers

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

[D]Rough sleepers

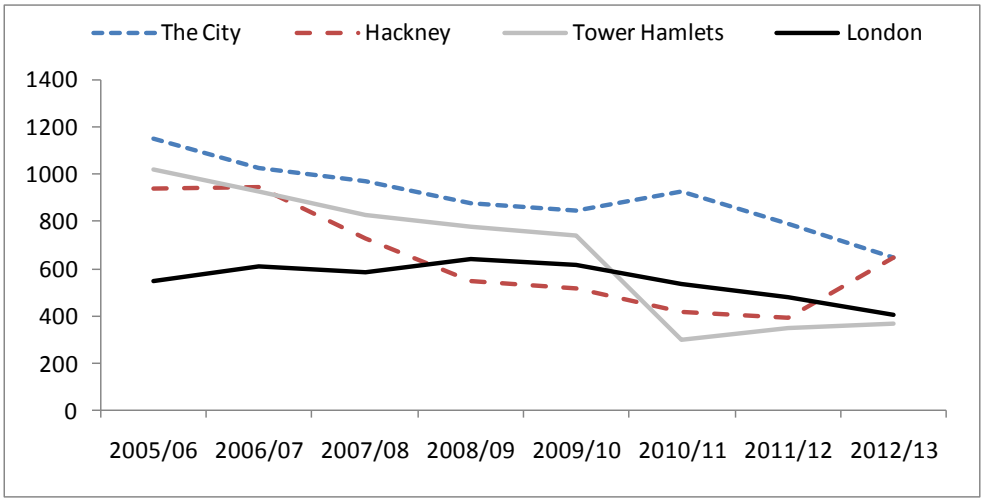
A national audit of the health and wellbeing of homeless people found that seven out of 10 had one or more mental health needs, a rate over twice that of the general population.[26] Within the City, the Combined Homeless and Information Network (CHAIN) database has identified 45% of rough sleepers as having a mental health issue.

[B]Social care for people with mental health difficulties

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

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

Figure 6.6. Number of adults (aged 18 to 64) with mental health problems receiving care packages per 100,000 population, 2005-13



Source: National Adult Social Care Intelligence Service

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

[A]Carers

[B]Support for carers

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

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

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

Caring role

G is the informal carer for T, who suffers from a neurodegenerative condition and is dependent on G in all areas of daily life. T is in a wheelchair and has some speech limitations, which means that G occasionally has to articulate his wishes for him.

Carer needs and support

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

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

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

[B]Carers in the City

The City Carers' Register lists 58 known carers of clients aged over 18. According to the Census 2011,[27] 576 City residents (7.8%) have some caring responsibilities, with 121 of these carers providing over 21 hours of unpaid care per week. Although lower than the national average, this figure indicates that many people are giving care in the City who are unknown to the Carers' Register.

[27] Office for National Statistics, Census 2011

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

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

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

The City of London Carers' Strategy, published in 2011,[28] recognises the significant contribution that carers make to the wellbeing of service users and residents. It sets out an approach whereby carers are able to design and direct their own support by engaging in the support plan of those they care for, and ensuring that support is tailored to their specific needs.

[D]City workers

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

[A]Disability

[B]Learning disabilities

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

For more information about learning disabilities, see **Error! Reference source not found.**'.

[B]Physical disabilities

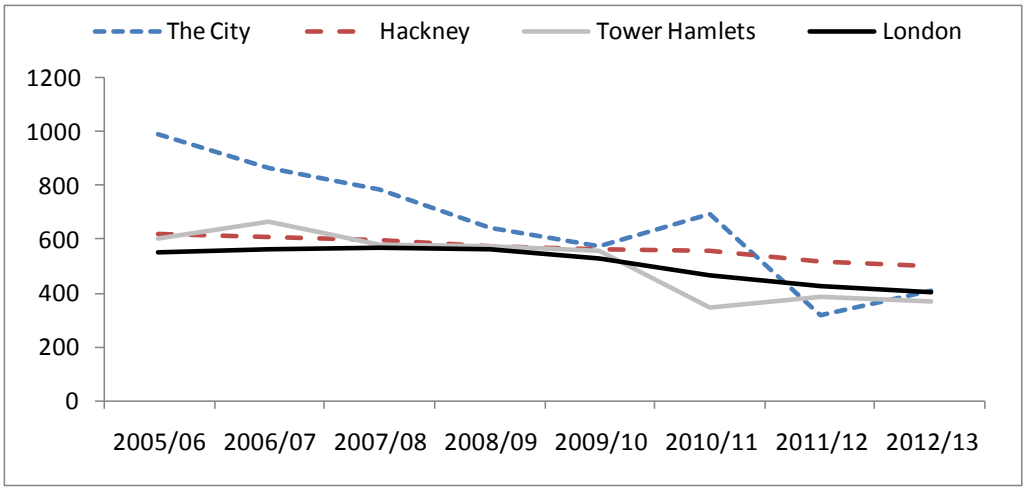
In 2012/13 the City of London provided services to 113 clients with physical disabilities, of whom 80% were aged over 65. A total of 56% of these clients received community-based support (not

[28] City of London Carers' Strategy, 2011

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

The number of people receiving ongoing support from the City of London Corporation has decreased since 2005/06, with a 46% drop in the rate per 100,000 population (Figure 6.7).

Figure 6.7. Adults with physical disabilities receiving care packages per 100,000 population, 2005-13



[C]Visual impairment

In 2010/11 there were nine people on the City's Visual Impairment Register, with fewer than five registered in each category as partially sighted, blind or deaf/blind.