# 8. Healthy life[CH]

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

## *[C]Key findings*

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

### *[D]Residents*

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

### *[D]City workers*

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

### *[D]Rough sleepers*

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

## [C]Recommendations

- Expanding pharmacy services could be an effective way to improve the health of City workers.
- Better linkage of health and social care with community assets from the voluntary sector has the potential to relieve pressures on care services, while building a more resilient community for the City's resident population.

#### *[D]City workers*

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

#### *[D]Rough sleepers*

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

## [C]Questions for commissioners

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

# [A]Chronic disease

## [B]Cancer

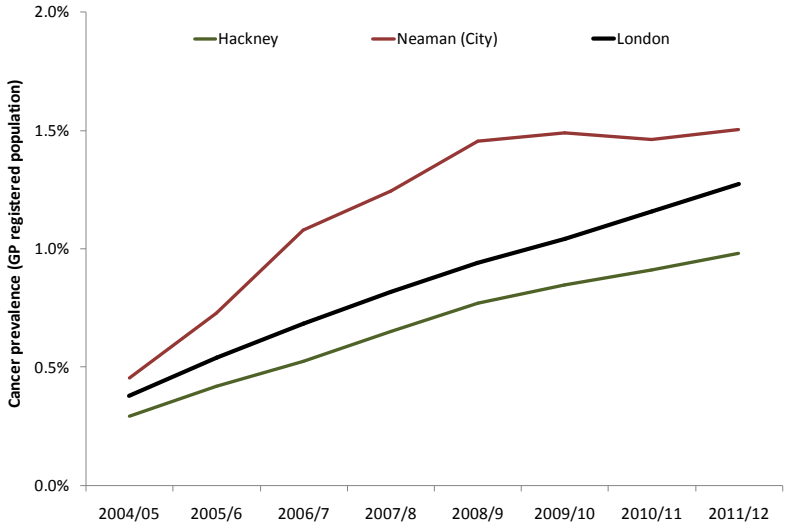
[C]Prevalence

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

In 2011/12 the crude prevalence of cancer recorded by the Neaman practice was 1.5% (134 individuals). This rate is relatively high due to the older population (rates are not age-standardised).

Primary care data extracts for the whole of the City suggest that the prevalence of cancer might be as high as 3%.

**Figure 8.1. Crude prevalence of cancer in the GP-registered population, 2006-12 (QOF)**



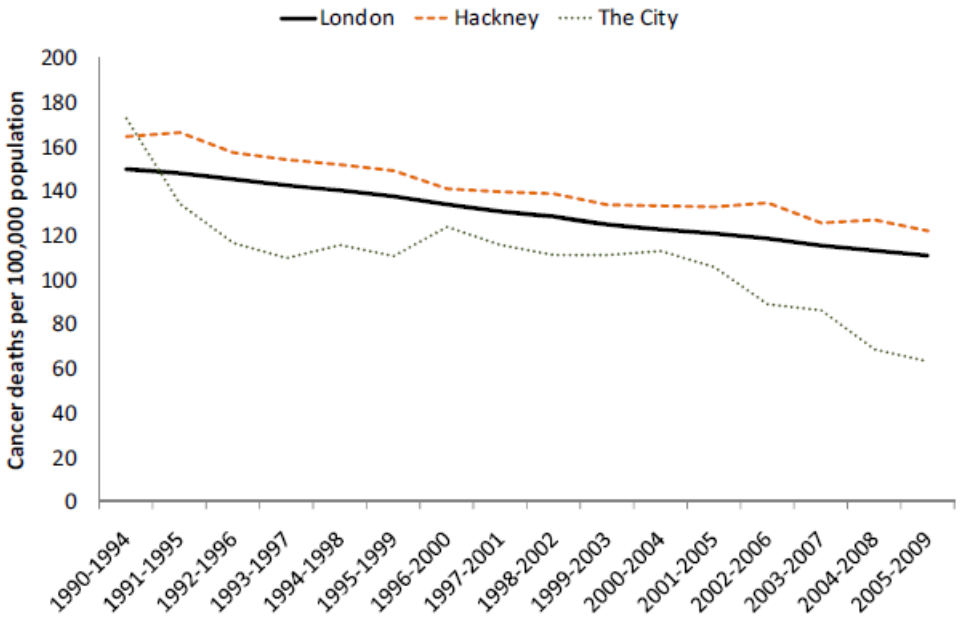

[C]Death and survival rates

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

Figures 8.2 and 8.3 illustrate the long-term trends in deaths from all cancers and from premature cancer (cancer affecting the under-75s). Both rates in the City are well below the average for London, and premature deaths from cancer have fallen markedly over the last six years.

**Figure 8.2. Long-term trend in deaths from all cancers, at all ages (Thames Cancer Registry)**


**Figure 8.3. Long-term trend in deaths from premature (<75) cancer (Thames Cancer Registry)**



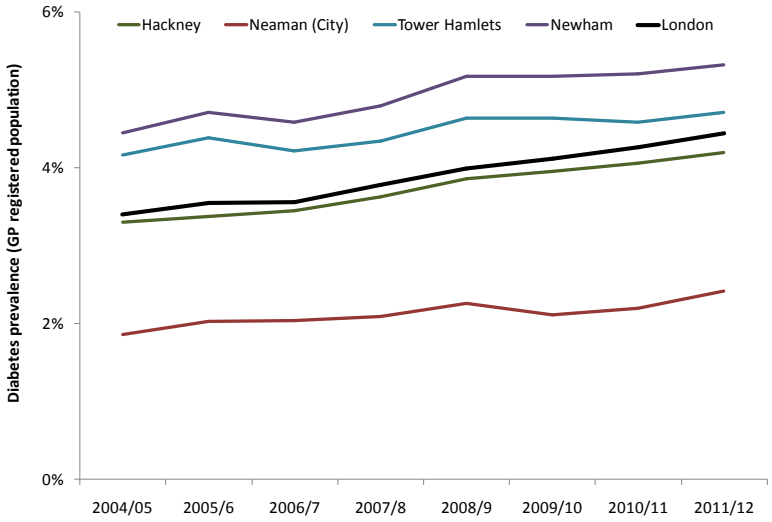

# [B]Diabetes

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

In 2011/12, the crude prevalence of diabetes recorded by the Neaman practice was 2.4% (215 individuals).

Primary care data extracts for the whole City population are similar, suggesting that diabetes affects about 3% of the City's population.

**Figure 8.4. Prevalence of diabetes, 2004-12 (QOF)**



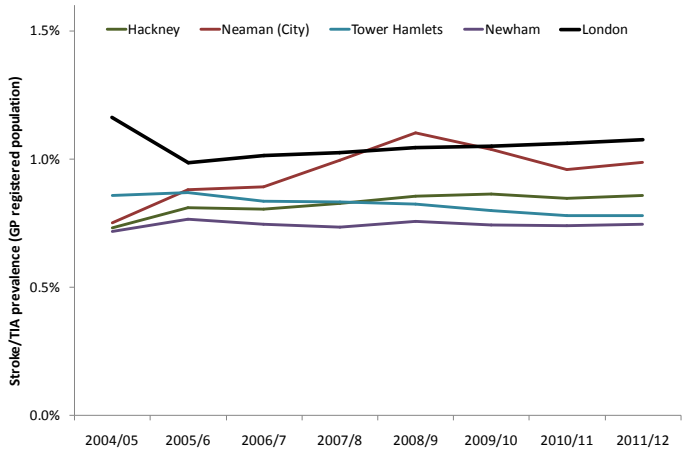
## [B]Stroke and transient ischemic attack (TIA)

Data on stroke and TIA prevalence comes from two sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

In 2011/12, the crude prevalence of stroke recorded by the Neaman practice was 1.0% (88 individuals) (Figure 8.5).

Primary care data extracts for the whole City population are similar, showing that 1% of City residents are affected by stroke.

**Figure 8.5. Crude prevalence of stroke/TIA in the GP-registered population, 2004-12 (QOF)**




## [B]Hypertension

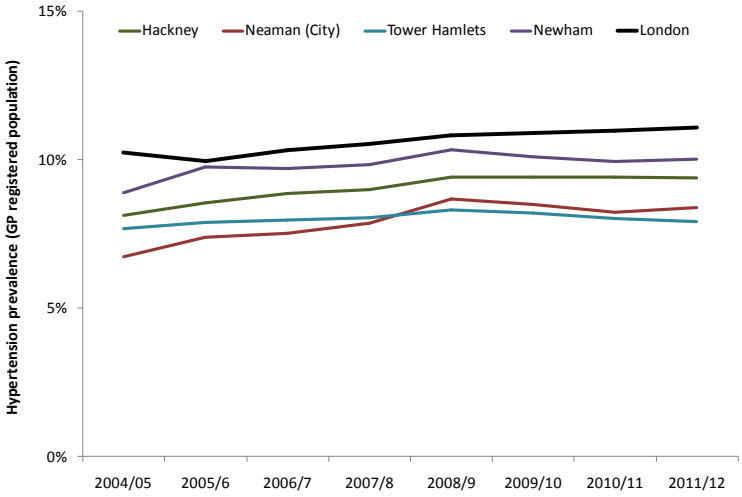
Data on hypertension prevalence comes from two sources: QOF data for patients registered at the Neaman practice in the north-west of the City (which the GPs compile); and primary care data extracts, which are of unknown accuracy.

In 2011/12, the crude prevalence of hypertension recorded by the Neaman practice was 8.4% (746 individuals).[1] This rate has been stable for the last four years (Figure 8.6).

Primary care data extracts for the whole City population estimate that 10% of residents have hypertension, but that this figure might be as high as 16% in patients who are not registered with the Neaman practice (i.e. those who live in Portsoken).

**Figure 8.6. Crude prevalence of hypertension in the GP-registered population, 2004-12 (QOF)**

[1] QOF data



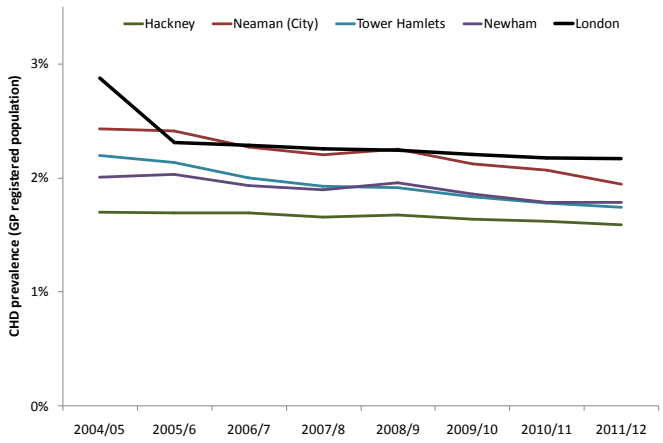

## [B]Coronary heart disease (CHD)

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

In 2010/11, the crude prevalence of CHD recorded by the Neaman practice was 1.9% (173 individuals).[2] This is comparable with the average for London. Prevalence has fallen slightly in the past eight years (Figure 8.7).

Primary care data extracts for the whole City population are similar, showing that about 2% of residents have CHD.

**Figure 8.7. Prevalence of CHD in the GP-registered population, 2004-12 (QOF)**




## [B]Sickle cell disease

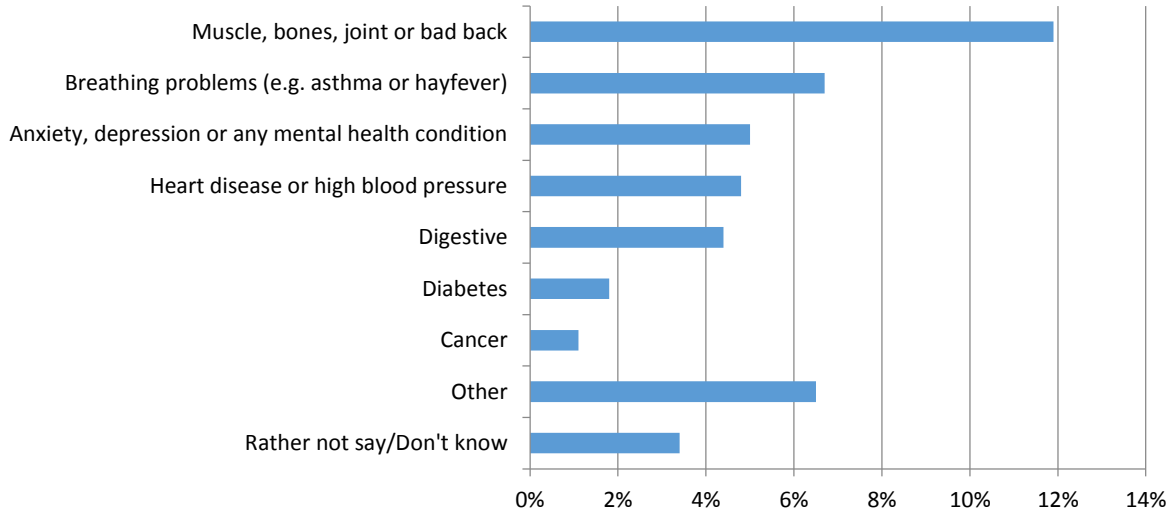
There were no hospital admissions for sickle cell disease in the City in 2010/11.

[2] QOF data

### *[D]City workers*

When asked, 'Do you have a health problem which has lasted, or is expected to last, at least 12 months?' City of London workers listed a range of conditions (multiple answers per respondent were allowed). Musculoskeletal, respiratory and mental health problems were the most common health conditions identified (Figure 8.8).

**Figure 8.8. City worker responses to the question, 'Do you have a health problem which has lasted, or is expected to last, at least 12 months?'**




# [A]Infectious diseases

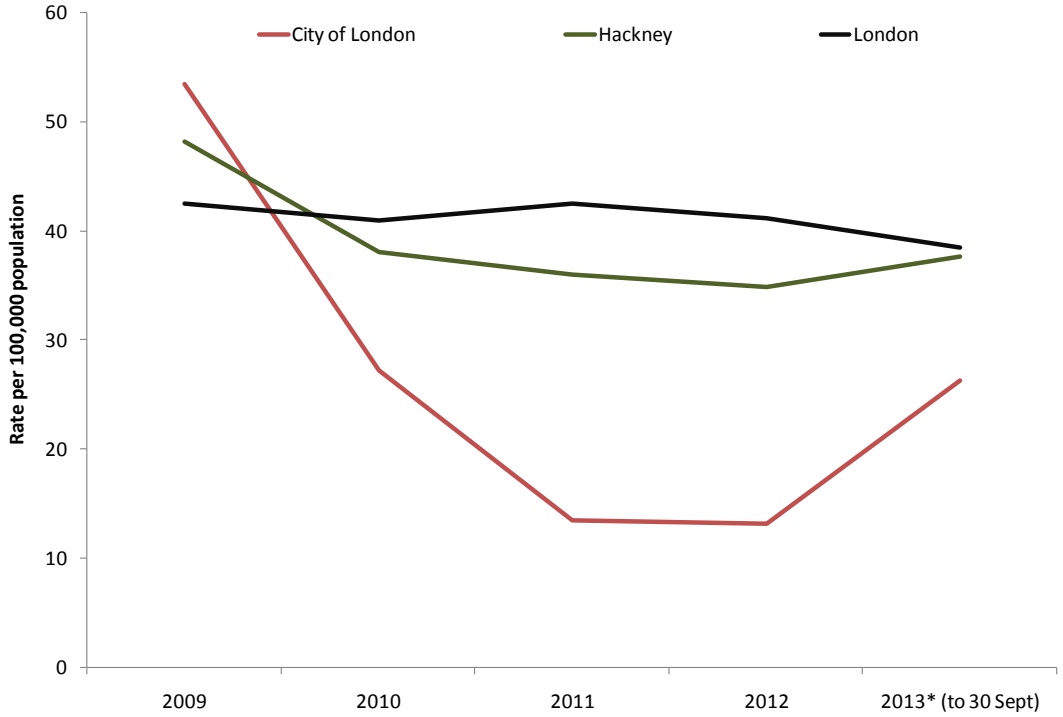
## [B]Hepatitis C

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

## [B]Tuberculosis (TB)

The rate of TB incidence among City residents has been steadily declining over the last few years, with a small upturn between 2012 and 2013. However, these rates are based on very small numbers.

**Figure 8.9. TB incidence among residents of the City, Hackney and London, 2009-13 (Public Health England)**




### *[D]City workers*

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

### *[D]Rough sleepers*

Rough sleepers are vulnerable to TB, with some studies showing that up to 15% of rough sleepers have past or active TB.[3] Compliance with treatment can be a particular issue for rough sleepers. The City's Homelessness Team works closely with Public Health England to manage active cases of TB in rough sleepers.

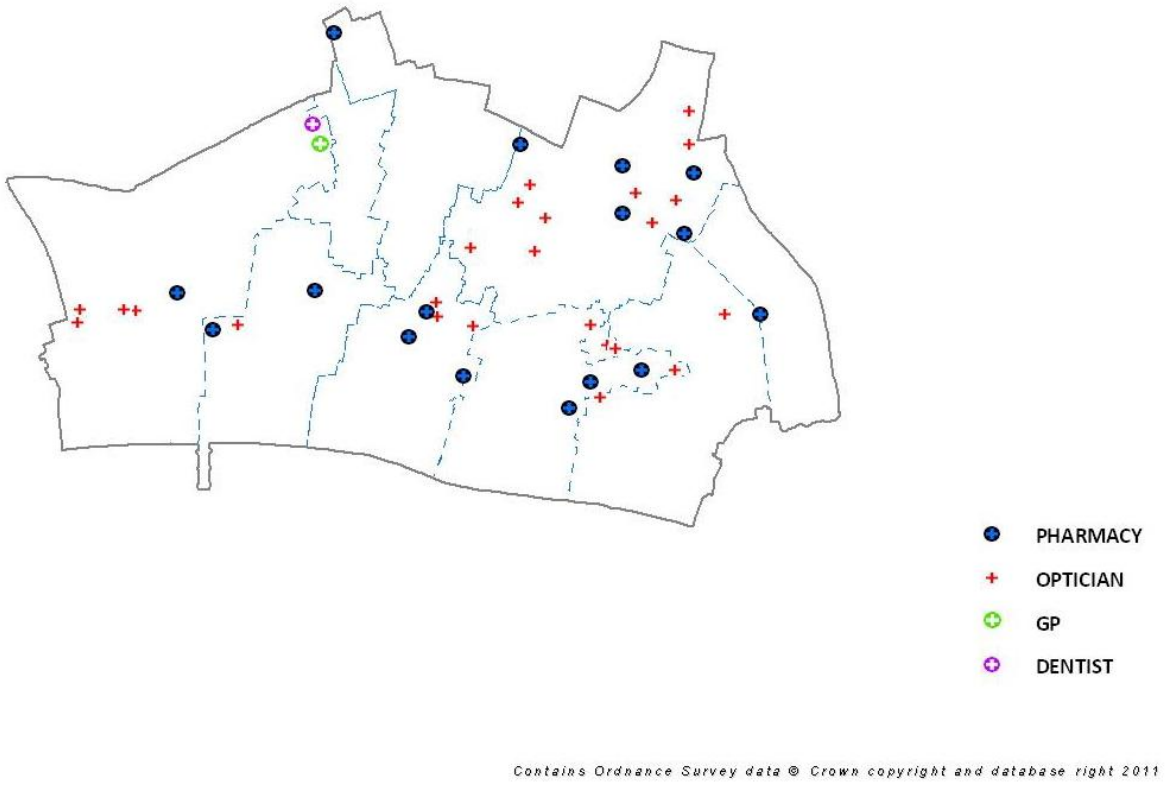
# [A]Health services

## [B]Primary care

Primary care services include the many services provided at GP practices, dentists, pharmacists and optometrists. The geographical distribution of these services in the City is shown in Figure 8.10. In addition, optometry is delivered in residents' homes where necessary, and GPs also offer home visits to residents.

**Figure 8.10. Primary care services in the City**

[3] NHS North West London (2013) *Rough sleepers: health and healthcare*. Available at: http://homeless.org.uk/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf



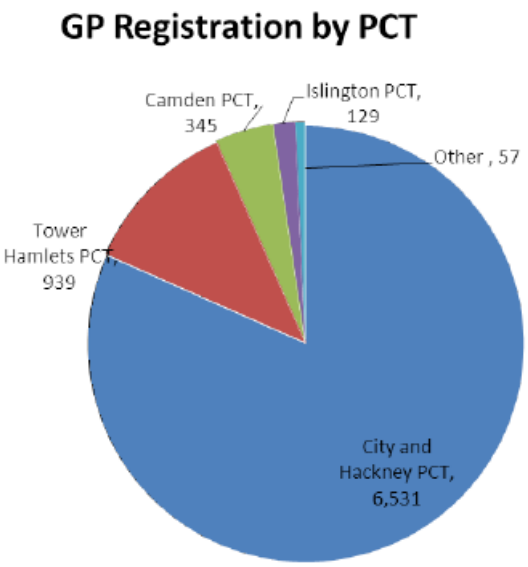

## [B]GP registrations

The majority of City residents are registered with the Neaman practice in the City of London (81%), with the second largest registration being at the Spitalfields practice in Tower Hamlets (9%) (Figure 8.11).[4] Overall, 18% of residents are registered outside City and Hackney Clinical Commissioning Group (CCG); the majority of these (12%) are registered with GPs in Tower Hamlets. While the practice with the third largest registration of City residents is in Camden, only 4% of City residents are registered with a GP in Camden CCG.[5]

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

**Figure 8.11. GP registration of City residents**

[4] City and Hackney CCG (2012) 'Mapping of health services in the City of London' (paper presented to City of London Health and Wellbeing Board)
[5] City and Hackney CCG (2012) 'Mapping of health services in the City of London' (paper presented to City of London Health and Wellbeing Board)




**Practices with largest number of City Residents**

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

Source: 'Mapping of health services in the City of London', 2012

### *[D]City workers*

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

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

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

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

### *[D]Rough sleepers*

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

## [B]Dental services

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

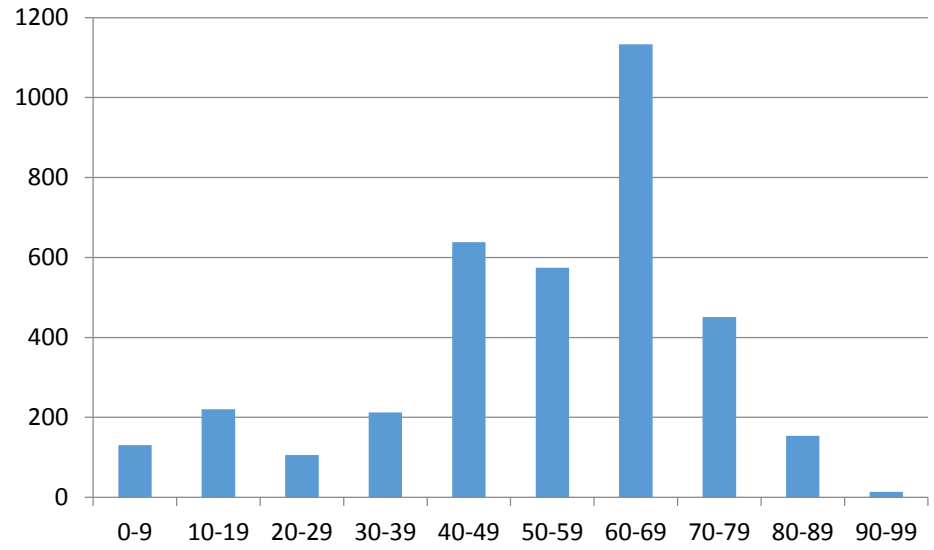
During the period April 2010 to March 2011, residents of the City accessed NHS dental services in the neighbouring boroughs of Hackney, Tower Hamlets, Camden and Islington. The number of

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

## [B]Optometry

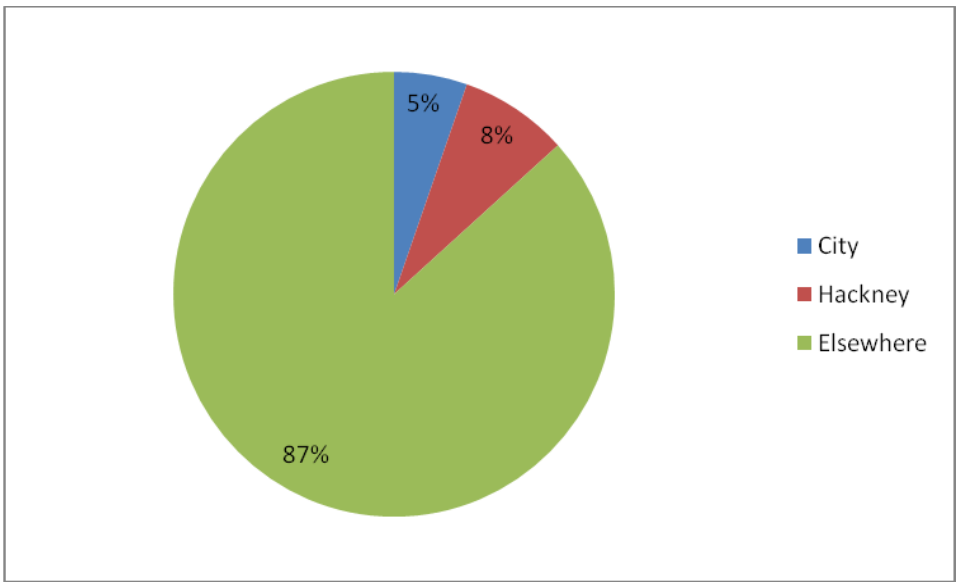
In 2009/10, NHS sight tests in the City were predominantly performed on people aged 40 or over.

**Figure 8.12. Age profile of those receiving NHS sight tests from optometrists located in the City**




In 2009/10, only 5% of reported NHS sight tests in the City were performed on City residents, with the rest being performed on non-residents, including 8% on people from Hackney (Figure 8.13).

**Figure 8.13. Residency of those undergoing NHS sight tests with optometrists located in the City**



# [B]Pharmacies and prescribing

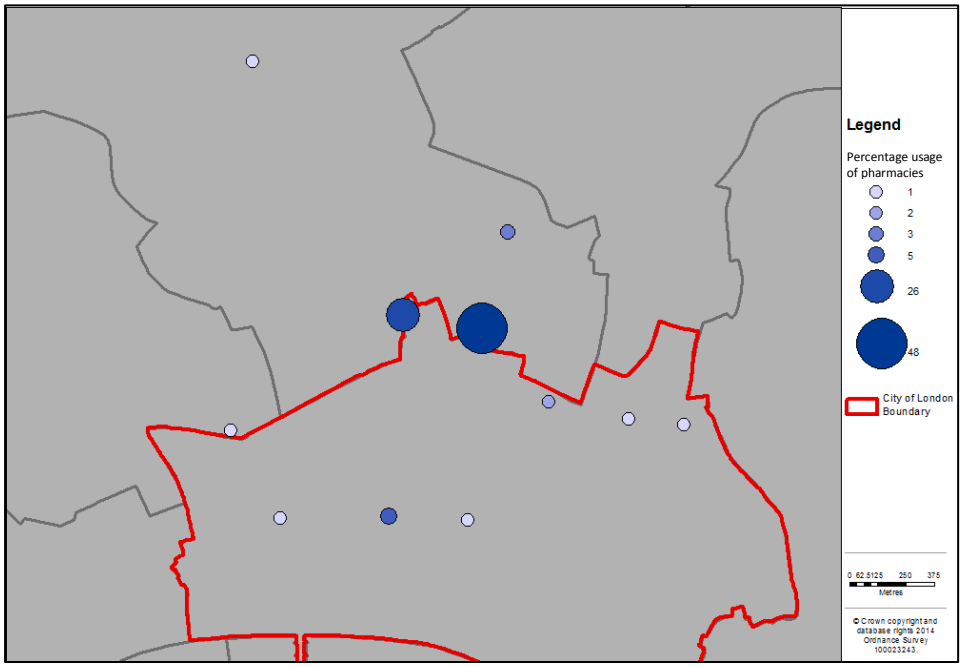
Community pharmacies have had an important role to play in reducing health inequalities, through increasing access to health information, prevention and screening services, signposting patients to other services and supporting them to take medication. There is potential to expand pharmacy services in order to meet local health needs.

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

- chlamydia screening and treatment services, targeting young people in particular
- minor ailments service
- weight management service, designed to help people manage their diet and exercise and maintain a healthy weight
- emergency hormonal contraception service
- Freedom condom distribution service
- drug misuse services, including needle exchange and supervised consumption
- TB treatment supervision service, supporting people with TB to adhere to therapy
- seasonal flu vaccination service
- stop smoking service

An analysis of prescriptions issued by the Neaman practice between June and December 2011[6] showed the locations where prescriptions were being dispensed. As can be seen, the majority of prescriptions were dispensed from two independent pharmacies, one of which is located in Islington.

**Figure 8.14. Percentage usage of pharmacies by Neaman practice patients, 2011**




[6] ePACT.net, 2011

### *[D]Rough sleepers*

Although there is no City-specific data, the healthcare utilisation and costs of rough sleepers in the City are likely to reflect patterns seen among rough sleepers assessed in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster.[7] The following healthcare needs and utilisation patterns were observed:

- Secondary healthcare costs are at least five times higher for rough sleepers than for the general population.
- Rough sleepers access A&E seven times more than the general population.
- They are more likely to be admitted to hospital as emergency cases, costing four times more than elective in-patients.
- They are four times more likely to attend out-patient health appointments (discounting 'did not attends') than the general population.
- They stay in hospital twice as long as the general population.
- They have more co-morbidity. One in five rough sleepers who had contact with a hospital had three or more diseases.
- Their healthcare usage increases over time.
- Hospital usage is highest among 30 to 49-year-old men and costs are significantly higher than for the general population.
- Most rough sleepers had clinical conditions related to mental health, trauma and orthopaedics, the digestive system and ophthalmology.

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

***Housing history***

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

***Health issues***

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

***Other issues***

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

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

Nearly half of those rough sleepers who attended hospital used all three hospital services (out-patient, in-patient and A&E).

[7] NHS North West London (2013) *Rough sleepers: health and healthcare*. Available at: http://homeless.org.uk/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf

# [A]Social care services

In 2011 the City of London held a number of consultations with service users and partners on changes to the way adult social care was to be delivered. In the wake of these consultations, the following changes were made:

- **Supported Assessment Questionnaire (SAQ)**
  The SAQ is designed to enable adult social care staff to gather relevant information from individuals who may require support to maintain their independence and choice.

- **Resource Allocation System (RAS)**
  The RAS allocates points to propose an indicative individual budget and agree a support plan, which can be managed through a direct payment to the service user themselves or via a third party agency.

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

***Better Care Fund***

*The Better Care Fund (BCF) was announced as part of the government's 2013 Spending Review. It brings together separate strands of funding, providing an opportunity to transform local services in order to deliver better integration of care and support, and better outcomes for individuals.*

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

- *person-centred care and support*
- *seven-day services in health and social care*
- *early intervention and prevention*
- *better data and information sharing to support care*
- *joined up and co-ordinated services, and support for carers*

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

- **Adherence to the Fair Access to Care Services (FACS) eligibility criteria**

  Under FACS there are four bands of eligibility:

  - Substantial/Critical: eligible for an individual budget
  - Low/Moderate: eligible for advice and information **[TYPESETTER: PLEASE USE EN DASHES FOR SUB-BULLETS]**

- **Carers' Strategy and carer's individual budgets**
  Carers are assessed through the SAQ so that their needs are addressed. The amount of financial support offered to carers has been increased. Those with Moderate eligibility receive an individual budget of £150; those with Substantial eligibility receive £750; and those with Critical eligibility receive £3,000.

- **Small grants scheme**

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

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

## [B]Performance data

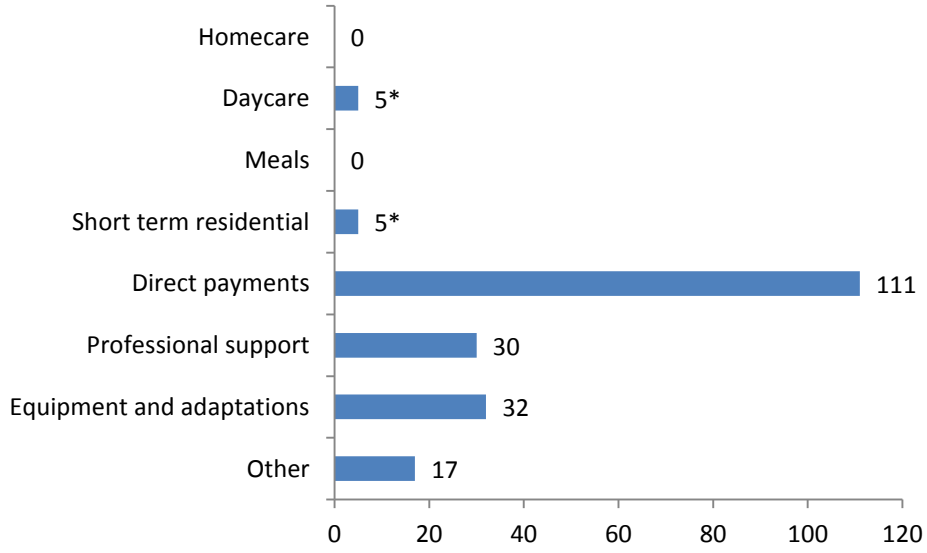
In 2011/12 the City of London carried out its first Adult Social Care User Survey. The survey had an excellent response rate of 63%. Of those who responded, 83% felt that the services they received made them feel safe and secure. In total, 74% of users felt that they had control over their daily life, and 70% of users found it easy to access information about services.

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

These social care clients were 88% white, 5% Asian, 3% black and 4% of mixed or other ethnicities. Compared with the Greater London Authority ethnic profile for the City, white clients are over-represented and Asian clients are under-represented. However, the numbers are relatively small so variations do not necessarily reflect inequalities in access.

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

**Figure 8.15. Community social care services received from the City of London Corporation, 2012/13 (some clients receive more than one service)**




* Fewer than five individuals were reported

## [B]Direct payments

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

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

## [B]Safeguarding

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

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

*A was admitted to hospital after he was found by district nurses (who visit three times a week) to be suffering from dehydration and confusion. He had been so confused that he had not used his pendant alarm. He was discharged back home with help from the reablement service, with care to be provided by an agency during evenings and weekends.*

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

***Safeguarding process***

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

*The agency worker who failed to attend was suspended pending further investigation and was dealt with by the agency's disciplinary procedures. The cause was identified during the investigation as the carer taking annual leave without appropriate approval, after which the agency responded with adjustments to their policies.*

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

# [A]The voluntary and community sector

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

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

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

## [B]Time Credits

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

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

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